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President's Column

by Len Handler

Dear SPA Members:

I would like to begin this letter to you with a short story. One fall evening, some years ago, with the days becoming noticeably shorter and colder, and the skies greyer, the young son of a colleague overheard his parents planning a Miami, Florida vacation. Excitedly, he asked, "Can I go to Your-ami, too? Since then, I, too, think of Miami as Your-ami, and I hope you do too.

By March, most of us will have had enough of winter and we'll be ready for another exciting SPA Annual (Midwinter) Meeting, in Miami, from March 10 through March 14, at the Sheraton Biscayne Bay Hotel. Wednesday, March 10 begins the first day of workshops, followed by the Scientific Program, from Thursday, March 11 through Saturday, March 13, that is filled with interesting presentations, followed by a coda of workshops on Sunday, March 14. Please refer to Barton Evans' article describing the workshops and the presenters in this edition of the Exchange, for the details of the workshop series, all of which earn CE credits.

In addition to these workshops, CE credit will also be given for the two Master Lectures, plus four symposia and one round table discussion. This year we have two prominent Master Lecturers: Stuart A. Greenberg, who will speak on "The Role of the MMPI-2 K-Correction in Forensic Examinations", and Edwin I. Megargee, who will speak on "Assessing the Risk of Aggression and Violence." Symposia that will earn CE credits are "What Can We Learn from 'Failed' Assessments," "Rorschach Assessment of Personality Disorders," "Further Research on the MMPI-2 Restructured Clinical (RC) Scales," and "The Incremental Value of the Rorschach for Insuring its Inclusion in Child Custody Evaluations." The Round Table Discussion that will earn CE credits is titled, "Release of Raw Data: New Rules and New Headaches."

I am also pleased to announce that Jim Butcher is the 2004 recipient of the SPA Bruno Klopfer award for outstanding, long-term professional contribution to the field of personality assessment. Dr. Butcher will be making a presentation at the Annual Meeting, in conjunction with receipt of the award.

The Sheraton Biscayne Bay Hotel is located near South Beach, which is filled with trendy restaurants and interesting places to shop; it is made for fun and for people watching. What about other entertainment, you ask? We are planning a sit-down dinner at the hotel, with Latin music. In fact, as I write this letter Paula Garber, our Operations Manager, is actively combing Miami for a Salsa Band and a Ricky Martin look-alike for your dinner time entertainment. There will also be a silent auction, supplemented by a live auction if the silent auction bids are too low. We have already received a large donation of books, but we also hope to have additional valuable items. I urge you to donate items or services. Remember, the money we raise is for student travel to the Annual (Midwinter) Meeting. Please email Paula Garber and let her know what you wish to donate.

For more information about the Annual Meeting, please consult our website, www.personality.org, and read the brochure we are preparing concerning the details of the meeting. The brochure will also contain a conference registration form, a workshop registration form and a conference schedule (which will also be on the website).

Please remember, think CE credits, warm sunshine, and a stimulating program. Join us in Miami for the Annual Meeting of the Society for Personality Assessment. I look forward to greeting each one of you in warm, friendly Your-ami and Mi-ami.

Sincerely,
Len Handler
President

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SPA Annual Meeting
March 10–14, 2004
Sheraton Biscayne Bay Hotel, Miami, FL

The SPA 2004 Annual Meeting will be held March 10-14, 2004, at the Sheraton Biscayne Bay Hotel in Miami, FL This annual event is designed as an educational, informative, and networking event for clinical psychologists, educators, and students, all of whom are interested in psychological assessment and psychotherapy.

As a member of SPA, we invite you to become an **exhibitor, advertiser, or sponsor** at the Annual Meeting. Products and services of interest to meeting attendees include: psychological tests and test scoring; books concerning psychology, treatment, assessment, or disorders; psychological treatment centers; psychotherapy tools and business management tools.

Increase your visibility and put your name before all of the participants in the meeting by becoming a **sponsor** of our 2004 Annual Meeting. Several sponsorship opportunities for events held during the meeting are available. Simply choose the event that best fits your needs. Deadline for sponsors is March 5, 2004.

The SPA Annual Meeting offers space for **exhibitors** and approximately 22 hours of exhibit hall exposure. Exhibit space is limited and will be assigned on a first-come, first-serve basis. Deadline for exhibitors is February 26, 2004.

There are **advertising opportunities**, for those who prefer not to exhibit, in both our promotional/registration brochure and the onsite Program Book provided to all registrants for the annual meeting. Deadline dates for all advertising copy for the promotional/registration brochure for the 2005 Annual Meeting are: November 15, 2004 for advertising copy for the promotional/registration brochure and December 15, 2004 for the *Program Book.*

For **detailed information**, see the Exhibitor/Advertising/Sponsor Information Packet on our web page: **www.personality.org**

If you have questions about sponsoring, advertising or exhibiting, please contact Paula J. Garber, SPA Operations Manager, at **manager@spaonline.org** or Anne Healy at Travelink (our meeting manager), 800–227–5689, or via e-mail at **ahealy@trvlnk.com**

SPA Midwinter Meeting Master Lecturers

SPA is honored to have Stuart Greenberg, PhD, ABPP and Dr. Edwin Megargee, PhD, ABPP, CCHP as master lecturers at the Annual Midwinter Meeting. Dr. Greenberg's lecture titled "The Role of the MMPI 2 Correction in Forensic Examinations." Dr. Megargee's lecture is titled, "Assessing the Risk of Aggression and Violence."

Dr. Stuart Greenberg received his B.A. from Rutgers University in 1969, his Ph.D. from the University of Southern California in 1972 in child clinical psychology, and completed a postdoctoral fellowship in development disabilities at the Neuro-psychiatric Institute, UCLA, in 1973 at which time he was first trained in the MMPI by Alex Caldwell. Dr. Greenberg is licensed in Washington and Alaska, maintains a private forensic practice in Seattle, and has been on the clinical faculty of the University of Washington since 1982. He was elected president of the American Board of Forensic Psychology 2002, chairs the committee that wrote the national examination for ABPP board certification in forensic psychology, and has mentored numerous other psychologists in their training to become Board Certified in forensic psychology. He has evaluated thousands of litigants and has provided sworn testimony more than 500 times. He has presented more than 250 continuing education workshops on forensic ethics and practice, and his publications, including his 1997 "Irreconcilable Conflict…" article with Daniel Shuman, JD, are frequently cited on those topics. Dr. Greenberg was elected a Fellow of the Society for Personality Assessment in 2003.

Dr. Edwin Megargee is Professor Emeritus of Psychology at Florida State University. A former consultant to the US Secret Service and to the US Bureau of Prisons, he has published 10 books and authored over 100 scholarly publications on personality assessment and criminal behavior, with particular reference to aggression and violence. His most recent book is "Classifying Criminal Offenders with the MMPI 2: The Megargee System." He has received awards for lifetime achievement in criminal justice and assessment research from the American Association for Correctional Psychology and National Commission on Correctional Healthcare, and for significant research on the MMPI from the University of Minnesota. Dr. Megargee has been a Fellow of SPA since 1968.

SPA Workshops 2004

by Barton Evans, Ph.D., Chair CE Committee

With over 400 registrants, the Continuing Education Workshops at the 2003 Meeting in San Francisco were the best attended and most highly rated in recent memory setting a high standard for the 2004 Miami meeting. The 2004 SPA Annual Meeting will again offer outstanding workshops by nationally known experts on a wide range of vital topics in personality assessment.

Featured this year is a series of forensic psychology workshops by national experts. We are fortunate this year to have the eminent forensic psychologists Stuart Greenberg and Randy Otto join us to present respectively on psychological injury assessment and on the assessment of response style in forensic evaluation. Edwin Megargee, developer of the Megargee criminal classification system, will present on his important contribution, the MMPI-2 with criminal offenders. Rounding out this expert forensic line-up will be Irving Weiner, a national leader in forensic psychology, who will present on effective expert testimony, and Nancy Kaser-Boyd, who will present her state-of-the-art work on the assessment of domestic violence.

Workshops on self-report assessment will be well represented this year. We are fortunate to be able to offer workshops in the 16PF Questionnaire (5th ed) by test developer Heather Cattell, and on the PAI by test developer Les Morey. David Nichols, author of numerous essential works on the MMPI-2, will present an advanced MMPI-2 interpretation workshop, and Alan Harkness and John McNulty will present a workshop on their MMPI-2 Personality Psychopathology Five (PSY-5) Scales.

Lest our Rorschach brethren feel left out, the 2004 Meeting will feature a variety of pertinent workshops. Bruce Smith, a leader in the integration of psychodynamic and Comprehensive System approaches to Rorschach interpretation, will present a workshop on the interpretation of difficult Rorschach protocols. Also, Robert Bornstein, developer in collaboration with Joseph Masling of the excellent Rorschach Oral Dependency measures, will present a workshop on the Dependent Personality. Forensic and clinical psychologists Carl Gacono and Barton Evans will cover the topical issue of how to present the strengths and weaknesses of the Rorschach in both forensic and clinical settings. Integrating self report and Rorschach assessment with psychotherapy, Ronald Ganellen, noted author on the topic, will present on developing treatment plans using Rorschach and MMPI-2 findings.

Completing this year's array of workshops, Robert Erard returns again to present his highly regarded workshop on professional ethics and psychological assessment, including HIPPA, which is designed to meet state CE Ethics requirements. Carrying on with SPA's commitment to present continuing education on empirical foundations in personality assessment, psychometric research expert David Streiner's workshop, "Diagnosing Diagnostic and Screening Tests," will address ways to evaluate empirically the efficacy of diagnostic tests.

The SPA Board invites you to attend several of the many outstanding Continuing Education Workshop Offerings at the 2004 Annual Meeting and requests that you consider inviting your non-SPA colleagues as well. Our goal is to offer our fellow SPA members the benefit of a series of workshops, which provide an excellent opportunity to earn CE credits from nationally renowned presenters in personality assessment at a good value. Please let us know how we are doing.

Dr. Linda Knauss Joins SPA Exchange

Linda Knauss Ph.D., ABPP, has joined the SPA Exchange as an Associate Editor. Dr. Knauss will be section editor of Ethical Issues in Assessment. Dr. Knauss is Assistant Professor and Director of Internship Training at Widener University. She has served as a member of the Pennsylvania Psychological Association's Ethics Committee, and as Co-chair of the Philadelphia Society of Clinical Psychologist's Ethics Committee. Dr. Knauss has taught courses in ethics at Widener University, Immaculata College, and the Philadelphia College of Osteopathic Medicine as well as many CEU programs on a variety of ethical issues. Dr. Knauss is past-president of the Pennsylvania Psychological Association, the Pennsylvania Psychological Foundation, and the Philadelphia Society of Clinical Psychologists She is a member of the American Psychological Associations Council of Representatives and was the recipient of the 2002 Ethics Educators Award presented by the Pennsylvania Psychological Association's Ethics Committee. She is also in private practice and works with children, adolescents, adults and families.

Dr. Knauss replaces Dr. Radhika Krishnamurthy, who has served graciously on the *Exchange* amid her many other professional responsibilities.

Special Topics in Assessment

by Alan Schwartz, Psy.D., Section Associate Editor

Self-report personality inventories are one of the anchors of a comprehensive psychological assessment and are notably represented among the most frequently used instruments when psychologists are surveyed about their assessment practices. Their ease of administration and scoring, psychometric robustness and interpretive usefulness provide invaluable information with which to integrate historical, interview and projective data. In our last issue, Yossef Ben-Porath discussed some of the emerging work on the Restructured Clinical (RC) Scales for the MMPI-2.

This section of Special Topics in Assessment focuses on two measures that are familiar to many clinicians but for whom an introduction or re-introduction may be helpful. In the first article, John Kurtz provides an overview of the Personality Assessment Inventory (PAI). Developed a little over a decade ago with a construct validation approach, the PAI addressed many important concerns about test construction and scale development, resulting in a rich clinical instrument. The PAI strives to represent not only the breadth of the various psychological content domains, but also the depth of severity within each domain (Morey, 2003). Its sophistication and usefulness have contributed it to becoming one of the more frequently used psychological tests for both clinical and research applications.

In the second article, Stephen Strack and Robert Craig provide an overview of *The Millon Clinical Multiaxial Inventory*, Third Edition (MCMI-III). Focusing on personality disturbances and individuals who are working with mental health professionals, the MCMI has continued to evolve in the more than twenty-five years since its original publication. The MCMI's unique use of base rate (BR) scores and focus on individuals in treatment contexts offer clinicians a useful and efficient tool for assisting their patients. The MCMI is now in its third edition, taking its place next to the MMPI-2 as one of the most frequently used self-report measures and considered to be integral to the training of future psychologists (Piotrowski & Zalewski, 1993).

This section also includes the second part of Tom Schaffer's article, where he addresses clinical integration of objective and projective tests within an ego psychological framework.

References

Morey, L. C. (2003). *Essentials of PAI Assessment*. Hoboken, NJ: Wiley.

Piotrowski, C., & Zalewski, C. (1993). Training in psychodiagnostic testing in APA-approved PsyD and PhD clinical training programs. *Journal of Personality Assessment*, *61*, 394–405.

An Ego Functions Model for the Organization of Psychological Test Data: Part II

by Thomas Shaffer, Ph.D.

Editor's Note: Part I of Dr. Schaffer's article appeared in the Summer 2003 edition of the *Exchange.* Part II is presented below.

A partial case example follows. Selected variables from each ego function are presented to illustrate the interpretative and treatment aspects of the EFM. Test Data for the example is listed in Table 1 (see page 5).

Validity data indicates the patient has produced a valid representation of ego strengths and weaknesses.

In structured, non-emotionally charged situations, perception is within normal limits (PIQ=100). The introduction of ambiguity, novelty and emotionally laden material is associated with considerable difficulty translating in a conventional fashion. (X+% = .30 & X-% = .54). This finding suggests that the treating clinician "check in" with the patient and ask her to describe how she is interpreting data in affect laden situations and to monitor this patient's distortions and provide her with more reality based, conventional translations. Is the patient psychotic? She does not endorse items suggesting perceptual disturbance (Sc6 = 53, SCZ-P = 55) indicating either their absence, her unawareness of them, or her unwillingness to share them; an aggressive approach to monitoring distortions is indicated.

Overall verbal abilities are in the high average range (VIQ = 113). In structured, non-emotionally charged situations (WAIS III); her knowledge of word meaning is above average (Vocabulary = 14) and abstract reasoning abilities, are well above average (Similarities = 16). Again, when novelty, emotionality and ambiguity are introduced serious problems with thought become apparent (Wsum 6 = 16). Her thinking becomes concrete (INC = 4) and very individualized (M- = 3). She is either unaware of these cognitive problems or chooses to not relay them in self report as the self report reflects no problems with indecisiveness (Beck #13 = 0) and no difficulty with concentration (Beck #19 = 0). She does not report difficulties with attention or concentration (MMPI-2, D4 = 56), obsessive thinking (MMPI-2 OBS = 52), strange thoughts (MMPI-2, BIZ = 53), nor persecutory beliefs (PAI, PAR-P = 58). This is an individual with solid cognitive abilities when structure is present but for whom semi-ambiguous, emotionally-laden situations simulate considerable difficulties with thought. When asked to report her own assessment of her thinking she reports an absence of problems. From a treatment standpoint, she should be asked to clarify how she is thinking when in affect laden situations. Treatment can be used to support situations in which her thinking has remained rational and clear in the face of emotion and challenged when it has not.

Overall, the patient presents herself as a woman for whom delay is difficult (M:FM = 1.3) and who is vulnerable to suicide (S-Con = 8, BDI # 9 = 3). These findings indicate that steps to monitor her safety need to be the first treatment intervention. Hospitalization, day treatment and/or increasing the frequency of sessions should be considered and reviewed with the patient. Referral for a medication evaluation is indicated. She denies hostile, aggressive impulses (Hy5 = 55) and this finding should be carefully reviewed with her. From a treatment perspective, underlying hostility could be carefully and slowly processed with her while monitoring her closely on a behavioral level.

Exacerbating her vulnerability to acting out in a self-destructive manner are an array of problems in managing affect. She has difficulty in modulating her affect (FC: CF+C = 1:3), is vulnerable to outbursts of emotion (Pure C = 2), and reports considerable depression (D1 = 75). Additionally, she reports anxiety and overall affective instability (ANX-A = 74, BOR-A = 72). These findings also point to a medication evaluation to determine if part of the treatment for her anxiety and depression lies in medication. Therapy also can be used to assist her in expressing problematic feelings in a more regulated, modulated fashion.

There is evidence of a negative self view (MOR = 3) and she herself reports diminished self esteem (LSE = 80), identity problems (BOR-I = 75) and a lack of self-confidence (DEP-C = 77). She reports a sense of failure (BDI II # 3 = 3) and the expectation of punishment (BDI II #6 = 2). Addressing these self issues will also need to be a treatment focus. Individual psychotherapy could be used to challenge her misperceptions about her sense of self, provide a safe environment in which her personality strengths and weaknesses can be realistically examined and offer the opportunity to suggest endeavors which she might pursue to attain a sense of success and accomplishment and self-esteem enhancement. Her cognitive skills suggests that some type of educational endeavor be undertaken which would likely be successful for her. Group psychotherapy could be another treatment modality in which her negative sense of self could be addressed; in a group she could directly experience and explore how others relate to her and she to them, thus providing the opportunity to "correct" self misperceptions.

Finally, test findings in the area of relational capacity suggest a solid knowledge base of social judgment, societal norms and values (Comp. = 13) as well as the awareness of socially appropriate interpersonal behavior (Pict. Arr. = 10). There are indications that establishing cooperative, collaborate relationships is difficult, (COP = 0) and that she experiences a considerable component of unmet affectional needs (T = 3). She, herself, reports a strong need for affection (Hy2 = 71) and the perception that her social environment is not supportive (NON = 76). She does not endorse items suggestive of authority figure problems (Pd2 = 59). Group psychotherapy could be a powerful treatment modality in which to address these relational issues. Group treatment could provide a safe environment in which the patient could observe and explore how she attempts to address her affectional needs and also observe how others in the group approach their own affectional needs. Individual psychotherapy could augment her group work and provide an additional environment in which to further explore what she is observing about her interpersonal functioning as well as offer an opportunity to solidify gains.

Because the EFM is, for the most part, tied to normed data, treatment recommendations are quantitatively based as opposed to a less psychometrically based approach. While the TAT and WAT are exceptions, the remaining six instruments in the EFM are psychometrically based allowing the treating clinician to clearly and numerically identify strengths and weaknesses and then base treatment on those quantifiably identified areas. For example, rather than suggesting an approach for a patient who is "depressed", self esteem enhancement can be recommended for the patient with a Rorschach egocentricity index = .10 and an MMPI-2 LSE (low self esteem) = 75. Specific recommendations focusing on impulse control such as medication, relaxation techniques or consequence enhancement can be recommended for the patient whose Rorschach M: FM ratio = 1:5 and whose PAI BOR-S (self harm) = 80. Hospitalization and/or medication may be suggested for the patient identified with weak reality ties based on a Rorschach XA% = .23 and an MMPI-2 Sc6 (bizarre sensory experiences) = 75. Finally, irrespective of theoretical orientation, treatment for the patient with an underlying thought disorder, as identified by the Rorschach Wsum6 = 21, can include frequent "checking in" to assure that the patient is cognitively tracking the therapist's ideas. Treatment recommendations based on this model can be clearly identified, presented to patients with clarity and explained to managed care representatives from a quantitative base. Additionally, this approach can lead to more sharply defined connections between symptoms and treatment recommendations when teaching and/or supervising, thus enhancing student learning.

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Shaffer, T.W. (2001). *An ego functions model for the organization of psychological test data*. Fresno: Haverford Press.

TABLE 1

Validity Indicators	
Test Variable	**Score**
Rorschach:	
R (>13)	26
MMPI-2:	
L (>65) —*Favorable, naively virtuous impression (Graham, 1990; Butcher, 1992)*	55
F (>90) —*Interpret very cautiously (Butcher, 1992)*	70
K (>65) —*Defensiveness (Butcher, 1992)*	60
PAI:	
INF (>74) —*Infrequency; atypical answers invalid (Morey, 1996)*	67
ICN (>72) —*Inconsistency; inconsistent responding invalid (Morey, 1996)*	66
WIM (73-84) —*Negative impression; element of exaggeration, interpret cautiously (Morey, 1996)*	66
Ego Function: Perception	
Test Variable	**Score**
WAIS III:	
PIQ	100
Rorschach:	
X+%: (.51, .15), XA% = WDA%—*Conventionality of perception (Exner, 1993)*	.30
X-%: (.21, .11) —*Very individualized translation, possibly serious weakening of convergent reality ties (Klopfer, 1954; Exner, 1993)*	.54
Underincorporation: (Zd<-5.0) – *hasty scanning, negligent (Exner, 1993)*	-6.00
DQ+ & FQ- —*Problems with disorganization when attempting to synthesize (Exner, 1993)*	8 & 6
MMPI-2:	
Sc6 (Bizarre Sensory Experiences): (>64) —*Perceptual impairment (Butcher, 1992; Graham, 1990)*	53
PAI:	
SCZ-P! (>65) Psychotic Experiences —*Unusual perception/impaired thought (Morey, 1996)*	55
Ego Function: Cognition	
Test Variable	**Score**
WAIS III:	
VIQ	**113**
Vocabulary (10,3) —*Abstraction (Kaufman, 1990)*	14
Rorschach:	
Wsum 6 (4.00/0.00) —*Index of cognitive slippage (Exner, 1993)*	16
Inc (0.00/0.00) —*Concrete thought (Exner, 1993)*	4
MQ – (0.00/0.00) —*Peculiar to markedly impaired thought (Exner, 1993)*	3
Beck Depression Inventory:	
#13 (indecisiveness) —*Difficulty making decisions (Beck, 1996)*	0
#19 (concentration difficulties) —*Difficulty concentrating (Beck, 1996)*	0
MMPI-2:	
D4 (Mental Dullnes) >64 —*Attention, concentration difficulties (Graham, 1990; Butcher, 1992)*	56
OBS (Obsessiveness) >64 *Worry, difficulty with decisions*	52
BIZ (Bizarre Mentation) >64 *Strange thoughts (Graham, 1990; Butcher, 1992)*	53
PAI:	
PAR – P (Persecution) —*Belief that others are interfering*	58
Ego Function: Regulation	
Test Variable	**Score**
Rorschach:	
M:FM: —*Delay vs. press for gratification (Exner, 1993)*	1:3
S-CON: (>7) —*Vulnerability to suicide (Exner, 1993)*	8
BDI:	
#9 (sui): —*Vulnerability to suicide (Beck, 1987)*	3
MMPI-2:	
Hy5 (Inhibition of Agression): >64 —*Denies hostile and aggressive impulses (Butcher, 1992; Graham, 1990)*	55
Ego Function: Affect	
Test Variable	**Score**
Rorschach:	
FC:CF + C: (1:1) —*Modulation of affect (Exner, 1993)*	1:3
Pure C: (0.00/0.00) —*Lack of emotional restraint (Exner, 1993)*	2
MMPI-2:	
D1 (Subjective Depression): (>64) *Feelings of depression (Butcher, 1992; Graham, 1990)*	75
PAI:	
ANX-A (>64) Affective —*Feelings of tension (Morey, 1996); Apprehension (Morey, 1996)*	74
BOR-A (>64) Affective instability —*Affective instability (Morey, 1996)*	72

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The *Millon Clinical Multiaxial Inventory-III* (MCMI-III™)

by Stephen Strack, Ph.D., U.S. Department of Veterans Affairs, Ambulatory Care Center, Los Angeles, CA
and Robert J. Craig, Ph.D., Chicago School of Professional Psychology

The MCMI-III™ (Millon, 1997) is a 175-item True/False self-report measure of 14 personality patterns and 10 clinical syndromes for use with adults 18 years-of-age and older who are being evaluated and/or treated by mental health professionals. Since the introduction of this test in 1977, it has become one of the most frequently used assessment instruments for the examination of personality disorders (PDs) and major clinical syndromes. Only the Rorschach and MMPI-2 have produced more research within the past 10 years. There are now over 400 empirical studies based on this measure and six books (e.g., Strack, 2002).

In this brief, introductory article, we present the history of the measure, describe how it was developed, and address a few commonly asked questions.

The first version of this instrument, the MCMI-I™, was developed to operationalize the theory of psychopathology introduced by Millon (1969/1983b) in *Modern Psychopathology*, and later expanded (e.g., Millon, 1996). In his original formulation, Millon proposed three axes—active-passive, pleasure-pain, self-other—as the basic building blocks of normal and abnormal personality. Conceived in terms of instrumental coping patterns designed to maximize positive reinforcements and avoid punishment, the model crossed the active-passive axis with four reinforcement strategies—detached, dependent, independent, and ambivalent—to derive eight basic personality patterns (asocial, avoidant, submissive, gregarious, narcissistic, aggressive, conforming, negativistic) and three severe variants (schizoid, cycloid, paranoid). Although Millon did not propose a formal model of clinical syndromes along with his personality taxonomy, he asserted that most or all psychiatric conditions (e.g., major depression, anxiety disorders, psychosis) could be best explained as extensions of personality.

Millon created his test using Jane Loevinger's three-stage method, where development and validation occur together. Overlapping items between scales were included to reflect the nature of polythetic traits and symptoms, as predicted by theory. Perhaps the greatest psychometric innovations for this instrument were the use of *base rate* (BR) scores rather than *T* scores to improve diagnosis, and use of a psychiatric patient population for developing norms rather than normals.

The second edition of the measure, the MCMI-II™, appeared in 1987 and was created to keep pace with changes in the revised 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders-III-R*. An experimental form was developed according to the model previously described, totaling 368 items. Scales measuring Self-Defeating and Aggressive-Sadistic PDs were developed. A total of 45 items in the MCMI-I™ were changed and Millon introduced an item-weighting system whereby prototype items (e.g., those items essentially related to the disorder) were given higher scores. He also derived three validity scales, and increased the number of PD scales from 11 to 13.

The MCMI-III™ was published in 1994, and was developed to bring the test in line with DSM-IV. Here 45 of the 175 items in the MCMI-II™ were changed, two new scales were added to the test (Depressive PD and Post Traumatic Stress), the item-weighting system was changed from a three-point to a two-point system, scales were reduced in length, and noteworthy items pertaining to child abuse and eating disorders were added but not scored on any of the scales. Significantly, Millon made sure that most test items directly reflected diagnostic criteria in the DSM-IV. The published version of MCMI-III™ contains a 3-item Validity index, three Modifier Indices to assess response bias, 14 personality scales, and 10 clinical syndrome scales. The personality and clinical scales contain 12 to 24 items each. Internal consistency of the scales was estimated to be .67-.90 using Cronbach's alpha, and test-retest stability was estimated to be .84-.96 over a period of 5 to 14 days (Millon, 1997, pp. 57-59).

The MCMI-III™ normative sample consisted of 998 psychiatric patients from the United States and Canada, which Millon divided into two groups for test development purposes. The first group of 600 patients was used to create scales, and the second group of 398 patients was used for cross validation to verify accuracy of the standardized scores. Although modest in size, the normative sample represents a broad range of demographic characteristics. Patients were men (54%) and women (46%) from outpatient (52%) and inpatient (26%) settings, as well as correctional facilities (8%). Age range was 18-88, although 80% were between 18 and 45. Most of the patients had completed high school (82%), with a large minority also having a college degree (18%). A notable limitation of the sample is that the ethnicity of most subjects was White (86%), with only a small number of Blacks (8%), Hispanics (2%), and all others (4%) represented.

As with previous versions of the test, MCMI-III™ personality and clinical syndrome scores were standardized as BR scores rather than *T* scores. *T* scores were considered inappropriate by Millon (1997) because they assume an underlying normal population distribution, and the MCMI-III™ normative sample consists of psychiatric patients. BR scores reflect the diagnoses of the individuals who make up the normative sample. For the MCMI-III™, Millon had experienced clinicians provide DSM-III-R multiaxial diagnoses for all of the patients in the normative group. By knowing the scores of these patients on the MCMI-III™, and their clinical diagnoses, Millon was able to create anchor points for his scales that would reflect the prevalence, or BR, of each psychiatric condition. BR scores of 60 were set at the median raw score obtained by all patients. BR scores of 75 were assigned to the minimum raw score obtained by patients who met criteria for the particular disorder or condition. BR scores of 85 were given to the minimum raw score of patients who were judged to have a particular disorder or condition as their primary problem.

Common Questions

Have the MCMI-III™ scales been cross-validated? Yes. Millon and his associates completed a cross validation study in 1997, after publication of the test. The study included ratings from 67 clinicians on over 300 psychiatric patients with whom they had substantial direct contact. The resulting diagnostic validity statistics were equal to or better than those obtained from earlier versions of the test. For example, *positive predictive power* (the percentage of patients identified by the MCMI-III™ as having a particular disorder who were also judged to have that disorder by the clinicians) ranged from 30% to 81% (Median = 68.5%) for the personality disorder scales, and 33% to 93% (Median = 66.5%) for the Axis I clinical syndrome scales. Likewise, *sensitivity* (the percentage of patients identified by clinicians as having a disorder who were also identified by the MCMI-III™ as having the disorder) was estimated to be 44% to 92% (Median = 60.5%) for Axis II disorders, and 24% to 100% (Median = 72.5%) for the Axis II syndromes. Results of the study were included in the second edition of the test manual (Millon, 1997, pp.88–102).

Does the MCMI-III™ overdiagnose PDs? No. This question has arisen from research with

earlier versions of the instrument where investigators have reported the number of subjects who have PD scale scores that meet or exceed the diagnostic cut-offs proposed by Millon. In some of these studies, the percentages of subjects with PDs has been as high as 90%. The problem with many of these studies is that the investigators failed to determine whether subjects actually met DSM diagnostic criteria for PD. No single instrument, including the MCMI-III™, can be used by itself to make a diagnosis. When studies have carefully cross-checked subjects for diagnosis by use of additional instruments or interview, and used reliable prevalence rates, the number of people identified by the MCMI-III™ as *probably* having a PD has not been found to be excessive.

Can the MCMI-III™ be used with normal samples? It depends. The inventory is recommended for use with adults being evaluated or treated for a mental disorder, including those referred to employee assistance programs, individuals seeking worker's compensation benefits, parents seeking custody of their children, and those seeking jobs in high risk positions such as police officer. It is *not* recommended for use with normals who are not being evaluated or treated by a mental health professional (e.g., students from the college subject pool). In cases where presumably normal persons are being evaluated (e.g., a candidate for employment), questions sometimes arise as to whether it is appropriate to compare these individuals against the patient population comprising the test's normative sample. Millon believes the answer is "yes" because the purpose of testing in these cases is the same as when testing a psychiatric patient; namely, to determine whether the examinee has a diagnosable disorder. As with psychiatric patients, if the person being evaluated obtains scale scores that meet or exceed the cut-offs for diagnosis, he or she is likely to meet DSM-IV criteria for an Axis I or II disorder.

The latest information on developments with the MCMI-III™ can be found on Theodore Millon's web site, **www.millon.net**, and on the web site of Pearson Assessments (formerly National Computer Systems), the company that distributes this test: **www.pearsonassessments.com**

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Division 12 Section on Assessment Psychology

by Irving B. Weiner

In the early 1980s, the Society for Personality Assessment gave serious consideration to applying for division status in the American Psychological Association (APA). An ad hoc SPA committee consisting of Sidney Blatt, Mary Cerney, Charles Spielberger, and myself as chair was charged with developing a position statement on the matter. Our report, which urged the Society to pursue divisional status, was distributed to the membership in 1982. The debate that followed was lively and sometimes heated. The pros addressed the publicity, political influence, and convention program time that SPA would gain from APA affiliation. The cons stressed the benefits of maintaining a scholarly and professional society focused on the interests of its members and not distracted by APA politics. A vote was taken, and the proposal to apply for divisional status was defeated by a substantial margin.

In retrospect, the decision to remain an independent society devoted to its members and its own purposes has served SPA well. The strength and vigor of our society, the many ventures in which we are successfully engaged, and the warmth and intimacy of our annual midwinter meetings speak to our prosperity. At the same time, however, personality assessment continued to lose ground within APA and organized psychology in general as a consequence of not having a visible presence and an influential voice in APA affairs. The many and varied negative consequences of having been largely invisible in the APA hierarchy are easy to identify and bemoan, but doing so is not my intent in this article. Instead, I want to share with the SPA membership the news that assessment psychology, whatever challenges it is currently facing, is no longer on the outside of APA looking in.

On October 6, 2001, the Board of Directors of Division 12 (Clinical Psychology) of APA voted to establish the American Academy of Assessment Psychology (AAAP) as Section 9 (Assessment Psychology) of the Division. AAAP is the instructional branch of the American Board of Assessment Psychology (ABAP), which had been created a few years previously to provide Diplomate examinations and certification in psychological assessment. Division 12 approval of the Assessment Psychology section was orchestrated by two prominent SPA members, Norman Abeles and Charles Spielberger, both of whom are former APA presidents and presently sit on the Division 12 Board as representatives to the APA Council.

The Assessment Psychology section of Division 12 is now fully organized, has already reaped for personality assessment some of the benefits that come from APA status, and is eager to expand its membership. The current Section 9 president is Alan Raphael, who was the moving force behind establishing the ABAP accreditation program. Norman Abeles is president-elect, and another SPA member, David Lachar, is treasurer. I am serving a 3-year term as Section 9 representative on the Division 12 Board of Directors, which is a voting position, and I also have been appointed to the Division 12 Finance Committee. This participation in Division 12 governance provides excellent opportunities not only to help advance the science and practice of clinical psychology, but also to advocate for assessment psychology and to influence decisions related to assessment issues. As a section of a division, moreover,Assessment Psychology has had program space at the 2002 and 2003 APA conventions. The allotted time was sufficient to allow scheduling of a symposium, a presidential address, a business meeting, and a poster session, all of which were duly noted in the convention program.

The Assessment Psychology section dues are $5 for students, $15 for members, and $10 for ABAP Diplomates. Membership in the section is based on interest in assessment and does not require being an ABAP Diplomate. It is also not necessary to be a Division 12 member in order to join the Assessment Psychology section, although the Division does require sections to maintain a certain percentage of division membership. I would like to encourage SPA members who are concerned about establishing a proper place for assessment issues in the administrative structure of organized psychology, and about maximizing our ability to convey the value of personality assessment through APA channels, to join the Assessment Psychology section. Our membership chair is Janet Matthews, who is a former chair of the APA Board of Professional Affairs. Membership applications can be obtained by writing to Janet at **matthews@loyno.edu**.

Personality Assessment Inventory

by John E. Kurtz, Ph.D.

The Personality Assessment Inventory (PAI) is a 344-item inventory of personality traits and psychopathological symptoms developed by Leslie Morey (1991). The main variables of the PAI were selected to reflect both historical stability within the diagnostic nomenclature and utility in contemporary practice. The 11 clinical scales, 4 validity scales, 5 treatment scales, and 2 interpersonal scales are composed of non-overlapping items written at a 4th grade reading level. Many of scales include subscales (31 total) to enhance interpretation of the broader construct and to assess more specific trait variables of interest (social detachment, egocentricity, etc.). The PAI has a several advantageous properties that make it a psychometrically sound and pragmatically useful instrument for research and practice in psychodiagnostic assessment, some of which are summarized here.

Construct Validation Approach to Development

The strategy for constructing the PAI was to integrate the numerous developments in the theory and methods of psychological measurement and test validity introduced in the last 40 years by psychologists like Cronbach & Meehl, Campbell & Fiske, Jane Loevinger, and Douglas Jackson. Thus, a combination of rational and empirical strategies was employed in scale development. Conceptual evaluations of item content were conducted using a bias review panel of diverse members of the community and item-to-scale sorting tasks by experts in psychopathology. Empirical analyses followed with two earlier versions of the test in order to extract the final item set from a pool of over 2,200 initial candidates. A fundamental principle guiding this process was that multiple empirical parameters should be considered in item selection, including the discrimination of relevant clinical groups from other patients and normals, part-whole correlations, convergent and discriminant correlations with existing measures, item bias with respect to demographic variables, dissimulation effects, and correlations with response set and response style indices. The final version of the PAI was normed using a census-matched sample of 1,000 adults from urban and rural communities in 12 states. In addition, norms were gathered from 1,246 mental health patients from 69 different inpatient and outpatient treatment sites in the United States; diagnostic status within this sample is representative of findings from the Epidemiological Catchments Area Survey. The availability of community and clinical norms allows the test user to evaluate the significance of scale elevations with respect to people in general and to patients in general. It is expected that this construct validation approach in development will produce scales that correlate higher with relevant external criteria, including unstructured assessment techniques like the Rorschach (see Mihura, Nathan-Montano, & Alperin, 2003).

Configural Scoring and Interpretation

Each PAI item utilizes a 4-point response format, which maximizes scale reliability with fewer items. Expanded response formats also generate more variance below normative means, creating "soft floor" scales that allow for meaningful interpretation of low scores and high scores. This feature lends itself well to interpretations based on the shape of the score profile rather than just prominent elevations. Thus, an individual score profile can be compared quantitatively to the mean profile of patients sharing a particular DSM diagnosis (e.g., Major Depression, Antisocial Personality Disorder, etc.) or referral status (e.g., alcohol abuse, self-mutilation, etc.) to aid in problem identification. The interpretive software package for the PAI calculates the similarity of an obtained profile to a database of mean profiles from such patient groups. In addition, cluster analyses of ipsatised scores were performed with the clinical standardization sample and yielded 10 distinct profile types. The similarity of a given profile to one of these cluster types provides an alternative approach to case conceptualization. The test manual provides narrative interpretations, diagnostic considerations, and clinical correlates for each of the 10 profile types (Morey, 1991).

Assessment of Protocol Validity

The validity of responses obtained from an individual patient is frequently a matter of concern to clinicians, particularly in forensic or employment scenarios. Detection of random responding or confusion is achieved by a scale composed of items answered uniformly in both community and clinical populations and an index of response consistency across empirically and semantically associated item pairs. The PAI employs several strategies to assess attempts to distort the results in either a positive or negative direction, including single scales, configural score indices, and discriminant function scores. For example, negative distortion is assessed using a scale of items reflecting rare or exaggerated symptoms that are infrequently endorsed by normal and clinical respondents (Negative Impression Management), a configural score index composed of unlikely combinations of symptoms (Malingering Index), and a discriminant function score designed to classify naïve and sophisticated attempts to simulate one of three specific mental disorders versus actual clinical patients (Rogers Function). Likewise, positive distortion is assessed via these three approaches with the Positive Impression Management scale, the Defensiveness Index, and the Cashel Discriminant Function score. Research suggests that the three approaches provide distinctive information about response style and may be differentially sensitive to explicit attempts to dissimulate versus less conscious sources of response distortion (e.g., Kurtz & Morey, 2001; Morey & Lanier, 1998). If the protocol is not rejected on the basis of established cut scores, no further attempts are made to correct PAI scores using validity measures; rather, these data are viewed as a source of substantive information about self presentation strategies that can enhance interpretation and diagnosis.

Assessment of Treatment Planning and Clinical Management

The PAI is intended to go beyond diagnosis or problem identification to assist clinicians in planning treatment and managing critical behavioral or attitudinal issues. Single scale and configural score approaches are employed in the assessment of a patient's receptiveness and ability to benefit from treatment (Treatment Rejection scale, Treatment Process Index). Scales and indices are also included to measure suicidal ideation and potential, verbal and physical aggression, and the potential to act out violently. Other scales assess the patient's perceptions of various psychosocial stressors and the availability of social support in their environment. Preliminary studies of internal consistency, test-rest reliability, convergent and discriminant validity, exploratory factor structure, confirmatory factor tests, and cluster analyses of profile types are described in the test manual (Morey, 1991). More detailed information regarding protocol interpretation and reviews of subsequent research with the PAI are found in other recent guides by Morey (1996, 2003).

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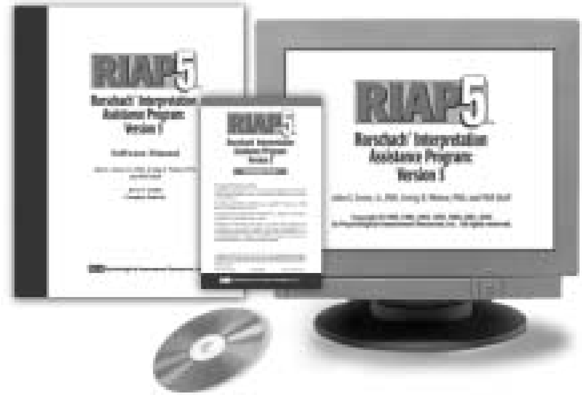

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The Teacher's Block

From Stacking Legos to Building Cities

by Pamela Abraham, Psy.D. and Jed Yalof, Psy.D.

Teaching assessment courses, regardless of degree of passion for the subject matter, can still make one a bit zany. Mundane events are subjected privately to peculiar coding schemes. For example, a student raising his hand gets Ma, but a student talking over another person and continually disagreeing with others also gets Ma, but with possible White Space and AG responses. The scoring criteria occurs in conjunction with the teacher's (and other students?) immediate silent speculation about various MMPI and TAT scores. Similarly, a teacher who always disagrees with student input is on the road to the same coding crises. A student who makes accurate inferences about individual components in a blend, but can not synthesize them correctly into a meaningful relationship, might be a candidate for a FABCOM. A teacher who has difficulty explaining shading concepts and mistakenly uses FY when trying to describe FT, even though it is reasonably clear that FT is the point of discussion, gets INCOM. A student who is upset and has a preoccupying self-doubt over the complexity of coding (or a teacher who feels the same way about his/her inability to get points across), might get ma. FY(or FC' if moody).FV. Needless to say, an active mind is a teacher's greatest teaching asset, but it comes at a peculiar cost.

With this backdrop, the idea of flexibility in mental representation comes to mind when teaching assessment. Is there a particular phase in training where doctoral students are better able to transform concrete knowledge into more general ideas? This type of difficulty typically surfaces in classes covering personality assessment and report writing, and in a diagnostic practicum seminar. The extrapolation of scoring to interpretation, the move from an orderly, scientific thought to creating adaptive possibilities and a narrative that describes the patient within a social context involves maturation to a more abstract level of clinical formulating on the road to becoming a competent assessor.

Metaphorically, one might analogize the development of a student's assessment skill maturity to the developmental achievement that is marked by the transition from stacking legos into identifiable single objects to building complex cities from lego parts. Staying within metaphor, the move from stacking legos to building cities requires that the student show persistence and motivation, and that the teacher and supervisor remain dedicated, creative, and attentive. These challenges lead to a few other metaphors that can capture this experience for student and teacher.

Lambda = 2.0 Types—Students who look for and see the same pathology no matter the developmental history, symptom presentation, and test data. They might also have difficulty making the transition from realistic to symbolic representation. Teachers who fit this group might minimize the value of supplementary MMPI scales, or only teach students how to score the TAT (eschewing the fun part), or look only at the Structural Summary (without enjoying content analysis, which is really what everyone wants to get to after methodically going through the summary of scores).

Avoidant Ambitendent Types—Students who want to pursue their own ways of interpreting, but are reluctant to go outside the usual parameters, and experience thought blocking or writer's block. Teachers in this group might present a scrambled approach to interpretation that has a creative streak, but bypasses a student's need for systems and order.

D and AdjD = -1 Types—Those who are stressed and just want to get through the whole process with out being thorough. Social ineffectiveness is another corollary of poor D scores; for example, instead of scheduling a meeting to review coding, students inexplicably arrive without appointment just as the teacher is about to go home. Or, the student makes an appointment, but the teacher is a no-show without explanation or apology. We know that neither event ever occurs.

Extreme a:p ratio Types (with possible HVI elevations)—Students who are suspicious of testing and can not envision themselves doing it after they graduate. Teachers in this group might still use old MMPI, MCMI, and the 1974 CS; they might also still be using the WAIS II.

Xu% = 0—"Cookie-cutter" types that disavow the creative aspect of interpretation and report writing. Teachers in this group might use the same lecture material without incorporating updates and need for fresh clinical examples. Both students and teachers in this group might also be under-incorporators and High Lambda types.

High Popular, High D Location, and Low Color Ratio—Students and teachers in this category understand the mechanics of testing, but not the art form. The connection between therapy and testing processes seems ego-alien.

MMPI-II scale 1 elevated—Students or teachers who are frequently missing class because of physical symptoms and other aches and pains. Teachers in this group might be very firm believers that the first ego is the body ego. Anyone who mentions Paul Federn as a name-dropping signal might be at risk here. Check the An +Xy tally.

Back to the more serious issues of teaching. What are they? Here is a list: Providing overviews of test instruments as well as depth of knowledge in terms of interpretation, applying social and cultural interpretations, balancing psychometric information with interpretive strategies, teaching students how to query, and teaching students developmental interpretations. It is easy for the teacher to get "blocked," so to speak, as he or she inches along with incredibly complicated teaching content for which students have little prior referent. The introduction of each new assessment concept carries the risk of someone in the class not grasping the material, which can rapidly escalate into a contagion effect. A minor glitch in clarity of teaching can necessitate a long recovery period and even lead to comments in the final course evaluation that flag the teacher as having "difficulty explaining subject matter." In the end, the assessment classroom remains a complex arena where the teacher facilitates the development of solid foundations and structures for building assessment competencies. The rewards far outweigh the cost.

Our Emerging Web Site

by Phil Caracena, Ph.D.

The SPA web site, whose internet address is "Personality.org," is five years old, having made its online debut in 1998. In 2003, I became the site's "webmaster." It's a dubious title, but I'm the one trying to keep it current and presentable. The position let me snoop around in old files still preserved in its off-line "storage bins." I discovered that in 1998 the Board fully recognized the exciting potential of our organization's having its own web site. Nevertheless, for one reason or another, the site remained relatively passive and dormant until very recently. Finally, its power is being gradually unleashed. I predict that by the end of 2004, Personality.org will have become an even more essential asset than our Board first envisioned. Accompanying the start of those changes is the acquisition of our very own server at headquarters. In tandem, they will benefit us and save us time and money, the true marks of a good thing.

That is not to say the road will be smooth and straight—not for technological development. As we implement the changes, please accept that there will be bugs, glitches, and "weirdnesses." We ask you to report them so we can make corrections. You are our final and best beta testers.

Our "rollout" for change is gradual and incremental. The first dramatic change in the web site, aside from its now staying almost current, is that it is now an "interactive" site. Instead of just sitting there saying "hello" to the world, now it can listen to you and do something useful. It starts out just trying to earn its keep by accepting your 2004 membership dues payment, processing your credit card, and reporting the transaction to Paula, our operations manager at head-quarters. If you try doing that (start the process on the web site's opening page), you'll notice that the site doesn't accept payment from just anyone. You have to pass muster by giving it your name and year of birth so it can check its database to see if you are a bona fide and current SPA member. If you are, and you also give us a valid email address, we return an email assigning you your login ID or "User Name." Then you can create a secret password all for yourself. That ID and password will be your entry ticket for all of the other "restricted" activities the site will offer in the future.

After you have a User Name and password, you can enter them to finally arrive at the dues payment form, fill it out, and submit it. That page is securely encrypted so you needn't worry about sending your credit card numbers across the internet. Or if you want to be defiant and resist progress, you can download the dues form from the web site and send it by mail—or you can even do nothing but wait to receive a form in the mail. We'll understand. Eventually we hope you will become comfortable enough with the forms that we can reduce our postage and printing costs by needing to send out fewer mailings. Paula is already using her new server to send out email notices to those for whom we have current and valid email addresses.

Sometime in December, another interactive form will enable you to register and pay your fees online for the 2004 Annual meeting in Miami. In January, we should be able to accept Call for Nominations forms from members. A bit later in the year, you'll be able to respond to our Call for Papers by submitting your abstracts electronically, with a copy going straight to the Program Chair and a copy to the central office. By mid-year 2004, your User Name and password will let you look up contact information for other SPA members and even update your own contact information so other members won't lose track of you. That makes use of our new central office computerized membership directory. Wow, are we getting 21st century or what?

Next year, we hope to provide a "resources page" so that members can download documents, forms, and papers that may be of practical benefit to your practice. We invite you to submit whatever you've found helpful to you and are willing to share with others. In addition, we plan to have a "links" page to make it easy to visit web sites of related professional organizations, test distributors, and suppliers. We'd like also to broaden our "audience" to include the general public so that we can be a more trustworthy source of information about assessment than is available in the lay press.

We'll try to keep the first page of the web site an "Announcement" page to keep you informed of late-breaking Society news. If you will fill out the small "Change Detection" form at the bottom of that first page, you will receive automatic email notices of changes on the Announcement page. That will save you the trouble of having to check the site periodically to see what's new - unless Change Detection goes out of business or starts charging us money as similar services have been prone to do. Change Detection promises not to sell or give your email address to spammers unless you check that you want that "service" from them. You don't.

We earnestly solicit your suggestions and ideas for what we might include on the web site that would be helpful in your professional work. Our members have some outstanding ideas, our combined experiences are vast, and I have no doubt that we can be more effective as a team. That's one of the things our society's web site can help build. Please contribute in that way to your Society. And when you see Paula, please thank her for her tremendous energy, enthusiasm, talent, and skills. Your Board members inspired the web site, Steve Finn got it moving, and Paula is making sure it all happens.

International Rorschach Events

by Irving B. Weiner

As President of the International Rorschach Society (IRS), I would like to announce two events taking place next August in Stockholm that may be of interest to SPA members. The first of these is the Summer Seminars program sponsored by the IRS. Previously held in Spiez, Switzerland, in 2002 and 2003, the Summer Seminars program consists of lectures, case presentations, and opportunities for small groups discussions and interactions with the faculty. The 2004 program will begin on Monday, August 23, at 3:00 p.m., with a lecture by Professor Bjorn Killingmo from Oslo. Professor Killingmo is one of the leading Rorschach scholars in Scandinavia and a psychoanalytic practitioner, and he will demonstrate his manner of working through a Rorschach protocol. The program on Tuesday, August 24, will consist of a morning lecture and afternoon case presentation by John Exner, and on Wednesday, August 25, Anne Andronikof will give a morning lecture, and she and Agneta Rosenquist will conduct an afternoon case discussion.

The second event is the annual meeting of the European Rorschach Association ERA), which will being with pre-conference workshops on Thursday, August 26. Participants in the Summer Seminars will have the option of adding a third day to their two-and-a-half day program by attending the ERA pre-conference workshops, which will be given by John Exner and Greg Meyer. Summer seminar participants will also be welcome to register as for the ERA Congress, in which Greg will be giving the keynote address. Brochures for both the Summer Seminars and ERA Congress will be available soon, perhaps by the time this notice appears. Persons interested in the 2004 Summer Seminars program can also write for information write to Agneta Rosenquist, who is IRS Vice-President and Continuing Education chair, at **agneta@rosenquist.org**.

The Reality of Psychological Testing in a Managed Care Environment

by Stephanie E. Yoder, Psy.D.

A marked decline of the utilization and reimbursement of psychological testing has emerged following the rise of Managed Care Organizations in our health care system. The use of psychological testing is a role that has traditionally separated psychologists from other professionals. Other providers do not receive the training necessary to ethically perform psychological testing. Therefore, in a time when psychologists are being asked more and more frequently to justify their role in the diagnostic and assessment process, it is essential to promote the skills that they possess that separate them from other providers, and that enable them in providing the most comprehensive and cost effective care to patients.

One model that appears to be a viable option for promoting psychological assessment with Managed Care Organizations is Stephen Finn's model of Therapeutic Assessment. The model of Therapeutic Assessment has proven to be a cost-effective and extremely valuable technique. Through the use of this paradigm, assessment participants have been shown to experience an increase in self-esteem, increase in hope, decrease in symptomatology, an increase of insight, and an increase in seeking mental health services with an increased motivation to engage in therapy (Finn & Tonsager, 1997; Newman & Greenway, 1997). The collaborative nature of the model helps clients begin to change their behaviors in the assessment. This method creates a bridge between the assessment and therapy proper and thereby accelerates the process of therapy while creating therapeutic effects on its own right. Dorr (1981) has said that using a focal assessment can accomplish in 1 ½ to 2 ½ days what could otherwise take weeks or months to achieve (Kubiszyn et al., 2000). Therapeutic Assessment is essentially a small microcosm of therapy. It helps clients to gain insight into their problems and begin working on alternatives to their behaviors. It helps to gather the necessary information for establishing a comprehensive treatment plan to assist with the therapy, while aiding the client simultaneously. In addition, this model has been shown to be multi-versatile and effective across a variety of populations and psychological problems.

In order to better assess how managed care currently views psychological testing, I have taken an independent survey of several local and national managed care corporations. Since several studies have been done in the past about this issue, I wanted to detect if there were any changes in the field, and to investigate some questions that had not been previously addressed. It is hoped that the results of the study will help with the future education of and advocacy efforts with managed care firms. Following are my findings from interviews that I did with various workers within eight managed care organizations in the Summer of 2000. These corporations consisted of local corporations (in the greater Philadelphia area), as well as some national organizations. All participants were asked eleven questions to ascertain the status of psychological testing with regard to reimbursement including qualifications for making reimbursement decisions, understanding of psychological assessment, and familiarity with the model of Therapeutic Assessment.

Participants were asked how their specific corporations reimbursed for psychological testing. Only one of the eight corporations said that they did not reimburse for any kind of psychological assessment. The other seven organizations reported that they did reimburse for testing, but there were certain criteria that had to be met before it would be reimbursed. Psychological testing was considered acceptable in all seven of these organizations for differential diagnosis purposes, and four of the seven corporations also reported that using testing to help with a "stuck therapy" or an unsuccessful treatment plan was also seen as an acceptable reason for testing. In addition, all seven of these organizations reported that they always referred any kind of psycho-educational testing, such as testing for learning disabilities, out to schools. Also, neuropsychological testing was covered under direct medical benefits for these corporations as well, and was therefore reimbursed at higher rates than psychological testing. Additionally, the method of reimbursement varied widely across corporations, with some paying on an hourly basis commensurate with psychotherapy, some paying at a lower rate than therapy, and some giving a limit (such as 5 hours/sessions) regardless of time spent on the testing.

As noted above, educational and neuropsychological testing were always referred out, and therefore not covered by the above seven organizations. Beyond this, the testing that is reimbursed is dictated by the needs of each individual case. This policy was consistent throughout the seven reimbursing corporations. Apparently, each case and request for testing was reviewed independently. Although it was reported that projective tests were covered, they were more often challenged by those making reimbursement decisions than were more objective test measures. In addition, one corporation noted that although their policy reimbursed for psychological testing, their culture did not encourage such requests, and was therefore not often utilized.

If testing is denied, each of the seven reimbursing corporations did report the availability of a formal appeals process that goes through the corporations' medical directors. When asked what qualifications people have who make decisions about reimbursement, each corporation reported that decisions were being made by varying levels of clinicians with some psychological experience including: licensed psychologists, licensed social workers, clinical nurse practitioners, psychiatrists, doctorate level psychologists, or masters levels clinicians in a psychology related field. Whether all of these professionals have experience or training with psychological testing appears less certain. While most people with whom I talked had a relatively good understanding of psychological testing, others were clearly less informed.

Participants were also asked whether or not they reimbursed for feedback sessions, and for time spent scoring, interpreting, and writing reports. One of the seven corporations who reimburse for testing said they did not reimburse for feedback sessions. Three of those corporations reported that the feedback could be billed as a therapy session, but this would detract from the number of sessions the patients would then have for therapy. The other two organizations reported that since there was a cap on the number of testing sessions allowed, that feedback sessions were rare commodities unless the therapist wanted to take the loss. Reimbursement for time spent scoring, interpreting, and writing the testing report appeared to be a mystery to most people I interviewed as well. Five of the seven corporations said that they didn't know how these aspects were reimbursed. The other two organizations said that these activities were included in the overall fee for the testing (these both had set time limits on testing, such as five total hours/sessions).

I asked a series of three questions to get a picture of the level of understanding that exists about psychological testing among those who reimburse for such services within managed care organizations. First, I asked if participants felt that psychological interviews

provided the same material that could be gleaned from psychological testing. Some respondents felt that they were not qualified to answer that question. One person stated that the answer depended on who was doing the actual interviewing, and how sharp his or her particular clinical skills were. Most others felt that psychological testing could provide more information, especially for the purpose of differential diagnosis. One person said that although he or she saw psychological testing as useful and helpful, he or she admitted that Managed Care facilities just did not see testing as cost effective. Fortunately, when asked if their corporations supported the use of medical trials to help with making a psychological diagnosis, only one respondent reported the use of this practice, suggesting that the benefit to alleviating symptoms justified this action. All other participants questioned the safety and ethical nature of such a practice. When asked what reasons were considered acceptable for using psychological testing, participants suggested assessment for: differential diagnosis, "stuck therapy" or previous unsuccessful treatment planning, the establishment of a baseline of functioning, the development of a treatment plan, and whenever a clinician feels that it is clinically indicated and can justify this necessity. However, the participants disagreed on whether or not testing could take place after therapy was completed. Although most agreed that testing could take place while therapy was in progress for some of the above-mentioned reasons, some felt that testing at the end of therapy would probably not be justifiable for reimbursement purposes.

The final question asked of participants was their familiarity with Finn's model of Therapeutic Assessment. None of those interviewed was familiar with this formalized concept. However, once the concept was briefly summarized for them, they all reacted in a positive and favorable way towards the concept. Several participants noted that they have always practiced in a fashion similar to what I had described, and said that it was good practice that they wished everyone embraced. Most also noted that any practice that can help alleviate symptoms would be looked upon favorably by the managed care corporations. Additionally, many people suggested that they would like to have more information about the process, and they thought it would be a good idea to present this information to those in charge at their companies. In essence, everyone was open to the concept of Therapeutic Assessment and seemed to agree that its benefits seemed to align with the philosophies of the managed care firms.

In general, most of the people whom I interviewed seemed like very caring and open people who were genuinely interested in helping the patients that they served. Although psychologists and other similar professionals often resent managed care, the abuse of insurance funds and the over-utilization of long psychological testing batteries, among other things, necessitated tighter restriction of our health care dollars. Hence, we have seen a revolution in the health care field, which has unfortunately resulted in absurd restrictions of our practices to the point where we feel that we cannot ethically treat our clients. However, I am arguing that the tide may be turning. The people with whom I spoke were not just looking out for the bottom dollar, but were concerned about patient well-being. Many people had personal stories to share about seeking treatment with managed care insurance, indicating their deep understanding of how frustrating managed care policies can be.

Several things that I encountered when talking to these participants encouraged me. First, I did not find blind denial of the value of psychological testing in most cases. Although practices for reimbursement are still very questionable, the fact that most cases were determined individually according to the needs of the clients was promising to me. Additionally, it appeared that those people who were making reimbursement decisions at least had some knowledge of the field of psychology or health care, although perhaps not psychological testing. Another facet I found hopeful was the fact that every company but one vehemently disagreed with the practice of using medical trials to make a psychological diagnosis. Furthermore, many participants appeared savvy about many of the appropriate uses and indications for psychological testing. However, my most pleasant surprise came from asking about Therapeutic Assessment. The responses to this question were overwhelmingly positive, and also indicated a willingness to learn and to listen to new ideas that have been proven to be effective.

Negatives apparently still exist with regard to psychological testing and Managed Care facilities, especially about time spent on interpreting, report writing, and providing feedback. Unfortunately, these activities contribute to the notion that managed care corporations have about the cost ineffectiveness of psychological testing. As a result, it is apparent to me that continual efforts to educate these corporations about the usefulness of assessment is imperative. We, as psychologists, also need to be able to support our actions and practices with research. Despite this lack of understanding about testing, however, it seems that corporations are willing to be educated. On the other hand, education of these corporations requires several things from psychologists. First, psychologists must be willing to take the initiative to educate these companies, and this would be easier done if psychologists would continue to work together on this issue. Secondly, we must have research and data to back what we do, such as cost effectiveness and helpfulness to our patients. Essentially, we must provide a rationale for our actions that goes beyond our "clinical instincts." Unfortunately (or fortunately), this is a reality that is not likely to disappear. In the end, this will make us all better and more efficient clinicians when it comes to helping our clients.

In conclusion, it is undeniable that managed care organizations have had a negative impact on the amount of psychological testing that is being done today. However, this current state is not hopeless. It appears that the pendulum may be swinging back from the more rigid reforms that psychologists first encountered with the advent of managed care health systems. Improvements in the quality of people making reimbursement decisions have increased, and along with this improvement, it appears that there is a better understanding of the value and necessity of psychological assessment. Through valuable tools such as Therapeutic Assessment, it is possible to unite both good clinical practice and efficacy. With clinical research about the undeniable efficacy and cost effectiveness of such models, psychologists are armed with valuable information to gain reimbursement. With continued research and the development of such paradigms, and with a continued push for public policy at all levels to aid in mental health related issues, it will be possible to stop if not reverse the trend in decreasing reimbursement and use of psychological assessment.

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In What Senses is Collaborative Psychological Assessment Collaborative?: Some Distinctions

by Constance T. Fischer, Ph.D., ABPP, Duquesne University

The term "collaborative" is appearing ever more frequently in regard to psychological assessment, and it is beginning to signify a broad range of practices. When I introduced "collaborative assessment" in 1978, the term referred to working jointly with clients (co-laboring) to individualize the assessment process and outcome. The goal was to collaboratively develop information about the client's actual life, including the contexts in which he or she did and did not experience and behave in various ways. In this frame, the client is an expert about his or her current views and remembered life events. The assessor is an expert about psychological tests, interviewing, theory and research of personality and development, psychopathology, change, and therapeutic interaction. Client and assessor contribute their respective expertise; in light of initial assessment findings, they together explore the presented issues and the client's personally viable choices. The goal, of course, is to be of greater usefulness to clients and to their other helpers, while also facilitating the client's discovery that he or she already knows how to be resourceful in reflecting on experience and in changing course. To the degree that this goal is met, the assessment is also therapeutic–healing and empowering.

In the 1970s, I also privately thought of the term "collaborator" in the wartime meaning of working with the underground against repressive authority! Persons who were clinically tested were never allowed to see or question psychologists' conclusions. Although collaborative themes are now increasingly common, my manuscripts on these practices were for some years rejected by editors as being "unprofessional" and "unethical." Currently, as American consumers press their professionals for more transparent communication, and as psychologists become more comfortable relating their technical expertise to ordinary life, use of the term "collaborative" is growing extraordinarily and is beginning to refer to a wide range of practices. A recent double-plus journal issue contained 21 articles describing collaborative assessment in diverse settings (Fischer, 2002); among the authors are SPA members Diane Engelman, Stephen Finn, Leonard Handler, Paul Lerner, Murray Mutchnick, Cynthia Neuman, Caroline Purves, and Mary Tonsager.

I welcome innovations in collaborative practices, but unfortunately "collaborative" also is beginning to refer to many one-way activities, from showing respect to providing HIPAA information to clients. I propose the following initial distinctions in order to enhance clarity of communication among professionals and to encourage innovation as we expand, examine, refine, revise, and re-understand our collaborative work.

DISTINCTIONS

Standard (Noncollaborative) Communications to Clients

Some professionals refer to the following steps in the assessment process as being collaborative in that the client is being informed or is giving permissions. Although these ethically and legislatively mandated steps can be carried out respectfully and honestly, they are unilateral, and do not in themselves lead to new understandings for either party. Standard communications include: assessor's explanation of the purposes of assessment, assessor's HIPAA notification, client's agreement to be assessed, assessor's explanation of any limits in regard to confidentiality, and clients' permission for a report and/or data to be sent to specified parties.

Feedback at the End of Testing (Unilateral, Noncollaborative)

Many psychologists regard giving feedback as being collaborative if technical jargon is reduced when the client is told "the results." However, this feedback is still unilateral in that one person tells the upshot to the other person, from the teller's perspective. There is no co-laboring, no mutually developed "product"—no concretizing and refining of the assessor's understandings in terms of the client's ongoing life.

Feedback at the End of Testing (Collaborative)

Many assessors plan in advance to explore their impressions with the client after testing, scoring, and integration are completed. Typically, the psychologist shares impressions (feedback) and asks for examples of these general findings and formulations, and then asks for examples of situations that were exceptions to these findings. The client may ask if a finding would apply to a particular situation, and typically raises new questions. The two persons continue to discuss the relevance of the psychologist's impressions, moving more and more into the client's life (from test-near to life-near), occasionally modifying the psychologist's initial phrasings or impressions. In short, they co-labor toward new understandings. Of course, feedback that initially was intended as unilateral sometimes leads to unplanned but productive collaborative discussion.

Even young children have collaborated with assessors, in all variations of collaborative assessment. In regard to end-of-assessment collaboration, some assessors write a fable as a report to the child. The child often offers additional characters, adjectives, outcomes, and morals to better portray his or her situation, and typically insists that parents listen to the story or read it aloud repeatedly.

Collaboration at the Beginning and End of Testing

Most collaborative assessors discuss the referral and what else the client might want from the assessment before starting. At the end, when the psychologist has integrated his or her impressions across data, he or she and the client collaboratively explore the likely implications of the test data, as suggested above (end of testing collaboration). In any form of collaboration, discussion extends the assessment; new information emerges and previous understandings (usually for both assessor and client) are revised or refined. Written reports summarize what emerged in this discussion.

Therapeutic Assessment. Steve Finn generally follows a beginning and end collaboration format, but in addition as an introduction to discussion of his findings, he presents the client with a task (selected TAT cards, for example), knowing that with guidance, the client will discover first hand some of what the assessor has formulated. This is a planned therapeutic intervention that typically is powerful in generating lived and reflective insight. Steve has published an excellent case study of Therapeutic Assessment (Finn, 2003). Also see Steve's readable and helpful manual on MMPI-2 therapeutic feedback (Finn,1996).

Most collaborative assessment is therapeutic in that clients participate actively in making sense of test patterns and observations presented by the assessor, in coming to recognize how they can apply new understandings in their lives, and in experiencing themselves as agents of their own change. Assessment interventions intended to facilitate clients' lived insight often are more powerful for the client than verbal discussion alone. Although unilateral feedback may be helpful, by itself it is not necessarily therapeutic.

Continuous Collaboration. Some psychologists, myself included, prefer to collaborate throughout the assessment. We start by clarifying the referral and developing the client's questions for the assessment, and then discuss impressions after each set of paper and pencil tests, and after each individually administered instrument. Each set of explorations informs the next set of data and often leads to refinement of earlier understandings. I try out interventions as we go, for example, by inviting a client to tell a TAT story from another character's perspective or to give WAIS III answers again but in a more authoritative voice. As we go, we discuss the contexts in which the client has and has not behaved and experienced in particular ways. By the end of the assessment, I summarize what our intermittent discussions brought us to understand. We also review related concrete suggestions for ways in which the client might modify habitual or defensive styles that have not worked particularly well. We have already tried out many of these suggestions during the assessment. See Fischer, 1985/1994. 2000.

Collaboration with Clients and Third Parties Together

Following an assessment with any of the above formats, some psychologists meet with both the client and the referring party (therapist, physician, employer, e.g.). Such meetings provide further clarification, reinforce understandings, and move all participants to "the same page." Steve Finn and his colleagues at the Center for Therapeutic Assessment in Austin, Texas regularly follow this practice. At their Center for Collaborative Psychology in Kentfield, California, Diane Engleman and Steve Frankel build periodic meetings of therapist, client, and assessor into psychotherapy (Engleman & Frankel, 2002). Graduate students enrolled in the Rorschach course at Duquesne University assess classmates' therapy clients, and all three meet to discuss new understandings and tie-ins with therapy progress. Many psychologists have followed variations of this practice for many years. For example, at the 1978 SPA annual meeting, Richard Dana, Phil Erdberg, and Peter Walsh presented a symposium on giving feedback to clients and their therapists in a joint meeting (Dana, Erdberg, & Walsh, 1978).

Parents can participate as collaborators as they observe their child in an assessment session, or review assessment performance with the psychologist. In both cases the parents recognize patterns of behavior and affect, and provide everyday instances. Parents also offer their understanding of the child's point of view at these times as well as examples of what interactions have and have not been helpful. This collaboration typically leads to insights and suggestions that none of the parties alone had developed.

Reports with Immediate Collaborative Potential

Many psychologists write reports in everyday language, and send these to therapists or other third parties, with the anticipation that these persons will initiate collaborative discussion with the client. These reports are especially useful when they indicate understandings that have already been developed with the client; this practice helps all parties "to get on the same page."

Some assessors encourage clients to write comments directly on the report. These comments become part of the report sent to all recipients. This practice results in a more accurate account, whether amplifying described characteristics or correcting or refining the psychologist's descriptions. The practice also emphasizes to client and reader that the client can engage directly with his or her helpers.

Among reports with immediate potential for collaboration are two computer-generated Rorschach feedback forms for clients. Phil Caracena's RorScan client check list asks the client to indicate the degree to which probable descriptions pertain to him or her. Irv Weiner's RIAP program includes a client narrative report. Both reports are written in everyday language and encourage the client to discuss the probability-based statements with the assessor or another professional.

Concluding Clarifications

Although assessors generally prefer a particular format of collaborating, they typically vary the format according to setting, client, and assessment requests. Steve Finn and I, for example, often wind up following the other's preferred format for collaboration. In addition, an assessor who usually works collaboratively may decide in advance not to discuss findings with the client when someone else has been designated to do so or when agency policies or forensic circumstances preclude full collaboration. When an assessment's primary purpose is for classification, for example to determine whether a student qualifies by IQ for gifted status, collaboration typically occurs only in a limited manner.

Formal testing is not always necessary in order to address referral questions. All of the above distinctions also hold for assessments carried out only through interview, review of records, and observation.

Further clarifications: assessors usually comprehend both more and less than the client understands about him- or herself. We share what is relevant to the current referral and client-presented issues, rather than share everything we have formulated. But unless there is a specified reason not to, we do share what will be in any report to third parties. Client and assessor may agree to disagree about some matters, which is reported. Most collaborative assessors write reports so that they can be read by the client, and they typically emphasize themes from the closing discussion.

Let me make explicit some themes that have been implicit in the above presentation. Whatever its form, collaborative client participation reduces client defensiveness and encourages openness and reflection, which contribute all the more to refinement and expansion of the assessment findings. Moreover, what clients learn is experienced in terms of their ongoing lives, and hence is more likely to be remembered and utilized. Having participated in making personal discoveries, and in considering and perhaps trying out alternative responses to various previously problematic situations, the client grows more confident of his or her future positive actions.

I hope that these distinctions will help psychologists to communicate clearly and consistently about collaborative and interventional assessment. I also hope that these clarifications will encourage assessors to try out and to describe their own variations and expansions of individualized, collaborative, and therapeutic assessment.

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SPA Fellows

Congratulations to newly elected SPA Fellows!

J. Christopher Fowler, Ph.D.
Stuart Greenberg, Ph.D.
Tamara Dzamonja-Ignjatovic, Ph.D.
Sharon Rae Jenkins, Ph.D.
Sharon Nathan, Ph.D.
Hedwig Teglesi, Ph.D.
Jed Yalof, Psy.D.

Tamara Dzamonja Ignjatovic, Ph.D., was elected a SPA Fellow. She is an Assistant Professor at Belgrade University at the Department for Social Work, and has practiced personality assessment and psychotherapy at the Institute for Psychiatry in Belgrade for over 15 years. She has also worked as an educator and mentor at specialization students for clinical psychology at the Medical Faculty, performed clinical researches of psychopathology and personality assessment techniques, and led educational workshops of personality assessment. Mrs. Dzamonja is a

Dr. Tamara Dzamonja Ignjatovic

member of several international associations, including the European Rorschach Association, Serbian Society for Psychology, and European Association for Behavioral and Cognitive Therapy. She is the author of the monograph *Psychodiagnostic and Contemporary Models of Personality*, and co-author of several publications. She has published papers about diagnostic application or comparative studies the Comprehensive System, Five Factor and Seven Factor modes of personality, and therapeutic assessment, and has participated in many conferences in Serbia and International Congresses.

Sharon Nathan, Ph.D., was elected a SPA Fellow. Marty Mayman, who stressed the importance of following one's empathic feel for the test responses – the "ah-ha" response, introduced Dr. Sharon Nathan to testing at the University of Michigan. Dr. Nathan learned about child testing during a postdoctoral fellowship at the Reiss-Davis Child Study Center in Los Angeles, and from there was hired to work in the Children's Division of the Menninger Clinic in Topeka, Kansas. "A passionate group of traditionalists, the psychologists at Menninger argued their way through each new version of the Wechsler tests and, before adopting the Comprehensive System, learned much more than Rorschach ever intended about the nature of reality." Dr. Nathan directed the postdoctoral training

Dr. Sharon Nathan

program in clinical psychology in the year before it closed, with Menninger's departure to Houston. She is now teaching and supervising interns, master's, and doctoral level psychologists at the Family Service and Guidance Center. "Topeka psychologists, at Family Service, the V.A., the Heritage Clinic, and in private practice, remain an enthusiastic group, committed to training and to rebuilding our professional community."

Jed Yalof, Psy.D., was elected a SPA Fellow. He read Schafer's *Clinical Application of Psychological Tests* and *Psychoanalytic Interpretation in Rorschach Testing*, and became hooked on psychoanalytic personality conceptualizations. He has combined this interest with a study of the Comprehensive System, and has also studied psychoanalytic applications to classroom teaching, academic administration, school psychology, and neuropsychology. He has published in the areas of psychotherapy, teaching, assessment, and supervision. Dr. Yalof is Professor and Chair of the Department of Graduate Psychology at Immaculata University, and Coordinator of the Psy.D. Program in Clinical Psychology. He maintains a private practice in psychotherapy, personality assessment, and school-neuropsychological assessment.

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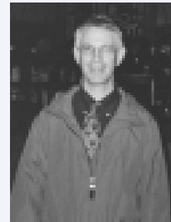
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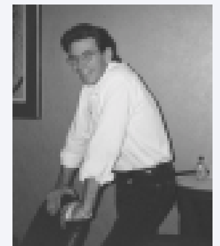
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Anna Maria Carlsson, Representative at Large

Barton Evans, Representative at Large

Continued from page 4...

Ego Function: Self **Test Variable** **Rorschach:**	**Score**
Egocentricity: (.37, .14) —*Self concern/Self esteem (Exner, 1993)*	.38
MOR: (1.00/0.00) —*Negative self image (Exner, 1993)*	3
MMPI-2:	
LSE (Low Self Esteem): (>64) —*Negative self view (Butcher, 1992)*	80
PAI:	
BOR-I (>64) Identity Problems —*Lack of self confidence (Morey 1996)*	77
BDI-II:	
#3 (failure) *(Beck, 1996)*	3
#6 (punish) *(Beck, 1996)*	2

Ego Function: Relational Capacity **Test Variable** **Weschler:**	**Score**
Comprehension: (10, 3) —*Social judgment (Kaufman, 1979)*	13
Picture arrangement: (10,3) —*Social judgment (Kaufman, 1979)*	10
Rorschach:	
COP: (1.00/0.00) —*Collaborative, cooperative relationships (Exner, 1993)*	0
T: (0.00/0.00) —*Affectional needs (Exner, 1993; Klopfer, 1954)*	3
MMPI-2:	
Hy2 (Need for affection): (>64) —*Strong need for affection and attention (Butcher, 1992)*	71
Pd2 (Authority problems): (.64) —*Resent authority (Butcher, 1992)*	59
PAI:	
NON (>64) Nonsupport —*Lack of perceived social support (Morey, 1996)*	76

Building a Foundation

by Bruce L. Smith, Ph.D.

In 2003, the Society for Personality Assessment took the major step of setting up a tax-exempt charitable foundation. In November, we received word that the Society for Personality Foundation had been granted tax-exempt status as a charitable foundation [501(c)(3)] by the IRS. What this means is that contributions made to the Foundation are fully tax deductible as charitable contributions.

We established the Foundation in order to raise money for the many projects that SPA envisions now and in the future. We are already supporting students through our Travel Grants and our Dissertation Awards, and we hope to expand these programs significantly in the coming years. In addition, the Utility of Assessment Project is a major undertaking that we hope will have a significant impact on the practice of assessment.

Over the coming months, you will hear more about SPAF and the many ways that you can contribute to the work of the Society. I have been honored to be chosen by the Board to be the first President of the Foundation, and I can assure you that I will do all in my power to ensure that it becomes a vibrant, growing concern that will have a positive impact on the future of our science and profession.

ADVOCATING FOR ASSESSMENT THE COORDINATOR'S CORNER

The main task of the Advocacy Office over the coming year will be to organize the advocacy efforts of the Society and to set priorities. Shortly after the new year, you will receive an email survey about your chief concerns for the future of personality assessment, the major problems you face in your work, and the areas you would like to become personally active in advocating for assessment. From this survey, I hope to develop a set of priorities as well as a cadre of dedicated advocators who can take the work forward in the various arenas that we find ourselves—with 3rd party payers, with legislators, within the profession of psychology, and in the academy.

This past year, we have been active in several areas: We have been trying to work more closely with APA, in particular on the redefinition of the CPT codes for assessment, in addition, our website is now linked with APA's page on assessment. We are also advocating for the privacy of test data under HIPAA, developing position papers on such topics as the Rorschach controversy, and HIPAA, and producing a brochure on the benefits of psychological assessment. As these become available, they will be posted on the website as well as, in some cases, published in *JPA*.

As always, I welcome input on the important problems facing you as assessment psychologists as well as our efforts in advocacy.

SPA Personal Column

John M. Haroian, Ph.D., has left Argosy University, Seattle, to work at the Washington Correction Center for Women (WCCCW). He continues to each projective personality assessment at Argosy, Seattle as an Adjunct Professor. He can be reached at WCCW at 253-858-4626 or at **jmharoian@Doc1.WA.GOV**

Adelbert Jenkins, Ph.D., is President of APA Division 24 (Theoretical and Philosophical Psychology for 2003–2004.

Radhika Krishnamurthy, Psy.D., has been appointed Program Chair/Director of Clinical Training of the Doctor of Psychology program at Florida Institute of Technology.

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From the Editor...

In this issue of the *SPA* Exchange, SPA President Len Handler invites you to Miami and makes it hard to say "no." Barton Evans highlights workshops at the upcoming meeting in Miami. The program is exciting and you won't want to miss it. Two eminent psychologists, Stuart Greenberg and Edwin Megargee will present Master Lectures. We also feature reader-friendly articles on the PAI by John Kurtz, the MCMI II by Steve Strack and Bob Craig, and the second part of Tom Schaffer's model of integrative interpretation within an ego psychological framework. In addition, Connie Fisher discusses the meaning of the term "collaborative" in assessment practice. Stephanie Yoder summarizes her research on psychological testing in the managed care environment. Pamela Abraham and Jed Yalof present a Rorschach interpretive schema for understanding blocks to teaching and learning. Irving Weiner updates the events of the International Rorschach Society and of APA's Division 12 Section on Assessment Psychology. Phil Caracena, SPA Webmaster, provides information about the updated SPA website. Bruce Smith updates his work as SPA Advocacy Coordinator. Please take note that the *Exchange* is accepting advertisements and has its first ads in this edition along information about size and pricing.

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