Remembering and diagnosing clients: Does experience matter?

Cilia L. M. Witteman & Marieke S. Tollenaar

a Behavioural Science Institute, Radboud University, Nijmegen, The Netherlands
b Institute of Psychology, Leiden Institute for Brain and Cognition, Leiden University, Leiden, The Netherlands


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Remembering and diagnosing clients:
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Cilia L. M. Witteman¹ and Marieke S. Tollenaar²

¹Behavioural Science Institute, Radboud University, Nijmegen, The Netherlands
²Institute of Psychology, Leiden Institute for Brain and Cognition, Leiden University, Leiden, The Netherlands

Experienced mental health clinicians often do not outperform novices in diagnostic decision making. In this paper we look for an explanation of this phenomenon by testing differences in memory processes. In two studies we aimed to look at differences in accuracy of diagnoses in relation to free recall of client information between mental health clinicians with different levels of experience. Clinicians were presented with two cases, and were asked afterwards, either directly (Study 1) or after 1 week (Study 2), to give the appropriate diagnoses and to write down what they remembered of the cases. We found in Study 1 that the accuracy of the diagnoses was the same for all levels of experience, as was the amount of details recalled. Very experienced clinicians did remember more higher-order concepts, that is, abstractions from the presented information. In Study 2 we found that the very experienced clinicians were less accurate in their diagnoses and remembered fewer details than the novices. In response to these findings we further discuss their implications for psychodiagnostic practice.

Keywords: Psychodiagnosis; Experience; Recall; Memory; Delayed memory.

In mental health, very experienced clinicians often do not perform better than novices in diagnostic decision making (Ágústsdóttir et al., 2006; Garb, 2005; Spengler et al., 2009; Strasser & Gruber, 2004; Witteman & Van den Bercken, 2007). To increase understanding of this intriguing phenomenon we chose to examine the role of memory processes (cf. Brailey, Vasterling, & Franks, 2001). How much do mental health clinicians remember about the intake information of their clients when they are asked to provide a diagnosis for their complaints? This is a highly relevant question, since information remembered from the first session(s) will be used while diagnosing, and a diagnosis in turn is an important starting point for treatment (as is described in recognised handbooks on behavioural assessment, e.g., Groth-Marnat, 2009; Haynes & O’Brien, 2000). In this paper we look at immediate and delayed recall of client information by clinicians with different levels of experience, in relation to the accuracy of their diagnoses.

The development of expertise is an intriguing and important area of study as is reflected by recently published handbooks (e.g., Ericsson, Charness, Felstovich, & Hoffman, 2006). Expertise refers to consistent high performance in a domain. Experts are able to identify relevant information and to apply this information consistently over varying situations (Weiss &
Diagnostic expertise in clinical settings is often operationalised by either years of clinical experience, peer-nomination, or a combination of both (Goodyear, 1997; cf. also Witteman, Weiss, & Metzmacher, 2012). We operationalise expertise in terms of years of clinical experience, with novices having 0–1 years of clinical experiences, intermediates between 2 and 10 years and very experienced clinicians more than 10 years.

Differences both in recall and in diagnostic decision making between novice and expert clinical decision makers in mental health have been studied (e.g., Brailey et al., 2001; Spengler et al., 2009; Strasser & Gruber, 2004) but not extensively, and as far as we know the relation between immediate and delayed recall and diagnosing within these groups has not been studied yet.

In general, be it in mental health or in any other domain, more deliberate practice is found to lead to an improved adaptation to the task and improved efficiency in processing task-relevant information (Ericsson, Patel, & Kintsch, 2000; Hill & Schneider, 2006). More practice also leads to the ability to expand working memory by storing more comprehensive mental representations in long-term memory (Montgomery, Lipshitz, & Brehmer, 2005; Vicente & Wang, 1998). Experts have superior memory for abstract features of problems in their domain, due to their vast and well-connected domain knowledge base and knowledge encapsulation (Boshuizen, 2004). In the mental health domain more experienced clinicians are indeed found to remember information differently than novices (Brailey et al., 2001).

Usually novices in these studies are students in clinical psychology, and experienced clinicians have at least 2 years of post-internship experience. In such studies, which measure recall directly after the information has been presented, very experienced clinicians are found to remember the same amounts of detailed information as novices, while more experience is related to also remembering more higher-order concepts, for example the summarising statement “communication problems” (cf. Dawson, Zeitz, & Wright, 1989; Hauser, Spada, Rummel, & Meier, 2006). The same was found in medical diagnosis, where novices tend to stay close to the surface level of the presented information, while more experienced practitioners construct summaries or abstractions (Rikers, Schmidt & Boshuizen, 2000; Strasser & Gruber, 2004).

Medical practitioners and mental health clinicians face similar tasks of diagnosing and treating patients based on knowledge about (psycho)pathology, but the knowledge available for diagnostic decision making is more factual in medicine than in mental health (cf. Hauser et al., 2006). Diagnosing clients’ mental health problems requires matching their symptoms against specific criteria for different disorders as listed in the DSM or the ICD, a task that requires judgements about client presentations. Often a clinician will have to rely on memory, for example when the diagnosis is not reached immediately during an intake session but over more than one session or when the clinician immediately continues work with another client, and decides on a diagnosis for the first client only later. Memory studies are thus important in the clinical domain for both medical and mental health, since memory may play an important role in diagnostic decision making. Also, as diagnoses seem to require attention to detailed criteria, it can be hypothesised that remembering more details would lead to better diagnoses. While novices mostly remember detailed information, more experienced clinicians remember both detailed information and abstractions (Dawson et al., 1989; Hauser et al., 2006). In this context it is important to assess which of these two diagnostic approaches is most beneficial. Namely, is an ability to work from both detailed information and abstractions superior to an approach focused on the use of only detailed information when discerning specific criteria for diagnoses?

While remembering details in diagnosing is important, clinical experience by itself may also increase diagnostic abilities. Gaining clinical expertise requires extensive theoretical education and practical training (Boshuizen, 2004; Feltovich, Prietula, & Ericsson, 2006; Gobet, 1998). With experience, a professional learns to encode domain-specific information differently compared to as a novice, that is, more holistically (Weber, Goldstein, & Barlas, 1995). Very experienced clinicians seem to benefit from their more integrated way of representing knowledge and from their cognitive andchunking abilities. They are able to process information faster, which may enhance their diagnostic skills. Somewhat surprising, however, is the finding that in the medical domain the accuracy of experienced physicians’ diagnostic decisions does not differ much from that of novices (Rikers et al., 2000). In mental health, very experienced clinicians also often do
not outperform novices in diagnostic decision making (Ægisdóttir et al., 2006; Garb, 2005; Spengler et al., 2009; Strasser & Gruber, 2004; Witteman & Van den Bercken, 2007). In fact, experienced clinicians typically show relatively poor accuracy in diagnosing mental disorders (Brailey et al., 2001). The absence of superior performance by more experienced psychodiagnosticians may be due to the dynamic nature of stimuli presented by variable human behaviour, including a lack of predictability (Shanteau, 1992), and the often missing or ambiguous patient feedback (Vicente & Wang, 1998). However, theories about expertise development (cf. Boshuizen, 2004; Ericsson et al., 2006) do suggest that experienced psychodiagnosticians should outperform novices. This highlights the importance of examining differences in memory between experience groups and the possible relations to diagnostic accuracy. In this study we aim to further investigate the intriguing phenomenon that suggests that experience does not necessarily lead to better diagnostic performance.

As experienced professionals begin to more frequently rely on an inferred "gist" (Reyna, 2008) to summarise the information provided to them (Dougherty, Gronlund, & Gettys, 2003), they may increasingly have fewer suitable memory representations (i.e., literal details) for diagnosis. Indeed, in medicine diagnosticians appear to retain mainly the general meaning and not the specific details of the information presented (Eva, Norman, Neville, Wood, & Brooks, 2002). While previous studies found equal numbers of recalled details between experts and novices in mental health care (Dawson et al., 1989; Hauser et al., 2006; LaFrance, 1989), when mnemonic abilities get compromised (e.g., after a delay) abstractions may be remembered in favour of details by more experienced clinicians—but not by the novices, who did not infer abstractions. For the task of diagnosing mental health problems when information has been gathered earlier or over a more extended period of time, more experienced decision making may therefore be less adequate than novices’ deciding, since it still requires detailed assessment information.

We test these hypothesised relations between detailed and abstract recall and performance in psychodiagnosis in two comparable studies. More specifically, we investigate possible differences between novices, intermediates, and experienced mental health clinicians in short-term memory (immediate recall), long-term memory (recall after 1 week of consolidation), and diagnostic performance for two clinical cases. We include an "intermediate" group in the current study, to augment insight from earlier studies that generally only compared novices and experts (cf. above). Intermediates are defined as professionals who have more experience than novices (more than 2 years) and less than experts (less than 10 years; cf. in medicine: Rikers et al., 2000; in mental health: Witteman & Van den Bercken, 2007).

We hypothesise (1) that there will not be much difference in immediate recall (Study 1) of details between the experience groups, since experience by itself does not affect short-term memory capacities. However, clinicians with more experience will presumably immediately infer more meanings and represent the information more abstractly, and we consequently expect (2) that experienced participants will directly recall more abstract information than novices. In delayed recall (Study 2) we expect (3) that experienced clinicians remember fewer details, since they will have stored and can thus recall mainly the abstracted “gist”. In line with other studies about the correctness of psychodiagnosis, we expect (4) no differences between experience groups when diagnoses are given immediately as they remember equal amount of details (Study 1), but we do expect (5) differences when the diagnoses are given after 1 week (Study 2). That is, if the number of details recalled after a week decreases with more experience, then the more experienced clinicians may actually perform worse after a delay, assuming that diagnosis requires attention to details.

**STUDY 1**

**Materials**

Each participant received a booklet with two descriptions of clinical cases (see the Appendix for the translated case descriptions). Both cases represented co-morbidity, with one very familiar diagnosis and one much more unfamiliar one. We considered these cases to be complex for two reasons. First, both cases allowed two DSM-IV-TR-diagnoses of the problems (American Psychiatric Association, 2000). And second, both cases also contain signs that are typical for yet other disorders, although insufficient to allow diagnosis of these disorders. We used expert
consensus as our standard for accurate responses in scoring the diagnoses given by the participants of the current study, as has been done in other studies (e.g., Witteman & Van den Bercken, 2007).

The first case description was adapted from a case described in a Dutch DSM-IV case book (Koster van Groos, 2004). This case is about Cindy, a 15-year-old Caucasian girl who has depressive complaints. In the case book the experts’ consensus conclusion is that a diagnosis of a Major Depressive Episode fits the case and Dysthymic Disorder does not, because it is unclear whether symptoms had persisted for at least 1 year (Koster van Groos, 2004). Our adaptations of the case consist of a specification of the family situation and of a clarification of the time that symptoms for Dysthymic Disorder had lasted, such that this diagnosis is also justified. Besides the fact that criteria are met for Major Depressive Episode as well as for Dysthymic Disorder, Cindy has mood-congruent psychotic features specifying the episode. These features do not allow diagnosis of a psychotic disorder.

The second case description, of Wouter (Walter), is an adapted description of a 4-year-old native Dutch boy who shows features of Attention-Deficit/Hyperactivity Disorder (ADHD), Tourette’s Disorder, and Autistic Disorder, taken from our own archives. Two experienced child psychologists together made the adaptations to the original description, also changing personal information for anonymity reasons. The resulting case description contains sufficient features to diagnose ADHD (inattention, hyperactivity, and impulsivity) as well as tics diagnostic for the much less familiar Tourette’s Disorder. Problems in communication and interaction are described, but these do not justify diagnosing an autistic disorder. Besides, these problems also match ADHD, and there is no indication that activities and interests of the boy are restricted, which is an essential feature of Autistic Disorder.

**Participants**

Participants were recruited through personal contacts and participated without compensation. There were 19 very experienced clinical child psychologists (with more than 10 years of experience; range = 10–30 years, M = 16.68, SD = 8.36; age range = 34–57 years, M = 43.21, SD = 7.03; 18 female) and 17 clinical child psychologists with intermediate levels of experience (between 2 and 10 years; range = 2–8 years, M = 5.06, SD = 2.22; age range = 23–43 years, M = 29.94, SD = 4.76; 16 female). Participants in both groups worked either in private practice or in an institute for mental health care. Then there were 36 students (age range = 21–28 years, M = 23.89, SD = 2.01; 33 female) of the Radboud University Nijmegen with little or no experience in clinical practice (M = .61 years, SD = .22), but with advanced-level theoretical training in DSM diagnosis.

**Procedure**

The order of the two case descriptions was counterbalanced over participants. For each case, participants were asked to read it carefully for 3 minutes and then to fill in, on two blank lines, what they thought to be the correct DSM diagnoses. They were also asked to indicate their confidence in the correctness of the diagnoses they provided, on a 7-point scale (1 = not confident at all, 7 = highly confident). When participants had given the diagnoses and confidence ratings for both cases, they were given a surprise memory task asking them to write down everything they remembered of the two cases, as literally as possible, in the order in which they had read the cases. They were given 5 minutes for each case.

While recognition tests are sensitive indicators of the availability of information in memory, free recall tests show what can be retrieved. For demonstrations of the use of (accessible) information, measures of recall are the more appropriate (Higgins & Bargh, 1987; Johnson & Russo, 1984), and, when taken after the choice task, they do not interfere with the choice (Weber et al., 1995). We thus chose to apply a free recall task.

**Data analysis**

The contents of the remembered aspects of both cases were coded by two independent judges who were not informed about the goals of the studies (inter-rater reliability Cohen’s Kappa > .96 after training) into three categories: correctly recalled Details, for example “Walter is four years old”; correct Abstractions, for example “he has communication problems”; “he dislikes changes”; and False memories, for example “he knows only few
words” (while the description says “he has word finding problems”).

We calculated our measure of accuracy by summing the correctness of only the familiar diagnoses of both cases (Major Depressive Disorder for Cindy and ADHD for Walter; range 0–2). The unfamiliar diagnoses (Dysthymic Disorder for Cindy and Tourette for Walter) were excluded, since too few participants got those right (62% of the participants had zero second diagnoses correct and only 9% had them both correct, with no differences between the experience groups), $F(2, 69) = 1.75, ns$. Multivariate tests showed that there were no effects of the order of reading the cases on any of the dependent measures (numbers of memories, accuracy), so the order was not taken into account in further analyses. Differences between the experience groups in recall, accuracy and confidence were analysed with one-way ANOVAs. Recall of literal, abstract and false memories was correlated to diagnostic accuracy using Pearson’s product–moment correlations. Alpha was set at .05.

Results

Memories. Participants remembered a mean of 22.03 ($SD = 8.96$) Details. The maximum number of details remembered was 50. They remembered 3.35 ($SD = 2.82$) Abstractions, with a maximum of 13, and they had 2.75 ($SD = 2.46$) False memories with a maximum of 12. We found significant between-groups differences in the numbers of Abstract memories, $F(2, 69) = 4.89, p = .01$ (see Table 1). Post hoc tests (LSD) showed that there were no differences between Intermediates and Very experienced, but that the differences between Novices and Intermediates ($p = .017$) and Novices and Very experienced ($p = .010$) were significant.

We found no significant differences between the numbers of Details, $F(2, 69) = 0.04$, ns, or False memories, $F(2, 69) = 1.96$, ns, of the three experience groups (see Table 1). One Very experienced participant recalled only five details, another as many as 46; otherwise they ranged between 15 and 35.

Accuracy and confidence. No differences were found between the three experience groups in accuracy over the diagnoses of the two cases, $F(2, 69) = 1.42$, ns (see Table 1); nor in their confidence, $F(2, 69) = .773$, ns.

There were no significant correlations between accuracy and any of the different types of memory ($N = 72, r < .11, ps > .05$).

Discussion

We replicated the finding that experienced clinicians are not more accurate in their diagnoses than novices. We also replicated earlier results that more experienced clinicians do not recall fewer details but do recall more abstractions when recall is tested directly after having read the cases. They thus seem to have a different representation of the clinical cases, which, however, does not translate into differences in accuracy. However, when diagnoses are not decided upon immediately but after some time, during which possibly a number of other cases have been seen, different representations (i.e., more abstract than literal memories by more experienced clinicians) may lead to differences in accuracy. We tested this expectation in Study 2.

### TABLE 1

<table>
<thead>
<tr>
<th>Experience level</th>
<th>Details</th>
<th>Abstract</th>
<th>False</th>
<th>Accuracy</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice ($N = 36$)</td>
<td>21.86 (7.86)</td>
<td>2.36 (1.76)$^a$</td>
<td>3.25 (2.88)</td>
<td>1.33 (.68)</td>
<td>10.78 (2.04)</td>
</tr>
<tr>
<td>Intermediate ($N = 17$)</td>
<td>21.82 (5.63)</td>
<td>4.29 (3.79)$^b$</td>
<td>2.65 (1.73)</td>
<td>1.06 (.75)</td>
<td>11.06 (2.25)</td>
</tr>
<tr>
<td>Very experienced ($N = 19$)</td>
<td>22.53 (12.97)</td>
<td>4.37 (2.95)$^b$</td>
<td>1.89 (1.94)</td>
<td>1.42 (.61)</td>
<td>11.47 (1.97)</td>
</tr>
</tbody>
</table>

Mean numbers (and standard deviations) of Details, Abstract, False memories, Accuracy (0–2) and Confidence (1–14) summed over the two cases, per experience group, Study 1. *Novices remembered significantly fewer abstractions than the Intermediates and the Very experienced ($p < .05$). $^a,b$Similar letters indicate comparable group averages.
STUDY 2

Materials

The materials were the same as in Study 1.

Participants

Participants were 19 very experienced clinical child psychologists (with more than 10 years of experience; 13 female), 20 child psychologists with an intermediate level of experience (between 2 and 10 years; 17 female). They all worked either in private practice or in an institute for mental health care. Then there were 20 students (17 female) in clinical child psychology of the Radboud University Nijmegen. Participants were recruited through personal contacts when they fell in the target groups of experience and working with children and adolescents, except the students who were still in training to become clinical child psychologists. They were excluded when they had participated in Study 1. Due to a computer error, data about the exact years of experience and age were lost. Participants were not compensated for their time.

Procedure

The study took place in two sessions, with 1 week in between. In the first session the participants were handed the first case and were told to read it in 3 minutes. Then they were asked to read the second case, again in 3 minutes. Then the cases were taken away and the participants were thanked for their participation. The order in which participants read the cases was counterbalanced. Participants were not informed of the goal of this session.

In the second session, 1 week later, we asked participants to give diagnoses for the two cases, to state their confidence in the correctness of these diagnoses, and to write down everything they remembered of them, in the same way as in Study 1.

Data analysis

Scores for the three types of memories, accuracy, and confidence were computed in the same way as in Study 1. Again the less-familiar diagnosis was excluded, since so few participants got it right (88% of the participants had zero second diagnoses correct this time, with no differences between the experience groups) $F(2, 56) = 2.26$, $ns$. Again, there was no effect of order of presentation.

Results

Memories. Participants in this study remembered much fewer Details than in Study 1 ($M = 5.53$, $SD = 4.49$, with a maximum of 16), more Abstractions ($M = 6.78$, $SD = 3.83$, with a maximum of 18), and they had fewer False memories ($M = 1.95$, $SD = 1.88$, with a maximum of 8). We found significant differences between the three experience groups in the numbers of details recalled, $F(2, 56) = 4.03$, $p = .023$. Post hoc tests (LSD) showed that Very experienced clinicians had significantly fewer Detailed memories than the Novices ($p = .007$) (see Table 2). We also found significant differences between the three groups in the numbers of Abstract memories, $F(2, 56) = 5.89$, $p = .005$. Post hoc tests showed that the Novices had significantly fewer Abstract memories than the Very experienced clinicians ($p = .001$). There were no significant group differences in the numbers of False memories, $F(2, 56) = 1.60$, $ns$.

Accuracy and confidence. There was a significant difference in the accuracy of the diagnoses (summed over both cases) between the groups, $F(2, 56) = 3.20$, $p = .048$ (see Table 2). Post hoc tests (LSD) showed that Very experienced clinicians were significantly less accurate in diagnosis than Novices ($p = .016$). Their inaccurate answers were in majority global descriptions of the type of problem, for example “problems in parent–child interactions”, instead of a diagnostic classification. No significant differences in accuracy were found between Novices and Intermediates, or between Intermediates and Very experienced clinicians. Confidence did not differ significantly between experience groups, $F(2, 56) = .667$, $ns$.

There was a significant positive correlation between participants’ accuracy and the number of Detailed memories ($N = 59$, $r = .425$, $p = .001$). No correlations between accuracy and the other memory types were found ($rs < .06$, $ps > .05$).
GENERAL DISCUSSION

Our first hypothesis—that there would be no differences between the experience groups in the recall of details when they were asked to recall case information immediately—was supported. So was our second hypothesis—that in direct recall (Study 1) more experience would be associated with more abstractions. In the delayed situation (Study 2) all groups plausibly recalled less detailed information than in the direct situation (Study 1). Very experienced clinicians had, in line with our third hypothesis, remembered fewer details after 1 week than novices. Our fourth hypothesis was that there would be no differences in the accuracy of the diagnoses between the groups in the immediate condition (Study 1). This hypothesis was also confirmed, as was the fifth, that very experienced clinicians would have fewer correct diagnoses compared to the novices in the delayed situation (Study 2).

To our knowledge, ours is the first study to address both direct and delayed recall in relation to diagnostic accuracy by three different clinical experience groups in mental health. Overall, in the situation involving immediate recall, we found an increase in abstract memories to be related to a higher level of experience with no other differences, either in recall or in correctness. In the situation where a time delay was applied we found that higher levels of experience were associated with increased abstract but decreased detailed memory recall, along with a lower level of diagnostic accuracy. In addition, recall of detailed memories after one week was positively related to accuracy in diagnosis. These delayed results appear to confirm the idea that details rather than abstractions are more relevant to a correct diagnosis.

Our findings may help explain why very experienced mental health clinicians are often found not to outperform novices. When a diagnosis is requested immediately after the presentation of information, experience does not make a difference, because in that moment experienced and novice clinicians have similar levels of details in their working memory. It is only after some time that experienced clinicians go with the abstracted “gist” of the information, and they lose the acumen to explicitly match client details to the diagnostic criteria. It would thus appear that in the psychodiagnostic sub-task here examined and specifically when there is a delay between gathering client information and making a diagnostic decision, novices may outperform experts.

The finding that the more experienced clinicians remembered fewer details than novices after 1 week may be explained by the phenomenon that they have formed abstract, “gist”-based representations in long term memory (Reyna, 2008). These representations do not include all the details, which are subsequently not available for recall. This might then also explain why their diagnoses deteriorate after a delay, as diagnosis requires matching details about a client to predefined criteria of different disorders. Interestingly, the correlation found between detailed memories and accuracy 1 week after having read the information, was not present when the recall task and diagnoses were given directly after having read the cases. In this direct recall condition there were no accuracy differences between the experience groups, possibly because the information was still equally present in working memory to all. Differences between the groups in the amount of falsely recalled information were not significant in either study. In the first (but not the second) study the very experienced clinicians had the fewest false
memories, although not significantly less than novices, as was reported by Brailey et al. (2001) who found that novices made significantly more errors in recall than clinicians.

The intermediates in our studies scored equal to or in between the novices and the very experienced, on the three types of memories. In the first study but not the second, the accuracy of intermediates’ diagnoses was lower (but not significantly) than that of both novices and the very experienced clinicians (an “intermediate effect”; cf. Witteman & Van den Bercken, 2007).

In future studies it may be beneficial to ask whether participants expected a memory task. Students (the “Novices”) may be more trained in remembering information than very experienced clinicians. Relevant to Study 2, clinicians may also have encountered more interfering diagnostic information in the week between the test sessions, which would limit their detailed recall (cf. e.g., Forcato, Rodriguez, Pedreira, & Maldonado, 2010). And of course students are younger, and recall capacities decrease with increasing age (cf. e.g., Craik & McDowd, 1987). It would therefore be of interest, although logistically challenging, to include novices, intermediates, and experienced clinicians with the same age in a future study, or to include a test of general memory recall ability.

In the present study participants were given 3 minutes to read each case. Pilot tests had shown that this was neither too long nor too short for participants to close-read the cases. In a typical practice situation clinicians would be able to look at the information for as long as they wanted, and to re-read case reports before making diagnostic decisions if necessary. This may be a limitation to the current study. A follow-up study could use more naturalistic settings, to see if the results are replicated. While it may seem artificial to allow a limited amount of time to study case information, time pressure in clinical practice tends to be high, and often there is a delay between seeing a client and deciding upon a diagnosis, for example when the next patient is already in the waiting room, or when a decision is made later in a diagnostic team. This team decision making tends to be regular practice, at least in The Netherlands. Team meetings are also the setting that is most similar to our experimental situation, when you are given brief written information about a colleague’s diagnostic session with a client. It would therefore also be very interesting to look at the notes clinicians make during their diagnostic interview, to see whether differences in the noting of details and abstractions between novices and experts are already found in this phase of the process. That is, novices may already note more details and very experienced clinicians more abstractions during examinations of their patients. Another limitation of the current study may be due to the involvement of many more female than male participants. Although this reflects the actual situation (at least in The Netherlands, where the large majority of mental health clinicians are female), it does not allow us to check possible gender differences.

Our finding that remembered details seem to help novices perform the task of psychodiagnosis correctly may be relevant to practice. When details are also accessible to intermediates and very experienced mental health clinicians (directly after having read the client’s information) they all perform on the same level of accuracy. This suggests that when a diagnosis is given immediately after a first session with a client, experience of the clinicians is not relevant for the accuracy of these diagnoses. But when a diagnosis is given after a delay, for example when there are more diagnostic sessions or when a team meeting in which the diagnosis is established does not follow immediately after the first session, it may be wise for experienced clinicians to re-read detailed reports. Novices remember and attend to details even after a delay, allowing them to compare client information to the criteria listed in the DSM with the different disorders and to diagnose accurately.

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REFERENCES


APPENDIX: CASE DESCRIPTIONS TRANSLATED INTO ENGLISH

Case 1: Cindy

15-year-old Cindy was brought to the outpatient clinic of a mental health institute by her father after he was called by the Dean of the school, who was worried that Cindy might be severely depressed and potentially suicidal. Her father was also concerned about her because she seemed very sad lately and increasingly seemed to withdraw.

Cindy lives with her father, mother, 12-year-old brother and 9-year-old sister. Father works as a representative, mother is at home. Cindy says that she has been feeling depressed since she had a fight with her mother two years ago. In the brawl her mother threw a pot of hot tea over her and burned Cindy’s shoulder. She was brought to the emergency room and treated for the burn. From that time on she avoids her mother.

Cindy’s mother has a long history of mental health problems with frequent hospitalisations and prolonged outpatient treatment. Her father says about her that she is chronically “psychotic” and has clear mood swings. There have been a lot of marriage conflicts over the years and the couple is now separating and selling the house. For the last two years, since the incident with the hot tea, Cindy’s mother has lived on the second floor of the house and she has had little contact with the family.

Before the incident with her mother Cindy had many social contacts, she followed dance and music lessons and participated in activities of the church and the school. She enjoyed school and was a student with high marks.

Since the incident Cindy has been very irritable. When her father asks something she usually responds angrily and annoyed. Cindy then often says that she never does anything right anyway or that there is nothing she can do right. Since the incident she also has had a lot of difficulty to fall asleep at night. She often lies awake for hours. In the morning it takes her a lot of effort to get up from her bed. Cindy tells that her mood has become much worse in the last six months. She feels depressed throughout the day almost every day. She worries about her mother and thinks the brawl was her fault. She no longer feels like going to school and does not undertake activities with her friends anymore. She spends only a little attention on her school work. Her marks have gone back from nines to sixes. She is tired all the time and takes a nap when she gets home from school.

The past three weeks Cindy has become anxious and twice she has felt “strange and unreal”. Often she hears the sound of a young child crying; but if she looks if there is something behind the door something, there never is anyone. Lately, especially when she is feeling guilty about the brawl with her mother, she is sometimes certain that she does not deserve to live and she has thought about putting an end to her life. Three weeks ago, while she was doing the dishes, she thought about cutting her wrists with a knife; but the thought how upset her father would be, restrained her for doing so.

The psychiatrist who examined Cindy recommended a voluntary hospitalisation. Cindy and her father did not like that idea; they thought Cindy would be able to continue with the outpatient treatment. She was given the phone number of the first aid and she called them the next day to say that the voices became worse and that she was afraid that she would hurt herself. She was told to come to the emergency room immediately and she was admitted to hospital.

Case 2: Walter

Walter is a cheerful boy of four years and eight months old. Walter lives with his father, mother and younger brother of two. Father works fulltime as a truck driver. Mother works part-time as an administrative assistant.

In preschool it was detected that there was a lag in Walter’s speech/language and social emotional development. He was not judged ready for a regular primary school. Walter was referred by the youth care agency to a medical day care centre for children, where further assessment and treatment now takes place. Parents are worried about his development and indicate that they think Walter’s behaviour is over-active. From his first year onwards Walter’s behaviour has become
more and more striking. The behaviour is generally not situation specific. He shows it everywhere. Mother recognises father’s volatile and busy behaviour in Walter.

Walter’s language development started late. He never babbled and he said his first words after a year and a half. The speech therapist has established that his vocabulary is of medium level and his understanding of spoken language low-medium. He has trouble understanding assignments or questions, especially when they are multifaceted. Walter sometimes stutters. Causes may include: word finding problems, wanting to speak too fast or being in exciting situations. Walter talks a lot, but it is incoherent. He finds it difficult to have an in-depth conversation and he associates a lot. He gives short answers to questions.

Walter is restless. He shows busy, agitated and impulsive behaviour both at home and at the medical day care centre. It is difficult for him to stay put in his seat. Since a non-slip mat was attached to his chair, he is somewhat calmer in his seat. Walter fiddles with his fingers a lot, virtually the whole day. Walter has a short attention span and is easily distracted, especially when he is in an unquiet environment. He regularly gets up from his activity to interfere with the work of other children. It often takes time to make Walter listen to what is being said. When he is given a task, he often does not carry it out. He has not understood the task, or he gets distracted and does not remember where he was doing. He also often has no idea where to start with the performance of a task. When there is a structured activity at the table, Walter is able to concentrate better.

Walter each day frequently makes the same sounds. He has done this for a year and a half. For example, he wrinkles up his nose, creates a “prrrrtt …” sound with his mouth, he pulls his ears, often produces a short loud laugh and he hums a lot when he is playing. He also imitates sounds from his environment and will continue to repeat this frequently. He is difficult to stop in doing so and not easy to reach. He does not seem to realise that he makes these sounds and he seems not to be able to suppress them. The humming he produces while playing seems to help him concentrate.

Walter has trouble playing with others and waiting for his turn. He is dominant and wants to be in control over the game. When another child does not play the game according to “his idea”, Walter throws a tantrum. He then begins to stamp on the ground and shouts: “no, no, no”. He is unable to indicate verbally what happens or what he wants. It is easier to have a conversation with Walter in a quiet environment. Walter’s eye contact is volatile and he only wants to be hugged when he indicates it himself.

Walter eats properly and he likes many things. However, he has trouble remaining at the table, and he often talks so much that he does not manage to start eating. Walter does not easily fall asleep and he always wakes up early. He does not use medication and is toilet trained.