Consumer-Focused Psychological Assessment

Eliot Brenner
Casey Family Services

To enhance the clinical utility of psychological assessments, the author recommends a consumer-focused approach to health care marketing—the “Four Rs”: relevance, response, relationships, and results (J. English, 2000). Research suggests 5 responses psychologists can take to increase the relevance of psychological assessments: (a) eliminate jargon, (b) focus on referral questions, (c) individualize assessment reports, (d) emphasize client strengths, and (e) write concrete recommendations. To build relationships with consumers, psychologists should collaborate with them when formulating referral questions and providing feedback of assessment results. Finally, psychologists should use the results of consumer satisfaction studies to improve the clinical utility of psychological assessments.

The use of psychological assessment is declining, even though the reliability and validity of individual psychological tests are well documented (see G. J. Meyer et al., 2001, for a recent review). The most commonly cited reasons for the decline include the proliferation of managed care, use of psychotropic medications to determine diagnosis, and a lack of studies measuring the value and cost-effectiveness of psychological assessment (e.g., Eisman et al., 2000).

Recently, the American Psychological Association’s Psychological Assessment Workgroup published a review of the clinical utility of individual psychological tests (Kubiszyn et al., 2000). Although traditional research focuses on establishing the reliability and validity of individual psychological tests, clinical utility research focuses on demonstrating the practical value and usefulness of these tests in clinical practice. On the basis of their review, the workgroup recommended that psychologists might stem the decline of psychological assessment by educating managed-care companies, other mental health disciplines, consumers, and lawmakers regarding the clinical utility and empirical support for psychological assessment (Eisman et al., 2000).

One way in which psychologists can begin to understand and assess clinical utility is to focus on the needs of the consumers of psychological assessments. The primary consumers of assessments are referral sources, such as physicians, other mental health practitioners, child welfare caseworkers, parents, and patients. Interestingly, for more than 4 decades, researchers have been asking consumers of psychological assessments what they want (e.g., Mussman, 1964; Smyth & Reznikoff, 1971; Tallent, 1956; Wiener, 1985), and some psychologists have been urging their colleagues to write assessment reports that focus on the needs of consumers (e.g., Shectman, 1979; Tallent, 1958). Still, the practice of assessment has changed little during that time (e.g., Budd, Felix, Pindexter, Naik-Polan, & Sloss, 2002; Camara & Nathan, 1998; Watkins, Campbell, Nieberding, & Hallmark, 1995). At the same time, practice has been enhanced in other areas when consumers’ needs have been addressed. Focusing on the consumers of health care services is a critical component of quality management, a framework for assessing and improving clinical, fiscal, and operational performance in health care organizations (see Sluyter, 1998, for review).

Focusing on the consumer, or customer, is also critical to most current approaches to marketing health care services (e.g., Rosen- garten, 1996). Although historically many psychologists have considered marketing to be aversive, psychologists could use modern approaches to marketing as a framework to begin to improve the utility of their assessments. Recently, English (2000) proposed an approach to marketing health care services that focuses on the needs of the consumer and is consistent with most quality management tenets (see also Schultz, 1999). He proposed the “Four Rs”: relevance, response, relationships, and results. Relevance involves listening to and getting to know customers. This includes gathering quantitative and qualitative data concerning customers’ needs. Response involves using information about customers’ needs to create a product or service that meets those needs and that is distinct from other products or services. Relationships involves establishing links with customers that extend beyond the discrete clinical episode (i.e., beyond a single visit or referral). Results involves measuring success according to such benchmarks as increased referrals, repeat customers, increased market share, and customer satisfaction.

In this article, I propose that the Four Rs of consumer-focused marketing can serve as a framework for psychologists to begin to improve the utility of psychological assessments in clinical practice. Toward this end, I use the Four Rs approach to organize and integrate research that has focused on the consumers (e.g., referral sources, parents, patients) of psychological assessments. My primary aim is to suggest concrete ways in which psychologists can improve the clinical utility of psychological assessments by focusing on the needs of their customers. In the first section, I review research on what is relevant to consumers of psychological assessments, and I suggest ways in which psychologists can respond to...
Continually assess attempts at consumer focus: Results

Build lasting alliances with consumers: Relationships

Create a useful product: Response

Identify consumer needs. Consumers indicate that reports:

Relevance

Reduce Jargon

Existing research suggests that many consumers do not understand psychological assessment reports because they are filled with jargon and written at a reading level that is too advanced. Interestingly, almost all of the published research on this topic was conducted more than 2 decades ago. Still, the one contemporary article I found (Harvey, 1997) suggested that psychologists continue to use jargon in their reports. Harvey noted that more than 72% of parents in the United States are unlikely to read comfortably above the 12th-grade level. Harvey used the Flesch Reading Ease Score (Flesch, 1948) to code 40 psychological testing reports.

Response

Reduce Jargon; write at a lower reading level

These two studies suggest that psychological assessment reports are written at a reading level that is too high for most parents. But what if the referral source is a mental health practitioner or teacher who has a graduate education and may read at a higher level than many parents? Rucker (1967) asked school psychologists and elementary school teachers to choose from different definitions of 31 technical words that frequently appear in psychological testing reports (e.g., defense mechanism, oral fixation). Rucker found that respondents chose the same definition 50% or more times for only 14 of 31 technical words. Further, she found that for 7 words (23%), school psychologists and teachers preferred entirely different definitions.

Using a similar methodology, Shively and Smith (1969) asked elementary and high school teachers, junior and senior high school counselors, and undergraduate students in a teacher education program to choose from different definitions of 30 technical words that frequently appear in psychological assessment reports (e.g., neurological impairment, perseverate, borderline intelligence). The results revealed that counselors defined 76% of words correctly, teachers 58%, and students 48%. Thus, even high school counselors chose incorrect definitions for nearly one quarter of the technical words contained in this sample of reports.

Finally, Caudra and Albaugh (1956) studied the ability of psychologists, psychology trainees, psychiatrists, social workers, nurses, and student nurses to comprehend critical material contained in psychological assessment reports. These investigators measured the percentages of agreement between the meaning of critical material as defined by the psychologists who wrote the assessment reports and the meaning as interpreted by study participants. The percentages of agreement varied by discipline: psychologists (57%), psychology trainees (59%), psychiatrists (51%), social workers (56%), graduate nurses (49%), and student nurses (48%). Thus, even psychologists and psychology trainees did not understand more than 40% of the key material in these assessment reports.

The data from this study are consistent with consumer satisfaction data reported by Tallent and Reiss (1959c), who asked psychiatrists, psychiatric social workers, and psychologists to respond to the open-ended question, “The trouble with psychological re-

[Table 1]

The Four Rs Approach to Consumer-Focused Psychological Assessment

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<td>Identify consumer needs. Consumers indicate that reports:</td>
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<tr>
<td>1. Contain too much jargon; reading level is too advanced</td>
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<td>2. Overrely on standard battery of tests</td>
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<td>3. Contain stereotyped content</td>
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<td>4. Are deficit-focused</td>
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<td>5. Contain vague recommendations</td>
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<td>Create a useful product:</td>
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<tr>
<td>1. Reduce jargon; write at a lower reading level</td>
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<td>2. Reduce use of standard battery; focus on referral questions</td>
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<td>3. Individualize content</td>
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<td>4. Focus on strengths</td>
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<td>5. Write concrete recommendations</td>
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<td>Build lasting alliances with consumers:</td>
<td></td>
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<tr>
<td>1. Collaborate with consumer to formulate referral questions</td>
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<td>2. Collaborate with consumer during verbal feedback session</td>
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<td>Continually assess attempts at consumer focus:</td>
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<td>1. Measure customer satisfaction</td>
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<td>2. Monitor frequency of referrals</td>
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ports is ’ . . . ’ “ (p. 444). The most frequent response across all disciplines was use of jargon and “wordiness.”

These studies suggest that psychologists may be writing at a level that even other psychologists or mental health practitioners may not understand. After years of graduate training, we must resist the temptation to write in a manner that proves to others our specialized knowledge and expertise. As Shectman (1979) said, “All too often, I fear, we write for our supervisors or each other under the guise of writing for a colleague” (p. 784). However, it is important for psychologists to remember that the primary purpose of a psychological report is to communicate with the consumer.

Response 1: Psychologists need to eliminate jargon and write at the level of their consumers.

Focus on Referral Questions

Studies of consumers suggest that they prefer psychological assessment reports that explicitly address referral questions. Wiener (1985) studied teachers’ comprehension and satisfaction with three kinds of assessment reports: a standard psychoeducational version; a question-and-answer version that responded explicitly to referral questions; and a brief, one-page version, which contained recommendations and results without elaboration. Wiener (1985) found that teachers’ comprehension of the standard psychoeducational and question-and-answer versions did not differ significantly, although teachers did comprehend less information in the short version. However, teachers preferred to read the question-and-answer version. Wiener and colleagues replicated these findings with parents (Wiener & Kohler, 1986) and school principals (Wiener, 1987). Data from these studies suggest that consumers want assessment reports that address referral questions explicitly.

Unfortunately, current assessment practice emphasizes administration of a standard battery of tests, which may not be the most effective way to address referral questions. Nearly 15 years ago, Sweeney, Clarkin, and Fitzgibbon (1987) showed that most psychologists used the same “standard” test battery that was used in the 1940s, which consists of a Wechsler Intelligence Scale, the Rorschach, and the Thematic Apperception Test. Recent research suggests that the standard battery is still widely used, although many psychologists have added the Minnesota Multiphasic Personality Inventory (Camara & Nathan, 1998; Watkins et al., 1995). There are practical, statistical, and ethical reasons why widespread use of a standard battery may be problematic.

From a practical standpoint, psychologists are more likely to address referral questions when they use instruments and procedures that are designed specifically for the problems at hand. For example, Sweeney et al. (1987) noted that many referral questions ask for a psychiatric diagnosis, yet the standard test battery is not usually the most effective way to determine a diagnosis based on the criteria of the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV: American Psychiatric Association, 1994). G. J. Meyer et al.’s (2001) extensive review indicates that there are many highly reliable and valid tests that psychologists can use to address specific diagnostic questions, yet most psychologists do not use these tests.

From a statistical standpoint, administering unnecessary tests, or comparing the results of many subtests or scales, increases the likelihood of Type I error (i.e., an assumed statistically significant finding that is actually due to chance). McDermott and Glutting (1997) demonstrated this problem in their study of the widespread practice of comparing many subtest scores on the third edition of the Wechsler Intelligence Scale for Children. The investigators referred to the results of these comparisons as “illusions of meaning” (p. 163).

These practical and statistical problems have ethical implications. First, it may be iatrogenic for the client if incorrect or erroneous assessment findings are used to make inappropriate or unnecessary service recommendations. Second, even a few unhelpful assessment reports may leave consumers believing that psychological assessment is not useful (Finn & Tonsager, 1997), increasing the likelihood that clients who might actually benefit from assessment are not referred. Customer satisfaction research has found that dissatisfied customers tell many more people about their experiences than do satisfied customers (see Albrecht & Zemke, 1985, for a review), suggesting that unhelpful assessments are likely to discourage future referrals.

Response 2: Psychologists should minimize their use of standard test batteries and focus assessments explicitly on referral questions.

Individualize Content

Tallent (1958) described a number of ways in which psychologists fail to individualize the content of their assessments, two of which I mention here. The first, the Barnum method (see also Meehl, 1973), is a description of personality using a few negative generalities within a mixture of more positive characterizations, resulting in a description that applies to many people and that is difficult to dispute. The second, the Aunt Fanny description, uses statements that could apply to many people, including your own Aunt Fanny. Statements such as “experiences unconscious angry feelings” or “experiences strong emotion when under stress” are so superfluous that they may prompt readers to say, “So does my Aunt Fanny!” (Tallent, 1958, p. 243).

Psychologists’ failure to individualize the content of their reports is a primary complaint of some consumers. In their survey of psychiatrists’ opinions of the usefulness of psychological assessment reports, Smyth and Reznikoff (1971) found that 23% of respondents cited stereotyped reporting as a limitation of most reports. Another study of psychologists, psychiatrists, and psychiatric social workers who were asked to rate the quality of psychological assessment reports at a Veterans Affairs hospital found that the most frequent complaint was a lack of individualized, behavioral description of the client (Garfield, Heine, & Leventhal, 1954). There is some empirical evidence that individualized reports help consumers address client problems. Bagnato (1980) found that when teachers of young children with developmental disabilities were given reports that included individualized, developmental information (e.g., the child “drinks with a cup unassisted”; p. 556), the teachers were able to construct individualized education programs with greater accuracy than were teachers who were given reports that contained generalized information (i.e., test scores).

Response 3: Psychologists need to individualize their assessment reports to capture the unique attributes of the client.
Focus on Strengths

Sheetman (1979) stated that “psychologists should improve their ability to articulate what is right with the patient as well as what is wrong” (p. 786). Tallent (1958) referred to the psychological assessment report that focuses only on a client’s negative attributes as the “prosecuting attorney brief” (p. 243). These reports “are prepared by psychological simians who hear no good, see no good, and report no good” (p. 244). I am aware of only one published study that examined consumers’ desire for greater description of client strengths in psychological assessment reports (Tallent & Reiss, 1959a). These investigators found that psychiatrists, psychologists, and social workers wanted to see more description of patients’ “assets” and “ego strength.”

The field of social work has a rich tradition of strength-based approaches to human growth and development (e.g., Weick, Rapp, Sullivan, & Kisthardt, 1989). Weick et al. (1989) noted the philosophical problems with deficit-focused approaches:

On a philosophical level, the intense focus on problems makes it difficult for practitioners to express some of the fundamental values of the profession. The belief in the dignity and worth of each individual and the corresponding belief in individual and collective strength and potential cannot be realized fully in the midst of concerns about assessing liabilities. (p. 352)

Psychologists have recently begun to reconsider strength-based approaches to human behavior. For example, psychologists are beginning to advocate for the inclusion of strength-based assessment tools in psychoeducational reports (Rhee, Furlong, Turner, & Harari, 2001). Psychologists’ research is also beginning to document the important role that strengths play in improving clinical outcomes (e.g., Lyons, Uziel-Miller, Reyes, & Sokol, 2000).

A recent issue of the American Psychologist on positive psychology (Seligman & Csikszentmihalyi, 2000) also highlights a shift toward recognizing human strengths. Positive psychology emphasizes the roles of positive emotions (e.g., Fredrickson, 2001), optimism (e.g., Schneider, 2001), and resilience (e.g., Masten, 2001) in guiding behavior. Behavioral approaches to treatment (e.g., Lewinsohn, Munoz, Youngren, & Zeiss, 1986), research on stress and coping (see Folkman & Moskowitz, 2000, for a review), and current trends in community-based treatments (e.g., England & Cole, 1998) also point toward the importance of strength-based approaches to behavior change. In spite of these forces in psychology, however, psychological assessments remain primarily deficit-focused. For example, in developing a statewide psychology consultation program for the Illinois Department of Children and Family Services that oversees more than 2,500 psychological assessments annually, a colleague and I found that psychologists usually fail to note client strengths in their reports, even when explicitly asked to do so (Brenner & Holzberg, 2000; see also Budd et al., 2002).

Response 4: Psychologists need to emphasize client strengths in their assessment reports.

Make Concrete Recommendations

For most consumers, the recommendations section is the most useful section of the psychological assessment report. This has been found with parents (Tidwell & Wetter, 1978), teachers (Mussman, 1964), and residential treatment staff (Isett & Roszowski, 1979). Similarly, in a recent study of more than 200 child welfare caseworkers, these caseworkers rated the recommendations as the most useful section of a psychological assessment report (Brenner, Holzberg, & Small, 2003). These studies support the work of Tallent and Reiss (1959a), who, more than 4 decades ago, asked psychologists, psychiatrists, and social workers the question “What sort of specific information do you want to get out of a psychological report?” (p. 218). The most frequent response was “recommendations.”

Consumers want recommendations that are concrete and pragmatic. When Mussman (1964) asked teachers how to improve reports, they told him “more concrete suggestions” (p. 36). When Salvagno and Teglas (1987) asked elementary school teachers to rate the helpfulness of three different kinds of recommendations, the teachers preferred the most concrete one, which contained a verbatim example of a statement the teacher might make to a student. In another study, elementary school teachers rated the usefulness of a recommendation for a student to stay in the classroom during recess (Witt, Moe, Gutkin, & Andrews, 1984).

The recommendation was written in three different styles: behavioral, humanistic, and pragmatic. The behavioral style emphasized punishment, contingency, and the development of social skills; the humanistic style emphasized understanding and expressing feelings; the pragmatic style emphasized how staying in at recess was a consequence of the student’s prior actions. Teachers rated the pragmatic recommendation as the most useful. Similar studies with elementary and high school teachers (Brandt & Giebink, 1968) and special education teachers (Owby, Wallbrown, & Brown, 1982) have also found that they prefer concrete recommendations to abstract or general ones.

Because studies suggest that referral sources carefully scrutinize recommendations, it is critical that psychologists create recommendations that address the unique concerns of the referral sources. For example, if a teacher refers a child because he or she has difficulty sitting still and the teacher believes that the child may have a learning disability, then recommendations should address specific ways in which the teacher can manage and address the behavior and learning difficulties in a classroom setting. The recommendations might also address ways in which the teacher can work with the child’s parents to ensure that homework assignments are completed. Analogously, if parents refer a child because of the child’s hyperactive, risk-taking behavior, then recommendations should address ways in which the parents could manage these behaviors in the home. If a physician or mental health provider refers a child to assist in making a differential diagnosis between attention-deficit/hyperactivity disorder and posttraumatic stress disorder, then recommendations should address this issue specifically, providing a diagnosis and outlining the pros and cons for the child of different psychosocial treatment approaches. Although technical terminology such as DSM–IV diagnoses will need to be used in this report, the terms and symptoms should be explained clearly enough so that even a nonprofessional person can understand them, because the child’s parents may read this report.

Response 5: Psychologists need to write concrete, pragmatic recommendations that address the specific needs of the referral source.
Relationships

If one develops and delivers a product or service that is relevant and that responds to consumers’ needs, this increases the likelihood of building relationships with consumers that extend beyond a single referral or episode of service. In health care marketing, building relationships with consumers means that they will return to the same hospital or clinic the next time they are sick, or select the same HMO when they move or change jobs. In addition to providing relevant assessment reports that respond to the needs of their customers, psychologists can enhance the value of assessments by building relationships with referral sources. In this section, I outline several ways in which psychologists can enhance relationships with consumers.

Formulating Referral Questions

One approach to building relationships with consumers is to collaborate with them throughout the assessment process, which begins with formulating referral questions. For example, Crary and Steger (1972) proposed a consultation model in which the psychologist works closely with the referral source to decide whether psychological assessment is appropriate, and if it is, to formulate explicit questions. This model contrasts with the prescriptive model of assessment in which the referral source decides whether to test and formulates referral questions.

One group of researchers found that when pediatric psychologists collaborated with health care professionals in making referrals, the level of satisfaction and frequency of referral of these health care professionals increased (Olson et al., 1988). This contrasts with the one published study I found that examined the clinical utility of referral questions formulated using a noncollaborative approach (i.e., minimal communication between psychologist and referral source), which reported that 37% of reports had little or no clinical utility, as rated by advanced clinical psychology graduate students (Howe, 1981).

Hamlett and Stabler (1995) expanded the consultative approach with their process consultation model, in which the psychologist collaborates with the referral source throughout the entire assessment, beginning with formulation of the referral question. The referral question is used as a means to create a liaison with the referral source. Hamlett and Stabler highlighted the importance of identifying the underlying personal concerns and worries of the referral source, which can help elucidate referral questions. The authors, who work in a pediatric hospital, cited an example of a 14-year-old girl with cystic fibrosis who was referred for a cognitive evaluation. After consulting with the referring physician, the authors learned that the mental health of the girl’s mother was deteriorating and that the physician wanted to know if the girl would be able to care for herself independently. Identifying the underlying or latent content in referral questions has also been noted by psychologists who assume a psychodynamic approach to psychological assessment (e.g., Cohen, 1980).

According to Hamlett and Stabler (1995), consultation regarding the referral question also informs the referral source about the strengths and limitations of psychological assessment, resulting in more realistic expectations on their part and thus more satisfaction with the evaluation. Another group of researchers described a similar collaborative model in which neuropsychologists worked with vocational case managers of schizophrenic patients to formulate referral questions and to review rehabilitation plans (Malla et al., 1997).

Research suggests that referral questions in assessment reports are often vague and diffuse (Lubin, Larsen, Matarazzo, & Seever, 1986; Sweeney et al., 1987). For example, Lubin et al. found that the three most common requests for assessment were for “a complete assessment” (35%), “assessment of personality functioning” (19%), and “intellectual assessment” (14%). It is no secret to most psychologists that psychological assessment is not particularly helpful when referral questions are vague. Morrow (1954) wrote that “the vague psychiatric request inevitably results in stereotyped, jargon-ridden psychological reports” (p. 105). Morrow named these reports “shotgun” or “omnibus” reports because they attempted to address every conceivable question or problem (see also Tallent, 1958). Collaborative approaches to assessment may help reduce these kinds of assessment reports, resulting in reports with greater clinical utility and increased consumer satisfaction.

Conducting Feedback Sessions

Little research exists concerning how frequently psychologists in clinical practice conduct feedback sessions of their assessment results with consumers. I am aware of only one published study in this area, which found that primary care physicians reported having received little or no verbal feedback from psychologists when patients were referred for psychological consultation (J. D. Meyer, Fink, & Carey, 1988). Providing feedback is important because sometimes consumers misunderstand written test results (Mason, 1973; Mertens, 1976). Feedback may also increase the likelihood that consumers implement assessment recommendations (Salvagno & Teglas, 1987).

Feedback sessions can also serve as an opportunity to build collaborative relationships with consumers. But feedback sessions must not be conducted in a unilateral manner in which the assessment results are “pronounced” to the referral source. As Berg (1984) noted, “The aura of omnipotence . . . has increased interdisciplinary strains to the detriment of diagnostic work and the welfare of patients” (p. 344). Cleveland (1976) referred to psychologists’ attitude of pronouncing test results as “test prediction in a vacuum.” Cason (1945) suggested that school psychologists should use “democratic methods of co-operative planning rather than assuming an authoritarian role” (p. 134) in their feedback sessions. Similarly, Gilmore and Chandy (1973) urged school psychologists to collaborate with teachers in designing and implementing classroom interventions that are based on assessment recommendations.

The collaborative feedback session can be operationalized in a number of ways that are likely to enhance rapport between the psychologist and consumer and to improve the clinical utility of psychological evaluations. Psychologists should include in their feedback concrete examples of the client’s behaviors, because these are likely to facilitate helpful dialogue concerning the client’s struggles (Holzberg, Alesi, & Wexler, 1951). Pollak (1988) proposed that psychologists conduct parent feedback sessions in which they (a) tailor feedback to the intellectual level of parents, (b) encourage parents to participate actively, (c) avoid blaming parents, (d) normalize the child’s behavior whenever possible, and (e) include information concerning the child’s strengths. Pollak
initiated feedback sessions by asking parents what, if anything, the child had told them about the evaluation and if additional concerns had arisen since the referral. Throughout the feedback, Pollak suggested evaluating the accuracy of test results and impressions by asking parents, “Have you noticed anything like this at home?” or “Have you ever wondered if this kind of thing might be a source of difficulty for your child?” (p. 148).

Pollak’s (1988) recommendations highlight the need for psychologists to use basic social and therapeutic skills during feedback—such as, active listening, avoiding blame, emphasizing strengths rather than pathologizing—to improve their relationships with consumers. Shectman (1979) summarized the need for psychologists to use therapeutic skills to build relationships during feedback sessions:

> Just as one assesses and facilitates a diagnostic and therapeutic alliance with a patient, so one needs to do that with a referring colleague—helping to develop a kind of consultative alliance in which . . . inter-professional and other difficulties . . . are themselves the objects of mutual scrutiny, open discussion, and collaborative endeavor. (p. 790)

Thus, collaborative approaches to providing feedback enhance relationships with consumers and bolster the clinical utility of assessments by increasing consumers’ ability to understand and use assessment findings. Collaborative approaches also enable the psychologist to gather qualitative data regarding the consumer’s perspectives on different components of the assessment. Berg (1984) urged psychologists during feedback sessions to encourage psychiatrists to give them feedback on the helpful and unhelpful aspects of the assessment. This enables psychologists to continually improve the quality and accuracy of assessments (Lanyon, 1972), which is consistent with most approaches to quality management, as well as with the Boulder model of clinical psychology, which encourages psychologists to use research to guide clinical practice. In the next section, I discuss the “fourth R”: outlining several ways in which psychologists can measure the results of their attempts to improve the consumer focus of assessments.

**Results**

Producing assessment reports that are relevant and that respond to consumer needs is an ongoing challenge that requires psychologists to continually assess the quality of their work. Commonly used health care benchmarks that denote service delivery success include increased referrals, repeat customers, increased market share, and customer satisfaction. I am not aware of any published studies that have examined the effects of improving consumer focus of psychological assessments on any of these variables. However, qualitative data collected in the study of child welfare caseworkers cited earlier suggest that caseworkers repeatedly made referrals to psychologists whose assessments addressed referral questions and who minimized jargon in their reports (Brenner et al., 2003). Designing and implementing studies that assess customer satisfaction are ways in which to begin to understand and improve the clinical utility of psychological assessments. Without prompting, consumers are not likely to voice dissatisfaction to the seller of a product or service, instead choosing to “vote with their feet” (Technical Assistance Research Programs, 1986). Thus, it is imperative that psychologists ask their customers about the quality of psychological assessments. When assessments have clinical utility, referral rates are likely to increase, and clients who need assessments are likely to get them.

Some of the same methodologies used to assess consumer satisfaction in health care service delivery could be used to assess the clinical utility of psychological assessments. These methodologies include personal interviews, focus groups, and surveys (Savitz, 1999). For example, in the study of child welfare caseworkers noted earlier (i.e., Brenner et al., 2003), my colleagues and I interviewed clinical managers and surveyed and conducted focus groups with caseworkers and clinical supervisors. The survey asked staff to (a) rank the importance of each section of the psychological assessment report; (b) rank the importance of various psychology provider performance criteria, such as timeliness in completing assessments and the ability to address case planning concerns; and (c) identify in open-ended questions what psychologists could have done to make assessment reports more useful. Combining methodologies improved the validity of the evaluation results while highlighting some of the unique needs of the staff at different levels of the organization.

**Conclusion**

In the first paragraph of this article, I noted that one of the commonly cited reasons for the decreased use of psychological assessments is the proliferation of managed care. The “Four Rs” approach may offer a way in which psychologists can begin to improve their ability to respond to the needs of managed care. Psychologists could begin by asking the question, “What is most relevant to managed care?” Stout and Cook (1999) suggested that psychologists could more effectively respond to the needs of managed care by producing assessments that (a) help develop more individualized treatment plans, (b) make more accurate psychiatric diagnoses, and (c) help primary care physicians identify patients who have psychiatric diagnoses and require psychosocial interventions. To build lasting relationships with managed-care organizations that result in repeat referrals, psychologists need to provide a useful product that responds to these kinds of needs. Results are also critical to managed-care organizations. Thus, psychologists working for managed-care organizations need to continuously evaluate how well their assessments improve service delivery criteria such as treatment plan specificity and diagnostic reliability.

Working for managed care demonstrates how the “Four Rs” could be used as a framework for formulating research questions and evaluating them within everyday practice settings. This example also highlights how psychologists can apply their assessment and evaluation skills—two skills that distinguish them from other mental health providers—to improve the everyday practice of psychological assessment. In today’s rapidly evolving health care marketplace, if psychologists do not take action soon, a cornerstone of their professional practice may begin to erode.

**References**


