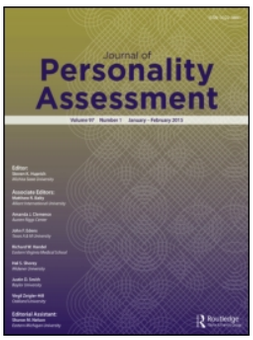

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Training and Consultation in Psychological Assessment With Professional Psychologists: Suggestions for Enhancing the Profession and Individual Practices

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ABSTRACT

Once central to the identity and practice of clinical psychology, psychological assessment (PA) is currently more limited in professional practice and generally less emphasized in graduate training programs than in the past. Performance-based personality tests especially are taught and used less, even though scientific evidence of their utility and validity has never been stronger. We review research on training in PA and discuss challenges that contributed to its decreased popularity. We then review continuing education requirements for ethical practice in PA and recommend that PA should be reconceptualized as a specialty best practiced by psychologists who have the resources and time to maintain competency. We offer recommendations about how professional organizations concerned with PA can promote its practice and how individual expert clinicians can assist. We conclude by describing a collaborative model for providing group consultation in PA to practicing psychologists. If implemented widely, this model could help promote PA and raise its standard of practice.

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From the beginnings of the profession in the first part of the 20th century to the advent of managed care in the late 1980s, psychological assessment (PA) was considered central to the identity of clinical psychologists, perhaps even the defining competence that differentiated psychologists from other mental health professionals. As a result, course work in PA was a critical component of graduate training in psychology both in clinical and counseling programs (Watkins, 1991). Watkins's (1991) review of the many surveys on assessment training in graduate school concluded that "internship directors regard psychodiagnostic assessment skills as very important, believe graduate programs should prepare their students in assessment skills" and "want beginning interns to possess psychodiagnostic abilities" (p. 429). He also noted a "good training background in psychological assessment can enhance graduate students' opportunities to obtain internship and job placements" (p. 429). In a follow-up survey, Watkins, Campbell, Nieberding, and Hallmark (1995) found that upwards of 90% of psychologists included PA in their work and concluded:

> (a) an identifiable, highly select core of assessment procedures is most often used by most clinical psychologists across most work settings; (b) psychological assessment as it is practiced now appears in many respects to be very similar to psychological assessment as it was practiced by psychologists 30 or more years ago. (p. 54)

Current graduate psychological assessment training

After discussions with many colleagues and informally reviewing Continuing Education (CE) offerings for American Psychological Association and state psychological association conferences, we have a general sense that currently PA is less central to the identity of many practicing psychologists, and that graduate students are less trained than previous generations in this area of practice. Indeed among the American Psychological Association's (2016) currently available 300+ online CE offerings, only 11 involve psychological testing. Other experts have also noted this decline (e.g., Handler & Smith, 2012). However, results of a recent survey seem to have generated confusion about the current status of graduate training in personality assessment. Ready and Veague (2014) surveyed 74 American Psychological Association–accredited graduate training programs in clinical psychology and divided them into three groups: clinical-science, scientist-practitioner, and practitioner-scholar programs. Regarding the period from 2001 to 2011, they concluded:

> Assessment training over the past decade was generally stable or increasing. Training in treatment effectiveness and neuropsychology were areas of growth. Across training models, there was remarkable similarity in assessment instruction except for coverage of projective instruments, number of required assessment courses, and training in geriatric assessment. (p. 278)

Although the survey indicates "stable or increasing" training in assessment, a close reading of the article shows that this conclusion is not true of personality assessment and is largely accounted for by increased training in neuropsychological assessment and treatment evaluation. Of the top 10 tests taught in graduate training, only 2 were personality tests (the Minnesota Multiphasic Personality Inventory–2 [Butcher, Dahlstrom,

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Graham, Tellegen, & Kaemmer, 1989] and the Personality Assessment Inventory [Morey, 1991]); the rest were intelligence and achievement tests or symptom inventories (e.g., the Child Behavior Checklist [Achenbach, 1991]). Furthermore, Ready and Veague (2014) found a trend toward less time spent teaching and learning PA in general, which in turn inevitably means that doctoral psychology graduates leave their training with less expertise. This appears to be especially true for clinical-scientist doctoral programs, as opposed to scientist-practitioner and practitioner-scholar programs. So in reality the "good news" about the stability of graduate assessment training is at best rather guarded.

A particularly disturbing trend found by Ready and Veague (2014) throughout psychology was a decline in training in performance-based and projective personality tests, which decreased 70.6% in clinical-scientist programs, 31.4% in scientist-practitioner programs, and 15.0% in practitioner-scholar programs. In spite of very persuasive evidence for the value of the Rorschach (Gacono & Evans 2008; Mihura, Meyer, Dumitrascu, & Bombel, 2013; The Status of the Rorschach, 2005), it is no longer in the top 10 tests taught in graduate programs. The Rorschach was taught in 75% of practitioner-scholar programs, 38% of scientist-practitioner programs, and only 12% of clinical-science programs. Piotrowski's (2015) review of graduate training of projective methods in academic training centers from 1995 to 2014 echoes Ready and Veague's (2014) findings, showing that fewer graduate courses are devoted to PA in particular and performance-based methods specifically. Piotrowski noted that his findings represent a substantial change from previous surveys (e.g., Piotrowski & Zalewski, 1993; Watkins et al., 1995). He also provided a review of scholarly publications in performance-based methods, which showed a robust interest in research. In turn, he demonstrated a mismatch between this growing empirical literature on performance-based measures and the lack of opportunity for training provided at the graduate level.

Challenges to psychological assessment

Why has the status of PA and, subsequently, graduate training in PA declined over the decades? Why has training in performance-based personality measures fallen so sharply? We note a variety of challenges, many within the profession, and some of which psychological assessors have been able to surmount more than others.

Behaviorism

One of the first challenges was the rise of behaviorism in the 1950s and 1960s. Ferster and Skinner's (1957) experimental behavioral analysis (also called radical behaviorism) addressed practical behavioral problems using single-subject design research methodology (see Sidman, 1960) and eschewed group normative approaches underlying test construction. Based on the first author's knowledge of his own doctoral training program with Ferster and similar radical behaviorist programs, a number of American Psychological Association–approved clinical psychology programs with a radical behaviorist perspective stopped teaching psychological testing entirely.

Humanism

Concurrent with critiques from behaviorists, some humanistically oriented psychologists asserted that psychological testing was dehumanizing, overemphasized psychopathology, and was inherently disrespectful to clients (e.g., Brown, 1972). This point of view influenced generations of psychologists in client-centered and other humanistic traditions, who virtually abandoned PA. The exception to this trend was Fischer (1985/1994), who vigorously defended PA and developed a collaborative assessment model that was compatible with a humanistic approach.

Cognitive-behaviorism

Another challenge to personality assessment is the current dominance of cognitive-behavioral therapy (CBT) symptom-focused approaches to such disorders as depression (Beck, Rush, Shaw, & Emery, 1979), anxiety (Clark & Beck, 2011), and posttraumatic stress disorder (PTSD; e.g., Foa & Rothbaum, 2001). Personality assessment in CBT has been largely limited to symptom-specific measures such as the Beck Anxiety Inventory (Beck & Steer, 1993), the Beck Depression Inventory–II (Beck, Steer, & Brown, 1996) and a wide variety of PTSD measures (see Evans, 2012). The explosion of CBT, with its rejection of the importance of personality, also led to a decreased emphasis on training in personality assessment.

The DSMs

The popularity of CBT runs parallel to the neo-Kraepelinian emphasis found in modern psychiatric diagnostic manuals, starting with the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. [*DSM–III*]; American Psychiatric Association, 1980) and continuing through the current edition (*DSM–5*; American Psychiatric Association, DSM–5 Task Force, 2013) and the International Classification of Diseases (ICD–10; World Health Organization, 1990). Various editions of the *DSM* have shown more or less acknowledgment of the potential role of personality in the development and treatment of mental disorders, and the *DSM–5* actually includes a personality measure recommended for research purposes, the Personality Inventory for *DSM–5* (PID–5; Krueger, Derringer, Markon, Watson, & Skodol, 2013). Nevertheless, the primary focus is on the assessment of symptoms rather than the personality or the cognitive skill profile in which these symptoms are embedded. This approach has led to a reduced role for comprehensive, multimethod psychological assessment (MMA) in evidence-based practice, and some graduate training programs use hours formerly devoted to PA to teach standardized diagnostic interviews. In addition, recent generations of psychiatric residents have little or no experience of the utility of PA. This trend flies in the face of the prevailing science, in which clinical judgment blended with the psychometric support from different types of psychological tests, each with its own strengths, weaknesses, and method variance (see Meyer et al., 2001), has been shown to produce the most reliable and valid measurement of psychopathology.

Managed care

Perhaps the most serious challenge to personality testing came in the mid- to late 1980s when a significant shift in service reimbursement by managed care companies gained ground, which dramatically limited reimbursement for psychological testing. Assessment psychologists were caught largely unprepared by these economic shifts, finding themselves without means to advocate for better inclusion for PA. To make matters worse, unlike other evidence-based mental health approaches, assessors had little to no research to support how PA directly affected patient well-being or treatment outcomes. Although it might seem that PA was unfairly burdened to prove itself, the ways of the marketplace soon became a reality (see Parloff, 1982). Indeed, Krishnamurthy et al. (2004) warned of the possible erosion of training of psychological testing in graduate programs in psychology as a chilling effect of this economic change.

Widely read critiques of performance-based personality tests

Although all of these factors surely were part of the decline in projective and performance-based personality testing over the past 20 years, there is another variable that appears to have had a huge influence. As the reader is no doubt aware, starting in the late 1990s and continuing for a decade or more, a small group of psychologists published a series of critiques of the Rorschach and other projective tests, both in scientific journals (e.g., Wood, Lilienfeld, Garb, & Nezworski, 2000) and in writings for the lay public (e.g., Wood, Nezworski, Lilienfeld, & Garb, 2003). The criticisms were widely reported in the national press, including the *New York Times* (Goode, 2001) and the *Los Angeles Times* (Mestel, 2003). In our opinion, some of the criticisms related to blatant misuses of these tests that were inadequately addressed by the PA community (a topic we return to later). Other concerns involved weaknesses in the research base underlying performance-based personality tests, which led to a very productive period of research undertaken to deal with some shortcomings, particularly with regard to the Rorschach. In our judgment, this new body of work addresses many of these issues and convincingly supports the validity and utility of empirically based interpretation of performance-based tests. Although this new evidence has been summarized in several comprehensive reviews (e.g., Gacono & Evans, 2008; Meyer et al., 2001), it has not been disseminated to the lay public and has not gained the same purchase in the minds of psychologists and the public that the original critiques did. It is impossible to know how much these events are responsible for the decreased graduate training in performance-based personality tests. However, Ready and Veague (2014) reported that in the narrative comments from the clinical psychology programs they surveyed, "Many respondents questioned the reliability, validity, and utility of projective tests" (p. 279). They also noted what appears to be a vicious cycle: "Newer faculty do not teach projective tests and, thus due to retirements, projective tests are being taught less often" (p. 279). If empirically sturdy performance-based tests are to remain part of the expertise of modern clinical psychologists, steps must be taken to reverse this trend.

Lack of leadership from the American Psychological Association

To compound the problem, the American Psychological Association has until recently made limited efforts to advance PA compared to the energy expended to promote areas of practice seemingly less central to psychology (e.g., prescription privileges). This lack of active leadership has created a void that includes, until quite recently, little advocacy for reimbursement of PA services; the failure to provide strong support to state psychological associations who are fighting PA standards being diluted by including undertrained mental health professionals; and the erosion of protection of raw psychological test data commensurate with psychotherapy notes under the Health Insurance Portability and Accountability Act (HIPAA; B. L. Smith & Evans, 2004). The American Psychological Association Board of Professional Affairs did convene the Psychological Assessment Work Group in 1996–1997, which resulted in important publications demonstrating the vitality of psychological testing (Kubiszyn et al., 2000; Meyer et al., 2001) as well as thoughtful recommendations for improving PA practice (Eisman et al., 2000). Unfortunately, there have been limited initiatives to advance PA since that time, although the American Psychological Association's official recognition of personality assessment as a proficiency in professional psychology (Society for Personality Assessment [SPA], 2015) and recent increased American Psychological Association activity on CPT committees working for increased reimbursement of PA are notable and very welcomed exceptions to this trend.

The current status of psychological assessment

Even with these difficulties, PA continues to advance as a science and an evidence-based practice. There is a resurgence of new tests and modifications of older ones (e.g., Rorschach-Performance Assessment System [R–PAS; Meyer, Viglione, Mihura, Erard, & Erdberg 2011] and the Minnesota Multiphasic Personality Inventory–2–Restructured Form [MMPI–2–RF; Ben-Porath & Tellegen, 2008), which offer greater practical value because of superior psychometric characteristics. New research on older tests continues to uncover important connections to other aspects of psychological science (e.g., fMRI studies of the Rorschach; see Finn, 2012). Even the major critics of performance-based personality tests (Wood, Garb, Nezworski, Lilienfeld, & Duke, 2015) have conceded that a recent meta-analysis (Mihura et al., 2013) provides compelling evidence of the validity and utility of the Rorschach to address certain diagnostic questions.

Important advances using PA as an intervention such as Therapeutic Assessment (Finn, 2007) and Collaborative Assessment (Fischer, 1985/1994) have provided the long-needed evidence base for its practical value and address the concerns of both humanists and behaviorists by integrating idiographic and nomothetic approaches (see Aschieri & Smith, 2012). Indeed the meta-analytic study by Poston and Hanson (2010) supports the therapeutic value of therapeutic and collaborative assessment, leading them to conclude:

> Clinicians should … seek out continuing-education training related to these models [of Therapeutic and Collaborative Assessment]. Those

> who engage in *assessment and testing as usual* may miss out, it seems, on a golden opportunity to effect client change and enhance clinically important treatment processes. Similarly, applied training programs in clinical, counseling, and school psychology should incorporate therapeutic models of assessment into their curricula, foundational didactic classes, and practica. (p. 210, italics in original)

With these fast-paced developments in mind, we conclude that it is becoming increasingly difficult for graduate students in psychology to be prepared in PA. It is difficult, as well, for practicing clinicians to keep pace with advances, especially if assessment is not a major part of their daily activities. As such, CE in PA has become more and more imperative for competent and ethical practice.

Postgraduate training in psychological assessment

Based on our research, it appears that, even in the heyday of graduate training in personality assessment, many doctoral-level psychologists continued their training in PA well after they were licensed, although CE requirements for licensed psychologists did not routinely come into being until the 1970s. Our impression is that little postlicensure training in PA was offered in the form of formal courses, although organized extended course work has long been available for licensed psychologists in many other areas of psychological practice (see, e.g., the Advanced Training Certificate Program offered by the International Society for Traumatic Stress Studies, 2015). Instead, 1- to 5-day CE workshops on PA appear to be the preferred venue for licensed professionals seeking training. Such workshops are typically offered by professional organizations (e.g., the SPA, the American Psychological Association, the American Board of Forensic Psychology), by groups of researchers and educators (e.g., Rorschach Training Programs, MMPI Workshops and Symposia), and by test publishers and test authors themselves (e.g., Pearson, Psychological Assessment Resources [PAR]).

One disadvantage of the workshop format is that typically it does not afford the individual attention and case consultation needed for practitioners to hone their skills to a high level of competence in PA. Also, although CE workshops offered by test publishers and test authors are often excellent sources of information on their particular tests, they generally do not help practitioners compare and integrate tests published by different companies. Further, such workshops generally do not deal with issues that cut across tests, such as case conceptualization and test feedback. Thus, we respectfully raise a question about whether CE workshops are adequate as a primary format for teaching PA to those psychologists who did not receive good training in graduate school or for those who wish to sharpen or maintain their skills at a high level.

Requirements for continuing education in psychological assessment

It goes without saying that maintaining competence is an ethical requirement for those practicing PA, but let us pause and review what American Psychological Association standards have to say relevant to ongoing CE. The Ethical Code of the American Psychological Association (2010a) provides clear and specific guidance about gaining and maintaining competence in all areas of professional practice, teaching and research:

> **2.01 Boundaries of Competence**
>
> (a) Psychologists provide services, teach and conduct research with populations and in areas only within the *boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience.*
>
> (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language or socioeconomic status is essential for effective implementation of their services or research, psychologists *have or obtain the training, experience, consultation or supervision necessary to ensure the competence of their services* …
>
> (c) Psychologists planning to provide services, teach or conduct research involving populations, areas, techniques, or technologies new to them *undertake relevant education, training, supervised experience, consultation or study.*
>
> (d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a *reasonable effort to obtain the competence required by using relevant research, training, consultation or study* …
>
> (e) In those *emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work* and to protect clients/patients, students, supervisees, research participants, organizational clients and others from harm.
>
> (f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles. (pp. 4–5, italics added)

As noted in italics, the American Psychological Association Ethics Code's clear and unequivocal emphasis is to ensure that psychologists receive "training, experience, consultation or supervision" both to maintain current competencies and to acquire new ones. The American Psychological Association Ethics Code also accentuates the importance of the ethical practice of PA by devoting an entire section to it (Section 9 on Assessment). Similar requirements are found in competency and specific assessment sections in American Psychological Association practice guidelines where PA is relevant, such as forensic psychology (American Psychological Association, 2013), child custody evaluations (American Psychological Association 2010b),

working with older adults (American Psychological Association, 2014), and evaluation of dementia and age-related cognitive change (American Psychological Association, 2012). The American Psychological Association *Guidelines on Test User Qualification* (Turner, DeMers, Fox, & Reed 2001) explicitly state:

> Those who use psychological tests in a health care context should strive to obtain knowledge, supervised training, and professional experiences that go beyond the profession-specific knowledge, training, and experiences they obtained during graduate education, practica, internship, residency, or fellowship. (p. 1110)

In addition to the American Psychological Association ethical considerations, currently all but 5 state psychological associations (Continuing Education.com, 2015) have ongoing, regular CE requirements as a condition of psychologist license renewal, although these requirements are generally nonspecific and vary from 20 credits every 3 years to 60 credits every 2 years. These requirements appear to be well understood among assessment psychologists, as evidenced by Neimeyer, Taylor, and Wear's (2010) survey indicating that PA was the third most frequently attended category of continuing education (CE) programs. Interestingly, this finding suggests that most PA CE is provided not by the American Psychological Association, but through state and specialty psychological associations. It also highlights a discrepancy between the interests of practicing assessment psychologists and the paucity of PA courses offered among the American Psychological Association's previously noted 300+ current online CE courses. Unfortunately, we could find no study addressing the specific kinds of CE programs in PA or whether there are any trends toward or away from the 2010 survey. In our opinion, this lack of knowledge leaves a significant gap in our understanding of how postdoctoral psychologists approach the issue of maintaining competence in psychological testing in general and personality assessment specifically.

As mentioned earlier, because PA has become increasingly more complex and is no longer taught in sufficient depth in many graduate programs (especially performance-based personality methods), postgraduate CE serves an increasingly important function in maintaining competency and developing new competencies. CE becomes necessary for clinicians to adopt, and become competent with, new tests (e.g., learning the PAI after graduate school) as well as with revised tests, such as the MMPI–2–RF and R–PAS, and to keep up with new science about existing tests. Further, CE is crucial for those assessment psychologists who want to expand their practice into new specialties, such as forensic PA. Given its rapid growth, along with the relative dearth of graduate schools offering doctoral degrees in forensic psychology (see Ruchensky & Huss 2015), competence in PA for forensic psychology is essentially gained at a postdoctoral level. Some specialized areas of forensic PA such as screening for police applicants and forensic assessment in immigration court are essentially only available through postdoctoral CE and supervision. The same applies in the clinical realm; most notably learning the cutting-edge advances in assessment practice found in Collaborative and Therapeutic Assessment.

Professional training and best practices in personality assessment

In recent years we have heard increasing concerns expressed, and see more and more examples ourselves, of PA that falls short of being adequate in quality. To us, this fact is an "elephant in the room" that few people in our profession are willing to discuss, but it affects all of us who practice PA as well as the entire profession of psychology. In reality, PA is a difficult, demanding, and high-overhead clinical activity. Therefore, it takes a huge commitment of resources for an individual clinician to practice assessment over time at a high level. In many instances, assessment also has paid much less than other clinical activities. As discussed earlier, psychologists these days are getting less graduate training in PA and, even for those with good training in their doctoral programs, maintaining expertise is a challenge. As assessment science and practice evolve, assessment psychologists must address new research, learn new tests, and buy updates of older tests. Perhaps an even bigger challenge for assessment clinicians are the kinds of clients generally referred these days for PA. Typically, these clients are referred by other competent professionals who have found them difficult to treat, and such clients are among the most difficult, puzzling, and emotionally evocative. Greater costs, limitations on third-party payment, and the inevitable number of unbillable hours required to complete a thorough assessment are powerful, although subtle influences; as a result, shortcuts might be employed and standards could start to slide. We each know of good, generally ethical, responsible psychologists who routinely use highly outdated versions of tests, know little about recent assessment research, or write "boilerplate" assessment reports full of contradictions or sentences cribbed from computerized interpretations. Even when such assessments "do no harm," they can represent an important missed opportunity for clients, their loved ones, and the professionals working with them. Also, unfortunately, many consumers of PA (clients, psychiatrists, psychotherapists, teachers, etc.) know little about what constitutes high-quality assessment and, after bad experiences, might conclude that PA is not all that useful. This negative appraisal hurts all of psychology, keeps reimbursement rates for assessment low, and in the end might be the biggest factor threatening PA. What, we might all ask, can be done? We do not profess to have the answers, but we offer suggestions, both for professional organizations and for individual practitioners.

Psychological assessment should be recognized as a postdoctoral specialty that is best practiced by highly trained and skilled experts

As mentioned earlier, the American Psychological Association recently recognized personality assessment as a proficiency in professional psychology, and the SPA will administer the proficiency certification program (SPA, 2015). The American Psychological Association (2011) defines a *proficiency* as "a circumscribed activity in the general practice of professional psychology … that is represented by a distinct procedure, technique, or applied skill set" (p. 3). This is in contrast to a *specialty*, which is seen as a broader area requiring specialized

postdoctoral training and education. Currently, almost all recognized specialties in psychology are administered by the American Board of Professional Psychology (ABPP).

We applaud the SPA for defining and administering the proficiency in personality assessment, given that with one exception—clinical neuropsychology—the specialties administered by ABPP do not focus particularly on assessment. Also, the certification sponsored by the American Board of Assessment Psychology (ABAP) does not focus particularly on the clinical practice of assessment (i.e., test developers can become ABAP certified). However, in our view PA is closer to a specialty as defined by the American Psychological Association than to a proficiency. PA represents a broad area of knowledge and requires considerable postdoctoral training to practice well. Therefore, we hope that ABPP will consider developing a specialty in PA or that the SPA will eventually petition the American Psychological Association to expand its proficiency in personality assessment to a specialty covering PA in general.

Redefining PA as a specialty would mean rethinking the way PA is taught in graduate school. Currently, there seems to be an assumption that doctoral training in clinical, counseling, and school psychology will adequately train psychologists to practice assessment psychology after they are licensed. We strongly question this assumption. As much as our profession likes to emphasize the science behind PA—which we agree is considerable—this does not mean that it is a simple process to make sense of assessment materials and use them to help clients with their problems in living. We acknowledge that newly licensed psychologists can differ greatly in the amount of assessment training they have had and that some might have excellent skills. Nevertheless, in our way of thinking, allowing the average newly licensed psychologists to do PA without supervision is akin to letting new MDs—who have completed their internship but not residency—practice specialty medicine. There might be contexts in which new assessment practitioners can do well without extensive postdoctoral training or supervision (e.g., in conducting routine assessments in general clinical situations). However, in our experience, this kind of assessment is much rarer these days than in the past—when every client entering a clinic or hospital often received comprehensive PA. Nowadays, many clients referred for PA have complex, puzzling problems; this makes sense, as this is one of the contexts where PA has its greatest value. However, it also requires more skill and experience—and consultation with experts—to assess these kinds of clients well. If this reality is acknowledged, graduate training programs would give a message something like, "Psychological assessment is an exciting area of specialization you may wish to consider for your career. We will train you in basic skills and expose you to what psychological assessment can be. If you are interested, you can even seek an internship that specializes in assessment. But, if you want to practice assessment on your own, you will need at least several years of postdoctoral training and ongoing CE and consultation after that to achieve full competence." Clearly such a proposal will require further development regarding the relative roles of graduate training, internship and specialization in PA. Solid training in graduate school and internship are, of course, the preferable first steps, although, as stated earlier, they cannot be counted on. An initial approach might use already existing specialization models such as neuropsychological assessment or forensic assessment, where basic skills will be developed in graduate training and internship (see Krishnamurthy et al., 2004) followed by diplomate-level specialization in PA.

In the meantime, we call on individual practitioners who do not specialize in PA to limit their independent use of psychological tests to those more easily learned and interpreted, perhaps those requiring Level B qualification (i.e., Master's level preparation; see Turner et al., 2001). We draw an analogy to certain areas of medicine, where it is generally acknowledged that the most successful hip replacements or open-heart surgeries or spinal taps are done by those physicians who frequently perform a high number of such procedures (Halm, Lee, & Chassin, 2002). Similarly, clinicians who do not use an individually administered cognitive test for 7 months will be very rusty when it comes time to give and score one. Those who do not regularly score Rorschach protocols will need twice as much time and make many more errors in administration, scoring, and interpretation than those who score the Rorschach weekly. Psychologists who rarely use psychological tests are less likely to buy new versions or seek regular CE to keep up with latest developments in those tests. These realities mean that clinicians who practice assessment infrequently (and do not seek consultation from expert assessors) are likely to produce assessments of poorer quality than those done by psychologists who make assessment the center of their practices. We realize that there will still be circumstances where nonspecialists will need to conduct assessments (e.g., in rural areas where no specialists exist), but we strongly recommend that occasional assessors who take on such work seek consultation from an assessment expert.

Psychology as a profession should take steps to raise the standard of care for psychological assessment and to help prevent poor-quality assessments from being viewed as acceptable

We do not relish the idea of "assessment police" scrutinizing reports done by assessment clinicians, or of more psychologists being reported to licensing boards for using out-of-date tests. Yet, if the psychology community continues to turn a blind eye to substandard work, it will be difficult to raise the status of PA in the eyes of clients and other professionals. As mentioned earlier, we believe that psychology's failure to confront incompetent and unethical uses of projective and performance-based personality tests, rather than the methods themselves, led in part to the Rorschach controversy of the 1990s. Although the series of articles and research studies that responded to this challenge eventually strengthened the evidentiary basis for performance-based personality tests, many allied professionals and lay people read imbalanced negative accounts in the national press and consequently believe incorrectly that performance-based tests are useless. If we are not careful to monitor professional practice, many other tests could get "thrown out with the bathwater" by public opinion.

One useful step would be for the American Psychological Association to consider publishing a document, such as "Specialty guidelines for the practice of psychological assessment in clinical, counseling, and school psychology." This would be

similar to existing guidelines on custody evaluations (American Psychological Association, 2010b), assessment of dementia (American Psychological Association, 2012), and forensic evaluations (American Psychological Association, 2013), which set the bar for improving the practice of PA in these contexts. Similar guidelines outlining best practices and standards of care for PA would be very valuable. *The Standards for Educational and Psychological Testing* (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 2014) is certainly a step in this direction, but in our minds it does not go far enough in outlining best assessment practices.

Last, we strongly believe it is time for all of us to step up to the plate and report psychologists who do egregiously poor PA to relevant regulatory organizations such as state licensing boards, the Ethics Committee of the American Psychological Association, and ethics committees of state psychological associations. In our experience, one reason this is so rarely done is because there are not clear standards for psychology boards to determine if a PA is in fact competently practiced, especially keeping in mind that psychology board members might themselves have limited experience and knowledge with PA. For example, some years ago, the second author became aware of a case where a psychologist had administered the Rorschach to a client using a black-and-white location sheet faxed to him from his office—instead of the actual Rorschach blots—and then testified in an administrative hearing that his client showed no signs on the Rorschach of being psychologically disturbed. In keeping with the ethical guidelines for psychologists, the second author approached the psychologist about this practice, and the clinician said, "Go ahead and report me; nothing will happen." In fact, the second author reported this clear misuse to his state licensing board, but this complaint was eventually dismissed, with the psychology board reasoning that it was a "difference of professional opinion" whether the psychologist's administration of the Rorschach was adequate and ethical. Such a determination would not have been made if there had been sufficient understanding of the basics of assessment practice. Although it is unclear whether published standards endorsed by the American Psychological Association and SPA would have changed this outcome, such standards are likely to be of great value to both assessment psychologists lodging a complaint and to psychology board members who might have little understanding of what minimum professional PA standards are. Clear standards seem especially needed as most state licensing boards have a majority of nonpsychologist members.

More research is needed on the practical benefits of PA; cost-effectiveness studies would be especially useful

Over a decade ago, there were repeated calls for research showing the incremental validity and utility of PA (e.g., Meyer et al., 2001) and a number of individuals and organizations responded, with the result that many more published studies now exist. To highlight one effort, in 2005 the SPA published a Request for Proposals for research on the utility of PA, and eventually funded a study that found that a brief PA intervention based on Therapeutic Assessment successfully impacted the trajectory of change of clients in the middle of outpatient psychotherapy (J. D. Smith, Eichler, Norman, & Smith, 2015). We applaud SPA's efforts and call on SPA and other professional organizations to continue to fund such research. In particular, studies are needed to assess economic advantages of including PA in a comprehensive treatment program. There is already evidence that PA can help save lives, for example, of suicidal patients (Jobes, Comtois, Brenner, & Gutierrez, 2011) and by identifying and separating violent prisoners from others (Megargee, Carbonell, Bohn, & Sliger, 2001), but as far as we know, no efforts have been made to develop cost–benefit models for such outcomes.

Professional organizations dedicated to PA must educate allied professionals and the lay public about the utility of PA

We fear that substandard practice in PA has become so widespread that many colleagues and former clients now have a diminished sense of how valuable PA can be. Even though research documenting the incremental validity and utility of applied PA already exists, few practicing clinicians have this information at their fingertips and allied professionals and the lay public are largely unaware of it. We call on SPA, the American Psychological Association, ABAP and other organizations concerned with PA to fund speakers to attend meetings of physicians, educators, and allied mental health professionals and present research summaries and compelling case examples demonstrating the value of PA. It would also be useful to develop brochures and other educational materials on the practical utility of PA for allied professionals and the lay public. Last, we recommend that efforts be made to get articles and stories of PA in action publicized in the national press, in part to balance negative accounts that were disseminated in the last decade. Psychologists tend to be quite circumspect about this type of "marketing," and indeed, important ethical guidelines must be respected. If we believe, though, that the future of PA does not depend in part on public opinion, we are naive.

Comprehensive postgraduate training programs in PA should be developed by organizations dedicated to PA (e.g., SPA, ABPA)

Given that graduate training programs are offering less instruction and supervision in PA, and time-limited workshops fall short of fostering the expertise needed for a high level of practice, we recommend that SPA, ABPA, and other organizations consider developing systematic, multicourse training programs in PA that include readings, Web-based lectures, individual consultation, and competency exams. Such initiatives would have been unthinkably costly in the past, but given the viability and success of online learning platforms and "virtual universities," they are now feasible. Such courses could be available to licensed psychologists who did not get adequate training in PA in graduate school, and to psychologists who wish to fill in a particular area of knowledge or become more expert in PA in general. Fortunately, thoughtful guidelines already exist on appropriate course requirements for an advanced training program in personality assessment (SPA, 2006).

Last, individual experts in PA can help raise the standard of practice by offering a cost-effective means for other psychologists to get ongoing consultation. To further this effort, we now describe a collaborative and cost-effective model of group assessment consultation that could be widely implemented around the world.

Consultation in psychological assessment

In our experience, although practicing psychologists frequently recognize the need for ongoing consultation and peer support for their work with psychotherapy, this is not generally true with PA. For example, until the second author began offering assessment consultation groups for licensed professionals in Austin, TX, 30 years ago, no such groups existed in the area, but there were numerous widely attended psychotherapy supervision groups. This pattern was also noted by the first author for the Washington, DC, area. Even accounting for the fact that more practitioners these days provide psychotherapy than PA, this still seems a noteworthy discrepancy and the situation seems to be similar in many other urban communities. No formal data exist on the consultation practices of assessment psychologists, so it is difficult to know why they might not seek more input for their clinical work. From informal discussions with colleagues, we suspect there are a host of reasons: (a) PA is currently assumed to be more "cut and dry" than psychotherapy, and there is very little discussion of concepts like transference or countertransference in assessment, as was true in the past (e.g., Schafer, 1954). Thus, practitioners might either not be aware of the utility of consultation or might feel embarrassed about wanting or needing it; (b) Reimbursement is typically lower for PA than for psychotherapy and overhead costs tend to be high; thus, many assessors might not have the financial resources to seek individual consultation; and (3) Many psychologists perform PA rarely, are not embedded in a community of assessors, and thus do not know how or where to seek consultation when they need it. Committed clinicians attend CE workshops to gain competence in new and updated tests, but they might not know or have access to a local expert who can assist them when they have a particularly difficult case or a confusing set of test results. Some assessment psychologists work together in practice groups, in part to share costs or tests, and this provides a ready source of peer consultation. However, many assessment psychologists appear to simply try to "go it alone."

We believe that the complexities inherent in practicing PA are such that regular consultation is greatly needed, whether it be peer or expert consultation and whether it is focused on test scoring, test interpretation, report writing, or on how to speak to a client or family member about the results of a client's psychological testing. Regular consultation helps maintain and increase professional competence, stimulates professional growth, and makes assessment practice less daunting and more sustainable over time. We next describe a model of collaborative assessment consultation that the second author developed based on the principles of Therapeutic Assessment, which can be used either for peer consultation groups or leader-led groups. These collaborative assessment supervision groups are highly cost-effective when there is a senior consultant and the structure of this model engenders shared openness that helps reduce anxiety coming from the all-too-common fear of judgment. Also, for clinicians who do assessment only two or three times a year, this format provides a regular structure for support and consultation, and therefore promotes ethical practice.

Collaborative assessment consultation groups

In general we find it is best to restrict a consultation group to licensed professionals, rather than including a mix of students and professionals. This format creates an open atmosphere and ensures there is not too wide a disparity in terms of participant expertise. In our experience the best size for a group is from five to eight members, as this keeps the group from being too small if one or more members miss occasionally and members do not have to wait long to present a case. It is useful when there is overlap in expertise and clinical focus among the members of the group so there is a common "language" or set of tests used by group members. However, it is also helpful to have diversity in terms of members' expertise or training. Members commit to attending all sessions and to rotating turns to present an assessment case with which they want help. The second author has found that once-a-month meetings work best for busy professionals, and that a 90-min length allows 30 min to discuss circumscribed matters followed by an hour for the case consultation. Generally, group meetings are held in person, but they could also productively take place by phone or via a HIPAA-compliant Internet Web conferencing service.

The member presenting the case for the next meeting sends other members a set of materials 7 to 10 days beforehand, including (1) complete test protocols including responses and scoring, (b) a brief description of the client's context and the assessment sessions, and (c) a list of questions the presenter would like to address in the consultation. Questions can range from concrete ones such as, "Do people agree with my Rorschach scoring?" or other test-based questions ("How would you interpret this MMPI–2–RF profile?") to broader questions about case conceptualization ("How to reconcile the apparent discrepancy between the PAI and MMPI–2?"; "What kind of treatment would you recommend for a person with these test scores?") or feedback ("What would you tell the client?").

By focusing consultation on presenters' questions, the group encourages members to define what they would find most helpful and at the same time to regulate their level of vulnerability. Also, we find that this focus limits "pontificating" or "showing off" by other members, which is a natural defense against the anxiety of collegial scrutiny when professional groups convene. Last, we find that the presenter's process in pondering, "What questions do I have? What help do I want from the group?" is often by itself very helpful to that person in understanding her or his case.

Group sessions can be led by the consultant, by the case presenter, or by another member who volunteers to facilitate the group that day so the presenter can focus on the consultation. In the first 30 min, the time is "open" to spontaneous questions from any member about circumscribed matters (e.g., "How would you code the following Rorschach response?" "What tests do you all use to assess for a math learning disability?")

and to follow-up reports on previously presented cases. The group also handles business matters during this part of the session, such as setting future dates and choosing who will present at that next meeting. Then the group focuses on the case that is scheduled to be discussed. It is useful first to review and clarify what questions the presenter wants help with and then for group members to ask questions of the presenter about the case materials sent beforehand. Depending on the goals of the consultation, the group can then proceed to examine and discuss each test, or members can share thoughts they had when reviewing the assessment information beforehand while considering the presenter's questions. The consultant or peer group leader makes sure the group does not get bogged down in discussions peripheral to the presenter's goals and checks to see if the presenter is getting what he or she wants from the consultation. Shortly before the end of the group, the consultant or peer leader summarizes the discussion, highlighting any consensus reached about the presenter's questions or outlining different points of view that were not resolved. Sometimes, questions or issues arise that either the members or the leader might investigate before the next session (e.g., What does research show about the effect of physical illness on scores of MMPI–2 Scale 1?). This information can be shared with the group afterward by email or brought to the next meeting.

Although assessment consultation groups are primarily "work groups" and not psychotherapy groups, we have found that it is important to occasionally discuss group process, especially when powerful emotional processes affect the group's task function. It is a vulnerable experience for a member to present a case with which she or he needs help, and sometimes one member feels hurt or angry in response another member's comments. Also, we find that members vary in their willingness to be more open than others, which can be reflected in certain members "passing" their turn to present for months on end ("Sorry, I just don't have any cases lately I need help with"). Discussing such behaviors might reveal underlying anxieties and can often resolve them and keep group sessions emotionally rich and productive. We encourage assessment clinicians to strongly consider forming and participating in assessment consultation groups, and we urge experts in PA to convene and advertise such groups to their colleagues.

Summary and conclusions

Once a central part of the identity of many psychologists and a core professional competence to which multiple courses were devoted in doctoral training programs, PA has changed drastically over the last 25 years. Increasingly, many doctoral programs in clinical, counseling, and school psychology have fewer required courses in PA. Those courses that remain are often taught by adjunct faculty or even by early tenure-track faculty who are required to teach the "testing course," even if assessment is not their specialty. Some doctoral programs (especially those in professional schools of psychology) still emphasize PA and others provide training in assessment subspecialties, such as forensic psychology or neuropsychological assessment. However, even graduates of these programs might be challenged to maintain competence and make the practice of PA a viable part of their professional activity as their careers develop. Restricted compensation by third-party payers, higher overhead costs, and the constant evolution of knowledge in PA can make it easy for psychologists to wonder, "Why should I keep practicing psychological assessment? It seems like an uphill battle." Regrettably, some psychologists might opt to keep practicing assessment while letting standards or their competency slide.

Although we (and presumably, other readers of this journal) might lament this state of affairs, many psychologists and major national psychological associations apparently do not. Although assessment subspecialties such as neuropsychological assessment and forensic assessment appear to be thriving, we believe there is a risk that most clients presenting at inpatient and outpatient treatment centers in the future will not be provided with competent P. Most clients do not receive psychological testing at all, depriving them of an experience that has clearly been shown to be of therapeutic value and to increase the success of subsequent treatment (see Finn, Fischer, & Handler, 2012, for a summary of research). Of even more concern are those clients who receive PAs that are not of adequate quality and that might even be stigmatizing or demoralizing.

Addressing these issues will not be simple or easy, and must involve efforts from multiple interested parties. Besides the excellent CE workshops offered by test publishers and at meetings of professional associations, we advocate that assessment experts and practitioners organize local assessment consultation groups to provide support and training for assessment clinicians. We also recommend that professional organizations take steps to recognize PA as a demanding, highly valuable clinical specialty and to raise standards of care for PA. Perhaps, through such coordinated efforts, PA will once again be recognized as a potentially life-changing clinical intervention that psychologists are uniquely suited to perform.

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