

Reliable Clinical Judgments

By Bob Woody, PhD, JD

Years ago, when I was doing my PhD dissertation, I was interested in the EEGs of behavioral problem versus well-behaved boys. My advisor wisely warned me that the judgments of my lone EEGer, although he was well trained and experienced, might not be reliable.

Subsequently, I brought three highly trained/experienced EEGers together. They created a system for judging the EEGs, including an agreed upon definition for what was a “normal” and what was an “abnormal” EEG. To their disbelief and dismay, when these astute EEGers made independent judgments of a batch of EEGs, all three of them agreed on a simple diagnosis (i.e., normal versus abnormal) for only 53.3% of the cases!

In the intervening years, I have encountered numerous incidents in which it was clear that diagnosticians often have poor intrajudge and/or interjudge reliability. I keep hoping for guidance to assuredly be able to make reliable clinical judgments. So far, however, I continue the futile search, like Diogenes wandering around ancient Greece carrying a lantern looking for an honest person.

When making judgments, such as for interpretations of assessment results, the “Ethical Principles of Psychologists and Code of Conduct” (APA, 2002) states that: psychologists should consider factors “that might affect psychologists’ judgments or reduce the accuracy of their interpretations”; and “They indicate any significant limitations of their interpretations” (Standard 9.06). Therefore, do not clinical judgments with questionable reliability create a potential ethical dilemma for psychologists?

I have previously warned (including myself) about how bias can creep into attributions [see “Scanning for Bias” on my website: www.bobwoodyhelpspsychology.com]. Having just read the book, *How Doctors Think*, by Jerome Groopman, MD (Houghton Mifflin, 2007), I have been reminded that reliability in clinical judgments should not be taken for granted, simply because of professional training and experience. As Groopman points out:

There can be attribution errors, such as force-fitting clients into negative stereotypes based on the socioeconomic, personal, or character factors.

“Representativeness errors” occur when thinking is shaped and guided by a prototype.

Emotion is always present in cognitions, which can be a harbinger of affective errors that occur because of the practitioner’s emotional perception or reaction to the client (i.e., liking or disliking).

Of course there are numerous other twists and turns in the trail of biases that can impede arriving at a reliable and accurate diagnosis.

In Florida, the Board of Psychology has mandated that the renewal of a license to practice psychology requires continuing education credits in avoiding psychological errors. The assumption is, apparently, that a psychologist can gain knowledge that will prevent psychological errors.

In contradiction, Groopman opines that very few diagnostic errors occur because of a lack of academic or technical knowledge: “Most errors are mistakes in thinking. And part of what causes these cognitive errors is our inner feelings, feelings we do not readily admit to and often don’t even recognize” (p. 40). Stated differently, the error comes from not thinking clearly about the information that is available about the client’s needs and conditions.

Therefore, I am a bit befuddled. On one hand, *there is ample reason to believe that professional training and experience do not assure reliable clinical judgments, yet the evolution of therapeutic interventions (e.g., integrative and cognitive-behavioral) has led to minimizing the usefulness of personal insight, as might reveal the feelings that portend to lessen the reliability of clinical judgments.* Certainly the prevailing notion of empirically based interventions, to which I am strongly committed, relies on research and cognitive processing, but I have yet to locate the guideposts for finding assured reliability in clinical judgments.

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