spa exchange

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President's Message

SPA Fever: Springtime in Brooklyn

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It has been a short time since the Society for Personality Assessment (SPA) Fall Board meeting was adjourned. I left the meeting feeling energized and excited about what we accomplished. At the top of the list of things I'm excited about is the 2015 SPA annual convention which will take place in Brooklyn, New York. For those of you whose image of Brooklyn comes from the 1970s and the movie *Saturday Night Fever*—think again! This is not the Brooklyn that John Travolta danced through. The Brooklyn of 2015 where we'll be staying is hip and vibrant and has many shops and restaurants to explore and enjoy.

For those who are not convinced that good food, good shopping, and easy access to the Big Apple are reason enough to attend the convention this year, let me mention that the program, put together by Program Chair Bob Bornstein, has plenty to offer. To give you a taste of coming attractions, there will again be an embarrassment of riches in the workshops scheduled by CE Chair John Porcerelli. There is not room here to list all the workshops and presenters, but John's committee has made sure the workshops will cover a wide range of topics. These include assessment of trauma-related conditions using the MMPI–2–RF presented by Paul Arbisi, R–PAS assessment of children and adolescents taught by Phil Erdberg, and a workshop led by Chris Hopwood and Mark Ruiz illustrating use of the PAI in forensic contexts. Seth Grossman will introduce the newest revision of the MCMI; the MCMI–IV is scheduled to be released in late spring of 2015. Other workshops will focus on improving report writing skills, issues in assessment of domestic violence, multi-method approaches to forensic evaluations of the potential for violent behavior, and applications of attachment theory to inform psychodynamically oriented psychotherapy. An approach to developing more productive, collaborative therapeutic relationships with clients who have a deep mistrust of others based on the Therapeutic Assessment paradigm will also be offered.

As I prepared the sample of topics covered in the workshops presented above, it seemed abundantly clear that the SPA convention offers something for everyone in terms of the assessment tools covered, applications in forensic settings, contributions to psychotherapy and treatment planning, assessment of children and adolescents, and teaching and improving assessment skills. Nearly all of the workshops are also relevant to developing proficiency in psychological assessment. As many of you know, SPA has been approved by the American Psychological Association to credential assessment psychologists as being proficient. SPA has begun accepting and reviewing applications for certification in proficiency in personality assessment. There have been some growing pains in establishing the process to review these applications. With Mark Blais's steady hand steering this initiative, most of the kinks have been worked out. Please be on the lookout as information is distributed by Hadas Pade, the new SPA Proficiency Coordinator, outlining the steps one needs to take to be recognized as being proficient in personality assessment. I invite you all to apply!

At the 2014 SPA convention I announced a program to allow SPA members to offer a one-year, free membership to colleagues interested in assessment who have never been a member of SPA. This free membership includes a one-year subscription to *Journal of Personality Assessment* (*JPA*) online. This program is now up and running. You likely saw the notice for the program when you received your dues statements. Let me encourage you to pass on the benefits of SPA membership to someone deserving.

SPA has benefitted from efforts to nurture a productive working relationship with the American Psychological Association Practice Directorate and the American Psychological Association Education Directorate. One of the fruits of this relationship borne this year was a joint effort by the Education Directorate, under Cynthia Belar's leadership, and SPA to produce the first in a series of webinars for graduate students. Gary Groth-Marnat presented a well-received webinar which focused on ways to improve the quality of psychological assessment reports. We received confirmation of the high quality of this program from Cathi Grus of the Education Directorate. Cathi told us recently that this webinar has gotten tons more hits than all of the other webinars for graduate students they put on last year. For those of you interested in enhancing your own report-writing skills or in showing the webinar to psychology graduate students or interns to improve their skills, the webinar can be accessed for free through a link on the SPA website (www.personality.org).

I hope you have all visited the SPA website and have noticed the updates and improvements put into place recently through the efforts of Monica Tune and J. D. Smith. One change reflects and honors the international composition of our mem bership with a banner proclaiming "welcome" in multiple languages. The homepage also provides links for viewing recent Master Lectures and other presentations from recent SPA annual conventions online for free. This is a great way to enjoy these interesting, informative, and entertaining talks a second time or, if you were unable to attend the SPA convention, to be able to view these top-notch presentations a first time. (And *then* a second time.) These free videos can also be used as teaching tools. Speaking of teaching, the SPA website offers other resources for members active in graduate training prepared by the Education and Training Committee headed by Radhika Krishnamurthy. This includes a list of volunteer SPA "experts" who are willing to consult and share information, ideas, and their experiences to

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In this issue...

Special Topics in Assessment

Clinical Pearls
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This Special Topics in Assessment section by Mark H. Waugh, PhD, ABPP, discusses an often overlooked topic in the assessment literature, or, for that matter, in the written literature of most scientific endeavors: 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 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 the first of a two-part article for the Special Topics in Assessment section, Mark Waugh focuses on technical matters in psychological assessment and unpacks some of his most valued pearls; Part II in the next issue of the *Exchange* will examine more clinical and interpersonal issues.

Clinical Pearls in Psychological Assessment: Part I

Mark H. Waugh, PhD, ABPP
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The *clinical pearl* concentrates information and wisdom with remarkable staying power. Teachers, supervisors, and mentors fade away—sometimes within one's career, surely across generations. But clinical pearls we have been bequeathed do not have to be mortal. In this spirit, I offer "lessons learned" from propitious interactions with mentors for others to share. In *Part I*, technical matters in psychological assessment are illustrated with vignettes of George S. Welsh, Mary McCaulley, Roger Blashfield, and Jane Loevinger. *Part II* (next issue) features Sidney Blatt, Molly Harrower, Jacquelin Goldman, and Paul Lerner addressing more experience-near aspects of psychological assessment.

George S. Welsh, PhD (1918–1990), was known for work with the *Minnesota Multiphasic Personality Inventory* (MMPI; Hathaway & McKinley, 1951), on the nexus of personality and creativity, and the *Welsh Figure Preference Test* (Welsh, 1959). He developed the "A" and "R" scales of the MMPI. In studies on personality and creativity, he described the domains of *Intellectence* and *Origence*, which in part anticipated *Openness to Experience* in the "Big 5" personality model (Digman, 1990). **Lesson Learned:** *It is not easy to write a good test item* (personal communication, 1975). Unpacking this pearl is revealing. A good test item requires understanding communicative intent and the phenomenology of the responder. Construct validity starts at the item level with items reflecting substantive and structural validity (Loevinger, 1957). The initial item pool casts a broad net with items wider than the target construct as well as discriminant constructs. Tellegen and Waller (2008) illustrate integration of theory making and theory testing at the item level, from the start, in a sequential and iterative manner in the *Multidimensional Personality Questionnaire* (Tellegen, 1982), over a 10-year period.

A depression scale with variants of "I feel sad" 20 times produces an impeccable Coefficient Alpha but poor psychometric integrity. Maximizing internal consistency produces an overly narrow test because high item inter-item correlation means each item essentially is equivalent to the rest. Little information is gained across the item pool (i.e., the "attenuation paradox"; Loevinger, 1954). Items should inter-correlate moderately; achieving homogeneity requires other techniques such as factor analysis (Clark & Watson, 1995). Gough (1965) described primary, secondary, and tertiary levels of test score meaning. *Primary* refers to predictive validity. *Secondary* involves explication of the latent construct in the test score. *Tertiary* analysis seeks understanding of broad implications, such as linkage to other realms of knowledge or application. When Dr. Welsh pronounced "it is not easy to write a good test item," these issues were explicit as Gough (1965) was assigned reading. When he opened class, Welsh presented a new vocabulary word. One was "shibboleth." My example: "some worship at the shibboleth of coefficient alpha."

Mary McCaulley, PhD (1920–2003), co-wrote the Manual for the Myers–Briggs Type Indicator (MBTI; Myers, McCaulley, & Most, 1985) and founded the Center for Application of Psychological Type. Despite her unassuming manner, she was the central driver in the wide success of the MBTI. She also was a student of the Rorschach pioneer, Zygmount Piotrowski. **Lesson Learned:** *Take good notes* (personal communication, 1978). That is, be practical; pay attention and record details of the assessment interaction. This is apt advice for many in psychology who, in the vocabulary of the MBTI, often are "NP" (intuitive-perceptive) types, not inclined to detail, tending to see the forest and not the trees. Taking "good notes" may seem a banal injunction. Assiduous note taking, however, permits the examiner to revisit the assessment session, potentially revealing important test and nontest information that may have escaped notice.

Roger Blashfield, PhD, had a gift for rigor while modeling compassion for patients and kindness toward students. He emphasized, in particular, Bayes's Theorem. **Lesson Learned**: *The most important part of an article is the method section* (personal communication, 1978). The "devil is in the details." applies to scientific articles, test manuals, and test application. The Millon Clinical Multiaxial Inventory (MCMI–III; Millon, Millon, Davis, & Grossman, 2009) is a well-known

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Differentiating Suicidal and Nonsuicidal Self-Injury in Self-Harming Individuals: Current Issues and Classification Systems

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In the past, suicide research has been complicated by a lack of clear definitions for effectively distinguishing suicide attempts from other forms of self-harm behavior. Suicide attempts, suicide "gestures," preparatory acts, self-mutilation, and other self-harm behaviors often share a number of similar features that have made classification difficult. Indeed, researchers may not have seen the need for distinguishing these acts from one another due to the inherent risk for suicide signaled by each, thinking instead of these features as falling somewhere along a single continuum. However, it has become clear that these are relatively distinct constructs that need careful classification as research on suicide and self-injury moves forward. As a result of more recent research on suicide and self-injury, efforts have been made to separate the cognitive construct of "suicidal intent" from the behavior of "self-harm." Doing so has led to the distinction between *suicide attempts* (defined as self-harm with intent to die) from *nonsuicidal self-injury*, which is self-harm with no intent to die as a result of the act. These operational definitions have improved our ability to conduct and evaluate research on suicide by enhancing our ability to determine the object of study.

Suicide remains a daunting problem for clinicians and patients due to the difficulty with prediction. In self-harming patients, the concern about suicide is often high and for good reason. Self-harming behavior has been found to be a major risk factor for suicide. While there is a high occurrence of nonsuicidal self-injury in the general population (lifetime prevalence rates of up to 38% for adults; Brown, 2009), which is nearly doubled in clinical populations (up to 60% of psychiatric inpatients; Victor & Klonsky, 2014), suicide is somewhat rare by comparison. Yet, among those who engage in nonsuicidal self-injury, approximately 50–75% go on to attempt suicide (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Researchers are just now starting to identify the risk factors that separate those who self-harm in the context of suicidal ideation and intent from those who self-harm for other reasons, typically to relieve negative affect or to exert some type of interpersonal influence. Currently, the research community is highly invested in working to discover why some with nonsuicidal self-injury go on to attempt suicide while others do not, as well as to understand when self-harm may be chronic or may remit over time.

Likely, at least in part due to the extensive research being conducted with adolescent and college populations, it has become apparent that self-harming behaviors are not isolated to individuals with borderline personality disorder (BPD; Selby, Bender, Gordon, Nock, & Joiner 2012). Traditionally, self-mutilation has been considered a hallmark of BPD, but research findings demonstrating the high occurrence of this behavior among those who do not meet criteria for BPD has challenged this relationship. Recent findings have led researchers to consider the behavior to be a marker of underlying processes, such as distress intolerance (Anestis, Knorr, Tull, Lavender, & Gratz, 2013), which can be present in those with or without personality pathology. This discovery has prompted the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013) to include a diagnosis of nonsuicidal self-injury in Section-III Emerging Measures and Models as a condition for further study. As with many aspects of the *DSM–5*, the "diagnosis" aspect of the concept is controversial; however, it is important to note the growing realization of the importance of distinguishing self-harm by intent. The proposed *DSM–5* criteria define nonsuicidal self-injury as intentional, self-inflicted bodily damage that is not socially sanctioned (e.g., tattoos or piercings) that occurs in the absence of suicidal intent. To meet criteria the behavior should be recurrent (occurring at least five days in the past year), and the individual who engages in the behavior must have an expectation that the self-harm act will provide relief from a negative feeling state or interpersonal difficulty. There may also be some preoccupation with the self-harm act when not engaging in the behavior. This definition is quite consistent with research on nonsuicidal self-injury and clinical observation and further marks the importance of discerning the quality or presence of ideation and intent to die in the context of self-harming behaviors.

Because self-harm chronicity, frequency, and co-occurrence with suicidal ideation vary in the magnitude of the relationship to suicide, the distinctions between suicidal behavior, suicidal ideation, and nonsuicidal self-injury have become especially important in the effort to improve prediction models for suicide risk. It is this need that has led to the development of classification systems for distinguishing self-harm behavior with and without suicidal intent. While several methods allow for identification of risk for suicide within more global personality formulations (e.g., Rorschach Comprehensive System [Exner, 1974], Rorschach Performance Assessment System [Meyer, Viglione, Mihura, Erard, & Erdberg, 2011], Minnesota Multiphasic Personality Inventory–2 [Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989], Schedule for Nonadaptive and Adaptive Personality [Clark, 1993], etc), these instruments do not allow one to classify self-harm behaviors into suicidal or nonsuicidal, specifically. There are several measures, however, that allow one to systematically collect information on features of self-harm behavior in order to measure the intensity of self-injury and to distinguish types of self-harm. The two most robust measures are the Suicide Attempt Self-Injury Interview (Linehan, Comtois, Brown, Heard, & Wagner, 2006; http://blogs.uw.edu/brtc/publications-assessment-instruments/) and the Self-Injurious Thoughts and Behaviors Interview (Nock, Holmberg, Photos, & Michel, 2007). Each of these structured interviews allows one to collect information on medical severity, frequency, intent, and context of self-harm events in a systematic and thorough manner. For more information and a full overview of assessment measures used to document self-harm behaviors, see Klonsky and Weinberg (2009).

In terms of brief interviews, probably the most popular scale in research circles is the Columbia–Suicide Severity Rating Scale (C–SSRS; Posner et al., 2008; www.cssrs.columbia.edu). The C–SSRS is often used due

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Guidelines for Clinical Supervision in Health Service Psychology

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Supervisors are assumed to be competent. However, psychology historically has not emphasized the definition, assessment, or evaluation of supervisor competence (Bernard & Goodyear, 2014; Falender & Shafranske, 2013). As psychology has begun to articulate specific areas of competence for health service psychologists, recognition that supervision is a distinct area of professional competence has occurred (Fouad et al., 2009). Yet, until recently there have been no agreed-upon guidelines for clinical supervision in health service psychology. That changed in August of 2014 when the American Psychological Association adopted as policy the Guidelines for Clinical Supervision in Health Service Psychology (supervision guidelines). As a caveat, health service psychology is a term that is inclusive of the overlap between clinical, counseling, and school psychology. Adopting the supervision guidelines as policy highlights the role of high-quality supervision in education and training of health service psychologists. While guidelines are aspirational, not required, the supervision guidelines outline practices that facilitate competent supervision and can both enhance the quality of services provided by trainees and minimize potential harm to patients and trainees (Ellis et. al., 2014).

A task force established by the American Psychological Association Board of Educational Affairs (BEA) in March 2012 developed the supervision guidelines. Dr. Carol Falender served as the chair. Other members included Drs. Beth Doll, Michael Ellis, Rodney K. Goodyear, Nadine Kaslow (liaison from the American Psychological Association Board of Directors), Stephen McCutcheon, Marie Miville, and Celiane Rey-Casserly (liaison from BEA). I served as the staff liaison from the Education Directorate. A draft of the guidelines was circulated for comment in the fall of 2013 and those comments led to several revisions that resulted in the final draft.

The supervision guidelines were developed not only to promote practices associated with high-quality supervision but also to foster competency development in trainees and communicate to those entities charged with regulating the practice of psychology that training occurs in the context of supervision that is of high quality. The supervision guidelines are based on a competency model with respect to both that of the supervisor and trainee. In addition, they are meta-theoretical; that is, they apply regardless of the theoretical or practice modality that might be applied to supervision. Of note, the supervision guidelines are meant to apply to the supervision of assessment activities as well as other types of clinical activities.

Included in the supervision guidelines is a series of statements that outline assumptions about supervision that the task force established as overarching. For example, supervision "is a distinct professional competency that requires formal education and training." The assumptions were considered foundational to the practice of quality supervision and therefore are not articulated as specific components of the guidelines.

Seven domains related to supervision were selected as a result of reviewing pertinent literature and guidelines for supervision in other behavioral health professions and those developed for psychologists in other countries. They are: Supervisor Competence; Diversity; Supervisory Relationship; Professionalism; Assessment/ Evaluation/ Feedback; Problems of Professional Competence; and Ethical, Legal, and Regulatory Considerations. With each domain there is a general overview describing the relevance of that domain to supervision. Following that are the guidelines for the domain that are presented with citations of current, relevant literature as available to support the guideline.

Supervisor Competence addresses the overarching need for the supervisors to be competent with respect to the services they are supervising, to maintain their competence, to coordinate with other professionals who may be supervising the trainee, to work to be competent with respect to serving diverse populations and settings, and to ensure when using technology to conduct supervision they have the requisite competencies to do so. The Diversity domain addresses the supervisors' diversity competence and maintenance of competence, that of the trainee, and that supervisors facilitate and model respect and awareness of issues related to diversity within the supervisory relationship. Guidelines related to the Supervisory Relationship address the role of the supervisor in creating a collaborative relationship with trainees under their supervision, that expectations are clear, and that there is a regular review of the trainee and the supervisory relationship. Professionalism addresses the role of the supervisor in modeling behaviors associated with professionalism and fostering the development of professionalism in trainees. The domain that addresses Assessment/ Evaluation/Feedback contains guidelines that relate to openness and transparency in feedback and assessment, regular monitoring and communication with trainees about their performance, specific and timely feedback that is delivered in a manner sensitive to the trainee and the supervisory relationship, fostering self-assessment skills, and ensuring supervisors obtain and use feedback about their performance as supervisors. Problems of Professional Competence includes guidelines that supervisors are aware of relevant policies and procedures, address performance problems directly and in a timely manner, understand how to develop and implement remediation plans, and are mindful of their roles as gatekeepers. The seventh domain—Ethical, Legal, and Regulatory Considerations—speaks to the importance of supervisors modeling ethical practice and decision making, upholding protection of the client/patient, fulfilling their role as gatekeepers, being clear about the parameters for supervision (which might include the development of a written supervisory contract), and ensuring that documentation is timely and accurate.

It is hoped that training programs will adopt the supervision guidelines and encourage supervisors to attain and maintain relevant competencies in supervision. Further, education and training programs should incorporate the supervision guidelines into courses or other didactic or experiential training activities meant to prepare trainees to supervise. The guidelines will be published in an upcoming issue of the *American Psychologist*. They can also be found at: http://www.apa.org/about/policy/guidelines-supervision.pdf.

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What Is a Collateral?

Linda Knauss, PhD, ABPP
Widener University

Mr. and Mrs. Miller were concerned about their 19-year-old son, Stephen (all names are pseudonyms). Although he was an average student in high school, he failed his first semester in college and said that he did not want to return to school. The Millers learned that Stephen had stopped attending classes in mid-semester and spent most days sleeping while he stayed up all night playing video games. When he returned home he began to dress all in black and seldom left his room. The Millers wanted to know what was wrong with Stephen and what to expect in the future. Their family physician referred them to me for a psychological evaluation with an emphasis on personality functioning. On our first meeting, I interviewed Stephen along with his parents. Stephen signed the informed consent form, the *Health Insurance Portability and Accountability Act* Privacy Notice, and a release of information form allowing me to share the results of the evaluation with his parents. I then spent two sessions testing Stephen. We scheduled the feedback session for Stephen and his parents for three weeks after the last testing session. However, only Stephen's parents arrived for the feedback session. They told me that Stephen had made a suicide attempt the previous week and was hospitalized on the psychiatric unit of their local hospital. However, they were very interested in the test results, so they decided to keep the appointment. Because Stephen had signed a release of information form permitting his parents to know the results of testing, I conducted the feedback session, indicating that I would give feedback to Stephen when he was released from the hospital. Stephen's parents found the test results very helpful and said they wished they had known some of the information earlier in Stephen's life. The testing feedback led to a discussion regarding the ways in which Stephen's parents could improve their relationship with him. The Millers had an insurance plan that covered testing and asked that I submit the bill to their insurance company.

There are several ethical as well as billing dilemmas in this situation. Other people are often involved in the treatment of a client, such as family members, significant others, or close friends. They give extremely valuable information that can be useful in an assessment or helpful to a client's therapy. Sometimes, as in this situation, other people attend therapy or feedback sessions without the identified client, such as when family members meet with a psychologist while a client is hospitalized. These persons attending treatment or feedback sessions are not clients of the psychologist, but they are collateral to someone else's treatment.

Section 10.2 of the American Psychological Association's *Ethical Principles and Code of Conduct* (American Psychological Association, 2010) states,

> (a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained.

In some situations, the client/patient is the multi-person unit, such as a couple or family, and the primary obligation of the psychologist is to the parties as a whole (Fisher, 2013). However, when someone is collateral to someone else's treatment, "The collateral is not the patient and, consequently is not the subject of treatment. Therefore, the psychologist's primary duty is to the patient and not the collateral" (Younggren, 2009, p. 19).

Collaterals do not have a separate record, and information from them becomes part of the identified client's chart. The collateral does not have access to the client's chart without the consent of the client, and clients control the disposition of their records (Knauss & Knauss, 2012). If the client is a minor, and the collateral is a parent, then access to the record and release of information is regulated by the legal rights parents have according to state law (Younggren, 2009). In addition, collaterals cannot keep secrets from the client because the collateral is not a client. The client has access to all information.

Although psychologists do not have the same legal obligations to collaterals as they do to clients, they should treat all persons, including collateral contacts, respectfully and orient them to their role in providing services to the client (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013). As part of informed consent, collaterals should understand how the information they provide may be used because the psychologist may be mandated to report the information obtained from the collateral, such as in the case of child or elder abuse and/or dangerousness to self or others as required by state law (Knauss & Knauss, 2012; Younggren, 2009). Collaterals are not responsible for paying for their visits unless they agree to be financially responsible for the client (Knauss & Knauss, 2012), or unless the collateral is financially responsible for the client such as when the collateral is a parent and the client is a minor (Younggren, 2009).

Consistent with the American Psychological Association *Ethics Code*, it is important to clarify who is a collateral and who is a client at the beginning of treatment or assessment. It is also important that collaterals understand and agree to their role. At the very least, psychologists should document a discussion of these conditions in the client's chart, and the use of a signed agreement that outlines the role of a collateral may be a very good idea. Templates for this type of agreement are available from a variety of sources, including the website of the American Psychological Association Insurance Trust at www.apait.org (Younggren, 2009).

Although collaterals are not the subject of treatment, they may derive some secondary benefit. Stephen's parents learned a lot about his personality and functioning, which allowed them to improve their relationship with him. However, problems occur when individuals in the room consider themselves clients while the psychologist considers them collaterals. This is most likely to become a problem when working with high-conflict families and the release of records becomes an issue. If someone is going to be involved in treatment on a regular basis, or if that person becomes the focus of treatment, it may be necessary to think of the case as couple or family therapy and get a new informed consent agreement (Knauss & Knauss, 2012).

In the case example at the beginning of this article, Stephen is the identified client, and his parents are collaterals. There are three distinct types of sessions in this case

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Advocacy Corner

Bruce L. Smith, PhD
Public Affairs Director

There hasn't been much on the legislative front these past six months. The rush for nonpsychologists to try to get assessment privileges has slowed down; to my knowledge, there are no current attempts at the state level. In addition, there have been fewer issues regarding parity that have come to my attention. Once again, if you are aware of such issues (e.g., unfair requirements for prior authorization for assessment), bring those to our attention through the Central Office and they will be forwarded to the American Psychological Association Practice Organization's (APAPO) Legal Affairs Department for action. We have heard that Anthem Blue Cross in some jurisdictions has been asking for complete records as part of "audits" (in contravention of *Health Insurance Portability and Accountability Act* rules). APAPO recommends that these *not* be given, and that they be contacted for further action.

Reimbursement issues may be coming on the horizon as Medicare seeks to reduce its budget (typically on the backs of non-MD providers); we will keep the membership informed if these emerge.

Regarding advocacy in general, the *number one* priority has to be increasing our membership so that our voice can be heard. Although APAPO relies on the Society for Personality Assessment (SPA) for expertise and representation of assessment psychologists, in order for us to have an independent voice in issues around health care we need to become a substantially larger organization. Toward this end, I am encouraging every member to do what you can to recruit new members. SPA is, as you know, a great organization and one that provides a lot of benefit for not much financial investment. The best way to do this is to publicize the organization in every forum that you might be a part of. This includes the Annual Convention, the Call for Papers for that convention, and any workshops sponsored by SPA, as well as membership in general. The effectiveness of our efforts to support assessment depends on it.

A second area in which we can all take a role is the visibility of SPA and assessment psychology in general with allied professional groups. Those of us who practice forensic psychology have access to groups of attorneys; presenting to these groups makes them aware of the role of assessment psychology in their areas of interest. Similarly with appropriate physicians' groups (e.g., primary care, pediatrics, OB-GYN, oncology, etc.), we need to branch out from the usual folks we hang out with.

Finally, let me put in a plea for advocacy within our own profession. The tension between academic psychology and the practice community has been particularly hard on assessment psychology and assessors. Most clinical science and clinical PhD programs are cutting back on classes in assessment, and as a result students at these places are more poorly trained than ever. This, of course, leads to a vicious cycle: fewer well-trained assessment psychologists leads to less quality assessment research, leading to more de-emphasis on the part of academic departments, etc. We are in a unique position to reverse that trend, as SPA is roughly half academics and half clinicians. Within our organization, the split has rarely been evident. It is incumbent on us to lead the way and to advocate for assessment within the academy so that the field remains vibrant.

One last note: there is a new blog post up on the About Assessment blog (personality-assessment.org)—this one on suicide prediction following the tragic death of Robin Williams. I welcome suggestions for other topics for the blog as well as guest posts.

Front row (*left to right*): Drs. Virginia Brabender, Cathi Grus of the American Psychological Association Education Directorate, and Radhika Krishnamurthy. Back row (*left to right*): Drs. Ronald J. Ganellen, Mark Blais, Bruce L. Smith, and Robert F. Bornstein.

Drs. Giselle Hass and Radhika Krishnamurthy.

Reflections on the Internship Application Process

Michael J. Roche, MS
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Greetings, SPAGS members! By the time this issue of the *Exchange* comes out, the Society for Personality Assessment (SPA) 2015 Brooklyn convention will be in the early planning stages. As a graduate student, I continue to be impressed with and thankful to SPA for supporting the professional development of graduate students. This support goes well beyond the travel award and student rates for registration and membership (although much appreciated!). Students are able to attend workshops for free by assisting the presenters with CE credits. SPA supports graduate students giving convention presentations, helping us build our presentation skills. The SPA Board also supports the student social, and each year a senior member of SPA is there to discuss psychology and other topics with the students. This is a great opportunity to connect with distinguished members of our field, and also to connect with each other.

In recent years, the SPA Board has encouraged us to focus on issues of professional development in the field of psychological assessment. SPAGS members have organized several symposia and roundtable discussions on topics relevant to our development in assessment (developing your own assessment practice, starting an assessment research career), diversity (current topics in personality assessment and diversity, diversity-focused student lunch), assessment measures (introduction to common personality assessments), and advice about internship (locating and securing internship and postdoctoral positions in assessment psychology).

Having just gone through the internship process (successfully!) myself, I can say that this symposium was a huge help (in case you missed it: http://www.youtube.com/watch?v=ycxdBu0xuFc). So in the spirit of SPAGS and professional development, I thought we could use this *Exchange* column as an opportunity to provide more information about the internship process. After a brief overview of the psychology internship, I describe my reflections and lessons learned from navigating the process last winter. They are organized roughly around a "stages of change" model.

What is internship?

The best resource to answer this question and more is in the APAGS internship workbook (Keilin, Prinstein, & Williams-Nickelson, 2013). This book goes into detail about all the phases of applying for and deciding on internships. Most internships are a one-year, full-time placement in a different institution from where you completed graduate school, designed to give you a more intensive clinical training experience. Beyond that, internships can vary widely along several important dimensions. A good internship can be a springboard to a successful career, so it is important to think about how your decisions in graduate school prepare you for that next step.

Precontemplation: No intention to change behavior in the foreseeable future.

This stage characterizes many graduate students who are early in their program. With so many other deadlines and expectations to fill, it is hard to find the time and energy to think about this next step. However, there are a few crucial things to keep in mind that can set you up for success. First, track your hours. In my graduate program we did this through a Microsoft Excel sheet or Access database, but there are websites now (www.mypsychtrack.com) which can be linked directly into the online application, saving you some time later on. The information to track changes slightly from year to year, but for sure recording the age, gender, race/ethnicity, disability status, diagnosis of clients, and tests you administered will put you in a good position to convert your list into the format required. Note that they ask for how many "integrative reports" you have completed, which is defined as two or more psychological or cognitive tests. If you have a standard intake procedure at your clinic, consider asking your training director how you might add in some tests to this intake process, because doing this can dramatically increase your number of integrative reports. Tracking your numbers can help to see gaps in your training early on (e.g., not having therapy clients in a certain age range) which you can address before it is too late. Regarding assessment, some sites require some performance-based testing. I may be preaching to the choir here, but try to complete at least one Rorschach in your graduate training to keep your options open. There is no good rule for number of hours you need, but shooting for at least 500 intervention hr and 150 assessment hr is a good start. You can also reference the Association of Psychology Postdoctoral and Internship Centers (APPIC) website for statistics on the average number of intervention and assessment hours held by successful applicants (http://www.appic.org/Match/Match-Statistics). This site is truly satisfying, with many helpful statistics regarding the match.

The final thing to keep in mind is that some sites require up to three clinical reports to submit to their internship program (for some sites, this can mean describing a therapy case; others require testing/assessment). If there is a particularly interesting case in your training, consider writing it up while it is fresh in your mind.

Contemplation: Aware the problem exists and thinking about overcoming it but not yet committed to action.

Hopefully I have moved you to this stage by now. This stage is most common in the spring before the year you apply. Enjoy your time at your institution; it will be gone before you know it. This is a great time to get moving on your dissertation because as the fall approaches the internship application process becomes more and more time consuming.

Preparation: Combines intentions and behavior.

This stage is ideally reached in the summer time to early fall. It is helpful to examine what internship sites are interesting to you, in consultation with your supervisor. All internship sites have information on the APPIC website, and once you create a profile, you can browse many sites with several search criteria (institution type, location, content, etc.). I found it helpful to identify these sites, but then use Google to locate the internship handbook (often a PDF document) that describes the site in greater detail. The APPIC website suggests 15 sites is a good number to apply to. It is helpful to identify the

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SPA Annual Convention

March 4–8, 2015

New York Marriott at the Brooklyn Bridge
Brooklyn, NY

Throughout its history, the Society for Personality Assessment (SPA) has been broadly concerned with both the science and the practice of personality assessment, and our theme for the 2015 Annual Convention is "**Charting the Future of Personality Assessment**."

Registration

A **promotional brochure** with details about the 2015 workshops and the Annual Convention has been mailed to the SPA membership the first week of December 2014. It also became available on the web page (www.personality.org) the first week of December. Participant convention registration includes all convention materials; refreshment breaks; the President's Welcoming Reception on Thursday evening, and a reception on Friday evening, as well as the Closing Reception on Saturday evening; entry to the scientific sessions, the Master Lectures, poster sessions, and the award presentations; and a collegial atmosphere to meet and interact with colleagues from around the world who are interested in personality assessment research and practice.

Convention registration can be completed by accessing the online registration form (www.personality.org, Convention tab, Register for the Convention link). For those who wish to send a check for payment, please use the downloadable form. To ensure your participation, please register early and take advantage of the advance registration fee.

Travel Grants

Diversity Support Grants: As part of its overall commitment to diversity, SPA intends to promote and support ethnic diversity representation at the SPA Convention. Toward that end, the organization is now offering one diversity support grant of $1,000 or two diversity support grants of $500 each to support ethnically diverse professionals or students involved in personality assessment who seek to attend the Annual Convention. On the Application Form (see www.personality.org), an applicant must indicate that they are a SPA member or student affiliate, or should apply to be a member or student affiliate when applying for the diversity grant. Priority will be given to students and professionals who may otherwise not be able to attend the Annual Convention.

Early Career Travel Grants: These grants are given annually to encourage and promote the training and education of early career psychologists in personality assessment, as well as participation in and consumption of personality assessment research and scholarly activity at the Annual Convention. Each year, awards are given to support travel to the Annual Convention. Applicants do not need to be presenters at the Annual Convention or members of SPA to receive this award. On the Application Form (see www.personality.org), applicants will need to identify how they hope the SPA Annual Convention will benefit their career development as assessment psychologists. First-time attendees of the SPA Annual Convention are especially encouraged to apply.

Student Travel Grants: The Board of Trustees has established the Student Travel Grants to help students attend the SPA Annual Conventions to present their work. The SPA Board considers this to be a very important activity in a student's development. See the SPA web page (www.personality.org) for a copy of the Student Travel Grant Guidelines and Student Travel Grant Application.

Annual Convention Registration Fees:

	Early Bird By 01/30/2015	Regular After 01/30/2015	Onsite
Member/Fellow/Associate	$215	$265	$280
Non-Member	$285	$335	$350
Student	$75	$85	$90
Member/One-Day Fee	$145	$145	$160
Non-member/One-Day Fee	$165	$165	$180
Student/One-Day Fee	$50	$50	$50
Student Volunteer	$55	$55	$55
Student Luncheon	$10	$10	$10

Workshop Fees:

Member or Convention Registrant	Full-Day $175	Half-Day $105
Non-Member/Non-Convention Registrant	Full-Day $225	Half-Day $140
Student	Full-Day $90	Half-Day $50

Note: On-site workshop registration will incur an additional $15 fee per workshop. Students will be charged an additional $5 for each onsite workshop registration.
Cancellation Policy: Cancellations will be accepted for the Annual Convention and/or a workshop, less a $75 administrative fee, until midnight ET 1/31/2015. After that date no refunds will be granted.

Workshops and Continuing Education Credits

As part of its Annual Convention, SPA will again present full-day and half-day workshops. The Society is approved by the American Psychological Association to sponsor Continuing Education (CE) for psychologists, and SPA maintains responsibility for the program and its content. The full-day workshops will offer 7 CE credits, and the half-day workshops will offer 3.5 credits. SPA offers between 15 and 18 workshops. The workshops will occur on Wednesday and Thursday mornings. During the Annual Convention, CE credits will also be available, at no extra charge, for the two Master Lectures, some award presentations, any lunchtime presentations, and for approximately 14–16 symposia sessions. Detailed information on the workshops appears in the brochure. Detailed information on the scientific sessions carrying CE credit will be listed in the Program Book. A draft of the Program Book will be available online after the first week of January 2015. A hard copy of the Program Book will be in all the registration packets for the Annual Convention.

Accommodations

The SPA Annual Convention, March 4–8, 2015, will be held at the New York Marriott at the Brooklyn Bridge. Iconic among Brooklyn Bridge hotels, it provides guests with a quintessential New York City experience. The hotel is minutes from shopping, dining, theaters, and museums in the heart of Dumbo, Brooklyn. Historic Brooklyn, NY, is home to everyone from everywhere—the world's neighborhood, the borough that puts the "new" in New York City.

New York Marriott at the Brooklyn Bridge
333 Adams Street Brooklyn, NY 11201

Tel Reservations: 1-718-246-7000 (toll-free: 1-877-303-0104)

Online Reservations: https://aws.passkey.com/event/11379218/owner/13490/home

Reservation deadline to receive the convention rate: February 9, 2015, at 11:59 PM EST

Rates: $220 Deluxe Room–Single; $220 King Suite; $240 Standard–2 Double Bed

Transportation

The New York Marriott at the Brooklyn Bridge is located near John F. Kennedy International Airport (JFK), LaGuardia Airport (LGA), and Newark Liberty International Airport (EWR). This hotel does not provide shuttle service.

2015 Annual Convention Continuing Education Opportunities

Robert F. Bornstein, PhD
Adelphi University

The 2015 Society for Personality Assessment (SPA) Annual Convention will take place March 4–8, 2015, at the New York Marriott at the Brooklyn Bridge in Brooklyn, New York. Aside from being right next door to one of the world's most iconic landmarks, we'll also be just a few blocks from what many consider to be the finest pizzeria in the city, Grimaldi's. While you're in Brooklyn you can visit Coney Island, following in the footsteps of Freud, who spent a day at Luna Park in August 1909, just prior to his Clark University lectures. And while you're there perhaps you'll sample a Nathan's hot dog—or try to break the Nathan's hot dog eating record, currently held by Joey Chestnut, which stands at a mere 69 wieners in 10 minutes.

Lest you think that Brooklyn is all about food, keep in mind that the Barclays Center is close by as well (having hosted recent concerts by Justin Timberlake and Sir Elton John). So are the Brooklyn Museum and Brooklyn Botanical Garden—both worth a visit. Two of my favorite books are set here: Betty Smith's *A Tree Grows in Brooklyn* and Chaim Potok's *The Promise* (which centers in part on the protagonist's struggle to reconcile his family's religious values with his desire to become a clinical psychologist). Brooklyn is also known as Kings County (so now you know how Queens got its name). And I'd be remiss if I didn't point out that Adelphi University was originally located in Brooklyn, founded in 1863 as the Adelphi Academy, on—you guessed it—Adelphi Street (it didn't move to its current location on Long Island until 1929).

The theme of the 2015 Convention is "Charting the Future of Personality Assessment," and it's a timely topic indeed. Whether you work primarily in an applied setting or in academia (or both), you'll agree that our field is evolving rapidly to adapt to an ever-changing landscape. As we continue to confront the challenges of managed health care we'll also need to accommodate the Patient-Centered Medical Home model—more than ever we must show how our assessment techniques are both efficient and effective. *DSM–5* is just over a year old, with ICD–11 soon to be released, and work is underway on the PDM–2 as well; we'll soon be using a whole new set of diagnostic manuals. The National Institute of Mental Health Research Diagnostic Criteria will play an increasingly prominent role in shaping federal funding for studies of psychopathology and treatment during the coming years, another challenge—and another opportunity—for those of us who work in personality assessment.

This year we'll be privileged to hear Master Lectures from two distinguished colleagues whose work has played—and continues to play—a central role in contemporary assessment practice and research. Terence Keane's talk will discuss the assessment of psychological trauma and post-traumatic stress disorder (PTSD) in a variety of settings including clinics, primary care and residential settings, and forensic contexts. This year's Paul Lerner Memorial Lecture will be delivered by Diana Diamond; her talk, which examines narcissistic features in patients with borderline pathology, will be a tribute to Dr. Sidney Blatt, groundbreaking researcher, influential mentor, and longtime SPA member (and former president of the society), who passed away in May 2014.

SPA's Continuing Education offerings are invariably first rate—important topics addressed by engaging, accomplished speakers. The CE Committee, chaired by John Porcerelli, and also including Greg Meyer, Steve Strack, and J. D. Smith, has put together an extraordinary lineup of workshops for this year's convention. In Brooklyn you'll have the opportunity to attend any of 16 terrific workshops, including Chris Front's always popular presentation on *Personality Assessment Consultation Opportunities With the Federal Aviation Administration*. We'll also have three workshops on various aspects of personality assessment teaching and report writing: Anthony Bram and Mary Jo Peebles's *Psychological Testing That Matters: Creating a Road Map for Effective Treatment*; Jessica Gurley and Steve Lally's *Challenges and Opportunities of Teaching Assessment in the Current Training Context*; and Steve Smith's *Teaching Personality Assessment (But Not Personality Testing)*.

A number of our workshops this year focus on challenging populations and difficult clinical and forensic issues. These include Paul Arbisi's *Use of the MMPI–2–RF in Evaluation of Trauma Related Conditions;* Don Viglione and Bob Erard's *R–PAS Contributions to Contextualizing Violence: Case Illustration and Recommendations for Use in Court*; Marita Frackowiak, Francesca Fantini, and J. D. Smith's *Therapeutic Assessment of Children: Using Psychological Testing to Change the Family Story*; Chris Hopwood and Mark Ruiz's *Forensic Use of the Personality Assessment Inventory*; James Kleiger and Ali Khadivi's *Assessing Psychosis With Clinical Interview and Psychological Testing*; Nancy Kaser-Boyd's *Domestic Violence Update: Assessment of Issues in Family and Criminal Courts*; and Pamela McDonald Schaber, Filippo Aschieri, and Lionel Chudzik's *Assessment With Difficult Clients: Building a Relationship That Fosters Change*.

Finally, we'll have five workshops presenting cutting-edge information on widely used psychological tests of interest to SPA members: Joni Mihura and Greg Meyer's *The Rorschach Performance Assessment System: Basic Interpretation With Cases*; Irv Weiner and Shira Tibon Czopp's *Advances in Rorschach Comprehensive System Assessment of Adolescents*; Seth Grossman's *Introducing the MCMI–IV: Assessment and Therapeutic Applications*; Carol George and Anna Buchheim's *Use of the Adult Attachment Projective Picture System in Psychodynamic Psychotherapy*; and Phil Erdberg's *Using the Rorschach Performance Assessment System With Children and Adolescents*.

It promises to be another great SPA Convention and a terrific program in 2015. So I hope you'll plan to attend, and please do circle the dates—March 4 through 8—on your calendar so you can finalize your travel plans in plenty of time to get the best rates. I speak for the entire SPA Board of Trustees: We look forward to seeing you in Brooklyn!

2015 SPA Annual Convention Tentative Schedule

Wednesday, March 4, 2015

8:00 am–5:30 pm	Registration
8:30 am–5:00 pm	Full-Day Workshops
8:30 am–12:00 noon	Half-Day Workshops (Morning)
12:00–1:30 pm	Lunch Break
12:00–1:30 pm	SPAGS Board Meeting Lunch
1:30 pm–5:00 pm	Half-Day Workshops (Afternoon)
5:00 pm–7:30 pm	Board of Trustees Meeting
5:30 pm–9:00 pm	Half-Day Workshop (Evening)

Thursday, March 5, 2015

8:00 am–5:30 pm	Registration
8:00 am–12:00 noon	Exhibits Setup
8:00 am–12:00 noon	Board of Trustees Meeting
8:30 am–12:00 noon	Half-Day Workshops (Morning)
12:00 noon–1:30 pm	Lunch Break
12:00 noon–5:00 pm	Exhibits Open
12:00 noon–1:00 pm	Lunchtime Presentation
12:15 pm–1:15 pm	Information Sessions: ABAP Preparation & Proficiency
1:30 pm–3:00 pm	Opening Plenary Session
3:15 pm–4:15 pm	Bruno Klopfer Award Address
4:30 pm–6:30 pm	Scientific Sessions
6:45 pm–8:00 pm	President's Welcome Reception
6:45 pm–8:00 pm	Book Signing
6:45 pm–8:00 pm	Poster Session I
8:00 pm	SPAGS Social

Friday, March 6, 2015

7:30 am–8:30 am	*JPA* Editorial Board Breakfast/Meeting
8:00 am–5:30 pm	Registration
8:00 am–5:00 pm	Exhibits Open
8:30 am–10:30 am	Scientific Sessions
10:45 am–11:45 am	Master Lecture I
11:45 am–1:15 pm	Lunch Break
12:00 noon–1:00 pm	Lunchtime Presentations
12:00 noon–1:00 pm	Interest Groups (3)
12:00 noon–1:00 pm	SPAGS Diversity Lunch
12:00 noon–1:00 pm	*JPA* Editor Lunch
1:15 pm–2:15 pm	Master Lecture II
2:15 pm–2:45 pm	Exhibitor Coffee Break
2:45 pm–4:45 pm	Scientific Sessions
5:00 pm–6:30 pm	Hertz Memorial Presentation and Award Presentations
6:45 pm–8:00 pm	Reception
6:45 pm–8:00 pm	Poster Session II

Saturday, March 7, 2015

7:30 am–8:30 am	Exchange Editorial Board Breakfast/Meeting
8:00 am–5:30 pm	Registration
8:00 am–3:00 pm	Exhibits Open
8:30 am–10:30 am	Scientific Sessions
10:45 am–12:45 pm	Scientific Sessions
12:45 pm–2:00 pm	Lunch Break
12:45 pm–1:45 pm	Student Lunch
12:45 pm–1:45 pm	Lunchtime Presentation
12:45 pm–1:45 pm	Interest Groups (2)
2:00 pm–4:00 pm	Scientific Sessions
4:15 pm–6:15 pm	Scientific Sessions
6:30 pm–7:45 pm	Farewell Reception for Journal Reviewers
6:30 pm–7:45 pm	Poster Session III

President's Message

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help other educators organize, prepare for, and improve courses in psychological assessment. These consultations are provided for free. If you have suggestions about other ways to make the website more user-friendly or more informative, please let us know.

SPA is a strong, dynamic organization because of our members. Our members come from different traditions in personality assessment, different theoretical orientations, and different arenas of professional activity (e.g., academic, research, clinical, forensic, child/adolescent, etc.). Or, put differently, our strength comes from diversity as well as from our willingness to acknowledge and respect these differences. Recognizing this, we seek, encourage, and welcome papers, posters, and symposiums addressing issues of cultural and racial diversity. To honor and promote the diverse nature of our membership, the Board has established travel grants to provide support to colleagues who come from diverse backgrounds. Information concerning these grants and applications to apply for them are on the SPA website.

During the 2014 SPA convention, I had the great pleasure of having lunch with members of the International interest group. One issue discussed during the lunch session was the importance of encouraging younger international members whose careers involve teaching, training, and supervising personality assessment to attend the annual conventions. As one member, who identified himself as one the "gray beards" in the room, put it, our younger colleagues are the future of psychological assessment. With this in mind, I was most pleased that the Board wisely agreed to invest in our future by funding travel grants for early career, international members. These grants will be in effect in time for the 2015 SPA convention.

The official journal of SPA, *JPA*, has continued to develop and thrive under the stewardship of Steve Huprich and his hardworking team of editors and reviewers. I know we all benefit from and are stimulated by reading *JPA*, which we receive neatly printed and packaged. I'm not sure, however, that we the readers take stock of the time, effort, and dedication it takes to produce, to whip into shape, the quality journal we learn from and enjoy. I should note that while the hard work of *JPA* authors, reviewers, editors, and production staff deserves to be appreciated by the readership, the value of *JPA* is recognized in the wider professional community. I know this because the *JPA* impact factor score, a measure of the impact journals have in terms of citations, has risen steadily over the past few years. The latest figures span the last years *JPA* was edited by Greg Meyer, and there is every reason to be confident this trend will continue. Both Steve and Greg deserve to be congratulated!

There has been a change in the Central Office. Monica Tune became the acting Administrative Director this past July. We appreciate her willingness to go the extra mile during a period of transition. I am most pleased to have seen Monica's growth over time and wish her the best in her new role. Monica is now being assisted by Sam Richardson. Please make a point of congratulating Monica and introducing yourselves to Sam in Brooklyn. I look forward to seeing you all there!

Clinical Pearls

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inventory for assessing psychiatric and personality disorders. What is less well known—or worse, ignored—is its proper application. The MCMI–III was normed on a clinical population and uses "base rate" scores reflecting prevalence of various disorders. This differs from the traditional *t*-score in which scales are standardized to the same mean and standard deviation. Thus, the MCMI–III is less suited to nonclinical populations. Unfortunately, psychologists sometimes use the test in settings where base rates of disorders are minimal. Knowing the nature of the MCMI–III makes proper realm of use clear.

Test validity is not invariant. Application setting affects validity. Validity coefficients apply to the extent that intended use resembles development and validation samples. Base rates and test accuracy interdigitate (Meehl & Rosen, 1955). Finn (2009) offers clear exposition of these fundamentals for clinical practice. In a setting with high prevalence of a disorder, given intrinsic test validity, a test's ability to identify an index condition surpasses that noted in the manual. The sword cuts both ways, however. Low prevalence settings constrain positive predictive accuracy. Finn (2009) summarizes: If the prevalence is high, the test is best used to rule in a condition; if the prevalence is low, the test is best used to rule out a condition. The test works best in settings where the prevalence is about 50%. In a specialty clinic for affective disorders, the base rate of Major Depressive Disorder (MDD) is high. But, a general office practice has a different base rate of MDD as does a psychiatric hospital. Accordingly, a test for depression performs differently in these settings. The "local base rate" of an index condition is most relevant (Meehl & Rosen, 1955).

I was asked to comment on a large study of psychological screening of employees in the national security sector. The ultimate consumer of the results (government administrators) thought the conclusions important. However, the study utilized an extraordinarily large number of multiple regressions, performed no cross-validation, and demonstrated severe predictor-criterion group contamination. These methodological vulnerabilities rendered conclusions suspect. As I studied this material, Dr. Blashfield's words kept ringing in my mind.

Jane Loevinger, PhD (1918–2008), a pioneer in psychometric theory, articulated a stage-theory of ego development. She also pioneered the study of women long before it was common, and she surmounted professional challenges due to gender (Loevinger, 2002). The theory of ego development is reciprocally and recursively integrated with its measurement by the Washington University Sentence Completion Test (WUSCT; Loevinger, 1998) illustrating a fundamental principle of her classic paper, "Objective Tests as Instruments of Psychological Theory" (Loevinger, 1957). She embodied rigor in her work and had little patience with the work of others that did not meet the highest standards. As a graduate student, I sent her an unsolicited copy of my master's thesis. She wrote back: "Theses are not my favorite art form. If you have something to say, publish" (personal communication, 1979). It is revealing that even if her response seems harsh, she nonetheless took the trouble to write. I followed her advice (e.g., Waugh & McCaulley, 1981). Later, in another setting, discussing "the problem of the ubiquitous 0.3 correlation" in personality research, an apparent ceiling that vexed many in the field at the time, she pronounced: "we cut great swaths through the personality, how could it be otherwise?" (personal communication, 1980). She brought piercing insights to what she investigated, eschewing orthodoxy. She challenged basic premises of the ascendant and widely accepted "Big 5" model of personality. A crucial flaw in the Five-factor model, she reasoned, was correlational methodology and assumption of linearity (Loevinger, 1994). She argued that crucial features of personality may be inherently curvilinear. She insisted that method should conform to the construct, that technique should not violate underlying properties of the theory.

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Her theory of ego development posits transformation of qualitative structures or typologies. Modern thinking, however, favors dimensional or continua models over categorical or taxonomic approaches (e.g., Markon & Krueger, 2005). Many (but not all) head-to-head comparisons of categorical and dimensional models support the reputed superiority of the latter (Haslam, Holland, & Kuppens, 2012). For some, categorical models have been likened to "carving nature at its joints" (Meehl, 1992, p. 121).

Wright (2011) cites the phase transformation of water (i.e., solid, liquid, gas) in which qualitative change manifests across the continuum of temperature, and in personality disorder some relationships may be quadratic, not linear. Typologies may involve within-category, dynamic "if–then" relationships (ipsative, dynamical interaction of trait, affect, and situation). In the same vein, Nobel Laureate physicist P. W. Anderson (1972) argued the reality of category/quality constructs in science. With humor, he says:

> I offer two examples from economics of what I hope to have said. Marx said that quantitative differences become qualitative ones, but a dialogue in Paris in the 1920's sums it up even more clearly: Fitzgerald: The rich are different from us. Hemingway: Yes, they have more money. (p. 396)

Quintessentially rigorous, Loevinger was entirely comfortable with unfashionable positions like typology (Loevinger, 2002). Thus, the **Lesson Learned:** *Think deeply, don't accept the conventional, and if you have something to say, say it.*

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Suicidal and Nonsuicidal Self-Injury

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to its emphasis on distinguishing suicidal from nonsuicidal self-injury in a systematic yet focused way while covering the broad spectrum of suicidal thoughts and behaviors. The scale stemmed from work done in collaboration with the Food and Drug Administration (FDA) in the 1990s in an effort to better measure suicide behaviors in adolescents who were prescribed antidepressant medication, and is currently the scale under consideration by the FDA as a gold standard for use in clinical drug trials (Department of Health and Human Services, Food and Drug Administration Center for Drug Evaluation and Research, 2010).

Around the same time, the Centers for Disease Control and Prevention also recognized the need for improved nomenclature in the area of suicide assessment and, in response, developed their version of a suicide and self-injury classification system. The Self-Directed Violence Classification System was adopted for use as the standard classification system in 2010 by the U.S. Department of Veterans Affairs and then in 2011 by the Department of Defense (Matarazzo, Clemans, Silverman, & Brenner, 2013; the system can be viewed at http://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf). The primary goal of doing so in this case was to improve assessment of risk level and to aid in identifying appropriate interventions. Thus, these distinctions are not only important for research but can assist the clinician in assessing risk in self-harming individuals and may be especially important for informing treatment models.

Clearly, our understanding of the mechanisms involved in the expression of self-harm behaviors is quite limited, although the research base is growing. With the widespread adoption of standardized classification systems, it is likely that our understanding of underlying processes will continue to expand.

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Guidelines for Clinical Supervision

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What Is a Collateral?

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example: a session with the client and family members, two assessment sessions with the client alone, and a session with family members without the client. Each of these sessions has its own billing code.

Billing codes are listed and described in the manual *Current Procedural Terminology: Professional Edition* (CPT; American Medical Association [AMA], 2013). This manual is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by health care professionals. The purpose of the terminology is to provide a uniform language that will accurately describe a variety of health care services and will provide an effective means for communication among health care providers, patients, and third parties. The CPT code set is the most widely accepted nomenclature for the reporting of health care procedures and services under government and private health insurance programs.

The first meeting with Stephen and his parents was an initial diagnostic evaluation coded 90791. This is an integrated biopsychosocial assessment including history, mental status, and recommendations. This evaluation may include communication with family members or other sources.

Psychological testing is coded 96101. This includes psychodiagnostic assessment of cognitive and personality functioning and is billed per hour of the psychologist's time, both face-to-face time administering tests to the client and time interpreting test results and preparing the report. A minimum of 31 min of service must be provided to report any per-hour code. Psychological testing administered by a technician with a qualified health care professional providing the interpretation and the report is coded 96102, and psychological testing administered by a computer with a qualified health care professional providing the interpretation and the report is coded 96103 (AMA, 2013).

Psychotherapy codes are used for face-to-face services with the client and/or family member. The client must be present for all or some of the service. For family therapy without the client present, the code 90846 is used. Although not relevant for this case example, the codes for psychotherapy with the client and/or family member would have been used if the client had been present. These codes are differentiated by the length of the session. For sessions 16–37 min use 90832, 38–52 min are coded 90834, and sessions 53 min or longer are coded 90837. There are also separate codes for crisis situations when the presenting problem is life threatening or complex and requires immediate attention to a client in high distress (90839 for the first 60 min, and 90840 for each additional 30 min).

In all situations, the clinician must choose the code that best fits the service which was delivered. Often other people are involved in treatment with or without the identified client, and these individuals can be very helpful to the treatment of the client. However, it is important that individuals who are collateral to someone else's treatment understand that they are not clients.

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Reflections on Internship Application

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types of internship sites first, so you can tailor your materials to fit these needs.

The things you need to prepare are: CV, four essays, transcripts, letters of recommendation, supplemental reports (depending on sites), the Director of Clinical Training to sign off on your reported clinical hours, and a cover letter. The APPIC Application for Psychology Internship (AAPI) website (www.appic.org/AAPI-APPA, where you submit applications) is a centralized website where you can submit the same four essays to each site, if desired (and usually this is preferable). The cover letter is where you make the case for your unique fit with their program, emphasizing how you will add value to their program (and not how you have large gaps you are trying to fill at their site). Regarding the CV, be sure to highlight clinical experiences since internship is a clinical year. Advice on essay writing and cover letters is in the APAGS workbook, a great resource to use. Be sure to get others to read your essays and take their feedback seriously. My first essay (the open-ended "Tell me about yourself" essay) was bland, and several sites (including the one I matched to) asked me about it.

Action: Modifying behavior to overcome problems.

This stage is when you have already submitted applications and begin to get interviews. Set aside some money to travel (APPIC has statistics on average travel costs). Most sites indicate when their interviews will be, so look at the sites you are applying to and head off potential conflicts on days by scheduling around things. Again the APAGS workbook has some great material on preparing for this step. Practice interviewing with colleagues or professors (if they are willing). In my experience, common questions to prepare for are listed below. All of them are a chance to demonstrate (1) competence, (2) interest in their program, and (3) fit with their program.

Clinical Experience	Length (hours/week, length of rotation)	Strengths (supervision? population? orientation?)	Weaknesses
Inpatient			
Outpatient			
DBT			
Group			

General: Tell me about yourself. Why psychology? Why clinical psychology?

Clinical: What kind of clinical training did you have? What is your career trajectory? Clinical strengths and weaknesses? What is your theoretical orientation? How do you conceptualize cases? Have a concise description of your clinical training, including the psychological clinic you came from. The career trajectory question may be assessing fit (e.g., some sites want to train academic researchers with clinical interests; others want to train practitioners).

Research: What do you research? How far along is your dissertation? You should prepare a 1–2-min and 5-min description of your dissertation.

You should prepare anecdotes about difficult cases, assessment experiences, an ethical problem you faced and how you handled it, anecdotes of effective cases from the therapeutic frames you learned (e.g., cognitive behavioral therapy, psychodynamic, etc.). These questions may be asked as: your most rewarding case, most difficult case, cases that involved diversity considerations, what would you do differently in a case, etc. Some places also ask about supervision (e.g., kinds of supervisors you get along with, how you dealt with difficult supervisors).

You will be asked if you have any questions about the program. The APAGS book lists several basic questions. It is good to also prepare site-specific questions that demonstrate that you've read the material on their website.

When going on an interview, I liked bringing a summary sheet with (1) the core ways that I fit with the internship site; (2) the core rotations/clinical experiences the site provides; (3) 5–10 stock questions about therapy, assessment, research, supervision, etc.; (4) real questions/clarifications that I had about the site; and (5) what questions I would ask of the current interns.

Maintenance: Consolidating gains.

After you complete an interview, it is good to write down any notes you have about the site. Before interviews begin (and criteria you have may shift along this process), try to identify core dimensions you want to compare the sites on. For instance, I noted the following separately for therapy and assessment experiences.

For research, I noted whether there was dedicated time, grant training, available data, post-doc opportunities, and track record of previous interns landing academic jobs.

Once this is complete, it is time to begin the matching process. Briefly, you select your top 15 internship sites, in order of preference. The internship sites do the same. Then a computer matches you to an internship, which you are required to attend (specifics of the matching process are found on AAPI website). Remember, there is no advantage to placing a site higher because you feel that they are likely to rate you highly. Once you lock in your selections, take a break, relax, and wait for (hopefully) some good news. If you don't match, there are other steps to take; again the APAGS book does a good job of detailing these.

I hope this SPAGS column has been helpful. Feel free to email me with any questions about this process.

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SPA Fellows

Rick Holigrocki, PhD's interest in personality assessment took off when as a graduate student he was mentored in general systems theory, constructivism, and depth psychology by Ray Daly at the University of Windsor. Theory turned to practice during his postdoctoral fellowship and staff positions at the Menninger Clinic in the late 1990s. During this period, he was fortunate to have received assessment supervision and training from psychologists such as Marty Leichtman, Lisa Lewis, Bob Athey, Mel Berg, Sid Frieswyk and Sharon Nathan. At Menninger, he, Trish Kaminski, and Sid Frieswyk, through consultation with Peter Fonagy, developed the Parent–Child Interaction Assessment–II (PCIA–II), a structured observation measure involving videotaping parents and children while at an imaginary zoo. Most of his research activities at the University of Indianapolis have involved the assessment of parent and child relational functioning with an emphasis on integrating data drawn from self-report, free response, and PCIA–II observations. Through his new position as Dean of the Graduate School of Psychology at California Lutheran University, he hopes to have a role in fostering the love of personality assessment in the next generation of psychologists.

Steven V. Rouse, PhD, is a professor of psychology and Chair of the Social Sciences Division at Pepperdine University. He earned his PhD in Personality Research at the University of Minnesota as an advisee of Jim Butcher. Since arriving at Pepperdine in the fall of 1998, his primary teaching responsibilities have been undergraduate sections of *Psychological Testing and Assessment* and *Personality*, and his primary research focus has been on the psychometric analyses of various tests, especially the MMPI–2. He has served on the editorial board of *Journal of Personality Assessment*, both as a Consulting Editor and as a Section Editor for the Book, Software, & Test Review Section.

SPA Personals

Andrea Castiello Antonio, PsyD-PhD, professor of applied psychology at the European University of Rome, Italy, has written: "Assessment delle quality; Managerialio e della leadership" ("Assessment of Managerial Qualities and Leadership"). The in-depth psychological assessment is outlined in the qualitative, psychodynamic, clinical, and psychosocial perspectives. It is also linked with the perspective of Positive Psychology, and with knowledge coming from personality theories developed in the last century. The "organizational personality" emerges as a central issue of all activities of knowledge, assessment, and evaluation carried out by the clinical-organizational psychologists. (*Editor's Note*: Please contact Professor Antonio at casti.a@tiscali.it for more information).

Mark H. Waugh, PhD, ABPP, of Oak Ridge, Tennessee, invites those interested in using or studying the *DSM–5* Alternative Model for Personality Disorders (PD) to contact him for a rating scale designed for this purpose. The Alternative Model for PD involves conjoint ratings for level of impairment and psychopathological personality traits derived from the Five-factor model. Considering disturbance in self (identity and self-direction) and interpersonal (empathy and intimacy) domains leads to an overall rating of level of impairment. Five general trait dimensions and 25 lower-order facets also are rated. The Alternative Model has algorithms for combining these ratings for PD diagnoses of antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, schizotypal, and a general category of PD-Trait Specified. Dr. Waugh has devised a clinician-friendly one-page (double-sided) sheet with the information needed for rating level of impairment and the trait domains, as well as algorithms for diagnoses within this hybrid categorical-dimensional model for PD diagnosis. Interested parties are welcome to use this rating scheme, called Clinician Rating Personality Disorder Level and Traits (PDLT–C). Please email Dr. Waugh for a copy (markhwaughphd@bellsouth.net).

Left to right: Dr. Robert F. Bornstein, President-Elect; Dr. Ronald J. Ganellen, President; and Dr. Radhika Krishnamurthy, Past-President.

Left to right: Dr. John McNulty, Dr. Virginia Brabender, Dr. Giselle Hass, Dr. Ronald J. Ganellen, Steven Hass, and Dr. Radhika Krishnamurthy.

From the Editor…

Jed A. Yalof, PsyD, ABPP, ABSNP

This issue of the *Exchange* offers an assessor-friendly array of articles and other tidbits. Ron Ganellen, SPA President, invites us to Brooklyn in early March for the 2015 Annual Convention. Bob Bornstein, SPA President-Elect, tells us about the workshop offerings that await us, while Monica Tune, SPA's Acting Administrative Director, alerts us to registration, travel grants, and transportation information. Alan Schwartz introduces the first article of a two-part series by Mark Waugh, who shares "pearls of wisdom" learned from assessment experts as part of his professional development. Jill Clemence writes about current issues and classification systems in the differentiation of suicidal and nonsuicidal self-injury in self-harming individuals. Cathi Grus of the American Psychological Association Education Directorate describes how the American Psychological Association is moving ahead with competency-based guidelines for clinical supervision in health service psychology that are important to all assessors who educate and train graduate students in assessment. Linda Knauss discusses the role of "collaterals" in assessment and clarifies some tricky items when it comes to coding procedures for different practices that involve collaterals. Bruce Smith provides an update on SPA Advocacy. Michael Roche, SPAGS President, helps to orient students to the internship process. We invite you to visit the SPA website at http://www.personality.org/.

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