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President's Message

Complexity and Simplicity in Psychological Assessment

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Several months ago, I received a phone call from a former colleague, a psychoanalytically oriented psychiatrist. We had worked together on an inpatient hospital consultation-liaison service. Since we both left the hospital, his practice focused on psychoanalysis and psychoanalytic psychotherapy while my assessment practice evolved to provide personality and neuropsychological assessments. We'd had sporadic contact but had not worked together for some years.

Mike said he'd been seeing a patient in intensive psychotherapy for a little more than two years. While the man, whom I'll call "Joel," had benefitted from treatment, Mike felt there was a piece of the clinical puzzle missing. In particular, he described Joel, a man in his late 30s, as showing a lot of potential but having trouble performing as well as expected. Mike had approached this from the perspective that Joel was handicapped by conflicts concerning success. Joel was clearly frustrated and distressed about these difficulties and was receptive to Mike's interventions, but little change in this area had occurred. Mike recalled that the psychological evaluations done by myself and the trainees I supervised on the Consultation-Liaison service had answered questions in some challenging cases in the past and wondered if an evaluation might be helpful in sorting this out.

Now, Mike is a sharp, seasoned, sophisticated clinician. For him to call because he was "stuck" about a case was significant. When I agreed to see Joel, I anticipated this would be a challenge.

Joel was eager to meet. When I introduced myself to Joel in the waiting room and invited him to come into my office, my first reactions ran along the line of wondering how he could have any problems in his life: He was, as the saying goes, tall, dark, and handsome; had a winning smile; and conveyed a sense of being self-confident and self-assured—with good reason. In terms of his academic background Joel had earned a law degree from a top-10 law school and then earned an MBA from a prestigious program.

Rather than practicing law, Joel became a consultant with a large consulting firm. After he had been there for about a year, the partner under whom he worked told Joel he was puzzled by him. The partner explained that, on the one hand, he saw Joel as being bright, creative, hardworking, and personable with clients. On the other hand, however, when given a project, Joel would start out strong but would falter and at some point seem paralyzed, unable to take the next step without being prompted or given direction. In addition, although Joel could present his analysis and recommendations clearly in meetings with the team he was part of, the partner expressed concerns that Joel's presentations in client meetings had been unclear and disjointed, particularly when he responded to questions, rather than following the material he had prepared. The partner said this was unexpected given Joel's level of experience and his standing in the firm. Joel commented, "That's the story of my career."

Joel has worked at several consulting firms since then. He described his performance in these companies as being mixed. While Joel has had some clear successes, similar issues concerning completion of tasks, making decisions, and staying "on point" in meetings have come up repeatedly. It has happened several times that a manager or coworker has stepped in to complete work assigned to Joel when a deadline is approaching. He worries that his current position may not be secure because of these issues. As Joel put it, "The problem is this. I have great credentials and drive. I want to succeed. Even though I work evenings and weekends, things don't always get done. I question if I keep putting myself in situations I'm not capable of doing."

I commented that Joel conveyed very clearly both how much he wanted to succeed and how frustrated and discouraged he was that he continued to struggle with these difficulties. I asked Joel how he understood the issues that hold him back. He replied that one important component of his work requires him to prepare written reports presenting his analysis of clients' problems and recommendations to solve these problems. Joel said he can think this through and have ideas set in his mind but feels blocked when he tries to put his conclusions and recommendations on paper. He has wondered if he has a processing problem affecting his ability to write.

When I asked Joel to describe the processes that affect his writing, he explained that while he is writing he will see a hole in an argument and realize he has to add material. At some point after he goes back to edit what he has written he starts to feel lost. Joel has noticed that while he is trying to write, an internal voice questions whether his work is "good enough." He added to this, "And I get bored easily."

Another issue Joel identified that affects his work involves his need to be independent. He sometimes feels "put off" and resentful if a manager gives very specific directions or if he feels he is being "micro-managed." It puzzles Joel that he sometimes cannot finish work without guidance while at other times he bristles when guidance is provided. As he put it, "With my personality I don't like to be told what to do. I like to figure it out. But after I figure it out I don't want to do the

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Special Topics in Assessment

Clinical Pearls

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In Part I of this two-part article for the Special Topics in Assessment section (see *SPA Exchange*, Winter 2015, Volume 27, Number 1), Mark Waugh, PhD, ABPP, introduced a discussion of an often overlooked topic in the assessment literature: the clinical pearl. As the metaphor suggests, these are distilled wonders of clinical expertise passed along from teacher to student and prized in the same manner as rare and valuable gems. The venue of communication of such distilled, compact, and beautiful wisdom is not typically the professional journal or scholarly monograph, but in the quiet intimacy of the supervisory relationship. While each may have personal meaning for the individual bequeathed these pearls, they often reflect a wealth of hard-earned knowledge, a multiplicity of experiences, and the skill of an excellent teacher to pare them down to their essence. In Part I, Waugh focused on technical matters in psychological assessment. In this second installment, he discusses clinical pearls that are more experience-near and may add to our own collection of clinical wisdom.

Clinical Pearls in Psychological Assessment: Part II

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> *Education is what remains after you have forgotten what you learned in school.*
> —Albert Einstein (1956, p. 36)

Sidney Blatt, PhD (1929–2014), is probably best known for his model of personality/psychopathology which is based on interpersonal (anaclitic) and self-definition (introjective) polarities of experience (Blatt, 1974). Less appreciated, however, are his early contributions (Blatt, 1975) that are consistent with and to some extent anticipatory of the welcome contemporary paradigm in psychological assessment called *Therapeutic Assessment* (Finn, 2007). I recall him examining test data on an individual receiving long-term hospital treatment (personal communication, 1983). He spoke his thoughts aloud and was puzzled by anomalous intra-test scatter on the Wechsler Adult Intelligence Scale (Wechsler, 1955). He said: "I think this patient has undiagnosed sub-clinical epilepsy" (personal communication, 1983). The patient had no abnormal findings on neurological evaluations, but Dr. Blatt wondered if a nuclear magnetic resonance (NMR) scan could be ordered. The NMR was obtained and showed an occult seizure disorder. Lesson learned: *pay attention to idiographic "noise," and think outside of the box*. Dr. Blatt was not enacting the "oracular" motive in psychological assessment (Schafer, 1954). Dahlstrom (1995) recounted the experience Paul Meehl and he shared in 1947 attending a Rorschach seminar by Klopfer (against the advice of their mentor, Starke Hathaway). Dahlstrom felt Klopfer was amazingly accurate in blind analysis. He reasoned that they witnessed Klopfer's recognition of small, information-packed *signs* in Rorschach data that represented a type or category of phenomena.

The literature on the cognitive activity of clinicians suggests that we think in terms of categories or prototypes (Cantor, Smith, French, & Mezzich, 1980; Kim & Ahn, 2002). Expert clinicians identify subtle clinical signs associated with larger categories (e. g., prototypes) learned from experience. This occurs rapidly without conscious articulation of links. It represents "System I" thinking (fast, intuitive pattern recognition) as opposed to the deliberate, logical mode called "System II" thinking (Kahneman, 2011), and also reflects "thin-slicing"—quick, rapid, accurate person-perception based on small bits of behavior (Ambady, 2010). Returning to Dr. Blatt's apparent prototype-matching, the lesson remains: Pay attention to idiographic noise, for it may not be noise.

Molly Harrower, PhD (1906–1999), was a renowned Rorschach psychologist whose numerous contributions included the Group Rorschach, studies of the Nazi war criminals' personalities, use of the Rorschach to predict success in psychotherapy, the therapeutic use of poetry, and publication of her own poetry. As an early doctorate-level professional woman, she broke ground for many given the cultural mores of the day. She herself counted as mentors Kurt Koffka, Arnold Gessell, E. G. Boring, Kurt Goldstein, and Walter Penfield (Dewsbury, 1999).

Dr. Harrower shared her experiences in designing group Rorschach testing (personal communication, 1978). This was during World War II when there was an urgent need for selection of soldiers and sailors for special duties and missions. Numbers and time constraints precluded traditional one-on-one assessments and she looked for ways to assess personality variables in large groups. One strategy was to show the inkblot images on the "big screen," like a movie theater, for groups of soldiers and sailors. When the enormous inkblots were displayed, however, many people in the room rapidly became unglued. Panic attacks, acute breakdowns, and overt behavioral disturbances occurred *en masse*. Dr. Harrower realized the soldiers and sailors, many of whom had seen combat, psychologically projected aspects of their traumatization 30 feet large on the big screen. Psychologically speaking, a 30-foot inkblot is very different from a 6-inch image. Needless to say, this strategy was not repeated. These results dramatically underscored the importance of respecting the patient's coping capacity. Psychological defenses exist for a reason. Dr. Harrower's lesson learned: *Our assessments are intrusions that can invite regression. We must*

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Personality, Stress, and Hypertension: A Research Update

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Psychologists have been interested in the link between personality factors and coronary heart disease since the 1940s, when one of the first Rorschach studies using hypertensive patients was conducted (Booth, 1946). Not long after, in the mid-1950s, the Type A personality gained popularity as a research construct, especially due to its hypothesized role as a contributing factor in the development of cardiovascular disease and hypertension. Type A personality is said to describe people who are hard working, competitive, impatient, irritable, and easily aggravated. This was the first personality type linked as a risk factor to cardiovascular dysfunction (Emery, Anderson, & Goodwin, 2013). However, over time, the only consistent research findings linking Type A personality and coronary issues involved individual differences in the experience of anger and hostility (Kent & Shapiro, 2009). These traits appeared to be related to the development of hypertension, whether or not an individual was characterized as having Type A personality (Kuper, Marmot, & Hemingway, 2002). Thus, research interest in Type A personality as a risk factor for hypertension has dropped off in the last 10 years.

Meanwhile, interest in what has been termed *Type D* has grown. Type D is referred to as the "distressed type" and is characterized by high degrees of negative affectivity and social inhibition. Type D, and more specifically the aspect of Type D that involves "concerns about negative social evaluation" has been linked to cardiovascular disease, hypertension, and infectious disease, but not to cancer or overall mortality by other causes (Marin & Miller, 2013, p. 942; see also Kent & Shapiro, 2009). Thus, the effect of Type D on physical health seems to be specific to cardiovascular and infectious disease expression, but not to other types of illness. But as was the case with Type A, results have been mixed despite early encouraging findings (Suls, 2014).

As the search for understanding the role of personality in cardiovascular functioning continues, researchers and theorists have more recently focused their attention on individual differences in physiological responses to stress. Most research has determined that acute stress, although it can trigger transient elevations in blood pressure, is not likely to be a risk factor for hypertension alone. However, chronic stress shows a strong link to hypertension, and recent models have found that individual differences in stress responsivity (via personality or physiology) may predispose a person to engaging a stress reaction that leads to chronic elevations in blood pressure. For example, in a meta-analysis of existing studies of stress and hypertension, Sparrenberger et al. (2009) found that among people experiencing chronic stress, the relative risk for developing hypertension at a later date ranged from .8 to 10.1, and this was over follow-up intervals ranging from 2.5 to 20 years. The authors concluded that exposure to persistent or repetitive stress produced significant risk for hypertension, but that this risk was greatly elevated when the individual's response was maladaptive or nonadaptive.

Research on the effects of the 9/11 attacks on hypertension rates provides another interesting example of the relationship between the ways individuals experience stress and later onset hypertension. Holman and colleagues (Holman et al., 2008; Silver et al., 2013) conducted a series of studies that followed a sample of 2,500 people over time, measuring a number of factors related to mental and physical health. They found that individuals who reported an acute stress reaction to watching live media coverage of the 9/11 attacks had a higher incidence of hypertension over a 3-year follow-up, controlling for all other risk factors. However, as evidence of the deleterious effects of anxiety and chronic stress on cardiovascular functioning, those who exhibited ongoing worry about future terrorist attacks were found to be at four times the risk for developing hypertension 2 years later. Further examination revealed that repeated exposure to traumatic images in the media led to a 20% increase in physical health problems in general, again controlling for all other risk factors.

The pathophysiological effects of acute stress are primarily explained via stimulation of the sympathetic nervous system which leads to a number of physiologic effects, including elevated heart rate and blood pressure, as well as to injury to endothelial cells lining coronary vessels. These effects may lead to a number of clinical consequences, including the development of myocardial ischemia, cardiac arrhythmias, and hemostatic changes (Rozanski, Blumenthal, & Kaplan, 1999). Although this effect is well known, it is clear that not everyone experiencing stress has the same risk for cardiovascular disease.

Recent research on individual differences in physiological response characteristics activated by stress has been quite promising. For instance, individual differences in blood pressure responsivity, defined as the magnitude of blood pressure response to stress tasks, predicts later onset hypertension independent of baseline blood pressure up to 20 years later (Chida & Steptoe, 2010; Flaa, Eide, Kjeldsen, & Rostrup, 2008; Treiber et al., 2003). Also, individuals whose blood pressure takes longer to return to baseline following stress tasks have higher incidences of hypertension at follow-up (Steptoe & Marmot, 2005). Thus, for some people, short-term, immediate responses to stress reflect stable differences in individual physiological reactivity.

There is some evidence that such hyper-responsivity is inherited. Light et al. (1999) found that individuals who had a parent with high blood pressure showed greater spikes in blood pressure following stress tasks and higher incidences of hypertension with a 7.5 increase in relative risk for developing hypertension at 10-year follow-up. However, the study found that the cardiovascular effects of blood pressure responsivity were minimized in individuals who experienced low levels of daily stress (Light et al., 1999).

Taking these findings into account, the following model has been proposed, which is called the "Psychophysiological Reactivity Model" (Schwartz et al., 2003). It is a causal model stating that stress, when of sufficient severity, triggers a response of sufficient magnitude, blood pressure then becomes elevated through activity of the sympathetic nervous system, parasympathetic nervous system, or local vasoconstrictors. However, the stress response may also lead to blood pressure elevations indirectly through the use of maladaptive behaviors designed to cope with feelings of stress, such as smoking,

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Ethical Considerations in Assessment Feedback

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According to Kenneth Pope (1992), "Feedback may be the most neglected aspect of assessment" (p. 268). This leads to the question of why that may be the case. The *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Assocation, 2010) clearly indicates in Standard 9.10, "Explaining Assessment Results," that psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes providing an explanation of the results, such as in certain forensic evaluations. When the examinee will not be given an explanation of the test results, this fact is to be clearly explained to the person being assessed in advance.

Several hypotheses have been given for the reason that many psychological evaluations do not include test feedback as part of the assessment. For example, some clinicians have not been trained in test feedback techniques and may feel uncomfortable discussing the results of an assessment with a client. They may feel uncertain as to how to present information to clients, especially negative results, and may be concerned about the consequences of a client receiving potentially negative feedback (Butcher, 1992). It is also sometimes difficult to translate for the client the jargon that is used in many test reports. Finally, test results often leave many important questions unanswered, which can be frustrating to clients (Pope, 1992). It is also important to note that lack of time and reimbursement for assessment feedback contributes to the tendency to avoid or neglect providing feedback.

Most people who are given psychological tests expect that the results will be discussed with them as part of the process. Sharing results with clients can build rapport between the client and the therapist, increase client cooperation with the assessment process, and leave the client with positive feelings. Assessment feedback itself can also be therapeutic for clients (Finn & Tonsager, 1992). Preparing for and giving feedback can also be beneficial for assessors. It requires the assessor to understand, integrate, and effectively organize the assessment findings, and helps the psychologist to develop a clearer understanding of the assessment results and implications (Tharinger, Finn, Hersh, et al., 2008).

Thus, providing effective feedback requires the skill of an effective therapist. The goal of most psychological assessments is to make recommendations that will affect the life of the examinee. In order for the assessment to be useful, the recommendations need to be followed. The effectiveness of the feedback session can determine whether or not the recommendations will be followed.

As noted earlier, giving feedback is not always easy. However, there are some considerations that contribute to the success of a feedback session. First, clients should know what sort of feedback to expect and from whom it will come (Pope, 1992). Sometimes there are other people in the client's life who are involved in his or her care or who will be carrying out the recommendations. This could include a parent, spouse, teacher, or therapist, to name just a few of the potential people who may benefit from being part of the feedback process. It may be necessary to give feedback to several people, such as a general practitioner and a therapist in addition to the client and his or her family members. In order to provide feedback to anyone other than the client (or the client's legal guardian if the client is a minor), it is necessary to get written permission from the client generally in the form of a signed release form, or it could be part of the informed consent form (Wright, 2011).

The feedback session should enable the client to understand what the tests covered, what the scores mean, the accuracy of the scores, and how the information will be used. Although there is no requirement that the assessor give a written report to the client, according to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (U.S. Department of Health and Human Services, 2002), clients generally have access to their test reports. Thus, language and context is important in both the written report and in the feedback session. Reports need to be both accurate and tactful in the event that they are read by the client (Knapp & VandeCreek, 2012). It can also be helpful to give clients a summary of the report with the major findings, themes, and recommendations (Wright, 2011).

There is no single model for providing feedback that has been widely adopted in the field of psychology, although there are several options for organizing the session. One option is to use the same format as the assessment report (Wright, 2011). If you have given a copy of the written report to the client, you can go through the report together explaining everything that is written, answering any questions the client may have, and checking to make sure the person understands the information. Another model is to organize the feedback session around the recommendations. In this model, the assessment results are provided followed immediately by the specific recommendation that relates to that finding (Wright, 2011). This model emphasizes the recommendations by summarizing them again at the end of the session. A third option is to use the structure of a Therapeutic Assessment (Finn, 2007). In this model, the first step is to present the assessment results that are consistent with the way clients think about themselves. This is followed by findings from the assessment that go beyond the clients' usual way of thinking about themselves but are not likely to threaten self-esteem. The last step is to present the assessment results that conflict with the clients' usual conception of themselves. Finn (2007) notes that research has shown that clients often continue to think about this information long after the feedback session. Receiving feedback from a relative stranger who says they know more about you than you are aware is an understandably difficult situation. This is the reason that some clients receiving feedback may leave the assessment process with negative feelings (Wright, 2011) and is probably the most significant reason that psychologists do not give feedback.

Another consideration is whether psychologists assessing children and adolescents should provide feedback to the child as well as to his or her guardian. It is recommended to provide feedback to children and adolescents that is developmentally appropriate whenever possible and clinically appropriate (Fisher, 2013; Wright, 2011). It may be best to give feedback to parents (guardians) first, and then to give feedback to the child with the parents in the room if you have tested a young child. This may occur in a separate session a few days or even a week later (Tharinger, Finn, Hersh, et al., 2008). As the client reaches adolescence, the opposite arrangement may be best so that the client knows what information will be shared with

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Public Affairs Report

Bruce L. Smith, PhD
Public Affairs Director

Several issues have emerged, mostly in regard to reimbursement and confidentiality.

1. Regarding confidentiality, *Anthem* Blue Cross has been demanding full records from psychologists doing psychotherapy (despite Health Insurance Portability and Accountability Act [HIPAA] stipulations that psychotherapy notes are not to be released). The concern is that they will do the same regarding test data—which still do not have the same protections as psychotherapy notes, despite assurances from the Centers for Medicare and Medicaid Services (CMS) that they would draw up regulations to make it so. So far, no insurer has asked for these data, but the threat remains until such time as we get the appropriate language in the CMS HIPAA regulations.
2. As I discussed last time, there is an emerging problem with the 96103 code (testing by computer). It turns out that there has been a huge increase in the use of this code (mostly by physicians who give computerized inventories), and CMS is looking to reduce the reimbursement for this code (and, oh, by the way, all testing codes while they're at it). Initially, this did not seem to be much of a problem, but now that much of testing involves computerized assessments (e.g., CPTs, the new WISC and WAIS, MMPI or PAI, etc.), this could become a thorn. We (the Society for Personality Assessment and the American Psychological Association) successfully fought off the first attempt to do so, as CMS decided to go with the current rates for professional activity and office expense for 2015, but they are talking about a wholesale revision of the reimbursement schedule next year. We have been working closely with Randy Phelps of the American Psychological Association, as well as with Katherine Nordal, on this. Stay tuned.
3. At the time of this writing, the annual threat to cut Medicare reimbursement rates across the board has emerged as part of the budget discussions on Capitol Hill. Currently, the automatic cut would be 21%, although the American Psychological Association along with the American Medical Association has been able to stop this in the past. By the time you read this article, the issue should have been resolved one way or the other.
4. Now that the Proficiency effort is in full swing, we are planning a major public relations effort to get out the word that individuals seeking services should seek out practitioners who are deemed *proficient* in personality assessment. A brochure is in the works as the first step in this effort.
5. Finally, we are going to get a liaison to the American Psychological Association Board and Committee dealing with tests and assessment through the good offices of Katherine Nordal. This should help us stay abreast of developments, as well as have more input into official American Psychological Association policies regarding assessment.

First Place Poster Session (Thursday) winners with SPA President-Elect Dr. Robert Bornstein.

Ryan Marek (*left*) receives the Mary Cerney Student Award from SPA President Dr. Ron Ganellen (*right*).

Practical Strategies for Manuscript Writing, Publishing, Reviewing, and Being Reviewed

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I was both energized and excited to go to Brooklyn this year and reconnect with so many SPAGS members. In case you missed it, students had a large presence at the Society for Personality Assessment (SPA) convention this year, contributed over one hundred scientific posters and presentations, and attended SPAGS-developed events, including the student social, student lunch, diversity lunch, and a SPAGS-sponsored roundtable discussion on journal articles.

The SPAGS board has transitioned with new members elected as president-elect (Emily Dowgwillo), Secretary (Jamie Anderson), and members-at-large (Adam Creighton, Stephen Snider, and Trevor Williams). My role has now also shifted to past-president. I wish to thank everyone I have worked with on the SPAGS board as well as the SPA board. In particular, the support from SPA has been outstanding for students, not only by providing financial breaks for the convention, but also opportunities to give presentations, become actively involved in the organization, providing infrastructure for meeting legends of the field through student lunches and social events, and granting several student achievement awards.

It has also been my great pleasure to serve on the education committee with Josh Eblin and Emily Dowgwillo, where we designed panels that focus on professional development for graduate students. Over the last several years, some of the SPAGS-sponsored panels included:

Graduate Student Development
- introduction to common personality assessments;
- expert strategies in manuscript writing, publishing, and reviewing for journal articles;
- current topics in personality assessment and diversity.

Transitioning and Early Career Development
- locating and securing internship and postdoctoral positions in assessment psychology;
- developing your own assessment practice;
- starting an assessment research career.

Emily Dowgwillo is taking over the education committee of SPAGS, and I'm confident she will do an excellent job. She has several great ideas already for the SPAGS-sponsored panels in Chicago 2016. If you have an idea for a panel that could serve the interests of SPAGS members, please contact her at emily.a.dowgwillo@gmail.com.

Writing, Publishing, Reviewing, and Being Reviewed

This year, our SPAGS-sponsored roundtable discussion brought together several experts in the field (Drs. Bornstein, Hopwood, Pincus, and Widiger) along with a few of their graduate students (Cristina Crego and myself) for an in-depth discussion of journal articles. I will review some of the highlights of this roundtable.

Manuscript Writing

Graduate student advice. From a graduate student perspective, we reminded the students that most struggle in the beginning to write, but that it gets easier over time and with practice. A common experience in graduate school is for a coauthor to recommend changing something, only to recommend changing it back at the next iteration. We reminded students that this is a common part of the writing process: A manuscript changes over time and especially as different sections are written (i.e., after writing the discussion section, often the focus of the introduction may change). This may also occur because as student writers, we have not been clear enough in what we are saying, which may lead coauthors in different directions.

Prewriting advice. In the preplanning stage, it was recommended to craft an outline, with the expectation that it will be modified throughout the writing process, and that is okay. Others talked about the importance of just starting the writing and allowing the editing phase to allow the paper to take form (much like a sculpture, with increased precision developing over time). Some recommended writing what you are passionate about at that moment, which may mean moving between manuscripts from time to time based on what is interesting to you. Others recommended a queue system with the projects you have committed to, and reasonable deadlines. This ensures that you have time to get to the manuscripts you agreed to do, and minimizes the need to ask for more time with colleagues. Several roundtable members discussed the importance of a thorough literature review to deepen your understanding of your contribution within the larger field before the writing process takes place.

Writing and structure. Some of the roundtable members choose to write a few hours each day, while others dedicate an entire day to focus on writing; however, the consensus of the round table members was to follow what works for you. One roundtable member discussed a funnel approach where the reader is taken from the general to the specific, crafting a coherent narrative that arrives at the end of the introduction with a reader who can clearly see why this study is needed. He reminded us that the funnel should move from narrow (this study) to general (broader implications) in the discussion, and should connect back to the introduction. Bob Bornstein made a great recommendation to save partially written drafts in a separate file to (a) be able to bring them back in case something that did not fit in the introduction made sense for the discussion and (b) to help you get unstuck in your writing process and allow that perfectly written (but ultimately unrelated) part of your paper to not get in the way of a cohesive narrative.

Revising. Several on the roundtable recommended revising multiple times before sending to coauthors/advisers for input. They also recommended trying to eliminate all typographical errors so that advisers can focus on the content/structure.

Manuscript Publishing

Graduate student perspective. We discussed how the reviewing process can be daunting, and less than stellar reviews on your paper may cause discomfort. Perseverance is important.

Deciding where to send it. The roundtable members recommended thinking about which journal to send to early on in the writing process, because this can matter for how the manuscript is written and which parts are emphasized. In particular, it is important to read articles published in that journal to ensure that you are not ignoring relevant research the journal has recently published related to your paper. Some recommended aiming high (i.e., high impact factor), and considering what audience you want to see your work. We discussed how the meaning of an impact factor may lose relevance over the next several years, but those aiming for a faculty position and tenure would be wise to continue trying to publish in high-impact journals.

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The Teacher's Block

Listen to the Music

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So what do personality assessors do when they have some conference downtime? They sit in a coffee shop and engage in one of their restricted (read: nerdy) interest areas, naturally. We have an affinity for trivia, and it runs the gamut from citing years when certain assessment articles were published to music to sports. Our mutual joy in poring over Structural Summaries issues from childhood experiences reading baseball box scores when you could not get the information anywhere else. There was no such thing as the Internet, so we found outlets for our investigative talents, if you will, in different areas.

In an attempt to kill a few hours, which neither of us can do all that well, we derived a Rorschach (Exner, 2003) teaching tool that allowed us to play music trivia with each other (never against; that would be too competitive!). We invite you to adapt, modify, and invite your students to use it as a method to work through the confusion and tedium of learning how to code the Rorschach.

Here are some examples. We date ourselves a bit, but the principle can be applied to any song and the ideas to any personality test.

1. Remember the old Procol Harum song, "Whiter Shade of Pale"? How about WSv/+ YF.C'F or C'.Y? It'd be easier if they just said, "lighter shade of pale." INC1 for whiter shade?
2. On to Donovan's "Mellow Yellow," and here's the coding. But wait, go ahead and ask: What makes it look "mellow"? Answer: "The yellow." Code Mp. C for the representation of an internal state? Code for Hx? Both Donovan and John Lennon sang on this song, but we do not know their state of mind at the time of the recording!
3. An oldie but goodie by the group Los Bravos: "Black Is Black." Code C' (high reliability on this coding).
4. The old Sugarloaf classic "Green Eyed Lady": Code CF and H. We might consider FC depending on inquiry. We'd add more coding if she was "moving slowly toward the sun," which she is (Ma and FABCOM). She is also a "windswept lady" (Mp). Who is this woman? Next year's Society for Personality Assessment convention is in Chicago. Will she be swept into the Windy City?
5. Now for the heavy stuff. Let's start with Cream's "White Room" (we're talking Eric Clapton, Jack Bruce, and Ginger Baker on drums). WS+ C'F, and remember they said: "In my white room with black curtains…" so add Hh to round it out. By the way, in their white room was "the station." Is that a FABCOM? Do we give "station" a Science content coding? And of course, if the "station" is set back in the room, then code FD, FV, or VF. "I'll wait in this place where the sun never shines… where shadows run from themselves." Whoa! They said it, we didn't: What were they thinking when they wrote this? Definitely a coding A-lister.
6. Now for a brain-teaser, we give you "Hazy Shade of Winter." Code Y, Na. We code it the same way, regardless of whether the song was sung by Simon and Garfunkel or by the Bangles. By the way, does "hazy shade" get a special score? How about DR or INCOM? Or, if one sees it as a double diffuse-shading, then Y^2? Can we invent a new code here?
7. Next, we go to Creedence Clearwater Revival's "Bad Moon Rising." This was also the name of an early Sonic Youth album. Code it ma and add INC1 but only if John Fogerty is also in "Centerfield" (a solo hit for John F.). Do we give it AG? Probably, if we include the lyric "I see trouble on the way." There's even room for a dimensionality response if the moon is rising behind something else.
8. What about the Rolling Stones' "Brown Sugar"? Code CF, Fd, Consider H, but only if Mick is referring to the "girl who looks so good" in the song. R–PAS alert: Give it ODL (Meyer, Viglione, Mihura, Erard, and Erdberg, 2011).
9. Staying with Mick and Keith, let's try the Stones' "Street Fighting Man." Temptation is to code Ma. H and AG (but only if he's actually fightin'; otherwise, F).
10. Back to the Sixties and ? and the Mysterians' "96 Tears." Recall that this song tells us that someone will "cry, cry, cry 96 tears." Really? Ma for crying? And maybe DR for 96 tears? It's stilted. Maybe even a qualitative acknowledgment of PSV for "cry, cry, cry." It could be worthy of an MOR if there is actual crying versus just a sadistic preoccupation with wanting someone else to cry. No, on second thought, anyone who is that mean spirited deserves AG for taunting!
11. Staying with the Sixties motif, how about "Dirty Water" by the Standells? Boston is their home; that's what the song says. Code Y or C' along with Na. Now, if they "loved their dirty water," and the song's lyrics actually say that they do, then Hx? DR for loving dirty water? MOR for dirty? What about Fd? Or ODL? FYI: The Standells were actually from the West Coast, so based on the lyrics, many listeners were vulnerable to drawing the conclusion that they were from Boston (a tendency toward ALOG is warranted here).
12. In a similar Sixties garage-rock vein, who can forget the legendary Trashmen with their oft-covered gem, replete with playful combinative thinking, "Surfin' Bird" ? Ma A INC1 or FABI? Let the students decide!
13. Or descendants of the Mysterians and Trashmen, the Cramps and their classic "Human Fly" whose lyrics specify its "96 tears and 96 eyes." Given to Card V, F- (ordinary spoiled by the added interior details to the W) A MOR INCOM2. Or a CONTAM? Don't confuse "Human Fly" with Curtis Mayfield's hit "Superfly," which gets A and INC1. We won't code "The Cramps"—could be too painful!
14. Back further in time to the Fifties and Sun Records, a big hit for Elvis but penned and originally recorded by Carl Perkins, "Blue Suede Shoes" (inquiry: "lighter here…looks soft like suede… see, one on each side." FT 2 Cg PER (for "*my* blue suede shoes").
15. How about some funk? George Clinton's "Atomic Dog" with lyrics "These are clapping dogs, rhythmic dogs..." Dig that playful INCOM!
16. Back to Creedence and "Green River," from 1969. Consider CF, Na again, but ask John Fogerty what "green" actually

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SPA Annual Convention

March 9–13, 2016

Chicago Marriott Downtown Magnificent Mile
Chicago, IL

Join us in Chicago, IL, March 9–13, for the 2016 SPA Annual Convention at the Chicago Marriott Downtown!

The Chicago Marriott Downtown hotel is located on Chicago's famed Magnificent Mile and a Windy City landmark on Michigan Avenue. The hotel is situated among world-class shopping and dining and within walking distance of top attractions, including Navy Pier, American Girl Place, Millennium Park, and the Theater and Museum Districts.

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Promotional information with details about the 2016 workshops and the Annual Convention will be available on the SPA webpage at www.Personality.org the first week of December 2015.

Cutoff date for reservations: February 8, 2016

Future Dates:
March 15–19, 2017, San Francisco, CA
March 14–18, 2018, Washington, DC

2015 Annual Convention Poster Session Winners

Poster Session I: Thursday, March 5, 2015

First Place:

Biological Foundation of Human Movement Responses to the Rorschach Test
Agata Ando, Adriana Salatino, Luciano Giromini, and Raffaella Ricci
University of Turin, Turin, Italy

Stefanie Cristofanelli and Laura Ferro
University of Falle D'Aosta, Aosta, Italy

Claudi Pignola
University of Turin, Turin, Italy

Donald J. Viglione
Alliant International University, San Diego, CA

Allesandro Zennaro
University of Turin, Turin, Italy

Honorable Mention:

Associations Between PID–5 Personality Traits and Performance on a Social Emotional Accuracy Task
Alyne D. Rodrigues and Emily B. Ansell
Yale Stress Center, New Haven, CT

PID–5 Pathological Personality Traits and Daily Assessments of Interpersonal Behavior and Perception

Nicole Ellerbeck and Emily B. Ansell
Yale Stress Center, New Haven, CT

Poster Session II: Friday, March 6, 2015

First Place:

Affective Symptom Endorsement in Individuals With Chronic Symptoms Following a Mild Traumatic Brain Injury (Persistent Post-Concussive Syndrome)
Irene Tseretopoulos, Nana Asiedu, Chava Creque, Ryan Duggan, and Christopher Adams
Brain Trauma Foundation, New York, NY

Jessica Little
Stanford University, Stanford, CA

Honorable Mention:

The Accuracy of PIM-Predicted Scores to Identify Underreported Symptoms on the PAI
Lindsey L. Bupp
Wichita State University, Wichita, KS

Corinne M. Henk
University of North Carolina Chapel Hill, Chapel Hill, NC

John E. Kurtz
Villanova University, Villanova, PA

The Moderating Effect of Culture on the Relationship Between Attachment and Narcissism
Elizabeth Gustafson, James Poole, Nicole Cain, and Kevin Meehan
Long Island University, Brooklyn, NY

Chiara DePanfilis
University of Parma, Parma, Italy

Poster Session III: Saturday, March 7, 2015

First Place:

Object Relations Inventory: A Multi-Method Validity Study With Urban Women Using Primary Care
Cathleen LaLonde
University of Detroit Mercy, Detroit, MI

Rosemary Cogan
Texas Tech University, Lubbock, TX

Tsveti Markova and John H. Porcerelli
Wayne State University School of Medicine, Detroit, MI

Honorable Mention:

Anaclitic and Introjective Personality Traits Predict Reactions to Trauma
Alesya Nazarove, Jim Sexton, and Anita Raman
George Washington University, Washington, DC

Understanding Interpersonal Problems in Individuals Using Contingent and Global Self-Esteem Measures
Aimee Sohnleitner, Ketrin Lengu, and Sharon Nelson
Eastern Michigan University, Ypsilanti, MI

Steven Huprich
Wichita State University, Wichita, KS

Welcome to Dr. David Streiner, Incoming Editor of the *Exchange*

By training, Dr. David Streiner is a clinical psychologist. He joined the Department of Psychiatry at McMaster University in 1968, and then became a member of the Department of Clinical Epidemiology & Biostatistics. After 30 years, he retired for one day, and then became the founding Director of the Applied Research Unit and Assistant V.P. of Research at Baycrest Centre, and a Professor in the Psychiatry Department at the University of Toronto. He retired from Baycrest after 11 years but remains on faculty at both universities. He is a co-Section Editor of Statistical Developments and Applications for *Journal of Personality Assessment*. He is also the Senior Scientific Editor of *Health Reports*, and sits on the editorial boards of four other journals. He has written or edited nine books in the areas of statistics, epidemiology, public health, and measurement theory, and has published nearly 400 articles in these and other areas. His main interests are quality of life in people with various medical conditions, woodworking, scale development, woodworking, research design, woodworking, treatment of the homeless mentally ill, and woodworking.

SPA Board Members: (*left to right*) Drs. Radhika Krishnamurthy (Past President), Virginia Brabender (Past President and Liaison to American Psychological Association Board of Educational Affairs), Hadas Pade (Proficiency Coordinator), and Giselle Haas (Secretary)

First Place Poster Session (Friday) winners with SPA President-Elect Dr. Robert Bornstein

Master Lecture I: Dr. Diana Diamond.

Master Lecture II: Dr. Terence Keane.

Dr. John Graham (*right*) receives the Bruno Klopfer Award from SPA President Dr. Ron Ganellen (*left*).

An Update on the Proficiency in Personality Assessment

Hadas Pade, PsyD
SPA Proficiency Coordinator

As the newly appointed Society for Personality Assessment (SPA) Proficiency Coordinator, I wanted to introduce myself and give you a brief update on the proficiency. My name is Hadas Pade, and I am a licensed psychologist in Northern California who teaches, supervises, and conducts assessments. I am honored and thrilled to be in this position and want to thank Mark Blais, the members of the proficiency committee, and the SPA Board of Trustees for all their work thus far.

For those of you who are not familiar with the proficiency, here is a quick recap. The American Psychological Association has recognized Personality Assessment as a formal Proficiency. SPA has been working toward establishing a recognition and application process for providers in the field. The main goal of the proficiency is to establish a minimal threshold or standard in personality assessment services to the public. It suggests a level of skills that is expected, as a minimum, of all licensed psychologists providing such services, and to a large part, those who are supervising or instructing in personality assessment. The hope is to reduce poor- or low-quality services, often demonstrated by written reports, which may be unhelpful or potentially harmful to the client. In general, the process entails three psychologists reviewing a deidentified written report, among other documentation, to determine proficiency.

At the moment, we are only processing applications from SPA Fellows and ABAP Diplomates. However, we are in the process of finalizing the report review rubric and will be making this document available to providers and training programs soon. We will encourage assessment instructors and supervisors to consider the rubric as part of their training, and we will invite active providers to reflect upon their work and whether or not they meet this level of proficiency via their reports. SPA is also developing workshops and resources for those who would like to enhance their skills toward meeting proficiency. Please check the SPA website for informative proficiency documents as well as periodic updates. I would be happy to address any questions or concerns you may have regarding the proficiency and the process. This is an exciting opportunity to enhance the standards in our field and I hope you find it as valuable and beneficial as we do.

SPA Personals

Charles Peterson, PhD, won the 2013 Dieperink Award (for psychoanalytic writing) from the Minnesota Psychoanalytic Society for the essay "Self-Object Misuse in the Production of the False Self: With Comments on Victor Hugo's *The Man Who Laughs*," to appear in a Special Issue on "Psychoanalysis and the Classics" in the venerable *American Imago*.

Richard Rogers, PhD, ABPP, Regents Professor of Psychology at the University of North Texas, received the Eminent Faculty Award at a black-tie awards ceremony on September 26, 2014. This award is one of the university's highest faculty honors recognizing one distinguished professor annually for outstanding and sustained contributions. In being presented with the Eminent Faculty Award, Dr. Rogers was cited for his nationally recognized contributions to forensic psychology and psychiatry. He received the title of Eminent Faculty, an engraved university medallion, and $15,000.

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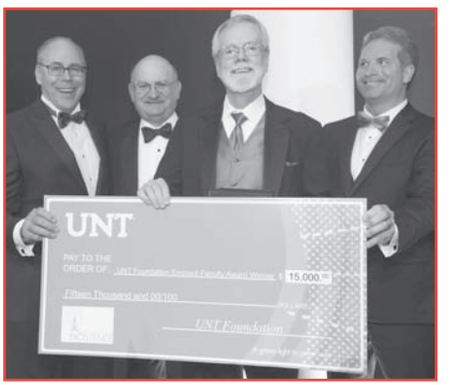

Dr. Richard Rogers receives the Eminent Faculty Award from the University of North Texas.

First Place Poster Session (Saturday) winners with SPA President-Elect Dr. Robert Bornstein.

Dr. J. D. Smith (*left*) receives the Walter Klopfer Award from *Journal of Personality Assessment* Editor Steven Huprich (*right*).

President's Message

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work. The process of figuring it out interests me. The process of doing the work doesn't." As a result, Joel frequently puts off starting to work on some assignments.

I had initially planned to administer a standard personality evaluation, a traditional battery of tests consisting of the Wechsler Adult Intelligence Scale–IV (WAIS–IV), Rorschach, and Minnesota Multiphasic Inventory–2 (MMPI–2). This seemed reasonable given Mike's suggestion of a conflict between failing and succeeding and the themes Joel had presented of anxiety about being evaluated; self-doubts and feelings of inadequacy; and mixed reactions related to his need to function independently, on the one hand, and feeling lost without guidance, on the other. As I processed what Joel told me during the clinical interview, however, I was struck by other issues he identified. These included a tendency to procrastinate, a tendency to get bored easily, a tendency to get derailed when interrupted, and difficulties organizing his thoughts. These issues suggested another possibility: difficulties with attention, organization, and follow-through as a function of attention-deficit/hyperactivity disorder (ADHD).

With this possibility in mind, I inquired about the issues suggestive of ADHD. When I asked Joel if the tendency to become bored had been true before he started working, for instance, he said this had been characteristic of him since he started school. Joel recalled that teachers consistently gave feedback about his school performance along the following lines: "They said I was bright and creative, but I wasn't very organized or focused." He often felt restless in classes, fidgeted, and daydreamed. When he had to do tasks that required sustained attention, such as reading or writing papers, Joel's attention wandered and he would get up before he had completed the task. In addition, it was characteristic of him to procrastinate.

The difficulties Joel reported could be conceptualized in terms of anxiety and psychological conflicts or in terms of neurocognitive processing deficits associated with the inattentive type of ADHD. What do the data say? Do the test results provide support for these frameworks?

Test Data

I'm going to present some selected test data. First, the MMPI–2 profile: It's a complex profile with the highest two-point code codetype, a 23/32 pattern. According to Graham (2011), the 23/32 codetype indicates that Joel's mood involves a mixture of worry, tension, and unhappiness about his current situation. He is someone who is invested in success, achievement, and status. In other words, Joel is ambitious. We can speculate the emotional distress Joel experiences is related to a sense of discouragement about the difficulties he's had in reaching his goals.

Another characteristic associated with the 23 profile is a coping style based on maintaining control over emotions. Joel typically responds to stress by trying to contain, suppress, or ignore negative feelings. Given the amount of energy it takes him to maintain control over his feelings, he may be emotionally "bottled up" and may feel tired and drained by the effort he expends.

There is one sentence in Graham's 23/32 interpretation that struck me as ringing very true in Joel's case: "They often feel they do not get adequate recognition for their accomplishments, and they are easily hurt by even mild criticism." This highlights that one factor driving Joel's need to succeed is a desire to be recognized and respected. At the same time, he can be rather sensitive to even mild criticism. This suggests that Joel is motivated not only to seek approval but also to avoid acting in ways that would lead him to feel embarrassed, ashamed, or criticized.

Adding elements from the 27 codetype indicates that disapproval activates feelings of inadequacy. When this happens, Joel is likely to devalue his abilities and accomplishments and engages in distressing, negative rumination about his worth and his potential to succeed. This may be a recipe for inefficiencies in thinking, difficulties making decisions, and avoidance of situations in which there is a risk he could fail.

Turning to findings from neurocognitive testing, it is no surprise that Joel is functioning in the superior range of intelligence overall with a WAIS–IV Full Scale IQ score of 126. Conceptual reasoning skills are a particular strength for him with MR = 16 and Sim = 15. The most striking finding involves findings of significant difficulties focusing and sustaining attention shown on the Continuous Performance Test–2. While Joel made few errors, his performance was notable for rapid speed of responding and greater than expected variability in reaction time. Response speed was less consistent and more erratic than expected and slowed across trials.

In terms of which direction the data point to understand Joel's difficulties, there is support for framing his problems in terms of his psychological dynamics as well as in terms of weaknesses associated with ADHD. While it may be tempting to approach an evaluation in terms of determining whether an individual's problems are due to psychological factors, such as anxiety, as opposed to ADHD, Joel's case illustrates that an either/or approach often does not fully account for the complicated issues which can affect performance; hinder progress toward reaching goals; and affect a person's sense of self-worth, competence, and agency. Stated differently, framing the goals of an evaluation in either/or terms may shortchange our understanding of an individual.

I've presented this clinical case in considerable detail to make the point that an evaluation in which ADHD is suspected should not automatically focus exclusively on neuropsychological issues. In some cases, many even in many cases, evaluation of neurocognitive functioning may address the clinical questions asked by a referral source. However, personality assessment is often valuable when evaluating an individual with ADHD, not just in the service of determining whether the person's issues are due to ADHD or psychological factors but because both sets of problems may be present. In other words, ADHD is often comorbid with other psychological disorders.

Comorbidity

We now know that adult ADHD occurs frequently. This was shown in the National Comorbidity Survey Replication study (NCSR; Kessler et al., 2006). The NCSR was a nationally representative household survey that examined the rates of a number of psychiatric disorders in roughly 3,200 adults between the ages of 18 and 44.

The NCSR found that 4.4% of the adults in their sample were diagnosed with current ADHD. To put this in some context, according to the 1-year prevalence estimates contained in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM–5*), roughly 8–10% of adults in the general population meet diagnostic criteria for an episode of major depression; about 3% of adults in the general population have generalized anxiety disorder (GAD); while 1–2% of adults suffer from panic disorder. These figures suggest that adult ADHD is not uncommon. To give you an idea of the scope of the problem, applying the estimate that 4.4% of the U.S. general population meets diagnostic criteria for adult ADHD, currently more than 14 million adults have ADHD.

Interestingly, of the adults diagnosed with ADHD in the NCSR, 75% had *never* been diagnosed with ADHD by a health care professional, although many individuals had

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Dr. James Choca (*right*) receives the Marguerite R. Hertz Memorial Award from SPA President Dr. Ron Ganellen (*left*) in honor of Dr. Ted Millon.

Dr. Seth Grossman (*right*) receives the Marguerite R. Hertz Memorial Award from SPA President Dr. Ron Ganellen (*left*) in honor of Dr. Ted Millon.

Dr. Steven Strack (*right*) receives the Marguerite R. Hertz Memorial Award from SPA President Dr. Ron Ganellen (*left*) in honor of Dr. Ted Millon.

been treated for other psychiatric problems, such as depression, anxiety, or alcohol abuse. Of the individuals found to have adult ADHD in the NCSR, only about 11% had been treated for adult ADHD; turning that around, what this means is that 89% had *not* been treated for ADHD. This suggests that although the prevalence of adult ADHD is significant, adult ADHD is a condition that is frequently underdiagnosed and, as a result, is frequently untreated.

Functional Impairment

Think for a moment about the adverse effects associated with ADHD in adults. The literature documents very clearly that ADHD, particularly untreated ADHD, has significant adverse effects in terms of major life activities, including performance in school and occupational settings, level of income, contact with the legal system, financial management and decision making, establishing and maintaining personal relationships, and functioning as a parent. Compared to individuals without ADHD, adults with ADHD complete fewer years of school, change jobs more often, earn less, are more likely to get into trouble with the law, and are more likely to have disruptions in their personal and intimate relationships.

Since adult ADHD can have significant social costs, it is somewhat astonishing that ADHD is so often unrecognized; recall that 75% of the adults diagnosed with ADHD in the NCSR study had never been diagnosed with ADHD by a health care professional. Extrapolating to the general population, that indicates there are currently more than 10 million people with ADHD who have never been diagnosed. Furthermore, of those diagnosed with adult ADHD in the NCSR study, 89% had never been treated for ADHD. While it is reasonable to assume that some of these people were not diagnosed or treated because they were well adjusted and functioning effectively, it is also reasonable to assume that some were not. This is a sobering finding which highlights an important need for assessment psychologists.

Comorbidity

The NCSR also examined rates of comorbidity in adults with ADHD. The literature shows that individuals with adult ADHD quite frequently also meet *DSM–5* criteria for other diagnoses: Estimates suggest that 50–75% of adults with ADHD also meet diagnostic criteria for another psychiatric disorder. To put that into some context, recall that the NCSR estimate is that approximately 14 million adults meet diagnostic criteria for ADHD. Of these adults, 7 to 10 million also meet diagnostic criteria for at least one other psychiatric disorder.

We're all aware that there is an increased risk for an alcohol or substance abuse disorder for individuals with ADHD. The NCSR estimated that 15% of adults with ADHD had comorbid alcohol or substance abuse problems, while only 6% of adults without ADHD had a substance abuse problem.

The NCSR also examined the co-occurrence of ADHD and other psychiatric disorders. They reported that:

(1) Thirty-eight percent of adults with ADHD had a coexisting mood disorder (major depressive disorder [MDD], dysthymia, bipolar disorder) versus 11% of adults without ADHD. Breaking this down further, the NCSR found that 19% of adults with ADHD had comorbid MDD, compared with 8% of those without ADHD. Thirteen percent of adults with ADHD had dysthymia versus 2% without ADHD.
(2) Forty-seven percent of adults with ADHD were also diagnosed with some type of anxiety disorder (GAD, posttraumatic stress disorder [PTSD], panic disorder, or a phobia), while 20% of those without ADHD had an anxiety disorder. The most common anxiety disorder diagnosed in adults with ADHD was social phobia; 29% of adults diagnosed with ADHD also met diagnostic criteria for social phobia versus 8% of adults without ADHD.

Transdiagnostic Factors

One very interesting area of psychopathology research has the goal of identifying psychological processes that underlie and cut across diagnostic categories (Kreuger & Eaton, 2015). Traditional approaches to studies of psychopathology have investigated categories of psychopathology, such as schizophrenia or bipolar disorder, that are rationally or theoretically defined. In contrast, transdiagnostic research uses empirical approaches, such as factor analysis, to determine the structure of disturbed psychological functioning shared by patients regardless of the traditional diagnostic category in which they are assigned.

Results of transdiagnostic research to date identify two major dimensions of psychopathology: disorders described as involving internalizing psychological processes and disorders involving externalizing psychological processes. This distinction between internalizing disorders and externalizing disorders is probably familiar to most of you, as it parallels Achenbach's work with children. Internalizing disorders

encompass mood disorders and anxiety disorders, whereas externalizing disorders encompass acting-out behaviors, such as conduct disorder, antisocial personality disorder (ASPD), or alcohol and substance abuse disorders.

This is a very broad distinction. What is fascinating about this in relation to adult ADHD is that the stereotype of an individual with ADHD is someone who gets into trouble because of their behavior, someone who quits their job impulsively, gets into fights, or drives recklessly. These can be thought of as part of the externalizing dimension. This stereotype is, of course, based on hard evidence. ADHD is associated with increased risk for conduct disorder, oppositional defiant disorder, ASPD, and alcohol and drug use disorders. Studies estimate that 30–40% of adults with ADHD are also diagnosed with ASPD, and approximately 15–30% of adults with ADHD are also diagnosed with an alcohol-related disorder, for instance.

However—and this may seem counterintuitive—the research presented here indicates that adult ADHD also carries an increased risk of internalizing disorders: According to the NCSR, 38% of adults with ADHD have a mood disorder and 47% have an anxiety disorder.

To summarize: (1) Current research has found that 50–75% of adults diagnosed with ADHD are also diagnosed with another psychiatric disorder; (2) between 15–40% of adults with ADHD have an externalizing disorder; while (3) roughly 30–50% of adults with ADHD have an internalizing disorder. In other words, there is a high degree of comorbidity associated with ADHD.

There are certainly individuals with adult ADHD alone. According to the NCSR, 25–50% of their sample were diagnosed only with ADHD. These are people who may experience difficulties in functioning due to problems with attention, organization, time management skills, or self-control. There are also certainly individuals with adult ADHD who have these issues, as well as other issues associated with comorbid disturbances.

I would like to suggest that we differentiate between these two groups. To borrow some terms from the PTSD literature, I suggest we differentiate between simple or uncomplicated adult ADHD and complex or complicated adult ADHD. Adults with ADHD alone would be viewed as having simple or uncomplicated adult ADHD while adults with ADHD plus one or more other psychological disorders would be viewed as having complex or complicated adult ADHD.

Assessment and Treatment

This distinction has important implications both for treatment and for assessment of adult ADHD. Individuals in the uncomplicated ADHD group can benefit from treatment targeting ADHD-related symptoms that cause problems in their lives. Treatment could include stimulant medication and behavior strategies to improve attention, focus, and follow-through.

Treatment for individuals with complicated or complex PTSD naturally is, well, more complex. Treatment would target problems due to ADHD using stimulant medication and psychotherapy, as well as target other symptoms and issues. The treatment approach would, of course, depend on the nature of the comorbid disorder. Some writers, such as Barkley, Murphy, and Fischer (2007), have suggested that separate treatment approaches are required to address ADHD symptoms and comorbid disorders.

This is where assessment has an important contribution to make. In recent years, assessment of adult ADHD has been discussed primarily by our neuropsychology colleagues. If you've looked at the workshops and scientific sessions offered at neuropsychology conferences for the past several years, presentations addressing neurocognitive issues in child and adult ADHD are offered regularly. These presentations are quite interesting and very valuable. What the material I've presented indicates is that mental health professionals, in general, and psychologists, in particular, should not conceptualize and assess adult ADHD only in terms of neuropsychological issues. Personality assessment has much to offer in this area. Let me be clear: I do not mean to suggest that, in terms of assessment of adult ADHD, personality assessment is more valuable than neuropsychological assessment or vice versa. From my perspective, what personality assessment offers complements what neuropsychological assessment offers and vice versa.

When people talk about ADHD and treating adults with ADHD, the focus often is primarily on the difficulties that characterize ADHD: the problems with attention, self-control, impulsivity, organization, or time management. I would like to suggest that this focus does not do justice to individuals, like Joel, who struggle with these issues. Instead, I am advocating that we consider the ways in which ADHD characteristics are woven into the fabric of an individual's overall psychological makeup.

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Dr. Ted Millon's son, Andrew Millon (*right*), receives the Marguerite R. Hertz memorial Award from SPA President Dr. Ron Ganellen (*left*) in honor of his father.

Dr. Theo Jolosky (*right*) receives the Marguerite R. Hertz Memorial Award from SPA President Dr. Ron Ganellen (*left*) in honor of Dr. Ted Millon.

Dr. Dustin Wygant (*left*) receives the Samuel J. and Anne G. Beck Award from SPA President Dr. Ron Ganellen (*right*).

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Going back to the case of Joel, for instance, here's a guy who is bright and has a lot of potential. As a youngster, he heard repeatedly that he was not living up to his potential. Imagine what it is like for other youngsters with ADHD to get the message that they are lazy, or to have their parents and teachers become frustrated with them. These messages can have a profound impact on a youngster. It is no wonder that the tension, fears of failing, and fears of disapproval highlighted by Joel's MMPI–2 profile are so much a part of his experience.

To state this as a more general principle, the experiences an individual with ADHD has as a consequence of difficulties with attention and self-control, and the responses they get from other people because of these difficulties, can have significant effects on their developing self-image, their social skills, their capacity to form interpersonal relationships, or their ability to regulate emotions.

A comprehensive, integrated psychological assessment can highlight issues to be targeted in treatment in addition to specific issues due directly to ADHD. An evaluation can inform a treating professional about the approach most likely to be effective with an individual, such as whether that person is most likely to respond to a directive or supportive approach to treatment. Assessment results can also clue professionals treating adults with ADHD into how likely they are to be engaged in a treatment process and potential roadblocks to treatment.

I would like to suggest that the distinction between the simple, uncomplicated presentation of a disorder as opposed to the complex, complicated presentation of a disorder can be applied to conditions other than ADHD. For instance, I regularly evaluate individuals with chronic pain disorders. For many of these patients, dealing with pain and changes in functioning are the problems to be addressed in treatment. Other pain patients may be depressed, anxious, or angry, or they may abuse alcohol or prescription medications.

In the workshop Paul Arbisi presented on trauma and the MMPI–2–RF at the 2015 Society for Personality Assessment convention, Arbisi similarly described different reactions to traumatic events: The problems experienced by some people who have experienced significant trauma are limited to the direct effects of the trauma, while other traumatized people may be demoralized, depressed, angry, or abuse alcohol and drugs.

The distinction between simple and complex presentations of a disorder has implications for the practice of psychological assessment. We are all aware of the pressures and limitations placed on assessment practice by the entities that approve and pay for psychological assessments. Reimbursement for personality assessment has decreased; we've all felt the pinch. Payment, of course, depends on having an evaluation be approved. There are more limitations on when and why an evaluation is approved today than even a few years ago and certainly more limitations today than when I started practice in the 1980s.

The distinction between simple and complex presentations of a disorder suggests the following. First, not every individual with a disorder, such as adult ADHD, PTSD, or a pain disorder, requires a full, comprehensive psychological assessment. As I noted earlier, for instance, 25–50% of adults with ADHD have simple, uncomplicated ADHD (ADHD with no comorbid disorders). The general principle here, in terms of a cost-benefit analysis, is that there is not much to be gained from a comprehensive evaluation for individuals who fall within the simple, uncomplicated group.

The cost-benefit ratio for individuals who fall within the complex group changes, however. This is where a comprehensive evaluation pays off. I would argue that it is a disservice to the 50–75% of adults with complex, complicated ADHD, or a complex, complicated pain disorder or PTSD, to *not* have a comprehensive psychological evaluation.

One significant challenge to the future of the community of psychologists who provide, teach, and research psychological assessment is the extent to which assessment services are recognized, respected, and paid for. It is our responsibility to educate the public, our colleagues who are referral sources, and the gatekeepers who approve, authorize, and pay for assessment services, about the value of comprehensive psychological evaluations. It is our responsibility to demonstrate through research and clinical practice when and how assessment contributes to clinical decision making and outcomes. It is also our responsibility to develop guidelines for practice that specify when a brief diagnostic evaluation is sufficient and when a comprehensive evaluation is needed. I hope that the distinction offered between simple and complex presentations of a disorder contributes to making the case that, in the appropriate situations, comprehensive, personality evaluations are meaningful, clinically effective, and cost effective.

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Clinical Pearls

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titrate what we do, taking care not to overtax or overwhelm the patient.

The literature on interpretation in psychotherapy, concerning issues such as receptivity to interpretation, technique and titration of interpretation, and models of mind that inform tactics (e.g., Pine, 1990; Weiner & Bornstein, 2009) equally apply in assessment. By definition, assessment involves probing and plumbing of an individual's experience. Dr. Harrower's vignette drives home the power of the act of assessment.

Jaquelin Goldman, PhD (1934–2008), former professor emerita of the University of Florida and President of the American Board of Professional Psychology, had a first-rate intellect. She demanded impeccable competence from her students, many of whom trembled inside when her focus landed on them. Dr. Goldman's lesson learned: *Pay careful attention to what it feels like with the patient as you are testing* (personal communication, 1978). Patients' test responses and interactions may evoke personal reactions in the assessor. Over time, one may codify and correlate countertransference (CT) responses experienced in assessments. A personal taxonomy of personality/psychopathology indicators, based on CT data, is built. When these feelings emerge, diagnostic cues are at hand.

The literature on CT is vast, but its specific relevance in psychological assessment is less appreciated despite discussions of the subject (e.g., Allison, Blatt, & Zimet, 1968; Bram, 2013; Sugarman, 1981). Exner and Weiner (1995) noted that strong examiner reactions (e.g., "skin crawl") in the projective

assessment of disturbed patients has diagnostic significance.

A case example: An 11-year-old boy was referred for testing due to reports of "hallucinations." He had school-based diagnoses of pervasive developmental disorder and "mild Asperger's disorder." After reporting "hallucinations" to his mother, psychotherapy was sought and he was referred for evaluation. Assessment data seemed discrepant with the hypothesis of psychosis or potential schizophrenia. He was interpersonally engaging, his hallucinations were of "scary" visual images, and he was distressed about a possible rupture in his relationship with his unavailable father. Although Rorschach responses involved many weak to poor perceptual accuracy responses, his content and verbalizations were not bizarre, and evoked little in the way of CT. A Continuous Performance Test showed strong indicators of attention-deficit/hyperactivity disorder (ADHD). The literature on childhood hallucinations indicates they are not pathognomic of severe psychopathology (Sidhu & Dickey, 2010). Hallucinatory symptoms may occur in 8–21% of 11-year-old children, and two-thirds of them have no formal diagnosis (Sidhu & Dickey, 2010). The case formulation was that the child had ADHD-primarily inattentive subtype and felt threatened by potential loss of a tenuous relationship with his father. The boy was socially immature and reacted by developing stress-induced hysteroid "hallucinations" which in turn garnered attention in the family. The clinical encounter was very different from that which is often experienced with deeply disturbed youth. The CT data were inconsistent with psychosis and supported a less pathological interpretation. CT data helped direct diagnostic attention to a more benign formulation that guided a different treatment approach than anticipated.

Paul Lerner, EdD (1937–2006), was a noted psychoanalytic writer and articulate spokesman for the Rapaport–Menninger tradition of the Rorschach and clinical inference (Leichtman, 2014; Lerner, 2004, 2007). I once consulted him because although I had a surfeit of psychotherapy cases, I was frustrated in developing a greater emphasis on psychological assessment in my practice. He listened patiently and eventually commented, "You value assessment and want more of it in your work? Then you must act like you value it. Respect this activity. Make it a priority in your practice" (personal communication, 1992). At the end of the session I asked his fee. With a straight face he said "$500" (very much higher than the going rate). I paused, and then understood. His fee was a provocation, paradox, and message: Value your work. I said, "I get it" and paid him the going rate, which he gladly accepted. Lesson learned: *Do what you want to do, value it, resolutely "follow your bliss."*

In the words of Joseph Campbell:

> If you follow your bliss, you put yourself on a kind of track that has been there all the while, waiting for you, and the life that you ought to be living is the one you are living. Wherever you are—if you are following your bliss, you are enjoying that refreshment, that life within you, all the time. (Campbell & Moyers, 2009, p. 120)

At first blush, pairing Joseph Campbell with Paul Lerner may seem odd. But Lerner's passions for baseball (New York Yankees), books (his book store in Camden, ME), psychoanalytic theory (Lerner, 2004), and psychological testing (Lerner, 2004) surely were that "kind of track."

It is my hope these clinical pearls resonate with others. In so doing, these words of wisdom live on, enriching psychological assessment and those who follow that "kind of track."

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Personality, Stress, and Hypertension

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inactivity, diet, or alcohol. And, at any point in the model, individual differences in personality or physiology may predispose a person to engaging a stress reaction that leads to chronic elevations in blood pressure, leading to hypertension and cardiovascular dysfunction.

The psychophysiological reactivity model has shed much light on the need for treatments for hypertension that go well beyond medication management alone. Individuals who appear to be at risk for hypertension due to high blood pressure responsivity are likely to benefit from accurate identification and access to behavioral treatments, in addition to standard treatments for

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hypertension. To date, there is good evidence that if you can assist a person to decrease their daily stress level and decrease the duration or magnitude of the physiologic stress response, you can help them reduce the impact of heightened physiological reactivity and stress responsivity on the system. Behavioral therapies designed to improve stress management skills show the most promise, and eventually greater understanding of underlying physiological processes may allow targeted pharmacotherapy (Blumenthal, Sherwood, Gullette, Georgiades, & Tweedy, 2002).

Primary care physicians and mental health providers should be careful to assess for psychosocial factors that contribute to hypertension and other negative health outcomes via direct effects on cardiovascular functioning as well as secondary effects due to behaviors that interfere with healthy functioning, which often are adopted to cope with stress. There are screening measures available to physicians designed for medical settings that help direct treatment recommendations when further assessment by a mental health provider is indicated (e.g., The Generalized Anxiety Disorder [GAD–7] scale; Spitzer, Kroenke, Williams, & Lowe, 2006).

And when issues of resistance to standard treatments for hypertension are part of a presenting problem for a patient involved in an assessment, it may be worthwhile to consider the patient's personal experience of stress and their subsequent management of life stressors. In particular, repeated exposure to stress on a regular basis should be minimized given its particularly damaging cardiovascular effects, and mindfulness therapies may be particularly useful. Furthermore, personality constructs should continue to be investigated at both the individual level and the population level in order to better understand the role that anger, hostility, negative affectivity, and social inhibition play in magnifying a maladaptive physiological response.

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Ethical Considerations

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his or her parents, and the parents will not receive information without the adolescent present (Wright, 2011). A unique method for providing feedback to children was proposed by Tharinger, Finn, Wilkinson, et al. (2008). They describe a process of providing feedback to children by developing individualized fables that are based on the assessment findings. The story that is created can help the child see him or herself differently and can provide hope for the future. Parents are often a part of this process and may be involved in writing or revising the fable.

The final aspect of the feedback process is ensuring that the client understands as accurately as possible the information the psychologist was trying to communicate. It is best to check in with the person receiving feedback throughout the session, not just at the end. A good feedback session includes providing an atmosphere where clients feel comfortable asking questions, and this provides an opportunity to answer questions as they arise (Wright, 2011). It is also important to assess clients' reactions to the feedback process, especially when their reaction may be negative and result in terminating treatment or failure to follow recommendations. Understanding clients' reactions to feedback is as important as test administration, scoring, and interpretation (Pope, 1992). Thus, there may be times when it is necessary to follow up with the client to make sure the recommendations

are understood and further resources or alternatives can be provided if necessary (Wright, 2011). However, not everyone follows through on recommendations.

When working in a supervisory relationship, whether the supervisees are students, interns, or employees, the psychologist is responsible for providing the feedback. This does not mean that psychologists must give the feedback, but they must take reasonable steps to ensure that feedback is given. The term "reasonable steps" allows for situations where the examinee may not want feedback, is unable to meet for feedback, or a supervisee has misinformed the psychologist about feedback already taking place. However, if an employee or supervisee is not able to provide feedback for any reason, the psychologist should do so (Fisher, 2013).

Some psychologists use scoring services for assessment instruments. Psychologists who are covered entities under HIPAA must include this information in their Notice of Privacy Practices, or get a specific release or information to use such services. Psychologists must also ensure that the service transmits information in a HIPAA-compliant manner that protects client privacy. However, when psychologists ask the scoring service to send a computerized interpretation to a client, it is important for the psychologist to review the information that will be sent to the client to be sure that the computerized interpretation provides understandable information (Fisher, 2013). In this situation, the computerized report is part of the feedback process. Some systems are useful for scoring, but their reports should not be sent directly to clients.

It is important to note that there are times when the Ethics Code permits exceptions to the requirement of providing an explanation of assessment results. Assessment feedback is not usually given directly to the examinee when testing is court ordered, or when assessments involve employment testing, eligibility for security clearances, or the ability to return to work. In those situations, reports are released to a third party and cannot be given to the examinees or anyone else without the consent of the third party. When feedback will not be given directly to clients or their guardians, psychologists are required to inform examinees of this prior to administering the assessment. If legally permissible, the psychologist should also provide the reason why feedback will not be given (Fisher, 2013).

Providing feedback is the final step in the assessment process. It is also required by the APA Ethics Code. The feedback process is valuable to both the assessor and the client. Effective feedback increases the probability that assessment recommendations will be followed, and in many cases feedback has the potential to be an intervention in and of itself. Thus, it is important not to avoid or neglect giving assessment feedback, but to consider it an essential part of the assessment process.

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Practical Strategies for Manuscripts

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Submitting a manuscript. The roundtable members agreed that the cover letter should thank the editor but is not the place to "sell" your paper. They warned against submitting names of people you wish to *not* review your paper. In contrast, roundtable members welcome hard reviewers so that they can better understand how others may find fault with their contribution once it is published.

Being reviewed. There is a strong consensus that if you are reviewed and rejected, you address the reviewer comments when you send it out to another journal. It is a good practice because reviewers likely raised important concerns, and you may get the same reviewer again even at a different journal. When attending to a revise and resubmit (R&R), it is important to address the editor's concerns as they will summarize the main areas they want to see addressed (or may add points of their own). It is important to address every reviewer comment (ideally with page numbers and lines where you changed the manuscript to address the concerns). Address each comment, even if the way you address it is to argue against the point. Several roundtable members cautioned against implementing every reviewer comment because it may cause the manuscript to lose focus or coherence.

Being a Reviewer

Graduate student perspective. Reviewing papers can be an invaluable learning experience in showing you how manuscripts are improved: You can see how your review compares with how other experts in the field think about the manuscript, and you can take advantage of observational learning about what not to do. We reported that a typical progression is to start co-reviewing late into graduate school, and once you have published a few papers. From there, you may receive invitations to review on your own. On your CV, you may cite the journals you have reviewed for (but not the number of times for each journal). Invitations to review can be monthly or about once every couple of months. We discussed how there may be a reluctance to review a manuscript where you are not expert in the topic of the paper. This reluctance must be balanced with the general advice from the roundtable members to agree to review when asked. One way I

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reconcile this is to remember that the action editor likely asked me for a reason, and that I represent the voice of a general audience who may not be immersed in the specific field but may still find the topic interesting and important. Some core questions during my review relate to the introduction (did they effectively introduce the topic to a psychologist who does not specialize in that segment of the field), method (do the statistics make sense with the hypothesis), results (are the results described coherently, clearly, and efficiently), and discussion (do they efficiently describe their contribution to the field; do they over generalize their findings; do they highlight relevant limitations in their concept, hypothesis, participants, measures, procedure, and analysis, etc.).

How often to review. Members of the roundtable were clear that it is important to review when asked to do so. Unlike some magazine publishers who hire people to review submissions, we rely on each other in the field for quality control. Because of this, science could not progress without reviewers to carefully consider what should be published, and by taking part we are doing our field a service. It was suggested that you could turn down a review for a journal you will likely not publish in, but if you hope to publish in the journal it is helpful to assist them when asked.

How to conduct a good review. The roundtable members suggested that a good review summarizes the contribution's main points and strengths in a first paragraph. Next, highlight the two to three main critiques you have with the manuscript. Then, highlight specific concerns with page numbers and line numbers to facilitate clarity. All recommended taking a tough, critical, yet careful tone. This is a small field where, although often a blind review process, one can often discern the source of the reviewer. It pays to be fair and objective, as you would wish the same for your manuscript. All the experts on the panel suggested that at one time or another they have reviewed, accepted, and rejected each other's work. Although this may feel like a dual-role relationship (friend, colleague, reviewer) with such a small field it is necessary, and in reality is not a good colleague also a tough but fair reviewer? When reviewing papers that are in your area, you may notice that you are not cited where you could be. The roundtable generally felt it is okay to recommend citing yourself in a review, but to ask yourself: "Why does *my* paper need to be the one cited?" If there is a more appropriate paper, recommend the other paper instead.

The Teacher's Block

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means here. He may have to consult with other members of the band on this one, but don't hold your breath because they've had some legal battles in the past.

17. Now for a softer sound: Linda Ronstadt (via Roy Orbison) singing, "Blue Bayou." How about CF, Na, and maybe even the rare Ge? As an aside, what if Linda gave a shout-out to her former beau, Governor Jerry Brown of California? Would it be DR? Also, are bayous actually blue? If not, then INCOM or, depending on the blot, maybe even the rarest code of them all: the good ol' CP! Lastly, do we give a MOR for the "blue" feeling?
18. The group Velvet Underground: Code possibly a Texture and Vista in the band name? And their tune, "Pale Blue Eyes" FC.FY 2 Hd. Another…what about the rock band Radiohead? Code INC? Or, CONTAM? Their song "Staircase" would get Sc and possibly Hd, whereas another one of their songs, "Lotus," would get the very rare combo of Bt and Ay. Or, more straightforward to score, Talking Heads? Ma 2 Hd and INC2 (heads don't talk; right?). We won't code "Stairway to Heaven"—it's rock-n-royalty and therefore above being coded, but…oh well, Hh? SC? Na? And a FABCOM? Ma as well; after all, she is climbing the stairway to heaven.
19. The amazing Chuck Berry's "Brown-Eyed Handsome Man." FC. Ma H (movement for lyric "rounding third… headed for home."). Also a nice, healthy fabulation in the Rapaport, Gill, & Schafer (1968) tradition.
20. Elton John's "Blue Eyes." Code it CF or FC? Well, he says, "Baby's got blue eyes," so it's FC for Sir Elton's song, and he adds that he longs to be by her side, so Mp and Hx? But then he also tells us about a "blue, blue day." So add MOR. A very complex coding for a very beautiful song.
21. Very different from Earth Wind & Fire's beautiful song, "Evil." Can "evil" be "beautiful?" Maurice White sings: "Me and evil are about the same." CONTAM? Not really, because they are "about" the same," but not yet fully merged. Check out the Hx consideration on this one. It's also borderline for Ma.Fr.
22. Oh, and lest we forget the Doobie Brothers' "Long Train Running." Is there such a thing as a "long train?" If not, then DR? Code Science for the train itself. Maybe if they meant that the train has been running for many years, then code ma and no special score. Recall that they also say that the train is "down around the corner, half a mile from here, see that long train run and then watch it disappear." If so, then FD for perspective? Plus, they sing: "You know I saw Miss Lucy down along the tracks. She lost her home and her family and she won't be coming back." We never know what happens to Miss Lucy, but we do not want to code MOR or think S–CON. They also sing: "Without love, where would you be now?" Not sure how to code it, but well worth trying just to hear the guitar riff that is your reward right after Tom Johnston sings "…where would you be now?"
23. How about the early Nineties rap "Bust a Move"? Code Ma for the movement. Not sure about AG because no one is actually getting hurt. We'd use the R–PAS method here because there are just too many lyrics coming too quickly to track. Even those of us with super processing speed would get lost. We need to structure the rap. Oh, by the way, the artist is Young MC. Hmm…M.C?
24. A bit of Brazil: Antonio Carlos Jobim's "Wave." He sings: "Whenever two can dream a dream together." Well, we have H, a pair (2), Na, and COP, but what about Ma for the act of dreaming together? Technically, no code is assigned because it is in the future tense, but it is an ideational activity nonetheless, so we'll give it Ma and deal with the teacher's comments. Now, for the kicker: Can two people really dream a dream together? Is this the ultimate COP, or is it spoiled by a FABCOM? We should probably ask: "You said whenever two can dream a dream together?" Who knows if they can or can't. FYI: Frank Sinatra was among the many who recorded this song, and we could get under his skin with an inquiry question, so we think it's best leave well enough alone. As another FYI: Sinatra did record: "I've Got You Under My Skin," but that's way too complex, so we'll let the Chairman of the Board (i.e., Sinatra), RIP on this one. We'd rather go with Franki Valli and the Four Season's version of this same song.
25. Last, it seems as if every large-scale charitable musical show or event that has all the major artists present closes with a Paul McCartney performance, so we, too, go to Sir Paul as our closer and trot out his great Beatles' single "Yesterday." Included among the poignancies in this song is the stanza: "I'm not half the man I used to be.

There's a shadow hanging over me." Okay, here goes: Hd because he is now a half man. INC1 for the strangeness of it? What about a MOR because of the dysphoria? Now, we also give it a FV for the way in which the song introduces perspective (i.e., anyone who is able to take a step back and see that they've changed, even if the change process itself has evoked a painful introspection, deserves a Vista code). But there's more: What about the overhanging shadow? mp? FY? Yes, FY if we assume that its Paul's shadow and caused by the light-dark blot features. If not, then YF.

This is what coffee shop regression is like. We like to think of it as regression in the service of the ego. We also like to put assessors in the artist category. So, code us W+, Ma. FC. FT + (2), P, H, Art, Z, COP. Otherwise, we're in trouble! Okay, we'll take a tendency toward DR.

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SPA Fellows

Chris M. Front, PsyD, ABAP, is the Clinical Psychologist for the Office of Aerospace Medicine at the Federal Aviation Administration's (FAA) headquarters. In that role, he is the specialty consultant reviewer of pilot and Air Traffic Control Specialist (ATCS) psychological evaluations for the Federal Air Surgeon and for FAA flight surgeons throughout the country. He manages the program for the psychological evaluation of all ATCS applicants, interpreting the MMPI–2 screening results of approximately 1,500 per year to determine their psychological eligibility for medical clearance, guiding and reviewing the psychological evaluations performed on applicants who require further evaluation, and making recommendations for final dispositions. Dr. Front also acts as the primary consultant to the Federal Air Surgeon and develops FAA policies related to psychological evaluation. He develops, coordinates, and provides training workshops and seminars for clinical psychologist and neuropsychologist consultants to the FAA regarding the assessment procedures and standards required for aviation-related psychological evaluations. He also coordinates research projects in aerospace clinical psychology and provides expert testimony to the National Transportation Safety Board. Dr. Front earned his BA in Psychology from West Virginia University. He holds an MA in Communication Studies from the University of California at Santa Barbara. His MA and PsyD in Clinical Psychology are from Pacific University. Dr. Front is a Diplomate of the American Board of Assessment Psychology (ABAP). He is an Associate Fellow of the Aerospace Medical Association and a member of the Aerospace Human Factors Association and the Association for Aviation Psychology, as well as the Society for Personality Assessment.

Christopher J. Hopwood, PhD, is an Associate Professor of Clinical Psychology at Michigan State University (MSU) and a licensed psychologist in the state of Michigan. He received his PhD under Leslie C. Morey at Texas A&M University, and completed his clinical internship under Mark A. Blais at the Massachusetts General Hospital/Harvard Medical School. He maintains a small practice in addition to teaching and supervising assessment and psychotherapy to MSU doctoral students. He has published numerous empirical articles, book chapters, and books about personality assessment, in addition to his federally funded research on personality pathology, substance abuse, and interpersonal processes. He is a former President of the Society for Personality Assessment Graduate Students (SPAGS), recipient of SPA's Beck and Exner awards, and former Associate Editor of the *Journal of Personality Assessment*. He is currently President of the Society for Interpersonal Theory and Research, Vice President of the North American Society for the Study of Personality Disorders, and Associate Editor for *Assessment* and *Journal of Personality Disorders*. SPA has been his professional home since early in his graduate career; Chris has attended every meeting since 2005.

Dustin B. Wygant, PhD, received his bachelor's degree in Psychology at Miami University and his master's and doctoral degrees in Clinical Psychology at Kent State University, where he was mentored by Yossi Ben-Porath. He is an Associate Professor of Psychology and Director of Clinical Training of the doctoral program at Eastern Kentucky University (EKU). His primary research interests include the conceptualization of the psychopathic personality and the *DSM–5* Section III model of personality disorders. Other research interests include the detection of malingering and deception in psychological evaluations and the use of the MMPI–2–RF) in forensic and medical settings. Outside of EKU, he is a licensed psychologist and maintains an active private practice conducting forensic psychological evaluations. He was recently awarded the Samuel J. and Anne G. Beck Early Career Award by the Society for Personality Assessment.

SPA Personals

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Steven Huprich, PhD (Editor, *Journal of Personality Assessment*), has had a new edited book released by the American Psychological Association Press: *Personality Disorders: Toward Theoretical and Empirical Integration*. This book includes contributions from notable personality psychology experts, including Robert Bornstein, Irving Weiner, Stephen Strack, Ken Levy, and John Clarkin. It also includes chapters by the late Drs. Sidney Blatt and Theodore Millon, which may be their last published pieces. The book may be ordered online at http://www.apa.org/pubs/books/4316164.aspx.

Drs. Steven Huprich and Robert Bornstein have also had a series published in *Psychoanalytic Inquiry* entitled "Toward an Empirically Informed 21st Century Psychoanalysis: Challenges and Opportunities." Contributors include Society for Personality Assessment members Drs. Jed Yalof, Jill Clemence, and Anthony Bram, along with contributions by Drs. Otto Kernberg, Patrick Luyten, Jon Mills, Steven Roose, Eve Caligor, and Nancy McWilliams. The series can be downloaded for free at http://www.tandfonline.com/toc/hpsi20/35/sup1.

From the Editor…

Jed A. Yalof, PsyD, ABPP, ABSNP

This issue of the *Exchange* includes articles on supervision, ethics of test feedback, assessment and psychosomatics, publication processes, clinical wisdom, and Rorschach coding; updates in other areas; a clinical illustration from SPA President Dr. Ron Ganellen as part of his President's Message; and photos that provide memories from the highly successful SPA Annual Convention in Brooklyn.

This is my last issue as Editor of the *Exchange*. Much appreciation goes to the Associate Editors and other contributors, including our SPA Presidents, SPAGS Presidents, and Public Affairs Director Dr. Bruce Smith; my colleagues on the SPA Board of Trustees; the SPA Administrative Directors; and Cathy Ott of Taylor & Francis, who has been so helpful in her role as Production Editor of the *Exchange*.

Beginning with the next issue, Dr. David Streiner assumes the role of *Exchange* Editor, and I will continue as an Associate Editor. Until then...

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