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Experience-dependent and profession-specific differences in attitudes toward psychodiagnostic testing among psychiatrists and psychologists

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Abstract

Background: Standardized psychodiagnostic testing remains variably integrated within mental health services. While psychologists and psychiatrists both engage in diagnostic decision-making, their professional training and service roles may differentially shape attitudes toward the utility of testing. Understanding these differences has implications for referral patterns, interdisciplinary collaboration, and service organization.

Methods: A cross-sectional online survey was completed by 144 Israeli clinicians, including 73 psychiatrists and 71 psychologists. Participants rated attitudes toward the scientific rigor, diagnostic utility, treatment influence, routine use, and referral practices related to psychodiagnostic testing. Associations between years of clinical experience and attitudes were examined within each profession, and between-group differences were tested using Fisher's r-to-z transformation.

Results: After correction for multiple comparisons, significant between-profession differences emerged in experience-related trajectories. Among psychologists, greater experience was associated with stronger endorsement of test validity and diagnostic reliance. Among psychiatrists, greater experience was associated with reduced routine use, reduced referral, and decreased reliance on test results. In both professions, experience was associated with increased confidence in diagnosing without tests.

Conclusions: Clinical experience appears to reinforce profession-specific orientations toward psychodiagnostic testing. These divergent trajectories may influence service-level decisions regarding assessment pathways, referral practices, and the integration of standardized tools in mental health systems. Policies aimed at strengthening interdisciplinary collaboration and clarifying the role of assessment within care pathways may benefit from addressing these experience-dependent differences.

Introduction

Modern medicine is increasingly integrating biomarkers for diagnosis and treatment, but this advancement presents a significant challenge in the field of mental illness. Reviews of candidate biomarkers (genetic, molecular, neuroimaging, EEG) conclude that very few reach sufficient reliability, validity, and practicality to change everyday diagnostic practice, while being more explored for susceptibility, prognosis, and treatment prediction than for categorical diagnosis (Abi-Dargham et al. 2023; García-Gutiérrez et al. 2020; Henderson et al. 2020). Inflammatory and oxidative markers, cytokine panels, and pharmacogenomics are promising for personalized therapy and treatment monitoring, but are limited by lack of standardization and validation, and are not yet routine for diagnosis (Woźny-Rasała and Ogłodek 2025). In the absence of objective gold standard or accepted biomarkers, core psychiatric diagnosis relies on clinical interviews and mental status examination, which are structure observation of appearance, behavior, thought, mood, cognition, and risk (Ferguson and Reiter 2022; Hall 2015). Psychodiagnostic tests (neuropsychological batteries, personality inventories, symptom scales) are used to quantify cognitive, emotional, and behavioral functioning and support differential diagnosis and treatment planning (Maruish 2004).

Psychodiagnostic batteries typically combine intelligence tests (especially Wechsler scales) with personality assessments (projective tests and Minnesota Multiphasic Personality Inventory; MMPI) to build a broad picture of cognitive and emotional functioning (Graham 1978; Reynolds et al. 2021). Wechsler scales (WPPSI-IV, WISC-V, WAIS-IV) are the most widely used cognitive tests worldwide in clinical, school, and neuropsychological assessment (Marnoufi et al. 2023; Salonen et al. 2023; Wilson 2024). They provide a Full Scale IQ plus index scores (e.g., Verbal Comprehension, Visual-Spatial, Fluid Reasoning, Working Memory, Processing Speed), as well as detailed cognitive profiles showing strengths and weaknesses (Marnoufi et al. 2023; Salonen et al. 2023; Wilson 2024). These scales are used in learning problems, neurodevelopmental conditions (e.g., autism, ADHD), brain injury, and intellectual disability assessment (Marnoufi et al. 2023; Nader et al. 2015; Wilson 2024). Objective and projective methods tap partly different facets of personality, so combined use can yield a more complete clinical picture, though each has a limited scope and requires expert interpretation (Graham 1978; Meyer 1996; Reynolds et al. 2021). Surveys show that Wechsler scales + MMPI + Rorschach are a classic core battery in personality assessment practice (Villanueva van den Hurk et al. 2024).

Psychodiagnostic testing is a central component of the psychological approach and forms a core aspect of the work of clinical psychologists. According to this approach, interpreting test results is considered an optimal means of gaining insight into the patient. Some studies suggest that the validity of psychodiagnostic tests is high and comparable to the validity of diagnostic tools used in general medicine (Meyer et al. 2001), but more recent studies have questioned the reliability of these findings (Areh et al. 2022; Neal et al. 2019; Slaney 2017).

Profession reliably shapes attitudes toward psychodiagnostic and standardized testing. Psychologists report greater appreciation of psychological tests and higher self-rated competence than other groups, and especially value structured/standardized diagnostic tools (Bohman 2023; Danielson et al. 2019; A. Jensen-Doss and Hawley 2011; Macqueen et al. 2024; Paulson et al. 2019). Compared to psychologists, psychiatrists rely more on the clinical interview (the DSM-style diagnostic act) and less on standardized tools (A. Jensen-Doss and Hawley 2011; Paulson et al. 2019). Both groups prefer interview + tests over interview alone, but psychologists rate the incremental utility of testing more strongly than psychiatrists (Paulson et al. 2019). However, it is less known how experience shapes these attitudes. For psychodiagnostic testing specifically, few studies directly model years since qualification or caseload as predictors, with most showing an association between more years and lower use (Ametaj et al. 2021).

Here, we examined whether occupation type and years of professional experience influence attitudes toward psychodiagnostic testing. Based on the findings presented above, we hypothesize that psychiatrists and psychologists will differ with regard to experience-dependent perceived accuracy, validity, and reliability of psychodiagnostic tests, which will be reduced among psychiatrists and increase among psychologists. However, we also hypothesize that growing confidence in one own diagnostic competence will increase, while clinical usage of psychodiagnostic tests will reduce, for both profession types.

Methods

Study design

This was a cross-sectional study including questionnaire disseminated to licensed clinical psychologists and psychology interns, as well as board-certified psychiatrists and psychiatry residents at various stages of training.

Participants

Participants were recruited via email using the mailing lists of the Israeli Psychiatric Association and the Israeli Psychological Association. Email served as the primary recruitment method, supplemented by recruitment through professional psychiatric and psychological groups on social media. Clinical psychologists and psychiatrists who had not been in active clinical practice within the past decade were excluded.

Ethical approval

This study was granted an ethics exemption by the institutional review board of Soroka university medical center. The exemption was approved on the basis that the study was non-interventional, involved no patient data, and surveyed competent adult professionals using an anonymous online questionnaire. Completion of the survey was considered to constitute implied informed consent. Participation was entirely voluntary.

The questionnaire

This study employed a questionnaire developed specifically for the present research (see supplementary material). Content validity for this study was assessed through expert review by two independent professional groups that included two psychiatrists (one junior and one senior) and two psychologists (one junior and one senior). Each expert group reviewed the questionnaire and identified items deemed inappropriate based on two criteria: content relevance (the degree to which an item was pertinent to the construct of interest) and linguistic quality (clarity, phrasing, and style). Items identified as inappropriate were either removed or revised in accordance with the experts' feedback.

The questionnaire assessed both demographic characteristics and professional attitudes toward psychodiagnostic testing. Demographic variables included gender, age, profession (psychiatrist or psychologist), clinical status (specialist or resident), and years of clinical experience. The attitudinal section examined clinicians' perceptions on the following domains of psychodiagnostic testing, with each item rated on a 6-point Likert scale (1 = strongly disagree, 6 = strongly agree):

1. Psychometric Properties and Scientific Validity
2. Perceived accuracy of psychodiagnostic tests in diagnosing psychiatric disorders
3. Perceived Influence of Psychodiagnostics Tests on the Need for Treatment
4. Professional engagement and expertise in psychodiagnostic assessment
5. Referral Practices and Diagnostic Self-Reliance
6. Emotional Reactions and Attitudes Toward Psychodiagnostic Testing

Data were collected using an online survey platform (Google Forms), and all responses were collected and stored anonymously. To enhance response rates for the email-based survey, reminder emails were sent up to three times to non-responders.

Data analysis

Pearson's correlation coefficients were calculated within each professional group, and between-group differences in correlation magnitude were assessed using Fisher's r-to-z transformation (Preacher, K. J. 2002). To control for multiple comparisons, p-values of between-group comparisons were adjusted using Bonferroni correction per domain. Statistical significance was set at a two-tailed α level.

Results

A total of 144 professionals (73 psychiatrists and 71 psychologists) completed the questionnaire and were included in the analysis (Table 1). Among psychiatrists, specialists were more highly represented than residents, whereas the distribution between specialists and residents was more balanced among psychologists.

Table 1. Demographic characterization

		Sample size	Female (%)	Age	Years of experience
Psychiatry	**All**	73	34 (46.58)	47.90 ± 1.39	17.47 ± 1.52
	Resident	12 (16.4%)	5 (41.67)	38.17 ± 1.77	4.83 ± 1.24
	Specialist	61 (83.6%)	29 (47.54)	49.82 ± 1.51	19.95 ± 1.63
Psychology	**All**	71	52 (73.24)	40.13 ± 1.25	10.68 ± 1.16
	Interns	34 (47.9%)	28 (82.35)	33.00 ± 0.71	3.85 ± 0.34
	Specialist	37 (52.1%)	24 (64.86)	46.68 ± 1.72	16.95 ± 1.63

The results below present the between-group differences in correlations linking years of experience with responses to the various statements. The exact statements (translated from Hebrew), together with Mean ± SEM for each profession, are presented in the supplementary material.

Psychometric Properties and Scientific Validity

The differences between the groups' correlations were significant for accuracy, validity, reliability and for correlation with psychiatric diagnosis (Table 2). For psychiatrists, increased years of experience were associated with reduced perceived rigor across variables, which was more pronounced for Accuracy. For psychologists, increased years of experience were associated with increased perceived rigor across variables with converse perceived rigor of fake detection.

Table 2. Psychometric Properties and Scientific Validity

		Accuracy	Validity	Reliability	Detect impersonation	Correlate with psychiatric diagnosis
Psychiatry	**r**	-0.201	-0.134	-0.075	-0.126	-0.146
	t score	1.732	1.141	0.636	1.073	1.241
	p value	0.088	0.258	0.527	0.287	0.219
Psychology	**r**	0.415	0.349	0.356	-0.039	0.293
	t score	3.788	3.093	3.160	0.326	2.542
	p value	0.000	0.003	0.002	0.746	0.013
Between groups	**Z score**	-3.792	-2.932	-2.626	-0.516	-2.632
	p value	**0.000**	**0.003**	**0.009**	0.607	**0.008**

Note. Between-group two-tailed p values shown in bold indicate statistical significance after correction for multiple comparisons.

Perceived accuracy of psychodiagnostic tests in diagnosing psychiatric disorders

The difference between the group's correlation was significant for Personality disorders (Table 3). For psychiatrists, increased years of experience were associated with reduced perceived accuracy across disorders, while for psychologists it was associated with increased perceived accuracy across disorders.

Table 3. Perceived accuracy of psychodiagnostic tests in diagnosing psychiatric disorders

		Psychotic disorders	Affective disorders	Anxiety disorders	Personality disorders
Psychiatry	**r**	-0.161	-0.053	-0.042	-0.048
	t score	1.372	0.447	0.358	0.404
	p value	0.174	0.656	0.722	0.688
Psychology	**r**	0.250	0.206	0.237	0.413
	t score	2.147	1.748	2.026	3.765
	p value	0.035	0.085	0.047	0.000
Between groups	**Z score**	-2.454	-1.538	-1.668	-2.860
	p value	0.014	0.124	0.096	**0.004**

Note. Between-group two-tailed p values shown in bold indicate statistical significance after correction for multiple comparisons.

Perceived Influence of Psychodiagnostics Tests on the Need for Treatment

The differences between the groups' correlations were not significant (Table 4). For psychiatrists, increased years of experience were associated with reduced influence across variables, while for psychologists it was associated with increased influence across variables.

Table 4. Perceived Influence of Psychodiagnostics Tests on the Need for Treatment

		Pharmacological	Pharmacological type	Psychological	Psychological type
Psychiatry	**r**	-0.187	-0.259	-0.063	-0.167
	t score	1.602	2.264	0.531	1.429
	p value	0.114	0.027	0.597	0.157
Psychology	**r**	0.170	0.107	0.190	0.142
	t score	1.437	0.891	1.606	1.188
	p value	0.155	0.376	0.113	0.239
Between groups	**Z score**	-2.121	-2.188	-1.498	-1.828
	p value	0.034	0.029	0.134	0.067

Professional Engagement and Expertise in Psychodiagnostic Assessment

The differences between the groups' correlations were significant for the routine use of psychodiagnostic assessment for diagnostic (Table 5). For psychiatrists, increased years of experience were associated with reduced use and follow-up on relevant literature, but with increased feeling of proficient knowledge. For psychologists, increased years of experience were associated with increased use of test results, follow-up on relevant literature and feeling of proficient knowledge, but reduced conduct of assessments.

Table 5. Professional Engagement and Expertise in Psychodiagnostic Assessment

		Routinely used for diagnostic	Routinely conduct assessments	Read the current literature	Proficient knowledge
Psychiatry	**r**	-0.323	-0.278	-0.014	0.150
	t score	2.877	2.436	0.114	1.276
	p value	0.005	0.017	0.909	0.206
Psychology	**r**	0.169	-0.047	0.219	0.201
	t score	1.426	0.392	1.869	1.707
	p value	0.158	0.696	0.066	0.092
Between groups	**Z score**	-2.972	-1.398	-1.390	-0.313
	p value	**0.003**	0.161	0.165	0.757

Note. Between-group two-tailed p values shown in bold indicate statistical significance after correction for multiple comparisons.

Referral Practices and Diagnostic Self-Reliance

The differences between the groups' correlations were significant for the feeling the results can be rely on when making a diagnosis (Table 6). The groups diverge with regard to the effect of increased years of experience over the tendency to refer to assessments and to rely on assessments, with reductions among psychiatrists and increases among psychologists. However, both groups demonstrated similar increase in their confident to diagnose without tests.

Table 6. Referral Practices and Diagnostic Self-Reliance

		Refer for assessments from public service	Refer for assessments from private service	Can rely on the results when makin
Psychiatry	**r**	-0.380	-0.091	-0.259
	t score	3.387	0.668	2.258
	p value	0.001	0.507	0.027
Psychology	**r**	0.058	0.171	0.341
	t score	0.428	1.213	3.012
	p value	0.670	0.231	0.004
Between groups	**Z score**	-2.493	-1.319	-3.641
	p value	0.013	0.187	**0.000**

Note. Between-group two-tailed p values shown in bold indicate statistical significance after correction for multiple comparisons.

Emotional Reactions and Attitudes Toward Psychodiagnostic Testing

The differences between the groups' correlations were significant for feeling angry when tests are spoken ill of and feeling significant when diagnosed through tests (Table 7). The groups converse with regard to the effect of increased years of experience over all variables, with reductions among psychiatrists and increases among psychologists.

Table 7. Emotional Reactions and Attitudes Toward Psychodiagnostic Testing

		Feel helpless when decision do not include tests results	Feel angry when tests are spoken ill of	Feel satisfied when great i
Psychiatry	**r**	-0.227	-0.127	-0.174
	t score	1.963	1.076	1.485
	p value	0.054	0.286	0.142
Psychology	**r**	0.113	0.357	0.152
	t score	0.948	3.174	1.278
	p value	0.346	0.002	0.205
Between groups	**Z score**	-2.025	-2.941	-1.930
	p value	0.043	**0.003**	0.053

Note. Between-group two-tailed p values shown in bold indicate statistical significance after correction for multiple comparisons.

Discussion

This study examined whether years of clinical experience are differentially associated with attitudes toward psychodiagnostic testing among psychiatrists and psychologists. To the best of our knowledge, this is the first study that directly compared those trajectories, while former studies examined the influence of less direct measures, such as age or the time spent in a specific setting (Bohman 2023; Danielson et al. 2019; Macqueen et al. 2024). Here, the central finding was a consistent divergence between professions in the direction of experience-related change, with psychologists demonstrating increased endorsement of the scientific rigor and diagnostic utility of psychodiagnostic testing and psychiatrists demonstrating decreased reliance on such assessments. At the same time, both professions reported increasing confidence in diagnosing without tests as experience increased.

Contextualizing experience-dependent patterns requires closer examination of the intersection between clinical reasoning and professional expertise and raises a broader normative question about the role of psychodiagnostic testing in clinical decision-making, particularly in balancing efficiency with diagnostic accuracy. While the findings do not establish causality, they may reflect a shift in diagnostic style with increasing experience. Dual-process models of clinical reasoning suggest that experienced clinicians tend to rely more on intuitive, pattern-recognition–based processing (System 1), and less on slower, analytical approaches (System 2), which often involve structured or standardized tools (Croskerry 2009; Norman et al. 2017). Within this framework, the observed decrease in reliance on standardized testing among more experienced psychiatrists may represent an increasing preference for internally generated clinical judgment over externally derived assessment data. However, as noted by Lewis and colleagues (Lewis et al. 2019), this is a double-edged sword. While standardized assessments certainly bolster reliability and facilitate measurement-based care, they inevitably introduce significant burdens in terms of time, cost, and resources. Hence, reduced reliance on psychodiagnostic testing among more experienced clinicians may reflect increased efficiency and greater reliance on accumulated clinical expertise, but may also entail reduced use of structured, standardized sources of information that can support diagnostic consistency and help mitigate cognitive biases in clinical reasoning (Croskerry 2009). Furthermore, the concept of cognitive entrenchment proposes that accumulated experience can reinforce established diagnostic heuristics, potentially limiting openness to alternative inputs such as formal psychodiagnostic assessment (Dane 2010). Accordingly, the present findings are best interpreted within a broader trade-off between efficiency, cost, and diagnostic precision, rather than as supporting a single optimal approach to clinical assessment.

From a services and policy perspective, these findings suggest that professional culture and role socialization shape how experience translates into assessment practices. In many mental health systems, psychologists are primary providers of structured psychodiagnostic evaluations, while psychiatrists function as medical diagnosticians and prescribers. Over time, clinicians may consolidate these role-specific orientations. Experience does not appear to homogenize epistemic preferences across disciplines; rather, it reinforces profession-consistent models of diagnostic authority and therefore has implications for service organization. Among psychiatrists, increasing experience was associated with reduced routine use of testing and reduced referral to assessment services. In systems where clinicians function as gatekeepers for access to psychological assessment, such patterns could influence referral rates, waiting lists, and allocation of assessment resources. Conversely, among psychologists, increasing experience was associated with greater perceived rigor and diagnostic reliance on testing, which may support continued investment in structured assessment services and training. Importantly, both professions showed increased confidence in diagnosing without tests. This shared trajectory may reflect accumulated clinical expertise and pattern recognition. However, the policy-relevant issue is not confidence per se, but how confidence interacts with system-level processes. If senior clinicians are less likely to refer for testing, this may shift diagnostic pathways toward interview-based models. Whether this shift enhances efficiency or reduces diagnostic precision may depend on context, case complexity, and service structure.

Our findings indicate that more experienced psychiatrists report reduced referrals to psycho-diagnostic testing and lower reliance on test results in clinical decision making. Hence, referral patterns may be driven more by professional enculturation than by clinical need. If so, existing guidelines and criteria for referrals to psychodiagnostic assessment in public mental health systems warrant reexamination.

The strongest disorder-specific divergence concerned the perceived accuracy of psychodiagnostic tests in diagnosing personality disorders, an area in which structured assessment has historically played a central role in psychological practice. Structured clinical interviews like SCID-5 and SCID-5-PD operationalize

categorical DSM personality disorders diagnoses, often supplemented by self-report tools such as PID-5, MMPI-2, and MCMI-III (Widiger et al. 2024). Differences in perceived utility in this domain may influence how services approach complex and comorbid cases, particularly in community mental health settings where personality pathology affects treatment planning, risk management, and continuity of care (Troup et al. 2022). These findings also intersect with ongoing debates about measurement-based care and the integration of standardized tools in mental health systems (Lewis et al. 2019, 2022; Whitmyre et al. 2024). Efforts to promote structured assessment often assume that increased experience leads to greater appreciation of standardized methods (Amanda Jensen-Doss and Hawley 2010; Lyon et al. 2015) and our results suggest that this assumption may hold for some professions but not others. Implementation strategies may therefore require profession-sensitive approaches. For example, policies that emphasize collaborative interpretation of assessment results or shared diagnostic case formulation may reduce epistemic fragmentation across disciplines.

Several limitations of the present work should be considered. The cross-sectional design does not permit causal inference or separation of developmental from cohort effects. The sample was drawn from one national context, while organizational structures vary across health systems. Moreover, psychiatrists are, on average, older and have substantially more years of clinical experience than the psychologist cohort. In addition, the gender distribution is markedly skewed, with females comprising the majority of the psychology sample but only about half of the psychiatry sample. Attitudes were self-reported and may not directly correspond to referral behavior or actual service utilization. Hence, future research should examine larger, more homogeneous populations, and incorporate objective indicators such as referral rates, test utilization patterns, and patient outcomes within integrated care pathways. Longitudinal and system-level studies are needed to determine whether these experience-related differences influence diagnostic accuracy, service efficiency, cost-effectiveness, and treatment outcomes. Research that integrates clinician attitudes with administrative data could clarify how epistemic preferences translate into resource allocation and patient flow within public and private sectors.

Conclusion

Experience is associated with profession-specific trajectories in attitudes toward psychodiagnostic testing. Psychologists increasingly endorse and rely on structured assessment with greater experience, whereas psychiatrists show reduced reliance and referral. Both professions demonstrate increased confidence in diagnosing without tests. These divergent patterns have implications for mental health service delivery, referral pathways, and the implementation of standardized assessment within care systems. Policies aimed at strengthening interdisciplinary collaboration and optimizing diagnostic pathways should consider how professional training and accumulated experience shape clinicians' engagement with psychodiagnostic tools.

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Authors' contributions

H.S: Conceptualization, Methodology, Project Administration, Supervision, Validation, Writing: Original Draft Preparation, Writing, Review & Editing.

Da.S: Investigation, Data Curation, Writing: Review & Editing.

R.B: Formal Analysis, interpretation of data, Writing: Review & Editing.

Do.S: Writing: Original Draft Preparation, interpretation of data, Writing, Review & Editing, Supervision.

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