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AUTHOR Fox, Ronald E.
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ABSTRACT

Changes have occurred in the training of interns and the functioning of psychologists at Ohio State University Medical School, none of which was effected by their psychometric laboratory. The number of tests administered by interns has decreased markedly. The existence of the laboratory changed training experiences and opportunities. Psychologists were free to spend more time talking with the patient and to order appropriate tests, thus their roles as consultants and problem solvers was emphasized. The psychologist was also in a better position to get his information into the system early while decisions were still being made. One side effect caused by the existence of the lab is that interns frequently do not consider it worthwhile to master projective testing techniques, but see the testing role as one appropriate for technicians, not professionals. Training requirements have shifted, from demanding an intern to demonstrate ability in the use of tests to today's requirement that they be able to evaluate clinical problems and formulate appropriate intervention. This training model has met the needs of the interns and staff and the demands of the setting. (Author/BW)

# IMPLICATIONS OF PSYCHOMETRIC LABORATORIES FOR TRAINING INTERNS IN PSYCHOLOGICAL ASSESSMENT

Ronald E. Fox
Ohio State University

For over ten years now, The Ohio State University Medical School has had a fully functioning psychometric laboratory. Today, I want to share with you some of the changes that have taken place, both in the psychologists' functioning and in the training of our interns, during that period. I have no way of knowing how much weight to assign to the psychometric laboratory as a factor in the changes in practice which have taken place, but I do believe that there has been some effect.

Before proceeding further, a brief description of the lab and its operation may be helpful. The laboratory is an administrative unit of the Division of Clinical Psychology which assumes full responsibility for its total functioning, including the hiring and training of psychometrists, billing and collecting for services, and all other clinical and business functions. The staff consists of two M.A. level psychometrists who do all test administration and scoring and a Ph.D. psychologist who is responsible for overseeing the proper delivery of clinical services.

The laboratory specializes in the utilization of over 60 objective tests including such individually administered instruments as the Wechsler tests, the Porteus, the Stanford-Binet, the Bender-Gestalt, the Reitan Battery, the

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Minnesota Percepto-Diagnostic, the Wechsler Memory Scale, the Graham-Kendall, and the Illinois Test of Psycholinguistic Abilities; as well as a wide range of instruments which can be administered in a group format such as the MMPI, the Strong, the Kuder and the Shipley-Hartford. The only projective instruments administered are the Incomplete Sentence Blank, the H-T-P, and the Gorham Proverbs.

Requests for laboratory services are initiated by any psychologist or physician on the College of Medicine staff from any department. In practice, most physicians are uncertain as to the appropriate tests to order and make referrals to a psychologist or psychiatrist, who in turn orders appropriate tests. After a request is received, a psychometrist administers and scores the requested tests, and enters the results on a laboratory result form which then is placed in the patient's chart. The entire process from request for services to the charting of results, typically, takes 48 hours, but can be expedited in emergency cases. The laboratory does not interpret results, its function is simply to administer tests and report results. Thus, a request for an MMPI results in a profile being generated; a WAIS request results in a report of raw score and scale score for each subtest as well as verbal, performance, and full scale I.Q. scores. (A complete, verbatim WAIS protocol can be supplied, if requested.) The interpretation must be generated by the psychologist or physician who initiated the request.

Utilization of laboratory services has increased steadily over the years. During the most recent 12 month period of operation, a total of 5,000 tests

were administered to 2,354 patients. This does not include any tests administered by interns or psychology faculty. The bulk of the laboratory services were performed for adult psychiatric inpatients (57% of all patients tested). Twenty-two percent of the patients tested were private patients of psychologists and physicians; 1[illegible]% were for other medical departments; and, 8% were adult psychiatry outpatients.

Interns relate to the laboratory in three ways. First, all MMPIs administered by the laboratory are interpreted by interns and co-signed by a staff member before being charted. Interns are given an intensive "cook book" interpretation course during their first week of training. Interpretations are made directly on the bottom half of a sheet whose top half contains the profile. Elegance of style is secondary to getting the facts stated and into the chart quickly. Interns are given access to available "cook book" formulations which cover some of the common profile types and are free to enter these directly if it is appropriate to the particular case. Within a few weeks, the intern is able to interpret his daily total of 2-4 profiles in less than twenty minutes. A second use of the laboratory by interns is for training. Interns lacking skills in the administration and scoring of tests such as the Wechsler, the Binet or the Reitan Battery are trained by the psychometrists. Lest anyone wonder about the wisdom of BA level persons teaching psychology interns, let me reassure you that the training is in administration and scoring and not in interpretation. These psychometrists can be relied on to give a "text-book" WAIS every time and their scoring decisions are subject to regular "quality

control checks," with discussion and clarification when needed by the lab director. In addition to being trained, our interns have occasionally trained laboratory personnel to use a new test and incorporate it into the available list of services offered. Finally, interns are free to request any of the laboratory services for any of their patients. In fact, learning to use such services, by requesting the appropriate tests and integrating the results with other findings, such as interview data, is considered an essential component of our training program.

Naturally, as the laboratory has taken on more and more, the amount of testing done by interns and staff has decreased markedly. This is to be expected. It is significant to note, however, that the amount of projective testing done also has declined sharply and this testing has not been transferred to psychometrists. Less projective testing is being done. In 1963, each of our interns administered and interpreted an average of two projective batteries per week. In 1973, the average per intern was reduced to one projective battery every 2 1/2 weeks.

Much of this reduction undoubtably can be attributed to the overall decline in the role of testing in psychological work. Lubin and Lubin (1972) found that the percentage of time institutional psychologists devoted to the testing function decreased from 44% to 20% between 1959 and 1969. If our experience at Ohio State University is any measure, the decline has been even greater since 1969--and is continuing. In part, the decline in use of testing may be explained as the consequence of increased time spent in psychotherapy,

In 1960, Kelly (1961) found that clinical psychologists devoted most of their time to psychotherapy. In all likelihood, this is even more true time in 1974. But, we have also noted an increase in the psychologist's role as consultant in our setting and the laboratory has been instrumental in helping this role definition. Having a laboratory has helped to change and reinforce consultant behaviors.

First of all, the laboratory has helped emphasize the role of the psychologist as a consultant problem-solver. Several years ago when a referral was received, the psychologist (or intern) spent several hours administering a battery of tests, and additional hours scoring, interpreting and writing up the results. Typically, close to a week passed before a typed report was delivered to the referral source. Now, the process is different. Upon receiving a consult, the psychologist visits the patient briefly, writes preliminary notes of plans in the chart and orders appropriate tests from the laboratory. The results are available in one or two days. Then, the psychologist interprets the results along with data from his interview with the patient and makes his recommendations. The process is completed in 2-3 days. Naturally, the psychologist can also administer tests to supplement the other material. But, with increased sophistication and experience in the use of psychometrists, the amount of testing done by the psychologist has declined. In such a professional practice context, the intern learns to use auxiliary help to carry out many functions formerly reserved to the psychologist. His interest becomes focused on gathering information that is of practical utility

to the problem at hand. In many contexts, the referring physician is not so much interested in how the patient came to be the way he is, or what keeps him that way, as he is in what can be done. Interns are thus encouraged to devote less time to the exploration of dynamics and more to the identification of practical solutions. The essence of the role of consultant, as we teach it, is oriented toward helping the referral source manage the case. In carrying out this task, much of the material gathered from traditional projective testing seems simply irrelevant.

A second impact of the laboratory on training is related to the speed with which information is generated. In the past, interns often complained, with considerable justification, of spending hours of hard work gathering and reporting information which then seemed to be utilized minimally in the diagnostic and therapeutic processes. Why spend so much time in an activity which is so little prized by others? The effect on a developing professional identity was quite negative. Interns were encouraged to have as a major part of their identity a role which was not highly valued by other professionals. Partly, the lack of utilization of test results resulted from the reporting of information of limited practical value, and partly from the long delay in obtaining results. I think that it has been well established that the crucial decisions concerning diagnosis and disposition in hospital settings are made in the first few days after the patient's admission and are highly resistant to change thereafter. We routinely order some group tests such as the MMPI for newly admitted patients and the results are available within twenty-four

hours. By having objective data available almost immediately, the intern finds that his input has a significant impact on both diagnostic and disposition decisions and that his expertise is highly valued by other professional personnel.

A third effect of the lab on professional practice (and, thus, training) in our setting is that the psychologist has more time to devote to interviewing the patient, his family and other professional personnel. With the lab, the intern is able to generate a large amount of data at no cost of his own time. He is, thus, in a position to obtain much of the information typically obtained from projective tests through interviews. Over the years, we have found ourselves devoting more and more time to teaching interviewing techniques and skills to our interns--mainly at their request. Also, interns are encouraged to be wide-ranging in the securing of information if it seems appropriate: e.g., calling relatives or the family doctor, or the employer, and talking with aides and nurses who have had the most direct contact with the patient.

In my opinion, an unfortunate side effect of the environment which our lab has helped create is that interns often get the idea that projective tests are not useful and are not worth the considerable investment of time needed to master them. Most of our recent interns came to us with less skill and more skepticism regarding diagnostic testing than was the case even ten years ago. Many have had little or no practical experience in the use of diagnostic testing beyond a survey course on test development and the major research studies. They appear to know a great deal about what testing cannot do, and

almost nothing about what it can do. In our setting, the laboratory, the emphasis on practically useful information and on quickness of response, not only reinforces a tendancy to deemphasize projective testing, but reinforces a tendency to see the testing role as one appropriate for technicians, not professionals. At one time, we attemped to counteract these effects by requiring all interns to demonstrate a minimal level of competence in the use of traditional tests before they were allowed to use laboratory services. We later dropped this requirement as we moved from the idea that all clinicians must share the common ability to administer and interpret a wide variety of diagnostic tests. Our present idea is that all clinicians must know how to evaluate clinical problems in order to formulate appropriate interventions. However, the evaluation can be accomplished by a variety of methods which may include diagnostic tests administered by the psychologist but which also may include only the ability to appropriately use the skills of technicians. Or, the evaluation may be a behavioral one conducted prior to the initiation of a modification program based on learning principles. Obviously, the intern must know about the problems and potentials of each approach and be aware of his limitations when confining himself to one or the other. It may be of interest to note in passing that we do still use diagnostic batteries, but they are limited to cases where the information gathered seems to be unavailable by other methods. The role function has not disappeared, its relative emphasis has changed. Occasionally, interns ask for intensive diagnostic testing experience and this is easily arranged. Sometimes, the career goals of a particular student lead us to insist on his learning to use some instru-

ments. For example, a current intern is interested in a career in the assessment and treatment of neurologically impaired patients. We have given him extensive and intensive experience with such tests as the Reitan battery.

While most of the above observations may seem appropriate only to interns working in an inpatient setting, the changes noted in intern behavior have not been so limited. In outpatient work, interns and other professionals have an interpreted MMPI, an incomplete sentence blank, and Shipley-Hartford scores available on their patients by the second interview. With this information, it is infrequent for additional questions to occur which cannot be left to emerge in the course of the psychotherapy. As this routine testing service was introduced, requests for psychological tests declined. We still do get referrals for testing but they are less frequent than before and, usually, involve very difficult diagnostic-evaluation problems. With such cases, it is not hard to communicate the excitement and usefulness of this unique role of the psychologist to the intern.

In my own private practice, I have more test information on my patients than I used to gather because of differences in the required expenditure of my time. Typically, I now obtain at least a pre-therapy MMPI with follow-up testing at periodic intervals to help pinpoint significant changes. The role modeling value of this behavior is not lost on interns.

At the present time, I think a fair assessment of our intern products would be as follows: a minority are good diagnostic testers, the overwhelming majority have only minimal to fair abilities in this regard, and a few would

be hard put to tell you which is the top of card X of the Rorschach. On the other hand, almost all of them are very skillful at generating relevant information to the clinical problem at hand (assessment of the problem) and then recommending specific, practical interventions. We make no claim that this is the best model for clinical practice, but we do feel that it is a valid one. It is also a model which seems to best meet the needs of our interns and the demands of our setting and is closest to the typical practices of our staff.

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