SPA Exchange

Volume 4, Number 1 Spring/Summer 1994

Health Care Crisis: What Is SPA's Role?

Mary S. Cerney, Ph.D.
President, SPA

"It was the best of times; it was the worst of times. It was the age of wisdom; it was the age of foolishness. It was the season of light; it was the season of darkness. It was the season of hope; it was the season of despair."
-- Charles Dickens
A Tale of Two Cities

How aptly these words penned by Charles Dickens could be applied to today's Health Care Crisis! Although we know the importance of psychological issues in the maintenance of physical health, this fact is not common knowledge, as evidenced by the lack of mental health coverage in many proposed health plans before Congress.

We ask the question: What is the role of psychologists in any mental health plan being proposed? We, a Society of academicians and clinicians, know the importance of diagnostic assessment and the power of our psychological tests to describe the intrapsychic patterning of strengths, weaknesses, and problem areas. We do not need to be convinced of how important this data is in planning treatment programs. But many health care plans and insurance companies are eliminating and/or curtailing the work for which psychologists can be reimbursed. Some groups have eliminated psychological testing altogether or permit only psychiatrists to do assessments; most groups limit the amount of testing time they will pay for, and the tests to be used are frequently determined by inexperienced clerks.

In this issue...

Trends in Psychology Positions

Psychologists are not faring as well as one might expect. The Veterans Administration is the largest employer of psychologists in the United States with over 1,600 psychologists and 400 internships. An unofficial report by the Resource Planning Committee, a top VA management unit, has recommended that 50% of its psychology staff nationwide be dropped. Since the average hourly cost for VA psychologists currently is $40 per hour, well below the hourly charge of an outside consultant, is it their plan to hire lower-cost counselors to replace psychologists?

The Health Care Financing Administration has completed its task of preparing rules for public comment. If these rules remain with their current definition as written, most psychologists would be eliminated from Medicare. The proposed rule also questions whether qualified psychologists who have been participating Medicare providers for the past three years will find themselves able to continue their participation. The threat of retroactive denials hangs over those previously approved by Medicare unless the regulations are corrected. If the federal government doesn't recognize you, third-party payers are not likely to deal with you professionally on an equal basis.

Continuing Problems

The quality of care is relevant for those individuals in various managed care programs, which pay a predetermined fee per hour regardless of training, experience, or credentials. Therefore, someone of the caliber of a John Exner, Paul Lerner, or Irv Weiner -- or any one of you -- would receive the same fee as a brand new psychologist. And that new psychologist would have little hope of having his fee increase as his experience and expertise developed.

Competition from psychotherapists with less training, fewer qualms about their own and their patients' autonomy, a weaker appreciation of the complexity of their patients' problems, and a greater willingness to bid their services low, can be expected to take a heavy toll on the practice of more experienced and ethical psychologists.

Joining managed care groups has become a racket. As insurance companies and enterprising individuals scurry to snatch up the health care dollar, they are capitalizing on the panic of psychologists who are fearful they will not be reimbursed if they are not a part of some managed care group. Invitations are sent out to join coalitions of insurance

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Mary Cerney

Therapeutic Aspects of Psychological Assessment

Stephen E. Finn, Ph.D.

Applied personality assessment traditionally has been viewed as an information-gathering task whose purpose is to aid therapists, teachers, administrators, etc., in making decisions about how to place or treat those persons being assessed. While this customary view of psychological assessment is clearly useful, it falls short of recognizing a potentially important use of psychological testing: it can be the centerpiece of a powerful therapeutic intervention. Many seasoned clinicians can tell of memorable and moving incidents with clients during an assessment, and several previous writers have stressed the intrinsic therapeutic value of assessment (Cf. Pruyser, 1979). To date, however, only one published study has formally documented the therapeutic effects of psychological assessment on clients. Using a very brief assessment procedure involving the MMPI-2, Finn and Tonsager (1992) demonstrated powerful benefits to clients which persisted over time and encompassed areas of functioning that are typically resistant to change (e.g., self esteem). Such controlled studies are clearly useful for they show that benefits of psychological assessment are nomothetic and not just restricted to a few clients.

At the newly founded Center for Therapeutic Assessment in Austin, Texas, we continue to study the ways clients can benefit from psychological testing. We are acutely aware from listening to clients' reports of past psychological testing that not all assessment experiences are positive or even neutral for clients. Rather, we are proposing that a certain set of assessment procedures, developed over a 10-year period of time through careful observation and client feedback, is of therapeutic benefit to many types of clients. Currently, virtually all clients who are assessed at the center go through a similar four-step process. This process includes:

1) an *initial interview,* during which the assessor helps clients frame individualized questions about themselves that they wish the assessment to address;

2) *early assessment sessions,* in which normative tests (e.g., WAIS-R, Rorschach, MMPI-2) are administered according to standardized procedures;

3) at least one *assessment intervention session.* Such sessions use psychological tests in an unstandardized fashion (Fisher) to elucidate and explore test findings with clients.

4) an *assessment feedback session,* during which the assessor answers the client's questions -- originally posed in the initial interview -- using the results of the psychological testing as guidelines.

If clients also wish to have written assessment feedback, we give them a letter or report detailing test findings. Our reports are written so as to be understandable by both the client and any referring professionals who facilitated the assessment.

We continue to find that psychological assessments conducted in this manner and using collaborative, humanistic principles are greatly beneficial to clients from many different settings with a wide variety of referral questions. The next logical question and the focus of our current work at the Center for Therapeutic Assessment is: Why is psychological assessment therapeutic? What are the underlying factors which influence clients in a positive way? We hope that by identifying the specific therapeutic elements in the assessment process, we may make our assessment procedures more efficient and more powerful. It is also possible that understanding why assessment helps clients may lead to new theories about human problems in living and the factors which help resolve those problems.

Preliminary findings from several ongoing studies suggest that three aspects of our assessment procedures are basic to therapeutic change.

Positive Accurate Mirroring

After an assessment, many clients comment on the experience of being closely attended to by an empathic assessor who appears to understand them and value them at the same time. For example, one client wrote in his post-assessment feedback to us: "I've never had anybody take the time to really listen to me and understand what I was going through. It felt absolutely great!" Self-psychologists have written extensively on the therapeutic power of the mirroring transference in psychotherapy; this power appears to apply to psychological assessment as well during which clients may have a very intense experience of positive accurate mirroring.

Self-verification

Swann (1983) and his colleagues have described a process where individuals feel relieved and comforted to have others affirm and validate their self conceptions. This process of self-verification is prominent in our assessment-feedback sessions, where we first confirm a client's self-concepts by reporting test results that match those self-concepts. Only then do we go on to report other information that reframes, adds to, or directly contradicts clients' usual ways of thinking about themselves. Our recent experimental research suggests that this combination of self-verification and reframing is a strong factor in how positively clients react to an assessment. One client's comments clearly reflect these aspects of our assessment procedures: "It is relieving to know that most of the criticism and positive aspects of myself were reflected on the test. It tells me that most of how I view myself is legitimate and not a fabrication...I also got some new understanding of myself."

Client-assessor Relationship

Another strong predictor of clients' responses to an assessment is whether they experience a positive, collaborative relationship with the assessor. For many clients, the sense of being accepted by a person who

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From the Board...

External Affairs Committee Report

Bruce L. Smith, Ph.D.
Chairman

The External Affairs Committee met in Chicago at the Annual Meeting, and we outlined an ambitious agenda for the coming year. Our main task at present is political. We hope to work with other groups and organizations -- especially the Practice Directorate and various APA Divisions -- to ensure that assessment services are taken seriously by insurers and managed care entities, and are included in health care reform legislation. We are working in coordination with Virginia Brabender's Task Force on Political Input and Barry Ritzler's Task Force on Training and Credentialing. Once there is general agreement on credentialing criteria, we intend to promulgate these as widely as possible. In addition, we are now working on developing a set of guidelines on assessment practice (modeled after the guidelines developed in California for Workers' Compensation assessments) that can be used by managed care intermediaries in making determinations about assessment claims. Toward this end, I have been in contact with Dianne Brown, who is the director of Testing and Assessment in the APA Science Directorate and responsible for coordinating the update of the *APA Standards for Educational and Psychological Testing*.

Once the review article on testing and treatment planning commissioned by SPA is completed, we intend to use it in lobbying efforts on behalf of the inclusion of assessment services in health care plans.Toward this end, we have the full support of the Practice Directorate, the leadership of which feels that testing is a crucial selling point for psychology as a whole.

In addition, while in Chicago I had the opportunity to meet Mary Jane England, M.D., the incoming President of the American Psychiatric Association. I was able to speak with her about the importance of testing in treatment planning. We also discussed the data reported by Sid Blatt from the Austen Riggs study that will have been published by the time this reaches you. For those who weren't at the meeting, among the findings that were reported from the book -- a massive longitudinal study of the outcome of long-term psychoanalytic inpatient treatment -- was the fact that, measured independently, various Rorschach measures were extremely sensitive in predicting therapeutic outcome. Data such as these underscore the value of psychological testing in managing health care costs, a point that we are going to stress.

On an entirely different note, our committee is also working to increase the involvement of minority psychologists in SPA. Assessment is an area in which ethnic and cultural issues are especially germane. We feel that increasing the involvement of minority clinicians and researchers will greatly enhance the dialogue about these issues within the organization. As a committee, we have been discussing various ways of getting the word out about SPA and would welcome suggestions.

What we would like to do is develop a database on members' experiences with assessment and managed care. Accordingly, we would like members to share their experiences with us. Please write to me c/o the Central Office (or directly to my office) with descriptions of specific incidents that have occurred with managed care entities. We are particularly interested in difficulties you have had in getting assessment services approved for reimbursement, and using particular tests that you felt were clinically necessary. We would also be interested in examples of good experiences in the unlikely event that such have occurred. Please try to include the following information:

- the managed care entity involved,
- the discipline or training of the case manager involved (if known),
- the clinical rationale for the testing referral,
- the assessment services requested by you,
- the reason for any denials or restrictions of approved hours,
- the nature and fate of any appeal process,
- any other specific information that would be of interest.

I need to emphasize that these data are extremely important. If we are to protect clinical assessment services in the coming months, we need to be aggressive in our defense work. In order to do this effectively, we need a comprehensive database from which to operate. Thank you for your time and involvement.

Bruce Smith, Ph.D.
2515 Milvia Street, Suite D
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Assessment Specialty Board

Paul M. Lerner, Ed.D.
Past President

In January, 1994, President Mary Cerney appointed an ad-hoc committee -- the Assessment Specialty Board Committee -- for the purpose of beginning to explore the advisability and feasibility of developing a specialty board under the auspices of the American Board of Professional Psychology for awarding a diplomate in assessment.

John Exner, Ph.D.; Marlene Kocan, Ph.D.; Rebecca Rieger, Ph.D.; Barry Ritzler, Ph.D.; and Irv Weiner, Ph.D.; all agreed to serve on the committee with myself as chair.

The committee was surveyed in regard to their reactions to the basic purpose and several related issues. With reservations, the committee cautiously supported the proposal of establishing a diplomate in assessment. Reasons to support this included the need for assuring levels of competence in assessment, the need to protect the consumer, and that if such a board were established, the Society for Personality Assessment was in the best position to effect it.

Reservations included the cost, the reaction of existing boards, and the potential to further fracture clinical psychology.

A manual from ABPP outlining the steps and costs involved in applying for specialty recognition and affiliation was obtained. Briefly, the process consists of three stages. The

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first stage -- *initial application* -- involves developing and submitting a detailed application with an accompanying fee of $2,500. The second stage consists of preparing an *implementation plan* that includes all credentialing exams. An additional $2,500 fee is required. The final stage -- *monitoring* -- involves ABPP's observation of the examination process for at least two years. Costs may be incurred here too.

At its recent meeting the board encouraged the committee to explore the issue further. Specifically, they recommended we speak to and obtain reactions from existing ABPP specialty boards, divisions of APA involved with assessment, and our own SPA membership.

This article is not meant as a polling of our membership, but rather as a communication to our members of current board activity. A polling will be conducted later. Nonetheless, if you do have ideas or reactions to this initiative, or are interested in becoming involved, please contact me. #

Nominations and Elections

Nominations and elections are conducted under the auspices of the Nominations and Elections Committee, a standing subcommittee of the Board of Trustees. The committee consists of the past president who serves as chair and two additional members appointed by the president.

Nominating ballots are sent to members with dues statements in the fall mailing. Results from the returned ballots are forwarded to the committee chair. Nominating ballots do not generally give large numbers of votes to any one person. On the basis of ballots and committee discussion, a pool of several names for each office is prepared and then presented to the entire Board.

Following board discussion and approval, the chair contacts the first two persons of the pool for each office, informing them of the duties of the said office and inquiring whether they would be willing to run. The remaining names are used if prospective candidates decline.

A ballot, including the final slate of candidates with their accompanying statements, is sent to the membership with the spring mailing. Returned ballots are tabulated by the central office staff and verified by the chair or a member of the committee.

Newly elected Board Members assume their office in the fall at the Board's Annual Retreat Meeting. Please vote! #

1996 Congress of the International Society of the Rorschach & Projective Methods

The 1996 Congress will be held Monday, July 8 to Friday, July 12 in Boston, Massachusetts at the Westin Hotel Copley Plaza. The scientific theme of the Congress is Rorschach & Projective Methods in a Changing World: Looking Back to Look Ahead. In addition to the scientific program, we are planning an entertaining social program including concerts, sightseeing tours, and visits to museums and art galleries.

On behalf of the organizing committee, I invite each member of our society to participate in the planning and organizing of the Congress. The following subcommittees have been established: Scientific Presentations, Finance, Social Arrangements, Publications, Advertising and Promotion, Translation, and Pre and Post Workshops.

We need your input and your help. If you would like to participate, please write or call me directly at the address below. If you have a preference, indicate the subcommittee on which you would prefer to work.

Paul M. Lerner, Ed.D.
445 Biltmore Avenue, #503
Asheville, NC 28801
(704) 252-9278 #

The Treasurer Reports...

Eugene Levitt, Ph.D.

The Midwinter Meeting in Chicago was not a howling success in terms of attendance, at lease not compared to the 1993 meeting in San Francisco. The attendance figures -- 336 for the meeting and 114 for the workshops -- were similar to the 1991 and 1992 meetings but down by almost 8% for the meeting and nearly 40% for the workshops in 1993. The revenue total of $23,272 for the Chicago meeting was up from the 1991 meeting, on par with the 1992 meeting, but again well below the almost $34,000 for the San Francisco meeting. Despite the attendance attrition, the 1994 meeting will be more successful financially than the 1993 meeting. Total meeting expense is not yet available but it will be far below the $45,000 of the San Francisco meeting, due largely to excellent planning by past president Paul Lerner who arranged the 1994 meeting.

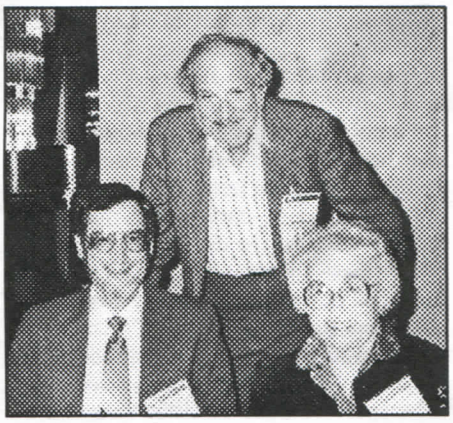
An interesting sidelight on attendance was that 34% of the registrants in Chicago were students compared to only 24% in San Francisco. There is no immediate explanation of this increase which the Board of Trustees must regard favorably.

Our fiscal status remains firm. We have over $90,000 in investments and about $3,000 in office equipment. Our checking account regularly runs over $20,000 (when it reaches $30,000 in the slow summer, another investment is usually planned for the fall). Our office is insured; so are our trustees. Our office manager is bonded. All told, the fiscal situation gladdens a treasurer's heart. #

Journal of Personality Assessment

Bill N. Kinder, Ph.D.

During 1993, 329 manuscripts were received, compared to 343 in 1992, 350 in 1991, and 369 in 1990. This is a slight decrease compared to previous years. The rejection rate for 1993 was 75%, compared to 73% in 1992, 81% in 1991, and 73% in 1990. The average turn around time (time between receiving a manuscript and notifying the author of an editorial decision) was 42 days in 1993, compared to 41 days in 1992 and 1991, and 44 days in 1990. The data from the last four years represents a considerable improvement from previous years, where the average turnaround time was 64 days in 1989, 73 days in 1988, and 79 days in 1987. The median publication lag



Bill Kinder, Gene Levitt, and Rebecca Rieger

(time between an editorial decision and actual publication) continued around ten months, comparable to the previous two years.

Virginia Brabender, Jane Duckworth, and Al Finch have resigned from the Board of Consulting Editors because of other commitments. I thank them for their many years of outstanding service to the *Journal*. I am happy to report that Judith Armstrong, Tim Trull, and Don Viglione have agreed to become new consulting editors. These individuals were chosen for their previous contributions to the Society and past experience as ad hoc reviewers. I look forward to working closely with Judy, Tim, and Don over the next few years.

The *Journal* continually needs more well-qualified ad hoc reviewers. If interested, please forward to me a copy of your vita and a brief statement outlining the specific tests, areas of interest, etc., in which you feel competent to provide reviews.

My first year as editor has been an exciting and rewarding experience and I look forward to continuing my service to the Society and the *Journal*. #

The Personal Column

Joan Weltzien, Ed.D.

From the response of our membership, this column seems to be popular, and I hope you will take a few minutes to be updated on some of the newest "cutting edge" information available about your colleagues.

LARRY C. BERNARD, Ph.D., associate professor of psychology at Loyola Marymount University in Los Angeles, published a new textbook entitled *Health Psychology: Biopsychosocial Factors in Health and Illness*. Harcourt Brace, 1994. Co-authored with Edward Krupat, Ph.D.

RAYMOND COSTELLO announces a postdoctoral fellowship in clinical psychology developed at the University of Texas Health Science Center at San Antonio. The fellowship emphasizes psychodiagnostic assessments, especially with projective devices and often with Hispanic clients. Interested persons should contact Dr. Costello at (210) 567-5484.

ROBERT J. CRAIG, Ph.D. and SPA Fellow, attained his Diplomate in Clinical Psychology this past year. He also authored two books: (1) *Millon Clinical Multiaxial Inventory: A Clinical Research Information Synthesis* (1993), is published by Lawrence Erlbaum, and (2) *Psychological Assessment with the Millon Clinical Multiaxial Inventory (II)* (1993), is published by Psychological Assessment Resources.

LOUIS A. DECOLA, Jr., began a private practice in Northeastern Ohio in December, 1993.

TOSHIO KOBAYASHI from Japan writes to inform us that her *Word Association Test-2* was published five years ago and that she is interested in investigating how to market it in the USA.

EUGENE LEVITT was recently elected to a two-year term as Executive Secretary of the Society for Clinical and Experimental Hypnosis.

ROBERT McCULLY has been named Professor Emeritus at the Medical University of South Carolina in Charleston. He has served for twenty years as consulting editor for *JPA*. Japan's *Rorschachiana Japonica* named Dr. McCully honorary foreign editor after Bruno Klopfer's death, an honorary post created for Dr. Klopfer. McCully is a pioneer in the application of Jung's concept of the Archetype to Rorschach theory and his books on the subject have been widely translated.

CARLA EGLY SCHULER writes to inform us that after twenty-six and one-half hours of "natural" labor, she is the mother of a son and has left her full-time position at Kaiser Mental Health Center, perhaps to pursue private practice. She would like to connect with other members about the dynamics of doing assessment in private practice. An article on MMPI personality disorders is in press with the *Journal of Clinical Psychology*, due out this spring.

LEO SHATIN has been elected to the Honor Counsel of the Mental Health Association of Palm Beach County. He is a member of the Board of Governors at Nova University School of Psychology.

CHRIS E. STOUT, Chief of Psychology and Associate Administrator of Forest Health Systems, recently spoke at an international conference in Egypt and at the Illinois Association of Community Mental Health Agency's annual meeting. He has an article coming out in the *Chicago Medical Magazine* on practicing in the managed care era. He was interviewed on CNN, The Oprah Winfrey Show, The Bertice Barry Show, and in *The Chicago Tribune Magazine* (on his newest book on therapists). He will be speaking at the University of Korea's School of Business Administration and he's also just completed the Dallas, Texas, Marathon. He has a contract with Praeger Publishing for a new book entitled *The Integration of Psychological Principles in Policy Development*. Chris moderated the Annual Legislative Breakfast and had a record number of senators and representatives in attendance. He is an invited speaker for upcoming

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meetings for the Mental Health Association of Illinois on Health Care Reform; for NCS Assessments on Outcomes Management; and for IBC on Capitation of Managed Care.

STEPHEN STRACK and MAURICE LORR have edited a book with the preliminary title *Differentiating Normal and Abnormal Personality,* to be published by Springer in the fall of 1994. Chapter contributors include a number of distinguished SPA fellows and members, among them, Yossef Ben-Porath, Hans Eysenck, Lew Goldberg, Sam Krug, Robert McCrae, Ted Millon, Lee Morey, Aaron Pincus, and Tom Widiger. The forward was contributed by Auke Tellegen.

NORMAN SUNDBERG at University of Oregon reported that in June, 1993, he retired after forty-one years of teaching. His frequent and favorite courses were "personality" and "personality assessment." He reported that he's become interested in life-history assessment and would welcome comments and articles on that topic. He will be teaching a workshop at the University of Hong Kong in mid-May, 1994. Another activity is honoring the memory of his colleague, Leona Tyler, who died in April, 1993, at the age of eighty-six. She contributed to the development of measurement of interest and individual differences as well as to counseling and clinical psychology. She was president of APA in 1972 and 1973. An annual visiting lectureship promoting her life themes is being established at the University of Oregon. Donations are very welcome; write checks to the "Leona Tyler Memorial" and send them to the University of Oregon Foundation, Eugene, Oregon 97403.

ROBERT WOODY, Professor of Psychology at the University of Nebraska at Omaha, continues his law practice primarily in the areas of business law for mental health practice and defending mental health practitioners from regulatory "licensing" and ethics complaints. He is co-author (with R.H. Woody, III) of the 1994 book, *Music Copyright Law and Education,* published by the Phi Delta Kappa.

One mystery remains: I received notice of a book being prepared on "Discerning Optimal Careers: Career Counseling with Very Able Clients," which was written from the wisdom gained through fifty years (1943 to 1993) of clients, but the author remains anonymous, at least at this point. Since this column is a regular feature of the newsletter, I would be happy to report the author of what sounds like a most interesting book.

IN MEMORIUM:
We received announcement of the death of Dr. Shanti Tayal on March 7, 1994. He was born in May, 1928, became a member of the Society in 1960 and a life member in 1993. His address at the time of his death was 2765 Knollside Lane, Vienna, Virginia 22180. #

SPA News

The Society for Personality Assessment would like to congratulate the following individuals who have been awarded the status of Fellow in SPA.

Edward Aronow
Carl Gacono
David Hayes
Elton Squyres
Paul Werner
Nancy Kaser Boyd

We encourage all members of SPA to become members of the International Rorschach Society for a $10.00 fee. You may elect this membership at the time of your next dues payment. Membership with this group will solidify Rorschach work and study for members of the International Rorschach Community. Membership brings with it the newsletter of the Society and the publication *Rorschachiana* under the excellent guidance of Irv Weiner.

In the Fall, 1993 edition of the *SPA Exchange,* Jed Yalof was erroneously referred to as Ph.D., instead of Psy.D.

A number of proposals were submitted to the SPA Board and Rorschach Workshops to review the assessment literature regarding treatment planning and treatment outcome. A project directed by Gregory Myer, Leonard Handler, and Ronald Ganellen has been approved after a review of several proposals. We wish them good luck in their efforts.

The practice directorate of APA has psychology contacts in each state. These contacts are notified when letter writing campaigns are needed for issues pertinent to psychology and health care. These contacts may or may not have interests in assessment similar to that of SPA members. We are seeking to develop a network of contacts to coordinate with the practice directorate concerning assessment issues. Ideally, there would be number of people from each state available to do this. Those interested should contact Virginia Brabender, Ph.D. at:

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The *SPA Exchange* is looking for someone with photography skills to take appropriate pictures for publication in the newsletter. Attendance at midwinter meetings is critical. Anyone interested please contact:

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The AMERICAN PROJECTIVE DRAWING INSTITUTE offers two Summer Workshops this year in New York City:
(a) BASIC -- July 25, 26, 27;
(b) ADVANCED AND CASES SEMINAR -- July 27, 28, 29

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From Testing to Assessment

Robert Lovitt, Ph.D.

The "managed care" mentality provides additional pressures for assessment efforts to be clinically relevant. Our efforts need to make a difference in the care of patients. Effective assessment functioning occurs when technology (good tests) is combined with good clinical practice. Good clinical practice skillfully translates testing technologies into information utilized by consumers. Practitioners learn the fundamentals of testing technology earlier and more rapidly than they learn to be good assessment clinicians. This occurs because of the structured rules for scoring, administering, and interpreting tests. As teachers we often emphasize these technologies in classes and workshops. This presentation describes a series of practices fundamental to good clinical practice which are the most difficult to teach and which are mastered with the greatest difficulty.

1. Referral Questions

The assessment literature emphasizes the central role of the referring person in developing referral questions. The paramount role of the psychologist in assuming additional responsibility for generating questions is often minimized or ignored. Referral sources, including experienced psychiatrists and managed care entities, typically have limited and overly generalized knowledge concerning what can be learned from tests. Referral sources are not able to keep abreast of categories of information that can be obtained from established tests (e.g. Rorschach), and they are not aware of information which can be generated from new tests. Therefore, how can they select the most appropriate questions to ask?

The patient's history and clinical presentation should be reviewed by the psychologist prior to formulating specific referral questions. Using a conceptual orientation, the psychologist asks what impairments in which systems of personality (Weiner, 1966) might account for the impaired behavior of this patient? Specific tests or test constellations are selected to evaluate these areas of personality. This practice discourages a mechanical and routine use of the same battery and same report style being used for every case.

For example, a psychiatrist refers a patient to clarify a DSM-III-R diagnosis. A review of history by the psychologist indicates a chronic employment problem related to an exacerbation of depressive symptoms. The psychologist generates his own referral questions, which are: Does the patient have a personality pattern provoking job instability and symptoms because of a clash between his personality style and the work environment? Might there be a more effective match between the patient's style and the world of work? The psychologist suggests an exploration of these issues to the patient and the referring source as crucial to understanding and treating the patient's symptoms. The psychologist also assesses the relationship between personality style, the work environment, and the development of depressive symptoms. The psychologist has assumed responsibility for defining which issues will be assessed and with what technologies. Assessment is linked to patient management. There has been a reformulation of the connection between symptoms and work activity, not considered in the original referral.

2. Assessment Alliance

An extensive literature exists relating the psychotherapeutic alliance to progress in psychotherapy. In assessment we refer to establishing an alliance as developing *rapport*. The specific manner in which rapport should be established is unique in assessment. Large percentages of patients find psychological testing mysterious and sometimes unpleasant. Under these conditions patients may exaggerate typical defenses and interfere with the psychologist about important personality conflicts and structure (e.g., MMPIs with high K and clinical scales under representing pathology). This is found most frequently in painful and medical surgical settings, forensic evaluations, and defensive and suspicious psychiatric patients.

To establish an assessment alliance, the psychologist should link testing to those problems described by the patient as distressing. These difficulties are frequently different from referral questions generated by the psychologist or the referring person. After establishing what the patient perceives as painful or problematic, the psychologist informs the patient how testing may help resolve his difficulties. Testing is presented as ameliorating those issues identified by the patient as problematic. When patients perceive the focus of testing as addressing such issues, maximally helpful data can be generated. For example, a patient states he is hospitalized because government agents wish to kill him for his insurance. He is able to acknowledge that this has created severe stresses. Testing is introduced by offering to identify this patient's unique pattern of coping strategies and skills -- a pattern that he can draw upon to cope with the distress engendered by this situation. The patient then views testing as a procedure which will help him deal with his perceived stresses more effectively. This alliance also services as an initial focus for feedback. During feedback the psychologist can also address the patient's unusual belief system in the context of positive attitudes about the assessment process.

3. Technical Jargon

A great deal of teaching emphasizes learning the relationship between test scores and technical concepts. One appropriate use of technical concepts is that it may facilitate the asking of appropriate questions of patients. If we know that someone has an "ambitent" coping style, this encourages the psychologist to search for inefficient problem-solving strategies in the everyday behavior of the patient. The term "ambitent" should not be used in feedback, written or verbal.

Technical concepts should be used as a springboard for reinterpreting crucial aspects of patients' lives in easy to understand language. Viable assessment occurs when patients and clinicians rethink problematic life situations and develop novel ways of managing them. Technical concepts must be retranslated and transferred into the everyday events and lan-

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From Testing

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guage of patients for this to occur. How does a psychologist learn to recognize "A Log" or "hi K" behavior when it is presented in a history? Technical concepts must be elaborated and modified from their original psychometrically grounded interpretations. The assessor needs to recognize the many behavioral correlates of the concepts; this allows the psychologist to bring a new understanding to the comprehension of problematic behaviors.

4. Use of Consultants

Assessment theory and technology have become very complex in at least four diverse areas: personality-psychopathology, neuropsychology, career and vocational assessment, and developmental-educational assessment. To perform competent personality assessments, the psychologist must be knowledgeable about psychopathology, normal personality development and functioning, a broad range of personality tests and strategies, and treatment resources and options. These areas are rapidly becoming more specialized and complex; it is increasingly difficult for psychologists to be competent in more than one of these four areas. In medicine, an internist often integrates data from related specialists in a holistic fashion before giving results to patients. A similar holistic integration of assessment data from various specialists may be more necessary than ever. Psychologists should be able to knowledgeably refer to and make use of consultants in related assessment areas and then integrate the findings of the consultants in a holistic fashion before giving feedback to patients. Surgeons do not try to perform as if they were radiologists. Instead some psychologists continue to practice by overextending and overestimating their competence or by ignoring the assessment of relevant areas. It is becoming more and more critical for psychologists not to overstep the boundaries of their knowledge and to acknowledge the limitations of their work. Many psychologists may give an occasional Rorschach, never attend continuing education workshops, and behave as though they have competence in this area. Appreciating the complexities of diverse fields of assessment is becoming increasingly important as knowledge increases. Learning to use assessment consultation will increase competent practice.

5. Appropriate Feedback

The American Psychological Association's (APA) revision of the code of ethics mandates that psychologists take responsibility for insuring that patients receive feedback about the results of assessment. The feedback session can be an important opportunity for therapeutic changes and a therapeutic focus to originate. Patients are to be treated as informed consumers entitled to feedback for time, money, and effort expended in evaluation. How do we decide from complex and extensive data what patients should be told? What should be omitted? Information is best presented within the structure of a psychotherapeutic interaction. The quality and quantity of information shared should be based upon the fragility of the patient and the types of defenses utilized. Resistant and negative attitudes should be accounted for in developing strategies of feedback. Only limited procedural directions have been offered that could serve as constructive guidelines to be followed in providing feedback (Finn and Tonsager, 1992). Referral issues generated by the psychologist and patient serve as general guidelines regarding what should be presented.

A guiding principle is to present that which can be constructively used by patients. Information which will be destabilizing may be omitted or dealt with very carefully. Identify those areas that are central to dysfunction and about which patients may have some control. Written reports should be prepared so they are accurate and in non-pejorative language. Patients often see original reports, even if we don't want them to.

6. Unique Information

Formal assessment is justifiable in terms of cost to the extent to which it adds information not available from less costly techniques. Reiterating what is already known from other sources does not lead to enduring and viable consulting relationships. Assessment may serve the role of a) documenting the obvious, b) establishing baseline data for comparison, c) stimulating a novel understanding of problems, d) stimulating appropriate treatment and management.

In cost conscious health care settings, "c" and "d" are clearly the most preferable approaches. Too often reports review and highlight what is already known from clinical data.

Tests are used most effectively if interpreted to provide a unique database to understand behavior. This data is used to view relevant history and clinical findings so as to provide new degrees of freedom for the actions of referring persons. A new frame of reference should be offered as to why patients are impaired and how their functioning can be facilitated. The psychologist should devote time to consider how the data can help redefine existing knowledge to help patients enter treatment in the most efficient and helpful fashion.

7. Processing Data

Interpreting data from single instruments using textbook derived concepts represents the first stage of psychodiagnostic data processing. Synthesizing data from multiple sources and dealing with clinical realities is necessary to capture the complexities of clinical situations. A disciplined and parsimonious use of clinical and personality processes are employed to accomplish this synthesis. Developing a systematic approach to effective synthesis of broad databases occurs by employing skills not routinely taught in graduate school, internship, or continuing education. In my experience, learning to integrate data from historical information, clinical observation and several tests occurs slowly and after a great deal of practice. Multiple data sources routinely yield information which may appear to be contradictory. Learning how to treat such contradictions enriches the assessment process. Beginning assessors tend to ignore contradictions and interpret that data which "speaks the most loudly."

Appreciating the difference between speculations and empirically grounded information in clinical work can be difficult. The distinction must always be made if we are to

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The Society for Personality Assessment Annual Meeting

Chicago, Illinois - 1994

Joan Weltzien, Ed.D.

Spring in Chicago was a perfect time of year and setting for the Annual SPA Meeting. The excellent programming coupled with the greeting of old and new friends and acquaintances under the umbrella of SPA was refreshing and renewing. Moving the Midwinter Meeting from March to April due to the location was strategic -- the weather couldn't have been better!

The Westin's superb location and many conveniences allowed for "eating one's cake and having it too" -- attending the meeting while sampling some of Chicago's delights, even during brief breaks. One attendee, whose name will remain unknown, forgot to pack her freshly cleaned suit and silk blouses. This created a need for a quick shopping spree so she could maintain the decorum by not wearing a jogging suit or the same dress for four days -- I'm happy to report that not one minute of the meeting was sacrificed.

Peggy Wood and Christine Fafchamps arrived before every one else in the morning and were available to help, chat, and create a homing place for all of us pigeon-like attendees to land, regroup and try to make the next choice as to which of the excellent programs to attend.

The five full-day workshops incorporated Rorschach, MCMI-II, two programs on the MMPI-2, and one on a procedure for therapeutic assessment. The half-day workshops included object representational and relational phenomena in psychological tests, multi-cultural assessment, the Apperception Personality Test, detection of faking on the MMPI-2, and psychological assessment of Latinos in a mental health setting.

Barry Ritzler opened the 55th annual meeting citing many "firsts" that were occurring at this meeting. This was the *first* meeting in Chicago, the *first* in which there were poster sessions, the *first* with new criteria for the Samuel Beck Award for Early Career Achievement, the *first* where there were double meetings at 7:30 each morning, the *first* at which a child's contributions were made, the *first* with special tributes given to psychologists by colleagues, and the *first* in which both the president-elect and president were born and raised in Indiana.

Our president, Mary Cerney, spoke on "Health Care Crisis -- What is SPA's Role?" The role of psychology is currently being threatened because of the position of managed care; i.e., trained clinicians lack credibility in determining appropriate care with the result being that non-clinicians are making major decisions about health care needs. She spoke of our times as being "the best of times, the worst of times, the age of wisdom, and the age of innocence." She focused on what each of us can do toward enlightening those who are making major decisions about us for the future. Her eloquent summary of the confused mental health picture prepared us for the presentation by Heather Stroup from the Practice Directorate who updated us on the ongoing activities in Washington. She reviewed Mr. Clinton's bill and Congressman Stark's plan to include mental health coverage as a third part to Medicare, and reported that the Senate hasn't done as much preparation as the House.

Sydney Blatt

The second Marguerite R. Hertz Memorial Lecture Series Award was presented to Sydney J. Blatt in honor of Samuel Beck. John Exner's honoring of Marguerite Hertz at last year's meeting was so creative that the SPA Board adopted the same format for this award. Hence, Erika Fromm chronicled her experiences with Sam Beck from early in his career when he was characterized as being shy and serious, and with little self-confidence, to the significant change in 1950 when he became president of Orthopsychiatry; then, he changed into being relaxed, more charming and more self confident. Angelica Sellas shared her experiences with Sam Beck later in his career.

Sydney Blatt presented information from his new book, *A Study of Long Term Change,* which is due to be distributed next week. The essence of the book is that the Rorschach is a valuable predictor of who can profit most from long term treatment. The study was most impressive in its thoroughness and incorporated work done by Barry Ritzler on degrees of boundary disturbance which he developed while working at Yale. The impetus for much of this work was from the importance of "M" responses as articulated by Samuel Beck.

The 29th Bruno Klopfer Award was presented to Grant Dahlstrom -- and he presented a delightfully witty presentation entitled "Pigeons, People and Pigeon-Holes." He described his first Rorschach course with Bruno Klopfer and how the students would look forward to the blind Rorschach interpretations which were held late in the afternoon and showcased the brilliance of their teacher. However, it was usually confusing in regard to how the conclusions were reached as the process did not match what was being taught in the morning class. It was concluded that he must have had some organizational schema from which he worked that was not apparent to anyone else. Hence, Dr. Dahlstrom emphasized the importance of zoological taxonomy which allows researchers around the world to communicate in a common language. His main point was that psychology does not have a common taxonomy and that to quote Stephen J. Gould, *"Science without taxonomy is blind."*

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Health Care Crisis

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companies as preferred health care providers -- for a fee. Investigation sometimes indicates that these coalitions, which clinicians respond to in panic, are mere figments of someone's enterprising imagination. These coalitions only serve to fatten the pockets of their management -- not individual health care providers.

Managed care companies are totalitarian. They control those who are accepted into their networks. When psychologists apply, they are frequently told their lists are closed. They have their quota of psychologists. One's years of experience, and one's reputation and skill appear to make no difference.

Some managed care companies do not accept psychologists. Companies also eject members who are not "managed-care friendly" as judged by "provider profiles" that note the average number of sessions per patient and "attitude" when speaking to Utilization Review personnel.

Many companies are "downsizing" their network; i.e., eliminating those who do not uphold the "party doctrine" -- short-term treatment without complaint and without filing appeals. Therapists who win independent appeals are subsequently ejected from the managed care network.

Managed care companies also control the flow of referrals. Companies are increasingly referring patients to a few large group practices that offer a variety of services, adhere to the brief therapy model, take over administrative duties, and assume risk.

In the *Bible* we read, *"In those days when these times are upon us, there will be wars and rumors of wars."* Threatening times are upon us. Disciplines are competing for a piece of the pie which is rapidly shrinking. Inequity prevails in reimbursement. Psychotherapy, if reimbursed, may be at 50%, while medication and other physical procedures may be at either 80% or 100%. And now the pressure is on for psychologists to get prescription privileges. That effort must surely endear us to the medical profession. Dr. Nelsky, Chief Psychologist at the Cleveland Clinic is quoted as saying, "As psychologists rush for prescription privileges without emphasizing the powerful role of psychotherapy, they imply by default that medications are the most effective treatment modalities." Thus they play into their opponents' hands.

It is up to us. Stop the panic! Take a stand.

When I first began my postdoctoral internship, I heard a speaker state:

"Get out of your ivory towers of academia; get up off your therapeutic couches and comfortable chairs; and get involved in politics. Direct the legislature and be there to shape policy," he thundered, *"or it will legislate you out of existence. Do research and document the important contribution assessment can make to strategic treatment planning. Document and study the outcome of your work."*

If only we had listened!

We can't undo the past, but we certainly can do something about the future. Skilled assessment is more important than ever before in these days of abbreviated treatment schedules. A good thorough assessment provides the treater with a road map to facilitate treatment. The research project currently being funded by SPA and Rorschach workshops is attempting to document that very issue.

What can we do to make a difference? Karen Shores in her article "Managed Care; Can We Survive?" gives some excellent suggestions which I have paraphrased and modified:

1. Take time to THINK!

We are so busy with our work that we don't take time to think through the overall picture. We are an intelligent group and can come up with some ideas, perhaps different and better than the ones I'm suggesting. Do something with these ideas.

2. Be active on your own and with your own organizations.

Write to your congresspersons. Speak with them. Let them know of your concerns and why you are concerned. Help them understand the consequences of what they are proposing. Get involved with your legislatures and national organizations. There are many coalitions confronting these issues.

3. Do outcome research on the value of assessment, its impact on treatment and treatment outcome.

Lay persons do not understand what our tests can do. Inform them. There are existing studies in both the United States and Europe documenting that those individuals utilizing mental health services have markedly reduced their utilization of medical treatment, which is more expensive.

The managed behavioral health care industry has taken the lead in arguing that extensive benefits for mental health are not only affordable, but essential: "the direct cost of mental health and addiction treatment services is less than the cost of lost productivity alone." Bryant Welch has said that the next stage in their health plan strategy is to "push the mind-body connection."

4. Legislative efforts

Visit, write, and call your state and federal legislators and elected officials. Some issues to be considered:

a. *Employer versus employee payment for insurance.*

When employers pay for health care, the patient is not in control. Tell your legislators that to ensure quality of care, insurers and clinicians must answer to patients, not to employers. What would that mean? Patients would have to pay for their own insurance and care according to their ability. That would force the patient to become more selective in both insurance coverage and treaters. Whether employers or patients pay, the money still comes out or their pockets through lowered salaries. Is this a feasible option? If so, how can it be done?

Fees could be set on a sliding scale determined by what the insurance would pay plus the patient's ability to pay. This would give the clinician some control over the fee. We all know the impact of the patient not paying for treatment and what happens when the patient begins to pay for the treatment. The quality is greatly improved when the patient assumes a greater responsibility for the bill.

b. *We must convince legislators that the values upon which a health plan is based will determine its success.*

Managed care places health care in the hands of executives who are more concerned with profits and stockholders than patients' needs. Is this the value system we want for America and Americans? Clinicians must serve patients -- not benefit plans.

c. *The federal ERISA law must be changed to make managed care companies subject to state insurance laws. Laws must:*

- mandate that any willing and licensed provider may join a network;
- mandate that networks print lists of their therapists:
- prevent ejection except for fraud or incompetence;
- mandate a minimal differential (approximately 15%) in reimbursement between networks and non-network providers.
- prohibit "hush" clauses, "hold harmless" clauses, and other unfair and repressive practices.

d. *Join the Coalition of Mental Health Professionals and Consumers*
P.O. Box 438
Commack, NY 11725
Phone/Fax: (516) 424-5232

5. Educate employers and the public.

Write to the media. Explain your health care concerns in simple terms.

6. Encourage patients to write to their legislators.

You may be reluctant to do this because it breaks the "frame" or "structure" of therapy. Every break in "frame" or "structure," if discussed, can be therapeutically very useful and may even be quite empowering for the patient. Most legislators report that letters from patients have more impact than anything we professionals tell them.

Our survival is at stake. If managed care -- as currently constituted -- has its way, only a few of us will survive the devastating effects of managed care on our practices. Patients will not have appropriate assessment, adequate treatment, nor well-trained clinicians because the industry tends to reduce therapists to "cheap labor." Many individuals in our profession are already being asked to change their orientation, leave practice, or see their incomes cut in half. Training programs are being seriously affected because patients do not stay around long enough to meet standard procedures and teaching needs. As the profession becomes less attractive, fewer students will enroll in graduate programs and fewer qualified instructors will remain to teach them.

Those in academia will have scant protection. If professional psychology fails, clinical and counseling psychology programs will fail; if those programs fail, few psychology departments will be able to operate on anything close to the budgets they have today.

In closing, I would like to paraphrase Martin Miemoler's commentary on Germany during Hitler's time.

"In the United States, they came first for the Masters Level psychologists, and I didn't speak up because I had a Ph.D. and a Psy.D. Then they came for the nurses, and I didn't speak up because I was a psychologist. Then they came for the social workers and I didn't speak up because again I wasn't a social worker, I was a psychologist. Then they came for the psychiatrists and I didn't speak up because I was in academia. Then they came for me and by that time no one was left to speak."

Let that not be true of any one of us! #

Therapeutic Aspects

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knows about their struggles, faults, and problems is entirely novel. Also, clients often come to our center for an assessment expecting to be treated as powerless assessees rather than as active collaborators. When they discover that we are interested in their goals for the assessment and would like their help in understanding test results, they are often initially flabbergasted and then quite pleased. One client's post-assessment feedback reflected these feelings: *"At first I couldn't believe that [the assessor] asked me what I wanted. I thought (sic) I would just be tested. I didn't know I would get to say what I want...(The assessor) treated me normal even though I have lots of problems."*

In addition to mirroring, self-verification, and a positive client-assessor relationship, many other aspects of our multi-stage assessment procedure may prove to be therapeutic. For example, we hypothesize that clients experience a decrease in distress and feelings of alienation after a feedback session because we often frame test results in such language as: *"Other people with test scores like yours..."* or *"This is a well-known pattern on the MMPI-2 that suggests..."* Such words clearly communicate that clients are not alone with their particular problems. We have also noticed that some clients appear to benefit simply from the regressive experience of taking the Rorschach during an assessment. This may be especially true in collaborative assessment, where clients often feel safe enough to become fully vulnerable and engaged in the test.

Of course, many of the therapeutic factors underlying psychological assessment are present in other therapeutic interventions. However, we believe that psychological assessment provides a brief and potentially more powerful experience of these therapeutic variables, because the use of tests allows for more accurate mirroring, for potent self-verification and reframing, and for an intense experience of supported vulnerability on the part of clients. At their best, psychological tests extend or heighten a clinician's empathy for clients, which should increase the impact of all comments and interpretations. Further empirical research will be needed to directly test the therapeutic efficiency of collaborative psychological assessment vs. that of other short-term therapies.

It may take years for a full paradigm shift to occur such that the therapeutic effects of psychological assessment are as widely recognized as its information-gathering capabilities. We at the Center for Therapeutic Assessment strongly advocate such a shift and believe that it may be crucial for the survival of psychological assessment. Currently, managed care programs are requiring justification of all mental health procedures and are asking for proof that psychological assessment is worth the cost and time it involves. Clients,

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Therapeutic Aspects

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too, are becoming better educated and more assertive when they seek mental health services and are insisting on more accountability from providers. The collaborative model of assessment clearly honors the right and ability of clients to become involved in finding solutions to their own problems in living and is of proven therapeutic benefit to clients. This model also honors the assessor and recognizes that assessment is not a simple technical procedure to be delegated to graduate students and psychometricians. Last, and most importantly, as more psychological assessors recognize the positive impact they can have on clients by slightly modifying traditional assessment procedures, more and more clients will be helped to live richer and more satisfying lives.

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Annual Meeting

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A new Political Impact Committee -- "PIC" -- was chaired by Virginia Brabender in direct response to the need for determining how we can be more active in providing information to our lobbyists and legislature -- how we can share the importance of the information we have toward treatment planning and appropriate use of mental health funding. An initial plan was drafted to work through the Practice Directorate in identifying key psychologists in each state who could provide the necessary information locally. Watch the newsletter for an upcoming article.

The Walter J. Klopfer Award was presented to Hedy Singer and Virginia Brabender for their study, "The Use of Rorschach to Differentiate Unipolar and Bipolar Disorders." Honorable mention went to Randy Otto, Norman Poythriss, Laura Starr and Jack Darkes for their work, "An Empirical Study of the Reports of APA's Peer Review Panel in the Congressional Review of the USS Iowa Incident." As usual, Bill Kinder, the editor of *JPA*, reported how very difficult it is to make a decision among the many fine articles for the award.

Hedy Singer, Carl Gacono, Virginia Brabender

Rebecca Rieger presented the Samuel Beck Award which is to honor excellence in early career research. The award was presented to Carl Gacono for his outstanding work on antisocial personalities. He delivered a beautiful tribute to his mentors and presented an intriguing report of his work with this most difficult population. The honorable mention went to William Perry for his work on the ego impairment index

The Task Force on Training and Credentialing headed by Barry Ritzler continues to be one of the most potentially important areas where the society can make a contribution to the field of psychology. Very impressive ground work has been laid in the development of some basic standards and the solicitation of opinions from psychologists who head training programs across the nation.

As usual, the breadth and level of the presentations were excellent -- making it necessary to employ strategic problem solving abilities, usually tinged with some amount of obsessiveness, in determining which programs to attend. There were many fine programs on Sunday morning which may have been missed by many who were on their way home. The poster sessions seemed to satisfy both a need for an additional format for information presentation as well as permitting attendees to stand instead of sit.

Once again, Barry Ritzler's huge effort and dedication paid off with an exciting and informative meeting. Please join us next March in Atlanta for the annual meeting and watch for a preview of coming attractions in the fall newsletter.

P.S. One last reminder for your calendar in July of 1996 when the International Rorschach Congress will be meeting in Boston. -- we will be participating in the planning for this exciting event; make your wishes and talents known and they will be utilized. #

From Testing

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take the scientific foundations of psychology seriously. Although taught in many graduate classes, the distinction often becomes blurred after being exposed to psychotherapeutic practices. The latter emphasizes being intuitive, using feelings and following hunches. Integrating these empirical and clinical approaches so that both are given proper weight occurs after lengthy and time consuming development and practice.

I have articulated some of the core clinical skills underlying competent assessment. Mastering the scientific foundation and technical interpretation of tests serves as a first step in the development of assessment skills. We cannot take for granted that our assessment procedures will continue to remain viable techniques for evaluation in a managed care environment. Reevaluating the assessment context within which we use our tests is important at this time.

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