

Letters

PSYCHOLOGICAL TESTING IN PSYCHIATRIC PRACTICE

Drs. C. Don Morgan and John Bober addressed the important topic of psychological testing in psychiatric practice ("Psychological testing: Use do-it-yourself tools or refer?," *CURRENT PSYCHIATRY*, June 2005, p. 56-66).

I would like to add some points that were not emphasized in the article:

- Psychological testing should never be used alone to diagnose or rule out a psychiatric disorder.
- Psychological testing can help screen for occult psychiatric disorders and confirm psychiatric diagnoses.
- Some psychological tests, such as the Minnesota Multiphasic Personality Inventory (MMPI-2), are vulnerable to practice effects and require time between subsequent administrations for results to be valid.
- Psychological tests should only be given, scored, and interpreted by properly trained individuals.

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I, too, would like to add the following in reference to the article by Drs. Morgan and Bober:

While this article refers to use of board-certified neuropsychologists, most psychologists who offer neuropsychological testing are not certified by a recognized credentialing organization. The current definition of a clinical neuropsychologist, published by the National Academy of Neuropsychology, does not require psychologists to be board-certified to offer neuropsychological testing. Practitioners, however, must meet specific criteria to be called a clinical neuropsychologist.

Forensic assessment, which Drs. Morgan and Bober mention in passing, is another important application of psychological tests. Numerous well-standardized screening instruments and in-depth

measures can be used to assess criminal responsibility or adjudicative competence and to gauge other features.¹

Few psychologists are competent to test patients across a broad age range. In general, children and adolescents should be referred to pediatric psychologists, and patients age >18 should see psychologists with expertise in adult testing. Many pediatric psychologists limit their practice to school-age children, so when referring a preschool-age child, look for practitioners who routinely test this age group.

Also, many psychologists who evaluate adults have little or no experience or training in testing elderly patients, so psychiatrists should seek clinicians who are well-versed in geriatric assessment.

Managed care companies usually authorize psychological testing when a known or suspected medical cause contributes to mental status change. However, authorization requests for other cases are sometimes denied, or the approved assessment period is limited. In these cases, the psychiatrist and testing psychologist must collaborate closely to provide clear rationales for the proposed assessment.

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Reference

1. Psychological Assessment Resources. What's new at PAR. Available at: <http://www3.parinc.com>. Accessed July 11, 2005.

Drs. Morgan and Bober respond

While tests of cognitive functions such as memory, intelligence, and achievement are susceptible to practice effects, the MMPI-2 is so lengthy (567 items) that it would be difficult to remember how one responded to individual items. The test, however, is state-dependent, meaning that situational stressors can influence test results.



These points aside, we agree with Dr. Menaster's comments. We also thank Dr. Pollak for his useful and important thoughts.

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WHY TROUBLED YOUTHS DON'T 'CONNECT'

“Adolescent violence: What school shooters feel, and how psychiatrists can help” (CURRENT PSYCHIATRY, June 2005, p. 12-22) is a good article but falls short. Youths do need “connection, connection, connection,” but this observation is too general.

I am a Bowen Family Systems Theory (BFST) coach and BFST emphasizes the family or system in which the patient finds himself. If a positive child/family relationship were as simple as just connecting, the family or system would already have done so. If it has not, it probably cannot for many reasons.

BFST explores family generational information, stressors within the family, and the anxieties these youngsters are being asked to lug around with them. All treatment, especially with children, needs to include looking at family patterns, helping “identified patients” see where they are in the system and to whom they are reacting, and helping them change their behavior so that they can differentiate themselves from others. The universal rule of change is that a person can only change himself. Working to change others is counterproductive and ineffective.

Armed with at least a preliminary understanding of these concepts, patients can march forward on their own. No one gets blamed and there is no polarization. Instead, the youth can stay neutral in the face of problems and stand for his or her beliefs.

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Kids with these skills need not resort to violence. They have many other choices.

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ADVANCES IN DETECTING ALCOHOL ABUSE

The article on carbohydrate-deficient transferrin percentage testing (%CDT) by Drs. Peter Miller and Raymond Anton with Cynthia Dominick was informative and relevant (*Out of the Pipeline*, CURRENT PSYCHIATRY, June 2005, p. 80-7).

The benefits and drawbacks of %CDT testing were mentioned, including factors that affect %CDT values. The %CDT test mentioned in the article—which used an exchange column separation followed by turbidimetric measurement—was the first %CDT test approved by the FDA a couple years ago. Early this year, a second %CDT test received FDA approval.

A recent article¹ indicated that this new %CDT test, which quantifies CDT as a percentage of total transferrin using capillary electrophoresis, was reported to provide better precision of its assay, and had a inter-day variation of <3%. The lower the inter-day variation, the more precise the test. The new test also offers a visual pattern of test results for each applicant, which increases specificity.

According to the article, this new test is an automated “walk-away” system that requires little technician involvement. Thus, it can prevent increased labor costs.

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Reference

1. Bean P. New advances in CDT testing provide simultaneous detection and confirmation of alcohol abuse. *On the Risk* 2005;21:58-61.