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7. The Future of Clinical Assessment

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At the outset, this writer’s frame of reference should be made clear. It is the perspective of the author of a book that contains more than five hundred references from the scientific and professional literature which raise doubts about the expertise of clinicians in their role as diagnosticians in general, and also, specifically, within the forensic arena. The perspective further is that of one who provides a consultation service to lawyers pointing out to them the weakness and shortcomings of psychiatric and psychological reports and testimony both in terms of the inherent problems and of any specific deficiencies of omission or commission in the particular case. Thus, clinical assessments are often seen in their most public form and under conditions in which weaknesses and deficiencies are most vulnerable to exposure.

Clinical assessment has been defined as “the process by which clinicians gain understanding of the patient necessary for making informed decisions” (Korchin, 1976, p. 124). Korchin and Schuldberg (1981) elaborate,

Clinical diagnosis, in the restricted sense, may be included, but more usually the intent is description and prediction towards the ends of planning, executing, and evaluating therapeutic interventions and predicting future behavior. Any of numerous techniques can be used, singularly or in combination, depending on the orientation of the clinician and the specific questions for which answers are sought. Thus, interviews with the client or with others; observation in natural or contrived situations; or the use of tests of different functions, varying in breadth, objectivity, psychometric refinement, and inference might all be included. The immediate goal may be the relatively precise measurement of a particular psychological function or the construction of a ‘working image or model of the person’ (Sundberg & Tyler, 1962), (p. 1147).
Generally, clinical assessment is distinguished from other types of psychological assessment such as educational assessment or personnel assessment by its focus on determination of the presence or absence of psychopathology or deviance—that is, problems or discomforts the individual is having with himself/herself or problems or discomforts the individual is causing to society or other people. Clinical assessment concerns itself not only with the nature of the psychopathology but also with its extent, the implications of its nature and extent for the individual’s prospective functioning, the potential for altering such functioning and the means to accomplish such alteration.

THE CURRENT STATUS OF CLINICAL ASSESSMENT

The current status of psychological assessment generally, and psychological testing particularly, could be described as paradoxical. The demise of psychological testing has been announced often enough over the past two decades. Yet there has been no funeral. There is no corpse because life has not yet left the body and indeed, there are those who assert that not only is the patient not dying, but that in fact this patient is on the way to recovery (Korchin & Schulberg, 1981). Rorer and Widiger (1983) state,

It is no secret that personality assessment has been in big trouble as it has come under attack from both expert and lay critics. Assessment takes up a decreasing proportion of the professional practitioners time, occupies a place of decreasing importance in the university graduate curriculum and has been legally outlawed in many selection situations. Many have reacted by jumping what they believe to be a sinking ship, others have come to the defense of the establishment, and have argued that with a few refinements we can continue with business as usual. . . . Clearly (to these reviewers), it is not a time for business as usual nor is it time to abandon ship. Rather, it is a time to question our basic assumptions. (p. 433)

Several articles (Davids, 1973; Leavitt, 1973; Lewandowski & Saccuzzo, 1976; Petzelt & Craddick, 1978) have indicated that many graduate programs in clinical psychology have de-emphasized the teaching of psychological testing. Nevertheless, it seems that employers of clinical psychologists by an overwhelming majority continue to consider the capacity to perform psychological testing as one of the major requirements for employment at their facility. The courts, usually perceived as bastions of conservative hard headedness when it comes to the admission of evidence, no longer debate the admissibility of conclusions based on psychological testing, despite a mountain of evidence (Ziskin, 1981) which suggests that there is too much doubt about these procedures for them to meet admissibility requirements that continue to keep other types of evidence such as conclusions based on polygraph examinations out of the court room. Judging by developments in the field of psychology and law such as the estab-
lishment of Division 41 of the American Psychological Association, a division on psychology and law, and the establishment of the American Board of Forensic Psychology and my own experience, it seems more likely that the use of clinical assessment in the legal situation is expanding. This conflicted or sick, but not dying, status of the field arises from a number of factors.

In part clinical assessment owes its continued existence to a serious need for its product. With a multiplicity of treatment methods and particularly with a proliferation of psychotropic medications, it has become more necessary than ever to evaluate the nature of the patients problems in order to utilize the most appropriate kind of treatment and/or medication. Similarly in the forensic situation, the questions of state of mind or psychological capacities or propensities are of extreme importance so that any modality which has some degree of respectability and purports to provide answers is eagerly welcomed. Further, assessment is a field in which new methodologies and/or revisions of old methodologies occur with great frequency such that there is always the hope that today’s new method will provide “the answer.” The vast size of the graveyard of yesterday’s great hopes does not appear to dampen enthusiasm.

Several factors impede the progress of clinical assessment toward a healthy state.

1. Lack of an Adequate Knowledge Base

Perhaps the most important of all, is the absence of a large, relevant, adequately validated body of knowledge on which to base clinical assessment. The mental health field consists of a conglomeration of unvalidated theories about human behavior, psychological conditions and so on. Havens (1981) states,

> Psychiatry as an agreed on body of knowledge hardly exists, instead we have a variety of psychiatry. Psycho-analytic psychiatry, biological and behavioristic psychiatry, social and interpersonal psychiatry, existential analysis—the list can be made even longer. (p. 1279)

All of these theories possess some supporting data and all have a body of followers and indeed, many of them have substantial bodies of followers. But the existence of so many different theories (and they are different) defines the problem because in order to know what it is that one ought to be assessing one has to have a basis in knowledge of what variables are relevant in human psychology and how those variables interact. Thus, it could be argued for example, that many of the present ills of clinical assessment spring from the fact that during the growth period of clinical assessment, the most popular theory of human behavior was the psychoanalytic theory and thus much of the early development of testing revolved around attempts to assess psychoanalytic variables. Given the skepticism concerning psychoanalytic theory that has emerged in the past few decades, it may be no wonder that the enterprise failed.
2. Lack of an Adequate Classification System

A parallel problem has been the lack of an adequate classification system for diagnosing or classifying mental disorders. While it can be, and is, argued by some clinicians that formal diagnoses are not necessary for treatment purposes, the fact is that most treatment modalities, procedures and medications are based on formal diagnoses. The dismal history of the official diagnostic classification system, the diagnostic and statistical manuals published by the American Psychiatric Association ought to be well known to everyone in the field. DSM-I was published in 1952 and found to be quite poor and was replaced by DSM-II in 1968. It soon became apparent that DSM-II was not adequate to the task and work was shortly thereafter commenced culminating in the production of DSM-III in 1980, representing a radical departure from the previous manuals. While one can readily acknowledge that DSM-III is a considerable improvement over its predecessors, as it does specify with some clarity what the criteria are for the various mental disorders, recognizes psycho-social factors, and provides preliminary reliability research data, there is little reason to hope that DSM-III will prove to be an adequate classification system.

Regarding DSM-III, Eysenck, Wakefield, and Friedman (1983) provide an extensive review and state the conclusion that “This new scheme is based on foundations so insecure, so lacking in scientific support, and so contrary to well-established facts that its use can only be justified in terms of social need” (p. 167). They warn psychologists of the weaknesses of a scheme based on democratic voting rather than scientific research and they assert that the reliabilities are unacceptably low and there is a lack of indication of validity. In 1982 at the Annual Meeting of the American Psychiatric Association, a debate was held under the title “Do the advantages of DSM-III outweigh the disadvantages?” The debaters were Dr. Gerald L. Klerman, Dr. Robert L. Spitzer who was the chairman of the committee which developed DSM-III, Dr. Robert Michels and Dr. George E. Vaillant, all psychiatrists of some eminence. This debate was taped and can be obtained from the American Psychiatric Association. One outstanding characteristic of the debate was the absence of a strong assertion by speakers on either side indicating that DSM-III really is a “good” diagnostic system. Even more impressive was the unanimity with which each of the participants referred to the coming of DSM-IV.

The literature contains numerous negative assertions concerning DSM-III (Ziskin, 1981). One must consider the effects of alterations in the definitions of various psychopathological entities every decade or so on the validity, meaningfulness and applicability of previous research. It seems quite likely that a research population described as “schizophrenic” in the 1960s would be a different population from a clinical population described as schizophrenic in the 1980s. Keisling (1981) found that when a group of patients admitted to St. Elizabeths hospital in 1979 and 1980 were re-diagnosed on the basis of DSM-III
criteria, the proportions of those diagnosed with schizophrenia and those diagnosed manic-depressive were altered radically. Therefore, in terms of application, one cannot apply the previous research to patients presently diagnosed with the same label. At the very least, the clinician must entertain doubts regarding the application of research performed on a group of patients designated as having a certain disorder in the past to patients designated as having that disorder in the present when it is known that there is a strong possibility that the two patient populations might be different.

Probably the only safe course for clinicians is to disregard any research done prior to the publication of DSM-III for conditions where descriptions have been changed. Unfortunately, this would leave them in the position of trying to deal with entities for which virtually no research information would be available for several years. Further, by the time the research is completed and published, DSM-IV will be out and the process will have to start all over again.

3. Situation and Examiner Effects

Situation and the examiner effects are problems that have plagued clinical evaluation as evidenced in the literature over the past several decades continuing up to the present. See, for example, (Anastasi, 1982; Arkes, 1981; Bartol, 1983; Treece, 1982). "Situation effects" refers to the contamination of data obtained in a clinical examination by temporary events which surround the time of the examination. For example, if the subject has had a fight with his wife that morning, or if he has been scared out of his wits by a close call on the freeway or if she is involved in a lawsuit out of which she hopes to obtain a great deal of money for a relatively minor injury and is very anxious about the outcome, all such events can have an effect on the individual’s psychological state at the time of the examination and cause him to produce data which could easily be seen by the clinician as an enduring characteristic. This has been more broadly referred to in the state vs. trait controversy which involves the problem of trying to tease out of the data that which represents relatively permanent characteristics of the individual versus that which is a resultant of some temporary condition. "Examiner effects" refers to the influence of the examiner and examiner subject interaction, not only on the data that is produced but on the data that is attended to and recorded and the interpretation of the data as well. Decades of studies (Ziskin, 1981, Chapter 6) have shown that the data produced and recorded and the interpretation of the data are influenced by such factors as the theoretical orientation of the examiner, personal characteristics of the examiner such as age, sex, race and socio-economic status, training and experience, personality characteristics and appearance as well as social or political values and attitudes and the expectations of the examiner. The effect of situational and examiner variables in reducing the reliability and validity of clinical evaluations should be obvious. It is difficult to avoid despair concerning an evaluation process in which the out-
come is partially determined by time, place and purpose and which one of many examiners conducted the examination.

4. Multicultural Issues

Research, particularly in the last decade and a half, has raised questions concerning the assessment of members of ethnic minority groups and has left those questions unresolved. Thus, a plethora of studies (Ziskin, 1981, Chapter 9) indicate that it may be inadvisable to assess members of ethnic minority groups on the basis of white majority normative data. These studies indicate that there may be significantly different response patterns for members of ethnic minority groups particularly on tests of personality or psychopathology or that even where the response patterns may be similar that the behavioral correlates of the responses may be different for ethnic minority members (nearly 50 such studies are reported in Ziskin 1981). Some research suggests that these ethnic differences disappear when education level and socio-economic level are controlled ((Bertelson, Marks, & May 1982; Davis, 1975; Davis, Beck, & Ryan 1973; Davis & Jones 1974). On the other hand several researchers have found that statistically significant differences do exist in test data even when education level and/or socio-economic status are controlled (Brown, 1974; Cross, Barclay, & Berger, 1978; Holland, 1979; Lowe & Hildman, 1972). These issues were discussed in several papers at the first multiethnic conference on assessments held in Tampa, Florida in March of 1982 (Raymond D. Fowler, University of Alabama, Chair). The fact that such a conference was held suggests that some of these issues have not been resolved. Similarly the problem of assessment of the members of ethnic minority groups was mentioned by several presenters at the 1983 program of the Society for Personality Assessment held in San Diego, California. It is clear that this is a problem that has not gone away and it remains to be seen whether re-norming of many tests with special norms for members of ethnic minority groups (Gynther, Lachar, & Dahlstrom, 1978) or some other solution would be the answer.

5. Ineffectiveness of Experience

A matter of considerable concern is the apparent inability of clinicians to improve their diagnostic reliability and validity as a result of experience. More than fifty publications (Ziskin, 1981) mostly within the last decade and a half indicate that experienced clinicians are no more reliable or accurate than are inexperienced clinicians and indeed a few studies indicate they are no more accurate than nonclinicians. These findings raise a serious question as to whether there is indeed a teachable and learnable skill of clinical assessment. The fact that experience does not sharpen such skills seems to suggest that the answer is negative and thus, raises a question of whether time is being wasted in graduate
education and, indeed, raises the question as to whether the enterprise should even be continued. Of course, it may be possible that some clinicians are very good at assessment on some basis other than training and experience.

6. Illusory Correlation

Illusory correlations create another serious problem for assessment (Chapman & Chapman, 1967). As used originally by Chapman and Chapman, illusory correlation describes a process wherein the clinician thinks that she observes a relation between an item of behavior and some psychological variable when, in fact, no such relationship can be shown to exist. The Chapman’s use the example of the hypothesis from the Draw-A-Person test that drawing of large eyes or emphasizing eyes is associated with paranoia or paranoid tendencies. While the hypothesis is logical, the research literature fails to substantiate it. Therefore, the sign is invalid, the relationship is “illusory.” Large amounts of what clinicians are taught in their training consists of such illusory correlations and then in the course of their practice, clinicians reinforce such false beliefs in each other by repeating what they have been taught or what they think they have observed and to be sure from time to time someone who draws large eyes does turn out to be paranoid so that there is always a certain amount of confirmation. These myths are perpetuated and become principles of assessment. There is an urgent need for clinical assessment to shed its mythologies.

7. Base Rates

A similar problem exists with regard to ignoring population base rates. What this means is that in many instances, behavior that is more likely than not within the realm of normal is seized upon and twisted and distorted to make it into a symptom of psychopathology (Rosenhan, 1973; Ziskin, 1981). I worked as a consultant on a case in which a very wealthy man who had been going around the country making substantial investments to the point where his family was worried that he might dissipate the fortune (all of which he had made himself), and managed to get him to return home in the middle of the night on the ruse that his wife was very sick and needed his presence. He caught several connecting flights and then drove for another 2 or 3 hours in the early hours of the morning to be greeted on the porch of his home by his perfectly healthy wife and family and four husky deputy sheriffs who told him that he needed to go to the hospital. He disagreed very strongly with their recommendations whereupon they placed him in restraints and took him off to the mental hospital. The psychiatrist’s report starts with this sentence, “On admission Mr. X was hostile and belligerent” presumably as an indication of the psychopathology later diagnosed as a manic state. Who would not be hostile and belligerent under those circumstances? Certainly it is more normal to be angry under those circumstances than to be
placid and accepting of having been fooled and forcibly hospitalized. Statements of this kind abound in clinical reports almost as though the clinician is determined to see everything through pathology colored glasses and rarely recognizes normal behavior when she sees it. This is carried to the point of absurdity in countless reports I have read in which the clinician states that the individual’s scale score of 9 on the WAIS shows that he is “below average” on that particular dimension.

8. Art vs. Science

There is controversy as to whether clinical assessment is and/or should be an art or a science with the most common opinion holding that it is a mixture of both. One can readily point to an analogy in medicine which is often described as an art based on science. I suspect that in clinical psychological assessment as well as in medicine, art begins where science leaves off. By that, I mean that generally speaking the professional would prefer to be able to generate conclusions based on hard scientific data, but where such data is lacking, art or intuition or whatever the clinician wishes to call it must necessarily be employed, although there is a seldom used alternative called “I do not know.” Neuropsychological assessment may provide a useful example in this regard. In the late 1950s we were trained to assess brain damage with a combination of blunt instruments such as the Rorschach and the MMPI along with a Bender-Gestalt and the scatter patterns on a WAIS along with some behavioral observations, perhaps, in conjunction with or as a result of an EEG. Our knowledge of brain functioning was limited. We were forced to rely on certain signs that most of the time left us with equivocal conclusions and consequently with unsatisfactory validity (Goldstein & Deysach, 1973). Advances since then in computerized axial tomography and the development of neuropsychological batteries such as the Halstead-Reitan and the Luria-Nebraska allow not only conclusions of brain damage or disease at commonly reported rates of accuracy between 80% and 90% but enable the clinician to assess fairly well the locus and functional significance of the damage. It is, of course, true that some of the old tests are included within these neuropsychological batteries and that the behavioral observations of the clinician still play some role. The heart of the procedures however, seem to fall to a much greater extent within the area of science with its formulas and quantification. Given the relatively short life of these methods, it is not at all unreasonable to anticipate that in the near future they will be producing results with even higher rates of accuracy.

9. Assessment of “Whole” or “Part.”

Whether and when to attempt assessment of some specific attribute or to assess the “whole” person is another issue that must be resolved. In the new era of accountability and reduced availability of funds for health care, there will be less
tolerance for diagnostic procedures that are expensive, inefficient or unproven. Sometimes clinical assessment may not require anything more than the question “Tell me about your problems.”

At least the foreseeable future is likely to see a continuation of this era of accountability and restriction of funds for both health research and health care. This suggests that clinical assessment is going to have to prove its value just as recent years have been increasing government pressure on psychotherapy to prove its value.

10. Derivation of Clinical Conclusions

Another issue that plagues the field is the general inability of clinicians to explicate the bases for their conclusions and the processes that led them to the conclusions. Possibly this problem is more noticeable in the courtroom setting where penetrating questions can be asked of the clinician as to how conclusions were derived in contrast to the clinic setting where, except for occasional case conferences, the clinician is not called upon to justify or explain the source of his conclusions. My experience has been that in the courtroom setting, it has been virtually impossible to get satisfactory information from the clinician in response to the question “What is the source of that conclusion?” The response almost invariably is more or less of the type “Not from any one thing, but from all of the data taken together.” Persistent questioning by the cross-examining lawyer seldom clarifies the basis of conclusions, producing only the impression that the clinician does not know how the conclusions were derived.

11. Problems in Computer Interpretation

Adair (1978), reviewing automated or computerized MMPI interpretive services, generally notes that the question of validity in personality measurement continues to be a problem and that validity studies must be continued as a constant check on the accuracy of computer generated personality reports. He notes that some validational studies by various services have been done and “showed some promise.” Butcher (1978) notes that most of the computerized interpretations are not pure actuarial systems but stem from programmed clinical decision rules utilizing clinical lore as the basic data in many cases. Butcher states:

At this stage computerized narratives using psychological test based information is little more than an art (or craft) disguised as a science. For the most part, the narrative reports are clinical hunches (often many steps removed from data) which are automatically cranked out by an electronic beast that will, without conscience, weave a devastating and sometimes contradictory tale about an individual’s personality and problems. The computer is a generally willing and efficient servant that will readily combine and give back stores of information from its vast memory. It cares not at all whether the information stored is from astrology charts, MMPI code
books, Rorschach indices, or Somatotype descriptors... the "artisan" nature of 
this endeavor has been demonstrated, the "clinical" astuteness is often compel-
ling, but the "science" is often neglected or of tertiary consideration. (p. 942)

Butcher additionally asserts that these clinical "hunches" are given more cred-
ibility than actually is deserved because of the aura of scientific mystique associ-
ated with computer outputs. He states:

The computer approach to personality assessment has been "oversold" and users 
place more stock in the "scientific truth" than is actually deserved. (p. 943)

He states further:

Once an MMPI interpretation program is written to print out sets of statements to 
given T score elevations, etc., a computer system can, in a matter of minutes, 
process thousands of cases producing an amount of halftruths and misstatements of 
staggering proportions. (p. 943)

He states further:

By far the most haunting problem and serious shortcoming of the automated MMPI 
assessment approach remains that of system validation. Demonstrating the validity 
of computer-generated narratives (like that of demonstrating clinical interpretations 
generally) is a formidable task. (p. 944)

Butcher points out that several attempts at validating narrative reports have been 
published but the criteria employed, frequently consumer ratings of acceptability 
or judged accuracy, are inadequate to provide a demonstration of validity.

THE FUTURE

My attempt to predict the future course of clinical assessment basically will 
follow two paths. One path springs from what seems to be reasonable extensions 
of trends that can already be discerned. The other path springs from my imagina-
tion, including an out of character optimism with regard to what can be accom-
plished in clinical assessment, if not now, at least in the foreseeable future.

1. Use of Computers

Despite the stringent warnings of Butcher and others given earlier, there can be 
no doubt that computers are going to make an enormous impact on assessment 
(Jackson & Paunonen 1980). The "Actuarial vs. Clinical" controversy triggered
by Meehl’s famous publications on that topic portends this development. My
summarization of the writing in this particular area of actuarial vs. clinical
assessment suggests that the demonstrated superiority of the actuarial method has
not yet made its impact on assessment because of the limited instances in which
the actuarial formulas were available. However, it seems clear that this problem
is being remedied to some extent by existing computer programs and one cannot
really doubt that the capacities of the computer will facilitate the development of
many more formulas. The speed with which the computer can analyze data and
its capacities for storing and processing large amounts of information that are
totally beyond the capacities of the individual clinician insure this development.
One need only glance at the long running advertisements in the APA Monitor
offering computerized interpretation services to recognize that this approach has
already established its economic viability. The task that remains to be accom­
plished is that of systematic validation. Most services report high degrees of
customer satisfaction and/or concurrence as evidence of validity. However,
“customer satisfaction” cannot be a substitute for published validation studies.

Even more challenging than validation studies (and perhaps likely to increase
validity) is the possibility of combining data from different sources into auto­
mated interpretive programs. At present the interpretive systems are mostly
associated with the MMPI, although some indications of automated Rorschach
interpretations have appeared. It does not seem utopian however, to imagine an
automated assessment program which includes within it, for example, not only
MMPI data and MMPI interpretive statements, but incorporates Rorschach data
and interpretive statements as well as demographic and interview data. The size
of the project may seem staggering but probably no more so than the idea of
being able to feed data into a machine which was cabable of responding with
more than twenty thousand different interpretive statements might have seemed
30 years ago. One day an operator may transmit into the computer an MMPI
profile code along with the ratios from the Exner Comprehensive Rorschach
System along with other similar data from these two tests and perhaps others plus
demographic data plus quantified interview data. Such quantified interview data
can be provided by means of structured interview procedures combined with the
use of rating scales which will enable the interviewer to translate the data and
even the behavioral observations into quantified form. Thus for example, the
clinician rather than writing a full report saying that the patient showed “flat
affect” will be able to punch in a number on a statement concerning range of
affect. In this manner, it may become possible for the computer to actually do
what clinicians say and think they actually do when they utilize information from
a number of diagnostic sources in reaching their conclusions. Thus for example,
when the clinicians say they use a battery of tests it has been my experience that
they use relatively little information from the battery. The computer however,
will be able to use vastly greater amounts of such information.
2. Classification Systems

There will almost certainly be a new classification system. Judging from the debate held by the American Psychiatric Association in 1981, soon there will be a DSM-IV that is likely to differ in substantial respects from DSM-III. Clinicians upset over particular omissions are already lobbying for their inclusion in DSM-IV. Similarly, certain classifications, such as “schizo-affective,” and “borderline” have come under considerable fire with their validities being questioned. No doubt some of the current categories will be deleted. However, these are only specific content changes and one does not readily forsee an abandonment of the particular model. In contrast, several years ago, the American Psychological Association established a committee to look into the development of a more behavioral description type of classification system. This committee appeared to conclude that while such a system would be valuable, the cost of developing it was out of reach at the time, the late 1970s and early 1980s. However, sooner or later the issue of whether to continue with the DSM type of diagnostic system or to shift to some other approach will have to be faced. Already statements in the literature favoring a dimensional over a categorical approach have appeared.

3. Greater Focus on Assets

Much greater attention to strengths or assets should be expected. Clinical assessment has for much too long been almost totally absorbed in reciting psychopathology so that the reading of a clinical report is almost always like listening to a symphony of defects, deficiencies, problems, stresses and so on. Yet the modern drift of treatment approaches tends to focus on problem solving with many therapies attempting to build on the strengths the patient already has or to augment those strengths to help the individual to function better. In light of this the assessment will have to take into account not only psychological strengths but also assets such as good looks, high intelligence, a wealthy family, a helpful spouse or whatever other assets the patient may bring to the situation.

4. Situational Variables

Similarly psychosocial stresses present in the patient’s life space will also require assessment. A step in this direction was taken in DSM-III, but the calibration appears to be crude and without any particular scientific foundation. Nonetheless, the idea is a good one and needs a more careful calibration as to the rating of stresses inherent in various kinds of situations plus some rating of the stress for the particular individual in a given situation. Along these lines it seems most likely that a state vs. trait controversy will dissolve into recognition that while there may be enduring traits or characteristics that an individual has, these traits
will become operative or will operate in a different manner according to various situations or contexts. It will be important for a therapist to have any significant situational information.

5. Projective Tests

Projective tests which have long been highly controversial within psychology face a future of change or disappearance. Those devices which are amenable to change to make them more scientific are likely to survive. Those that are not amenable or can be modified only with great difficulty are likely to disappear. Thus for example, the Draw-A-Person (DAP) technique which has a long history, would appear to me to have a very short future. Over its lengthy history numerous attempts have been made to validate its propositions. The net sum of all of this effort is most discouraging (Adler, 1970; Swenson, 1957). Very few of the existing DAP hypotheses have been validated. Economy and ease of administration do not compensate sufficiently for the failure of the test to provide conclusions about an individual in which one who reads the literature could have confidence. On the other hand, the Rorschach, long the object of vehement and derisive attacks by those alleged to be “hardnosed” unsympathetic scientists may very well be on the verge of a re-birth with John Exner and his colleagues as the attending physicians. Exner (1974, 1978) has pulled together diverse approaches and methodologies of the Rorschach into what appears on the way to becoming a unitary and standardized procedure which may bring it within the purview of science. Indeed, Exner and his associates are treating the Rorschach in a scientific manner, performing research to determine the reliabilities of various components and the validities of various interpretive principles. Clearly, they have met with impressive early successes. It is premature to conclude that the Exner Rorschach has now been fully validated, but at least it is being subjected to validation procedures and in time it is likely that we will know what it can do and what it cannot do.

6. Recognition of Limits

This leads me to another prediction for the future, one which I make with some hesitation. That is, I think the future will see those who do clinical assessment shrinking the territory somewhat and abandoning, at least in an applied sense, those areas for which the field is simply not ready. The two examples which come most readily to my mind are from the forensic area. One is the attempt to assess “dangerousness.” It is clear from an overwhelming body of literature that neither the knowledge nor the methodology exists to do this with a respectable degree of accuracy. Already the American Psychiatric Association and the American Psychological Association have acknowledged the limitations of the field in this regard. Similarly, attempts to assess a defendant in a criminal case
with regard to his state of mind at the time he committed the crime, usually
weeks or months before he was seen by the clinician, will be recognized as
beyond the clinician’s present capability.

7. Standardized Interviews

The future is likely to see more use of structured or standardized interview
methods. These methods offer some promise of increasing reliability by virtue of
the fact that they will require that each clinician be gathering the same kind of
data. They will also be an aid to the clinician in helping to insure that no relevant
areas are overlooked. Additionally, it is likely that more frequent interviews will
be conducted prior to drawing firm conclusions about an individual. Seeing the
individual more than one time provides the clinician with opportunities to ob-
serve the possible operation of situation effects which may be present on one
occasion but not on another. I do not expect the clinician to give up the flexibility
to adapt the examination to the individual patient’s needs and psychological
state. I am however suggesting that the examination not be considered complete
until all of the information required of a standardized interview has been
obtained.

8. Demographic Variables

The issue of race and perhaps other demographic variables such as age and socio-
economic status will have to be dealt with in the future of assessment. One
possibility is that a series of definitive studies may dispose of the problem as a
pseudo-problem, thus, eliminating these variables from further consideration.
The alternative is to begin the development of separate norms for various assess-
ment devices such as that initiated by Gynther et al. (1978). If further research
supports this approach by indicating that indeed there are racial, age, socio-
economic, or geographic differences that make a difference, then assessment for
members of any of these groups is in for a period of considerable uncertainty
while such norms are being developed. Once again, the computer may come to
the rescue by expediting the research necessary to establish such norms.

9. Relation to Treatment

It seems likely that research establishing relationships between treatment modal-
ity effectiveness and some sort of typology whether it be psychiatric diagnosis,
behavioral description, or some other classificatory scheme will have to be done
if the purpose of clinical assessment as a treatment guide is to be accomplished.
That is, even if some excellent classification system were to spring forth tomer-
row, in terms of being a reliable and accurate descriptor of many deviant or
nondeviant characteristics of an individual this would still not resolve the ques-
tion of how to treat that individual, although it obviously would be a critical first step. The second step simply does not seem achievable without the first unless it should turn out that the type of treatment makes no difference or that there is one treatment, perhaps some as yet unknown, wonderful pill which treats all psychological disorders effectively.

10. Some Other Views of the Future

Anastasi (1982) describes current trends involving application of item response theory, Bayesian approaches to validity generalization, growing emphasis on construct validation, progress in analysis of trait, state, and situational variables, and recognition of the need for psychometrically sound assessment techniques in behavior modification programs.

Korchin and Schuldberg (1981) suggests trends that indicate “the development of more focused techniques of psychometric purity,” more reliance on lower level interpretations rather than sweeping generalizations; more concern with situational and environmental factors; more attention given to the individual’s own views of his character or problems rather than relying as heavily on external measures; and greater acceptance that there is an inevitable role for clinical judgment in collecting, integrating and interpreting assessment data, although they suggest that more disciplined thinking will be required.

On the other hand Rorer and Widiger (1983) clearly disagree with Korchin and Schuldberg’s position that with a few refinements, assessment can continue with its business as usual. Their view is that “psychology is burdened with an outmoded philosophy, and a distorted view of science, to both of which it adheres with messianic fervor.” The essence of their position, as I understand it, is that psychology has adopted a philosophy of science, namely that of emulating physics when that philosophy of science may never have existed and pretty clearly, according to these authors, no longer exists in physics. They assert that psychology adopted logical empiricism at a time when philosophy abandoned it. I am not going to attempt to deal with the entirety of their article. I can do no more than suggest that anyone interested in the future of clinical assessment ought to read the article, because it encompasses a radical change at the very core of assessment—the nature of the science (or nonscience, or different science) of psychology. According to these authors these changes are so radical that they would require logical empiricism be replaced by more contemporary philosophical positions on methodology; “analysis of variance, null hypothesis significance testing, and classical test theory would be replaced by taxometric methods, Bayesian statistics, analysis of covariance structures (including causal modeling), generalizeability theory, decision theory, and other methods appropriate for construct validation; sole reliance on the experimental method would be replaced by an emphasis on using methods appropriate for the study of personality structure, in particular those of clinical psychologies: and theoretical and integrated
papers would be encouraged in place of the fragmented laboratory studies of unrelated personality traits that have added so little to our knowledge.'

They do conclude their article with a statement "Finally and most difficult of all, we would become comfortable with the idea that there is no test that can separate science from non-science, and consequently that science is distinguished from religion precisely by the fact that it does not require acceptance of certain beliefs as an act of faith."

I take some comfort from the last statement if I correctly interpret it to mean that clinical assessment will continue to require validation of some kind. My sim pleminded understanding of an applied science requires no less. It does not have to be logical empiricism or even physics but it does have to work. If it can be demonstrated (not just taken on faith) that it works in the field, then its existence is justified.

REFERENCES


