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President's Column

Why is it so Difficult to Write a Good Psychological Report?

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I first began puzzling over how to write a good psychological report when I was in graduate school. While casting around for some way to begin, I noticed that many fiction writers had more insight into human thoughts and feelings compared with me and my colleagues. Fiction writers allowed their readers to experience, in an uncensored manner, their characters' thoughts, feelings, and world-views. Reading such material, I thought, seemed to be an excellent training ground for someone who wanted to learn how to write a good report. After all, I said to myself, didn't I remember reading somewhere that Henry James, the novelist, was considered to be a better psychologist than his brother, William James, who actually *was* a psychologist? This led me, as a fiction writer "wannabe," to embellish my reports with dramatic attempts at literary description. I spent lots of extra time crafting such statements as :

"Mr. Arther is tall and heavily-built, much like an ex-football player who has taken on some excess weight." Or, "Mr. Arther's voice resounds with assurance and determination, as he carefully chooses his words," Or, "The patient's entire body comes alive as he attempts to drive home a point; his eyes widen and flash, he doubles his fist and leans forward in his chair to demand, challenge, or otherwise manipulate the situation," Or, and finally, "The patient appears enamored with himself; any weaknesses are played down or quickly glossed-over, as if they were of no significance. He has the uncanny ability to find a weak spot in the other person and then proceed to explore and widen this area of vulnerability—all the while presenting a picture of himself as a flawless character."

Fellow students, supervisors, and faculty were amused by these reports, and no one said they liked them. I don't write reports like that any more, but I've had an abiding interest in learning and teaching report writing for many years, especially after giving up the fantasy of writing good fiction.

But it was last March, in Miami, when I spoke to you about the crisis in our graduate programs in the education and training in personality assessment, that I actually decided to speak about report writing today. While doing research for that address I again became aware of the major problem in assessment, how to capture on paper the essence of a human being. I began, at that time, to think about *this* address, titled, "Why is it so Difficult to Write a Good Psychological Report?"

Students almost universally state that report writing is the most difficult task in the assessment process, and it is a task not addressed enough in courses and at internship settings. Judging from a sample of reports I have been collecting from practicing clinicians over the years, practicing clinicians also have difficulties in writing assessment reports. That's another reason I decided to speak to you today about report-writing problems; the problem persists, even in the work of more advanced practitioners. I'd like to make some observations about the problem, and also offer some solutions.

Many years ago a famous neuropsychologist who spoke at a workshop I attended, made a statement with which I've come to agree. He said, if a psychologist doesn't know much about a subject, he or she writes a *book* about it. If the psychologist knows a little more about it, he or she will write *a chapter, or an article*. But if the psychologist knows a great deal about the topic, he or she will write *an abstract*. Well, just for a lark I entered the term "psychological assessment reports" in Google. Guess how many hits I got back? I got back one million, seven-hundred and fifty thousand citations. I didn't check most of the citations, but of the ones I did check, *none* were abstracts. The comparable number of hits for the MMPI were two hundred and thirty thousand, and for the Rorschach, one-hundred and thirty-two thousand. I didn't check for abstracts on these two searches either, but hopefully there were a substantial number.

More evidence concerning the difficulty in learning to write good assessment reports comes from student complaints in class and from the looks of panic when I announce the date the first report is due. I distribute an outline and we discuss what sorts of statements might go into each section. I used to believe that providing annotation like this would be enough help and structure, but I've leaned from students' helpless looks that it is entirely insufficient. They have the same frightened look in their eyes *after* discussing the outline—and perhaps even more—than they had *before* discussing the outline.

It has probably become obvious to you by now, but let me say that report-writing problems begin not with the actual writing itself, but rather, with the initial process of interpreting responses or response patterns in the data, and dealing with emotions, defenses, and social concerns. Therefore, putting one's thoughts and impressions about a patient down on paper takes some getting used to. I tell students how anxious I felt when I looked at the blank piece of paper in the typewriter in the cold of the night, wondering where to begin and how to begin writing the report. When I describe this experience students snicker in recognition of their own private panic states when they stare at the data and nothing comes forth. I want them to become aware that the experience is universal—that a person is not automatically able to write a good psychological report because it is some kind of an inborn trait. *Anyone* can learn to write a good assessment report if they can deal effectively with the issues I will soon discuss.

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Len Handler (L) & Steve Smith (R), who received the Samuel J. and Anne G. Beck Award

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In a wonderful chapter called "The Trouble with Learning Assessment", Chris Fowler (1998) documents students' problems in learning assessment. Students are fearful he says, that they will make mistakes that cannot be rectified. In this sense learning to do psychotherapy is less stressful, because in psychotherapy it is possible to readdress most mistakes or misconceptions. Students are reluctant to say negative things about a patient in a test report, because they fear these statements might just be projections of their own problems rather than the problems of the patient. Fowler states, "The white knuckled fear of taking up the voice of the expert was rife with personal meanings. Students feared pathologizing the patient and had problems balancing morbid vs pollyanish interpretations" (1998, p.34). Students worried whether they were helping their patients by understanding and naming their mental processes or whether they were reducing their patients' uniqueness to labels. They also worried whether they were merely calling their patients dirty names so they could feel better about themselves. Unless these issues are discussed and resolved, students' reports will miss the mark. We discuss these issues early in the course so students will recognize their own similar thoughts and feelings, and may be better able to deal with them more directly.

As an additional antidote, before any full report is required, I attempt to simulate the writing task in the classroom. After we've been working on a protocol for some time, and before we've completed analyzing less than 25 percent of the data, I ask students to write a few paragraphs summarizing their evaluation of the patient so far. My goal is to help them get used to the report-writing process a little bit at a time. Most students struggle with the "on the spot" assignment. I see many "deer in the headlights" type reactions. Most students work through their immobilization, and, in general, produce high-quality paragraphs, although they do not recognize their quality until they got feedback from other students or from me. It became obvious to me that support and encouragement were vital aspects in teaching students to learn good report writing. Here's where understanding Kohut is important. I began to incorporate extensive praise and encouragement in my feedback to students, providing extensive mirroring, because students had no other experience at this point by which they could measure their success. I suggest such active feedback be given during the internship year as well (Handler & Hilsenroth, 1998).

Many years ago the ability to write good reports was explained away by implying the process required hunch and intuition, which only sometimes eventually came with experience. The implication was that writing good reports could not be taught or learned directly. But we can't afford to wait until the intuition muse touches us. There are ways in which we can teach new clinicians how to write good reports. In my quest to do so I spent a great deal of time talking to students about the problem.

Over many years I've asked students to discuss what it was about report-writing that was so intimidating. In general, four areas were identified. The first concerned the difficulty of translating test data into meaningful psychological interpretations. The second problem concerned combining individual interpretations into larger, more encompassing statements about the person.

The third issue concerned the need to find some organizing philosophy or theoretical glue to help the integration process, in order to develop a more comprehensive picture of the person tested. Personality theory provides help in organizing a report. Theory also provides direction concerning the integration of seemingly unrelated pieces of information and it operates as a guiding function to facilitate clinical prediction. The use of theory in the interpretive process allows the clinician to be more specific in making recommendations. An excellent example of how the use of theory enriches the process of interpretation in assessment is Paul Lerner's forthcoming case study in JPA, titled, "Red Beavers and Building Bridges between Assessment and Treatment."

The fourth problem concerns the ability of the clinician to develop an empathic connection with the test data in the interpretive process, just as he or she develops such a connection with the patient when collecting the data. We teach students how to administer tests, how to score them, how to make interpretations from test data, but the job of making meaningful integrations of the data, using theory in the process, and in writing an experientially-focused report has often been neglected.

I decided, some years ago, to study the problems involved in report writing. Given my discussions with students I decided to study "cognitive flexibility," "creative thinking," "empathy," and a variable we called "intuition." There are two types of creative thinking described in the literature on creativity—Divergent and Convergent thinking.

In Divergent thinking we ask the subject to generate as many different ways as possible in which an ordinary object can be used. In testing this approach the researcher might ask the subject to generate as many different ways as possible a person might use a stick, a piece of string, a paper clip, and so on. We found that college students who generated the greatest number of possible uses of objects performed significantly better in an interpretive process compared with those students who generated fewer possible uses (Burley & Handler, 1997). We felt that findings here could be applicable to concepts as well as to objects.

This approach was incorporated in teaching the first step in the interpretive process by asking students in the assessment class to first generate an interpretation of a piece of data and then to generate alternatives to the first interpretation, for example, a high K score on the MMPI-2. By generating more than one response the students avoid reliance on a sign approach; they become more open to other possibilities, resulting in a more open interpretive stance, thereby avoiding confirmatory bias.

The second type of creative thinking, Convergent thinking, describes the unique, creative combination of several pieces of data, often seemingly discrepant data. In our research we measured Convergent thinking with Mednick and Mednick's Remote Associates Test (Mednick & Mednick, 1967). In this test multiple sets of three words are presented to the subject, one set at a time. The subject is asked to find another word that can incorporate the three words. For example, what word can incorporate the words "round," "dance," and "base"? If you said "ball" to yourself you would be correct. A ball is round, a fancy dance is a ball, and base+ball is "baseball". We found that both undergraduate and graduate students who earned high scores on the Remote Associates Test were significantly more successful in the interpretive procedure, compared with those who scored lower on the test. There were no significant differences on demographics or intelligence between the two groups. There were also significant differences found for the good vs poor interpreters on the empathy and intuition measures, the good interpreters scoring better on both measures.

The result of the students' fears and inexperience is that interpretations typically lack depth and are couched in an overly-generalized manner. Students tend to rely on nomothetic data rather than searching for a more specific contextualized interpretation. When asked to interpret what they see in an MMPI-2 protocol, or a drawing, or a Rorschach, students ordinarily begin with an observable: "She drew the hands behind her back;" "The K score is elevated;" "The first Rorschach response is an F- ." I then ask, "What could it mean that the K score is elevated; that the hands are behind her back; that the first response is an F- ?" Struggling, students try to remember what their textbooks say these observations "mean" in their efforts to provide a correct translation, but eventually they come up with relevant alternative hypotheses.

In applying our findings for Convergent thinking, I present a finding from one or another test and ask students to interpret that finding. Typically, I encourage several possibilities. I then ask them to make a choice between or among the possibilities, which now involves a search for other findings to support one or another interpretation. Students are faced with the task of combining often seemingly discrepant pieces of data, which is a task that is similar to the one involved in the Remote Associates Test, mentioned earlier.

Typically, hypotheses are generated that appear too general and therefore, I might ask

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students to sharpen that interpretation, by examining other findings in the data. For example, to say the patient is impulsive is not specific about where, when, and how he or she is impulsive. At this stage there is still some resistance to making psychologically meaningful interpretations. For example, "She seems to be alternating between a more concrete level and an abstract level," or "He seems to respond to this card with anxiety." When asked to make a *psychologically relevant* interpretation concerning the meaning of this observation in reference to the patient's life issues, it is also suggested to the student that he or she examine other findings in the test protocol. To date, I am unaware that anybody has described this approach any better than Mary Jo Peebles-Kleiger, in a paper titled "Elaboration of Some Sequence Analysis Strategies: Examples and Guidelines for Level of Confidence," published in JPA in 2002, and for which she earned the coveted SPA Mayman award.

The next important aspect of interpretation concerns our research findings about empathy. Remember that in the study I mentioned earlier those graduate and undergraduate students with higher scores on an empathy measure did significantly better in data interpretation compared with those who had low empathy scores. To me the best reports are those in which the writer is empathically attuned to the patient during testing, while interpreting the findings, and writing the report. This empathic attunement process allows the writer to maintain his or her connection with the patient as life issues are described, resulting in an experience-near report, which, I believe, is the goal of ideographic assessment.

The empathic attunement approach is critical because it provides the report writer with a focal point with which to begin the report. Many new report writers ask where to begin in writing the report. While it is of course possible to begin with the referral questions, to me it makes more sense to begin instead with a description and analysis of the patient's major life issues, an overriding signature that helps to define the individual, and from which related problems and strengths flow. I feel I am in a better position, at this point, to speak intelligently about the referral issues.

To help facilitate this stance in the interpretive process I ask students to imagine giving the response being considered, and I ask them how they are feeling. I also ask them, for example, to *be* the person drawn on the DAP, or the person in the story given on the TAT. I ask them to consider the patient's test-taking approach and to interpret test responses in that light. As one very talented student report writer explained to me, "I keep a picture of the patient and how I felt about him or her, and I keep coming back to it as I write the report."

I feel it is important to understand what it is like to be the person about whom I am writing and to describe this awareness in the report. I also want to experience what it is like to be *with* that person. I ask students to imagine what the person who gave such and such a response feels about himself or herself, how he or she would be as a dinner partner, or as a business colleague (Potash, 1998). Unless I can describe how the person experiences his or her world, I have not done enough to capture that life. It is by first understanding the person's world-view that I can now make specific, detailed predictions, answer referral questions and make informed recommendations.

I have read too many reports that make only vague predictions. For example, one person wrote, "It is possible that the patient may act out." Another writer said, "It is possible the patient will return to taking drugs. These vague and useless "pseudo-predictions" are perhaps taken from printouts or perhaps the writer did not understand the patient well enough to say under what conditions the behavior would occur. Some writers hedge by focusing on stress as the precipitating factor—"Under stress the patient will act out," or "will begin to drink," or to "demonstrate disturbed thinking," and so on. In this situation the writer is using the term "stress" as a unitary factor, implying that any and all stressors will produce the problem behavior, rather than describing just what is experienced as stressful for this specific person, in what specific setting.

If the processes described in this paper are attended to, the report will contain few if any such vague statements. I believe that without the use of empathic attunement, convergent and divergent thinking, and the use of theory, clinicians will resort to writing test-centered reports, where the data from each test are interpreted independently, with only a brief summary, rather than producing a person-centered report, one that allows the person to come through to the reader in all his or her complexity. Bouchard and Guérette, two Canadian phenomenologists who write about assessment and psychotherapy, believe that to do assessment well the interpreter of the data must have "intimate contact with the internal life that makes the [assessor] the same as his [or her] patients" (Bouchard & Guérette, 1991).

I will end this talk with another quote from Bouchard and Guérette: Effective experiential interpretation cannot be done if the interpreter "stays enclosed in his or her own expectations of meaning." Under such circumstances, "the many possibilities conveyed [by the data] will pass unnoticed and the patient will not have been truly understood" (p. 388).

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The Teacher's Block

What's in a Name? Bridges to New Understanding: MMPI-2 Restructured Clinical (RC) Scales and Personality Psychopathology Five (PSY-5) Scales

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When teaching courses in intervention, diversity, and assessment, we continuously re-evaluate the impact of descriptive language in psychology. Certain words carry particular connotations, and these connotations are embedded in our understanding of personality theory and diagnostic nomenclature. In psychology, we continually refine our language usage with respect to cultural/societal influences regarding gender, racial, and ethnic groups. Psychologists agree that names used to describe clinical subgroups need to reflect these sociocultural trends. Names distinguish us from one another, convey information about our history, and are inherited inter-generationally as part of our professional culture.

These general characteristics about the implications of a name also have relevance for test constructs or test scales. For example, some of the names for a few of the clinical scales on the MMPI-2—Hypochondriasis, Hysteria, and Psychasthenia—are reminiscent of psychology's historical tie to psychoanalytic theory, but carry connotations that might benefit from further study with respect to diversity trends. Butcher and Williams (2000) noted that despite the considerable research, development, and the attention given to language concerns (on the test items) during the revision of the test, it was decided to keep the names/titles of the clinical scales.

In this article, I offer a perspective on how MMPI-2 scale names generate challenging and interesting comments and questions by doctoral students learning the test in an advanced assessment course. I use a vignette to develop different points. I present the MMPI-2 in the context of a teaching illustration and note how the teacher can facilitate an enriching and informative discussion about components of psychology's history and systems through a studied review of the names of different MMPI-2 test scales.

Following classes on the development of the MMPI (Hathaway & McKinley, 1943) and MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), history, purpose and administration, test taking strategies and validity scales, the first power point slide goes up (Scale 1 Hypochondriasis) to commence discussion of the clinical scales. A flurry of hands begin to emerge, signaling that something has sparked a large group interest that requires attention. Questions are asked: "Why are we still using the name hypochondriasis?" "Isn't

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that name based on analytic theory?" Some students ask about the original definition of hypochondriasis, which represented repressed castration anxiety or a way to handle guilt (Freud, 1914). This information is then contrasted with the current interpretation of the scale to indicate somatic concern. "Doesn't the use of this name promote an analytic interpretation of the symptoms represented by the scale?"

Discussion begins to address how to bring the names of the MMPI-2 in line with new diagnostic concepts, personality theory, and definitions familiar to student's training experiences. Students then point out that current scale names are at odds with prevailing practice in the field. We discuss the relationship between scale names and the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) [*DSM-IV-TR*]; American Psychiatric Association, 2000), noting that differences between *DSM-IV-TR (2000)* and the MMPI-2 may have more to do with different purposes (i.e., *DSM-IV-TR, 2000* is a standard diagnosing manual, MMPI-2 describes personality profiles in descriptive terms), historical understanding of terms, and lack of theoretical basis between the two diagnostic methods. Some students indicate historical connotations have implications even if we do not mean for them to be influential. We end this discussion with a reflection about the importance of re-evaluating language.

Scale 3, Hysteria, also elicits many comments and questions by the students. They ask why we continue to use names/titles of scales that may convey and continue to promote bias. Scale 3, identified by the term Hysteria, historically represented dysphoric feelings and denial as well as conflict around genital incest strivings and/or oral frustrations (Breuer & Freud, 1893-95). Students wonder whether the use of this name perpetuates gender bias associated with ideas about female weakness and tendencies to dramatize. Interestingly, the term *neurotic triad* is often used to explain pattern configurations on scales 1-3. This name also stimulates questions about the name *neurosis* which is also a well known psychoanalytic concept indicating conflict between sexual and aggressive drives and their expression. Students have a strong reaction regarding Duckworth and Anderson's (1986) interpretation of the ascending pattern found on scales 1-3 as the "hysterectomy profile," which the teacher helps them process.

Students pose many concerns about the continued use of Scale 5, Masculinity-Femininity, currently interpreted as indicating stereotypic male and female behavior/roles. They have difficulty understanding why a scale that originally was used to identify homosexuals continues to be used. We discuss how this scale may be misinterpreted as disclosure regarding homosexual behavior still carries strong stigma and may place one at risk for further discrimination and bias. Students question the current purpose of the scale given the changing norms over time and stereotypic differences between males and female traits have lessened.

We then arrive at a discussion of Scale 7, Psychasthenia. This scale is intended to describe those individuals with anxiety, worries and obsessive-compulsive features. Given our previous discussions, students again speculate that the term may imply something more since the historical definition viewed psychasthenia as representing ambivalence over bodily pleasures (Henry, 1938).

After an intriguing discussion regarding the history of psychopathology terms, changes in the language of psychology, linguistic reform, bias, and diversity issues, we now are ready to cross the bridge and cover the Restructured Clinical (RC) Scales (Tellegen, Ben-Porath, McNulty, Arbisi, Graham, & Kremmer, 2003) and the Personality Psychopathology Five (PSY-5) Scales (Harkness, McNulty, & Ben-Porath, 1995; Harkness, McNulty, Ben-Porath, & Graham, 2002). The RC Scales attempt to capture core components of constructs on the clinical scales, improve convergent and discriminate validity, remove demoralization items from the clinical scales to form a new scale, and use descriptive terms (except for RC9) rather than diagnostic labels for scale names (Ben-Porath, 2003; Tellegen, Ben-Porath, & Abisi, 2005). For example, the restructuring of the clinical scales changed Scale 1, Hypochondiasis, to RC1 Somatic Complaints, Scale 3, Hysteria, to RC3 Cynicism, and Scale 7, Psychasthenia, to RC7 Dysfunctional Negative Emotions. The new RC scale descriptions diminished the student's concerns about the original clinical scale names being out of sync with current diversity sensitivities. These new additions to the MMPI-2 are paving the way to a new understanding. Students found relief in discovering that researchers are attempting to form a link between psychopathology and personality (Harkness & McNulty, 1994; Harkness, McNulty, & Ben-Porath, 1995; Harkness, McNulty, Ben-Porath, & Graham, 2002) as well as utilizing conceptual theory about mood and temperament (Watson & Tellegen, 1985; Tellegen, Watson & Clark, 1999; Watson, Wiese, Vaidya, & Tellegen, 1999) to explain the scales. Likewise, the Psy-5 scales (Aggressiveness, Psychoticism, Disconstraint, Negative Emotionality/Neuroticism, and Introversion/Low Positive Emotionality) examine relatively stable personality characteristics, with the term *neuroticism* defined as negative emotionality based on current research about personality and individual differences (Harkness, McNulty, & Ben-Porath, 1995).

A review of these newer MMPI and PSY-5 scales seemed to assuage student concerns about the names of the scales. Scale name revisions in the RC scales and the PSY-5 appeared to make a positive impression on students because they utilized descriptively relevant terms that were linked clinically to personality theory, and because diagnostic findings could be viewed readily from an individual difference basis, rather than from the basis of a disease model. Butcher's (2000) article on lessons learned from revising the MMPI was also helpful in expanding student understanding of the parameters of change when revising a test.

In this class, students were able to learn that the MMPI and the MMPI-2, though influenced historically more by statistical properties than constructs and theory (Tellegen, Ben-Porath, McNulty, Arbisi, Graham, & Kremmer, 2003; Tellegen, Ben-Porath, & Arbisi, 2005), could be bridged comfortably to newer constructs that reflect contemporary conceptualization about psychopathology and personality. The RC clinical scales and the PSY-5 are a welcome addition to the teacher's base of information. They allow the teacher to talk about the MMPI-2 in a way that provides a history lesson in the service of supporting adaptation to newer terminology and its conceptual underpinnings.

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References from President's Column

Bouchard, M., & Guérette, L. (1991). Psychotherapy as a hermeneutical experience. *Psychotherapy, 28(3),* 385-394.

Burley, T., & Handler, L. (1997). Personality factors in accurate interpretation of projective tests: The Draw-A-Person Test. In E. Hammer (Ed.), *Advances in projective drawing interpretation* (pp. 359-377). Springfield, IL: Thomas.

Handler, L., & Finley, J. (1994). *Convergent and divergent thinking and the interpretation of figure drawings.* Unpublished manuscript.

Handler, L., Fowler, J., & Hilsenroth, M. (1998). Teaching and learning issues in an advanced course in personality assessment. In L. Handler & M. Hilsenroth, *Teaching and learning personality assessment* (pp.431-452), Mahwah, NJ: Erlbaum & Associates.

Lerner, P. (in press). Red beavers and building bridges between assessment and treatment, *Journal of Personality Assessment.*

Mednick, S., & Mednick, M. (1967). *Examiner's manual,: Remote Associates Test.* Boston: Houghton Mifflin.

Peebles-Kleiger, M. (2002). Elaboration of some sequence analysis strategies: Examples and guidelines for level of confidence. *Journal of Personality Assessment, 79(1),* 19-38.

Potash, H. (1998). Assessing the social subject. In L. Handler, & M. Hilsenroth (Eds.), *Teaching and learning personality assessment* (pp.137-148), Mahwah, NJ: Erlbaum & Associates.

References from The Teacher's Block

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text revision).* Washington, DC: Author.

Ben-Porath, Y. S. (2003, Summer). Introducing the MMPI-2 Restructured Clinical (RC) Scales, *SPA Exchange*, 15 (2), 16-17, 23.

Breuer, J. & Freud, S. (1893-95). *Studies on hysteria. S.E., 2*, 1-306. London: Hogarth.

Butcher, J. N. (2000). Revising psychological tests lessons learned from the revision of the MMPI. *Psychological Assessment, 12 (3)*, 263-271.

Butcher, J. N. & Williams, C. L. (2000). *Essentials of MMPI-2 and MMPI-A interpretation (2nd edition).* Minneapolis: University of Minnesota.

Duckworth, J. C. & Anderson, W. (1986). MMPI interpretation manual for counselors and clinicians (3rd ed.). Muncie, IN: Accelerated Development.

Freud, S. (1914). *On narcissism. S. E., 14*, 83-102. London: Hogarth.

Harkness, A. R., McNulty, J. L., & Ben-Porath, Y. S. (1995). The Personality psychopathology five (PSY-5): Constructs and MMPI-2 scales. *Psychological Assessment, 7*, 104-114.

Harkness, A. R., McNulty, J. L., Ben-Porath, Y. S., & Graham, J. R. (2002). *The Personality Psychopathology Five (PSY-5) scales: Gaining an overview for case conceptualization and treatment planning*. Minneapolis: University of Minnesota Press.

Henry, G. W. (1938). *Essentials of psychiatry (3rd ed.).* New York: Williams & Wilkins Company.

Tellegen, A., Ben-Porath, Y. S., & Arbisi, P. A. (2005). *The MMPI-2 Restructured Clinical (RC) Scales*. MMPI-2/MMPI-A Workshops and Symposia, Fort Lauderdale, Florida.

Tellegen, A., Ben-Porath, Y. S., McNulty, J. L., Arbisi, P. A., Graham, J. R., & Kremmer, B. (2003). *MMPI-2 Clinical, Restructured Clinical (RC) Scales: Development, validation, interpretation.* Minneapolis: University of Minnesota Press.

Tellegen, A. Watson, D., & Clark, L. A. (1999). On dimensional hierarchical structure of affect. *Psychological Science, 10*, 297-303.

Watson, D. & Tellegen, A. (1985). Toward a consensual structure of mood. *Psychological Bulletin, 98*, 219-235.

Watson, D., Wiese, D., Vaidya, J., & Tellegen, A. (1999). The two general activation systems of affect: Structural findings, revolutionary considerations, and psychobiological evidence. *Journal of Personality and Social Psychology, 76*, 820-838.

Advocacy Corner

Bruce Smith, PhD

SPA Advocacy Coordinator

This has been a rather frenetic six months in the world of assessment advocacy. Your intrepid coordinator has at times been feeling like Disney's sorcerer's apprentice, trying to cope with brushfires all over the place (to mix images badly).

The biggest issue with which we have been dealing has been the ongoing effort on the part of the APA Practice Directorate and SPA to develop new CPT codes for billing assessment services. Many of you participated in the survey this spring that was designed to establish values for the work that is done in assessment. A grateful "thank you" to all of you. We achieved a return rate of over 50% on the surveys that APA mailed out, and these have gone a long way toward establishing the legitimacy of the data that we submitted to the groups that will determine reimbursement rates for psychological assessment in Medicare and the insurance systems. The data were presented to HCPAC (Health Care Professionals Advisory Committee) and RUC (Relative Value Scale Utilization Committee) in April, and we hope to hear soon about the acceptance of the new testing codes and the appropriate valuing of assessment services.

As you undoubtedly know, the Board has issued a "white paper" or official statement on the Rorschach controversy that can now be viewed on our website and will be published in JPA. As you can read, it is our position that while scientific controversy is proper and healthy, singling out one instrument or technique for censure, or calls for a moratorium on the use of the Rorschach are improper and seriously misstate the scientific literature. We are now discussing ways of disseminating this position paper more widely so that those in the health care and legal systems will be aware of what the science truly does and does not say.

Much of the effort of the advocacy office has been devoted to dealing with threats to the professionalism of personality assessment in various jurisdictions. Masters level counselors in several states are lobbying their respective state legislatures to be allowed to conduct psychological assessment within the normal scope of their licenses and without requiring any demonstration of appropriate training or education. This issue first reared its head in Maryland (a grateful "shout out" to SPA member Jane Sachs who first brought this to our attention). After much consultation with Jane and others in the Maryland Psychological Association, it appears that the threat has died down, at least temporarily, as legislators appear willing to hear reasonable proposals for which kinds of assessment instruments would require specialized training and would thus be beyond the scope of a counselor's license. We next heard about a similar bill being introduced in the state of Indiana (again, through the watchfulness of Jane Sachs), but in this instance it appeared that there was an immediate deadline. In order to combat this threat, I produced a draft of an "amicus" statement to the legislature on behalf of SPA, documenting our view of what would constitute appropriate education and training in psychological assessment. This was circulated as widely as possible, given the time constraints. In addition, we contacted all SPA members in Indiana with information about the pending legislation and a request that they contact their legislators immediately. A heartfelt "thank you" to all of you who were able to do so. We were informed that the bill that is now being considered by the legislature in Indiana will protect the public from untrained practitioners using assessment instruments and is apparently in line with the recommendations we have endorsed. What this series of "crises" has pointed out, however, is the importance of SPA updating our recommendations on training and having a position paper on the minimal standards for competence in assessment. Accordingly, the Board has appointed a task force to prepare such a document that can be used in circumstances such as these.

We are also in the process of preparing another "white paper," this time on the impact of the HIPAA Security Rule (which officially went into effect on April 20th) on the practice of assessment. In addition to outlining the potential problems that the new rule poses for assessors, we will propose recommendations to psychologists on how best to cope with the new regulations in order to protect the privacy of our patients and the integrity of assessment instruments.

Meanwhile, various attacks on assessment continue to appear in the lay press. We have been discussing ways in which we may counter these, although it is, admittedly, an uphill battle. (The press is always more interested in debunking than in articles that support something). Toward that end, I have been consulting with several individuals in the field of journalism, and hope that we may be able to develop a plan for dealing with the media in a more effective manner.

As always, I invite you all to be a part of our efforts to advocate for personality assessment. Talk up SPA whenever and wherever you get a chance. When you encounter problems (e.g., with 3rd party payers) inform the Central Office and let's see if we can get some action going. With your participation, we can ensure that our field remains healthy and vibrant.

Computer Scoring and Interpretation in Psychological Report Writing

Roger L. Greene[1]
Pacific Graduate School of Psychology

I would like to suggest that computer scoring and computer interpretation of all psychological assessment techniques should become the basis for the psychological report. In essence, I want to advocate that psychological assessment should become a computer-based field to decrease the reliance on hand scoring of psychological assessment techniques and the clinical interpretation of these same techniques in the process of creating the psychological report. In this computer era, it makes little sense for psychological assessment techniques to be scored by hand and then interpreted clinically. It does not seem too controversial to argue for computer scoring for psychological assessment techniques, but it is estimated that from one-half to two-thirds of MMPI-2s are hand scored. Hand scoring is not cost effective given the amount of time it takes to score even the basic validity and clinical scales and content scales, and hand scoring is very prone to errors. In addition, most individuals, who hand score the MMPI-2, are not going to score all of the possible 150+ scales and subscales at a potential loss of valuable information for the interpretive process. The most likely scales not to be hand scored are the Variable Response Inconsistency (*VRIN*) and True Response Inconsistency (*TRIN*) scales because of the complexity of the scoring process, yet *VRIN* is invaluable in determining whether the person has endorsed the items consistently. Most clinicians, who hand score the MMPI-2 and who purchased their scoring templates some time ago, are not going to purchase a new set of templates for the Supplementary scales so that they can score the Infrequency Psychopathology (*F*(*p*)) scale. *F*(*p*) is another scale that is invaluable in assessing the validity of this administration of the MMPI-2. It also should be required that the data entry for computer scoring be verified to eliminate errors. Computer scoring of the MMPI-2 without verification is prone to the same errors that are found in hand scoring except that errors of data entry can result in the raw scores being either higher or lower than they are supposed to be because the erroneous entry can produce either a "deviant" or "non-deviant" response to that specific item. Hand scoring of the MMPI-2 almost always results in lower raw scores because deviant responses are being summed and it is easy to miss one or two items.

Once the data have been computer scored, the next step in creating a psychological report would be to have the psychological technique interpreted by computer. This computer interpretation then would become one of the basic building blocks of the psychological report. The clinician's task would be to integrate the computer interpretation of the various psychological techniques that were administered along with the clinical history and interview into the final report. There should be several rules in the implementation of this process. First, it would be expected that the clinician would modify and adapt the computer interpretation to correct any inaccuracies that might be contained therein. The computer interpretation would never be a stand alone product that is accepted as is, but regarded as an electronic assistant who quickly provides the basic interpretation of any psychological technique. Rather than the clinician looking up the basic interpretation from the standard references on the various psychological techniques and then entering that information into the word processor, the electronic assistant would provide this information. Second, any modification made of the computer interpretation would require the clinician to be able to point out explicitly the information that contradicts the computer interpretation. That is, clinicians cannot use their clinical judgment to override a statement simply because they do not like it or are sure that it cannot be correct. Meehl (1957) reminded us that we are to use our heads infrequently in this type of task. Third, the routine use of computerized interpretations will facilitate the clinician's familiarity with and use of them in more complex cases. If computerized interpretations are only used in complex cases, the clinician loses the learning experience of the process of working with computerized interpretations in more straightforward cases where potential problems can seen more easily. Finally, it must be remembered that every statement in a computerized interpretation is a hypothesis that must be validated by additional information.

Reference

Meehl, P. E. (1957). When shall we use our heads instead of the formula? *Journal of Counseling Psychology, 4*, 268-273.

[1]*I am the author of a computerized interpretive system for the MMPI-2 that obviously reflects a conflict of interest for the opinions reported herein.*

Congratulations to newly elected SPA Fellows

John S. Auerbach, PhD

David L. Streiner, PhD

Special Topics in Assessment

The Joy of Writing Psychological Assessment Reports

Alan Schwartz, PsyD
Section Associate Editor

If one were to pose the question, "What aspect of your work as an assessment psychologist do you enjoy the most?" to a meeting of professionals, one would likely generate a wide and varied sample. This question often results in our colleagues waxing metaphorical: the enjoyment of solving the mystery, the process of putting together the puzzle and the thrill of the detective on the trail punctuate these responses. However, when posed with the question, "What aspect of your work do you enjoy the least?", suddenly our once creative meta-thinkers become consistent and concrete in their answers: report writing. The construction and production of psychological assessment reports (note the verbs connoting onerous physical labor) is frequently the single most time-intensive aspect of a psychological assessment, requiring more time than actually sitting face to face with one's client. While many of us may dread the hours behind the computer searching for words to best capture the many forms of data we have collected in the course of an assessment, we also recognize the importance of our task. The final report not only serves as a symbol of our work with the client, but provides a permanent product of the assessment process—like a psychological snapshot—that can be referred to months, years and even decades into the future. I am fond of saying that the difficulty of the report writing process is justified, given the nature of capturing such important information about an individual.

In talking to colleagues about report writing, one of the fascinating aspects which emerges is how different each clinicians process is in approaching, conceptualizing, and committing their ideas to paper, not to mention the variations in the final products. This section of Special Topics in Assessment will explore how several noted assessment professionals approach the process of report writing. In the first article by Roger Greene, he proposes a provocative idea, suggesting a greater reliance on computer scoring and interpretation for psychological assessment reports. The second article by James Kleiger provides a window into the universal struggle of organizing and drawing the essence of the person out of the voluminous testing data. The final article by Ron Ganellen discusses how experiences around feedback contributed to him shifting the manner in which he structured and composes his assessment reports. These are three unique perspectives on the joy and the arduous process of writing reports.

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How I Work: Confessions of an Assessment Junkie

Jim Kleiger, PsyD, ABPP
Private Practice, Bethesda Maryland

As I contemplated the request to write a brief article about how I approach the testing process, I thought that, like many of my colleagues, I probably have a great deal of ambivalence about assessment. My ambivalence is both general and specific to each individual case I encounter. In general, testing is an enormously labor-intensive and time-consuming venture. If done properly, the time it takes to administer a sufficient variety of instruments, score multiple protocols, make inferences, write well thought out—versus boiler plate—reports takes so much time and energy that many of us decide that it is not practical to continue with this. On the other hand, I can think of no other professional activity as intellectually interesting and challenging. Like a good detective novel, the process of piecing together the clues, puzzling over the data that fit with my initial inferences, and struggling with those that do not, is inherently pleasurable. For some of us, pattern analysis in extremely satisfying, for others, finding linkages from empirically supported test inferences to aspects of theory provides a sense of mastery.

Regarding each person I test, I have noticed a predictable pattern that begins with a sense of eager anticipation when I start to work with the individual. Like the feeling I get early in the morning, as the day is filled with a sense of hope, I start with each new person with a sense of budding optimism and nascent discovery. I anticipate the satisfaction of encountering coherence in the data. Interesting relational patterns will appear in graphic and compelling forms; fascinating examples of disordered thinking will emerge; and clear-cut patterns of cognitive difficulties will announce themselves to me.

Unfortunately, this myth fades quickly. By the time I have finished gathering the data, the early morning hope has grown faint, replaced by a late afternoon sense of futility. Feeling slightly overwhelmed by the proliferation of data, the swirling of complex, often contradictory pieces of information, I begin to feel worried that I will be unable to find the person in the morass of standard scores, profiles, ratios, sequence of responses, printouts, pages of verbalizations, not to mention school records and copies of previous reports, in the cases of psychoeducational evaluations. The person's folder grows thicker, and I begin to question why I continue to choose to do this kind of work. I wonder, where are the so-called "pure culture" cases? The answer, of course, is that they are the ones that do not need to be referred for testing in the first place.

The task then becomes one of sitting with the uncertainty and ambiguity. Like looking at the inkblots, themselves, and trying to sift through the complexity and find meaning, it is necessary to tolerate the haze of confusion and indefinable nature of the initial collection of data. Sometimes, taking a break of a day or two proves useful before digging into the work of scoring the protocols, making inferences, and writing the report.

I always spend a great deal of time with the Rorschach. Beginning with a careful review of the Structural Summary and Sequence of Responses, I then ascertain where the minus responses and Special Scores seem to cluster. How does the individual's ego functioning hold up on cards where there is color or on responses that use color? What happens to the patient's functioning on cards that pull for human content or interaction, as well as on those responses in which the individual uses human movement or human content? A sequence analysis follows, with attention to patterns of relational paradigms and shifts in the patient's functioning in the context of certain affects, conflicts, or relational themes. I try to do a similar analysis of the thematic quality of the TAT, looking both at the formal qualities of the narrative, as well as the way in which the patient typically represents affect and human interactions. Finally, I am curious whether the patient is able to take distance from his/her stories and reflect upon what they might mean. This may provide some clues about the potential for reflective space and self-observing capacities.

The use of an inference map has always helped impose order, structure, and meaning on the data. I remember Stephen Applebaum at Menninger asking "How the heck are you going to keep track of all this stuff without having some way of organizing it on paper?" So, on a single page, I make headings like Management of Affect, Thought Processes and Reality Testing; Experience of Self and Other; mapping of data relating to the patient's symptoms, ego functioning, cognitive, and characterological issues under the various headings and subheadings. Likewise, aspects of self experience and internalized relational paradigms and themes can be clustered and organized. I go from the data to the inference map and back to the data. It is from the inference map that

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Reflections on Writing Meaningful, Readable Reports

Ronald J. Ganellen, PhD, ABPP
Department of Psychiatry and Behavioral Sciences, Northwestern University Medical School

Several years ago, a woman I'd evaluated contacted me and asked to meet to go over the results of the evaluation. I assumed the colleague who referred this woman had summarized the results when she met with her patient after receiving the report and, since we'd had no contact since, also assumed the feedback session she'd conducted had gone well. I scheduled the appointment with some trepidation when I recalled the test findings highlighted this woman's anger, sensitivity to feeling misunderstood and slighted, and readiness to criticize, blame, and attack others as a means of protecting herself from feeling belittled and humiliated.

On the day of the appointment I rehearsed what I intended to say when I met with the patient, reminded myself to maintain empathy for her struggles, took a deep breath before opening the door, and invited her to come into my office. My heart sank when I saw her perch on the edge of the couch, reach into her purse, and pull out a copy of the report I'd written. The level of tension and apprehension I experienced exceeded 9.0 on the Richter scale when I noticed comments and question marks scrawled in red ink in the margins of the report. I'd assumed my colleague had given her verbal feedback, but never anticipated she would hand the woman a copy of the report, which I viewed as a communication between two professionals, not cannon fodder to be aimed at me.

Around this time I also realized that requests for psychological evaluations were coming not only from mental health professionals, but more and more frequently from people who had little or no background in psychology, including internists, neurologists, lawyers, and employers. This realization, as well as the experience described above, prompted me to think about how to write reports that would be read and understood by mental health professionals, colleagues from other disciplines, and patients, as well as have practical applications. In addition to making an effort to explain concepts understood by therapists (e.g., reaction formation or projective identification) using down to earth language and to avoid using professional jargon as much as possible, I also decided to structure the body of reports differently than I had previously.

Engaging the Reader. I now assume that every report I write will be read by the patient. With this in mind, when describing test findings, I try to start with a data point I think will be easily accepted by the person who was evaluated, a finding that is experience near and that is unlikely to provoke defensiveness. For instance, for a person who has elevations on MMPI-2 Scale 2, DEP content, a Rorschach D Score of -1.0, C′ 4, and Y = 5, I might start by saying, "Mr. X is currently experiencing considerable emotional distress. He is bothered by a sense of unhappiness, tension, and sadness and is dissatisfied with his current life situation." My intent is to begin writing the report to capture a salient element about the person, a characteristic that will promote a sense of recognition and understanding that encourages a patient or other reader to be interested in reading on with an attitude of openness and curiosity and, as much as possible, decrease their skepticism and defuse their need to be defensively dismiss, devalue, or reject the report. In other words, my goal in the early part of a report is to create a "good-enough holding environment" which facilitates the reader's openness to hear what is said and to consider findings presented later in the report that may be unfamiliar, threatening, or which challenge established views of the patient and their world.

As another example, for a person who obtains a low score on the MMPI-2 Social Introversion scale (Scale 0=45), I might start out by saying, "Mr. P is a friendly, outgoing, self-confident man. He is comfortable in social settings, finds it easy to talk with people, and enjoys being with other people." I'm likely to say this even if the referral question has nothing to do with Mr. P's social skills because I'm confident Mr. P (or someone who has known him for any length of time, such as his internist) would be nodding his head and saying "that fits" by the time he finished reading those two sentences. The goal of engaging the reader by describing features of a person they know affects how I organize writing the body of reports. I do not write reports using a fixed structure, with a section for affect, self-perception, thought processes, etc. or a section for each of the tests administered. Instead, I usually start with findings that are experience near and then go on to describe other salient findings and themes that may be less apparent, less accessible to the patient's conscious awareness, or that may challenge their self-image or understanding of their current life situation. As a result, I invariably organize findings from an MMPI-2 two-point codetype differently than the description contained in standard MMPI-2 references or cookbooks and deviate from the sequence suggested by Rorschach Structural Summary key variables if I believe that by doing so readers will start the body of the report with a sense of recognition.

Contending with Negative Biases. I also feel strongly that because standard psychological tests were developed with the intent of detecting different dimensions of psychopathology and identifying problems with coping, behavior, thinking, or emotions, there is potentially a bias for assessment psychologists to paint a negative picture of a person. I try to counterbalance this by trying to identify and describe the adaptive, positive implications of test findings, not only the problematic, negative implications of the data. This is not a novel idea. Schafer (1982), for instance, eloquently discussed similar issues when describing the attitudes therapists should ideally strive for in empathizing with and responding to patients. From a different vantage point, Caldwell (2001) recently presented an innovative conceptualization of the MMPI-2 which incorporates an appreciation of the struggles, conflicts, and efforts to cope he hypothesized are associated with each clinical scale.

For instance, one characteristic of individuals who produce a 27/72 MMPI-2 codetype is a tendency to have strong needs for achievement and to be perfectionistic and self-critical. I may describe the positive and negatives aspects of these characteristics as follows: "Ms. F is the kind of person who takes responsibilities seriously. She expects a lot of herself and of other people, is invested in making sure things are done the right way, and has high standards of performance. On the one hand, these characteristics can be positive as they provide motivation for Ms. F to try to be dependable and conscientious and to work hard, if not be driven to succeed. On the other hand, Ms. F is likely to be dissatisfied with herself and her achievements as she becomes quite impatient when she doesn't meet goals and has little tolerance when she falls short of the standards she's set for herself. She also has a tendency to question herself and to evaluate herself and others in a negative, critical manner."

Another example. I recently evaluated a college student who began treatment because he was having difficulty settling into college life and reported having trouble connecting with people he met. This man produced two Reflection responses and an Egocentricity Index of .33 on the Rorschach. In an effort to present the upside and downside of these findings, I said (taking into account other test findings) something like, "One important feature of Mr. G's psychological functioning involves the efforts he exerts to maintain his self-image. He often gives the impression he is self-assured and self-confident as means of compensating for underlying self-doubts, question about his worth, and feelings of inferiority. There is the possibility this could rub some people the wrong way if they see Mr. G as being arrogant, cocky, or self-centered."

What I hope these brief examples convey is that while remaining true to the interpretations of significant variables in the Structural Summary or descriptions of MMPI-2 codetypes, I attempt to go beyond the statements in standard assessment references.

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Assessment Supervision: Covering all the Bases

Virginia Brabender, PhD
Widener University

Good assessment supervision requires a commodity of which few of us are in possession: time. Yet, when we undertake the responsibility of supervising a case, we have an ethical and legal responsibility to supervise well. In my travels, I have discovered that there are several areas in which corners are routinely and disturbingly cut. Some of these gaps are due not to supervisory neglect but rather to systems that do not allow for continuous involvement on the part of the supervisor or sufficient time for supervision.

In some settings in which a very rapid turnaround time must characterize the assessment, supervisors are brought into the process after the student has begun the case. Such an arrangement deprives the supervisor of the opportunity to assist the student in the clarification of the referral question and even, in some cases, to provide input into the creation of a battery of instruments. As such, students are denied mentoring in how to forge that initial alliance with the person and how to create a framework in which the assessment is likely to be maximally beneficial to the client.

Supervisors assume that students know how to score or code responses. The premise is that an activity as rudimentary as scoring must have been addressed adequately by the doctoral program. Unfortunately, doctoral programs assume that scoring will be mastered through supervised field experiences. Classroom experiences are never adequate to produce competency in a task so complicated and demanding as coding Rorschach responses. Not unusually, a student will present for supervision and the supervisor will ask, "Did you have any coding problems on the Rorschach? Are there any responses you feel we need to go over?" Such an approach fails to recognize that the most pernicious mistakes are those of which the student has not a shard of awareness. These misconceptions are carried from assessment to assessment and in fact, can last the duration of the student's career in assessment. Where scoring is concerned, the notion that "students don't know what they don't know" applies. Unless the student has had extensive supervised experienced, the supervisor should proceed through the protocol response by response. The pedagogical yield is tremendous: once the student corrects a misconception, usually, it is corrected forever. Also, such assiduousness enables the supervisor to address administrative problems—for example, insufficient queries on TAT stories or responses to client questions during the Rorschach administration that are too directive.

In supervision, often, the lion share of the time is devoted to developing the description of the client's personality and psychopathology. Although this effort is a crucial one, other components of the assessment are also important. Not uncommonly, short shrift is made of using the assessment data to develop treatment recommendations. Part of the reason for the relatively superficial consideration of recommendations is simply lack of supervisory time. However, another reason is that we may simply lack good models for drawing treatment recommendations from personality data. Dialogue among assessors as to what types of recommendations can most defensibly be made given available data would aid both the supervisee and supervisor in developing a recommendations section that is as rich, detailed, and empirically grounded as the description of personality functioning. For example, fairly robust data exist to help assessors determine what types of therapeutic goals can be accomplished over a fairly short interval (e.g., lessening of dysphoria) and what categories of goals typically require long-term treatment (e.g., diminishing of thought pathology). From the supervision, the supervisee should obtain not only the content of the recommendations but also a method for writing the recommendations section.

The feedback process is also a part of the assessment that often receives too little attention. Supervisees benefit from assistance in seeing how the assessment findings themselves might enable the assessor to make a clinically-informed decision concerning such matters as the number of feedback sessions and the way of structuring the presentation of different types of information. The supervisor and supervisee together can develop metaphors drawn from the client's own narratives, the use of which will render the content of the feedback compelling. The supervisee would leave the supervision with a feedback plan that is at once clear and flexible, allowing for emerging reactions of the client during the feedback process (Finn, 1996).

To what extent does the assessment supervisor model the kind of openness and respectfulness that he or she would like to see the supervisee exhibit with the client? Does the supervisor build in the supervisee's feedback to the supervisor as a regular part of their interaction?

All of these areas, when covered thoroughly, could make for an inordinately long supervisory time. Supervisors may not be accorded the time within a given healthcare system to deliver what this article requests. For example, Clemence and Handler (2001) found that internship supervisors spend on the average 1.67 hours of assessment supervision a week. With interns averaging almost 27 assessments over the course of a year (according to these same authors), this does now allow for a generous allotment of supervision for any one assessment. To provide training that is comprehensive but also manageable, the supervisor might craft a plan that unfolds over time and across a series of assessments. Each supervision could address all of the areas identified above but in each case, identify a particular area of the assessment for intensive exploration. Perhaps for one assessment, coding of responses would be in the spotlight even while all other areas are addressed; for another assessment, the formulation of recommendations could receive intensive attention. By covering all bases, the supervisor would not only effect the skill enhancement of the supervisee in a variety of ways. The supervisor would also be contributing to the cultivation of an attitude on the part of the supervisee that no aspect of psychological assessment is incidental; all parts of the process are important.

References

Clemence, A. J. & Handler, L. (2001). Psychological assessment on internship: A survey of training directors and their expectations of students. *Journal of Personality Assessment, 76 (1),* 18-47.

Finn, S. (1996). Using the MMPI as a therapeutic intervention. Minneapolis: University of Minnesota Press.

George Stricker, recipient of the Bruno Klopfer Award

2006 SPA Annual Meeting - Hyatt Regency Islandia Hotel, San Diego, CA

SPA Personals

John S. Auerbach, PhD, was elected a Fellow of SPA. He shares some personal information with us.

"John S. Auerbach, PhD, is a Staff Psychologist and the Coordinator of the Post-traumatic Stress Program at the James H. Quillen Veteran's Affairs Medical Center in Mountain Home, Tennessee. John graduated magna cum laude from Brown University with an A.B. in psychology (honors) and history. He received his MA and PhD in clinical psychology from the State University of New York at Buffalo. He is Professor of Psychiatry and Behavioral Sciences in the James H. Quillen College of Medicine at East Tennessee State University and a Research Affiliate in Psychiatry at the Yale University School of Medicine. He is also in private practice in Johnson City, Tennessee. He is an honorary member of the American Psychoanalytic Association and he serves on the editorial board of Psychoanalytic Psychology. With Kenneth Levy and Carrie Schaffer, he is coeditor of *Relatedness, Self-Definition, and Mental Representation: Essays in Honor of Sidney J. Blatt*, published by Routledge in 2005. In addition to posttraumatic stress disorder, his interests include projective testing, borderline disorders, narcissism, attachment theory, and the relationships among intersubjectivity, representational processes, and the development of the self."

Bob Craig, PhD, ABPP, has published his third book on the MCMI. Titled, "New Directions in Interpreting the Millon Clinical Multiaxial Inventory." It is an edited volume that addresses many new developments with the MCMI-III including the new content scales and new personality disorder subscales that will soon be available via computer scoring. It is available through Wiley. Bob also recently published "Personality Guided Forensic Psychology through APA as well as a second edition of his edited book "Clinical and Diagnostic Interviewing" published by Rowman and Littlefield (Aronson). Bob is nearing completion on his test for personality disorders using adjectives—called the Personality Disorder Adjective Checklist. As they say, "more will be revealed." Anyone wishing more information on this test can contact him at rjcraig41@comcast.net.

John M. Haroian, PhD, was awarded the first-ever, Washington State Department of Corrections, "Health Services Provider of the Year" Award. He was acknowledged for his innovative leadership, work with students, and service delivery to inmates at the Washington Corrections Center for Women (WCCW). John is the Supervising Psychologist for WCCW's General Population Mental Health Clinic. He has been at WCCW for two years. Along with Dr. Iris Rucker, who works at the Washington Correction Center, John is one of the few DOC psychologists who routinely uses and advocates the use of the Rorschach when doing risk assessment on inmates in Washington State.

Jennifer Imming, PhD, has been writing a couples' column for the Medical Alliance Association newsletter, "Vital Signs."

Alexander C. Kristevski, PsyD, was recently granted the FICPPM, Board Certified, Diplomate Master Fellow {450 HOURS rained} in Advanced Psychopharmacology & Related Sciences. Board Certification was issued by the International College of Prescribing Psychologists and the Prescribing Psychologists' Register {ICPP/PPR}. In addition, he passed the First Proctored National Written Examination in Psychopharmacology and Related Sciences {VERITAS Exam} in New York City on September 18th 1999. Dr. Kristevski is also Board Certified—Registered as a Medical Psychologist {M.P.}, by the Academy of Medical Psychology/ American Board of Medical Psychology. He is currently employed as a VA staff Clinical Psychologist.

Robert E. McCarthy, PhD, continues to serve on the Executive Advisory Board of the American Psychotherapy Association, and he was recently named a Master Therapist by the American Psychotherapy Association and appointed Chairperson of the Insurance Committee for the International Society of Neuronal Regulation, or ISNR. ISNR is perhaps the largest body of healthcare professionals in the world utilizing neurofeedback with their patients.

Michael P. Quirk, PhD, has successfully completed the ABPP examination in Organizational and Business Consulting Psychology. Mike has two diplomates; his other diplomate is in Clinical Psychology. He continues to be the director for the Behavioral Health Department at Group Health Cooperative of Puget Sound. Mike is also the chair and facilitator for the organization's Ethics Advisory Committee, where senior leaders and executive board members consider the values implicating of adapting to current, new, and anticipated changes in the healthcare industry.

David Streiner, PhD, was recently elected a Fellow of SPA. He shares some personal information with us.

"After graduating from Syracuse University in 1968, I took a job at a brand-new Faculty of Health Sciences at McMaster University in Hamilton, Ontario. Having taken the requisite two courses and statistics and one in measurement theory, I knew more about quantitative methods than 99% of the faculty at that time, and was branded the 'statistics maven'. This required me to teach statistics and measurement to others, meaning that I to struggle to keep up with my reputation and teach it to myself first. Perhaps because this didn't come naturally to me, I had to find ways of making these topics understandable and interesting for people who had little background and often even less interest. Finding the existing textbooks either inappropriate for the students, or—even worse—too dull and humorless, my colleague Geoff Norman and I wrote our own. To date, we have written four books, which have been quite successful. I also continue to write a series of articles, now numbering 25 or so, explaining statistics in non-technical terms for people with photonumerophobia-a dreaded disease discovered by Geoff and me, describing people with fear that their fear of numbers will come to light. And more advanced level, I co-edit the Statistical Developments and Applications section of the Journal of Personality Assessment."

Serge Sultan, PhD, who was formerly Assistant Professor at the University of Burgundy (France) has been appointed Associate Professor at the University of Paris-Rene' Descartes (France). His new email address is serge.sultan@univ-paris5.fr

Carolyn Williams, PhD, has relocated her practice and is now in Las Cruces, New Mexico. She is conducting a variety of assessments there, including forensic competency to stand trial, sanity, and sex offender evaluations. She also provides personality and cognitive testing for all ages. She can be contacted at 1990 E. Lohman, Las Cruces, New Mexico, 88001.

Jed Yalof, PsyD, ABPP, ABSNP was awarded the Lindback Distinguished Teaching Award by Immaculata University.

Greg Meyer (R) with Martin Mayman Award recipients Jim Allen (L) and Dick Dana (M)

Reflections on...Readable Reports

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Rather than "cutting and pasting" and leaving it at that, I use the descriptions in assessment texts as a foundation to build on. In particular, while writing each report, I try to challenge myself to expand on material from assessment references to point out the costs and benefits associated with different coping styles while conveying empathy for the individual's strengths, limitations, conflicts, and desire for growth.

References

Caldwell, A. (2001). What do MMPI scales fundamentally measure? Some hypotheses. *Journal of Personality Assessment*, 76, 1-17.

Schafer, R. (1982). *The analytic attitude*. Basic Books, New York.

How I work

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the structure of my report begins to take form. I will include separate sections on each of the headings from the inference map in my report.

I notice that the data inhabits my mind, sometimes for several days, before I actually sit down to write my report. Consciously, and no doubt preconsciously, the data percolates while I am driving, working out, or cooking. In spare moments, I may review, churn, and turn the data and emerging patterns in my mind. On occasion, consultation with respected colleagues has been of invaluable assistance.

I both enjoy and hate the process of writing reports. The source is my aversion is obvious: Writing is tremendously time-consuming; and there are always other things I would rather be doing. Nevertheless, I take some pleasure in finding ways to craft a report that others can read and find interesting and convincing. Most challenging and rewarding is finding words to capture something unique about this individual in ways that are easy to understand. Knowing that the patient (if he/she is an adult) or the parents will be reading the report forces me to take the time to use language and concepts that the readers will understand. I do not shy away from using actual responses from the testing when I feel that it is appropriate. The caveat is that whatever response from the Rorschach or snippet of a TAT story I choose, it must be compelling and unequivocal in the symbolic meaning it conveys. Using test responses that are less convincing or ambiguous to the reader detract from the effectiveness of the report.

I include a summary of salient issues towards the front of the report. I divide this section into issues pertaining to cognitive processing; academic proficiency; and psychological and emotional functioning. When appropriate I will include diagnostic nomenclature in a brief section that follows.

I compose my drafts on the computer, editing as I write. Word processing simplifies what used to be an even more arduous process. Because I do a lot of psychoeducational testing, I routinely include tables of data, with ample additional information to assist the reader in understanding the scores. I take care in trying to help the reader understand what the tests are for and what the various scores mean. The tables also serve a useful function in helping me organize, cluster, and collate the data so that patterns of strengths and weaknesses are more clearly evident.

The Treatment Implications section of the report addresses what issues are most likely to emerge in therapy and what kind and intensity of treatment may be indicated. I do not hesitate to raise questions about medications issues when the data indicate that a consultation or review of medications may be helpful. Finally school-related issues are always a focus with children and adolescents referred with a range of learning disorders. Discussion here includes general issues pertaining to learning setting and need for supports, as well as more specific suggestions for classroom accommodations when indicated.

So, that does it. This is a partial window into my internal experience of testing and certain aspects of how I work with the data. Of course, it is incomplete and does not capture how my experience or way of working may vary from case to case. In general, however, it reflects what I find both so fascinating, and yet so difficult about testing. In balance, the satisfaction and benefits seem to outweigh the masochism and suffering, ensuring that, like any long-term committed relationship, my ambivalence attachment to testing will continue to be part of my day-to-day professional experience for some years to come.

General Information

SPA General Information: Please remember to let the SPA Central Office know of any changes in contact information, including mailing address, and phone numbers/fax numbers/e-mail addresses.

Call for Workshops: Please note that in an effort to confirm the workshops that will be offered before and after our 2006 SPA annual meeting, SPA has sent out its Call for Papers in the Spring (April) Mailing. Look for this change in format and submit your abstracts online or via mail or fax no later than July 1, 2005.

Dissertation Award Applications: The Society for Personality Assessment (SPA) will be making awards out to $500.00 to support dissertation research in the area of personality assessment. The student's dissertation must have been approved by her/his committee before applying for the award; the student must be a Student Affiliate of SPA, or may apply for Student Affiliate at the time of the Dissertation Award application; and the proposal must be sponsored by a member of SPA. It is expected that the student will present the results of the dissertation at a forthcoming annual meeting of SPA. Deadline for applications: August 30, 2005. Award will be made by: September 30, 2005. For further information and application please see our web page: www.personality.org.

Mary Cerney Award: The Society for Personality Assessment is now excepting manuscripts for the annual Mary Cerney award, given to the best student paper (a paper generated sometime over the past year) dealing with some aspect of personality assessment. The paper could be based on either quantitative or qualitative research, or could be theoretical in focus. Research studies should be well-designed and the format should preferably be APA journal article style. Deadline for submissions: July 1, 2005. For further information, please see our web page: **www.personality.org**.

Dues: Deadline for dues payment: **December 31 of each year** for the upcoming year. Late charges will be assessed as follows: Dues paid between January 1 February 28 will be $105 ($15 late fee), and you will receive your backorder journals for the year. Dues paid March 1 or after will be $105 ($15 late fee), and you will have online access to all of the journals; if you wish to paper copy of the backorder journals you have missed, each backorder issue will be $15 to cover the administrative costs. You must contact the SPA office with this request. If you fail to pay a late fee after December 31, you will not receive any backorder journals.

SPA Personals: Members who wish to post in the Personal section of the Exchange can access, complete, and submit the form online at **www.personality.org**. Please submit information, including your degree, to the SPA Exchange Editor by November 15 (for winter issue) and April 15 (for summer issue). Please also include your preferred email address along with your submission.

2006 Annual Meeting: The SPA annual meeting is March 22-26, 2006 and will be held at the Hyatt Regency Islandia Hotel, a unique find among San Diego hotels. Picture a resort-like landscape setting in the heart of Mission Bay Park, offering panoramic views of the marina and the Pacific Ocean. Of Mission Bay hotels, ours is closest to Sea World, where you can grab some fun in the sun with your ocean-dwelling friends. Hyatt Regency Islandia is 8 miles from the San Diego Convention Center and San Diego's central business district. San Diego is known for its near-idyllic climate, 70 miles of pristine beaches in dazzling array of world-class family attractions, including the world-famous San Diego Zoo and Wild Animal Park, Sea World San Diego and Legoland California. San Diego offers a wide variety of things to see and do, appealing to guests from around the world. For all attendees, the conference offers: CE workshops, CE scientific sessions, paper sessions, symposia, case discussions, and open consultations with experts. For students, the conference offers: reduced fees, volunteer opportunities, the workshops for volunteers, free student luncheon, and an opportunity to see and hear your favorite textbook authors.

Silvan S. Tomkins

Bertram P. Karon, PhD
Michigan State University

Silvan Tomkins was the only faculty member in Psychology at Princeton that all the graduate students called by his first name.

Silvan loved ideas and hated status differentials. According to Harold Schiffman, Silvan intentionally picked an argument with each graduate student early on. Superiors and inferiors do not argue. Once a graduate student has had an argument with you, Silvan told him, they deal with your and their ideas on their merits. Harold's own dissertation was a mathematical model of how people magnify the meaning of a communication depending on the status of the other person and how much they like the other person. On reading the proposal, Silvan said, "I don't like it." Taken aback, Harold said, "You don't like the proposal?"

"No, the proposal is fine. I don't like the fact that people do this."

Silvan was liberating. I was going to do a dissertation on his theory. In the course of our discussions, he described the national Gallup sample that he and Jack Miner had administered the Tomkins-Horn Picture Arrangement Test. He remarked casually that someone could use that data to study the effects of segregation. The next day when I saw him to continue our discussion of his theory, I said, "You know, that idea of studying segregation is interesting."

He said, "Does that interest you more than working on my theory?"

Embarrassed and not wanting to annoy him, I hesitatingly stammered, "Well, yes."

"Then for God's sakes, do it." And he helped me get a grant to properly study segregation instead of working on his theory. I remind myself of this whenever I think of all the faculty who cannibalize their students' work.

After not seeing him for several years, I saw him at an American Psychological Association meeting. I waited until he finished talking to someone else. When he turned to me, his first words were, "I've been thinking, Bert, the reason we have so much trouble developing an adequate theory of personality is ..." as if we were just continuing an ongoing conversation.

When interviewed for a fellowship in Psychometrics at Princeton, I told them honestly, "I am not really interesting in Psychometrics, I am interested in studying the human Personality. But most people who are any good at studying Personality have trouble with mathematics. I don't. There might be useful quantitative tools, and it might be useful to have someone studying Personality who knew about them." I don't think they believed me, because they gave me the fellowship, but they said, "All we have in Personality is Silvan Tomkins. Would you like to meet him?" People at Harvard had a high opinion of Silvan, so of course I said yes.

I was doing an undergraduate honors thesis with Gordon Allport on earliest childhood memories.

Many early memories sounded like Freudian dreams. A friend said, "Why don't you interpret them?", so laughingly, I did, making use of Freudian symbols. These blind clinical predictions turned out to be the most statistically significant findings in the study. As an undergraduate in 1952 that seemed embarrassing, but as an empiricist I had to report it. Even in my final draft there were three pages of apology for taking Freudian symbols seriously. When I mentioned this to Silvan, he said, "Of course, people react to the symbols," and then told me about published research and published clinical studies that no one at Harvard had mentioned. He also told me about work of members of the Murray group that they had published and about work of members of the Murray group that they had not published. Earlier I had discussed childhood memories with Gordon Allport, Henry Murray, Daniel Levinson, and Walter Tomans. Silvan spent over an hour with me, and I learned more than I did from all the others put together.

When I left that interview I decided that if that's all they had, that's all they needed, and decided to go there. It was the soundest decisions I ever made.

Silvan Tomkins was not always appreciated for being bright. He was kicked out of graduate school in Psychology at the University of Pennsylvania for having interests not suitable to a psychologist. His crime was that he wanted to study values. The apocryphal story told by graduate students at the University of Pennsylvania was that the chairman said that he would see that Tomkins not only did not get a PhD from Penn but would not get a PhD in Psychology from any American University

When he was kicked out of Psychology, he switched to Philosophy, doing a dissertation on values. In the course of that dissertation, he read a new book, *Explorations in Personality* by Henry Murray (Murray et al, 1938) and his co-workers at Harvard. He wrote to them, and both Henry Murray and Robert White wrote to him, saying you are just exactly the kind of person we need in Psychology, and inviting him to join their group at Harvard. That is how he re-entered Psychology.

The happy ending was that Penn many years later tried to hire Silvan as a full Professor of Psychology. The same man was still Chairman, and Silvan insisted on two conditions—his salary had to be higher than the chairman's and the chairman could have no administrative control over him. The administration considered his requests seriously, told him they would meet the first, but could not really meet the second. The fact that they seriously considered his requests must have sent a wonderful message to the chairman. Silvan turned Penn down.

I have been told there was a 15 year period during which he read every journal in the field—which for him meant every journal in Psychology, Psychiatry, and Psychoanalysis. I must admit I was relieved when he told me he was not doing that any more, because there were now so many journals that it was impossible, even for him. But there is a story about Silvan's omnivorous reading. He told me he had suffered from a severe reading block. Whenever he read a book, he would have to hold a handkerchief because the sweat would pour off his face. Despite this, he got through college, went to graduate school, was kicked out of Psychology, switched to Philosophy, where they really require people to read, and finished a Ph.D. When he went to Harvard, he went into psychoanalysis 6 days per week for 8 years.

In his analysis he lost his reading block. My guess is that he went on a reading binge for the rest of his life. Having done so much reading the painful way, it must have been exhilarating to find, "My God, you can just pick up a book and read it!"

It would be a mistake to think that his problems with the powers that be in Psychology Departments ended with graduate school. At Harvard he was told to take a year, write a book, and they would give him tenure. Or, if he did not want to do that, to take a year, write a series of articles and they would give him tenure. But he did not approve of the publish or perish principle, and insisted that he would publish when he was ready to publish. That is why he left Harvard and went to Princeton. He said he felt it was a moral issue at the time. Many years later he said he wasn't sure he would make the same choice again.

A psychologist whose field was the physiology of the inner ear was promoted to chairman at Princeton. He proceeded to fire every faculty member in Clinical, Personality, or Social Psychology who did not have tenure, and to harass in unbelievable ways those, like Silvan and Hadley Cantril, who had tenure.

Silvan returned from sabbatical and was told by the chair that we no longer have the kind of students who would want to take your seminar. Silvan said if no one signs up, it won't be given. Princeton was a small department. The chair would meet with the graduate students, tell them what courses were to be given, and they would sign up. The chair announced that Tomkins was too busy writing, so his seminar would not be given. No graduate student signed up, and Silvan was told that no graduate student enrolled. However, three graduate students asked him if he could possibly reconsider. They realized it was an imposition, but could he perhaps even give it for one term? They had come to Princeton when he was on

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Silvan S. Tomkins
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sabbatical. There was some chance that they might be able to complete their course work in two years, and they felt it would be a great pity to get a PhD in Psychology from Princeton and never have a chance to study with him. When he realized what happened, he was furious, raised it at the next faculty meeting, his seminar was offered, and it was the most popular graduate course that year since it had not been offered the previous year.

Six months after he returned from sabbatical, he wondered why he had not heard from the Foundations Fund for Research in Psychiatry. Representatives of that Foundation had urged him to submit a grant for 7 years of basic research on his theory. He had done so before he left on sabbatical, but had heard nothing. When he inquired, he was told that they thought they had been as clear as they could be that they wanted to support research on his theories and were puzzled why he never submitted an application. He then discovered that the secretaries were told by the chair not to type the application nor submit it.

Eventually, he left Princeton for City University of New York, and later when they did not live up to all of their promises, left City for Rutgers.

Nonetheless, Silvan still valued universities. After my PhD orals he said he wanted to speak to me, that I might be the last student he would see through Princeton, but urged me, as he had before, to become a college professor. It is not that bright people do not make good therapists. They obviously make better therapists than less bright people, but it is a waste of talent. Bright people, he said, had a duty to reproduce themselves intellectually.

I took a job for 6 months at the minimum security reformatory (barbed wire and guards with rifles) for male adolescents for the state of New Jersey. During the 6 months I was there, I instituted a policy of 5 consecutive days of psychotherapy without medication for psychotic breaks. All of the patients were not psychotic after that week and could live in the reformatory and carry out their duties with continued therapy of at least once per week. I had never seen anyone improve that fast. Of course, these were adolescents, and they were in my office within 24 hours of their break. Before and after that period, one or two psychotics per month were sent to the state hospital, medicated, and, in the 1950's, hospitalized for an average of 2 years before being returned to the reformatory.

I was excited and talked about it. An older psychologist, who thought he was giving me good advice, said, "Stop telling people you are curing schizophrenics. No one cures schizophrenics, and you are only making people angry at you." But when I told Silvan, he said, "Really? What do you think accounted for it?" which is of course the right question.

As graduate students, most of us would intentionally try to get Silvan off his general theory and on to any specific problem in the field. He would bring more knowledge and insight about any problem in Psychology than any one else we knew. It was only after I learned a great deal more that I realized what the problems were that his general theory was trying to solve.

I once told him after the publication of the first two volumes of *Affects, Imagery, and Consciousness* (Tomkins, 1952, 1963) that it seemed slightly anti-psychoanalytic, but that I knew that was not true, that Silvan knew more about psychoanalysis than anyone I ever met. He said, "Anyone who is serious about studying the human personality already knows all about psychoanalysis, so you only have to mention it when you think it is wrong." My thought was, "In your world, Silvan."

Silvan was a horse player. He was the only person I know who consistently made money playing the horses. We graduate students asked him about it, and he said, "You do not know what a real depression is like. People really did sell apples to keep from starving. You came out with a PhD and there were no jobs. Somebody told me I could earn a living betting on the horses. I tried it and I found I could. But it is not a part time job. You have to spend all day, watch the horses in the morning being exercised, talk to jockeys, trainers, and owners, because horses aren't always run to win. There are only thirty or forty things that make a difference in a horse race, and if enough of them are in the right direction you bet on it." I always felt that the evaluation of his professional work was so uncertain and delayed that it was satisfying to think through a horse race, and bet on his reasoning. The race was run. He won, while most people lose, demonstrating that his inferences were accurate.

He once said that he felt he had the ambition and the talent to be a great psychologist, a great horse player, and a great beachcomber, but these three ambitions were inconsistent with each other.

Among Silvan's most important contributions to Psychology are his theory of affect, which is the best in the field, including his delineation of specific affects as motivators and part of the process of rational thinking, of the role of the face, and his theory of intellectual creativity. His theories of thinking and memory, of the role of consciousness, script theory, and of norm vs. communion orientations are all important.

But here we are most concerned with his contribution to projective tests. His book on the TAT (Tomkins, 1947) is still the best book on the subject in my opinion. It is the only book that discusses the issue of assessing the level at which an impulse functions. He developed a theory of why multiple choice projective techniques tend not to work, and then standardized the Tomkins-Horn Picture Arrangement Test with Jack Miner to demonstrate that his ideas led to a usable and valid multiple choice projective test (Tomkins & Miner, 1957).

Basically his approach to the TAT was that there was no substitute for the human mind. For any element of a story or the story as a whole, the question was why might a human being say that. You ought to use everything you know about human beings to arrive at possible inferences. If the same inferences came up again and again, that was what was going on.

He never gave a seminar on the TAT when I was in graduate school. He said students wanted a course in comparative personalities, and that did not interest him. What interested him was what were the psychological processes that go into telling a story, and what were the processes that go on in a psychologist trying to draw inferences from a story. I remember asking him when I was working at the Reformatory about predicting suicide. He thought for a moment and then said that stories about suicide sometimes predict suicide. A casual, accurate, insightful, and very useful bit of information.

Bellak's text says that suicidal stories do not predict suicide. But Bellak is wrong. Bellak does not consider levels.

A seminar on clinical methods studied one subject for a year by a variety of procedures. At the end of the year, they administered 10 TAT cards. They asked Silvan to discuss the stories. He started by saying that he had not looked at the stories, that he was out of practice, that he would undoubtedly make mistakes, but that was not important, what was important was how you should think about this kind of material. The first sentence of card one was "This boy once had a father who was a famous violinist." He speculated that the subject's father was an overwhelming identification figure, that fame and success were important values, and that aesthetics were not. All three of these were true. By the time he finished the first story, he had told us everything we had learned in a year, although he was not sure of any of it. By the time he finished the tenth card, he not only told us everything we had learned in a year, and now was sure of it, but he told us a great deal more and everything we checked out later turned out to be true.

As we left, I asked Norman Cliff, the psychometrician, what he thought of the TAT now. He said, "I don't know about the TAT. But the SST is one hell of a diagnostic instrument."

Silvan was the brightest, most thoughtful, and warmest person I have ever met. Those of us who were lucky enough to study with him will never recover.

References

Murray, H. A. et al (1938). *Explorations in personality.* New York: Oxford.

Tomkins, S. S. (1962, 1963). *Affects, imagery, and consciousness, Vols. I, II.* New York: Springer.

Why Don't We Follow the Rules?

Linda K. Knauss, PhD, ABPP
Widener University

Alice, a ten-year-old fifth grade student was referred for testing because she was struggling in school. Dr. M. discussed cognitive and achievement testing with Alice's mother and obtained her informed consent for testing. However, Dr. M. suspected that Alice could be a victim of sexual abuse. Dr. M. felt strongly that sex abusers should be identified and prosecuted. Thus, he decided to administer projective tests and other personality tests to Alice in pursuit of his suspicions. He did not obtain further informed consent from Alice's mother for this additional testing because he said he did not want to alarm her.

Why didn't Dr. M. follow the rules? It is likely that if Dr. M. were given a multiple-choice exam on the APA Ethical Standards and Code of Conduct (APA, 2002), including the sections on informed consent, he would know the correct answers. Yet people like Dr. M. who know the ethics code still get into trouble. They make different decisions when confronted with the same information in their office. This is because ethical matters arise in an interpersonal context. The decisions that must be made require reasoning because usually the questions are more complex than information that can be referenced in any ethics code.

Today's clinical practice often involves competing interests, values, and uncertainty. However, professional training often leaves people unprepared to sort out ethical, clinical, and emotional issues. Ideas that seem to be clear in a textbook, classroom, or workshop become murky in the context of clinical practice. There are many considerations that compete for a therapist's attention and inclination. Psychologists need to understand the personal and interpersonal nature of ethics and morality (Betan & Stanton, 1999).

Currently, most ethical decision making models emphasize a rational approach. However, incorporating the role of emotions and values helps clinicians to take ethical action. Clinicians need to be able to make sense of the conflict and ambiguity in the interpersonal context of ethical dilemmas. It is important to be able to respond ethically without reducing the decision to a concrete rule (Betan & Stanton, 1999). This means giving a broader view of ethics that includes the philosophical underpinnings of ethics, understanding one's own personal values, and recognizing the role of emotions on decision-making. Psychologists will be better at ethical decision-making when they can identify the moral and ethical issues within their practice.

Studies show that many times people know the right thing to do, but they still do not do it. This was the case with Dr. M. Benard and Jara (1986) studied why people chose not to apply ethical principles even when they were well understood. When responding to vignettes involving a colleague acting unethically, 50% of graduate students and an average of 32% of practicing psychologists (Bernard, Murphy, & Little, 1987) indicated that they would not live up to their own interpretation of what should be done. There was no difference between the participants who indicated they would do what they considered ethical and those who would not based on demographics. Also, most of the participants in the studies had taken a course in ethics. Wilkins and colleagues (1990) reported similar results in their sample of practicing clinicians in APA Division 12 (Clinical). Betan and Stanton (1999) continued this work by studying how emotions and concerns interfere with a *willingness* to implement ethical knowledge.

These studies demonstrate that ethical knowledge is not sufficient for ethical behavior. The decision not to report the unethical behavior of a colleague seems to be a matter of personal values, as was the decision of Dr. M. According to Bernard and Jara (1986), the issue is not how to communicate the ethical principles more effectively, but how to motivate people to implement the principles they understand.

The consequences of disregarding the law or code of ethics are well known, but the consequences of disregarding one's own values can be equally damaging. When discussing real or hypothetical ethical dilemmas, several clinicians said their decisions were guided by the need to be able to "look at myself in the mirror in the morning". This need has led psychologists to violate confidentiality and other ethical principles in clear conflict with the APA Ethical Standards and Code of Conduct (APA, 2002) when they were acting in a manner consistent with their own values. Examples include reporting a past crime committed by a client, or sharing information relevant to a family member that was learned from a client.

The conflict between values and formal legal or ethical obligations needs to be addressed in education, training, and supervision. Thus, a different thrust may be needed in the teaching of ethics in graduate programs. While considerable time and attention are given to teaching the ethics code and even ethical decision-making, students are seldom encouraged to explore their personal values. Abeles (1980) urged psychologists to teach ethics by means of value confrontations. Clarifying moral and ethical values and making them prominent in our thinking may help to realign behavior (Handelsman, Knapp, & Gottlieb, 2002).

Betan and Stanton (1999) also suggest that training encourage an awareness of the emotional pulls and subjective concerns of the clinician. In addition to training in the application of ethical guidelines and higher order principles to promote ethical reasoning, training models should encourage awareness of personal emotions and concerns that arise during ethical dilemmas. If psychologists are making poor decisions about ethical dilemmas because they are not paying attention to the influential role of emotion, values, and contextual concerns, then those who are more aware of personal emotions and values may be better able and more willing to intervene ethically (Betan & Stanton 1999).

Attending to one's emotional reactions in the context of an ethical dilemma can and does produce personal distress. Kitchener (1986) said, "Ethics educators need to help students understand the meaning of their feelings. For example, students need to understand that acting ethically does not always lead one to feel good" (p. 307). However, if people know why they do not want to implement what they know is the most ethical choice, it opens the door for them to seek consultation regarding their values and priorities rather than attempting to justify inappropriate behavior.

Ethical dilemmas require taking action in situations that are ambiguous. This often creates strong emotional reactions. Values and emotions influence a person's ability to make the best ethical decision. However, they must be integrated with cognitive decision-making skills.

Emotions can interfere with the willingness to use ethical knowledge. Understanding how emotions might guide behavior in ethical dilemmas can help psychologists to make more informed choices about their actions. Normalizing the emotional process may enhance the motivation and commitment of practitioners to work through challenging ethical dilemmas and seek consultation when needed (Betan & Stanton, 1999).

Everyone has values and emotions. As psychologists we try to hide our values and emotions and pretend they do not exist. However, they do not go away. They continue to influence us, so it is essential to understand our values and emotions and integrate them into our work. Only by taking full account of the influence of emotions and values in our work, can we truly practice ethically.

...References found on page 15

Steve Finn (L) & Martin Sellbom (R) , who received the Mary S. Cerney Memorial Award

References from 'Why Don't We Follow the Rules?'

Abeles, N. (1980). Teaching ethical principles by means of values confrontations. *Psychotherapy: Theory, Research and Practice, 17*, 384-391.

American Psychological Association. (2002). Ethical standards and code of conduct. *American Psychologist, 57*, 1060-1073.

Bernard, J.L., & Jara, C.S. (1986). The failure of clinical psychology graduate students to apply understood ethical principles. *Professional Psychology: Research and Practice, 17*,313-315.

Bernard, J.L., Murphy, M., & Little, M. (1987). The failure of clinical psychologists to apply understood ethical principles. *Professional Psychology: Research and Practice, 18*, 489-491.

Betan, E.J., & Stanton, A.L. (1999). Fostering ethical willingness: Integrating emotional and contextual awareness with rational analysis. *Professional Psychology: Research and Practice, 30*, 295-301.

Handelsman, M., Knapp, S., & Gottlieb, M. (2002). Positive ethics. In C.R. Snyder & S. Lopez (Eds.), *Handbook of positive psychology*. New York: Oxford University Press.

Kitchener, K. (1986). Teaching applied ethics in counselor education: An integration of psychological processes and philosophical analysis. *Journal of Counseling and Development*, 64, 306-310.

Wilkins, M.A., McGuire, J. M., Abbott, D.W., & Blau, B. I. (1990). Willingness to apply understood ethical principles. *Journal of Clinical Psychology*, 46, 539-547.

Greg Meyer & Ellen Hartmann (receiving the Walter G. Klopfer Award on behalf of Cato Grønnerød)

SPA Board
(Board member Dave Nichols was recovering from an injury and missed this photo op)

Irv Weiner (L) & Bert Karon (R), who gave the Marguerie Hertz Memorial Presentation

spa exchange

From the Editor...

This issue of the Exchange includes lots of excellent information that keeps SPA members posted about topics of interest. Len Handler's Presidential Address discusses some if the issues associated with writing good psychological reports. Alan Schwartz's assessment section extends this discussion, with articles by three assessment experts –Ron Ganellen, Roger Greene, and Jim Kleiger- each of whom offers a perspective on report writing. Bruce Smith reports on his work as SPA Advocacy Coordinator. Virginia Brabender discusses the importance of being thorough when conducting assessment supervision. Linda Knauss discusses some of challenges of making ethical decisions in assessment practice. Pam Abraham presents a vignette illustrating how the teacher can help students process questions related to MMPI-2 scale names relative to the new RC Scales as part of teaching MMPI history and systems. We also include Bert Karon's Marguerite Hertz Memorial Presentation honoring Silvan Tompkins. Lots of other information as well. Hope you enjoy it.

Call for Research Proposals

Members may recall that the SPA board has been working on developing a mechanism for supporting research on the utility of personality assessment. The board's subcommittee on the Utility of Assessment research project developed a Request for Proposals document and has been engaged in fund-raising over the last few years. Our goal to provide grant funding for research focused on the applied value of clinical personality assessment for clients, therapists, or referral sources. We are now ready to start reviewing research proposals for one year of funding.

The full description of the RFP detailing the purpose, eligibility requirements, terms of the grant, application procedures, and selection criteria is available on, and can be downloaded from, the SPA website: **www. personality.org**. The deadline for submission is **October 31, 2005**. Notification of selection will occur by March 1, 2006 and we expect funding to be made available on July 1, 2006. For further inquiries, please contact Stephen Finn at sefinn@mail.utexas.edu or (512) 329-5090.

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