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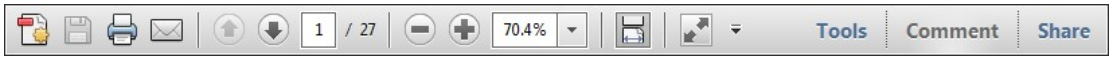

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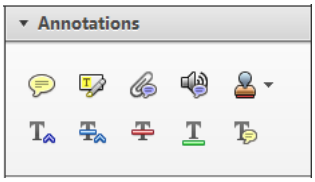

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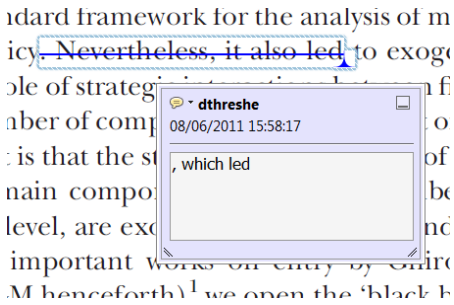

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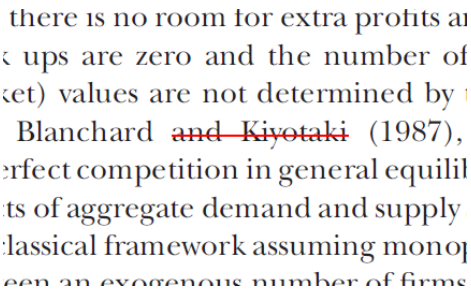

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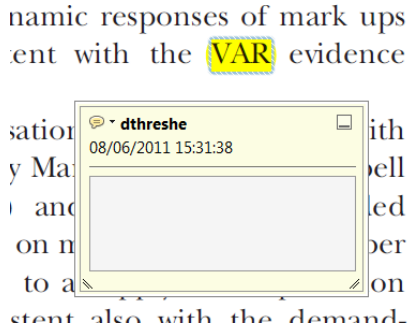

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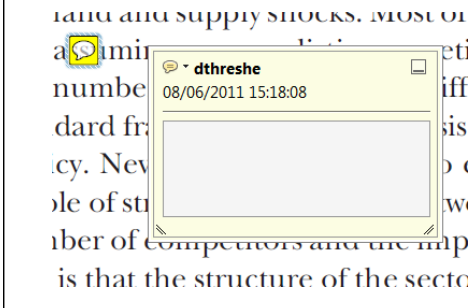

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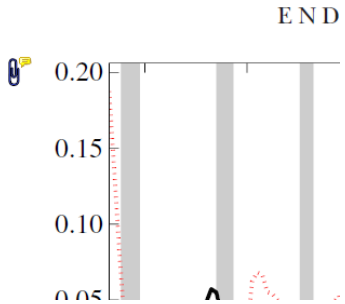

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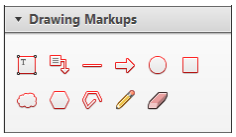

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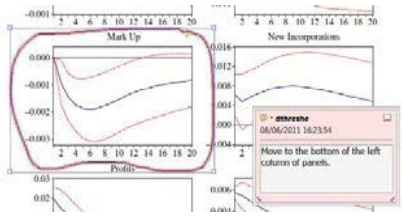

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COMMENTARY

Evidence-Based Assessment in the 21st Century: Comments on the Special Series Papers

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Key words: **clinical utility, evidence-based assessment, psychological constructs, psychological testing.** ***[Clin Psychol Sci Prac, 2016]***

Although assessment is the central skill of applied psychologists and the foundational basis for research and practice, evidence-based assessment (EBA) has lagged behind other domains within the evidence-based movement. Therein lies the importance of this issue, about which we are grateful for the opportunity to provide comments. Overall, the articles in this Issue provide a broad overview of EBA within four areas of applied assessment: children and adolescents, medical settings, treatment planning, and forensic settings. The articles collectively review the history of applied assessment in each area, current standards of EBA, and directions for expansion toward a more evidentiary approach. As a collection, this issue provides a very nice sampling on a series of four excellent articles that set the stage for EBA in a variety of settings and contexts.

We have organized this commentary around two sections. First, we discuss two important general themes that arose during our readings of these articles, which we believe to some degree will also dictate how EBA and its practice can further evolve. Second, we discuss some important considerations that pertain particularly to the four articles (and thus, the four EBA contexts) in this special issue.

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GENERAL THEMES

Assessment of Psychological Constructs

In contemporary clinical practice, assessment generally serves as a method for estimating an individual's scores on theoretical constructs (Morey, 1991) to help professionals make behavioral predictions about individuals. A basic question in developing EBA is therefore: What constructs are being assessed? The common tie among clinical, health, child/adolescent, and forensic practitioners is their interest in constructs that help them make predictions that are relevant for their particular context. Often the focus is thus on individual differences in personality and psychopathology that are relevant for treatment planning, prognosis, risk assessment, and other kinds of clinical decisions.

As an overall framework for thinking about the nature of such constructs, we find it helpful to step back and consider the state of the science about the organization of personality and psychopathology variables. Two general conclusions come from a big picture perspective. First, with very rare exceptions, personality and psychopathology data are dimensional (Haslam, Holland, & Kuppens, 2012; Regier, Narrow, Kuhl, & Kupfer, 2009). This creates a dilemma for practitioners dealing with categorical diagnostic schemes, as in principle, there is no valid way of determining where, on a dimensional psychopathology construct, people "have" or "do not have" a disorder. In applied settings, we generally rely on conventions, such as the diagnostic criteria of professional manuals, law and judicial precedent, or cut scores based on empirical predictions of certain outcomes. However, it is important to recognize that (a) typically categories are less reliable and valid than dimensions (Markon, 2011) for most clinical predictions, and (b) diagnostic status based on a measure with an arbitrary cut-score (such as a categorical diagnosis) is a rather weak criterion for clinical decision-making or measure validation. The psychometric

advances advocated by Butt (2016) were clearly in line with this perspective. In contrast, we saw the reliance on categorical variables as a primary weakness of the approach to EBA proposed by (Youngstrom and Van Meter 2016).

Second, personality and psychopathology variables can generally be integrated via a hierarchical framework (e.g., Krueger & Markon, 2014). In this framework, there is often a general factor that reflects that general covariance of psychopathology (e.g., Caspi et al., 2014). Internalizing and externalizing factors are often the second level the hierarchy. At lower levels, internalizing splits into factors such as introversion and neuroticism, whereas externalizing splits into low agreeableness and conscientiousness. More specific diagnostic variables, such as variations in psychotic or anxiety disorders, can generally be fit into this framework in psychiatric data (Wright et al., 2013). This structure helps explain problematic patterns in diagnostic data such as comorbidity and heterogeneity, connects clinical assessment to a large body of basic research on normal personality, and provides a coherent model for determining the appropriate level of assessment for a particular clinical question. From our perspective, any EBA must therefore take the structure of personality and psychopathology into account. For instance, our view is that the Bagby et al. (2016) review is an important step forward in organizing EBA around the five-factor model (FFM), but that this approach could be more integrative if it did not focus on one particular level of the personality hierarchy. Likewise, Archer, Wheeler, and Vauter (2016) emphasized the importance of multidimensional assessment, but did not take this argument one step further by suggesting how the variables from various multidimensional assessments fit together in an integrative framework. Doing so would ~~get~~ applied assessment away from its current test-centered biases and toward more truly evidence-based models.

Pragmatic Assessment

State-of-the-art EBA assessment can be great in theory, but its implementation in practice requires careful thought. One of the major challenges we perceive as we move forward with innovative EBA procedures is articulating the clinical utility of these approaches. Youngstrom and Van Meter (2016) propose an actuarial model that is rooted in Bayesian thinking. Although quite appealing in theory, and perhaps manageable for clinicians with expertise in statistics, this is not easily implemented in psychological practice and (in our opinion) goes beyond inputting data into an Excel spreadsheet. Psychologists would need training in how to best incorporate these practices and, to a significant degree, it would also require some level of curriculum shift in graduate training. Similarly, we agree with Butt (2016) that Item Response Theory (IRT)-based methods, including CAT applications and real-time symptom monitoring, could be quite useful in psychological assessment in the medical setting. However, the implementation of such techniques is challenging, especially in light of some ambiguity with respect to the types of constructs being assessed and the physical status of patients undergoing these assessments.

Evidence-based assessments do not always need to include psychological tests, especially self-report, and it is not always feasible (or even appropriate) to do so. Archer et al. (2016)for instance, place a high premium on the use of psychological testing in forensic psychological evaluations (a sentiment with which we wholeheartedly, perhaps even passionately agree), but the necessity and feasibility of testing in forensic contexts is not always indicated. For instance, it is very difficult to get an individual in a manic episode to complete a long questionnaire. For some psycho-legal questions, such as criminal responsibility, the utility of self-report assessment is outright questionable, as they provide little with respect to evidence concerning mental state at the time of the offense. Similar feasibility arguments can be raised about Bagby, Gralnick, Al-Dajani, and Uliaszek (2016) emphasis on normal-range personality testing. Particularly in United States, reimbursement considerations might prohibit extensive evaluation of personality, especially via self-report questionnaires.

EBAS IN SPECIFIC POPULATIONS AND SETTINGS

Children and Adolescents

Youngstrom and Van Meter (2016) offer a novel and thoughtful approach to systematizing assessment. Although it is discussed in the context of child and adolescent assessment, there are many aspects of the approach that could and should be applied to

assessment in general, such as the specific focus on prediction and the incorporation of Bayesian modeling/consideration of base rates in making predictions. Overall, we applaud the authors for the development of a highly systematic conceptual scheme that is well situated in a world in which efficiency is at a premium but diagnosis remains a complex process. The article also made us speculate about how such a model could be tested empirically against other approaches to making clinical predictions about behavior, as a way of moving it even further toward EBA.

We viewed the tight organization of the approach around clinical diagnosis as both a strength and a weakness. On the one hand, this focus provides a clear outcome variable and constrains the system in a manner that is helpful and clarifying. That said, we are concerned that the model assumes the validity of clinical diagnoses and therefore implicitly contains attendant limitations, such as questionable relations between diagnosis and treatment planning, arbitrary cut scores, etc. Indeed, while the focus on base rates and prediction is a strength, this focus makes an assumption that there are categorical phenomena to be predicted. To the extent that this assumption does not hold—and in general it does not—the argument undergirding the approach loses some heft. It would be interesting and useful to extend the kind of systematic thinking displayed in this article to a more dimensional and evidence-based scheme of individual differences in personality and psychopathology.

Another issue with the focus on diagnosis is that this is only one of the goals of applied assessment. It is not clear how this system would address other goals, such as establishing a therapeutic bond or helping patients and their families develop insight or reframe problem behaviors in a more adaptive manner. In fact, in some ways, the highly algorithmic focus on efficiency might be counterproductive for some of these goals, in that they get away from treating the client as a whole person living within a system, and move toward understanding specific problem behaviors relatively free from the context in which they occur.

Another reaction to this article has to do with our second general theme, practicality. While the system offered by Youngstrom and Van Meter (2016) was impressively systematic and well conceived for ideal settings, we wondered whether clinicians in applied settings would have the resources to apply some of the recommendations. In general, we were skeptical about the likelihood of practitioners calculating local base rates, deriving decision weights, or plugging individual case data into algorithms for making clinical predictions. To move this system forward, much of this would probably need to be automated.

A final thought involved other developments in EBA could be integrated within the framework offered by Youngstrom and Van Meter (2016). Specifically, there is a relatively large literature on idiographic modeling of within-person variation over time (Wright & Hopwood, 2016). This literature provides an important complement to the nomothetic approach that was emphasized throughout this issue. Although much of applied assessment remains firmly rooted in nomothetic models (i.e., What causes this problem for people on average, and what typically helps people like this?), clinicians working with individuals need to apply nomothetic evidence to idiographic situations (i.e., What is going on with this person, and what would be helpful for them?). Often nomothetic answers are not satisfying in idiographic situations, and developing a system that is more person-centered and time-sensitive can therefore fruitfully augment variable-centered frameworks common in applied assessment.

Forensic Settings

Archer et al. (2016) have provided an excellent overview of EBA issues in forensic psychological assessment. They offer a helpful operational framework and up-to-date guidelines for such assessments. Their coverage of the *Daubert* and subsequent U.S. Supreme Court cases that led to guidelines for evidence-based evaluation of assessment procedures in the court setting is quite valuable for those with little forensic experience. We also appreciate their guidelines for the evaluation of psychological tests for forensic psychological practice; they are comprehensive and useful.

Archer et al. (2016) clearly favor general clinical tests over specific forensic assessment instruments that have been tailored to psycho-legal questions. We think this is a positive, as psychologists are interested in the assessment of psychological constructs that have implications for addressing psycho-legal standards. The

tailored tests of course can serve as useful guides from a psycho-legal perspective, but their utility in measuring personality, psychopathology, cognitive status, etc., is questionable. The main exception to this bias, however, is risk assessment instruments (e.g., Heilbrun, Yashuhara, & Shah, 2010The question in our mind, though, is how many of the general clinical tests actually meet the rigorous evidence-based criteria that Archer and colleagues proposed? They provide good examples for tests for individual criteria, but we can only think of very few tests that would meet all five (e.g., MMPI-2/MMPI-2-RF, PAI, STATIC-99), whereas several others such as the WAIS-IV/WISC-V would undoubtedly be very useful in forensic psychological practice.

We were also somewhat surprised that a discussion of EBA in forensic psychology did not draw more from a rather extensive risk assessment literature. This is indeed the area within which forensic assessment instruments have shown the most utility, as well as meet most (if not all) of the factors outlined by Archer and colleagues. Indeed, in the context of EBA in forensic settings, we think the field can learn a lot from innovative work by risk assessment scholars. They were among the first to develop actuarial assessment tools that have received substantial empirical support, including the Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993) and the STATIC-99 (Hanson, 1997), for predicting general violence (Yang, Wong, & Coid, 2010) and sexual violence (Hanson & Morton-Bourgon, 2009) risk, respectively. Moreover, they focus on clearly identified psychological constructs according to empirically supported theory (e.g., Andrews & Bonta, 2010) with validated operationalizations (e.g., Level of Service Inventories; Olver, Stockdale, & Wormith, 2014). Thus, we encourage those interested in EBA for forensic settings to study this literature in particular.

Finally, we also want to emphasize what we alluded to earlier in this commentary: EBA in forensic settings does not necessarily need to be centered explicitly on psychological testing. We are by no means suggesting that testing is unimportant, but some scholars would argue that there is often very little role for testing in addressing psycho-legal questions (see, e.g., Melton, Petrila, Poythress, & Slobogin, 2007). We disagree with this stronger stance, but would also suggest that in the context of a forensic psychological evaluation, save for ~~some~~ objective measurement of response bias, testing might be the first to be excluded if time/resources is an issue (with interviews, records, and collateral sources often being more important). Thus, we are encouraging that EBA for forensic settings look beyond tests (which are the easiest to evaluate from an EBA perspective) and rather view them as one of many ingredients in a more comprehensive framework.

Treatment Settings

We found it refreshing that Bagby et al. (2016) organize treatment planning and diagnostic information into broad individual differences domains. If one has to pick a single framework, the FFM seems like a reasonable choice as it is the most common level of abstraction for organizing comprehensive models of personality, and it is increasingly understood as a viable structure for psychopathology as well (Wright et al., 2013).

We also applaud the authors for pointing out that treatment planning involves more than connecting a diagnosis to a treatment model. It is also important to establish a therapeutic relationship and engage clients in treatment. Collaborative models of assessment have proven useful in this regard, and we thought that the authors' point that normal personality assessment could be used for this purpose was interesting and worthy of further investigation. Indeed, to the degree that collaborative assessment is a treatment itself, it would be generally interesting to evaluate what assessment variables contribute to treatment as a general question.

The authors focus on the FFM raised for us questions about appropriate level of ~~an~~ analysis, as well as the connection between models of personality/psychopathology and specific instruments. For instance, there is good evidence that the major dimensions of common psychopathology instruments like the MMPI-2 (e.g., Sellbom, Ben-Porath, & Bagby, 2008) include dimensions that align closely with FFM domains. Therefore, while we acknowledge that there is a difference between instruments that focus on normal versus abnormal functioning, we also think it is easy to push this point too far. Framing the FFM as separate from symptom assessment is perhaps an example. Our preferred approach would have been to develop models of

treatment planning based on integrative, hierarchical models of individual differences in personality and psychopathology, rather than one particular level of the hierarchy.

We found it useful to frame this particular article around the questions posed in the classic Harkness and Lilienfeld (1997) article. This raised an interesting question for us though: Are characteristic adaptations the same thing as symptoms or are they different? Our view is that characteristic adaptations are dynamic constructs that are responsive to environmental stressors and interventions (Hopwood et al., 2013). As a general rule, characteristic adaptations/symptoms are the things that we try to change in patients, whereas we try to help patients adapt to their traits. In contrast, Bagby et al. (2016) frame characteristic adaptations as mediating processes between traits and symptoms. It would be interesting to test these competing conceptions; our bias is for the more parsimonious model, and we find it difficult to conceive of what symptoms might be if not characteristic adaptations.

A final reaction to this article was that personality models can provide opportunities to understand heterogeneity within clinical diagnoses (e.g., Thomas et al., 2014). Indeed, this may be one of the more powerful applications of personality variables in applied practice. For instance, one group of patients with depression might do better with homework involving behavioral activation, a second group with treatments designed to change their characteristic patterns of thinking, and a third by identifying developmental and relational dynamics that maintain their symptoms. The key question of course is which treatments work best for whom. We would add to this interesting article the potential for normal-range personality variables to answer these kinds of questions, which would be tremendously useful in applied settings.

Medical Settings

Finally, Butt (2016) provided an overview of innovative assessment in medical settings. He revealed up front that he would not review EBA as much as discuss some issues that would advance EBA for patients in medical settings. Both of us have the least amount of experience with medical settings relative to the other contexts/populations discussed in this commentary. As such, this might admittedly be the most naïve of the reactions. In general, we found the introduction helpful and the context-specific and practical issues discussed interesting and thoughtful.

Butt (2016) clearly discusses several innovative issues, including PROMs, alignment with FDA guidelines, IRT-based methods, and real-time assessment. PROMs seem like a promising way for the efficient collection of data from patients, both for research and clinical purposes. Tablets and touch screen computers (or smartphones, where feasible) provide for good alternatives for data collection. Efficient measurement can be further improved via IRT-based methods that culminate in computer-adaptive assessment that could help deal with the problem of patient burden. Real-time assessment might be particularly useful in medical settings as well to examine illness course, treatment adherence, and treatment outcomes.

Despite these interesting and innovative advances for medical settings, we raise some questions about actual current EBA in medical settings that were not extensively discussed. More specifically, what assessment frameworks already work for what purposes? Can general clinical assessment instruments be used with similar utility as in, say, forensic settings? Butt (2016) touched on this issue in the beginning of his article, but never elaborated. There is evidence that the MMPI-2-RF, and to some degree, the PAI can be useful in predicting treatment adherence and outcomes in the context of a presurgical evaluation (see, e.g., Marek, Heinberg, Lavery, Rish, & Ashton, in press; for a review). Similar evidence exists for health-related quality-of-life measures (Andersen et al., 2015) and neuropsychological tests (Gunstad, Mueller, Stanek, & Spitznagel, 2012). It would be very interesting to learn empirically the value of a more integrated system for EBA in medical settings that combine traditional methods with promising innovative advancements (e.g., PROMs).

We further believe, as touched upon earlier and to some degree by Butt (2016), that the delineation of what clinical psychological constructs, including personality traits and psychopathology symptoms, are of utility in medical settings [illegible] important to articulate, and EBA frameworks around these be developed. Psychological and cognitive variables are clearly valid

predictors of medical treatment adherence and outcomes (Marek et al., in press), but from an EBA perspective, how can they best be operationalized?

Finally, Butt (2016) briefly mentioned an issue that we believe to be of particular importance in medical settings: under-reporting. For a variety of reasons, individuals undergoing psychological evaluations in medical settings might have reasons to under-report; for instance, to appear more psychologically healthy when considered for a surgical procedure or to avoid stigma associated with psychological conditions. EBA practices for under-reporting in medical settings do not appear to be well established. Broadband measures such as the MMPI-2-RF and PAI have under-reporting validity scales which can be considered when these instruments are used in medical assessment, but what about when integrating PROMs and other innovations? We believe this might be an important area of inquiry with respect to EBA in medical settings.

CONCLUSION

All four articles in this Issue were informative, thoughtful, and provide good guidance for clinical psychologists. They also offer many more answers than the questions we raise. Nevertheless, we hope as EBAs continue to develop across populations and settings that careful thought is considered with respect to (a) exactly what is being assessed, and (b) how valid innovative methods can be best integrated into psychological practice.

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