spa exchange

Volume 15, Number 2 Summer 2003

Presidential Address to the Midwinter Meeting of the Society for Personality Assessment, San Francisco, March 20, 2003

Obstacles to Practicing Psychological Assessment

by Stephen E. Finn, Ph.D.

This is my second and final time to address you all as SPA president, and once again I'm extremely honored and grateful to have this opportunity. The last year and a half have been an incredible learning experience for me and have only deepened my passion for and commitment to personality assessment. Thank you again for giving me the chance to serve in this role.

Last year I spoke to you about the power and potential of psychological assessment to transform clients' lives (Finn, 2002). I'm glad that a similar view of assessment seems to be springing up independently in a number of places and is more and more evident in the work of psychologists around the world. You need only look at the list of presentations we will hear over the next four days to see evidence that assessment is viewed as an effective therapeutic tool in places as far away as Israel, Finland, Italy, and Texas.

This year, I have decided to take a different tack, and to talk about "restraining forces" that work against the effective use of psychological assessment. Those of you who are therapists might not recognize my strategy, so I'll spell it out up front. Good clinicians know that when attempting an intervention, it's useful to alternate between what is called "content work" and "defense work." So, having expounded upon the utility and transformative power of assessment last year, this time I want to discuss the forces that interfere with, minimize, or even deny the usefulness and best practice of assessment. I also want to say right here at the outset that I don't disparage any of us affected by these "restraining forces." I keep discovering evidence of my own lack of vision about assessment, and am coming to realize that this shortsightedness is a kind of coping mechanism, and—like other "defenses"—serves some very reasonable purposes that I'll talk about later.

The "Best Practice" of Clinical and Forensic Assessment

Before describing restraining forces, let me define what I mean by the best practice of clinical/forensic personality assessment. Here I refer to those situations where assessors and clients have a significant interpersonal encounter centered around psychological assessment. Typically clients come to such an event because of some difficulty, puzzle, or major life decision they are facing. They may come on their own, or be referred by a friend, helping professional, school, or the court. Such assessments take time and effort on behalf of both parties, a great deal of expertise on the part of the assessor, and an attitude of mutual trust, openness, and respect. Typically these assessments involve at least three major components: 1) some initial discussion of a client's situation, 2) time spent administering psychological tests, and 3) the communication of assessment findings to the client and other interested parties. We know that assessments conducted in this way have the potential to result in new insights and emotional awareness on the part of clients and their families, and to affect the course of their lives either directly—through actions that follow the assessment—or indirectly—through a change in the way clients and significant others conceptualize themselves and the world. Incidentally, as I mentioned last year, I believe that such assessments can affect assessors deeply also. I'll be chairing a symposium on Saturday where this latter point is discussed further.

Obstacles

So what constraints keep us from practicing assessment in the way I've described, where the majority of our contacts with clients would result in significant transformations? Let me start with those restraining forces that originate outside of the assessor.

Obstacle #1: A view of psychological assessment as something akin to a "blood test" in medicine.

Here I'm referring to an attitude that denies or minimizes the interpersonal or human aspects of psychological assessment, and that views tests primarily as standardized instruments whose purpose is to "gather" or "extract" information from minimally cooperative clients. This view of assessment was clearly evident in the inpatient medical ward where I did my training, where psychiatry residents would make checkmarks at admission on a brief order form to request blood work, specialized medical exams, and what was referred to as "psychometrics" on particular "patients."

Insurance regulations may have curtailed the freedom with which psychological assessments are ordered in such situations, but I believe that the underlying attitude toward psychological assessment shown by those forms remains the same in many settings. I further believe that psychology itself has helped foster this view of psychological assessment as a highly automated, impersonal situation. Paradoxically, we have done this in an attempt to prove that psychological assessment is just as "objective" and "scientific" as medical tests. And then we wonder why our colleagues do not fully appreciate our work, so many graduate students see psychotherapy as "sexier" than psychological assessment, and why APA has devoted such resources to pursuing prescription privileges for psychologists, while doing relatively little to promote psychological assessment!

Obstacle #2: A view of psychological assessors as semi-skilled technicians whose job is to apply a highly standardized set of procedures—with minor modifications—to most clients and to interpret them by a fixed set of guidelines.

This is an attitude I still run into frequently with some referring professionals and even clients. Last year I found myself attempting to explain to an impatient and apparently anxious referring psychiatrist why I couldn't

...continued on page 2

In this issue...

Presidential Address

...continued from page 1

yet tell him whether his client was psychotic, even though my assistant and I had already spent 3-4 hours with the client. In spite of my best efforts, the psychiatrist just couldn't seem to understand why we didn't just "make" his client take the MMPI-2 in the first or second assessment session, "run it through" the computer, and then get back to him immediately with a diagnosis. The implication was that if I would just hurry up and complete this minor task, then he could get on with the really important work of conducting the treatment.

I also remember a similar encounter five years ago, when I was trying to explain to a managed care gatekeeper why I needed more than an hour and a half to administer the WISC-III to a highly distractible and angry adolescent. Her "guidelines" said the WISC-III could be given, scored, and interpreted in 1.5 hours, thus she insisted that was all she could authorize. Obviously, these types of pressures from outside the assessment can make it extremely difficult for an assessor to devote the time necessary to do a good job, especially if the outside party controls the reimbursement for the assessment.

Obstacle #3: A belief that for psychological assessment to be useful and valid, it must be "scientific" in the narrow definition of 19th century logical positivism.

I did my Ph.D. in psychology at the University of Minnesota and my minor was in statistics. Thus, I have a strong grounding and identification with quantitative methods in psychology, and I'm proud of my publications on the validity and reliability of various psychological tests. Nevertheless, I find myself mystified at times by the prevailing notion in psychology that there is some absolute "Truth" about individuals that we can observe and measure if we could only somehow eliminate the troubling tendency of human beings to construe similar situations differently and to make meaning in idiosyncratic ways. The goal of logical positivism—to gather knowledge that is completely independent of the observer and which can be replicated again and again by different observers using the same procedures in similar situations—has long since been acknowledged as inadequate by physicists. How then could we still be so stuck on it in psychology—where we are dealing not with natural phenomena, but with human beings?

I believe that psychologists' being dominated by a 19th-century philosophy of science—especially since most seem aware there is any alternative—interferes with the training and practice of assessment psychologists. Let me mention just a few ways. First, there's the fixation of many psychologists with gathering "data" by standardized procedures, when in certain situations you can learn more about a client by allowing alterations in these procedures. Some of you have heard the story of my failing my first observed WAIS administration as a graduate student, because I let a client recovering from a stroke keep going after the time limit on several Block Design items, to see whether he could get the correct answers with more time. The TA who graded me gave me a stern lecture about how I wouldn't be able to tell anything about a client unless I stuck with standard administration procedures. I also remember testifying in court years later against a psychologist who insisted that one could tell nothing about certain client from her MMPI, because she had omitted over 30 items and the profile was "invalid" according to a number of major MMPI texts. I argued that since the resulting profile was already highly elevated, things could only have looked worse if the client had completed the missing 54 items. It wasn't hard to convince the lay jury of my point of view. It may be unfair for me to blame such lapses in logic on psychologists' training in logical positivism, but I do believe that rigid application of this philosophy of science sometimes leads to positions that defy basic common sense.

I personally think another consequence of residual positivism in assessment psychology is the preponderance in assessment research of studies on the validity and reliability of tests—and the dearth of studies on whether assessment actually helps people understand themselves and feel better. When I first started doing research on Therapeutic Assessment, several of my esteemed colleagues at the University of Texas took me aside to say this line of inquiry was too "applied" and "had little theoretical interest." I had better go back to my previous research on the structure of masculinity-femininity self-ratings.

A third consequence of psychology's fixation on logical positivism is the large amount of energy now being required of us to answer critiques from within psychology about the reliability and validity of various assessment procedures that have recognized clinical utility. I'm not saying that such critiques have been entirely without merit, or that the time we spend responding to them doesn't strengthen assessment in the end. But I do wonder if this is the best use of our time, especially when we know so little about how to conduct assessments so that we maximize the chances of people's being happier and more functional afterwards.

Now I'd like to consider restraining forces typically operating *within* the assessor, and which keep us from conducting psychological assessments according to my definition of best practice.

Obstacle #4: Personality assessment is a professionally demanding specialty. The best practice of assessment demands a good knowledge of psychometrics, personality, psychopathology, and psychotherapy, and frequent ongoing training as new tests are developed or old ones are revised.

It's really daunting, when you think about it, to realize all that you have to know to be a top-notch assessor. This is especially true for those of us who practice assessment as consultation, where we get asked to see clients that other professionals are confused about or having difficulty treating. And the knowledge in our subspecialty advances fairly rapidly compared to some areas of practice, so the best practice of assessment requires us to be constantly learning new things. I realized some years ago that it was impossible for me to keep current in all the areas of psychology that interest me unless I wanted to work 70 hours a week! In fact, often it's difficult to keep up with all the major journals and books about personality assessment!

There are real, practical, and financial implications of the professional demands placed on assessors. How many of us who do assessment haven't groaned somewhere inside us to see another revision of one of our favorite tests, even though it's likely that the test has been improved in its latest incarnation? This is understandable in that we realize we'll be devoting time and money to learning and purchasing the new test. And I have to admit that there are days when I'm envious of the lower overhead of my colleagues who simply practice psycho-therapy. While I'm saving for the newest version of the WAIS, they're purchasing a lovely new couch for their office.

Obstacle #5: The best practice of psychological assessment is also personally demanding.

I remember "getting this" one day during my internship, when I realized that the really effective assessment psychologists I most admired, had done more than simply memorize a bunch of MMPI code books or Rorschach scores and apply them in a rote way to clients. These people were fully developed human beings—compassionate, wise, and strong—and they brought these qualities to bear in deep ways in their contacts with clients.

I now understand better the personal challenges that an assessment practice entails: how we assessors are continually forced to look at our own blind spots in order to make sense of clients' situations, how the slightest tendency towards being judgmental on our part can keep clients from revealing on tests what we need to understand them, and how humbling and daunting it can be to try to help clients look differently at themselves and the world in a relatively brief space of time. I've also come to appreciate how fully present I

must be if I want my assessments to deeply impact clients, and how challenging it is to do this day after day. (And this doesn't mean, by the way, that I don't have my days where I'm harried and distracted and have to count on the patience and good will of my clients.) Still, I continue to be really "stretched" by the assessments I do, and I'm very grateful for my colleagues at our clinic, because we all have the same commitment to life-changing assessments and we support each other to help make this possible.

Obstacle #6: Highly competent psychological assessment is more time consuming than is generally acknowledged.

I find myself a bit conflicted about making this point. For I still believe that psychological assessment is a relatively brief way—when compared to other psychological interventions—to have a lasting impact on clients. Yet, there are constant institutional pressures on us to be more efficient and cost effective in our assessment procedures, and our critics already question the cost-benefit ratio of psychological assessment. Still, I feel I must say this clearly: really good psychological assessment takes some time! Although the amount of time depends on a number of factors, most notably the complexity of the client situation we are asked to assess, there probably is some lower limit to the number of hours we must put in if we wish to deeply impact clients with our work. And some of this time is difficult to account for precisely. Have you ever found that you just needed to "sit" with a Rorschach or a set of assessment materials for several days, looking at them from time to time, in order for the complex story that they told to become clear to you? Or do you sometimes feel guilty about the amount of time it takes you to write a psychological report, imagining that all your colleagues could do it in half the time? Well before you jump to this conclusion, let me tell you a best kept secret: if you put your heart into it and try to produce a document that will really affect clients and the major players in their lives, it takes time! Surely there are individual differences in writing speed and if you're like me you must continually check your tendency to obsess over your writing. But we can't just churn out boilerplate reports and expect them to have a great deal of impact on a client's situation. Once again, however, I believe it's worth the time—perhaps more than we have acknowledged! For example, I know that later in this conference Brianne Lance and Radhika Krishnamurthy (2003) will present an interesting paper on just how important these written documents can be to clients.

Obstacle #7: If we fully acknowledge both the value and the professional demands of high quality assessment, we will have to start insisting on better recognition for our work and higher compensation.

This may not seem like much of an obstacle, but I sense a lot of us are challenged in this area. Many assessment psychologists seem to have internalized the prevailing negative or short-sighted views of psychological assessment, and to almost be apologetic that they continue to believe in assessment or that they can't do a complete assessment for a small amount of money.

I found myself confronted in this regard by two recent assessments I helped conduct—one of a very successful couple in severe marital crisis, and the other of a well-to-do young man who was extremely lost, depressed, and confused, despite years of psychological treatment. In both these instances, it was quite clear that the assessments we did with these clients helped shed light on problems and patterns that had eluded understanding for years. The clients were extremely grateful, relieved, and hopeful at the end of the assessments. I charged my typical fixed fee for the assessments—which is not cheap—but afterwards I realized that I undersold myself given the difficulty of the clients' situations and the amount of time and emotional energy that went in to the assessments. This fact was glaring in these two cases in that for these clients—money was not really an issue—and in fact, the second young man said repeatedly at the end of the assessment that I should have charged more, the assessment was worth much more, and that it was the best money he had spent in quite a while. Just before I left town to come here, the woman from the first assessment sent a check for some consultations I had done with their new couples therapist, with a note saying something very similar. And I had to ask myself, have I been undervaluing my services?

My friends, these two experiences strengthened a sense I've been developing about the future direction of the Society for Personality Assessment. I believe we have to get off the defensive about our work, to fully recognize and acknowledge the value of psychological assessment to make a difference in people's lives, and to demand fair compensation for the high degree of skill, time, and energy involved in really excellent assessments. And while others may accuse us of grandiosity, I actually believe the major obstacle to psychological assessment of all the ones I have mentioned is our own lack of vision about its potential impact and value.

In conclusion, I hope that by elucidating the challenges facing us in our work, I haven't encouraged you all to go home and give up your assessment practices, courses, and research! In fact, as I'm sure you realize, all these challenges are incredible opportunities, and make psychological assessment one of the most fascinating, fulfilling, and exciting lines of work that I know. As I said to you last year, my love for and appreciation for psychological assessment only keeps growing. And I've tried to use my role as SPA President to help ensure that psychological assessment stays strong and vital. This organization represents one of the real solutions to the obstacles I mentioned here today. By coming together, sharing our love of assessment, learning new things, and being challenged in positive ways, we inspire each other to go back to our respective communities and continue the very important work that we all do.

Thank you again for being who you are and for all that you do to make the world a better place.

References

Finn, S. E. (2002, March). *The power and potential of psychological assessment*. Presidential address to the annual meeting of the Society for Personality Assessment, San Antonio, TX.

Lance, B. R., & Krishnamurthy, R. (2003, March). *A comparison of the effectiveness of three modes of MMPI-2 test feedback*. Paper presented at the annual meeting of the Society for Personality Assessment, San Francisco, CA.

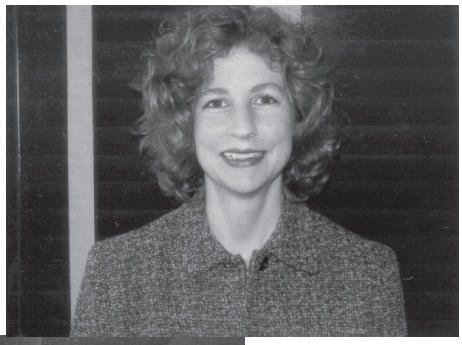
Call for Papers for the 2004 Midwinter Meeting

In order to offer the membership of the Society for Personality Assessment the most efficient member services, the SPA office is working toward a change in announcing the call for papers for the 2004 Midwinter Meeting. In the past, the office has mailed each member the Call for Papers announcement, along with the proper abstract submission forms to complete and return to the office by "snail mail," or by fax. This year, the office is working toward sending the Call for Papers announcement and abstract forms electronically and asking our membership to send their abstract submissions electronically via e-mail (a new e-mail address will also be in effect by that time).

If you have a new e-mail address, or if you think we do not presently have your e-mail address, please contact the SPA office via its present e-mail address at **officeSPA@aol.com** or call toll free at 866-849-3725. Those members for whom there is no e-mail address will be mailed the information as in the past.

SPA Photo Gallery

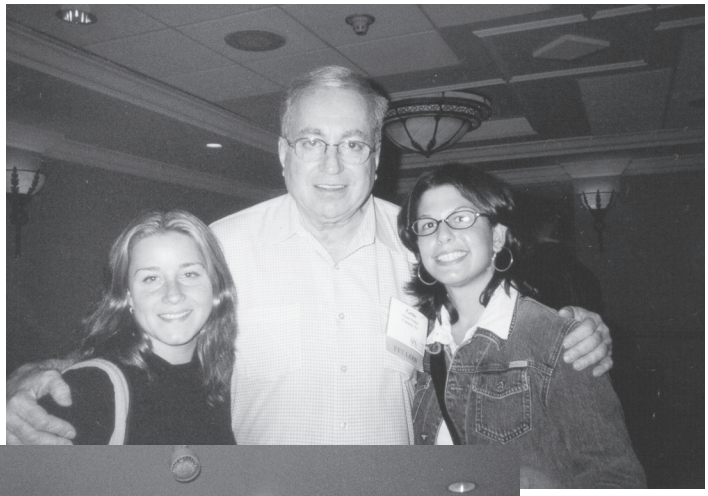
Brianne Lance and Jen Hartey: Student volunteers from Florida Technical Institute studying under Radhika Krishnamurthy.



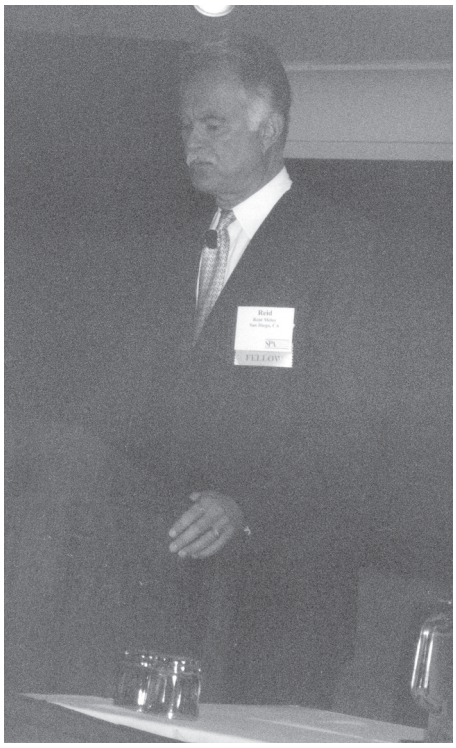
Dr. Anita Boss
SPA Fellow

Marty Leichtman, Ph.D. and Secretary of the SPA Board with members of the Society from Israel.

Gene Nebel, who does all our taping at the Midwinter meetings, with his student volunteers who helped during the taping.



Alex Caldwell and his wife receiving the Bruno Klopfer Award from David Nichols, Awards Chair, SPA Board of Trustees



Reid Melpoy, Master Lecturer,
Indirect Personality Assessment of the Violent True Believer

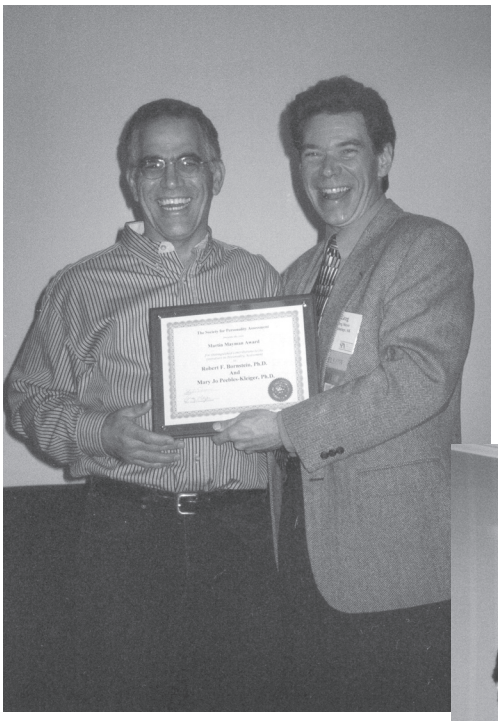
Herbert Eder, "Rick" Cattell, and Richard Gorsuch who made presentations in honor of Dr. Raymond B. Cancattell, recipient of the Marguerite Mertz Memorial Presentation.

*Linda Grossman and Orest Wasyliw accepting The Walter G. Klopfer Award from Greg Meyer, Editor of **JPA**.*

Robert F. Bornstein accepting the Martin Mayman Award from Greg Meyer.

Peter Heinze accepting the Mary Cerney Award from David Nichols.

John McNulty accepting the Samuel J. and Anne G. Beck Award from David Nichols.



Don Viglione accepting the Martin Mayman Award on behalf of Mary Jo Peebles-Kleiger who was unable to attend the conference.

International Members of SPA who were in attendance.

Members of the Board commiserating: Barton Evens, Rep-at-Large; Stephen Finn, President; and Greg Meyer, Editor of ***JPA.***

Joy Iligan from the United Arab Emirates and Ilian Diamont from Israel.

Phil Caracena, SPA's Web master and Morgot Holaday.

Radhika Krishnamurthy, Rep-at-large on the Board and Yossef Ben-Porath, Workshop Leader.

Two participants enjoying the closing reception for the meeting.

Gene Nebel sharing his magician's talents with an SPA Midwinter Meeting participant.

Greg Meyer and Steve Finn.

Len Handler and Adi Uhinki, one of our Finnish members.

A gathering of SPA members.

Ethics and Standards Column

by Radhika Krishnamurthy, Psy.D.

In the Winter 2002 issue of the *SPA Exchange* (Vol. 13, No. 1), Bruce Smith gave us an overview of the Health Insurance Portability and Accountability Act (HIPAA) and its implications for assessment psychologists in his article, "Alphabet Soup: HIPAA and CPT." This spring, the term "HIPAA" has become a crucial reality for all of us. It has become a topic of much discussion and confusion, a conversation starter ("are you HIPAA compliant?"), practically a chant. Even as psychologists rushed to attend workshops and obtain printed guidelines to achieve HIPAA compliance in their practices, most have expressed incomprehension about some aspects of it, particularly in terms of how to comply with HIPAA *and* abide by profes-sional/ethical guidelines concerning pro-tection of test security. There is also much confusion, and strong reaction, to the language of the revised APA ethical code concerning the release of raw test data.

Overall, some of the pivotal questions are — Do psychologists have any discretionary judgment left in determinations of releasing information? Would they be considered noncompliant with HIPAA if they chose to withhold releasing raw data? Attendant questions for assessment psychologists concern the differentiation between "test data" and "test materials." I have heard from some colleagues that they have actually received erroneous or misleading information at HIPAA training workshops about the release of raw test data/materials ("basically, we were told we have to release *all of it* to clients and third parties upon request.")

Given the salience of these professional questions, we decided to devote the Ethics and Standards column in this issue to the interconnected issues of HIPAA, the APA ethics code, state licensing regulations, and copyright protection of test materials, with the contributing article below by Jane Iannuzzelli. We expect that discussion about HIPAA will continue for a while, and we would like to hear from you about your thoughts and experiences. Please submit comments for the next issue of the *SPA Exchange* to: Radhika Krishnamurthy, School of Psychology, Florida Tech, 150 West University Blvd., Melbourne, FL 32901 or e-mail **rkrishna@fit.edu**.

HIPAA, Copyright, Ethics, Forensics, and Assessment in Action

by Jane Iannuzzelli, M.Ed., M.A.

As the HIPAA compliance date approached rapidly, my colleagues and I scrambled toward compliance. Most of our work is within forensic circles, which carries its own special risks; however, the advent of HIPAA and its potential implications for our work, along with a few parameters around the release of test data, gave us extra motivation to review the new HIPAA regulations. Anticipating that our work could be challenged by clients and/or attorneys, we studied HIPAA and its relationship to the APA Ethics Code, copyright, and our state licensing laws. What follows is a brief illustration of one such challenge and how it was addressed.

Sooner than expected, just a few days after the compliance date took effect, I received a faxed request from a client to fax back a full record of a nearly year-old, comprehensive forensic evaluation. The evaluation itself was thorough (e.g., testing, interviews, meetings with collaterals, home visits, record review, issuance of a report), but the request, because it was the first such request of my practice under HIPAA, led me to immediately take the following steps in order to assure the right course of action. (1) I anticipated that the present situation would not resolve until after the June 1 date at which time the new APA ethics code would take effect. I reviewed the manuals and articles that I had accumulated about the interpretation of the code, with specific focus on the release for psychological testing data. (2) I reviewed HIPAA (Section 164.524) and determined that because the evaluation was forensic, the client did not have the right of access. (3) I consulted with two trusted colleagues and called my state psychological association's Professional Affairs Officer, Dr. Samuel Knapp. (4) I reviewed my obligation to respond to the request.

After completing these steps, I wrote back to the client well within the five-day requirement. My letter was copied to the involved attorneys and quoted directly HIPAA sections that were relevant to the client's request (including the client's right to contact the Secretary of the U.S. Department of Health and Services for clarification). I did not, however, integrate information from the ethics code into my decision making.

Very soon after receiving my letter, the client's attorney wrote back and included a signed release from the client requesting that all psychological test data be sent to the attorney. I consulted Dr. Knapp, who noted that neither the 2002 or 2003 codes precluded the release of raw testing data. For example, the 1992 code, which permits release of test data to another qualified professional, had not been defined clearly and could arguably include an attorney within this particular category.

I then reviewed the raw testing data, consulted with colleagues and with Dr. Knapp, and went back over articles related to the release of raw data, and considered the following points in before making my decision. (1) The need to protect test integrity by not releasing raw data. (2) Copyright restrictions related to printed materials that are not meant for public domain. (3) Scoring and scaled scores when recorded on test forms and booklets, and when produced from a computer program printout. (4) Notes on behavioral observations and test inter-pretation. Dr. Knapp was again consulted.

I concluded that only a limited amount of information could be sent. I could not send tests that included questions, Rorschach location sheets, and no computer printouts that were copyright protected. What was sent, in essence, was information that could be understood only by a trained psychological interpreter of data (back to the 1992 code). In anticipation of another series of communications, it is conceivable that I could be asked to copy sentence completion responses without stems onto a separate piece of paper or that the attorney could request permission to review the non-copied material in my office.

As new case situations emerge in relation to assessment, HIPAA, ethics, copyright, and state law, consultation will be a vital part of resolving dilemmas. The need to comply with these requests, however, is open to further review. The value of consulting was highlighted by my discussions with colleagues. Professional consultation throughout the process was clearly a significant source of support and information.

Announcements

Dr. Alan Schwartz Joins Exchange Editorial Board

Alan Schwartz, Psy.D., has been appointed Associate Editor of the SPA Exchange and will be coordinating a new section entitled, "Special Topics in Personality Assessment." Dr. Schwartz is presently the Director of Psychology at Christiana Care Health System in Wilmington, DE, and has presented at SPA conferences on the topics of reconciling Rorschach and MMPI data, narcissism and the Rorschach, and ethical considerations in assessment.

Drs. Constance Fischer and Leonard Handler named Distinguished Psychologists

Dr. Constance Fischer and Dr. Leonard Handler were recognized for their distinguished contributions by their state psychological associations. Dr. Fischer was selected as Pennsylvania's 2003 award winner for Distinguished Scientific and Professional Contributions, primarily for her writing on collaborative assessment and qualitative research. Dr. Handler recently received the 2002 Distinguished Research Psychologist Award from the Tennessee Psychological Association.

Midwinter Meeting Audiotapes Now Available

Dr. Gene Nebel has done it again! Out of the goodness of his heart, Gene has audiotapes available from the 2003 midwinter meeting. Order forms can be requested from Gene Nebel, 285 Mc Farlane Road, Apt. 173, Colonia, NJ 07067–3429.

MMPI-2 Test Users Needed for Student Web-Based Research Project

Mark Deskovitz, a doctoral student in clinical psychology, is completing his research under the direction of Dr. Nathan Weed and is looking for MMPI-2 test users to participate in a research study. Mark submitted the following announcement.

We are conducting a Web-based study beginning 6/1/03 designed to examine how reliably test users interpret the MMPI-2. Participation takes approximately 30 to 60 minutes and involves interpreting an MMPI-2 profile; all participants will receive feedback about how their MMPI-2 interpretation agrees with that of an expert. For more information or to participate, please visit **www.chsbs.cmich.edu/pal/reliability** *or contact Mark Deskovitz (***markdeskovitz@chartermi.net***) or Nathan Weed (***weed1nc@cmich.edu***), Department of Psychology, Central Michigan University.*

Position Opening

DIRECTOR OF TREATMENT at Coastal Evaluation Center of Juvenile Justice near beautiful coastal Charleston, South Carolina. Supervise clinical staff, psychologists and social workers in evaluations, oversee reports to court. Good job for person with testing and administrative skills. Must be S.C. license eligible. Brand new facility. For information call Dr. David Berndt at 843–533–9171 or write at **davidjberndt@yahoo.com**.

Item Theory Workshop

SSI is proud to announce a two-day Item Response Theory (IRT) workshop presented by Susan Embretson and Steve Reise. For details: **www.ssicentral.com/workshop/irt.htm,** contact SSI at 1–800–247–6113 (North America) or +847.6750720 directly for more information.

Dr. Anna Maria Carlsson—First International SPA Board Member

Dr. Anna Maria Carlsson was appointed to the SPA Board of Trustees to fulfill Dr. Bruce Smith's term. Dr. Smith is now the SPA Advocacy Coordinator. Dr. Carlsson is the first international SPA Board Member. Anna was kind enough to prepare a brief biography on short notice.

I am a licensed psychologist and I also have research training (separate training programs in Sweden). I finished my specialist level training in personality assessment in 1982. Between 1990 and 2000 I taught personality assessment within the Swedish Rorschach Society. For eight years I was a member of the board of the Swedish Rorschach Society, and for five years president of the Swedish Rorschach Institute, the latter having main responsibility for the teaching of the Rorschach in Sweden.

I have been a member of SPA since 1990 and I was elected as fellow in 2001. Contact with other SPA members and participation in the annual meeting has been of great importance for my work and I would be glad to help other colleagues share in this experience. I have been a frequent presenter at SPA Midwinter meetings and am perhaps best known as the director of the S-COMPAS project in Stockholm—a long-term study of the effects of psychotherapy, which uses the Rorschach as one of its outcome measures.

At present, I am working at a psychiatric outpatient department with both clinical and research tasks.

SPA looks forward to Dr. Carlsson's insights and contributions, and encourages participation of international psychologists who are interested in personality assessment.

Advocacy Coordinator

by Bruce L. Smith, Ph.D.

I am writing to you as the new Advocacy Coordinator. Recently, Wood and his colleagues referred to Irv Weiner as a "paid lobbyist" for assessment (NY Times, 4/27/03); I guess that makes me an unpaid lobbyist.

I'd like to fill you in on where our advocacy efforts are today. Irv did a masterful job of making an eloquent case for personality assessment within the professional community, and I am happy to be able to report that his efforts will continue, as he is active now in the governance of Division 12, as well as being President of the International Rorschach Society. On the other hand, it is clear to me that we need to direct the efforts of SPA more broadly. As the recent *Times* article points out, there are challenges to the practice of personality assessment outside of the professional community.

I take the title of my position quite literally. It is my intention to *coordinate* the advocacy efforts of as many members of SPA as can be enlisted. It is not my intention to be a lobbyist or the sole advocate for assessment. My first task will be to create a database of members willing to be involved in this effort. We will set up either a listserve or e-mail tree so that it will be possible to communicate with all of the members interested in advocacy. In this way, we can utilize the strength of SPA's entire membership and not need to rely on the word of a few spokespersons.

I see the following issues as paramount at present. In the first place, the ongoing debates within the profession of psychology about the utility of assessment in general, and particular instruments in specific, continue to be important. It is our task as a Society to ensure that those debates are carried out in the tradition of scholarly exchange, and that recommendations or "demands" that aren't supported by data be given short shrift. Secondly, we need to continue to assert the importance of assessment within the healthcare marketplace through lobbying efforts with legislators, third party payers, and the general public. Similarly, we need to ensure that assessment techniques are treated properly within the forensic arena. Finally, the new HIPAA Privacy Rule and the concomitant changes in the APA Ethics Code have presented new challenges to the practice of assessment that need to be addressed.

As you can see, there are significant challenges to our profession that require vigorous efforts. I encourage all members of SPA to become involved in ensuring the continued health of our field.

The Teacher's Block

Multicultural/Diversity Assessment: An Evolving Process

by Pamela Abraham, Psy.D.

The teacher's ability to present students with an overview of historical trends in the development of personality testing and multicultural psychology establishes a model for the importance of considering and contextualizing human diversity when conducting assessment. The integration of multiculturalism and human diversity into personality testing has gained momentum mainly due to the devoted work of such pioneers as Richard Dana, who has provided scholarly cross-cultural research and challenging recommendations for best practices in the area of multicultural assessment, including the TAT and story-telling techniques.

The Thematic Apperception Test (TAT) is a mainstay among story-telling techniques, despite limitations in relation to a diverse client population. Constantino, Malgady, & Rogler (1988) challenged the notions of previous researchers (culturally relevant test stimuli were not needed) by developing the Tell-Me-A-Story test (TEMAS) as a culturally relevant story-telling procedure. The TEMAS manual provides a literature review that calls attention to different historical influences which hindered psychologists from addressing minority issues. In particular, reasons are suggested for the "disappearance" of Thompson's TAT for Blacks. The contributions of Dana and Constantino, Malgady, & Rogler are noteworthy for consciousness raising and influencing changes in our practices to better meet the assessment needs of a pluralistic society.

Multicultural/Diversity competency among graduate students is a best practice standard. What may be helpful in broadening the student's perspective is a discussion around issues pertaining to the strengths and limitations of cultural applications of story-telling techniques. For example, many attempts were made to adapt Morgan & Murray's TAT to various cultures. Little is known about the early modifications and why they have not survived use over time. What happened to the Thomson TAT? Why did attempts to be culturally sensitivity fail? Why did the modified versions cease to be developed and adopted? Was the cultural context considered when making test interpretations? Was the sociopolitical environment such that the TAT modifications did not survive peer review? History provides valuable information for current considerations and future explorations.

Classroom discussions in assessment courses often include questions, such as: What is the availability of racially and ethnically sensitive story-telling techniques? Why is the traditional TAT used with culturally different individuals? Given the increase in cultural blending (biracial & intergenerational families) is there a movement and professional support to design new tests to reflect cultural changes? Has the TAT been analyzed for bias by expert panels?

As a teacher of personality assessment, it has been my observation that assessment textbooks with sections on the TAT and story-telling techniques do not give full justice to historical and social influences pertaining to multicultural psychology in testing. Such lengthy discussion is probably beyond the bounds of survey texts, but the information base itself is important from a historical perspective when teaching students about thematic measures. In the following schema, I offer a sampling of references and topical issues that might be helpful in orienting students to some of the literature that might be otherwise overlooked.

TAT Adaptations and Articles

Here are a few TAT adaptations and articles. Reading the original articles would provide students with an added level of exposure to multicultural information and TAT history outside the traditional format of learning test administration and interpretive procedures. The original material also offers opportunities for students to evaluate and analyze the research conclusions from a different sociopolitical climate.

Morgan & Murray (1935)—TAT Test—this is the initial reference

Murray (1943)—Murray TAT (M-TAT)—Murray assumes sole authorship

Thompson (1949)—Thompson TAT (T-TAT)— Black adaptation (central stimulus figures are Black)

Korchin, Mitchell, & Metzoff (1950)—proposed that White M-TAT represents a "more stable, universal stimulus" for Whites and Blacks; found there was no significance in story length between Black and White groups; proposed Blacks are not homogenous enough due to social class differences, education, racial awareness, "minority mindedness" to justify a separate set of stimulus cards.

Riess, Schwartz, & Cottingham (1950)—found no significant differences between Northern Blacks and Whites in story length to the T-TAT cards as compared to the M-TAT cards even when the examiner, stimulus cards, and examinee were the same race; there was a tendency for Whites to produce longer stories than Blacks to the stimulus cards with the Black figures irrespective of the examiner's race.

Schwartz, Reiss, & Cottingham (1951)—found that story length was not significantly different for Blacks and Whites regardless of the type of stimulus card (T-TAT or M-TAT); when administered the T-TAT or the M-TAT, Blacks expressed more ideas in the stories when given the tests by a White examiner; despite the race of the examiner, Whites expressed more ideas in their stories when the T-TAT was administered.

Cook (1953)—following interviews upon completion of the T-TAT & M-TAT, Blacks indicated both sets of cards represented "people in general" and Whites indicated the T-TAT did not represent "people in general"; Blacks expressed more words of uncertainty in response to the M-TAT

Mussen (1953)—was interested in the qualitative differences between Black and White children's TAT story productions and found that children from different socio-cultural backgrounds demonstrated differences in fantasy production.

Light (1955)—In response to the T-TAT, Whites revealed prejudices toward Blacks in story content. Story length, however, was not significantly different between groups. It was proposed that individuals should be given stimulus cards of their own race to avoid racial attitudes being elicited by pictures.

Riessman & Miller (1958)—proposed that Blacks did not need a separate test (e.g., T-TAT) because they are unfamiliar with taking tests with Black stimulus figures. It was indicated that because it was an odd experience for Blacks to be exposed to Black figures in a testing situation, to expose Blacks to Black figures on cards may hinder their ability to relax and be involved.

Murstein (1965)—concluded, based on a review of previous research, that a socioeconomic approach to interpretation would be better than to treat Blacks as a homogenous group and to have separate stimulus cards of Black characters.

Cowan & Goldberg (1967)—found that Blacks produced longer records to the T-TAT than to the M-TAT.

Bailey & Green (1977)—found that Blacks produced longer stories to the T-TAT and the

E-TAT (characters had Black racial characteristics) than to the M-TAT.

Constantino, Malgady, & Rogler (1988)—TEMAS (Tell-Me-A-Story), 23 pictures of Hispanics & Blacks in an urban setting with a nonminority version: normed for Hispanics, Blacks, & Whites

Constantino, Malgady, & Vazquez (1981)—found that there was greater fluency on the TEMAS 2nd edition than the TAT with Hispanic children.

Constantino, Malgady, Colon-Malgady, & Bailey (1992)—TEMAS discriminated between normals & clinical groups.

Flanagan & DiGiuseppe (1999)—a critical review of the TEMAS

Other TAT Adaptations and Story-Telling Versions

There have been many attempts to model story-telling procedures on the TAT format. Students and teachers who are "TAT-minded" might enjoy searching out these sources.

Lasaga Y Travieso & Martinez-Arango (1946)—Nun and priest adaptation

Henry (1947)—American Indian adaptation

Bachrach & Thompson (1949)—modification for handicapped children (physically challenged)

Henry, W. E. (1951)—cited other modifications in Anderson & Anderson, *An Introduction to Projective Techniques*—Mexican Indian (John Collier, U.S. Office of Indian Affairs, Mexican Institute of Indian Affairs), American Indian (Obibwa, William Caudill, Dept. of Anthropology, U. of Chicago), Japanese American (William Caudill & Setsuko Matsunaga Nishi, U. of Chicago), South West Africans (Boris Iflund, Dept. of Psychology, U. of California), South Pacific Micronesians (Francis Mahoney, U. of Chicago & A. Lessa, U. of Chicago). Proposed the stimulus cards should represent relevant cultural interactions

Briggs (1954)—modifications for Naval enlisted personnel (N-TAT)

Weisskopf & Dunlevy (1957)—adaptation for physically challenged/"crippled" and obese

Chowdhury (1960)—Indian modification for the TAT & CAT

Marui—Japanese version of the CAT (reference in Bellak & Adelman, 1960).

Murstein—(1965) concluded, based on previous research, that treating Blacks as a separate group with separates was not warranted.

Soloman & Starr (1968)—School Apperception Method, used some Black stimulus cards

Ritzler, Sharkey, & Chudy (1980)—a Picture Projective Test (originally SM-TAT now PPT) Utilized pictures from a published photo essay, "Family of Man" stimulus cards chosen to incorporate a balance of feelings states

Roberts & McArthur (1982)—Roberts Apperception Test (RATC), picture story-telling technique with supplementary test pictures for Black children

Pervez (1983)—Pakistan version of the CAT

Mirza—Pakistan version of the TAT (reference in Ansari & Farooqi, 1987)

Karp, Holmstrom, Silber, & Condrell (1989)—Apperception Personality Test (APT) included young and old, male & female, & minority groups on stimulus cards; attempted to avoid negative tone

Silverton, L. (1993)—Adolescent Apperception Cards, offers Black version of the stimulus cards

Zhang et al. (1993)—Chinese modified version (TATC)

Nagaty & Wagdy—modification to fit Egyptian culture; referenced in Abdel-Khalek (1998).

Recommendations

Here are a few recommendations for continuing to study and implement practice strategies for students in the area of multicultural psychology and story-telling techniques.

- Adopt Dana's (1999) Cross-Cultural Standards for TAT interpretation in training, research & practice for professional psychologists.
- Promote dissertation research in the area of multicultural and diversity issues as related to story-telling techniques.
- Facilitate discussions about socio-political issues impacting test continuation & use.
- Advocate for test publisher support for further test development in the area of multicultural assessment.
- Funding for testing supplies at practicum & internship sites.
- Increase multicultural and diversity workshops for clinicians and supervisors in practice.
- Assist supervisors in obtaining funds for the purchase of multicultural assessment instruments at practicum and internship sites and/establish a lending program whereby local training sites can borrow departmental tests as part of their commitment to training students.
- Encourage research regarding the development of stimulus cards representing cultural blending (multiracial), diversity of socioeconomic settings, multigenerational families, & intergenerational groupings.
- Encourage student participation (posters & presentations) at SPA meetings.
- Consider adapting components of alternative assessment models to story-telling techniques: Bio-Cultural model of assessment (Gopaul-McNicol and Thomas-Presswood, 1998).

I am most interested in feedback about your experience teaching Multicultural/Diversity assessment! Please e-mail me at: **pabraham@immaculata.edu**

References

Abedel-Khalek, A. (1998). Personality Research-Arab World. In R. A. Ahmedd & U. P. Gielen (Eds.). *Psychology in the Arab countries*. Cairo, Egypt: Menoufia University Press. Retrieved May 9, 2003. www.5/kuniv/edu/kw/baderansari/PresArab.htm

Anderson, H. H. & Anderson, G. L. (1951). *An introduction to projective techniques.* New York: Prentice Hall.

Ansari, Z. A. & Farooqui, G. N. (1987). Cultural adaptation of Pickford Projectives in Pakistan: A preliminary report. *British Journal of Projective Psychology*, *32*, 31–44.

Bachrach, A. J. with the collaboration of **Thompson, C. E.** (1949). *Experimental set, Thematic Apperception Test, modification for the handicapped, Series A: Child*. 16 cards & manual (6pp. mimeo).

Bellak, L. & Adelman, C. (1960). The Children's Apperception Test (CAT). In A. I. Rubin & M. R. Haworth (Eds.) *Projective techniques with children*. New York: Grune & Stratton.

Briggs, D. L. (1954). A Modification of the Thematic Apperception Test for Naval enlisted personnel (N-TAT). *Journal of Psychology, 37*, 233–241.

Chowdhury, U. (1960). *An Indian adaptation of the C.A.T.* Delhi, India: Manasayan.

Chowdhury, U. (1960). An Indian modification of the Thematic Apperception Test. *Journal of Social Psychology, 51,* 245–263.

continued on page 22...

...continued from The Teacher's Block, page 11

Special Topics in Assessment

by Alan Schwartz, Psy.D.
Section Associate Editor

Self-report personality inventories are one of the anchors of a comprehensive psychological assessment and are notably represented among the most frequently used instruments when psychologists are surveyed about their assessment practices. Their ease of administration and scoring, psychometric robustness and interpretive usefulness provide invaluable information with which to inte-grate historical, interview, and projective data.

This section of Special Topics in Assessment will provide an opportunity to revisit our most familiar self-report measure—the MMPI—to examine important new work involving the composition and interpretation of the clinical scales. We will continue in the next *SPA Exchange* with a focus on two tests that are familiar to many clinicians but for whom an introduction or re-introduction may be helpful. By virtue of training and experiences, clinicians frequently find themselves migrating toward instruments with which they are comfortable and may not avail themselves of opportunities to include new measures amongst their list of favorites. To provide an essential overview of The Millon Clinical Multiaxial Inventory-Third Edition (MCMI-III) and the Personality Assessment Inventory PAI) we have invited Stephen Strack and Robert Craig (MCMI-III) and John Kurtz (PAI) as contributors to our next issue.

For this issue, we turn to the quintessential self-report instrument—the MMPI. In Friedman, Lewak, Nichols and Webb's (2001) recent Psychological Assessment with the MMPI-2, we are reminded of the MMPI's stature as the most widely used self-report inventory throughout the world, which is used by most psychologists who conduct assessments and dominates the research in personality assessment. The test's ongoing scientific and clinical scrutiny has clearly contributed to its longevity. In this regard, we have asked Yossef Ben-Porath to introduce some of his and his colleagues exciting new work with the Restructured Clinical (RC) Scales of the MMPI-2. Ben Porath and his colleagues' work is likely to greatly impact the way we use one of our most familiar instruments.

References

Friedman, A. F., Lewak, R., Nichols, D. S., Webb, J. T. (2001). *Psychological Assessment With the MMPI-2*. Mahwah, NJ: Lawrence Erlbaum Associates.

Rorschach and Cognitive Behavior Therapy: Strange Bedfellows or a Perfect Match?

by Bruce Zahn, Ed.D., Philadelphia College of Osteopathic Medicine

In the age of empiricism in clinical psychology, many clinicians are reluctant, at best, to use projective techniques such as the Rorschach Inkblot Method (RIM) as part of their assess-ment toolkit. At first blush, it almost seems antithetical that cognitive-behavioral psychologists should find the Rorschach to be useful. Yet to discredit the contributions to the art and science of personality assessment that have been made by the RIM, and reject its continued utility for even the most devoted cognitive-behavioral psychologists is suggestive of distorted thinking of the first magnitude, hallmarked by cognitive errors of all-or-nothing thinking, minimization, and discounting the positive, to name just a few.

Despite the constraints on psychological testing typically imposed in the era of managed care, psychology training programs and internship settings continue to expect clinical psychology students to be proficient in the use of the Rorschach as a primary method of personality assessment. Recent surveys of predoctoral internships, including one survey of 329 internship training programs (Stedman, Hatch, & Schoenfeld, 2000) and another survey of 324 APPIC internship programs, most of which are APA-approved (Clemence & Handler, 2001) revealed that internship programs continue to value competency in Rorschach assessment in prospective trainees. At the same time, cognitive-behavioral therapy continues to be the most "in demand" psychotherapeutic orientation of prospective internship trainees, regardless of type of internship setting (Stedman, Hatch, & Schoenfeld, 2001).

So what are the psychologists of the future to do? Are the training demands of the profession encouraging future practitioners to develop dual persona: projective assessment maven when performing comprehensive evaluations, then quickly into the changing room, donning the garb of an empirically driven practitioner when it comes to treatment interventions? How do practitioners integrate their use of classic "projective techniques," such as the RIM with their identification as cognitive-behavioral psychologists without decompensating into a fog of theoretical eclecticism and confusion?

Perhaps part of the problem lies in the his-torical categorization and lore of the Ror-schach as an exclusively "projective technique" that is rooted deeply in psychoanalytic theory According to the projective hypothesis, individuals supply structure to unstructured stimuli in a manner consistent with the individual's own unique pattern of conscious and unconscious needs, fears, desires, impulses, conflicts, prior conditioning, thought processes, and ways of perceiving and responding (Frank, 1939). Schachtel (1966), among others, described how Rorschach responses were considerably influenced by examinees' "attributions to their percepts of their own qualities, feelings, exper-iences, and strivings . . . ." (Weiner, 1998, p.6).

Cognitive behavioral therapists and theorists (CBTers), however, can also find merit in the Rorschach. Cognitive behavior therapy is based on the premise that psychological disturbance is rooted in individuals' perceptions about self, world, and future. The operative word here is "perception," hence the focus on cognition as a primary (but not exclusive) area of exploration and inter-vention. It is the "meaning" and "attributions" that individuals ascribe to events and stimuli, neutral or otherwise, that shape and define one's emotional and behavioral responses to those events and stimuli.

For CBTers, The Rorschach Inkblot Method should be an intuitively logical instrument for studying personality. The decisions about to which responses to attend, articulate, and elaborate lend an invaluable view into the individual's problem-solving strategies and coping resources. Critics of cognitive-behavioral therapy often mistakenly conclude that it is a one-dimensional, "paint-by-numbers" therapeutic method. Nothing could be further from the truth. Cognitive-behavioral therapy is not about correcting Automatic Thoughts alone by thinking positively and rationally. Like competent Rorschachers, CBTers are grounded in their treatment approach by science and data, but are not bound and restricted by such one-dimensional methods alone. Similarly, Exner (2000) and Weiner (1998) have repeatedly cautioned that "adequate" Rorschach interpretation

should not be based on structural summary data alone. The synthesis of propositions developed from structural summary data, content analysis, and sequence analysis reveals a rich, multidimensional portrait of personality that is greater than what could be achieved by relying on normative data alone.

Treatment interventions that are systematically delivered without accounting for the unique meaning that an individual relates to his or her experience and history are bound to miss the mark. Case conceptualization should always consider intrapersonal and interpersonal experience, memories, and emotions that contribute to the development of core beliefs, or schema, and personal prediction systems. Content analysis from the Rorschach responses that is based on consistent themes may provide clues to schema or core beliefs. Sequence analysis permits an examination of the individual's style of coping, on a micro level, providing another angle on processing and coping styles.

For example, say we have a client who is depressed on self-report and on the CDI, but not on the DEPI. On Card III, he says, "2 people negotiating, like at the UN, but they can't reach a compromise and the guy on the right tells the guy on the left that he is going to do it his way, regardless. There is no cooperation at all. The guy on the left looks confused." [Code: D1+ Ma 0 (2) P H 3.0] Then, on the follow-up response, the client looks at Card III and sees "A black beetle, 4-legged insect crawling around, like in Kafka's novel, which I read." [Code: D7o FC'. FMa- A PER]. A psychoanalytic interpretation of this response sequence might focus on tension and interpersonal pressure, aggressive drive derivative with sublimatory efforts that do not reach the desired end, and, on the heels of a control theme, a sense of possible shame (i.e., the insect and FQ- response) in the follow-up response. A cognitive-behavioral analysis of these responses might key in on the narcissistic schemata of entitlement, with automatic thoughts, such as "I should always get what I want," and "If I do not get what I believe I am entitled to, I am a nothing." These prevailing schemata have been formed by early learning and activated when triggered by a crisis, are the subject of treatment interventions aimed at modification and adaptive restructuring.

In addition to studying response content from a CBT lens, several of the RIM variables might be of special interest to cognitive behavioral therapists, including processing efficiency, stress tolerance and control, and self-perception. This interest is rooted in using the RIM as a treatment-planning tool, since these variables lend themselves to specific cognitive-behavioral intervention protocols. For example, individuals who exhibit an underincorporative style may profit from cognitive restructuring and problem-solving training, while overincorporators may be able become more efficient information processors with cognitive-behavioral skills geared to intervene with obsessive and perfectionistic thinking.

There are a number of empirically-supported cognitive-behavioral treatment protocols for improving stress coping skills and self-control. The Rorschach can enrich the use of these treatment protocols by providing specific information about the internal thought-emotion processes that may be currently impacting the individual, in relation to his or her usual coping style. Individuals with a low Egocentricity Index ratio typically engage in negative self-comparisons with perceived internal standards or external expectations. Comparisonitis, perfectionism, and should statements are three cognitive distortions (Freeman & DeWolf, 1992) that appear to be operative in this process, and would appear to be a natural fit for cognitive-behavioral intervention.

In summary, the Rorschach promises significant rewards for those CBTers who are willing to not be prejudiced by "old" conceptions of the test as a "projective technique." The RIM has considerable value when used as a prescriptive treatment-planning tool, and a rich resource for generating hypotheses related to schematic representation based on the uniqueness of each individual's perceptions of self, world, and future.

Dr. Zahn can be reached at
BruceZ@pcom.edu

References

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

Exner, J. E. (2000). *A primer for Rorschach interpretation*. Asheville, NC: Rorschach Workshops.

Exner, J. E. (1974). *The Rorschach: A comprehensive system, Volume 1: Basic foundations*. New York: Wiley.

Frank, L. K. (1939). Projective methods for the study of personality. *Journal of Psychology, 8*, 389–413.

Freeman, A. & DeWolf, R. (1992). *The 10 dumbest mistakes smart people make*. New York: Harper-Collins Publishers, Inc.

Schachtel, E. G. (1966). *Experimental foundations of Rorschach's test.* New York: Basic Books.

Stedman, J. M., Hatch, J. P., & Schoenfeld, L. S. (2001). Internship directors' valuation of preinternship preparation in test-based assessment and psychotherapy. *Professional Psychology: Research & Practice, 32*(4) 421–424.

Stedman, J. M., Hatch, J. P., & Schoenfeld, L. S. (2000). Preinternship preparation in psychological testing and psychotherapy: What internship directors say they expect. *Professional Psychology: Research and Practice, 31*, 321–326.

Weiner, I. (1998). *Principles of Rorschach Interpretation*. Mahwah, NJ: Lawrence Erlbaum Associates.

The Rorschach and School Psychology Evaluations

by Bonnie Clement Socket, Ph.D., Lower Merion School District

The use of the Rorschach as part of the psychoeducational battery in traditional public school settings has been significantly declining in recent years. Some of the reasons for this include lack of familiarity with the use of the test, constraints on psychologists' time due to increasing demands to identify students in need of special education within mandated time-lines, and current federal and state regulations which de-emphasize traditional psychological diagnostic methods when determining eligibility for special education. In addition, few training programs in school psychology offer coursework on the Rorschach and focus, instead, on a cognitive, statistical and curriculum based approach to the identification of students exhibiting a wide range of problems which interfere with the learning process. Although the realities of these issues cannot be readily dismissed, it must also be argued that the complexity of the problems with which students present in school settings cannot be uniformly evaluated using only cognitive assessments, functional behavior assessments and instructional grade levels.

Traditional psychoeducational assessments in the schools focus almost exclusively on the quantification of the learning problems (e.g., *Johnny is reading two years below grade level*) rather than focusing on the underlying dynamics of '*why Johnny can't read*.' Barbanel (1994) discusses the interface between psychoanalysis and school psychology as differences in diagnostic focus, the former on the affective component, the latter on the cognitive. During the 1970s, the definition of learning disabilities, according to Barbanel, became more agreeable to educators when the explanation became more scientific (e.g., presumed neurological origin) and therefore offered more hope. Psychodynamic determinants of learning problems have become largely rejected in the schools. Assessment instruments, in particular, projective evaluations of personality functioning, have taken a back seat to more objective and quantifiable descriptions of manifest behavior found in behavior rating scales and teacher checklists.

The use of the Rorschach and other projective measures in school settings is essential when one attempts to determine the oftentimes complex and multiple issues involved in school failure. A frequent challenge to school psychologists, for example, is the task of differentiating students exhibiting emotional disturbance from social maladjustment. According to the Individuals with Disabilities Education Act (IDEA) a student is eligible to receive special services if the evaluation results indicate an emotional disturbance. Students are ineligible for services based on social maladjustment. A task of this sort is a challenge to even the most seasoned diagnostician! Problems begin to arise when there is a need to make discrete differentiations between two overlapping diagnostic categories, particularly when determining whether one will or will not receive services based upon them. This issue becomes even more complex when funding issues and special programming rely upon precise definitions.

Exner and Weiner (1995) indicated that children and adolescents who misbehave do not represent a homogeneous group. Indeed, research has defined four groups of students who misbehave, conceptualized as: (1) *socialized misconduct* whereby little psychological disturbance exists; often engaging in antisocial behavior and membership in a delinquent subculture; (2) *characterological misconduct* defined as antisocial acts centered around self-centered and inconsiderate personality traits; (3) *neurotic misconduct* identifies misbehavior as a symptom of underlying needs; and (4) *psychotic or neuropsychological misconduct* where misbehavior is a result of impairments in judgment, impulse control, and other integrative functions of personality.

In a previous paper (Socket, 2000), I reformulated Exner and Weiner's fourfold classification of misbehavior as a model for differentiating emotional disturbance from social maladjustment. As such, I suggested that emotional disturbance might be operationally defined as *neurotic misconduct* and *psychotic/neurologically related misconduct* whereas social maladjustment defined as *social misconduct* and *characterological misconduct*. Rorschach variables related to each category have been identified by Exner and Weiner and would offer a basis for the differentiation of emotional disturbance from social maladjustment. For example, from the neurotic misconduct and psychotic/neurologically related groups, some Rorschach indices of emotional disturbance might include elevations of C′ and V responses, Color-Shading or Shading-Shading blends; a low Egocentricity Index; an elevation of m and Y responses D < 0; an elevation of T responses; or a low Affective Ratio. By contrast, examples of Rorschach variables related to social maladjustment, inferred from the social and characterological misconduct groups, might include a high Egocentricity Index; an *absence* of FD, V, or Morbid responses; a T-less record; low frequency H; low Pure H; CF + C > CF; low P; Lambda > 1.00.

Empirical research differentiating emotional disturbance from social maladjustment using the Rorschach would be an important contribution to the literature. The continuing lack of consensus when differentiating emotional disturbance from social maladjustment speaks to the need to look elsewhere when attempting to identify assessment instruments which are sensitive enough to answer referral questions requiring fine diagnostic discriminations. This is particularly prudent when one considers the number of challenges to this issue as parents exercise due process when they believe that, because of faulty decision making on the part of the psychologist in the schools, their son or daughter is denied legal rights and entitlements, including special services and treatment.

Dr. Socket can be reached at:
socketb@lmsd.org

References

Barbanel, L. (1994). Psychoanalysis and school psychology. *Psychoanalytic Psychology, 11(2)*, 275–283.

Exner, Jr., J. E., & Weiner, I. B. (1995). *The Rorschach: A Comprehensive System, Volume 3: Assessment of Children and Adolescents, Second Edition*. New York: Wiley.

Socket, B. C. (2000). The Rorschach and differentiation of serious emotional disturbance from social maladjustment. In J. Yalof (Chair), *Personality assessment and special education evaluation.* Symposium conducted at the meeting of the Society for Personality Assessment, Albuquerque, NM.

An Ego Functions Model for the Organization of Psychological Test Data

by Thomas Schaffer, Ph.D.

An Ego Functions Model (EFM) for the Organization of Psychological Test Data (Shaffer, 2001) was developed to assist clinicians who perform psychological assessments, students learning assessment, and the faculty who teach and supervise them. Its development arose from the difficulty inherent in organizing complex data into a meaningful, readable presentation. Frequently, test findings are presented in a test by test format. While this is the simplest form to write, learn and teach, it lacks integration and forces the reader to synthesize information into the integrated framework clinicians use when treating patients and clients. To organize data into an integrated framework, a theoretical orientation must serve as the basis for the integration and *An Ego Functions Model (EFM) for the Organization of Psychological Test Data* (Shaffer, 2001), based on the work of Heinz Hartmann, provides this integration.

Sigmund Freud, in his 1923 publication of *The Ego and the Id,* presented his tripartite theory of personality (Freud, 1923). Freud focused much attention on the ego's attempts to mediate between the id and the superego and the anxiety which resulted within this process. In contrast, Hartmann focused on the ego and its various functions, including thought, perception, regulation, etc (Hartmann, 1981). For Hartmann, a salient feature of personality theory was the ego's capacity to assist the organism in managing the environment by calling upon various ego functions. The effectiveness of specific ego processes is directly related to the quality of an individual's life.

EFM uses Hartmann's focus on ego functions to provide the theoretical basis for organizing psychological test data in report writing. The manual assists with organizing and integrating information from eight assessment instruments: Rorschach, Minnesota Multiphasic Personality Inventory-2 (MMPI-2), Personality Assessment Inventory (PAI), Weschler Adult Intelligence Scale III (WAIS III), Word Association Test (WAT), Thematic Apperception Test (TAT), Beck Depression Inventory II (BDI II), and the Beck Hopelessness Scale (BHS). The model may be expanded to include other measures and it is not necessary nor even expected that clinicians would always use all eight of these instruments. Any combination of these tests allows for the utilization of the manual for the interpretation, organization, and integration of a test findings section of a psychological report, as well as generating treatment recommendations. While written for use with adults, the theoretical framework and the overlap in some tests across developmental lines allows for extrapolation to adolescents and children. This work is consistent with multiple attempts to utilize empirically grounded and conceptual efforts to anchor treatment recommendations to clinical test data.

The manual describes six ego functions about which psychological tests have much to offer. Number 1 is perception which is understood as the translation of data. It informs us as to how accurately a person translates events. While human beings, like other animals, translate data through the five senses we also translate interpersonal and personal data. Psychological tests like the WAIS III, Rorschach, MMPI-2, and others, can provide a wealth of information on how an individual translates these data.

Number 2 is cognition which is synonymous with thought and here we are evaluating how reasonably a person understands relation-ships between events. While different from perception it is inextricably tied to it and together they form the basis for many behaviors and reactions. Tests provide much insight into thought and when combined into a battery enable the comparison of cognition both in structure (WAIS III) and out of structure (Rorschach).

Number 3, regulation of instinctual behavior and actions in general, reflects a person's capacity to satisfy need states in a socially acceptable fashion. Self report instruments (MMPI-2 and PAI) provide an opportunity for an individual to describe how broad, wide sweeping drives, such as sex and aggression are managed, as well as more discrete behaviors like drug and alcohol use. Projective techniques (Rorschach, TAT) offer information relevant to control by providing data on the capacity to delay how aggression is managed and extent of internal controls versus the need for external regulation.

Number 4 is affect which encompasses what people are feeling and how those feelings are managed (MMPI-2, PAI, BDI, BHS). More specific aspects of affect can also be assessed, such as the extent to which one is responsive to emotionally laden situations and how complex or restricted is the range of emotionality (Rorschach, TAT).

Number 5, self, reflects an individual's sense of self for stability and reality foundation. Tests provide information on the defenses erected to protect the self (Rorschach, TAT, and MMPI-2). Additionally, tests offer information on one's level of self esteem, self confidence, or self criticalness (BDI II, PAI).

Number 6, relational capacity, reflects an individual's interpersonal functioning ranging from the individual's knowledge about social values and mores (WAIS III–Compreshension), capacity for healthy relationships (Rorschach) to the person's own self report (MMPI-2 and PAI).

The EFM requires a listing of test scores patients achieve on each of these six variables and offers a brief interpretative statement for each. For each test variable the model presents the mean and standard deviation, or median and mode, a brief statement about the basic information provided by that variable and a reference guiding the reader to additional information (for example, Similarities (10, 3), the mean and standard deviation, measures "abstraction, verbal concept formation," and Kaufman, 1990). This information provides the user with the basics of a given variable and those who need additional information are referred to the cited reference.

The importance of monitoring patients' response sets upon test responses cannot be overstated and future assessment development will continue to improve and refine current test validity indicators. Accordingly, the EFM highlights information on assessing validity. Three of the eight instruments which are addressed in the EFM contain sophisticated, psychometrically-based validity indicators. The Rorschach, MMPI-2 and the PAI have elaborate and sensitive systems for assessing validity while the WAIS III, TAT, and Word Association Test rely heavily upon clinical judgment and behavioral observations. The validity of the Beck Depression Inventory II and the Beck Hopelessness Scale are dependent upon thoroughness and compliance for their validity.

In addition to assisting with the organization of test data obtained on the above discussed six ego functions, the EFM addresses treatment recommendations. Test variables from each instrument which might assist the clinician in developing treatment recommendations are articulated. For example, if the self section indicates that the individual suffers from low self-esteem as a result of conflictual relationships with parents and the clinician is considering recommending psychotherapy, consulting the treatment indicators for test variables which shed light on the appropriateness of that modality for this particular individual is useful. Should the clinician wish to recommend insight-oriented psychotherapy to address this self-problem but the treatment indicators reveal a Similarities of 7 (limited abstract reasoning facilities), and a Zd of –5.5 (suggesting negligent processing), a more direct approach to these self issues with this particular individual might be more appropriate. (Part II of this article will be published in the next edition of the *Exchange*).

Correspondence can be directed to Dr. Schaffer at **tws1@inreach.com**

Introducing the MMPI-2 Restructured Clinical (RC) Scales

by Yossef S. Ben-Porath, Ph.D.

At the 2002 SPA Mid-winter meeting in San Antonio, we (Tellegen, Ben-Porath, McNulty, Arbisi, & Graham, 2002) introduced the MMPI-2 Restructured Clinical (RC) Scales, which represent the most important innovation in MMPI-2 interpretation since the test's re-standardization. Auke Tellegen, of the University of Minnesota, developed the RC Scales recognizing that, although proven and valuable, the original Clinical Scales can be improved. Tellegen, Ben-Porath, McNulty, Arbisi, Graham, and Kaemmer (2003) provide a detailed description of the RC Scales' development and initial validation. This article, based in large part on the Tellegen et al. (2003) monograph, describes the rationale for constructing the RC Scales and the methods used in their derivation. Next, findings of research conducted to date with the RC Scales are summarized. Recommendations for RC Scale interpretation are offered next. Finally, some observations are made regarding directions for further MMPI-2 RC Scale research and application.

The need for restructuring the clinical scales arose from their well-known saturation with a common, emotionally-laden factor, which has been described in the literature alternatively under many labels, including *Anxiety, First Factor Variance, General Maladjustment, General Psychopathology, Sensitization*, and many others. Tellegen et al. (2003) discuss how the method of empirical keying, employed by Hathaway and McKinley in constructing the MMPI Clinical Scales, coupled with its specific application with relatively small, non-replicated samples contributed to this phenomenon, which serves to limit the Clinical Scales' discriminant validity.

Their limitations notwithstanding, the MMPI-2 Clinical Scales have withstood the test of time because a vast unparalleled body of empirical research has established their validity and may be relied upon to guide their interpretation. Recognizing, therefore, that these scales measure clinically meaningful and empirically verified variables, Tellegen sought to develop a set of restructured scales that preserve the Clinical Scales' valuable descriptive features while enhancing their discriminative abilities.

RC Scale construction proceeded in four steps. These involved a series of analyses of MMPI-2 data generated by four clinical sub-samples—samples of male and female psychiatric inpatients and samples of male and female pa-tients at a residential substance abuse treatment facility. Reliance on replicated empirical findings across multiple samples was designed to reduce the likelihood that chance would play a role in item selection for the RC scales as it did when the Clinical Scales were constructed with much smaller, non-replicated samples.

The first step in RC Scale construction entailed development of a scale measuring the broad emotionally colored factor just mentioned, labeled *Demoralization*. This label reflects Tellegen's theoretical view of Demoralization as a higher order affective dimension positively correlated with the disposition to experience negative emotions (reflected in anxiety symptoms) and associated negatively with the disposition to experience positive emotions (underlying a predisposition toward depres-sion.), but distinguishable as a more general dimension from both these affective dispositions. By this characterization he equated demorali-zation with Watson and Tellegen's (1985) higher-order mood construct they labeled *Pleasant-Unpleasant* (PU) affect, which he had similarly linked to anxiety and depression. At the Unpleas-ant end of the PU dimension are mood des-criptors, such as "sad," and at the Pleasant end one finds adjectives, such as "happy." On the basis of this conceptualization of Demoralization as an overarching dimension related to both depres-sive and anxious affective experiences, Tellegen selected items for the Demoralization scale by identifying those that loaded on a com-mon factor emerging from a series of analyses of the items that make up Clinical Scales 2 and 7.

The second step in constructing the RC Scales was designed to identify a core construct underlying each of the Clinical Scales that is relatively independent of Demoralization. This involved a separate set of factor analyses for each of the Clinical Scales' items coupled with the Demoralization scale items. For each Clinical Scale, these analyses identified a Demoralization factor that pulled in some of the Clinical Scales' items (those that were saturated with Demoralization variance) and an additional factor (or factors) that contained items that were used to define the core, non-Demoralization construct underlying that scale.

The third step in RC Scale construction involved development of a set of "Seed (S) Scales" that would form the basis for eventual construction of the RC Scales. An S scale was constructed for each of the 10 original clinical scales, except for Scale 5 where factor analyses had identified two relatively broad, non-Demoralization constructs labeled *Aesthetic-Literary Interests* and *Mechanical-Physical Interests*. Each S scale was constructed by selecting initially items that loaded uniquely on their underlying factor, followed by item analyses designed to eliminate those that did not correlate adequately with the S scale remainder and ones that correlated more highly with an S scale other than the one to which they were assigned.

The fourth and final step in RC Scale construction involved derivation of a new set of scales corresponding to the S Scale for Demoralization and each of the eight original clinical scales. Clinical Scales 5 and 10 were excluded because these are not traditional psychopathology measures. In this step, correlations were calculated between each of the S scales and all 567 MMPI-2 items. An item was added to a given S Scale if it correlated consistently (across the sub-samples) with that particular scale beyond a certain threshold and did not correlate consistently with the remaining S Scales, including the one corresponding to Demorali-zation. This procedure was designed to increase the RC Scales' length while at the same time enhancing their discriminant abilities. This methodology also allowed for adding to the RC Scales items that were not included on their original Clinical Scale counterpart, including items added to the MMPI-2 when the test was restandardized.

A final set of analyses was designed to refine the RC Scales by examining their correlations with collateral criterion measures. Data for these analyses came from outpatient and inpatient mental health settings where clinicians had provided descriptive information about patients who had completed the MMPI-2. A small number of final changes were made to the RC Scales based on these analyses.

The procedure just described yielded the MMPI-2 RC Scales listed in Table 1. Also included in this table is the number of items on each RC Scale and comparable information regarding their Clinical Scale counterparts. As evident in Table 1, the RC Scales are considerably shorter than the Clinical Scales. The total number of items on the RC Scales is 192, and there is no overlap among them. The Clinical Scales have a total of 257 unique items, many of which are scored on multiple scales.

Tellegen et al. (2003) present a series of analyses of the RC Scales' psychometric properties. These data show that the RC Scales are at least as reliable (and often more so) as their clinical scale counterparts. Additional analyses demonstrate that, as intended, the RC Scales are generally less highly correlated with Demoralization than are their clinical scale counterparts and that this is particularly true for scales measuring non-affect-related constructs, such as Clinical Scales 4, 6, and 8. Our findings also indicate that the RC Scales show considerably lower inter-correlations between themselves, in comparison with the Clinical Scales. Finally, these data show that the RC Scales are comparable to or better than the Clinical Scales in terms of their convergent validity while demonstrating considerable improvement in discriminant validity.

RC Scale Interpretation

Tellegen et al. (2003) recommend that the RC Scales be used to supplement information derived from the Clinical Scales in MMPI-2 interpretation. By disentangling common Demoralization variance from each clinical scale and enhancing their discriminative abilities, the RC Scales function the same as the Clinical Scale code types, Harris Lingoes subscales, Content Scales, and other supplementary scales in clarifying the interpretive picture. With experience, MMPI-2 users may find that much of the interpretive clarification offered by the

other supplementary sources just mentioned can be found more directly and efficiently in the RC Scales. Until a satisfactory research literature has been developed and clinicians have accumulated sufficient experience with the RC Scales, we recommend that their interpretation focus on clarifying the interpretive picture presented by the Clinical Scales. RC Scale scores can serve to inform the interpreter on the extent to which an individual's standing on the core construct measured by each Clinical Scale departs from his or her level of Demoralization.

One general consideration in interpreting the RC Scales as just recommended is the *K*-correction's impact on Clinical Scale scores. The *K*-correction procedure was not adopted for the RC Scales because our analyses indicated that a uniform suppressor correction across different criteria would not be warranted. As a result, interpreters who rely on *K*-corrected T-scores on the five relevant Clinical Scales will need to consider the procedure's impact on those scales (particularly Clinical Scales 7 and 8, the two scales with the largest *K*-corrections) which is to increase scores on the scales in cases where *K* is elevated, and decrease *T* scores on the scales when *K* is below average.

Although the *K*-correction procedure is not applied to the RC Scales, the score on *K* and the other MMPI-2 Validity Scales will be available to the interpreter. Because of their relatively transparent content, the RC Scales resemble the MMPI-2 Content Scales in their susceptibility to over- and under-reporting test-taking approaches. As is the case with all other MMPI-2 scales, close examination of the Validity Scale scores and consideration of their implications should precede RC Scale score interpretation.

Tellegen et al. (2003) provide detailed recommendations for incorporating the RC Scales in MMPI-2 interpretation. Like the Clinical Scales, the cutoff for clinically significant elevation on the RC Scales is a *T* score of 65, corresponding to the 92nd percentile. Following, is a brief description of each of these scales and its recommended interpretation.

Demoralization (RCd): RCd is the starting point for RC Scale interpretation. It provides an indication of the overall emotional discomfort the individual is experiencing. Individuals with elevated scores on RCd describe themselves as discouraged and generally demoralized, insecure, and pessimistic, and as having poor self-esteem. They expect to fail or believe they have done so in various aspects of their lives. At greater levels of elevation (RCd $\geq$ *T* score 75) individuals may be experiencing significant emotional discomfort and a sense of helplessness, and report feeling overwhelmed and incapable of coping with their current circumstances.

Somatic Complaints (RC1): Of all the RC Scales, RC1 bears the strongest resemblance to its Clinical Scale counterpart. Because of their substantial similarity, caveats pertaining to Scale 1 interpretation apply to RC1 as well. Thus, individuals experiencing and reporting significant health problems are likely to produce elevations on this scale, and elevation on RC1 in itself is not evidence of the absence of genuine somatic dysfunction. However, the higher the score on RC1, the less likely it is that physical health problems alone can account for the elevation. Individuals who produce high scores on RC1 report a relatively large number of somatic complaints and are excessively preoccupied with bodily concerns. They may present with diffuse health concerns and complain of fatigue, weakness, or chronic pain. Individuals who produce markedly elevated scores on RC1 (*T* score $\geq$ 75) report an unusual degree and combination of somatic complaints, even for those with bona fide health problems.

Low Positive Emotions (RC2): The item composition of RC2 differs substantially from that of Clinical Scale 2, but the correlation between the two scales still averages approxi-mately .80 in clinical samples. Individuals who produce an elevated score on RC2 report a lack of positive emotional engagement in their lives. They are at increased risk for experiencing depression and they are likely to be withdrawn and passive in social situations. They are likely to be pessimistic and report a sense of boredom and social isolation, and feel they do not have the energy needed to deal effectively with the demands of living. They find it difficult to take charge, to make decisions, to get things done, and have low expectations of success.

Cynicism (RC3): RC3 represents a relatively circumscribed component of Clinical Scale 3 that was singled out as distinctive. The largest proportion of Clinical Scale 3 items concerns somatic complaints, which are assigned to RC1. A smaller component of Clinical Scale 3 items assess excessive avowal of trust associated with the traditional conception of conversion disorder. This set of items serves as the core for RC3, with the keying reversed so that a high score reflects increased levels of cynicism. Individuals with elevated scores on RC3 endorse assertions that people are untrustworthy, untruthful, uncaring, and exploit others. Conversely, individuals who produce very low scores on RC3 (*T* score $\leq$ 40) may be naïve, gullible, and overly trusting of others.

Antisocial Behavior (RC4): RC4 items allow the test taker to acknowledge a variety of past and current antisocial behaviors and related family conflict. While tapping a similar construct, Clinical Scale 4 also includes a large number of items that measure demoralization rather than externalizing behavior. As a result, individuals without substantial antisocial propensities can nonetheless have elevated scores on Clinical Scale 4 if they report high levels of demoralization. Conversely, test takers relatively low in demoralization sometimes produce non-elevated scores on Clinical Scale 4 that may mask antisocial tendencies. Individuals who produce elevations on RC4 are likely to engage in various antisocial behaviors, tend to behave aggressively toward others, and are viewed as being antagonistic, angry, and argumentative. They find it hard to conform to societal norms and expectations and may, as a result, experience legal difficulties. They are at increased risk for engaging in substance abuse and other forms of acting out behavior and are likely to have conflictual family relationships and histories of poor achievement.

Ideas of Persecution (RC6): Compared with Clinical Scale 6, RC6 is considerably less saturated with demoralization and, as a result, elevations on RC6 are more clearly and uniquely associated with persecutory thinking. An elevated score on Clinical Scale 6 coupled with a non-elevated score on RC6, suggests that the former is probably not a reflection of persecutory ideation. Individuals with high scores on RC6 may feel mistreated and picked on, and may have significant difficulties forming trusting relationships. Those with particularly high scores on RC6 (*T* score $\geq$ 75) are likely to be characterized by paranoid thinking that may be symptomatic of a schizo-phrenic or delusional disorder.

Dysfunctional Negative Emotions (RC7): RC7 items reflect a tendency to have negative emotional experiences conceptualized as underlying anxiety, irritability, and other forms of aversive reactivity. RC7, like RC2, is correlated substantially with RCd, in other words with general unhappiness and feelings of dis-couragement. Individuals high on RC7 are at increased risk for experiencing anxiety and/or developing anxiety disorders. They also tend to ruminate and worry a great deal, are sensitive to criticism, and perceive negative appraisals when none is offered. They may also experience intrusive, unwanted ideation.

Aberrant Experiences (RC8): RC8 items describe various sensory, perceptual, cognitive and motor disturbances that indicate impaired functioning of the self. The scale is considerably less saturated with demoralization than Clinical Scale 8, and hence is a more focused predictor of possible psychotic symptoms. Individuals who produce elevated scores on RC8 report frank psychotic symptoms that may include visual or olfactory hallucinations, bizarre perceptual experience, and non-persecutory delusional beliefs. Individuals who produce particularly elevated scores on this scale (*T* score $\geq$ 75) may meet diagnostic criteria for a schizophrenic, delusional, or schizoaffective disorder. At more moderate levels of elevation, RC8 scores may suggest the presence of schizotpal characteristics.

Hypomanic Activation (RC9): RC9 items describe a variety of emotions, cognitions, attitudes, and behaviors consistent with hypomanic activation. Test takers who produce elevated scores on RC9 report a hypomanic symptoms including a grandiose self-view, general excitation, tendencies toward sensation seeking and risk taking, poor impulse control euphoria, decreased need for sleep, racing thoughts, and aggression. Individuals who produce particularly elevated scores on RC9 (*T* score $\geq$ 75) may be experiencing a manic or hypomanic episode.

...continued on page 23

Interview With Dr. Leonard Handler

Dr. Leonard Handler, a distinguished member of SPA, assumes the gavel as the next SPA President. SPA members know Dr. Handler as an expert assessor and prolific author, but there is more to tell. The following interview provides members with some additional information about our colleague from Tennessee.

Exchange: How did the book you did with Mark Hilsenroth, *Teaching and Learning Personality Assessment* come about?

Dr. Handler: The story about how we got the idea for the book came from rejection. Let me clarify what I mean. Mark and I were sitting in my office, about a month before the Annual Meeting, passing a few leisure minutes together and complaining about our recent bad luck. He told me about an article he sent to *JPA* that had been rejected. The reviewers liked the article but said that it was more appropriate as a book chapter than as an article. I began to laugh, which puzzled Mark because the rejection of a submission to *JPA* is certainly no laughing matter. When I told him why I was laughing, he began to laugh, too. I had just received a very similar letter about an article I had submitted. Then suddenly it hit us both at about the same time. Well, we already have two chapters; why not do a book?

We constructed a tentative list of possible chapters and we identified possible authors. When we got to the meeting we talked to people we thought would write excellent chapters, constructed the final list, and we informally pitched it to Larry Erlbaum. We submitted a short description of what the book would cover, along with reasons for writing the book, and sent it, along with a provisional table of contents, to Larry. The rest "is history." We were very fortunate to have had a group of excellent clinicians and teachers who agreed to write chapters and John Exner was kind enough to write the Foreword. Larry and his staff, including Susan Milmoe, were wonderful to work with; they made publication very easy and painless.

Exchange: What is the hardest part of assessment to teach?

Dr. Handler: I don't have a simple answer to that question, because there are several ideas or concepts that are difficult. One of the hardest things to teach new students is how to see the world through the patient's eyes. This is among my most important goals as a teacher. New students are imbued with the desire for precision and objectivity, learned in their undergraduate education. They don't mean to be harsh or rude, or inflexible; they are doing "science" so to speak, as they attempt, at first, to gather the assessment data. It is difficult to get them to focus on the patient's experience and on their own experience of the patient. However, they eventually get the idea and they begin to use much more descriptive language in their reports; the technical jargon eventually disappears.

When I began teaching assessment, many years ago, I seemed to have forgotten how frightening the prospect was of committing oneself to paper as part of the assessment process. Students fear making a mistake and possibly injuring a patient, and they are also afraid of saying negative things about a patient, despite the fact that there is ample evidence for the negative statement. I try to allay these anxieties, as well as others they have, so that they can feel more at ease about the task. This requires a great deal of support and the creation of a "holding environment" so they can feel safe in their interpretive work. There is nothing so grim, one student explained, as sitting in front of the computer and being so frozen that they were unable to even begin the report. They need to learn how to begin to conceptualize the data, so they can organize the report.

I try to teach the students how to begin the data analysis and combination by the use of convergent and divergent thinking, concepts used in creativity research. Divergent thinking has been studied by asking people to generate as many possible uses for a specific object, such as a stick or a piece of string. In the class I use this concept to ask the students to generate as many possible meanings of a data sample, be it a specific response, or a combination of various pieces of data. This gets them to avoid the use of a sign approach, in which only one meaning is applied to a specific piece of data. I ask them to write down each possibility and eventually to rule out those that are not supported as they continue the analysis.

The other concept, convergent thinking, concerns the combination of several pieces of data that take on a new meaning in their association, meaning that is different from their interpretation separately. As the data comes together, various themes emerge and the report then begins to come together. When I teach the class we do blind interpretations. One of the students brings in a protocol from a patient he or she has assessed. The other students are blind to any information, other than age and gender, as am I. We go step by step, reviewing each test in great detail, and the students are encouraged to generate hypotheses. I try and model the interpretive approach with the first one or two protocols, offering assistance to those who are struggling to formulate the interpretation. This procedure can take up an entire three hour seminar, and sometimes more time than that. After we are done we ask the student who did the assessment to comment on each of the interpretations we generated. They are surprised about how well they have done, and I offer a great deal of praise and encouragement. By the end of the term they are more relaxed in the assessment and the interpretive process and they continue doing assessments in our psychological clinic with a great deal less apprehension.

There are other difficult things to teach, such as the use of more flexible approaches in the assessment process. Students initially want to administer the tests "by the book," so to speak, without relying on themselves to be flexible and creative in the assessment process. They believe too much in standardization. It's not that I don't think standardization is not important, but it should also not constrict the exploration of the test and the patient's performance once the test is administered in standardized fashion. They appreciate how such post-assessment inquiry, in an extended

"testing of the limits" fashion can help them to understand the patient. They require a great deal of encouragement to extend the rules and to investigate unusual responses. I find that urging them is only superficially helpful, as is giving them examples from my own practice. What seems to help is being more patient with them and in discussing the sources of their reluctance.

Exchange: How do you keep a balance between work and leisure?

Dr. Handler: Keeping a balance between work and family life has not been a huge problem, because Barbara, my wife, and our two children, Charlie and Amy, enjoyed knowing the graduate students. They were often considered part of our extended family. The children enjoyed them as much as we did. The students often came to the house to work on research or on other projects and they spent leisure time with us as well. They also enjoyed participating in family outings, such as riding an old time steam locomotive from Tennessee to North Carolina, and going ruby mining in North Carolina, as well. Many of the students (and their families) who stayed in Knoxville after graduation have become our close friends and several came to family affairs, such as weddings and surprise birthday parties and we did and still do the same with them.

While the balance between work and family life has never been a problem, it is sometimes a problem to find enough time to do research and writing. Luckily, I have typically been able to feel quite refreshed on four or five hours of sleep, although lately, as I get older, that is sometimes not enough. I did most of my writing when the kids were younger, late at night, or when everyone was sleeping. I enjoyed the peace and quiet and was able to do a great deal of writing. Nevertheless, there was about a 10-year period when I did little research and tended more to family needs. Much of that time was devoted to doing more child care when Barbara went back to graduate school to earn her doctorate in math education.

I enjoy the diversity of these many work activities, such as teaching, research, private practice, and social life activities. It is refreshing to change activities during the day, which is what I do on most days. On any day I might see a patient or two in the early morning, teach and supervise students for part of the day, and then retreat to some quiet place to write. There is a great deal of synergy among these seemingly diverse activities, each informing the other. Nevertheless, I find, lately, that at the end of the day I am tired, and I sometimes "veg out" and watch West Wing or some other TV show.

Exchange: As SPA President, what will be your agenda?

Dr. Handler: I have been interested in issues of training in personality assessment for many years. It has always troubled me that assessment is taught very poorly in some graduate programs and that the area of assessment often receives such bad press. I believe this has always been true in graduate programs; assessment is the so-called "red-headed stepchild" of psychology in clinical programs, although this is not true in other professional programs, such as school psychology and industrial-organizational psychology. For example, someone (it might have been John Exner) told me that neither Samuel Beck nor Bruno Klopfer ever held a tenure track position in academia. They taught as part-time adjuncts. Also, as graduate curricula expand, to encompass many of the newer areas of psychology (such as health psychology, neuropsychology, and a variety of social-issue areas), traditional assessment seems to get lost in some programs. Many times, courses in assessment have become survey courses in which the students read about various assessment instruments and sometimes see them in class. In several programs there are no assessment courses; students learn by using a few selected instruments with their therapy patients.

Although I believe we should continue to fight the battle of adequate training in assessment in graduate programs, I believe that we need to do more about providing additional training for graduate students, as well as for practitioners who feel their skill is lacking in an area of assessment. We also need to develop a group of SPA members who are willing to become advocates for assessment, within the university and outside the university as well, especially with APA. I have recently completed a three-year term on the APA Committee for Psychological Tests and Assessment, and a two year stint on the APA Committee on Testing on the Internet. I was surprised about some of the negative attitudes of the diverse members of the former committee concerning clinical assessment. There is much work to be done to convince our colleagues that our work in assessment is important and vital and that it is scientifically and clinically sound. We also need to demonstrate the effectiveness of assessment with patients and I know of no better way than to illustrate the direct effectiveness of therapeutic assessment.

We also need to educate the public about the effectiveness of assessment to answer many important patient questions, just as physicians use their many tests to figure out how to treat a patient. Most undergraduates in the USA who take introductory psychology or abnormal psychology courses, and there are many thousands of them every year, are taught that projective tests, at least, are unreliable and invalid. So far I have not found a single textbook in either area that is not extremely negative about this area. I'm not certain what SPA can do about the very bad press we have had and continue to have, especially in light of the excellent skills many clinicians have and the excellent research they produce affirming the reliability and validity of our instruments. The SPA Board has begun to work on these issues, in several important ways and I would like to continue this activity.

Personal Column

Pamela Abraham, Psy.D., gave a CEU presentation on ethics and supervision, April 2003.

Johnathan Ahr, Ph.D. has been promoted to Director of Psychological Services at Holly Hill Hospital, which serves Piedmont and Eastern North Carolina. His job description combines personality assessment for diagnostic classification and determination of safety with administrative duties, particularly with regard to efforts to limit restraint procedures by providing less restrictive and more effective interview times.

Kevin D. Arnold, Ph.D., ABPP has, within the last year, been elected to the Board of Governors of the Hannah Niel Foundation, elected as Vice-President of the American Board of Behavioral Psychology, began his term as President of the American Academy of Behavioral Psychology, is running for Treasurer of Division 31 of APA, and was appointed to the Ohio State Board of Psychology.

Teresa Bailey, Ph.D. has completed a two-year post-doctoral fellowship in neuropsychological assessment. She practices in Los Altos, CA, and is enjoying integrating personality and neuropsychological perspectives for diagnosis and treatment planning.

Richard W. Bloom, Ph.D., ABPP, SPA Fellow, and **Nancy K. Dess, Ph.D.** (who served as the American Psychological Association's senior scientist), have just co-edited *Evolutionary Psychology and Violence: A Primer for Policymakers and Public Policy Advocates*. This book has been published as part of Praeger's series on *Psychological Dimensions to War and Peace*. Dr. Bloom is Dean, College of Arts and Sciences, and Director, Terrorism, Intelligence, and Security Studies, at Embry-Riddle Aeronautical University, Prescott, Arizona, where he engages in policy analysis and the review of applied research on psychologically based security and intelligence initiatives.

Robert F. Bornstein, Ph.D. and **Mary A. Languirand, Ph.D**. recently co-authored their second book together. *Healthy Dependency: Leaning on Others Without Losing Yourself* (Newmarket Press, 2003) outlines the authors' strategy for replacing destructive over-dependence and dysfunctional detachment with flexible, adaptive help- and support-seeking.

Anita Boss, PhD, ABPP is currently in private practice in the Washington, DC, metropolitan area. Her practice is focused primarily on personality assessment, most often in a forensic context, including criminal responsibility, sentencing, risk assessment, and sex offender examination. Formerly, she was a clinical psychologist at St. Elizabeth's Hospital in Washington, DC, where she evalu-ated criminal defendants for both DC and federal courts. Dr. Boss has also worked at Patuxent Institution in Maryland, where she conducted personality assessments of adult and juvenile inmates for treatment program tailored to Axis II disorders. Dr. Boss holds board certification in Forensic Psychology from the American Board of Professional Psychology.

Alison W. Brett, Ph.D. has joined Lakeside Psychology & Counseling Services in Bannockburn, IL. She provides personality, neuropsychological, and academic testing for Chicago's northern suburbs.

Robert J. Craig Ph.D., ABPP has published, *Counseling the Drug and Alcohol Dependant Patient: A Practical Approach* through Allyn & Bacon Publishers. Bob is a fellow in SPA and in APA (Division 50- Addiction).

Dr. David Donnay was promoted to Divisional Director for Research at CPP, Inc., formerly known as Consulting Psychologists Press, Inc. Dr. Donnay has been centrally involved in major revisions to the Myers- Briggs type indicator instrument, the Strong Interest Inventory assessment, and a short- form of the California Psychological Inventory instrument.

Robert Erard, Ph.D. has two articles in press in *Psychology, Public Policy, and Law* debating the forensic value of the Rorschach , written with Barry Ritzler and Gary Pettigrew (Contra Grave, Barden, and Garb). He also recently testified on behalf of the Michigan Psychological Association before the Michigan Supreme Court defending the right of psychological experts to generate their own assessment evidence as part of the basis of their testimony.

Harry Fiss, Ph.D. presented a paper in June 2002 on "The Dreaming Self" at an annual meeting of Rapaport-Klein Study Group, Austen Riggs, Stockbridge, MA. In October 2003, Dr. Fiss will present a paper, en-titled, "Dream Research in the 20th Century" on the occasion of the 50th anniversary of the discovery of Rapid Eye Movement (REM) sleep in Vienna, Austria. Other speakers include William Dement, the discoverer of REM sleep, Allan Hobson of Harvard University, Michel Jouvet of Lyons, France, Pinchas Noy of Israel, and many others. Dr. Fiss is a native of Austria and fled from the Nazis in 1939, after Kristallnacht, the beginning of the Holocaust. This will be his third return to his native city.

Dawn Gettman, Psy.D. has relocated to Lawrence, Kansas, where she has opened her private practice with a specialization in forensic and child custody evaluation.

Edward J. Hyman, Ph.D., Professor of Psychology at the Psychology and Law at Berkeley Center for Social Research and Senior fellow at the California Institute of Forensic Sciences, presented a paper on "Parental-Child Relation: a Reformulation for the New Millennium" at the American College of Forensic Psychology in April 2003.

Charles E. Kelly, Ph.D. is the acting President Elect 2002, Montana Psychological Association. In 2003, it is anticipated that Dr. Kelly will be nominated President for the period of 2003–2004 of Montana Psychological Association.

Dr. Raymond E. King was recently honored by the Aerospace Medical Association (AsMA) with the Major Raymond F. Longacre award for "outstanding accomplishment in the psychological and psychiatric aspects of aerospace medicine." Dr. King, a personnel research psychologist with the Federal Aviation Administration, most recently directed the psychological screening at the medical offices of the Federal Air Marshal program. He currently oversees the Air Traffice Selection and Training testing battery, which is the selection tool for the Air Traffic Control Specialist career field.

Alvin Krass, Ph.D. was just granted patent #5 in a neuropsychological testing program, a system delivered via computer with a touch screen and some peripherals: headset, joystick, finger tapper, and rotary turner to measure fine motor skill adeptness. A validity study is underway to screen for ADHD, dementia, mild cognitive impairment, and to dif-ferentiate depression-dementia or the presence of both.

Sophie L. Lovinger Ph.D., ABPP gave a workshop at George Fox University in Oregon on the use of the Rorschach in the diagnosis and treatment of abuse/trauma in children.

William McCown, Ph.D. requests that anyone interested in contributing to a new volume concerning the rapidly developing field of youth adult studies, please send an e-mail to **mccown@ulm.edu** and adds that "your contribution is only limited by your

creativity." "We are looking for people who share our interests." Contributions emphasizing either theory or research from any theoretical perspective are welcomed. Presently, there is both a book and journal contract.

Peter F. Merenda, Ph.D. was bestowed the highest honor awarded by the University of Rhode Island at the 117th commencement, May 17, 2003, an honorary doctorate of Humane Letters. This honor was awarded in recognition of continued dedication, advocacy in education and training in the field of psychology and career at the University. Among accomplishments specifically mentioned in the citation was that Dr. Merenda was the co-founder of the Department of Psychology in 1960, and the Department of Computer Science and Statistics in 1968 at URI. Dr. Merenda was invited by Danilo Silva (SPA member) to participate in a special "Scientific Session" at the University of Lisbon, Portugal, sponsored by the Department of Psychology and Education in honor of Professor José Ferreira Marques upon his retirement. On the way back to the USA, Dr. Merenda passed by Lisbon to be one of the seven invited participants to honor Professor Marquez who has been one of his international psychology colleagues since the 1970s.

Bernard I. Murstein, Ph.D. recently had a book published, entitled "*Getting Psyched for Wall Street: A Rational Approach to an Irrational Market*." This research-oriented book combines psychological and financial data to show how educated readers can succeed in the stock market. Members of SPA can obtain the book from the author at the special discounted price of $18.95 + $3 for postage and packaging by using the code "SPA." The book normally sells for $23.95. The book may be ordered by e-mail to **bimur@conncoll.edu** or by mailing a check for $21.95 to Bernard I. Murstein, 46 Beacon Hill Drive, Waterford, CT 16385–4110. Descriptions of it may be found at Cypressbooks.com and Amazon.com. Dr. Murtstein is May Buckey Sadowski Professor Emeritus of Psychology, Connecticut College, an SPA Fellow, and a Past-President of SPA.

John F. Newbauer, Ed.D. was elected President of the North American Society of Adlerian Pyschology (NASAP) for 2002–2004. Dr. Newbauer practices in Fort Wayne, Indiana and is a core faculty member at the Adler School of Professional Psychology in Chicago, where he teaches projective methods and other assessment classes in addition to classes in Adlerian Psychology.

Edward Petrosky, Ph.D. recently began a professorship in the Iona College Psychology Department and opened a private practice in Queens, NY.

William Picker, Ph.D., longitme SPA member, has founded a softward company. Notes 444, Inc. makes software that enables therapy sessions notes to meet HIPAA requirements to maintian the Psychotherapy Note Exemption. **www.notes444.com**

Daniel J. Rybicki, Psy.D., DABPS recently published results of a national survey of law enforcement pre-employment and work- fitness practices in the Fall edition of the *Journal of Police and Criminal Pyschology*. He also conducted a 40-hour seminar series on topics involved with assessment in child custody evaluations. Upcoming seminars and a segment of his forthcoming book on expert witness testimony are listed on his Web site at **www.forenpsychservices.com** under the seminars page.

Kathryn M. Sheneman completed her doctoral dissertation at Widener University under the direction of Dr. Virginia Brabender. Her dissertation was entitled, "Traitors in the ranks: Understanding espionage-related offenses and considered implications for the use of personality assessment in the personnel selection for federal law enforcement and intelligence candidates.

Charles D. Spielberger, Ph.D., ABPP, Past-president of SPA, received an Honorary Doctorate of Science from Kent State University on May 10, 2003. Professor Speilberger will also receive the 2003 APA/American Psychological Foundation Award for Distinguished Contributions to Applications of Psychology at the APA convention in Toronto.

Manda Nel Strong, Ph.D. has been appointed Supervising Psychologist, State Security Program, Larned State Hospital, Larned, KS. She leaves 21 years of private practice to oversee psychological services for approximately 200 patients receiving services in the forensic division of the psychiatric hospital.

David D. Stein, Ph.D. presented the following paper at the California Psychological Association Convention this April: "Psychological and Neuropsychological Evaluations in Forensic Practice: Risk Management."

Norman D. Sundberg, Ph.D. published: Sundberg, N.D., Winebarger, A. & Toplin, J.R. (2002) *Clinical Psychology: Theory, Practice and Research*, Upper Saddle Creek, NY, Prentice-Hall. Dr. Sundberg and Holly Arrow gave an invited address to the International As-sociation of Cross-Cultural Psychology entitled, "International Identity," Yogyakarta, Java, Indonesia, July 18, 2002.

Norman Sundberg, Ph.D. authored, along with **Allen Wineberger** and **Julian Toplin**, the *4th edition of Clinical Psychology*, published in 2002 by Prentice Hall.

Tom Sutton, BA was appointed by the Minister for Health as Chair, Australian Capital Territory Psychologists Registration Board.

John Thibodeau, Ph.D., ABPP presented to a national meeting of the Prescribing Psycholigst's Register in Los Angeles in March. The title of his talk was "Psychological Test Data in the Prescribing Process." He initially presented some data on the unreliability of the clinical interview. He then went on to use a case that had been a diagnostic dilemma in terms of mediation treatment for both outpatient and inpatient psychiatrists. Following initial hypotheses generated with the Bender (Patricia Lacks, Max Hutt, and Fred Brown strategies), through WAIS data (Rapaport, Gill, and Schafer; Blatt and Zimet discriminant function of WAIS subtests) and then closing with the Rorschach (Exner). Dr. Thibodeau was able to illustrate clinical reasoning and decision-making in relation to sequential use of anti-depressant and anti-psychotic medications. Dr. Thibodeau reports that his creative integration of assessment data gave the group room to pause and received positive accolades (e.g., "I didn't know that psychological testing could tell you so much!").

George Tolomiczerks, M.P.H., Ph.D. began as Director of Research, St. Joseph's Health Centre, Toronto in July 2002.

Shoshana Shapiro Adler, Ph.D. graduated from the Denver Institute for Psychoanalysis in adult analysis in 2001 and in child analysis in 2002. In addition to conducting analysis, she focuses on the use of psychological evaluations to assess adult patients and children who are considering analysis.

Patricia D. Whitt, Ph.D. completed over 250 hours of Ericksonian hypnotherapy training in the past two years and achieved certification through the National Board of Certified Clinical hypnotherapists (NBCCH). Dr. Whitt is a certified practitioner of NLP.

Jed Yalof, Psy.D. gave a CEU presentation on assessment supervision, April 2003.

Eric D. Zillmer, Psy.D., Pacifico Professor at Drexel University, is the Current President of the National Academy of Neuropsychology.

Constantino, G., Malgady, R. G., & Rogler, L. H. (1988). *Technical manual: TEMAS Thematic Apperception Test.* Los Angeles: Western Psychological Services.

Constantino, G., Malgady, R. G., & Vasquez, C. (1981) A comparison of the Murray-TAT and a new thematic apperception test for urban Hispanic children. *Hispanic Journal of Behavioral Sciences, 3,* 291–300.

Constantino, G., Malgady, R. G., Colon-Magady, G. & Bailey, J. (1992). Clinical utility of the TEMAS with non-minority children. *Journal of Personality Assessment, 59,* 433–438.

Cook, R. A. (1953). Identification and ego defensiveness in thematic apperception. *Journal of Projective Techniques, 17,* 312–319

Dana, R. H. (1956). Selection of abbreviated TAT sets. *Journal of Clinical Psychology, 12,* 36–40.

Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology.* Boston: Allyn & Bacon.

Dana, R. H. (1996). Culturally competent assessment practice in the United States. *Journal of Personality Assessment, 66,* 472–487.

Dana, R. H. (1998). Cultural identity assessment of culturally diverse groups: 1997. *Journal of Personality Assessment, 70,* 1–16.

Dana, R. H. (1999). Cross-Cultural-Multicultural use of the Thematic Apperception Test. In L. Geiser & M. I. Stein (Eds.), *Evocative images. The Thematic Apperception Test and the art of projection.* Washington, DC: American Psychological Association.

Flanagan, R. & DiGiuseppe, R. (1999). Critical review of the TEMAS: A step within the development of thematic apperception instruments. *Psychology in the Schools, 36,* 21–30.

Gopaul-McNicol, S. & Armour-Thomas, E. (2002). *Assessment and culture: Psychological tests with minority populations.* New York: Academic Press.

Gopaul-McNicol, S. & Thomas-Presswood, T. (1998). *Working with linguistically and culturally different children: Innovative clinical and educational approaches.* Boston, MA: Allyn & Bacon.

Greenbaum, M. Qualtere, T., Carruth, B., & Cruickshank, W. (1953). Evaluation of a modification of the Thematic Apperception Test for the use with physically handicapped children. *Journal of Clinical Psychology, 9,* 40–44.

Henry, W. E. (1947). The thematic ap-perception technique in the study of culture-personality relations. *Genetic Psychology Monographs, 35,* 5–135.

Henry, W. E. (1951). The thematic ap-perception technique in the study of group and cultural problems. In H. H. & G. L. Anderson (Eds.). *An introduction to projective techniques.* Englewood Cliffs, NJ: Prentice Hall.

Holmstrom, R. W., Silber, D. E., & Karp, S. A. (1990). Development of the Apperception Personality Test, *Journal of Personality Assessment, 54,* 252–264.

Karp, S. A., Holmstrom, R. W., Silber, D. E., & Condrell, C. (1989). *Apperception Personality Test.* Orland Park, Il: International Diagnostic Systems.

Korchin, S. J., Mitchell, H. E., & Meltzoff, J. A. (1950). A critical evaluation of the Thompson Thematic Apperception Test. *Journal of Projective Techniques, 14,* 445–452.

Light, B. H. (1955). A further test of the Thompson TAT rationale. *Journal of Abnormal Psychology, 51,* 148–150.

Morgan, C. & Murray, H. (1935). A method for investigating fantasies: The Thematic Apper-ception Test. *Archives of Neurology and Psychiatry, 434,* 289–306.

Murray, H. (1943). *Thematic Apperception Test Manual.* Cambridge, MA: Harvard University Press.

Murstein, B. I. (Ed.). (1965). *Handbook of projective techniques.* New York: Basic Books.

Mussen, P. (1953). Differences between TAT responses of Negro and White boys. *Journal of Consulting Psychology, 17,* 373–376.

Pervez, S. (1983*). Personality dynamics of Pakistani children.* Islamabad: National Institute of Psychology.

Riess, B. F., Schwartz, E. K., & Cottingham, A. (1950). An experimental critique of assumptions underlying the Negro version of the TAT. *Journal of Abnormal and Social Psychology, 45,* 700–709.

Riessman, F. & Miller, S. M. (1958). Social class and projective techniques. *Journal of Projective Techniques, 22,* 432–439.

Ritzler, B. A., Sharkey, K. J., & Chudy, J. F. (1980). A comprehensive projective alternative to the TAT. *Journal of Personality Assessment, 44,* 358–362.

Roberts, G. E. & McArthur, D. S. (1982). *Roberts Apperception Test for Children.* Los Angeles: Western Psychological Services.

Schwartz, E. K., Riess, B. F., & Cottingham, A. (1956). Further critical evaluations of the negro version of the TAT. *Journal of Projective Techniques, 15,* 394–400.

Sharkey, K. J. & Ritzler, B. A. (1985). Comparing diagnostic validity of the TAT and a new Picture Projective Test. *Journal of Personality Assessment, 49,* 406–412.

Silverton, L. (1993). *Adolescent Apperception Cards.* Los Angeles: Western Psychological Services.

Soloman, I. L. & Starr, B. D. (1968). *School Apperception Method.* New York: Springer Publishing Company.

Thompson, C. E. (1949) The Thompson modification of the Thematic Apperception Test. *Rorschach Research Exchange, 13,* 469–478.

Thompson, C. E. (1940). *Manual for the Thematic Apperception Test: Thompson modification.* Cambridge, MA: Harvard University Press.

Weisskopf, E. A. & Dunlevy, G. P. (1957). Bodily similarity between subject and central figure in the TAT as an influence on projection. *Journal of Abnormal and Social Psychology, 47,* 441–445.

Zhang, T., Xu, S., Cai, Z. et al. (1993) Research on the Thematic Apperception Test: Chinese version and its norm. *Acta Psychologica Sinica, 25,* 314–323.

Zubin, J. Eron, L. D. & Schumer, F. (1965). An experimental approach to projective techniques. New York: Wiley.

...continued from Introducing the MMPI-2..., page 17

Code-Type Interpretation

Interpretation of MMPI-2 Clinical Scales is often based on patterns of scale elevation. This approach classifies MMPI-2 profiles into code types, reflecting typically the two or three most highly elevated Clinical Scales. MMPI-2 users may wonder whether the RC Scales could not also be classified into code types and whether the Clinical Scale code-type correlates could be applied in interpreting RC Scale code types. Although it is possible to classify RC Scale profiles into code types, more often than not Clinical Scale and RC Scale code types will not be congruent. That is, the RC Scale counterparts of the Clinical Scales that define a code type will not be similarly elevated. In light of the substantial modifications introduced with some of the RC Scales, this incongruence is neither surprising nor problematic, because these scales directly provide information that would be available from the Clinical Scales only via Code type interpretation. In any event, it will not be possible to interpret patterns of scores on the RC Scales based on the Clinical Scale code-type literature.

Although not interpretable on the basis of the Clinical Scale code-type literature, some RC Scale profiles will have multiple scale elevations. In such cases, RC Scale interpretation can proceed in a cumulative, additive manner, without considering implications of scores on one RC Scale in interpreting another. This is not to suggest that combinations of RC Scale elevations may not, in themselves, be informative. For example, whereas an elevation on RC6 alone may suggest paranoid ideation and/or a delusional disorder, and an elevation on RC8 alone the presence of psychotic disorder, elevations on both scales may indicate more specifically a possible paranoid schizophrenic disorder.

Future Directions

Validation data presented by Tellegen et al. (2003) provide the first, necessary information supporting use of the RC Scales to help clarify the meaning of Clinical Scale profiles. There is, however, a clear need for additional studies of these scales using other criterion measures in other settings. Fortunately, an abundance of previously collected data may be used for these studies, since all RC Scale items are in the existing MMPI-2 item pool. In addition to exploring the scales' correlates in other settings and with other measures, future studies should examine the extent to which RC Scale correlates can account for information provided by the Clinical Scale code types.

Other investigations and analyses could focus more explicitly on the RC Scales' construct validity. Starke Hathaway, one of the creators of the MMPI, repeatedly expressed the view that the Clinical Scales were to be a starting point for a continuing effort to advance our assessment and understanding of psychopathology. The RC Scales, developed in the hope of clarifying and capturing the Clinical Scales' core constructs, are intended to be steps in that direction. They may encourage conceptually driven investigations linking these core constructs to contemporary models of psychopathology and personality. Such inquiries may encourage test users to interpret MMPI-2 findings within a larger, theoretical framework.

References

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

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

TABLE 1

The MMPI-2 RC Scales and Their Clinical Scale Counterparts

RESTRUCTURED SCALES

Scale Name	Abbreviation	Items
Demoralization	RCdem	24
Somatic Complaints	RC1som	27
Low Positive Emotions	RC2lpe	17
Cynicism	RC3cyn	15
Antisocial Behavior	RC4asb	22
Ideas of Persecution	RC6per	17
Dysfunctional Negative Emotions	C7dne	24
Aberrant Experiences	RC8abx	18
Hypomanic Activation	RC9hpm	28

CLINICAL SCALES

Scale Name	Abbreviation	Items
Hypochondriasis	Hs	32
Depression	D	57
Hysteria	Hy	60
Psychopathic Deviate	Pd	50
Paranoia	Pa	40
Psychasthenia	Pt	48
Schizophrenia	Sc	78
Hypomania	Ma	46

Membership

FELLOWS

Congratulations to new SPA Fellows

2001
Dr. Anna Maria Carlsson
Dr. Jacqueline Singer
Dr. Susana Urbina

2002
Dr. Anita L. Boss
Dr. Barton Evans
Dr. Mark Hilsenroth
Dr. Stephen Lally
Dr. Shira Tibon
Dr. Bruce Zahn

NEW MEMBERS

Congratulations to the following new SPA members

Members	Sponsors
Rosa Jesus Ferreira Novo, Ph.D.	Danilo Rodriguez, Ph.D., Maria Fagulha, Ph.D.
Theresa Miller, Ph.D.	George I. Athey, Jr., Ph.D.
Clarence Morgan, Ph.D.	Darwin Dorr, Ph.D.
Masamichi Noda, B.A.	Rorschach Workshops
Serge Sultan, Ph.D.	Christine Mormont, Ph.D.

STUDENT AFFILIATES

Congratulations to the following new SPA student affiliates

Student Affiliates	Sponsors
KerryAnn Kennelly, M.A.	John Newbauer, Ed.D.
Nicole Levaillant, M.A.	Thomas Shaffer
Pietro Lofu, M.A.	William Ryan, Ph.D.
Norma Martin, M.S.	Philip Erdberg, Ph.D.
Michelle Stein, B.A.	Mark Hilsenroth, Ph.D.
Rosemarie Stewart, M.A.	Mark Hilsenroth, Ph.D.
Gwen Vogel, M.A.	Hale Martin, Ph.D.
Yifat Weinberger, B.A.	Shira Tibon, Ph.D.

spa exchange

From the Editor...

In this volume of the *Exchange*, we present a series of reader-friendly articles that should be of interest to practitioners, teachers, students, supervisors, and supervisees. Alan Schwartz, Psy.D., joins the *Exchange* as an Associate Section Editor. Alan will coordinate a new section on special topics in assessment. Yossef Ben-Porath's article on the MMPI-2 RC scales is the section's first entry and provides a very useful overview of RC scale construction. The next volume will include overviews of the PAI and MCMI-II. Steve Finn's Presidential Address draws attention to obstacles that work against assessment and reminds us not to under-sell the uniqueness of what assessment brings to clinical practice. Jane Iannuzzelli offers a compelling account of a clinical situation involving the HIPAA/APA Ethics/Copyright axis to which so many of us gave extended thought over the past few months. Her article highlights issues that have become focal points for assessors, with special implications for forensic practice. In other articles, Bruce Zahn and Bonnie Socket discuss unique Rorschach applications, Tom Schaffer presents the first of a two-part article on the application of an ego-functions model to the integration of cognitive, objective, and personality tests, and Pam Abraham provides an overview of the TAT and multiculturalism, with a treasure trove of references. Bruce Smith outlines his role as new SPA Advocacy Coordinator. An interview with incoming SPA President Len Handler offers a personal glimpse of our new "volunteer" leader from Tennessee. The Personal Column updates the happenings of members. Don't be shy. Remember, Kohut gave us a second developmental line to feel good about our accomplishments, so use it, even if you don't believe it!

Society for Personality Assessment
6109 H Arlington Road
Falls Church, VA 22044

Presorted
First Class Mail
US Postage Paid
Clifton, N.J.
Permit No. 1104

Volume 15, Number 2
Summer 2003