Susanne M. Wilkie BA, Dip.Psych.
Suite 32, Silverton Place,
101 Wickham Terrace,
Brisbane 4000

Psychologist
Telephone (07) 3832 5454
Office Fax (07) 3839 9716

Attention: Chair, Psychology Board of Australia
chair@psychologyboard.gov.au

Comments on the Consultation Paper – Options for the protection of the public posed by the inappropriate use of psychological testing

Psychology tests have been designed and standardized by psychologists for use by psychologists, and their use is restricted to psychologists who have the required background training in psychology to use them for the purpose they were developed.

I quote the statement in the preface to the WISC III Manual:
"Today, professionals who use the WISC-III would do well to employ the same type of clinical sensitivity shown by Wechsler as they examine each person's abilities with the test, and also to gather the *essential* extra-test information and background history with which to compose a psychological portrait that is unique and personally and societally meaningful for each individual." Joseph Matarezzo (1991). This applies to all psychological tests.

Similarly in the Introduction to the WAIS – III Manual summarizing Matarazzo (1972,1990) and Wechsler (1950) "the clinician should view each examinee as unique and take into account nonintellective factors and other life-history information when interpreting the test results…..Test scores, behavioural observations, and life histories are critical sources of information in all diagnostic assessments, but clinicians should keep in mind that they themselves are the cornerstone of any assessment. Those who are responsible for interpreting the results of intelligence testing must be careful to distinguish between cognitive abilities, conative factors (i.e. personality traits, such as anxiety, persistence and goal awareness). And other nonintellective variables that contribute to test performance."

And again, in the foreword to the WISC-IV Manual – "Wechsler never forgot the importance of gathering a complete picture of the individual, including socio-educational experiences, personal motivations, and personality characteristics. Wechsler knew well the art of psychological assessment. And that while psychometrically sound cognitive assessments are an important piece. They are only one source of information about an individual." Matarazzo (2003).

I also note the statement "Often in neuropsychological evaluation, qualitative interpretation of test performance, analysis of errors, and testing of the limits are viewed as important or more important than the scores themselves." Kaplan (1988).

The emphasis, as most critical, is "the professional clinical insight of the practitioner".

I believe that the training of psychologists (at least as I experienced it) is uniquely designed to equip psychology practitioners with an understanding of test construction, test administration, scoring and interpretation as well as a knowledge of the many factors involved in interpreting test

the person being tested. There are members of professions other than psychology who are using psychology tests which they are able to access through their workplace. There are also psychologists using tests without adequate training.

Over more than thirty-five years in clinical practice I have seen many missed or faulty diagnoses made on the basis of test results – some without regard to background history, some with poor knowledge of test interpretation, some with no psychological background knowledge to underpin their interpretation, and even some who cannot competently add up scores.

Unfortunately, it would be too time consuming for me to go through hundreds of files to find many examples, but some come to mind.

An 8 year old girl tested by a Guidance Officer for "an evaluation because of academic problems and learning problems". The WISC-III and the Peabody Picture Vocabulary Test were used. (There was no evidence that any clinical history had been taken.) The subtest scores were miscalculated with the result that "Her general cognitive ability is within the **borderline** range of intellectual functioning." When correctly calculated her Verbal IQ was in the Average range, Performance IQ in the Borderline range and Full Scale IQ in the Low Average range. There was a significant difference between Verbal and Performance IQs. This was not noted. There was wide discrepancy between individual subtest scaled scores. This was not noted. There was no attempt to relate very low scores to possible specific learning difficulties, although examination of subtest scaled scores might have indicated problems with working memory and fine motor skills. The report was incorrect and unhelpful.

It is not unusual to see a diagnosis of ADHD on the basis of one or two subtest scores on the WISC and no reference to actual environmental or clinical factors. Similarly, it not unusual to see these serious diagnoses made based on a tick-box questionnaire.

For example, a young girl aged 10 having difficulties with concentration and classroom learning and not wanting to go to school was diagnosed as having ADD (no hyperactivity) based on test scores (a reported IQ of 73 and very low scores on Arithmetic, Digit Span, Coding, Symbol Search). She was then prescribed medication which made no difference to her situation except a reduction in appetite and complaints that it made her feel 'sick in the tummy'. She had a good vocabulary, good expressive language skills and average social comprehension.

A comprehensive clinical history revealed a difficult pregnancy, premature birth (25 weeks, 535 grams), septicaemia at 4 weeks followed by cerebral haemorrhage at 7 weeks, no damage shown on tests 4 weeks later, milestones in normal range except slow to talk. Mother reported that she was a very sensitive child. She had allergies, eczema, asthma, sinus problems and hay fever, restless sleep, frequent ear infections from a very early age with grommets at age 3 and 7.

This suggested possible **auditory processing** difficulties given other information from the history i.e. slow to talk, background noise interfering with concentration, difficulty with phonics, difficulty with music and poor auditory short term memory (very low scores on Arithmetic and Digit Span).

Further, she had problems with organisation, was clumsy (spilling), difficulties with development of fine and gross motor skills, poor throwing and catching skills. This suggests poor **sensorimotor integration** and would account for her poor performance on subtests requiring eye-hand coordination and on those requiring (timed) writing skills (Coding and Symbol Search).

This child's concentration was also impaired at the time she was originally assessed because she

had separated the previous year. The reluctance to go to school was due to a desire to stay home and make sure her mother was OK.

This was a highly sensitive, anxious child with specific learning difficulties. She did not have ADD.

I recently saw a fourteen year old boy who was depressed, rebellious and not doing well at school. He was overreacting to minor incidents at home with frequent bouts of shouting and tears. He had been briefly suspended from school.

As an eight year old he had been assessed at a child development unit and diagnosed with Aspergers Syndrome. He had been assessed by a number of different professional people. On the WISC – IV he had above Average intellectual ability, and with some scores, when taken in conjunction with school performance, might have indicated mild learning difficulties. However in the view of the person making this diagnosis, he did not have learning difficulties because he had above average IQ. He was said to have poor social skills (he was being bullied at school), and because he also collected match box cars (an 8 year old boy!), he warranted the label of Aspergers Syndrome.

This diagnosis had a significant impact on his self image and also in the way he was treated at school. He believes he is "dumb" and "disordered". By age 14 he was stressed and depressed as a result of unrelenting bullying. He was beginning to react to the bullies and had retaliated twice and been suspended. He says he "was provoked and lost it". The bullies went unpunished. He was frustrated, explosive and not interested in cooperating at school or at home.

In fact, he did have a learning difficulty. The physiotherapist had found him to have problems with coordination control, proprioception and motor planning and low muscle tone – difficulties that impacted fine motor (writing) and gross motor activities. The psychologist had noted reluctance to perform written tasks, very good attention, no impulsivity and above average intellectual ability.

However, there was no comprehensive clinical history so what was not taken into account was the effect of being consistently bullied at school every day; that outside the school setting his social skills were fine. He did very well in scouts and became a leader. His parents were in the process of being divorced. He had a history of frequent ear infections as a child with three lots of grommets before Grade 1. He has allergies and food sensitivities. His play behaviour as a child was normal and active. Developmental milestones were in the normal range except for sensorimotor coordination problems. He was always a bright child, learning quickly until he went to school. He has a good sense of humour. His mother describes his personality as "sensitive, caring, thoughtful, empathetic and helpful, and really good at teaching and explaining things to younger children".

He also has Pyroluria which is treated and controlled but can still cause symptoms. These include poor stress control, nervousness, anxiety, mood swings, an explosive temper, poor short term memory and depression.

Over the years in practice I have seen many people who have been misdiagnosed and harmed by interpretations of personality tests without reference to their real life history and experience. I have seen computer generated results and summaries totally applied (not as suggested possibilities) to a person where they in fact had no resemblance to that person's real life experience, attitudes, behaviour or symptoms. This causes considerable stress. I have on a number of occasions seen the MMPI misused by medical practitioners to discredit a patient in compensation or insurance claims.

I believe that the basic training in research and scientific method in Psychology is more comprehensive and rigorous than in any other profession, This underpinning basic training equips the clinically trained practitioner psychologist with skills to gather data through detailed clinical history and observation, to make hypotheses or differential diagnoses, to test these out, add in psychological test results and test behaviour, refine hypotheses and accurately diagnose. Psychological tests have been designed by trained scientific psychologists. Psychologists are (or should be) trained to know how to use them and how they fit into the practitioner's overall diagnostic process. When Psychology tests are used and misinterpreted by non psychologists or by poorly trained and inexperienced psychologists, it negatively affects the reputation of these tests as well as the reputation of Psychology as a profession – and it is harmful to the public.

Questions for stakeholders - p 11 of Consultation Paper

1. It is my impression from my 35 year experience in clinical practice that this problem is widespread and increasing. Harm is done to both adults and children, but the potential harm to children is significantly greater. Wrongly labeling children with inaccurate diagnoses leads to lifetime problems with self image and self confidence, wrong or inadequate treatment, inappropriate or inadequate teaching at school, lost potential (affecting life, relationship and career choices and financial stability), depression, anxiety and other mental health problems, and in some cases, suicide. I have noted a few cases above, but these are just a few of many.

2. In my view Psychology training today does not always adequately equip graduates with skills to appropriately use psychological tests. I had the opportunity to attend a number of University course accreditation meetings as a Board member for some years. It was apparent that far less time was being allocated to psychological testing than I had experienced many years ago. In one university, the Masters course included training in the WAIS, but not the WISC. When I queried this, I was told that there was only time in the course to cover the WAIS. They did not have a WISC in the test library. Four year graduates today seem to be graduating with little knowledge about psychological testing or the necessity for a clinical history. It is difficult to admonish non psychologists for using psychology tests, if they have at least been trained to use them and we are not adequately training psychologists in this very important area.

Questions for stakeholders – p 19 of Consultation Paper

1-3. Children at school are being "diagnosed" by teachers as having one or more of a range of disorders, and parents are then requested to have their child assessed by the guidance officer, or a GP or a paediatrician. Often a diagnosis is made on the results of tick box scales/questionnaires. This is rarely accompanied by a comprehensive history. Children who are stressed or anxious (sometimes with acting out behaviour) often end up with a label of ADHD as a result, but nothing is done to address the cause of the child's distress. By adolescence they have lost hope, accepted they are in some way "inferior", have some "disorder" and cannot see a place for themselves in this world.

A child who is withdrawn, not playing with other children in the playground, and spending his play time in the library is sent for assessment and ends up with a label – Aspergers/ ASD (with poor social skills). Nobody addresses the reason for his school behaviour and he continues to be teased and bullied throughout his schooling (preferring the library to bullies in the playground). By adolescence he is depressed, anxious, has no self confidence and has accepted he is "disordered".

While these simple tick box scales do not require extensive training to use, the use of them by untrained or inadequately trained people can cause harm, and should not take the place of the

The crucial point is that psychology training is unique in not only acquiring the knowledge and skills associated with test construction, theory, and administering, scoring and interpreting psychology tests, but also it equips the psychologist with skills in scientifically collecting data (e.g. history taking), examining evidence and processes, considering multiple factors etcetera. All of this training is the underpinning to psychological testing and clinical diagnostic skill. Psychological testing without this psychology training, OR without applying this training, is potentially invalid and harmful.

4. There is a compelling case for action to be taken to restrict the use of psychological testing to psychologists. But, there is also a need to look at how well psychology test training, and the role of testing in the overall diagnostic process, is being carried out today across all universities.

5. I cannot see any significant risks. I was involved in discussions on this topic with legislators who were working on the legislative review in Queensland in the early 90s. Their primary concern in reviewing and developing the legislation was to comply with the National Competition ACCC legislation promoting competition and fair trade. These considerations outweighed the psychologists' arguments for the need to restrict the use of psychological testing to psychologists. I believe the risk of harm to the public should outweigh issues of fair trade and competition.

Questions for Stakeholders – p 28 of Consultation Paper

1. There is already a range of tests that have been considered as requiring restriction to psychologists. This list would be a good starting point.

2. & 3. There seems to be no enthusiasm on the part of other professional regulatory bodies to restrict or prohibit the use of psychology tests by members of the profession they regulate. Discussions with the Queensland Education Department yielded no cooperation in restricting psychological testing in schools to qualified psychologists. Rather, it was claimed that the guidance officers were well trained. Psychologists, in general, seem to be more restrained in protecting their own profession than are other professionals.

4. There is a practice for a psychologist in an organisation or department to buy the restricted tests and then non qualified employees can have access to them. Possibly, it is more profitable for distributors to have more sales. There is anecdotal suggestion that some psychologists will relegate testing to non qualified employees. They obviously have no idea, or do not care about, the importance of test behaviour observation throughout the testing process. Only Board based legislation with the threat of sanctions can stop or inhibit these practices.

Questions for stakeholders – p 30 of Consultation Paper

3. Highest areas of priority would be in assessing children in any setting (except for educational, non psychological, tests), assessing people in clinical settings (public or private) where any mental health issue is involved, assessing people in forensic, workcover, veterans affairs or similar settings, neuropsychology.

Questions for stakeholders – p 33 of Consultation Paper

1. The problem with non government professional associations is that they can have vested interests and lack the perception of complete non bias toward non members. In my experience,

constantly complain about that body, but take no interest in it and take no action to address their concerns. Many psychologists choose not to join a particular professional body and in Australia there are many professional organisations.

All psychologists who are intending to work in areas where testing is involved should be properly trained by the university where they are obtaining their qualifications. This is a very important skill for psychologists and it should be taught in a standardised and thorough way as part of the psychology degrees and integrated with other areas of study. This training should not be relegated to a professional body or any other outside agency. It is an integral part of training as a psychologist, not a tacked on after thought.

Questions for stakeholders – p 34 of Consultation Paper

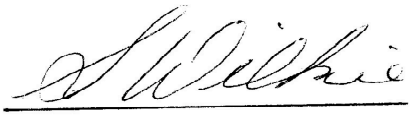
1. Legislation should be accompanied by guidelines and public education.
2. I do not believe that an education-based approach alone is adequate.

Questions for Stakeholders – p 36 of Consultation Paper

1. An approach could be made to improve publisher self-regulation; however one psychologist may buy a test, but may not be the only person using that test and the publisher or distributor has no control over that.

2. I do not believe this approach would be sufficient by itself.

3. & 4. I do not think this approach is workable or sufficient



Susanne Wilkie
Psychologist in Clinical private Practice