Advancing Responsible Adolescent Development

Shira Tibon-Czopp
Irving B. Weiner

Rorschach Assessment of Adolescents

Theory, Research, and Practice

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Preface

This book is addressed to practitioners and researchers who are interested in adolescent development, personality assessment, and the Rorschach Inkblot Method. Adolescence is a complex and varied developmental phase, characterized by dramatic physical, mental, and psychological changes. Physically, the usual adolescent growth spurt transforms adolescents from their childhood stature to much of their adult size and strength, and the pubertal emergence of secondary sex characteristics alters their shape and appearance. Mentally, adolescents become capable of abstract thinking and increasingly familiar with the world around them. From a developmental perspective, adolescents come to grips with the tasks of adjusting to their bodily changes, individuating from their parents, becoming involved in social and romantic relationships, and beginning to establish a sense of their personal identity and advance toward adulthood.

Adolescents vary considerably in the pace of these transitions from childhood to adulthood. Some early adolescents show adult characteristics, while some young adults are mainly coping with adolescent issues. Moreover, the pace of developmental changes is commonly uneven within as well as between individual adolescents. Some adolescents are mentally sophisticated but socially immature, while other adolescents of the same age show mature social skills but childishly concrete reasoning. The wide variability of developmental issues both between and within adolescents can make it difficult to distinguish normal from abnormal development. This variability also makes it challenging to distinguish between transient reactions to developmental crises that would be resolved and psychological disorders that are likely to persist into adulthood.

The difficulty in distinguishing normal from abnormal development in adolescents has been compounded by an often expressed but erroneous view of adolescence as a stormy period during which young people ordinarily show symptoms of emotional disturbance. To the contrary, extensive research has documented that disturbance is not an integral feature of normative adolescence and that apparent symptoms of psychological disorder in young people should not be taken lightly, as in “She’ll grow out of it” or “He’s just going through a phase.” However, regarding

and treating transient adjustment problems as evidence of diagnosable psychopathology is as misguided as ignoring or making light of symptom formation in adolescents.

As for personality assessment, the distinction between normal range adolescent functioning and diagnosable or emerging psychopathology can best be accomplished by accurate evaluation of a young person's personality characteristics. Personality characteristics that differentiate healthy from psychopathological states can be observed in the four domains of cognitive functioning, affective experience, interpersonal relatedness, and self-perception. In the domain of cognitive functioning, for example, psychologically healthy adolescents are usually able to think logically and coherently, whereas loose associations and arbitrary or circumstantial reasoning are likely to indicate psychological disorder. Similarly, normal range adolescents are for the most part able to perceive people and events accurately, whereas disturbed adolescents often display impaired reality testing.

In the domain of affective experience, normal range adolescents are reasonably capable of recognizing and expressing their feelings, whereas severely constricted emotionality, recurrent depressive moods, and persistent inability to experience pleasure usually delineate the presence of some disorder. In the domain of interpersonal relatedness, adolescents are normally interested in and able to form rewarding relationships with other people, whereas social disinterest and withdrawal may reflect developmental arrest or abnormality. Normal range adolescents are also able to feel comfortable in close relationship, whereas those with psychological problems may regard other people with suspicion and distrust, and avoid any intimacy with them. As for self-perception, psychologically healthy adolescents usually are progressing toward forming a stable sense of identity and self-worth. Substantial confusion about the kind of person the adolescent is or would like to become, extremely lowered self-esteem, and feelings of being inept or unworthy often characterize adolescents with psychological problems.

The Rorschach Inkblot Method is a sensitive and psychometrically sound assessment instrument that measures personality functioning in the cognitive, affective, relatedness, and self-perception domains. As such, the Rorschach proves useful in distinguishing between normal and abnormal development in adolescents and delineating the type of psychological disorder that might be present. The clinical implications of Rorschach measurements depend on how the obtained findings accord with normative reference data. Only on the basis of such comparisons can a valid evaluation be made concerning whether a young person is functioning within the normal range or is instead likely to be experiencing or susceptible to psychological disorder. The adolescent norms of the Rorschach Comprehensive System (CS) have not been changed since the publication of the first edition of Volume 3 of the Rorschach CS (Exner & Weiner, 1982). Recently collected normative reference data on international samples of nonpatient adolescents provide contemporary cross-cultural data that update the previous norms and are presented in this volume.

The book begins with three chapters (Part I) that provide readers with basic information on the topics to be discussed in the text. The first of these chapters reviews

the development and foundations of the Rorschach Inkblot Method, with attention to the continuing evolution of the CS and its utility for assessing adolescents in the twenty-first century. The second chapter discusses key issues in the assessment of adolescents, with particular attention to differentiating patterns of psychopathology from normal developmental variations. The third chapter presents general considerations in utilizing performance-based assessment instruments in the evaluation of personality functioning in adolescence, including the importance of integrating the structural, thematic, and behavioral data in Rorschach interpretation and combining the data with information obtained from self-report inventories.

Following these three introductory chapters, the text continues with three chapters (Part II) that discuss the current status of the Rorschach with respect to theoretical formulations, research findings, and practice guidelines. Chapter 4 discusses psychodynamic perspectives on Rorschach interpretation and elaborates the theoretical assumptions that responses to the inkblots (a) reflect how people generally experience and respond to events and (b) reveal underlying thoughts and feelings that are likely to influence their behavior. Chapter 5 reviews research findings demonstrating that the Rorschach is a reliable, valid, and useful assessment instrument and presents normative reference data obtained recently from an international sample of several hundred nonpatient adolescents. Chapter 6 on practice guidelines addresses the issue of when and with whom the Rorschach works. This chapter describes the utility of Rorschach assessment whenever decisions are being made in light of personality characteristics and delineates the cross-cultural applicability of the Rorschach to people of all ages, except for very young children. The contemporary adolescent reference data provide the basis for presenting the cut-off scores for 45 CS variables and CS-based indices that have implications for normal or abnormal functioning and five stylistic variables that should be considered while interpreting the data. This diagnostic approach is illustrated in the text with a case study of a normally functioning adolescent.

The next five chapters (Part III) elaborate diagnostic, forensic, and therapeutic applications of Rorschach assessment. Chapters 7–9 discuss how Rorschach findings can facilitate differential diagnosis and treatment planning by providing information about personality characteristics and psychopathological manifestations. With eight varied case illustrations, these chapters show how Rorschach data, when used properly in relation to age-based norms, can help delineate the presence, nature, and severity of internalized and externalized symptom patterns. These eight cases of symptomatic adolescents encompass a broad range of psychopathology, including cognitive, affective, anxiety, avoidant, obsessive-compulsive, somatization, and eating disorders. Each case illustration focuses on variables in the adolescent's protocol that deviate from normative expectation and thereby provide clues to the nature of the young person's disorder. Descriptive information and cutoff scores for each of the 45 evidence-based variables are discussed in the course of the case illustrations. Chapter 10 discusses the utility of Rorschach assessment in resolving psycholegal issues, particularly in cases of criminal misconduct in which the court is referring to trial competence, criminal responsibility, and correctional dispositions. Special attention is paid to evaluating whether a behavioral problem

reflects a transient developmental crisis, is symptomatic of some underlying disorder, or indicates the emergence of antisocial behavioral manifestations in adulthood. Chapter 11 shows that Rorschach assessment can be therapeutic in its own right and discusses the positive therapeutic impact that can derive from a well-conducted Rorschach examination.

The twelfth and concluding chapter (Part IV) draws on information in the preceding chapters to formulate an empirically based psychodynamic model for Rorschach assessment of adolescents that helps to delineate personality characteristics conducive to positive adolescent development. The presented model of *Rorschach Psychoanalytic Science and Practice (RPSP)* derives from standardized-individualized conception of Rorschach assessment in which personality descriptions are based on well-validated CS variables but also capture the individual uniqueness of adolescents' subjective experience of their psychological problems.

This book follows in many respects the second edition of Volume 3 of the Rorschach Comprehensive System (Exner & Weiner, 1982, 1995), which has been the major reference source for Rorschach work with young people. The present text extends the evolution of the CS in several aspects. Beyond reviewing the basic CS administration and coding guidelines, this CS-based volume presents and applies several new structural variables, provides updated normative reference data for distinguishing between healthy and faltering adolescent development, and illustrates with detailed case studies how Rorschach assessment can help to delineate a wide range of psychological disorders. Accurate evaluation of adolescents' personality functioning and symptom formation is essential for promoting progress toward responsible and rewarding adulthood.

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Part I
Basic Considerations

Chapter 1
Historical Foundations of the Rorschach Inkblot Method

According to available reports, Hermann Rorschach, a Swiss psychiatrist born in 1885, had been exposed to inkblots as an adolescent, in the form of a popular parlor game called *Klecksographie*. *Klecks* is the German word for "blot," and the *Klecksographie* game was played by dropping ink in the middle of a piece of paper, folding the paper in half to make a more or less symmetrical blot, and then competing to see who among the players could generate the most numerous or interesting descriptions of the blots or associations to what they resembled.

From 1917 to 1919, while serving as Associate Director of the Krombach Mental Hospital in Herisau, Switzerland, Rorschach pursued a notion he had formed earlier in his career that patients with different types of mental disorders would respond to inkblots differently from each other and from psychologically healthy people. To test this notion, he constructed and experimented with a large number of blots. Nevertheless, unlike the formless inkblots of the parlor game that were made by dropping the ink on a blank sheet of paper, the blots with which he experimented were carefully drawn by him, and over time he selected a small set that seemed particularly effective in eliciting responses and reflecting individual differences. The original blots drawn by Rorschach, who was a talented artist, have been on display in the Rorschach Archives and Museum in Bern, Switzerland, since September 2000. In June 2012, there was a fire in the upper floor of the building in which the archives and museum were located. Although none of the items in the collection was damaged, they had to be removed from the building and are currently being stored in the Institute of the History of Medicine in Bern.

Rorschach administered his selected set of blots to samples of patients and nonpatients, using a standard instruction (*What might this be*?), and he published his findings from this research in the form of a monograph titled *Psychodiagnostics: A Diagnostic Test Based on Perception* (Rorschach, 1921). In 1942 the monograph was translated into English (Rorschach, 1942). The monograph was a preliminary work and initially did not attract much attention. Nevertheless, the materials and methods described by Rorschach in *Psychodiagnostics* have provided the basic

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foundation for the manner in which Rorschach assessment has been most commonly practiced since that time, and the standard Rorschach cards currently in use are the same ten inkblots that were published with Rorschach's original monograph.

As elaborated in this chapter, the subsequent early years of Rorschach development produced what might be defined as Confusion of Tongues. The differing methods of administration and coding prevented clear communication among Rorschach scholars and clinicians and systematic accumulation of research findings. To address these problems, John Exner developed the Rorschach Comprehensive System (CS), which was originally published in 1974 and provided a standardized method of Rorschach assessment that became widely adopted method. The discussion that follows reviews the continuing evolution of the CS, its enrichment by psychodynamic conceptualization, and its utility for validating the Rorschach method.

Early History: Confusion of Tongues

Between the two world wars, Switzerland was an internationally prominent education and training center for medical scientists and researchers. Some of the scholars and practitioners who visited Swiss institutions in those years were told about Rorschach's method and took copies of the inkblots home with them. One of these visiting scholars was an American psychiatrist, David Levy, who brought several sets of the inkblots back to New York and suggested to Samuel Beck, then pursuing his psychology doctorate at Columbia, that he considered doing his dissertation with the Rorschach. Beck accepted this suggestion and undertook as his doctoral research a standardization study of Rorschach responses in children.

While collecting his data, Beck published the first English language article on the Rorschach method (Beck, 1930). In 1934, Beck went to Switzerland for conducting a study with Emil Oberholzer, who had been a close friend and colleague of Rorschach, and his departure coincided with the arrival from Zurich of Bruno Klopfer, who had received a doctorate in educational psychology in 1923 and by 1933 had advanced to a senior staff position at the Berlin Information Center for Child Guidance. However, the restrictions being placed on Jews in Germany at that time led Klopfer to move to Zurich. Without a job in Zurich, he was helped by Carl Jung to obtain a position as a technician at the Zurich Psychotechnic Institute. Klopfer's responsibilities at the Institute included psychological testing of applicants for various types of jobs, and the Rorschach was among the tests he was required to use for this purpose. He had no previous interest or experience in testing, but he soon became intrigued with the ways in which Rorschach responses could reveal the underlying thoughts and feelings of the people he was testing.

Klopfer was dissatisfied with his low-status role as a technician, however, and soon began looking for other opportunities. In 1934 he was appointed as a research associate in the Department of Anthropology at Columbia University. Having learned of his arrival on campus, a group of psychology graduate students asked their department to arrange for Klopfer to give them some Rorschach training. Unimpressed with Klopfer's credentials, the department declined to hire him for

this purpose. The students were not deterred, however, and they approached Klopfer privately about offering some evening seminars for them in his home. Klopfer agreed to offer the seminars, and the group started to meet for what may have been the first Rorschach workshop.

Giving seminars for this and subsequent groups of students and professionals produced a network of psychologists who were eager to keep in touch with each other and continue exchanging ideas about the Rorschach. In response to this interest, Klopfer in 1936 founded the *Rorschach Research Exchange*, which has been published regularly since that time as the *Journal of Projective Techniques* beginning in 1950, as the *Journal of Projective Techniques and Personality Assessment* beginning in 1963, and since 1971 as the *Journal of Personality Assessment*. In 1938, Klopfer founded the Rorschach Institute, a scientific and professional organization that continues to function actively today, and more broadly than Klopfer had envisioned, as the Society for Personality Assessment.

Although both Klopfer and Beck gained international acclaim for developing the Rorschach and for pioneering the publication of the English version of guidelines for working with the test (Beck, 1937; Klopfer & Kelly, 1942), they approached their work from quite different perspectives. Having been educated in an experimentally oriented department of psychology, Beck was interested in describing personality characteristics and was firmly committed to advancing knowledge through controlled research designs and empirical data collection. He stuck closely to Rorschach's original procedures for administration and coding, and he favored a primarily quantitative approach to Rorschach interpretation.

Klopfer, on the other hand, who had been trained as a Jungian analyst, had strong interest in symbolic meanings and with unraveling the phenomenology of each person's human experience. He applied statistical procedures for obtaining normative data (Davidson & Klopfer, 1938), but he also recommended qualitative approaches to Rorschach interpretation that Beck considered inappropriate. Klopfer developed new response codes and summary scores on the basis of imaginative ideas rather than research data, which Beck found unacceptable. This difference in perspectives led Beck and Klopfer to formulate distinctive Rorschach systems with dissimilar approaches to administering, scoring, and interpreting the test. Nevertheless, their professional debate evolved into personal hostility, and these two leading figures refused ever again to speak to one another, let alone resolve their different approaches to the Rorschach.

One of Beck's friends, Margaret Hertz, who was educated primarily as a developmental and child clinical psychologist, pioneered in promoting Rorschach assessment with children and adolescents and in formulating procedures and normative standards for using the instrument with young people. With respect to adolescents, Hertz emphasized that adolescence is a stage of development in which many physiological and psychological phenomena undergo both quantitative and qualitative changes. It is accordingly necessary, she said, to focus on this relatively circumscribed period of development by obtaining descriptive and normative data, determining common characteristics, and studying growth patterns and the conditions that facilitate or retard the occurrence of these growth patterns (Hertz, 1970). Hertz considered both the Beck and the Klopfer systems useful for assessing adolescents, as long as examiners kept in

mind the particular procedure they were following in working with the Rorschach. Nevertheless, she developed some distinctive variations of her own in Rorschach administration, scoring, and interpretation.

Another Rorschach system was developed by Zygmunt Piotrowski, who received his doctorate in experimental psychology in Poland in 1927 and later came to the USA for postgraduate study in brain functions (known today as neuropsychology). He subsequently pioneered in conducting Rorschach research with brain-injured patients and formulated many original ideas about how inkblot responses should be conceived, coded, and interpreted (Piotrowski, 1957). Also emerging in the 1940s was the work of David Rapaport, who shared Klopfer's psychoanalytic approach to Rorschach interpretation, but from a different perspective. Rapaport had fled his native Hungary in 1938 and joined the staff of the Menninger Foundation in Topeka, Kansas, where, in collaboration with Merton Gill and Roy Schafer, he conducted an empirical evaluation of the utility of psychological tests, including the Rorschach, in facilitating differential diagnosis.

The many original ideas formed by these authors (Gill, 1954; Rapaport, Gill, & Schafer, 1945, 1968; Schafer, 1954) about personality functioning and adaptation produced a modified inkblot method that differed substantially from the Beck, Klopfer, Hertz, and Piotrowski systems and provided numerous alternative perspectives on Rorschach assessment. Rapaport and his colleagues' perspectives on the Rorschach have proved more enduring than those of the other American pioneers and have influenced both classical and contemporary psychoanalytically oriented Rorschach interpretation (see Chap. 4).

Thus, by 1950 there were five major Rorschach systems in the USA, each with its adherents. Moreover, even though the Beck and Klopfer systems had become well known abroad, the Rorschach landscape also included distinctive systems developed in other countries and popular among psychologists in Europe, South America, and Japan. Supplementing these many overall systems were numerous specific Rorschach scales intended to measure certain personality characteristics, and assessors differed in which of these specific scales they added to their basic scoring. It became common practice for clinicians to combine features of the various systems and specific scales into an individualized Rorschach method that they felt worked well for them. This kind of practice characterized by confusion of tongues made it difficult for Rorschach practitioners to communicate with each other and almost impossible for researchers to cumulate systematic data concerning the reliability of Rorschach findings and their validity for particular purposes.

The Comprehensive System (CS)

The diversity of methods persisted until John Exner published in 1969 *The Rorschach Systems,* which was a comparative analysis of the five American systems that, as reported by Handler (1996), was initially aimed at bridging the gap

between Beck and Klopfer. Exner subsequently established a research program to measure the impact of the methods of administration used in the five systems and examine which of their response codes could be explained clearly and coded reliably. This research program led to the development of the Rorschach *Comprehensive System* (CS), which was introduced by Exner in 1974 and designed to standardize the Rorschach in a conceptually reasonable and psychometrically sound manner. He accordingly included in the CS the empirically supported features of each of the five systems and dropped those features that failed to show such support. While he was developing the CS, Exner began in collaboration with Irving Weiner to conduct Rorschach workshops. As reported by Perry (1994) and other authors, Weiner's (1966) approach to assessing personality functioning in schizophrenia had had considerable influence at that time on graduate students and practicing clinicians and had enhanced the role of the Rorschach as a reliable and valuable instrument in describing patterns of impaired functioning in schizophrenia.

The first Rorschach workshop presented by Exner and Weiner was held in June 1971, on the Brooklyn Campus of Long Island University. This 1971 program was followed for the next 27 years by Exner–Weiner workshops given several times a year and sometimes with other Rorschach workshop faculty. Consistently supported by extensive empirical research, the CS soon became frequently used by Rorschach practitioners. In 1991, Exner introduced the CS cluster approach to interpretation, which has also become widely used and provides clinicians with a structural summary organized around groups of variables relating to the personality functioning dimensions of ideation, mediation, processing, affect, self-perception, interpersonal perception, and stress management.

The prominent statistical foundations on which Exner built the CS and the primarily quantitative emphasis in his interpretive approach have led some authors to refer to it as largely an atheoretical method lacking a conceptual basis (e.g., Mihura et al., 2013; Sugarman, 1991). This is a mistaken characterization of the CS. Exner (1974) did write in the preface to the first edition of his basic text that the CS "is not based on any theoretical position" (p. xi). However, what he meant was not that the CS is an empirical method without conceptual basis, but rather that the CS can be used effectively by assessment psychologists regardless of their theoretical preferences. Moreover, Exner presented abundant conceptual as well as statistical grounds for the decisions he made in constructing the CS. He provided the rationale for the inclusion or exclusion of each of the codes derived from the five different systems, codes that were based primarily on conceptualizing personality functioning in terms of responses to the inkblots. He indicated whose operational definitions were adopted and why he chose to develop his own criteria, and in subsequent editions he indicated as well why operational definitions and criteria for the CS have been revised since the initial publication of the system. The statistical strengths of the system and the fact that it has continually been reexamined with respect to its psychometric properties do not detract from the conceptual basis of the selected variables used for interpretation.

Exploring CS-Based Data within a Conceptual-Empirical Matrix

The conceptual basis of the CS was emphasized in the CS Volume 3, *Assessment of Children and Adolescents* (Exner & Weiner, 1982, 1995), in which empirically supported data are interpreted in terms of psychodynamic concepts and applied to clinical case studies. Weiner (1996) has further stressed the importance of integrating conceptual and empirical perspectives in the interpretation of CS data. This integration is elaborated in Weiner's (1998, 2003) *Principles of Rorschach Interpretation*, in which the traditional CS interpretive process is extended to encompass psychoanalytic perspectives on sequence analysis of the structural variables and response contents, based on a model elaborated in Schafer's (1954) *Psychoanalytic Interpretation in Rorschach Testing*. An ego psychology model presented in Weiner's book enhanced the development of other contemporary psychoanalytic models of integrative Rorschach interpretation, including those based on object relations theory, self psychology, and relational psychoanalysis (see Chap. 4).

The original Volumes 1, 2, and 3 that comprised the CS basic textbooks were followed by revised editions incorporating new empirical findings that have made the CS the most frequently used method for administering and coding the Rorschach (Archer & Newsom, 2000). In contrast to the chaos that preceded the development of the CS, its standard Rorschach procedures fostered systematic collection and comparison of data concerning intercoder agreement, retest reliability, and criterion, construct, and incremental validity, both in the USA and abroad. The advent of the CS additionally allowed clinicians who were using it to exchange information about their Rorschach findings with confidence that these findings were obtained and codified in accordance with the same guidelines.

As has been noted, the CS has been updated and expanded over the years, and every facet of the test, from seating arrangements to newly developed scores and scales, has been carefully investigated. New findings have been compared to previous findings, and additional research has been conducted to answer questions generated by these new findings. With Exner's basic text now in its fourth edition (Exner, 2003), the widespread adoption of the CS standardization made possible the development of large sample normative standards and international collaboration in examining cross-cultural similarities and differences in Rorschach responses. Multinational collaborations involving 5815 CS-administered and coded protocols have provided unique opportunities to compare nonpatient samples of children, adolescents, and adults and contrast different cultures from all over the world (Meyer, Erdberg, & Shaffer, 2007).

These developments in the CS further enhanced newly developed psychoanalytically oriented models of Rorschach interpretation that drew on non-CS methods for administering and coding the test. In the tradition of some previous non-CS theoretical views of the Rorschach as reflecting healthy as compared to psychopathological developmental processes (e.g., Ames, Metraux, Rodell, & Walker, 1974; Blatt, Brenneis, Schimek, & Glick, 1976), Martin Leichtman formulated a non-CS

model of Rorschach interpretation derived from a developmental perspective (Leichtman, 1996). The seminal work of Paul Lerner added an object relations perspective to the interpretation of non-CS data (Lerner, 1998). Leonard Handler, influenced by Winnicott's (1971) observations on the developmental importance of play, designed a therapeutic assessment procedure in which responses are quantified for their playfulness and the standard CS administration is followed by a testing-of-limits procedure in which people are asked to give playful responses to the inkblots (e.g., Handler, 1999).

For a while, these and other alternative perspectives created some divergence among Rorschach clinicians, and protocol interpretation tended to proceed in two distinct directions. The empirically based approach focused on interpreting structural variables, usually comparing the CS findings to normative data, whereas the psychoanalytically oriented perspective focused on individual experience as illuminated by the thematic imagery in response contents. Gradually, however, proponents of both these approaches came to recognize that integrating them would increase the accuracy with which an individual's personality functioning and subjective experience could be described. The gap between the two perspectives was notably addressed and narrowed when psychoanalytically oriented authors have started to present case studies in which Rorschach protocols of young and adult patients have been analyzed by applying psychoanalytic concepts to CS data (e.g., Murray, 1997; Smith, 1997). As noted, Weiner's (1998, 2003) book similarly presented an interpretation paradigm based on joint analysis of CS structural variables, thematic imagery, and sequential data, and this paradigm gradually became the one used for interpreting Rorschach CS data in clinical practice, as shown in the consultation model presented in the third edition of the CS Volume 2 (Exner & Erdberg, 2005).

A similar integration of CS data with psychodynamic conceptualization has begun to emerge in research as well as in practice. Although psychoanalytic theories have given rise to numerous well-constructed and empirically validated Rorschach scales (Bornstein & Masling, 2005; Huprich & Greenberg, 2003), these scales have been based mainly on non-CS variables and have been employed more frequently by researchers than by clinicians. At the same time, there has been a substantial development in psychoanalytically oriented concepts and ideas about normal and abnormal development that added greatly to the understanding of psychopathological conditions, together with a reawakening of psychoanalytic interest in the Rorschach, after several decades of relative neglect. Accordingly, the interest in Rorschach research aimed at interpreting CS findings in relation to accumulated normative data has also prompted researchers to explore CS-based indices that apply psychodynamic conceptualization. Some of these indices are used in the present volume to assess personality functioning in adolescents (see Chap. 6).

Over the years, the Rorschach has been the target of unrelenting criticism and denigration, consisting mainly of alleged psychometric inadequacy and limited utility. More than a few commentators have predicted that the Rorschach as an assessment instrument would disappear from evidence-based clinical practice. Although these allegations have for the most part been unwarranted, the attention of critics to various shortcomings in Rorschach research and practice has had the positive effect of

leading to improved research designs and new empirical findings that have strengthened the psychometric foundations of Rorschach assessment and amplified its utility for a wide range of clinical and nonclinical applications (see Mihura et al., 2013; Society for Personality Assessment, 2005). Rorschach critics have continued to the present day to voice harshly negative comments without acknowledging validating data or presenting any new supportive data for their hostile views. Meanwhile, contemporary developments in Rorschach research accord with John Exner's vision (e.g., Exner & Sendin, 1997) that the CS would continue to develop and evolve. In the preface to the fourth edition of his Volume 1 he wrote: "There is no apparent end in sight to the continuing research questions posed by this awesome test. Although many of its mysteries have been solved, many remain" (Exner, 2003, p. xvi).

As for its use, survey findings demonstrate the sustained frequency of clinicians who apply the CS in many different settings and in countries all over the world (e.g., Meyer, Hsiao, Viglione, Mihura, & Abraham, 2013). These findings, together with a steady flow of new books and book chapters, as well as journal articles featuring research and case studies concerning the utility of the CS in assessing personality functioning, suggest that CS-based Rorschach work plays a prominent role in the field of assessment psychology and in any context in which personality characteristics have a bearing on decisions to be made.

Conclusion

The Rorschach Inkblot Method has had a long and interesting history, particularly with respect to illustrating several common characteristics of advances in scientific theory and practice. The first of these common characteristics is the role of serendipity, perhaps the best known example of which is the apple falling on Newton's head and giving rise to his laws of gravity. In the case of the Rorschach Inkblot Method, its coming to America and its initial development as a broadly system of personality assessment were a serendipitous consequence of Beck's needing a dissertation topic and Klopfer's needing a job.

A second common characteristic of scientific advance is the emergence of multiple perspectives on theory and method, which was the case in Rorschach history. On the positive side, collaboration among creative thinkers with diverse views can enrich scientific theories and methods, particularly when they agree on standard measurements that make possible systematic accumulation of data. On the negative side, when influential figures with disparate different views are unable or unwilling to collaborate or even speak to each other, as were Beck and Klopfer, their diverse perspectives can delay advances in knowledge and produce confusion of tongues rather than creating a basis for universal communication. With such concerns in mind, the CS was developed to provide standardized Rorschach administration and coding that would facilitate cumulative data collection and make it possible for all Rorschach clinicians to speak the same language.

In addition to illustrating the role of serendipity in scientific advance and the disadvantage of impermeable boundaries between disparate perspectives, the history of the Rorschach reflects the importance of evolution. Whatever the initial value of creative ideas and sophisticated methods, they must evolve over time in light of newly emerging conceptual formulations and newly obtained empirical data. As a vibrant method in this respect, the Rorschach CS was frequently modified with new variables and interpretive strategies from its initial publication in 1974, and Rorschach clinicians have continuously made revisions in the form of a CS-based system, as exemplified by the present volume.

Of further note in scientific advance and in Rorschach history is recognition that the understanding of events is facilitated by integrating various sources of information about them. In Rorschach assessment of personality and psychopathology, useful information comes from quantitative scores for the response structure, qualitative inferences from the thematic imagery, and observations of the respondent's test-taking behavior and manner of relating to the examiner. Integration of these three sources of information enriches the scope and utility of inferences based on the method, whereas sole emphasis on structural variables, thematic imagery, or behavioral observations discards valuable data and narrows the breadth and applicability of whatever conclusions are derived from the Rorschach.

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Chapter 2
Developmental Considerations in Rorschach Assessment

Functional and psychodynamic assessment of adolescents presents a particularly challenging task in clinical practice. Assuming that the structures of psychopathological syndromes in adolescence differ from those in adulthood (e.g., conduct problems might hide major affective disorders), distinguishing between transitional developmental crises and psychopathological manifestations is essential (Weiner, 1992). With respect to developmental crises, adolescence poses some difficult tasks (Lerner, 2002; Lerner & Steinberg, 2004). Adolescents must adapt to rapid bodily changes; recognize and learn how to express their sexuality, individuating from their parents, becoming involved in social and romantic relationships, and beginning to establish a sense of their personal identity; and advance toward adulthood.

Developmental theories and empirical evidence have nevertheless confirmed that, in contrast to a previously prevailing view, personality functioning in normative adolescents is characterized by stability, provided that their rearing environment is expectable and facilitating (e.g., Rutter, 2007; Weiner, 1990, 1992). Normal developmental demands can at times induce regressive reactions that resemble psychopathological manifestations, but these reactions are not typical of adolescence.

Yet, research on the effect of the internet revolution and rapid social changes in recent decades shows that these changes increase the risk for adolescents of experiencing loneliness and lack of support, which makes the confusing period of adolescence even more complicated to adapt to in the twenty-first century than it was in earlier years. These findings suggest that developmental research should apply a multi-perspective approach that integrates neurobiological, cognitive, emotional, and social psychological concepts for understanding various types of symptom patterns and maladaptive behaviors (e.g., Boyer, 2006). Such a multi-perspective approach can promote treatment aimed at psychopathological development rather than at overt behavioral manifestations.

Empirical studies have shown further that there are important changes in the rate and patterns of psychiatric disorders and maladaptive behaviors during adolescence (Rutter, 2007). Schizophrenia and other psychotic disorders are rarely seen in children but become progressively more frequent in adolescents (Weiner, 1992).

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Similarly, major depressive disorder is relatively infrequent during childhood but increases in frequency during adolescence. Use and abuse of drugs and alcohol as part of a general liability to engage in disruptive, risky, and sometimes antisocial and criminal behavior also rises during adolescence and is usually associated with diminished achievement in school. Such behavioral problems may mask diagnosable disorders, and should thus be taken into consideration in any adolescent's evaluation.

There is general agreement among psychoanalytically oriented clinicians that traditional descriptive diagnostic categories are less useful in understanding and working with adolescents than with adults. Psychodynamic conceptualization of personality development, such as the normally expected progression from primary to secondary thought processes, can accordingly be essential in differentiating between healthy and disturbed adolescents. Normative reactions to developmental crises may temporarily interrupt an adolescent's maturation without there being any obvious external stimulus to this interruption. Such reactions typically follow a stable period of adjustment and are characterized by a brief crisis in which the adolescent shows some regression to a prior developmental phase. The impact of such a developmental crisis is likely to be manifest in the adolescent's patterns of behavior, and it can at times be exacerbated by changes in a young person's family structure or in other situations in which the adolescent is involved.

Symptom Patterns in Adolescents: A Psychodynamic Developmental Perspective

The *Psychodynamic Diagnostic Manual* (*PDM* Task Force, 2006) is addressed to understanding symptom patterns by applying concepts derived from psychoanalytic theoretical formulations. The manual is based on the conviction that mental health comprises more than simply the absence of symptoms. Instead, it involves an individual's overall personality functioning, including cognitive, affective, relational, and self-observing capacities that should be assessed from a dimensional rather than a categorical perspective. This perspective derives from psychodynamic theories of psychopathology that link some personality characteristics with specific patterns of symptom formation.

Psychodynamic developmental conceptualization of psychopathology suggests that character formation is incomplete until the challenges of adolescence have been met and adolescent concerns resolved (e.g., Baudry, 1995). This conceptualization can be helpful in distinguishing between healthy and psychopathological functioning in young people, and it also identifies the particular importance of the adolescent years in character formation. Freud was interested in developmental issues occurring in young children, but he hardly referred to developmental issues in adolescence. Nevertheless, he did include in his early essays a seminal discussion of changes in sexual aims and objects following puberty (Freud, 1905). Anna Freud similarly stressed the significant influence of puberty on the maturation of character and the integration of ego functions (Freud, 1936), and Erik Erikson emphasized the importance of establishing a stable sense of identity during adolescence, including

consolidation of values and ideals and thereby attaining an integrated self-concept (Erikson, 1956).

There is accordingly good basis for considering adolescence a qualitatively new developmental phase of individuation (e.g., Bleiberg, 2001; Blos, 1962) and the steps of character formation as a normal unfolding of maturational sequences, along with potential developmental discrepancies between various domains of functioning. These discrepancies run the risk of increasing confusion, vulnerability, and subjective distress. Empirical findings as well as clinical observations have further supported the notion that a considerable level of ego development, including capacities for internalization, self-object differentiation, and formation of ideals, is necessary before a stable and integrated character to be considered formed.

In general, severe disturbances in adolescence are related to a breakdown in the developmental process that interferes with an adolescent's capacity to preserve an adaptive balance between different mental structures. This developmental breakdown might be observed, for example, in the incapacity of some of them to allow their body image to change so that it would include mature sexuality. Instead, they use maladaptive defensive operations to avoid normative mature functioning. Accordingly, Rorschach evaluation of adolescents should differentiate between fixation and regression to less mature developmental stages than those already obtained. In this regard, evaluating whether observed symptoms reflect a disorder or a compensatory defensive operation in a neurotic personality organization is essential.

Although the notion of age-appropriate behaviors has recently been challenged (Hollenstein & Lougheed, 2013), extreme deviations from Rorschach CS normative data, in any of the domains of personality functioning, can help to distinguish between healthy reactions to developmental challenges and psychopathological manifestations that would be likely to persist in adulthood. By focusing on personality functioning rather than on currently observable symptoms, the Rorschach has important implications for assessment and treatment as well as for issues of prevention and reversibility of severe disorders and their effects in adulthood.

Generally speaking, the integration of a developmental perspective in drawing inferences from Rorschach data is based on the premise that, although many adolescents demonstrate occasionally impaired cognitive or affective functioning, most do not show indications of diagnosable disorder. Nevertheless, difficulties establishing mature patterns of functioning (e.g., controlled emotional communication) may put adolescents at risk for personality problems or disturbances, including such internalized deficits as depression or isolation and such externalized maladjustment manifestations as delinquent or antisocial behavior (Kimmel & Weiner, 1995).

Two Conceptual Models for Integrating Developmental Considerations in the Interpretation of Rorschach Data

The present discussion explores two psychodynamic models that integrate developmental considerations in Rorschach assessment and are used to illustrate developmental trends in CS data. One of these models of interpretation was derived by

Weiner (2003) from ego psychology and elaborates the implication of CS variables from an adaptation perspective emphasizing the nature and effectiveness of a person's style of coping with age-related life demands. The other interpretive model was suggested by Leichtman (1996, 2009). This model, based on orthogenetic developmental theory, applies the concept of development as an organizing principle for drawing inferences from Rorschach data according to an expected developmental sequence from an initially undifferentiated state toward increasing differentiation and coordination of specific personality components.

The Ego Psychology Model

Historically, Freud's structural theory with id, ego, and superego as basic components, and his formulation of psychosexual development (i.e., oral, anal, and phallic stages) were implicit in the psychoanalytic conceptualizations that guided the interpretation of Rorschach findings (e.g., Rapaport, Gill, & Schafer, 1946; Schafer, 1954). In this work the Rorschach was used to assess the basic components of Freudian personality structure and their interplay while focusing mainly on the assessment of ego strength, especially with respect to thought disorder and impulse-defense configurations. Although Freud focused mainly on psychosexual issues, he, and his followers even more so, used many of the same central concepts (i.e., ego development, fixation, and regression) to explain disturbances in character formation and in the experience of self and other people (Leichtman, 2009). On the basis of these concepts, maladaptive personality traits were linked to certain patterns of symptom formation and psychopathological manifestations.

Weiner (2003) applies concepts derived from ego psychology in his interpretive model for CS data. In this model, which focuses on adaptation to external reality, CS cognitive variables provide well-validated markers of cognitive maturation as reflected in logical thinking and accurate perception. Most teenagers have not yet attained adult cognitive capacities for reasoning and concept formation. Like preadolescents, they often have difficulty understanding and integrating new kinds of experiences. Moreover, because adolescents are often convinced, even in the absence of solid evidence, of the correctness and appropriateness of their ideas and attitudes, they are more likely than adults to give responses that reflect circumstantial reasoning and illogical thinking (*FABCOM, ALOG*).

Simultaneously with the expected developmental changes in some CS cognitive variables during adolescence, age-related changes typically occur as well in certain CS affective, interpersonal, and self-perception variables. With respect to their affective functioning, adolescents become increasingly capable of modulating their emotional experience, and normative adolescents can be expected to provide Rorschach protocols in which the scores on CS variables of affective modulation closely resemble those of normative adults. In this regard, normative adolescents are expected to give more form-dominated color responses (*FC*) than color-dominated and formless color responses (*CF+C*). Nevertheless, because of their susceptibility

to episodes of anxiety and dysphoric mood, normative teenagers are more likely than normative adults to show CS markers of subjective distress.

Thus, the developing cognitive-affective schemas of young people may sometimes be marked by temporarily distorted patterns of thinking and/or unmodulated emotionality that have conscious and unconscious components and can influence a wide range of subsequent internal experiences and overt behaviors. Distorted patterns of thinking may sometimes become a prototype of how adolescents think and feel about other people and about themselves that is activated in interpersonal situations. In this regard, the construct of mental representations, which has become a prominent developmental concept (Ainsworth, 1969; Blatt, 1991; Fonagy et al., 1995; Piaget, 1954; Stern, 1985), can be reflected in CS variables. For example, the normatively increasing awareness of and positive attention to people over time, reflected in *SumH,* the sum of responses coded with *H,(H), Hd*, or *(Hd)* as representations of human figures, steadily increases from childhood to adulthood. Although mentally healthy adolescents are still learning social skills and typically lack the interpersonal competence and self-assurance of mature adults, they retain an age-appropriate capacity for establishing relationships. Developmental studies have confirmed adolescents normatively search for and are capable of maintaining close interpersonal relationships.

With respect to self-perception, however, contemporary normative reference data show a gradual increase from childhood to adulthood in the *Egocentricity Index*. This indication of increasing self-focusing during adolescence differs from traditional CS reports of greater egocentricity in children than in adolescents (Exner & Weiner, 1995). Possible reasons for this change in CS markers are discussed in Chap. 5.

The Orthogenetic Developmental Model

The orthogenetic developmental theory, which draws on biological metaphors to articulate the structure of mental phenomena, provided the conceptual basis used by Leichtman (1996, 2009) to articulate Rorschach assessment from a developmental perspective. The central organizing principle of the orthogenetic theory, and of various other developmental theories as well, stresses dialectical patterns of developmental change from an undifferentiated state to coordinated integration (Werner, 1957). This principle has been deployed as a key construct in understanding faltering developmental patterns and their corresponding psychopathological manifestations (e.g., Cicchetti, 1984; Piaget, 1954; Winnicott, 1971). It has also been empirically validated in brain research (e.g., Johnson & Vecera, 1996) and in studies of personality functioning as assessed with both explicit measures such as self-report inventories and implicit measures such as performance-based methods.

Leichtman's (1996, 2009) model is in accord with the *PDM* mental functioning axis for children and adolescents (MCA), which describes the capacity for differentiation and integration as a substantial factor in the representational world of

mentally healthy adolescents. In this regard, Rapaport (1967) used the notions of both the *relative autonomy of the ego from the id* (one's even and solid relationship with the outside world) and the *relative autonomy of the ego from external reality* to demonstrate how reality can serve as a defense against fantasy and, conversely, how fantasy can serve as a defense against reality. Rapaport attributed the literal and concrete thinking of patients with schizophrenia to impairment in the ego's autonomy from the id, and the intrapsychic blocking of instinctual drives in other patients (e.g., patients with obsessive–compulsive disorder) to an impairment in the ego's autonomy from external reality. From a developmental perspective, however, what might be viewed as psychopathological functioning in adolescents and adults is conceived as being normative in children. A Rorschach percept of "a pink bear" coded as an incongruous combination is quite a common, playful response in protocols of children but would rarely occur in a protocol of well-functioning adolescents (Leichtman, 1996).

In order to apply the two conceptual models to Rorschach CS data, clinicians should first ask themselves what normality looks like. Modern psychoanalytic conceptualization of what constitutes healthy functioning has substantially changed and adaptation is now defined in terms of both external and internal reality. The emphasis has turned from concepts like rationality to those of self-relation and object relations, authenticity, creativity and playfulness (e.g., Mitchell & Aron, 1999). With respect to adolescents, some of them might be very well adapted to their society, but missing something fundamental in their experience. In these cases the very adaptation to the external world should be regarded as the problem, not the solution (Winnicott, 1971).

Accordingly, a new type of psychopathological personality functioning, the *normotic personality* (Bollas, 1987), has been described, which delineates psychopathology of subjectivity. This type of psychopathology, which is also described by applying the psychoanalytic construct of *Alexithymia* (Nemiah & Sifneos, 1970), is demonstrated in individuals who function "abnormally normal" in their adjustment to external reality but show substantial difficulties in relating to their own subjective experience that are reflected in various disorders, particularly those involving somatic and obsessive–compulsive symptom patterns (McDougall, 1989; Ogden, 1989). However, the elusive quality of the *normotic personality* and the *Alexithymia* constructs makes them difficult to be captured in symptom-based diagnostic systems and requires instead a psychodynamic-based diagnosis for which the Rorschach CS is particularly suitable.

Developmental Trends in Normative CS Data

Although cross situational variability in personality functioning has been interpreted against the utility of the personality construct and its measurement by assessment tools, modern theory of personality shows that on the contrary, this variability reflects some of the essence of personality coherence (Mischel & Shoda, 1995). In

line with this conceptualization, Rorschach CS normative data can be used for detecting the interactional effects of situations, dispositions, dynamics, and invariance in the development of personality structure.

Rorschach (1942) noted developmental trends in normative responses to the inkblots. Research of developmental trends, which evolved in Europe and in the USA, served further for establishing foundations of integrating psychometric approaches with developmental psychoanalytic conceptualization to Rorschach assessment of children and adolescents. Ames, Metraux, and Walker (1959) explored normative data of adolescents from a developmental perspective. As noted in Chap. 1, Margaret Hertz, who promoted Rorschach assessment with children and adolescents, emphasized that because adolescence produces both quantitative and qualitative changes, it is necessary to focus on this relatively circumscribed period of development by obtaining normative data (Hertz, 1970). Analyzing Rorschach findings, derived from an adolescent's protocol, in comparison to age-based normative data, thus offers utility for assessing developmental capacity, mastery of psychological resources, and ability to communicate effectively about the world (Leichtman, 2009).

New imaging techniques developed in neuroscience have recently broadened the understanding of the interactional effect that neurological and personality factors as measured by the CS can have on faltering development in adolescence. These studies (e.g., Porcelli, Giromini, Parolin, Pineda, & Viglione, 2013; Zillmer & Perry, 1996) have shown the impact of outside demands on inducing internal regressive experiences and primitive defensive reactions and confirmed the use of the CS as useful neuropsychoanalytic tool for assessing personality functioning. This conception has been confirmed by neuropsychological studies (e.g., Paus, 2005) showing changes in multiple regions of the prefrontal cortex and improvement in various aspects of executive functioning, including metacognition, self-regulation, and the coordination of affect and cognition from childhood to adolescence and throughout adolescence.

As noted by Leichtman (2009), the most influential empirical work with respect to developmental trends shown in Rorschach normative data was conducted while developing the CS. The CS age-group reference data for children and adolescents (Exner & Weiner, 1995) have generally confirmed the expected developmental trends in the various domains of personality functioning (Wenar & Curtis, 1991), with attention becoming more focused, perception more individualized and less conformist, and thinking more coherent from childhood to adulthood. Analysis of CS developmental changes has also demonstrated affective functioning becoming more modulated and more distressful and the capacities for differentiating and integrating various aspects of functioning more developed. Accordingly, Exner (2001) provides age-based adjusted cutoff scores for children and adolescents, for three of the CS variables: *WSum6*, *Afr*, and the *Egocentricity Index*. The adjusted cutoff scores for these variables have also been implemented in the CS constellation indices.

Whereas most of the CS variables show consistent linear trends from childhood to adulthood, with decreasing maladaptive and psychopathological markers, some of them demonstrate curvilinear patterns with elevated psychopathological and/or maladaptive CS markers in adolescents. However, when comparing Rorschach

scores of an adolescent to normative data of adults, caution should be made with respect to the previously noted difference in how various disorders are manifested in children and adolescents as compared to adults. Furthermore, statistical norms should not be equated with psychological normality, which although having no satisfactory definition involves both internal and external adaptability (Exner & Weiner, 1995). In this regard, it should be stressed that the interpretations of Rorschach scores do not change in different age groups.

Developmental theories suggest that personality functioning in normative adolescents is characterized by stability. Indeed, the CS data of children and adolescents (Exner, 2001; Exner & Weiner, 1995) have shown stability coefficients similar to those of adults when retested over brief intervals. However, as would be predicted from the evolving nature of personality, Rorschach scores can often fluctuate throughout development and do not stabilize until mid-adolescence (Weiner, 2001). On the other hand, the long-term stability of Rorschach variables gradually increases during adolescence, which is consistent with the expected gradual consolidation of personality characteristics during this developmental stage thus further supporting the construct validity of the Rorschach as a personality assessment method. This implies that during adolescence, individuality features become more prominent than those reflecting normative developmental trends.

Consistent with what is known about normative developmental processes, most of the changes in CS variables are expected to occur between childhood and adolescence. These trends were validated in normative samples (see Chap. 5). Accordingly, except for some of the CS variables, in which changes are expected to occur during adolescence, most of the CS reference values for adults can be applied for adolescents. It should be stressed, however, that developmental changes, whether occurring in childhood or in adolescence, do not call for corresponding changes in the interpretation of related CS variables. As an example, the *FC:CF+C* ratio commonly indicates the degree of affective control regardless the age group. Instead, the implications of deviant CS scores would be age related, and the presence of values that exceed the CS cutoff points for adults should be interpreted accordingly. In line with these guidelines, internalized emotional distress, as shown in CS variables, might quite frequently suggest normative development in adolescents while implying psychopathological functioning in children.

The extent to which the CS normative data, collected from nonpatient samples in the USA, also represents adolescents from other countries could not have been explored until large cross-cultural samples were collected. However, supporting evidence for the cross-cultural applicability of the CS cutoff scores cross-culturally has been provided by three normative samples of nonpatient adolescents from Italy (Lis, Salcuni, & Parolin, 2007), Israel (Tibon-Czopp, Rothschild-Yakar, & Appel, 2012), and Iran (Hosseininasab, Mohammadi, Weiner, & Delavar, 2015). These data provided empirical evidence for some of the expected cross-cultural developmental trends in most of the CS data (see Chap. 5). Based on the general similarity shown between these three samples and the international sample of nonpatient adults (Meyer, Erdberg, & Shaffer, 2007) as well as on the developmental trends reflected in comparisons of two age-based groups (11–14, 15–18) within each of the

three samples, the samples have been combined into one cross-cultural sample. The international combined sample, presented in this volume, provides clinicians with updated CS reference data for adolescents.

Applying CS and CS-Based Indices for Assessing Psychopathological Development

The present volume elaborates the utility of 45 CS structural variables for distinguishing between healthy and psychopathological functioning in adolescents. The selected variables refer to *cognitive functioning, affective experience, interpersonal relatedness,* and *self-perception* (see Chap. 6). Five additional variables that are indicative of personality style rather than psychopathology are also used for providing a contextual framework for interpretation. Specific forms of psychopathology associated with deviant scores on the selected variables are discussed in Chaps. 7–9.

While most of the selected variables are drawn directly from the CS (Exner, 2003; Exner & Weiner, 1995), some of them are relatively new CS-based indices, including two derivations of the *Reality–Fantasy Scale Version 2.0* (*RFS-2*; Tibon-Czopp, Appel, & Zeligman, 2015) that have been validated as measures of psychotic thinking and dissociation proneness, respectively; the *Ego Impairment Index* (*EII-2*; Viglione, Perry, & Meyer, 2003), which has been validated as a measure of psychopathological cognitive and relatedness functioning; and the *AdjDMD* index (Weiner, 2003), which has been validated as a measure of likelihood of anxiety symptoms. These indices are described and applied in relation to psychopathological development in the second and the third part of this volume. The well-validated new indices enable clinicians to distinguish between healthy and psychopathological development and point out that the CS should not be viewed as a fixed or closed method, but rather as an evolving system, which should be further explored and revised.

As has been noted, with psychological development and the mature capacity for differentiating and integrating experiences, the representational world of mentally healthy adolescents becomes increasingly complex. The notion of mature personality functioning as reflected in adequate processing of stimulus has recently been explored by applying Rorschach CS variables to the construct of *Integrative Complexity* (Tibon-Czopp, Appel, & Zeligman, 2014). This construct, which is related to the capacity to tolerate paradox, has been extensively investigated in relation to decision-making, negotiation, and conflict resolution issues, in high-functioning adolescents and adults (e.g., Tibon-Czopp, Appel, & Zeligman, 2015), by using various CS and CS-based variables. As noted by Pizer (1998), the capacity to tolerate paradox implies a mode of organizing continuing experience in which distinctions between self and other, internal and external, and fantasy and perception are dissolved. The boundaries separating these apparent paradoxical or polarized conceptual pairs reflect fluidly shifting experiences that change at different

times and different contexts thus making them sensitive to developmental and cross-cultural issues.

The progressive maturation in the capacity to tolerate paradox is expected to be shown not only in the cognitive functioning of normative adolescents but also in their affective experiences, interpersonal relatedness, and self-conception. With respect to affect, for example, the normal maturational tendency for adolescents to become emotionally more reserved and the intense subjective distress derived from developmental challenges are assumed to be reflected in some of the CS affective variables (Weiner, 1996, 2003). The previous CS age-group norms for children and adolescents (Exner, 2001; Exner & Weiner, 1995) confirmed the expected reduced intensity of emotionality, reflected in a decreasing number of color-dominated (*CF*) and no form color (*C*) responses, as compared to form-dominated color responses (*FC*). Interestingly, a recent study in adult patients diagnosed with severe dissociative disorders (Zeligman, Smith, & Tibon, 2011) has shown that the immature capacity of modulating affect, assumed to characterize dissociative patients, would be demonstrated not only in chromatic color responses but also in those using achromatic or shading, reflecting subjective distress. Accordingly, the less modulated distress would be reflected in elevated number of shading-dominated (*C'F, VF, TF*, and *YF*) and no-form shading (*C', V, T*, and *Y*) responses, as compared to form-dominated shading responses (*FC', FV, FT*, and *FY*).

Conclusion

The developmental considerations discussed in this chapter by using normative data have substantial implications with respect to construct validity of CS variables beyond enhancing their clinical utility. Normative age-based CS data can be particularly useful for validating deviant scores that point to immature functioning because they constitute observed variables of demographic that have little, if any, error variance and are independent of test findings. Should age differences emerge contrary to what would be expected according to developmental theories, the suitability of these theories to contemporary adolescents in different countries has to be reexamined. However, as stated by the developers of the CS (Exner & Weiner, 1995), when cross-cultural differences are shown with respect to expected developmental trends, particularly in perceptual variables of Form Quality (*FQ*), it seems reasonable to review the items in the tables for frequency. In other words, if a response currently not found in the *FQ* tables occurs frequently in some countries, the form quality scoring for this response should be adjusted accordingly. Likewise, if a response currently presented in the *FQ* tables as unusual occurs with a high frequency in nonpatient adolescents in some countries, it should be scored with *FQo*. This is a very different procedure from establishing country-specific reference data and thus allows the use of combined international norms.

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Chapter 3
Assessing Personality Functioning of Adolescents with Performance-Based Measures

Assessment of personality functioning consists of evaluating personality structure and dynamics. Evaluation of personality structure integrates assessment of mental states and personality traits. Whereas mental states consist of a broad range of relatively transitory, situational-related phenomena such as being distracted, depressed, or enthusiastic, personality traits consist of relatively enduring patterns and abiding dispositions such as being an agreeable, kind, angry, or abrasive type of person. Although often interrelated, states and traits should be independently assessed so as to provide a personality picture of both transitory reactions and more permanent patterns of functioning. Evaluation of personality dynamics refers to a person's underlying needs, attitudes, conflicts, and concerns and to the manner in which states and traits interrelate and influence mental functioning. For example, a person who is characterized by impulsivity would react differently to stressful conditions from one who usually does not show poor impulse control (Weiner, 2003, 2005).

Clinicians who work with adult patients have generally recognized the clinical interview as the primary reference point for understanding symptoms and problematic habitual patterns of behavior. Several sessions of diagnostic interviewing, sometimes with the patient and also significant figures in his or her life, are usually needed to conceptualize the person's main difficulties and sources of subjective distress and to devise a treatment approach. With respect to psychological tests, commonplace practice with adults adds them to the assessment process when clinical interviews are inconclusive for resolving questions of differential diagnosis. Unlike adults, most young people seen in clinical practice with either symptom-focused complaints or more enduring patterns of maladaptive mental functioning need to be assessed more comprehensively than clinical interviews allow, by using psychological tests and comparing the test results to those of their peers (e.g., Exner & Weiner, 1995; Weiner & Kuehnle, 1998).

Psychological tests for assessing personality characteristics are of two kinds: self-report inventories and performance-based measures, until recently commonly referred to as projective tests. The Minnesota Multiphasic Personality

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Inventory-Adolescents (MMPI-A; Butcher & Williams 1992) and the Rorschach Inkblot Method are the assessment instruments most frequently used in clinical practice with adolescents (Archer & Newsom, 2000). As elaborated by Meyer (1997), there is clear conceptual basis for expecting the two kinds of psychological tests to tap different levels of conscious awareness and consequently to differ in their relative sensitivity to state and trait dimensions of personality functioning.

Although not exclusively, self-report inventories are relatively more sensitive to overt mental states of which people are consciously aware, whereas performance-based measures, because they present test stimuli that are intended to evoke subjective meanings and individualized personality organization, are relatively more sensitive to implicit or underlying traits that individuals may not fully recognize in themselves. Particularly important for capturing implicit traits is the nature of the performance-based task, which sets few limits on how people can respond. Instead, individuals are asked to consider numerous possibilities in expressing their private world of meanings, significance, affect, and organization (Frank, 1939).

It should be stressed, however, that neither the particular sensitivity of self-report measures to personality states and explicit motives nor the particular sensitivity of performance-based measures to personality traits and implicit motives constitutes an absolute advantage of one type of approach over the other. Self-report test data can speak also to characterological dispositions of the individual, and performance-based test data can tap also mental states and psychological disorders (Weiner, 2005, 2013).

On the other hand, self-report inventories may indicate clearly what people know about themselves but be limited by the accuracy of respondents' self-judgments and their reluctance to describe themselves openly and perhaps unfavorably. As for performance-based measures, they may not provide specific details about specific symptoms, but they can provide meaningful information about normal and abnormal personality characteristics, patterns of thinking, affect regulation, and interpersonal functioning that parallels or complements information obtained from other sources (Bornstein, 2012; Ganellen, 1996, 2007).

Based on the advantages and limitations of these two kinds of personality tests, this chapter (a) discusses the implications of their method difference with respect to the utility of the Rorschach Comprehensive System (CS; Exner, 1974, 2003) for evaluating adolescents and (b) endorses a multi-method model for assessing personality functioning in adolescents. Empirical evidence for the utility of the Rorschach CS as a substantial component of this model is discussed in Chap. 5.

Self-Report Inventories and Performance-Based Measures: Implications of Using the Rorschach for Personality Assessment of Adolescents

Self-report inventories are relatively structured and explicit tools that inquire directly about a person's self-perceptions, state of mind, and subjective experiences. As such, this task is a descriptive procedure in which respondents are asked whether

a list of statements is characteristic of them, either with a "yes" or "no" answer or by selecting from a range of possible answers (e.g., from "very often" to "never"). This assessment procedure can accordingly be conducted with minimal participation of the examiner. In contrast, performance-based tools are implicit methods that sample not how people describe themselves, but how they perform on certain tasks. When conducting performance-based methods, clinicians can therefore obtain information about the individuals being tested not only from their test responses but also from observing how they cope with the task and how they relate to them.

Indeed, unlike self-report inventories, performance-based tests, particularly the Rorschach, provide assessors with observable clues to behavioral tendencies as well as to personal characteristics of which individuals are not fully aware or may be reluctant to disclose. To capture these clues fully, examiners should be well trained on each aspect of Rorschach testing, beginning with establishment of rapport and followed by administration, coding, and interpretation. In addition to the extensive training needed to gain expertise in Rorschach assessment, administering the test can be substantially more time consuming than less complex and self-administered measures. The time required to administer the Rorschach varies with the number and complexity of responses a person gives and can extend to half an hour or more. This time demand often raises concerns about eligibility for third-party reimbursement that may lead clinicians to decide not to include the Rorschach among the assessment tools.

As the following discussion indicates, the cutting edge of the Rorschach in the assessment process, particularly with adolescents, can usually outweigh the flaw of its limited profitability in business terms. The advantages of the Rorschach are notable in five important aspects: (a) facilitating cooperation, (b) restricting impression management, (c) distinguishing between healthy and disturbed adolescent development, (d) detecting continuities and change from adolescence to adulthood, and (e) capturing personality dynamics, underlying disturbed patterns of functioning, and level of personality organization.

Facilitating Cooperation

The utility of any assessment method depends primarily on the willingness of individuals being tested to respond (i.e., how fully committed they are to being open in revealing aspects of themselves). Adolescents are typically reluctant to cooperate with an adult examiner and, when asked about them directly, disinclined to admit their shortcomings and report difficulties they are experiencing. This is particularly so when they are required to conform to a clearly specified set of behavioral guidelines provided by an authoritarian figure (the examiner). Such reluctance is a normative developmental response, as discussed in Chap. 2. Adolescents are more likely to be relaxed and cooperative when they are coping with a playful examination procedure than when they are being asked specific questions about themselves. They may dislike or even resist being pinned down by structured test items that

resemble those they are accustomed to in school examinations, and they are usually more cooperative when they have greater freedom to report their thoughts and experiences in their own words and in their own preferred manner.

The Rorschach task calls for responding to the inkblots by answering a question (*What might this be?*) that opens the door to free associating. It is frequently seen by adolescents as a playful task in which they need to create a response within the transitional space (Winnicott, 1971) between reality and fantasy (see Chap. 4). As noted in Chap. 1, this circumstance parallels the development of the test by Herman Rorschach, who transformed an inkblot game he had played as an adolescent with his peers into a psychological test. As a test, the Rorschach free-association task enables experienced clinicians to process even a highly guarded protocol by searching for implicit clues (e.g., deviant verbalizations, lack of human content) that illuminate a person's subjective experience.

In line with this unique advantage of the Rorschach, Bram (2010) presents the evaluation and treatment of a 14-year-old girl who was referred for consultation because of chronic depression, self-mutilating, peer conflict, oppositional behavior with adults, poor academic performance, and a variety of somatic symptoms. A guarded protocol produced by this patient, whose previous therapists had failed to establish a cooperative relationship with her, was an essential element in the Rorschach assessment. Despite the examiner's experience of the patient as being negativistic and quite annoyed by the assessment process ("the testing was rocky"), he was able to use her aversive stance by taking her oppositional attitude as informative data. Based on his observations, he drew inferences about what would be required for her to form and sustain a connection with a clinician whom she experienced as rigidly pursuing his own agenda (e.g., Rorschach inquiry), which perhaps made her feel that her productions were inadequate or insufficient and led to her angrily and dramatically turning away from collaboration. Applying these inferences, he was able to obtain this adolescent's cooperation in both the therapeutic process and a second administration of the Rorschach that was conducted as a follow-up evaluation of therapeutic change.

Restricting Impression Management

The utility of psychological test data can be compromised not only by the guardedness of respondents who seek to restrict the amount of information they provide, but also by impression management. Impression management typically takes the form either of creating a personality picture of psychological disorder (faking bad) or of presenting a positive picture of psychological capability (faking good). The relatively direct and obvious item content of self-report inventories makes them generally more susceptible than performance-based measures to malingering and deception. Unlike self-report inventories, on which impression managers can often easily decide whether to answer "true" or "false" on different items, it is not easy to anticipate how to appear more disturbed or better adjusted than is actually the case

when dealing with a less-structured performance-based task (Weiner, 2005, 2013). This difference between types of personality tests has been formulated as a general principle that the susceptibility of a measuring instrument to impression management is likely to be directly related to the measure's face validity (Bornstein, Rossner, Hill, & Stepanian, 1994).

Given the differences between self-report inventories and performance-based methods, McClelland, Koestner, and Weinberger (1989) concluded that, in contrast to self-report scales, performance-based measures are less subject to being filtered or consciously controlled and are therefore less susceptible to self-presentational biases than explicit measures. Some people may consciously and deliberately misrepresent their history and present state for a variety of reasons. For example, patients with antisocial personality disorder (ASPD) might intentionally mislead clinicians simply for their own amusement. People may also deny maladaptive personality characteristics not because they fail recognize them, but because they are aware that admitting to these characteristics would involve making an unflattering statement about their attitudes and behaviors (Bornstein, 2012).

As has been noted previously (Weiner, 2013) with respect to the susceptibility of self-report inventories to impression management, the face validity of their obvious items is supplemented by readily available textbooks and Internet websites that describe the scales to which items relate and elaborate the personality correlates of high and low scores on these scales. This threat to test security was explored in a study examining potential misuse of Internet websites that provide information about psychological tests. The websites were classified into three levels according to the degree of threat they posed to test security. The authors concluded that only about 5 % of the websites appeared to constitute a direct threat to test security (Ruiz, Drake, Glass, Marcotte, & Van Gorp, 2002). Nevertheless, research findings indicate that enterprising respondents who inform themselves beforehand by reading the literature or who receive coaching in how to answer certain kinds of items can sometimes shape their responses on self-report inventories to give a misleading impression without elevating a measure's validity scales (e.g., Ben-Porath, 2003).

In contrast, having to respond without obvious content to guide them, guarded adolescents typically find it more difficult to choose their course of action on the Rorschach than on the MMPI-A, and they may consequently provide on the Rorschach more information about their personality characteristics and psychopathological functioning than was their intent. Adolescents may unwittingly reveal personal shortcomings and adjustment difficulties in their manner of dealing with the relatively ambiguous test stimuli and unstructured task requirements of the Rorschach and other performance-based personality measures. This is particularly important in forensic cases in which performance-based methods like the Rorschach may add important information on personality structure and dynamics beyond the information gleaned from self-report measures (see Chap. 10).

Nevertheless, available website presentations of the Rorschach cards have raised concern about its being susceptible as well to impression management. Recent research has provided some empirical reassurance in this regard. For example, in a recent study (Schultz & Brabender, 2013), two groups of nonpatients were administered

the Rorschach with fake-good instructions after reading either the *Wikipedia* article on the Rorschach (the experimental group) or an irrelevant article (the control group). The experimental group gave more *Popular* (*P*) responses than the control group and had higher scores on *X+%*, *XA%*, and *WDA%*. However, when the influence of the *P* responses was removed from the data analysis, there were no longer any significant differences between the groups on these indicators of perceptual accuracy. Empirically as well as conceptually, above-average number of *P* responses, especially in the context of a guarded record (i.e., low *R*, high *Lambda*), should thus alert examiners to the likelihood of a problem of impression management.

Distinguishing between Healthy and Disturbed Adolescent Development

As suggested in Chap. 2, accurate diagnosis and suitable intervention with adolescents are sometimes blurred by a persistent myth that most adolescents tend to lurch maladaptively from one crisis to the next, frequently showing psychopathological-like cognitive, emotional, and/or behavioral problems. Clinicians influenced by such notions may disregard symptoms of emotional disorder that should be treated (Weiner, 1990). Exner and Weiner (1995) state that young people who show disordered thinking and impaired reality testing on the Rorschach, in the absence of evidence of expressive language disorder, are likely to have a developing schizophrenic disorder, even if prominent clinical manifestations of schizophrenia are not yet present. Exner and Weiner note further that severity of disturbance in schizophrenia is directly reflected in the Rorschach in the extent to which features of the responses deviate from normative expectations: "Generally speaking, the more deviant the indices of disordered thinking, inaccurate perception, interpersonal ineptness, and inadequate controls are in schizophrenic person's record, the more chronic his or her condition is likely to be" (p. 155).

When an adolescent demonstrates thinking disturbances, a combination of findings derived from multiple instruments improves the accuracy of descriptions of psychopathological mental functioning. Because various disorders are differentially sensitive to types of testing procedures, the context in which disordered thinking appears is important for understanding the disturbance. As a disturbance becomes more severe, it tends to emerge on structured measures as well as on unstructured measures like the Rorschach. A suggested guideline for distinguishing between a psychotic and nonpsychotic disorder in these cases has been to combine Rorschach data with data from a more structured test. There might be lapses in logical thinking in the Rorschach of an adolescent who does not give evidence of an underlying psychotic disorder on a structured test. When notable markers of thinking disorder appear in the Rorschach but not in more structured assessment instruments, they usually delineate a lower and probably nonpsychotic degree of impaired cognitive functioning (Kleiger, 1999; Lerner, 1998; Sugerman, 1980). Furthermore, thinking

disturbances can sometimes be incorrectly interpreted as demonstrating severe disorders, when such is not the case. For example, young people who are exposed to traumatic events may temporarily show thought disturbances (Viglione, 1990). Similarly, adolescents with ADHD may sometimes show problems with perceptual accuracy that resemble the failures in reality testing that characterize psychotic disorders.

Empirically, psychological tests indicate healthy mental functioning in adolescents when the test results fall within a normative range established in nonpatient samples. Results for a test variable that deviate markedly from those of reference samples are likely to indicate maladaptive dysfunction in the aspect of personality functioning measured by this variable. However, this benchmark must be applied while recognizing that the implications of personality dispositions for psychological adjustment depend on cultural context, consisting of whatever national, ethnic, religious, neighborhood, family, or other group values have a bearing on an adolescent's subjective experience. As elaborated in Chap. 5 of this volume, recently collected Rorschach data from different countries enable clinicians to compare Rorschach findings against age-based normative data and to point out marked deviations that suggest the likelihood of adjustment difficulties of behavior problems.

With respect to the advantage of the Rorschach in distinguishing between normative and psychopathological functioning, Murray (1997) provides an illustration of a 15-year-old girl who was referred for treatment because of depressive symptoms and regressive behaviors. The complex interaction of developmental issues, situational stressors, personality dispositions, and level of organization, together with changes achieved in the course of psychotherapy, are demonstrated in this case by analysis of two Rorschach protocols: the first taken at the very onset of the girl's treatment during a period of crisis and significant regression and the second taken more than a year into her treatment. The two protocols are analyzed using both Weiner and Exner (1991) CS structural variables of personality characteristics related to changes in psychotherapy and certain content variables, as well as the language usage in her responses.

Detecting Continuities and Change from Adolescence to Adulthood

As noted, using the Rorschach in adolescents can be helpful in establishing a differential diagnosis of conditions that are conceptualized in terms of personality dispositions (e.g., impulsivity). This application makes the method particularly useful in evaluating risk factors for developing disturbed functioning and resulting disorders, such as antisocial personality disorder, in adulthood.

Generally speaking, patterns of social functioning and interpersonal relationships have substantial implications for exploring developmental continuities and

change. Contemporary psychoanalytic thinking about patterns of interpersonal relationships refers to these patterns in terms of internalized object relations, assuming that the quality of interpersonal relations and susceptibility to various types of psychopathology are affected by the maturity of the individuals' object representations. Evaluation of an adolescent's object representations should take into account that relational capacity develops progressively and that, in this developmental process, fragmented representations gradually turn into complex, differentiated, integrated, and consistent representations of self and objects (Blatt, Brenneis, Schimek, & Glick, 1976; Leichtman, 1996). This process takes place within the context of developmental tasks that reactivate the separation–individuation conflict and involve searching for a balance between autonomy and relatedness, renegotiating the threat of regressing to dependence, and reintegrating new cognitive, social, biological, and familial factors (Blatt, Tuber, & Auerbach, 1990; Bleiberg, 2001). Adolescents who fail to develop mature object representations are likely to show interpersonal problems that can evolve into a personality disorder in adulthood.

The relevance to personality disorders of continuities and change from adolescence to adulthood has clinical implications for many types of youth referral problems. As previously suggested (Tibon-Czopp, 2011, 2012), these implications are particularly important in assessing adolescents with conduct disorder (CD) and or posttraumatic stress disorder (PTSD), who are at high risk for developing antisocial personality disorder (ASPD) and borderline personality disorder (BPD), respectively. Research on ASPD generally confirms that the best predictor of antisocial behavior in adulthood is CD in adolescence (Piquero, 2011), but it also provides empirical evidence that, although similar from phenomenological perspective, CD-externalized behavioral manifestations are likely to reflect diverse psychodynamic processes, character problems, and psychopathological states. It is accordingly essential to assess thoroughly the personality structure of adolescents who show maladaptive behaviors and to pursue diagnostic clarity and an understanding of etiological issues, especially those related to the CD adolescent's proneness to develop violent delinquency and ASPD in adulthood (e.g., Fonagy, 2003; Frick, 2002; McConville & Cornell, 2003). The Rorschach is particularly useful for assessing these dispositions (Gacono & Meloy, 1994).

Capturing Personality Dynamics and Describing Patterns of Functioning

A major advantage of performance-based measures as compared to self-report inventories is their utility in elucidating personality dynamics and identifying underlying disturbances. This advantage is clearly illustrated in the Rorschach, which provides a rich source of data that reflect different aspects of cognitive and affective functioning, relational patterns, and self-perceptions, including behavioral tendencies of which people might be unaware or unwilling to expose.

As noted, the Rorschach and other performance-based methods yield information relevant to personality characteristics that are not consciously accessible when people are responding to questions asked in a clinical interview or answering a self-report inventory. For example, an adolescent referred for evaluation may acknowledge having symptoms of anxiety and obtain elevated scores on a self-report measure of anxiety, but be unable to articulate the relationship between these emotional reactions and an underlying need to obtain recognition and admiration, that are characteristics frequently captured by Rorschach reflection responses. Reflection responses in this case would alert the clinician to likely narcissistic components in the adolescent's personality dynamics that play a part in the young person's symptoms.

Furthermore, there are some personality characteristics that can be difficult to assess by using self-report inventories and inferences drawn from a clinical interview, even if this interview was conducted by an experienced clinician. For example, the tendency to react to situations with considerable emotional intensity can go unnoticed if during the interview a person does not confront a stimulus that could provoke such a reaction. Widiger, Mangine, Corbitt, Ellis, and Thomas (1995) pointed out some difficulties in assessing this trait, including the possibility that some people, when in the midst of an emotional crisis, may describe themselves in an exaggerated manner that does not represent their usual reaction patterns.

Nevertheless, the threshold for what should be defined as exaggerated is unclear. Information provided by the Rorschach may be helpful when considering these issues. For example, the ratio between form-dominated color responses and the sum of color-dominated and pure color responses ($FC:CF + C$) is a valid Rorschach marker of the capacity for affect modulation. The tendency of an adolescent to display intense and unrestrained emotional reactions might be demonstrated if he or she produces a highly skewed score on this ratio, even if the young person does not endorse self-report items measuring intense emotional reactions. However, the utility of a Rorschach variable such as the $FC:CF + C$ ratio depends on whether the dimension of personality functioning in question is adequately measured by it.

It should nevertheless be stressed that, although many personality attributes inferred from Rorschach data have important implications for diagnostic decisions (e.g., reality testing), the Rorschach is not a diagnostic tool that relates directly to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*; American Psychiatric Association, 2013). Rather, it enables clinicians to describe how various dimensions of personality form the unique personality organization and structure of an individual being tested and can be used for assessing this person's proneness to develop disorders specified as either symptomatic or personality disorders.

With respect to adolescents, clinicians who use the Rorschach in the assessment process can establish a diagnosis in terms of the three axes of the *Psychodynamic DiagnosticManual* (*PDM*; PDM Task Force, 2006). These include profile of mental functioning for children and adolescents (MCA axis), child and adolescent personality patterns and disorders (PCA axis), and child and adolescent symptom patterns and subjective experience (SCA axis). In accord with the main assumption of the *PDM* that mental health comprises more than simply the absence of symp-

toms, psychoanalytically-oriented clinicians who work with adolescents may arrive at a psychodynamic diagnosis in terms of the adolescent's capacities. These terms should include capacity for regulation, attention, and learning; capacity to develop and sustain intimate and satisfying relationships; capacity to attain a sense of vitality and realistic self-esteem that is present even during times of stress; capacity to experience and perceive a wide range of subtle emotions in a purposeful and flexible manner; capacity to use defenses and coping strategies adaptively; capacity to use internal representations to experience and regulate impulses and behavior; capacity for differentiation and integration of internal experiences (e.g., reality and fantasy, self and nonself) and emotional states; capacity to observe and reflect on a wide range of one's own and other person's feelings or experiences (psychological mindfulness); and capacity to use internal standards and ideals. The Rorschach is particularly useful for assessing these capacities (Bornstein, 2011).

As noted previously, psychoanalytically informed diagnosis refers to personality functioning in terms of the level of personality organization (see Chap. 2). For example, in adolescents functioning at the borderline level of personality organization, cognitive functioning is usually characterized by (a) failure to maintain focus due to the intrusion of irrelevant internal and/or external stimuli; (b) concrete thinking, overdependence on external stimuli, and lack of critical objectivity, with passive acceptance of circumstances; (c) lack of self-cohesiveness; and (d) boundary disturbances. Rorschach structural markers of cognitive special scores, particularly those representing incongruous combinations (e.g., *a pink bear*) are likely to capture these phenomena. What might be considered a playful and normative response in 6-year-old (e.g., *a dancing tree*) would rarely occur in the Rorschach protocol of a well-functioning adolescent (Leichtman, 1996). Comparison to age-based norms is therefore a substantial component in Rorschach assessment (see Chap. 5).

As shown in Chap. 9, the Rorschach can be particularly useful in diagnosing an adolescent who on referral presents as being anxious, depressed, and vulnerable. Based on the understanding that one of the major developmental tasks in adolescence is associated with the separation–individuation process as a part of the crystallization of the personality structure, the Rorschach protocol provides data concerning the adolescent's experience in the process and a psychodynamic diagnosis in terms of level of personality organization. The psychodynamic conceptualization can prove helpful in conducting psychodynamic psychotherapy.

The advantages of using the Rorschach for assessing adolescents are clearly demonstrated in the case studies presented by Exner and Weiner (1995) in the third volume of the CS concerning assessment with children and adolescents, which provides the basic Rorschach source for the present book. Five of the case studies in the CS third volume present Rorschach protocols of patient adolescents age 11–15 that illustrate the utility of the test for diagnostic decisions based on analyzing structural data and applying psychodynamic understanding in interpreting Rorschach data. For example, in analyzing the Rorschach protocol of a 12-year-old girl who was referred to evaluation because of immaturity and underachievement (Case 4, pp. 162–184), Exner and Weiner illustrate how the onset of schizophrenia among

children and adolescents might often be neglected or misunderstood and how the Rorschach can illuminate the underlying disorder.

Additional Rorschach protocols in the CS third volume illustrate the utility of the Rorschach for diagnostic decisions in adolescents referred for evaluation because of academic problems and inappropriate social conduct (Case 6, pp. 246–263) and those referred because of disruptive, antisocial, and violent behavior (Case 7, pp. 263–272; Case 8, pp. 302–319; Case 8, pp. 302–319). These case studies in the CS third volume (Exner & Weiner, 1995), as well as other published Rorschach case studies of adolescents (e.g., Exner and Erdberg, 2005), show how to apply an integrative approach that considers both structural data, in comparison with appropriate norms, and response content to arrive at clinical decisions and recommendations concerning young people. In line with these case studies, we suggest in Chap. 6 some interpretive guidelines for analyzing adolescents' Rorschach data, together with some case illustrations.

Toward a Multi-Method Assessment of Personality Functioning: Congruence and Complementarity

With an appreciation for the relative advantages and limitations of both self-report inventories and performance-based measures, assessment psychologists generally conclude that integrating the two kinds of tests paints a more accurate picture of an individual's personality functioning and psychopathology than using just one type of method. Such integration is consistent with recommendations made many years ago by Campbell and Fiske (1959) for multi-method assessment in psychology. Rorschach research shows that conjoint use of both kinds of instruments in assessing people of all age groups illuminates a wider range of information about mental and emotional functioning than emerges from using them separately (e.g., Ganellen, 2007; Meyer, 1997; Rosenthal, Hiller, Bornstein, Berry, & Brunell-Neuleib, 2001; Weiner, 2005, Weiner, 2013).

Historically, personality assessment in clinical practice was a highly idiographic enterprise in which individual methods were used to generate complex inferences about personality, affect, cognition, conflicts, and psychodynamics (Huprich & Meyer, 2011). Although some contemporary perspectives (e.g., Wiggins, 2003) followed the classic multi-method approach of Rapaport, Gill, and Schafer (1968), there has been an increasing emphasis on overt symptom assessment, typically through focused self-report inventories.

Despite accumulating clinical experience and empirical evidence demonstrating the advantages of using multi-method assessment in general, and with adolescents in particular, this type of assessment has not been routinely applied. Although preference for self-report inventories might be related to the nature of most performance-based tests particularly because they are quite time consuming, it is also likely that the psychoanalytic construct of *projection,* which these tests are presumed to reflect, has rendered them being devaluated in mainstream academic research. However, as

has been elaborated by Tibon-Czopp (2011, 2012), the use of performance-based methods for empirical exploration of psychodynamic constructs has substantially changed their status within the field of assessment in the twenty-first century. Psychodynamic constructs have steadily given rise to numerous useful indices derived from these methods. The psychometric soundness of many of these indices shows that statements about a lack of empirically validated psychodynamic tools are neither accurate nor relevant for personality assessment (for further discussion see Chap. 5).

Nevertheless, from a practitioner's point of view, question might be raised about the extent to which Rorschach assessment is really necessary to obtain a comprehensive and reliable picture of the personality functioning of an adolescent seen in clinical practice. One might argue that a thorough clinical interview and a self-report inventory (e.g., the MMPI-A), used jointly with other sources of information (i.e., parental and school reports, previous treatment experiences), would render the information obtained by Rorschach testing redundant and of little use. If so, the time and expense of conducting a Rorschach assessment would be difficult to justify. To the contrary, however, accumulated evidence has shown that including the Rorschach in the assessment process enables clinicians who work with adolescents to expand their understanding of a young person's symptom patterns, whether of biological or experiential origin, within the broad context of the individual's developing personality an understanding that is essential for providing professional interventions that meet the particular adolescent's needs for help.

The advantages of including the Rorschach in a multi-method assessment of adolescents' functioning derive from several aspects of Rorschach assessment that have received considerable attention in the literature and define the basic nature of the task. Rorschach assessment constitutes a multifaceted, evidence-based method of data collection that comprises both objective and subjective features, measures both perceptual and associational processes, and provides information on both structural and psychodynamic aspects of personality functioning (Weiner, 2003).

In assessing adolescents, the combination and convergence of Rorschach structural, thematic, and sequential data, together with the clinicians' observations on patient–examiner relationships during the administration of the test, illuminate not only the personality dispositions that contribute to the current difficulties of the patient, but also the conditions under which a therapeutic alliance might be facilitated. Bram (2010) suggests that generating such ideas about how an adolescent is "put together" or internally organized increases the clinician's understanding of who this adolescent is, beyond the presenting symptoms, and is an efficient way of enlarging on what might have been learned in the course of a clinical interview, administration of self-report inventories, and even some initial therapy.

It should be stressed, however, that the relative contribution of self-report inventories and the Rorschach or any other performance-based method to clinical decision-making in the individual case can rarely be known before the test data are in hand. What can be known in advance is that personality assessment proceeds most effectively when the tests used measure both mental states and trait characteristics, provide sufficiently extensive data to warrant drawing

inferences from them, and include adequate procedures for detecting or minimizing impression management.

Weiner (2013) states that, because of the method difference, conjoint use of self-report inventories and performance-based methods can enrich personality evaluations and facilitate clinical decision-making by virtue of either congruent or complementary findings. Congruent findings point to the same or similar personality characteristics. Except for data that are invalidated by impression management, congruence provides a strong indication (a) that certain characteristics are present and recognized by the person being evaluated and (b) that these characteristics are likely to be evident in both relatively structured and relatively unstructured situation. Should both self-report inventories and performance-based methods point to a substantial psychological disturbance, for example, respondents are likely to be disturbed, to be aware of their disturbance, and to show this disturbance in a variety of contexts, both structured and unstructured. The same can be said for virtually any personality state or trait, such as being an anxious, depressed, dependent, or emotionally reserved person.

In general, phenomena that are sufficiently notable to appear in both self-report and performance-based test data are confirmatory findings that clarify the personality picture of the adolescent patient. Accordingly, clear indications from diverse sources of information about specific characteristics that exist in a patient, are recognized by this patient, and are broadly manifest in this patient's behavior increase the confidence and certainty with which examiners can draw diagnostic inferences, formulate treatment recommendations, and comment on decision-making issues of various kinds.

Whereas congruence between self-report inventories and performance-based measures clarifies the personality picture and facilitates clinical decision-making, divergence in these data complicates the interpretive process. However, being divergent does not mean being contradictory nor does complexity preclude clear clinical conclusions. To the contrary, valid self-report and performance-based test data are both meaningful in their own right, and divergent findings do not signify that inferences based on one type of measure should be accepted and inferences based on the other should be discarded. Instead, divergence between measures provides information that can and should be used in clinical decision-making, and poses the question of why a respondent has shown different characteristics or a different extent of specific characteristics on the two kinds of measures. The possible answers to this question enrich rather than detract from what examiners can learn about people from their responses to a multifaceted test battery. Among other possibilities, divergent test findings may be tapping different aspects of particular personality characteristics, and they may be reflecting respondents' attitudes toward ambiguity (i.e., relatively comfortable or uncomfortable with it) and their level of self-awareness and openness.

This chapter has reviewed the conceptual and empirical basis for a multi-method approach to personality assessment that integrates in addition to a clinical interview two kinds of psychological tests: self-report inventories and performance-based measures. We pointed out the advantages of the Rorschach, which in combination with

self-report inventories, can add substantial features to the assessment of personality characteristics in adolescents by establishing boundaries between normal and abnormal functioning, by demonstrating whether an adolescent has some enduring maladaptive personality characteristics that hinder effective functioning or cause significant subjective distress, and by applying these formulations to clinical decision-making, treatment planning, and the evaluation of therapeutic change. We suggest that, even though there may not be a direct relation between *DSM* criteria and Rorschach variables, information provided by the Rorschach complements and in some cases enlarges on the information obtained from other sources for establishing a *DSM* diagnosis. The Rorschach additionally provides substantial source of data for establishing a *PDM* diagnosis.

Conclusion

Personality assessment with psychological tests should be guided by three considerations. First, because self-report and performance-based tests measure personality characteristics in different and complementary ways, the assessment process should include and integrate both kinds of instruments. Specifically, self-report tests are direct and explicit measures that are particularly sensitive to personality characteristics people recognize in themselves and are willing to report, whereas performance-based tests are indirect and implicit methods that are particularly sensitive to underlying attitudes and concerns of which people are unaware or reluctant to report.

Second, with respect to Rorschach assessment, the interpretive process should take into account and integrate structural, thematic, and behavioral features of the test responses. Failure to consider all three response characteristics and attend to both quantitative and qualitative features of the data ignores valuable information and limits the utility of the assessment.

Third, with regard to Rorschach assessment of adolescents, interpretation of the findings should attend to age-related reference norms and the cultural context of the young person being examined. Rorschach variables always reflect the same personality characteristics, but the implications of these characteristics for adjustment difficulties depend on normative expectations for persons of similar age, country, ethnic group, family, and neighborhood.

In summary, the preceding discussion indicates how and why drawing inferences from a multi-method assessment approach that includes the Rorschach improves the accuracy and utility of conclusions about an adolescent's personality functioning, adjustment problems, and treatment needs. However, because personality characteristics are not yet fully developed in adolescence, these conclusions should address not only present personality functioning, but also the likelihood of continuities and change as the young person matures into adulthood.

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Part II
The Rorschach Inkblot Method: Theory, Research, and Practice

Chapter 4
The Rorschach Inkblot Method: Theory

Rorschach interpretation is a complex and intriguing process. It requires a theoretically based conceptualization of how responses to the inkblots reflect mental states and personality traits. Weiner (1986) suggests that searching for a conceptual linkage between test findings and behaviors associated with them, which may not be readily apparent, is a substantial component of the interpretive process. As noted in Chap. 3, the phenomena occurring during Rorschach assessment provide considerable data that are not readily accessible in other methods of assessment. Particularly important in this regard is the utility of conceptually informed inferences that help clinicians translate referral questions and diagnostic criteria into personality dispositions and communicate their diagnostic impressions effectively. From an intellectual perspective, however, this approach offers practitioners the scholarly satisfaction of understanding why the test works as it does, beyond knowing only how it works on the basis of empirically supported inferences. In a broader sense, conceptually based inferences provide a framework for understanding human behavior and the etiology of psychological disorders.

The basic issues to be explored in conceptually informed assessment practice are thus related to the nature of the Rorschach task and to the respondent's functioning on this task: why a particular subject perceives the inkblots in a certain manner and how this manner can be translated into psychodynamic understanding of symptom formation. By posing these questions, practitioners can move beyond empirically based interpretations based on normative findings to conceptual formulations of personality structures and processes that are essential for arriving at meaningful diagnostic conclusions. The key to justifying inferences drawn from Rorschach responses becomes a theoretical construct that provides a link between an aspect of these responses to the inkblots and an aspect of personality functioning that these responses are presumed to measure. However, as discussed in Chap. 2, the interpretation of Rorschach findings in adolescents is particularly complicated and involves as well the application of developmental theory to distinguish between healthy and disturbed personality functioning.

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Conceptual Perspectives on the Nature of the Rorschach Task

The most remarkable aspect of Rorschach literature is how little attention has been paid to theoretical perspectives on the nature of the task (Leichtman, 1996). Rorschach (1921/1942) described his conceptualization of the inkblot experiment as measuring a particular form of perception while acknowledging that the theoretical foundations needed further exploration. The seemingly speculative nature of the interpretive process, in which responses to the inkblots are analyzed in terms of personality characteristics, psychodynamic processes and subjective experience, has frequently raised question about how these elusive constructs and complex phenomena can be interpreted from a person's responses to these ambiguous stimuli.

Weiner and Greene (2008) summarize conceptual perspectives on the nature of the Rorschach task in terms of three sources of information in the test data:

1. The Rorschach Inkblot Method is a perceptual task that provides information on how individuals perceive external reality. In this regard, the CS approach (Exner, 1974, 2003; Exner & Weiner, 1995) suggests that a perceptual act is at the core of each Rorschach response. Nevertheless, the task is to "misperceive" the blot, that is, to say that it looks like something when it is only an inkblot. Accordingly, inferences are drawn on the basis of (a) how much the Rorschach responses in a given protocol deviate from what is considered to be acceptable misperception, (b) which clues in the stimulus (the inkblot) made it look like the deviant perceptual impressions, and (c) what patterns of personality functioning are reflected in the use of these external clues.
2. The Rorschach presents an associational task that is conducted within an interpersonal context and generates content themes that provide clues to psychodynamic processes. This conceptualization, which invokes a psychoanalytic perspective in the understanding of the Rorschach task (e.g., Blatt, 1990; Leichtman, 1996; Lerner, 1998; Rapaport, Gill, & Schafer, 1968; Schachtel, 2001, Schafer, 1954), suggests that the projection of internal representations and subjective experiences onto the external stimuli (the inkblots) has a crucial effect on what the blots look like and how much the reported percepts fit the external stimuli. The associative perspective illuminates the structure, psychodynamic processes and subjective experience of personality functioning.
3. The Rorschach is a decision-making and problem-solving task conducted within an interpersonal context. This conceptual perspective suggests that, by integrating perception and association, the individual being tested restructures the stimulus and decides on a solution for the problem of saying what the inkblot might be, and communicates this solution to the examiner. To communicate the selected response, the individual uses verbal language. In this respect, Rorschach responses reflect a *dual coding* (Bucci, 1985) process in which nonverbal, image representations are integrated with verbal, linguistic features. Furthermore, being conducted within an interpersonal context, the Rorschach task makes it likely that interventions of the examiner are experienced as having an interpersonal meaning and may influence response content (Gill, 1995).

The decision-making aspects of the Rorschach task are thus particularly helpful in providing clues to the person's behavioral patterns in interpersonal situations.

These three conceptual perspectives on the nature of the Rorschach task are complementary and, as such, should be used jointly in the interpretive process. The basic assumption in Rorschach assessment is that the inkblot stimuli are assimilated into an organizational scheme shaped by a person's unique experience. When the effect of external properties of a stimulus is reduced as in the case of an inkblot, subjective aspects of perception become increasingly prominent and likely to point out elements of personality structure and psychodynamic processes. Recent neurobiological research conducted with advanced technology appears to provide some basis for understanding how the visual stimulus properties of the Rorschach inkblots reflect internal representations. What this means is that the Rorschach stimulus, which is assumed to be emotionally arousing, captures implicit schemas about one's experiential world (e.g., self and other representations) that in some people are quite different from their explicit, conscious conceptions.

This research relating neuroscience findings to performance on the Rorschach task is currently developing but there are already studies showing a link between brain activity and Rorschach percepts, including percepts involving feelings of movement (e.g., Giromini, Porcelli, Viglione, Parolin, & Pineda, 2010) or affective responsiveness (e.g., Asari et al., 2010; Jimura, Konishi, Asari, & Miyashita, 2009). These findings add important information about differences between the verbal stimulus of self-report inventories for assessing personality functioning, in which left hemisphere functions are activated and the visual stimulus of performance-based methods.

In general, the inkblot stimuli and the nature of the Rorschach instructions *(What might this be?)* present a task that calls for a dialectal process involving both internal and external experiences. In this process, the blots are simultaneously perceived and misperceived, created and discovered, involving the mental processes of both perception and projection. Some people may have difficulty providing responses to the inkblots. They may begin their responses by insisting that the stimulus is just an inkblot, or they may deny responses they have already given. Their explanations during the inquiry may be limited to cataloging which parts of the percept are present or not present. They operate as keen observers who would note, for example, what should be added to Card I to make it look like a real bat (Smith, 1990). These responders do not adapt to the basic task of the test, which is to "misperceive" the stimulus. They have limited capacity of coping with reality beyond the threshold where perception as recognition becomes perception as interpretation (Leichtman, 1996).

From the point of view of thought organization, the fluctuating psychic levels from perception to projection appear to involve shifts between reality and fantasy. Each Rorschach response is not a creation from scratch, but instead combines finding meaning and giving meaning (Schafer, 1954). Accordingly, Rorschach responses reflect the dynamic process of thinking as it moves across various content areas and different levels of thought organization (Blatt, 1990). The interpretations drawn

from Rorschach data are therefore both representative and symbolic. Representative interpretations are based on perceptual processes (e.g., accurate perception) and tend to be closely related to observed behaviors. Symbolic interpretations, on the other hand, are based on projective processes (e.g., seeing human or animal figures in movement or describing their emotional state), are more speculative than representative interpretations, and are suitable for generating hypotheses more than predicting specific behaviors (Weiner, 2003).

Applying Psychoanalytic Perspectives on Personality Functioning in the Interpretation of Data

Traditionally, models for describing the aspects of personality functioning that Rorschach responses reflect have involved two approaches. An empirically based approach has focused on cognitive-behavioral aspects of how people deal with outer reality (the inkblot stimulus), whereas a psychodynamic approach has focused more on the experiential aspects of inner reality and on underlying thoughts and feelings that are reflected in response content. The most prominent example of an empirically based Rorschach model has been the Comprehensive System (CS; Exner, 1974, 2003; Exner & Weiner, 1995). As noted in Chapter 1, some authors (e.g., Mihura et al., 2013; Sugarman, 1991) concluded from Exner's description of creating the CS that it represents an "atheoretical" approach and fails to apply a conceptual linkage between test findings and personality functioning. This criticism has proved unjustified, at least for the majority of CS variables (Kleiger, 1992). In this regard, Weiner's paradigm for interpretation (e.g., Weiner, 1986, 2003; Weiner & Greene, 2008) demonstrates the advantages of integrating the empirically based CS with psychoanalytic perspectives.

The following illustration shows how CS-based interpretations can involve conceptually based assumptions about psychodynamic processes. Suppose an adolescent produces a protocol with a relatively elevated number of form-dominated color responses compared to the number of less-structured color responses ($FC > CF + C$), which is interpreted to suggest a reserved pattern of emotional discharge, regardless of the age of the individual being tested (e.g., Weiner & Greene, 2008). This type of interpretation assumes a linkage between color and affective functioning (e.g., Shapiro, 1956), as well as the use of form (F) as indicating cognitive control over emotional discharge (e.g., Schachtel, 1967). A developmental perspective (e.g., Leichtman, 1996) would further enrich this interpretation by conceptualizing how a normally developed adolescent is likely to respond to the Rorschach task. That is, normative data would be used to confirm the expectation that young people who produce Rorschach protocols with an elevation in form-dominated color responses tend to be less impulsive and more emotionally reserved than their peers who give more numerous color-dominated responses (Exner & Weiner, 1995; Exner & Erdberg, 2005).

Conceptualization of personality functioning as reflected in Rorschach data has commonly been based on a variety in psychodynamic formulations. However, this does not mean that the interpretation of a Rorschach protocol must necessarily follow directly any particular psychoanalytic perspective. Rather, Rorschach-based inferences can be translated into any theoretical model, their only necessity being consistency with findings that validate them. Deciding which theoretical concepts to select for understanding a specific case depends on the clinician's preferred approach and also on the nature of the referral question and the goals of the assessment.

As in therapy, however, defining goals is itself a challenging task. Chap. 11 that defining the goals of assessment in a psychoanalytic-oriented practice begins with the premise that any assessment process can and should be essentially therapeutic. Accordingly, the process would be conceptualized as being primarily person oriented and experience near while preserving, with any necessary adaptations, the standardized guidelines for test administration and an adequate balance of *asymmetry–mutuality* (Aron, 1992) between the two persons involved in the encounter.

As noted in Chap. 1, psychoanalytic approaches for interpreting the Rorschach were elaborated in particular by Rapaport (1967), who pioneered in applying principles of ego psychology to diagnostic testing. However, significant shifts toward variety in psychoanalytic perspectives on personality functioning influenced Rorschach theorists to begin applying newly emerging psychodynamic concepts. These new concepts complemented and were not incompatible with Rapaport's approach, and they expanded the contribution of psychoanalytic formulations to the understanding of Rorschach responses.

Similarly to Pine (1988), who combined elements of diverse psychoanalytic theories to create a set of guidelines that can be used flexibly to construct an integrative picture of personality functioning, applying multiple theoretical perspectives in interpreting a Rorschach protocol can broaden the clinician's understanding of a respondent's personality organization. The discussion that follows presents four major psychoanalytic perspectives for interpreting Rorschach data. These include ego psychology, object relations theory, self psychology and relational psychoanalysis. For each of these perspectives, we relate some of its major concepts to developmental issues in adolescents, and describe its terms of reference for providing a psychodynamic diagnosis. The discussion also delineates selected Rorschach variables that have particular implications for these perspectives.

Ego Psychology

The ego psychology model, with its focus on adaptation to external reality, fostered the psychoanalytic investigation of key processes in normal development (Mitchell & Black, 1995). Although the concept of adaptation was initially elaborated by Hartmann (1939) in his essay *Ego Psychology and the Problem of Adaptation*, classical Freudian theory also included an implicit adaptational point of view. Nevertheless, Hartman's conception of the individual as being born with

potentiality to adapt to the external environment is consistent with structural psychoanalytic theory, in which the ego is conceived as the major means by which the psyche adapts to external reality. According to the ego psychology model, adaptation is evaluated by assessing the maturational level of an individual's ego functions, including thought processes, reality testing, judgment, affect regulation, defenses, impulse control, object relations, and integration or synthesis. Additionally, the adaptive adequacy of a specific behavior must be described in terms both of the current level of functioning as reflected in this behavior and its developmental origins. Not uncommonly, the maturational level of a person's ego functioning may change from time to time to serve some adaptive purpose and quite different or even totally unrelated to the developmental level originally obtained (Noam & Malti, 2010). Two types of relationship between adaptive ego functioning and developmental processes are central to ego psychology conceptualization. One is *progressive adaptation*, which occurs along expected developmental lines, and the other is *regressive adaptation*, which can be a temporary detour "in the service of the ego" (Kris, 1934) and runs counter to expected developmental advance.

In accord with this theoretical perspective, ego-related concepts became a major topic in developmental psychoanalysis. Some authors suggested that, instead of viewing character formation as beginning at birth, it is more useful to define this process as a developmental step that normally starts during latency and continues through adolescence (e.g., Baudry, 1995). Ego development has generally been utilized as a broad theoretical construct that describes the changing organization of an individual's management of psychosocial developmental tasks (Noam & Malti, 2010). Clinical evidence suggests that a considerable level of ego development, including capacities for neutralization, internalization, self-object differentiation, and formation of ideals, is necessary for the formation of a stable and integrated character. There is also general agreement that character formation cannot be completed until before the various conflicts of adolescence have been resolved. Clinicians and theorists who use concepts derived from ego psychology for understanding personality functioning in adolescence stress the development of elements of decision-making, problem-solving, and competence as playing a major role in character formation.

These concepts have constituted a framework for distinguishing between healthy and psychopathological functioning in adolescents and for exploring continuities and changes from adolescence to adulthood (Weiner, 1986). As has been noted, Rapaport's (1967) work originated the application of theoretical constructs derived from ego psychology to exploring data of psychological testing. With the inception of the empirically based Rorschach CS, clinicians commonly utilized this interpretive paradigm, which organizes and integrates test data around concepts derived from ego psychology, by examining the extent to which CS variables show adaptive ego functioning. Researchers have also developed new Rorschach CS indices based on ego psychology, a valuable example of which is the *Ego Impairment Index* (*EII-2*; Viglione, Perry, & Meyer, 2003). The *EII-2* has consistently proved valid in distinguishing nonpatients from patients with psychological disorders (Diener et al., 2011).

Applying ego psychology concepts to the interpretation of adolescents' responses to the Rorschach task provides clinicians with theoretically based guidelines for organizing the findings around the notion of ego functions. This theoretical approach can be used to arrive at a psychodynamic diagnosis in terms of personality structure, which would fit into the profile of mental functioning for children and adolescents (MCA axis) of the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006). Concepts related to ego development can be helpful in distinguishing between healthy and psychopathological functioning. Moreover, an observed ego dysfunction that is reflected in Rorschach findings (e.g., impaired ideation) can be explored with respect to its implications for diagnosis (e.g., schizophrenic-spectrum disorder or dissociative disorder) and accordingly be interpreted as demonstrating developmental fixation or adaptive regression. These concepts can be particularly useful for evaluating continuities and change from adolescence to adulthood (Tibon-Czopp, 2012).

Object Relations Theory

Interest in assessing object relations and their impact on psychopathological functioning has substantially increased since the construct first appeared on the psychoanalytic scene and became a major psychoanalytic term used for understanding personality functioning (Huprich & Greenberg, 2003). The original ideas of Klein (1930) about the internal object world and the importance of symbol formation were further developed by numerous psychoanalytic theorists (e.g., Kernberg, 1976; Ogden, 1989; Winnicott, 1971) into a vast array of complex and elusive constructs such as *object representations, transitional object, and autistic object.* Some of these constructs are derived from a mixed theoretical model (Greenberg & Mitchell, 1983), but all of them preserve the classical psychoanalytic understanding of the nature of drive (Gill, 1995).

Greenberg and Mitchell (1983) define object relations as "an individual's interactions with external and internal (real and imagined) other people, and the relationship between their internal and external object worlds" (pp. 13–14). With the increasing recognition of the distinction between external and internal object relations, this perspective has received growing attention as a key factor in the personality picture of adolescents, even though there have been methodological problems in translating the construct into measurable indices. This growing attention has been striking, given the breadth and complexity of the construct (Huprich & Greenberg, 2003).

Mental representations have become a major topic in the Rorschach psychoanalytic literature dealing with developing personality organization in adolescents. Cognitive capacities, affective experience, self-images, and interpersonal relationships are all viewed as being related to a child's earliest experiences with significant objects. Furthermore, vulnerability to regression to earlier modes of relating, which usually arises when conflicts from previous phases of development reemerge, is

considered particularly characteristic of adolescents, who normatively show exacerbated dependency needs, resistance against these needs, and the resulting conflicts concerning independence. However, there are some conceptual issues involved in transporting this theoretical construct to clinical practice that should be addressed in assessing object relations in adolescents. For example, it is unclear to what extent object relations represent fixed cognitive structures that might be subjected to modification and, if not fixed, the conditions under which they can be changed or modified (Huprich & Greenberg, 2003). What is clear, on the other hand, is that object relations and their representations are not fully accessible to consciousness and therefore cannot be assessed solely by self-report measures. Instead, the assessment of these representations require as well the use of implicit performance-based methods (e.g., Blatt et al., 1988; Stricker & Healey, 1990; Westen, 1991).

Concepts of object relations theory and Rorschach markers that are assumed to reflect them include representations of self and other and the cognitive and affective phenomena associated with them. These representations may involve a focus on several different aspects, including separateness of the self from the object, affective links between self representations and object representations, the cognitive level of mental representations and the level of ego functioning they reflect, and various functional features of the representations (Lerner, 1998). Developmental aspects of object relations that can be assessed by using the Rorschach have also been explored (e.g., Blatt et al., 1997). As an important recent example, neuropsychological studies (e.g., Schore, 2009) have suggested that early attachment experiences influence critical areas of brain development and that the right hemisphere is dominant for processing attachment and affective experiences and the resulting object representations.

Indeed, empirical research and accumulated clinical experience have demonstrated the utility of several CS variables, especially those included in the interpersonal cluster of the Structural Summary, and of such non-CS scales as the Mutuality of Autonomy Scale (*MOA*; Urist, 1977) for providing clinicians a glimpse into a person's object relations. For example, individuals whose inner world is populated by fragmented part objects tend to give numerous fragmented percepts that are notable for their discontinuity and might indicate dissociative disorders.

Self Psychology

The major concepts of self psychology evolved as a paradigm shift in the prevailing psychoanalytic models. By the 1960s, practitioners were reporting that the existing models failed to describe the main complaints of some of their patients. Rather than showing difficulties related to inadequate adaptation or separation–individuation conflict that could be explained in terms of ego psychology and object relations theory, respectively, these patients lacked a sense of inner direction and self-confidence despite being apparently well adapted and even demonstrating impressive

personality functioning. They were observed to be constantly searching for reassurance, acceptance, and admiration, apparently seeking compensation for an empty and depleted internal experience. With their chronic need for mirroring from outside sources, these patients were regarded by psychoanalytically oriented practitioners as essentially narcissistic and lacking a sense of authentic, subjective experience (McWilliams, 1994).

In response to this new type of difficulty seen in a growing group of patients, Kohut (1971) reconceptualized personality disorders as disturbances of self-cohesion and established the theoretical paradigm of self psychology, which postulates a psychoanalytic psychology predicated on the primacy of deficit rather than the centrality of psychic conflicts. The self psychology paradigm focuses on the three normal needs of mirroring, idealizing, and twinship. In the absence of responsive and empathic figures who can meet these three needs during childhood and adolescence, people are vulnerable to experiencing severe threat to their self-cohesion, to which they tend to respond by various maladaptive pathways for sustaining self-esteem, forestalling fragmentation, and preserving a satisfied self (Silverstein, 2006).

This conceptualization of self-developmental processes and their possible distortions has been applied in assessing adolescents' susceptibility to developing personality disorders in adulthood as well as in diagnosing severe mental disorders such as schizophrenia during adolescence. In this regard, schizophrenia-spectrum disorders in adolescents involve an impaired reflexive self-awareness in which confusion and perplexity prevail, as if a sense of identity were lacking altogether. Among adolescents with borderline-spectrum disorders, by contrast, a sense of identity exists but is usually unstable and highly reactive to changes in mood (Kohut & Elson, 1987). Such differences in psychopathological manifestations, which have crucial implications in clinical practice with adolescents, are usually quite evident in Rorschach configurational analysis involving behavioral observations, CS structural variables, response content, and sequence analysis (Peebles-Kleiger, 2002; Weiner, 2003).

The new self psychology language has been gradually integrated into psychodynamically oriented Rorschach assessment and has added a substantial component to experientially oriented approaches in evaluating personality functioning (Lerner, 1998). Practitioners began to recognize that psychodynamic psychotherapy aimed at supporting self-cohesion can be observed even in adolescents who are not notable for their overall level of narcissism. Furthermore, some *DSM* diagnostic categories, particularly those delineating faltering personality development, can be reconceptualized in terms of disorders of the self (Silverstein, 2006) by implementing self psychology concepts in Rorschach work.

In this regard, the contents of Rorschach responses can be particularly illuminating with respect to the subjective experience of the self (Lerner, 1998; Silverstein, 1999). Percepts like *a dry leaf* and *a broken glass*, when interpreted within the conceptual paradigm of self psychology, can be considered to reflect an internal experience of a devitalized or fragmented self, respectively. Elaborations or response embellishments can also have a revealing narrative quality, even when

they are not so unusual as to be coded as a deviant response (*DR*). Applying sequence analysis (Peebles-Kleiger, 2002; Weiner, 2003) can further illuminate psychodynamic processes by indicating the experience of an injured self (e.g., *a wounded butterfly*) together with the compensatory defenses employed to ease this experience. These qualitative data complement and expand on what is learned from the Structural Summary about one's self experience.

Relational Psychoanalysis

The tradition that has come to be known as relational psychoanalysis (Mitchell, 1988, 2000) reflects a blending of diverse theories into a broad, multidimensional model of understanding personality functioning. This model includes concepts derived from intersubjective, object relations, and self-psychology theories that commonly depart from the classical psychoanalytic vision of mind by applying dialectical thinking for understanding human experiences specifically within an interpersonal context. The model takes into account both experiential and innate factors probably more equally in practice than in theory: the experiential is viewed as shaping the innate and the innate as shaping the experiential (Gill, 1995). Because of the varied approaches by which relational psychoanalysis has been inspired, it does not constitute a separate psychoanalytic school, in the traditional meaning of the term. However, this problem of definition has made the relational model useful in molding a professional and intellectual experience free of the constraining impact of a specific school of thought (Berman, 1997).

The relational vision suggests that all psychological phenomena, concepts, categories, and activities should be conceptualized as being dialectical rather than discrete and dichotomous. In line with this conceptualization, apparently clear dichotomized phenomena such as reality and fantasy, me and not me, and self and object are not at odds with each other, but rather involved in a constant dialectical tension that promotes healthy personality functioning. Mitchell (2000) states that fantasy and reality are usually understood as incompatible. However, separating fantasy and reality is only one possibility to construct and organize experience. For experience to be meaningful, vital, and robust, fantasy and reality cannot be fully distinguished from each other. Fantasy cut adrift from reality becomes threatening. Reality cut adrift from fantasy becomes vapid. Meaning in human experience is generated by a mutual, dialectical, and enriching tension between reality and fantasy. Accordingly, healthy functioning would be demonstrated in adolescents who manage to separate their own psychic reality from that of other people while adequately maintaining an intermediate, transitional space (Winnicott, 1971) where reality and fantasy are perceived as separate yet interrelated.

The *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006) describes the capacity for differentiation and integration as one of the crucial areas to be assessed while evaluating mental functioning of children and adolescents (MCA axis). This capacity has usually been explored in terms of the relational model (e.g., Fonagy &

Target, 1996; Greenspan & Shanker, 2007). As noted in Chap. 2, adolescence brings with it a clear recognition of the divergences between inner self and outer appearance, together with a developing capacity for differentiating and integrating these divergent and even contradictory aspects of the self (e.g., internal affect states and overt behavior). With psychological development the adolescent's representational world becomes increasingly differentiated and integrated, as a reflection of a growing appreciation of mutual relatedness.

Applying a relational model enables practitioners to distinguish between adolescents who are able to create bridges between internal experiences of self and nonself; self and others; reality and fantasy; past, present, and future; and a range of affective states from those of adolescents whose internal experience is fragmented most of the time and who consequently show severe impairment in ego strength, self-cohesion, and reality testing. In Rorschach terms, both a literal and concrete approach to the task and an overwhelmed approach loaded with fantasy demonstrate substantially impaired personality functioning. In contrast, playfulness shown in Rorschach responses is likely to indicate healthy functioning (Handler, 1999).

Smith (1990) applied Winnicott's (1971) construct of potential or transitional space between reality and fantasy and Ogden's (1986) description of psychopathological states in terms of collapse of potential space to the interpretation of Rorschach findings. The Rorschach Reality–Fantasy Scale Version 2.0 (*RFS-2*; Tibon-Czopp, Appel, & Zeligman, 2015) operationalizes Smith's conceptualization of diagnosing psychopathological states with the Rorschach and is particularly applicable in assessing adolescents' patterns of functioning in terms of the *PDM* criteria of differentiation and integration.

Another example of Rorschach interpretation applying a contemporary relational approach that is consistent with the empirical features of the CS has been provided by Overton (2000), who focused specifically on color determinants and the *FC:CF+C* ratio. This approach traces back to Schachtel (1967), who argued that how one perceives other people reveals the quality of relatedness between oneself and others. Accordingly, it is assumed that a developmental sequence of relatedness (perceptual-relatedness modes) is linked to the Rorschach color determinants and defines the expected or normative course of relatedness. Relatedness levels and the developmental transitions between them are described in Piaget's (1954) terms as the underlying assimilation and accommodation processes. Within this general approach, the *FC:CF+C* ratio is defined as reflecting four fundamental styles of relating to one's interpersonal environment, including healthy, egocentric, veneered egocentric, and defensive patterns of relatedness.

With respect to the interpersonal context of the assessment encounter, the relational tradition has replaced the classical authoritative, neutral, and objective stance of the practitioner with more mutual even though still asymmetric relationships (Aron, 1992; Mitchell, 2000). According to relational psychoanalysis the clinical encounter is viewed as *Meeting of Minds* (Aron, 1996) in which the analyst explores personality functioning by applying a two-person psychology model. Corresponding to this perspective, a two-person Rorschach model portrays interaction and enactment as unavoidable features of the assessment process.

This does not mean that classical and relational psychoanalytic theories are incompatible in either psychotherapy or personality assessment. Although some theorists would argue that the relational view of the practitioner as a *participant observer* (Sullivan, 1953) is very different from the image of an objective interpreter, the richness of the classical tradition can certainly be preserved by reformulating its clinical contributions within an interactive, relational theory of mind and moving toward an integrated complementary perspective (Gill, 1995).

As discussed in Chap. 3, interpersonal factors play an important part in fostering cooperation in adolescents who are referred to assessment. Moreover, adolescents' behavior within the interpersonal context of the assessment encounter, and not only the structural data and content of their responses, provide information about the quality of their mode of coping with reality, maladaptive immersion in fantasy, and object relations. Furthermore, applying a relational model to Rorschach assessment with adolescents illuminates the issues explored by Rorschach theorists concerning the interpersonal factor involved in the nature of the task, which should be considered while interpreting the data. The interpersonal factor includes but transcends what is known as behavioral observation by taking into account that the respondent's behavior in the test occurs in a particular interpersonal context. This interpersonal matrix enables clinicians to use the assessment alliance as a screen test.

Emphasis on the centrality of the development of mental representation in personality organization, on the one hand, and on different psychoanalytic perspectives, on the other, has enhanced the use of the Rorschach in presenting case studies of adolescents (e.g., Bram, 2010; Exner & Erdberg, 2005; Exner & Weiner, 1995; Viglione, 1990). Analyses of these case studies are based on the theoretical assumption that psychological development moves toward the emergence of a consolidated, integrated, and individuated sense of self-definition and empathically attuned, mutual relatedness with significant figures (Aron, 1996; Blatt, 1991; Mitchell, 1988; Stern, 1985). From this perspective, differentiation and relatedness are viewed as interactive dimensions. The dialectical interaction between these two dimensions facilitates the emergence and consolidation of increasingly mature levels of both self-organization and intersubjective relatedness.

We have presented four different psychoanalytic perspectives based on ego psychology, object relations theory, self psychology and relational psychoanalysis that, although sometimes being viewed as essentially contradictory, can be used jointly in the interpretation of an adolescent's Rorschach protocol. To illustrate this joint approach, consider the following response of a 14-year-old boy to Card X: "*Looks like all kinds of things…clothes, toys in many colors that are being thrown all over the place by an angry little boy who got a chocolate candy shaped like a bird…he wanted a lion…he's not seen in the picture. I can imagine he's sitting here in the middle throwing things all over the room*" The content of this response reflects childish outburst of rage suggesting unregulated affect that appears at odds with its CS scoring of *W+ mp.FCo (A) Sc, Cg, Fd AG, DR1* 5.5, in which the form-dominated color (*FC*) indicates capacity for mature affect modulation. The conflict between the stormy response to frustration ("*throwing things all over the room"*) and the

apparent capacity to modulate affect, as inferred from the contrast between the content and the scoring of this response, may well have caused internal tension, which is reflected in the passive inanimate movement (*mp*).

How can each of the four theoretical perspectives enrich our understanding of the affective functioning of this adolescent? From an ego psychology perspective, we can see an uneven maturational level of this boy's affective ego function, which is consistent with developmental expectation in a 14-year-old adolescent. It is nevertheless reasonable to hypothesize that the unregulated affect in the response is secondary to some intrapsychic conflict and that his lapse in ego functioning (as shown by some dissociated thinking coded as *DR1*) is related to particular stimulus characteristics (e.g., the color in the blot) or specific dynamic themes (e.g., concerns around aggression or dependency). From an object relations perspective, the content of this response raises questions about the possible role in his adjustment difficulties of unmet dependency needs, as indicated by the *Food* (*Fd*) content ("a chocolate candy") and the experience of frustrating object relations.

Applying self psychology concepts would further illuminate the narcissistic injury ("*I can imagine he's sitting here in the middle"*), the experience of being invisible (*"he's not seen"*), and the ineffectiveness of using devaluation and idealization (*"a bird and a lion"*) as defensive strategies that can be viewed in terms of prominent deficits and empathic failure resulting in narcissistic rage. Looking at the response from a relational psychoanalysis perspective would provide a glimpse of the style of this adolescent's relatedness to his interpersonal environment and, most importantly, how a suitable therapeutic alliance might enable the emergence of more mature levels of personality organization.

Clinical practice usually requires movement beyond the strictly empirical evidence into a theory-derived inference. The main complaints of this adolescent on referral were consistent with a *DSM* diagnosis of depression. This diagnosis would be sufficient for a clinician who takes a unitary etiologic and therapeutic stance toward all adolescent patients. However, more sophisticated assessment would take into consideration that there are many sources of depression and that the subjective experience of adolescents who meet the *DSM* criteria for diagnosis of depression is likely to vary from one adolescent to another. In keeping with this multi-model approach to assessment, analyzing the adolescent's response to Card X from four perspectives has generated the hypothesis that, in this particular case, the depression was a manifestation of an underlying narcissistic disorder.

In summary, we have presented this brief case excerpt to illustrate an integrative theoretical paradigm for interpreting Rorschach data. In this multi-model approach the Rorschach protocol is analyzed within the framework of a conceptual understanding of psychopathology and personality functioning in adolescence from four psychoanalytic perspectives that are sometimes held to be contradictory. Our recommendation for integrating diverse conceptual perspectives derives from the clinical purpose of this book and from our observation that most clinicians search to assimilate a diversity of approaches and concepts.

Conclusion

Rorschach theory consists of conceptual formulations that seek to account for how and why the Rorschach works. Formulations of how the Rorschach works look at the Rorschach responses as a representative sample of behaviors and as a stimulus to fantasy. As a representative sample of behaviors, Rorschach responses provide clues about a person's response style in ambiguous, affect arousing, and decision-making situations. In this regard, people who perceive the blots accurately are likely to perceive objects and daily events accurately as well. As a stimulus to fantasy, the Rorschach evokes imagery that can reveal a person's underlying needs, attitudes, and concerns. For example, respondents who frequently report percepts of people helping each other may have pressing dependent needs.

Formulations of why the Rorschach works link personality and behavioral characteristics indicated by Rorschach findings to personality and behavioral characteristics that have implications for differential diagnosis and treatment planning. Thus, frequent inaccurate perceptions of the Rorschach blots can indicate the impaired reality testing that is characteristic of psychotic disorder, and prominent-dependent imagery may signal the particular importance of providing support in a treatment relationship.

Theoretical notions of how and why the Rorschach works are complemented by information about whether it works. Information about whether the Rorschach works comes from empirical evidence of its validity for the purposes it is intended to serve. Such validation is the province of Rorschach research, which is the topic of the next chapter. Nevertheless, it should be noted that theoretical formulations, no matter how well and reasonably conceived, are hypothetical until relevant research confirms their dependability and utility. Inferences drawn from Rorschach imagery are particularly likely to be speculative and to suggest alternative possibilities rather than definite conclusions. On the other hand, theoretical formulations often suggest lines of research not yet pursued and fruitful hypotheses to employ, and they are more likely than strict empiricism to foster new ideas and methods. A case in point is Winnicott's conceptualization of transitional space between reality and fantasy, as described in this chapter, which led to the development and validation of the Reality–Fantasy Scale Version 2.0 (*RFS-2*; Tibon-Czopp, Appel & Zeligman, 2015). This and other CS-based variables represent the creative side of science, which is a necessary prelude to its confirmation side.

Rorschach scholars have developed both conceptually based and empirically based approaches to interpretation that together encompass the discovery and the confirmation components of science. Rorschach interpretation should accordingly integrate sound conceptualization and adequate empirical evidence. For the Rorschach, as for other measuring instruments, relevant empirical evidence includes normative reference data against which obtained scores can be compared to show concordance with or deviance from expected scores on variables conceptually related to certain personality characteristics.

Of further note with respect to Rorschach theory is the distinction between theories and models. Theories can be proved true or false by evidence that substantiates or disconfirms their premises. Models, on the other hand, are neither true nor false. They are perspectives on phenomena and are more or less useful in helping to understand these phenomena, but they cannot be right or wrong. The present chapter describes four models of psychodynamically oriented Rorschach interpretation. These include ego psychology, object relations theory, self psychology, and relational psychoanalysis. Each of these models adds useful perspectives on the nature of people, why they behave as they do, and what may cause them to have psychological adjustment problems. It requires that Rorschach clinicians would be familiar with each of these models and to draw on them jointly in arriving at inferences and reporting their conclusions and recommendations.

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Chapter 5
The Rorschach Inkblot Method: Research

Rorschach research is aimed at enhancing the scientific status of the instrument and thereby promoting conceptually derived and evidence-based assessment practice. However, the nature of the Rorschach task and the specific procedures of administering and coding the test pose some unique psychometric issues in addition to those usually encountered in examining the scientific foundations of psychological tests. Despite these challenges, properly conducted Rorschach studies can yield new and compelling insights into personality organization and its development from childhood through adolescence to adulthood.

The main issue with regard to the psychometric properties of the Rorschach concerns the role of response frequency (*R*). Traditional Rorschach administration procedures did not specify the expected number of responses to each of the cards. This unconstrained approach was in accord with how the method had initially evolved (see Chap. 1). The variability of *R*, together with whatever the influence the length of a record may have on the frequency of other interpretive Rorschach variables, could complicate the standardization of the test. Nevertheless, extensive exploration of this possible problem in the Rorschach literature led to the conclusion that an *R-Controlled* method of administration might resolve numerous psychometric problems, but it would entail disagreements that could outweigh the benefits of controlling *R* (e.g., Meyer, 1992).

In particular, the *R* variable is a substantial and interpretable component of the Rorschach, and any *R-Controlled* method violates the basic premise of the Rorschach as a free-association task. Indeed, all empirically derived Rorschach data, most of which have been formulated in terms of the Comprehensive System (CS; Exner, 1974, 2003; Exner & Weiner, 1995), were collected with an *R-Free* administration procedure. Accordingly, evidence-based practice should draw its inferences from studies in which the Rorschach data were obtained with the *R-Free* administration method.

Despite the quite evident benefits of using the Rorschach in clinical assessment of both adults and young people, the method has received mixed reviews and evoked

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criticisms related to a variety of psychometric issues. The development and initial publication of the CS in 1974 was a turning point in the field of Rorschach assessment, because it provided standard guidelines of administration and coding that fostered cumulative research and scientific study. Nevertheless, as discussed in Chap. 1, the scientific status of the CS has over time been challenged by critics who asserted that the reliability and validity of CS variables had not yet been adequately evaluated validity and that its normative data were outdated and insufficient to warrant using the Rorschach with culturally diverse populations. These criticisms, not always just but sometimes warranted, had the positive effect of stimulating extensive examinations of the instrument that have established the reliability, validity, utility, and cross-cultural applicability of numerous CS variables, and much of this systematic and well-designed research is documented in the present chapter.

As noted, the majority of Rorschach empirical studies have been conducted with the CS, and these studies have largely been concerned with validating the relation between structural variables, particularly global indices composed of a group of individual variables, and personality dispositions or behavioral manifestations. However, Rorschach data lend themselves to interpretations derived not only from CS indices, but also to those derived from CS-based indices that have evolved over the years and from indices derived from non-CS methods of coding. To serve adequately as a basis for clinical evaluation, the newer indices, like the CS indices, should demonstrate adequate psychometric properties.

This chapter focuses on the psychometric properties of some of the major interpretive Rorschach indices: *Perceptual Thinking Index* (*PTI*), *Depression Index* (*DEPI*), *Coping Deficit Index* (*CDI*), *Suicide Constellation* (*S-CON*), *Hypervigilance Index* (*HVI*), *Ego Impairment Index Revised Version* (*EII-2*; Viglione, Perry, & Meyer, 2003), and two derivations of the *Reality–Fantasy Scale Version 2.0* (*RFS-2*; Tibon-Czopp, Appel, & Zeligman, 2015), the *RFS-P* and the *RFS-S* indices, that delineate a person's proneness to psychotic and dissociative states, respectively. Whereas *PTI, DEPI, CDI, HVI*, and *S-CON* are integral features of the CS, *EII-2* and the two *RFS* derivations are indices that were developed by Rorschach researchers as derivations and are based on the original method.

Recent conceptual and methodological innovations have led to new strategies for documenting the psychometric properties of the Rorschach. These strategies enhance supportive evidence regarding the reliability and validity of Rorschach variables and help resolve some long-standing issues concerning their clinical utility (Bornstein, 2012). The accumulated research has led to the conclusion that the Rorschach can be reliably coded, has adequate retest reliability, provides valid results when used appropriately, and performs as effectively as self-report measures (e.g., MMPI) and as accepted medical diagnostic procedures, including MRI and PET (Meyer & Archer, 2001; Society for Personality Assessment, 2005; Weiner, 2001).

In line with the unique psychometric issues related to Rorschach research, practice applications of data derived from empirical Rorschach studies should be limited to Rorschach variables that (a) operationalize theoretical constructs, (b) are based on configurations of refined variables with specified cutoff scores for maladaptive

or psychopathological functioning, (c) obtained according to standardized procedures of administration and coding, and (d) show psychometric soundness with respect to levels of reliability and validity in age-based samples of both nonpatients and patients (Exner, 1995; Meyer, 2000, 2001; Viglione & Exner, 1995; Weiner, 1995, 2001). The present chapter explores various psychometric considerations including standardization, reliability, validity, and normative reference data, in relation to data collected from samples of both nonpatients and patients, with particular attention to adolescents.

Of further note, the discussion includes empirical data concerning the psychometric properties of core Rorschach variables that have appeared since the publication of the second edition of Volume 3 of the CS (Exner & Weiner, 1995) on Rorschach assessment of children and adolescents. In addition to empirical data concerning the psychometric properties of Rorschach CS global indices (e.g., *PTI, DEPI*), the chapter also includes psychometric information for selected CS variables of cognitive functioning, capacity for experiencing and expressing affect, interpersonal relatedness, and self-perception. Although an inclusive review of literature concerning the scientific status of the Rorschach is beyond the scope of this volume, selected findings of some well-designed studies are introduced to help frame basic foundations for effective Rorschach assessment of mental functioning in adolescents.

Standardization

Standardization of a psychological test consists of its comprising specific stimuli, a set of instructions to respondents, and well-defined guidelines for administration and coding. The scientific status of Rorschach assessment has often been challenged with respect to its standardization, based on the argument that, to be considered scientifically valid, Rorschach data can and should be collected, scored, and interpreted independently of any subjective perspective. To address this issue, it might be useful to apply the psychoanalytic construct of *Irreducible Subjectivity* (Renik, 1993), which acknowledges that every aspect of psychoanalytically oriented clinical activity inevitably consists of an interaction between two persons. In this interaction, the analyst is a *participant–observer* (Sullivan, 1940) whose subjective experience is part of the context in which the data are collected.

The implications of *Irreducible Subjectivity* for the theory and methodology of Rorschach assessment are quite clear. Indeed, any procedure related to the Rorschach (administration, coding, interpretation, report writing) might be suspected of being contaminated by *Irreducible Subjectivity*. For example, the number of well-developed guidelines for administration can hardly match the variety of contextual conditions in which evaluations are conducted, and there is good reason to take interpersonal factors into account in interpreting a Rorschach protocol (Lerner, 1998; Schafer, 1954).

Likewise, coding decisions may sometimes reflect an examiner's subjectivity in interpreting the CS guidelines for coding (Exner, 2003), which can lead to inter-coder discrepancies. Additionally, people being tested might respond differently to the Rorschach task and Rorschach protocols vary accordingly. However, some such subjective aspects can characterize interpretations derived from any assessment instrument, and it does not make the Rorschach less scientific. Rather, this subjectivity speaks not only to the limits, but also to the advantages of what is defined as psychoanalytic science (Wallerstein, 2009), and it should therefore be utilized to improve the clinician's work with the Rorschach (see Chap. 12).

Over the years, Exner's (1974) original guidelines evolved into well-defined standardized procedures and have become the most widely used system for administering and coding a Rorschach protocol. The CS workbook (Exner, 2001) prescribes the specific guidelines to be used in Rorschach administration and coding, and Viglione (2002) and Scaria, Weiner, and Ritzler (2014) provide further guidelines that clarify Exner's instructions and help examiners solve various coding problems. Rorschach researchers and clinicians around the world generally follow the CS administration guidelines, except for some minor adaptations dictated by cultural constraints, such as sitting at a 90-degree angle from the person being examined instead of the side-by-side seating recommended by Exner (e.g., Dumitrascu, 2007; Tibon, 2007). Preservation of the common procedures of data collection, with minimal allowance for necessary adaptations, enhances the cross-cultural applicability of whatever normative reference data are obtained (Allen & Dana, 2004; Meyer, Erdberg, & Shaffer, 2007).

As a well-defined approach to collecting and coding Rorschach data, the CS is recommended as the system that should be applied in evaluating the adequacy of standardization of the instrument. Idiosyncratic and individually adapted styles of administering and coding the Rorschach would inevitably result in misleading and inconsistent Rorschach data. As in the case of other widely used tests, uniform administration and coding is the key to adequate standardization, whereas interpretive perspectives on the data can vary with the examiner's preferred approach and the aim of the assessment as defined in the referral question without violating the standardization of the instrument.

In line with the Wechsler Intelligence Scales, to assess intellectual functioning and to draw inferences about personality functioning, there is no need for uniform interpretive guidelines in working with Rorschach data. As has been noted in basic CS essays (e.g., Weiner, 2001), the procedural standards intrinsic to the CS do not include the interpretation of the Rorschach data. The CS recommended interpretive strategies (Exner, 2000), while well-conceived and highly effective, constitute one among other feasible approaches to deriving clinical inferences from a Rorschach protocol. Furthermore, Rorschach data lend themselves both to nomothetic comparisons to reference samples and to idiographic conceptualization of their meaning to the individual respondent. Nevertheless, variations in approaching the interpretive process should not be considered as detracting from the basic standardization of the Rorschach administration and coding procedures. The information in Rorschach research reports should accordingly describe the administration and coding procedures

that were employed, together with the time and place of collecting the data, the nature of the target sample, and statistical evidence of acceptable psychometric properties of the variables studied in this specific sample.

Reliability

As noted in the assessment literature, inferences based on test measures can evaluate personality and mental functioning adequately only if these measures are reliable. The literature also stresses that reliability must be examined for specific test variables or configurations rather than any entire test, with the exception of tests that yield a single overall score (Cicchetti, 1994). Thus, the reliability of the Rorschach in general and the CS in particular cannot be referred to in a global manner, because the Structural Summary comprises a great many interpretively distinct scores, scales, and indices compiled from individual response codes. Furthermore, the intercoder reliability of the various individual codes must be examined along with the retest reliability of the scoring compilations, and attention must also be paid to the precision with which coders are able to use the recommended guidelines for coding each of the eight possible segments in every response. Four of these response segments (location, pairs, content, and popular responses) usually show excellent intercoder agreement, whereas the other four segments (developmental quality, determinants, form quality, and special scores) tend to be somewhat less often agreed upon.

The extent to which the CS variables are reliably coded in empirical studies and in clinical practice has been a topic of concern among clinicians. Coding a Rorschach protocol can be quite time consuming and sometimes requires collaborating with colleagues to decide how best to code a particular response. As an interesting possibility, intercoder discrepancies can be addressed in part by applying the psychoanalytic construct of *Irreducible Subjectivity* (Renik, 1993), which has been previously described. In this regard, clinical experience has suggested that these discrepancies might reflect conflicts in the individual being tested. For example, intercoder disagreement as to whether a response should be coded *FC* or *CF* may often reflect a respondent's internal conflict between being emotionally reserved or emotionally spontaneous and extroversive.

There are also varying opinions concerning the appropriate method for evaluating Rorschach coding reliability, especially in light of the many complex decisions involved in CS coding procedures. Debates on this matter have focused on whether reliability should be calculated as a percentage agreement or with such more conservative chance corrected agreement coefficients as *Kappa* and its derivative, *Iota* (Janson & Olsson, 2004); whether the whole response or response segments should be used as the compilation unit; whether individual variables or constellation indices based on a group of variables are more suitable for computing reliability; what percentage of agreement or level of correlation should be the cutoff point for acceptable intercoder reliability; and whether the data are collected in a clinical or research

setting has an effect on the reliability value that is obtained (McGrath et al., 2005; Meyer, 1997; Viglione, 1999; Weiner, 2001).

Intercoder agreement data with respect to the CS segments of coding (e.g., location, determinants) have repeatedly shown acceptable coefficients, the majority in the excellent range, in age-based nonpatient samples from different countries tested in their native languages (e.g., Lis, Salcuni, & Parolin, 2007; Tibon, 2007). These samples were part of an international reference data project (Meyer et al., 2007), in which Rorschach protocols were obtained from 21 samples of nonpatient adults in 17 countries (N = 4704) and 31 samples of nonpatient children and adolescents in five countries (N = 2647).

As noted in some reviews of the research literature (Society for Personality Assessment, 2005; Weiner, 2001; Viglione, 1999), the consistent evidence drawn from Rorschach empirical studies and meta-analyses has demonstrated that examiners can readily be trained to achieve adequate intercoder agreement and to reduce their coding errors in both research studies and applied practice. Rorschach protocols coded according to the CS criteria and guidelines provided in textbooks and workbooks (Exner, 2001, 2003; Exner & Weiner, 1995; Scaria et al., 2014; Viglione, 2002; Weiner, 2003; Weiner & Greene, 2008) thus allow clinicians to draw evidence-based inferences from their findings. Data drawn from recent publications show that reliable coding is possible in field settings where practitioners perform under the time constraints and conditions typical of their daily work (e.g., Kochinski et al., 2008; Meehan et al., 2008; Perfect et al., 2011).

Adequate intercoder reliability in response-level codes does not necessarily ensure adequate reliability of protocol-level indices, which are the aggregated indices based on a respondent's complete list of response codes. Because interpretation is based mainly on these summary scores, the reliability coefficients obtained for them can be considered more important than agreement in coding individual variables. Rorschach research published during 2000–2012 shows acceptable reliability coefficients for the major global CS-based indices (*PTI, DEPI, CDI, HVI, S-CON, EII-2, RFS-P, RFS-S*) used in this volume for assessing personality functioning (see Chap. 6). These coefficients were found in nonpatient and patient samples of both adults and young people to be within the excellent range (e.g., Acklin, McDowell, Verschell, & Chan, 2000; Meyer et al., 2000; Dao & Prevatt, 2006; Diener, Hilsenroth, Shaffer, & Sexton, 2011; Meyer et al., 2000; Tibon, 2007; Viglione & Taylor, 2003). In addition to Rorschach global indices, all of the CS summary scores recommended in this volume for use in assessing personality functioning in the clinical practice with adolescents have demonstrated at least acceptable and most often excellent intercoder reliability in different age-based samples of nonpatients and patients (e.g., McGrath et al., 2005; Sahly et al., 2011).

As in the case of evidence supporting Rorschach intercoder agreement, studies exploring test–retest reliability over intervals ranging from 7 days to 3 years have demonstrated substantial reliability for almost all of the Rorschach global indices and summary scores (e.g., Grønnerød, 2003, 2006; Perry, McDougall, & Viglione, 1995; Viglione & Meyer, 2008). Rorschach interpretable variables that are related to trait characteristics usually show retest correlations above 0.75, and some of

these correlations, for example, the *Affective Ratio* (*Afr*), approach 0.90. Substantial retest correlations have also been found for global CS and CS-based constellation indices.

In this regard, findings derived from a metaanalysis on the *Ego Impairment Index,* for example, show the stability of the underlying construct measured by the index (Diener et al., 2011). In general, The only CS variables that show low stability coefficients are inanimate movement (*m*) and diffuse shading (*Y*), both of which are conceptualized as markers of situational distress and are expected to change over time. Children show stability coefficients similar to those of adults when retested over brief intervals. Nevertheless, as would be predicted from the evolving nature of personality during the developmental years, until mid-adolescence young people typically do not show adult levels of 2-year retest reliability for most Rorschach variables (Weiner, 2001). On the other hand, the long-term stability of Rorschach variables gradually increases during adolescence, which is consistent with the expected gradual consolidation of personality characteristics and contributes to confirming the construct validity of Rorschach assessment as a personality assessment method.

Validity

Assessment instruments serve little purpose in clinical practice unless they have been validated against objective external criteria (e.g., behavioral manifestations, demographic characteristics, a diagnosed disorder, exposure to some event). A conceptually informed approach to assessment research formulates predictions on the basis of personality characteristics that are believed to account both for a particular test score that measures these characteristics and for particular behavioral manifestations that reflect it. A positive finding in a Rorschach validation study should accordingly go beyond demonstrating what goes with what, which constitutes criterion validation, and provide as well some conceptualization of why a specific score measures what it does (e.g., narcissism, antisocial behavior), which is the essence of construct validation (Viglione, 1999; Weiner, 1995, 2001).

Weiner (2001) elaborates three issues that should be considered in evaluating the validity of Rorschach assessment. First, the validity of an assessment tool that is multidimensional in nature cannot be captured by a single numerical value or narrative statement. Instead, Rorschach scores have multiple validity coefficients, and the size of these coefficients would vary with the purposes for which the score is used. Second, the validity of the Rorschach should be judged primarily from its correlations with observed rather than inferred variables. Correlations between inferential measures derived from other assessment tools are especially limited in their significance for validating Rorschach measures when they involve different methods of approach. Thus, for example, an extensive conceptual and empirical literature points out substantial differences between Rorschach and MMPI findings

on variables that are assumed to measure similar constructs, without invalidating either instrument (see Chap. 3). Third, because the Rorschach is a measure of personality processes, its scores and indices should be expected to show substantial validity coefficients only when they are used to measure observed variables that are assumed to be associated with personality characteristics to which they are conceptually linked.

Validity is not a static psychometric characteristic, however, and scores and inferences from an assessment measure can be valid only to a particular degree and for a particular purpose. These purposes may include classification of healthy or psychopathological mental functioning, specification of diagnosis, prediction of behavioral manifestations, selection of appropriate interventions, and evaluation of treatment outcomes. Although the utility of the Rorschach for clinical practice extends beyond diagnostic decision-making and prediction to include unique experiential understanding of the individual being examined (e.g., Lerner, 1998), there is much to gain from exploring the linkage between personality dispositions and the development of psychopathological mental functioning, especially in adolescents (Miller & Nickerson, 2006). As a case in point, Rorschach indices of disordered thinking and impaired reality testing can be helpful in predicting an adolescent's susceptibility to developing schizophrenia in adulthood, because schizophrenia is characterized by these personality impairments (Weiner, 1999). Similarly, Rorschach assessment of adolescents with conduct disorder (CD) may assist in evaluating their propensity for developing antisocial personality disorder (ASPD) in adulthood (Tibon-Czopp, 2011).

Reviews of research using non-test variables as the external criteria indicate that the Rorschach method has consistently proved valid when applied for its intended purposes (Weiner, 2004; Weiner & Meyer, 2009). More recently, a systematic review of meta-analyses examining CS variables against externally assessed criteria found supportive validity evidence for over 75 % of the variables for which data were available (Mihura, Meyer, Dimitrascu, & Bombel, 2013).

The Rorschach has shown validity coefficients similar to those of MMPI and IQ scales (Meyer & Archer, 2001), and a large scale meta-analysis comparing relevant Rorschach and MMPI research produced two important findings. First, the obtained data demonstrated adequate and approximately equal validity for the two instruments. Second, the meta-analysis discovered noteworthy differences between Rorschach and MMPI variables in the strength of their relationship with different types of dependent variables. Rorschach variables proved somewhat superior to the MMPI in predicting behavioral outcomes, such as whether patients in psychotherapy remain in or drop out of treatment, whereas MMPI variables were found to correlate more highly than the Rorschach with other self-report measures and psychiatric diagnosis, which is based largely on patient self-reports (Hiller, Rosenthal, Bornstein, Berry, & Brunner-Neuleib, 1999). The particular sensitivity of the Rorschach in predicting certain behavioral dispositions seems consistent with the primarily trait implications of most Rorschach variables.

Contemporary publications have also provided cumulative data demonstrating the predictive power of Rorschach global constellations, often above and beyond

that of self-report inventories and clinical interviews (e.g., Blais, Hilsenroth, Castlebury, Fowler, & Baity, 2001; Dao & Prevatt, 2006; Diener et al., 2011; Janson & Stattin, 2003; Handler & Clemence, 2005; Meyer & Handler, 2000; Viglione, Perry, & Meyer, 2003). Studies conducted with children and adolescents have shown similar results (e.g., Fowler et al., 2001; Ilonen et al., 2010; Kochinski et al., 2008; Meehan et al., 2008; Stokes et al., 2003).

More specifically with respect to young people, Smith et al. (2001) examined the relationship of the *PTI* to thought disorder indices of behavior rating and self-report scales in a patient sample of children and adolescents. Using a cutoff score of *PTI*>2, representing approximately 1 SD above the mean for the sample, they found that the *PTI* differentiated between patients with and without elevated thought disorder scores on the behavior rating and self-report scales. *PTI* has also been found to distinguish adolescent patients who were clinically considered to be at high risk of psychosis from their peers diagnosed as having nonpsychotic disorders, but not from those diagnosed as psychotic (Ilonen, Henimaa, Korkeila, Syirski, & Salokanga, 2010) and to distinguish between self-mutilating inpatient adolescents and their inpatient peers (Kochinski, Smith, Baity, & Hilsenroth, 2008). Among children, the *PTI* constellation has been able to differentiate those with ADHD symptoms from peers without indications of this disorder (Meehan et al., 2008).

In addition to the global constellation indices, research with children and adolescents published since 2000 has validated other Rorschach summary scores that are conceptually related to the external criteria being examined. As one example, reflection (*Fr*+*rF*) responses, which are assumed to measure narcissistic dispositions, were found to characterize a sample of psychopathic juvenile offenders, and psychopathic behavior has been conceived as conceptually related to an aggressive subtype of narcissistic personality disorder (Meloy, 1988).

Normative Reference Data

Normative reference data serve important purposes in psychological assessment, and the collection of adequate reference data is a basic foundation of test construction and evaluation. With respect to clinical decision-making, data obtained from nonpatients are essential for providing Rorschach reference norms against which test results can be compared. Nevertheless, data obtained from samples of patients with various kinds of psychological disorders are also needed to assist in drawing conclusions about specific features of impairment. Combined patient and nonpatient reference data are particularly helpful in enabling clinicians who work with adolescents to establish cutoff points for distinguishing between healthy and psychopathological scores on Rorschach variables.

Attention to cross-cultural normative data is also an important component of the science of psychological assessment. Normative information concerning cultural similarities and differences in test performance enhances the cross-cultural utility of assessment instruments. In addition to facilitating decision-making and cross-

cultural applications, normative data can at times contribute to demonstrating the construct validity of test variables. For example, comparisons involving such demographic characteristics as age, sex, and nationality can provide strong validation for test indices considered to be related to these characteristics, because these characteristics are objective variables that have little or no error variance and are completely independent of the test findings.

In the case of the Rorschach, there are normative age changes that are consistent with theoretical conceptualization of personality development and support the construct validity of certain Rorschach variables. Two examples are the decrease in *CF* and the previously noted increase in the stability of Rorschach variables during adolescence, as indicators of the developing capacity of modulating emotionality and personality consolidation during adolescence, respectively.

As has been noted, an adolescent who shows apparent impairment on the Rorschach might, except for instances of severe cognitive or affective disorder, be displaying problems related to developmental crises and perhaps exacerbated by character disorder, a trauma-induced reaction, or an environment that is failing to meet the adolescent's developmental needs (see Chap. 2). However, classifying psychopathological states, particularly those characterizing adolescents, requires a working definition of what constitutes age-appropriate healthy functioning. Rorschach protocols of adolescents should therefore be analyzed not only with respect to basic guidelines for interpretation, but also in relation to age-based, cross-cultural normative data (Exner & Weiner, 1995; Tibon-Czopp, 2011; Weiner, 1996, 2001).

The adequacy of the Rorschach CS age-based normative data for samples of all ages from both the USA and other countries has been extensively discussed and debated. Some authors who have criticized the use of the Rorschach as an assessment tool have argued that it frequently suggests psychopathology in mentally healthy persons. However, abundant reference data prove this criticism to be unwarranted and misleading. In Rorschach protocols obtained from several thousand nonpatient adults from many parts of the world, only a very small percentage show elevations on such key Rorschach indices of psychopathology as the *PTI, DEPI*, and *HVI* (Meyer et al., 2007).

Furthermore, although the possibility of overpathologizing is an important consideration in the Rorschach assessment of adolescents, both CS reference data (Exner, 2003; Exner & Weiner, 1995) and those derived from recently collected samples of adolescents show that allegations of overpathologizing are as faulty for adolescents as for adults. Thus, for example, data collected from Israeli nonpatient adolescents are quite unlikely, and not more likely than adult nonpatient data, to show elevations on the major CS constellations of psychopathological manifestations (Tibon-Czopp, Rothschild-Yakar, & Appel, 2012). This is what normative data of other CS indices and individual variables show as well, with some very small adjustments for *WSum6*.

As noted, earlier concerns that Exner's CS normative reference data were collected in the USA only have been somewhat resolved by the international project of Meyer et al. (2007), which presents Rorschach CS data of nonpatient samples of adults, adolescents, and children from many parts of the world. The accumulated

adult nonpatient data from the 17 participating countries have supported the cross-cultural transportability of the CS norms and also made it possible to create a composite set of international norms for adults that can serve as a benchmark for clinical evaluations. However, whereas the average scores across the 21 adult samples of Meyer at al. are fairly similar, their 31 samples of nonpatient children and adolescents derived solely 5 countries only vary notably on many CS score averages. Although this variability could reflect differences in administration procedures and coding practice, they have led some clinicians to propose establishing normative data by country or language, at least for young people.

Developing country or language specific Rorschach norms would be a difficult task, however, and the score variability among the samples of children and adolescents would argue against constructing a composite set of norms, as Meyer et al. (2007) did for the adult samples. Composite norms for the samples of children and adolescents could lead to inaccurate inferences about the psychopathological implications of certain scores presented in a Rorschach protocol.

While addressing the problem of variability among the samples of young people, Meyer et al. (2007) suggested inferring abnormal functioning when scores on a variable deviate from the most extreme mean score on that variable among nonpatient children and adolescent international samples. Nevertheless, T Scores derived from the adult nonpatient composite data can be used effectively in analyzing protocols to delineate psychopathological manifestations as shown by deviant scores on certain Rorschach variables. This method of Rorschach score analysis, as elaborated in the discussion that follows, can provide clinicians with interpretive guidelines to use at present. However, the method differs substantially from establishing country-specific norms, and as interim guidelines pending the availability of further samples of nonpatient adolescents, it makes possible the preliminary presentation in this volume of some contemporary reference data for evaluating adolescents aged 11–18.

The discussion of CS norms for adolescents in the present volume integrates data from three nonpatient adolescent samples, from Italy (Lis, Salcuni, & Parolin, 2007), Israel (Tibon-Czopp, Rothschild-Yakar, & Appel, 2012), and Iran (Hosseininasab, Mohammadi, Weiner, & Delavar, 2015), to create a combined international sample of nonpatient adolescents. This combined sample is compared to a psychiatric sample composed of 84 inpatients aged 13–17 from the USA (McGrath et al., 2005). The Italian sample, which was included in the Meyer et al. (2007) international project, comprises two age groups: 116 respondents aged 12–14 and 117 respondents aged 15–18. The Israeli sample likewise comprises two age groups: 48 respondents aged 11–14 and 52 respondents aged 15–18. The Iranian sample also includes two age groups: 125 respondents aged 11–14 and 123 respondents aged 15–18. The combined sample thus contains 581 participants aged 11–18, with an approximately equal number of younger and older adolescents.

Table 5.1 presents age-based means for CS variables in each of the three samples and for the combined sample of nonpatient adolescents from Italy, Israel, and Iran. Table 5.2 presents age-based weighted T Scores for CS variables in the combined sample of nonpatient adolescents from Italy, Israel, and Iran. Also presented in this

Table 5.1 Means of CS variables for three age-based groups and for the combined international sample of nonpatient adolescents from Italy, Israel, and Iran

	Age 11–14				Age 15–18				Age 11–18			
	Italy	Israel	Iran	Int.	Italy	Israel	Iran	Int.	Italy	Israel	Iran	Int.
R	22.31	22.14	23.64	22.87	21.79	20.71	26.29	23.44	22.05	21.31	24.95	23.16
W	9.47	8.33	5.98	7.76	8.15	8.00	6.67	7.51	8.81	8.14	6.32	7.63
D	8.71	10.07	12.34	10.52	9.44	10.09	14.00	11.45	9.08	10.08	13.16	10.99
Dd	4.14	3.74	5.33	4.61	4.20	2.62	5.59	4.47	4.17	3.09	5.46	4.53
S	2.74	2.50	1.72	2.25	2.10	2.81	1.04	1.80	2.42	2.68	1.38	2.02
DQ+	5.21	6.26	4.16	4.90	4.98	5.59	4.04	4.71	5.09	5.87	4.10	4.80
DQo	14.52	15.14	17.04	15.73	13.21	14.07	19.65	16.04	13.86	14.52	18.33	15.88
DQv	1.59	0.50	2.21	1.70	2.50	0.69	2.13	1.99	2.05	0.61	2.17	1.85
DQv/+	1.00	0.24	0.22	0.54	1.09	0.36	0.45	0.68	1.05	0.31	0.33	0.62
FQx+	0.03	0.00	0.31	0.15	0.03	0.00	0.17	0.08	0.03	0.00	0.24	0.11
FQxo	8.27	9.29	9.71	9.06	8.17	9.38	11.34	9.71	8.22	9.34	10.52	9.39
FQxu	9.60	9.14	8.20	8.91	9.50	7.16	8.81	8.76	9.55	7.99	8.50	8.83
FQx–	4.33	3.38	5.32	4.63	3.81	3.86	5.70	4.60	4.07	3.66	5.51	4.61
FQxNone	0.08	0.33	0.09	0.12	0.28	0.31	0.25	0.27	0.18	0.32	0.17	0.20
MQ+	0.01	0.00	0.09	0.04	0.03	0.00	0.13	0.07	0.02	0.00	0.11	0.05
MQo	1.02	1.60	1.59	1.36	1.48	1.83	1.75	1.66	1.25	1.73	1.67	1.51
MQu	1.20	1.69	0.62	1.02	1.38	0.90	0.79	1.04	1.29	1.23	0.70	1.03
MQ–	0.57	0.57	0.55	0.56	0.64	0.69	0.67	0.66	0.61	0.64	0.61	0.61
MQNone	0.00	0.05	0.01	0.01	0.01	0.00	0.03	0.02	0.01	0.02	0.02	0.01
SQual–	0.72	0.90	0.48	0.64	0.53	1.05	0.35	0.56	0.62	0.99	0.42	0.60
M	2.79	3.90	2.87	2.99	3.53	3.41	3.37	3.44	3.16	3.62	3.12	3.22
FM	2.68	3.52	3.56	3.19	3.09	2.91	3.65	3.29	2.89	3.17	3.60	3.24
m	1.98	2.40	1.81	1.97	1.62	1.72	2.13	1.85	1.80	2.01	1.97	1.91
FC	1.90	1.19	1.47	1.60	1.38	1.26	1.71	1.49	1.64	1.23	1.59	1.55

CF	2.27	1.57	0.94	1.58	2.08	1.24	0.74	1.36	2.17	1.38	0.84	1.47
C	0.13	0.79	0.61	0.44	0.22	0.57	0.84	0.54	0.18	0.66	0.72	0.49
Cn	0.01	0.00	0.00	0.00	0.01	0.02	0.02	0.02	0.01	0.01	0.01	0.01
Sum Color	4.30	3.55	3.00	3.61	3.68	3.09	3.31	3.41	3.99	3.28	3.15	3.51
WSumC	3.41	3.35	2.60	3.04	3.10	2.72	2.84	2.92	3.25	2.99	2.72	2.98
Sum C′	2.78	1.98	1.08	1.91	3.00	1.62	1.71	2.20	2.89	1.77	1.39	2.06
Sum T	0.52	0.40	0.60	0.54	0.62	0.36	0.30	0.44	0.57	0.38	0.45	0.49
Sum V	1.35	1.24	0.30	0.87	1.63	0.67	0.30	0.89	1.49	0.91	0.30	0.88
Sum Y	2.03	1.62	0.32	1.21	2.21	1.12	0.40	1.25	2.12	1.33	0.36	1.23
Sum Shading	6.68	3.26	2.31	4.24	7.46	2.16	2.74	4.48	7.07	2.62	2.52	4.36
Fr+rF	0.54	0.14	0.34	0.39	0.55	0.69	0.23	0.45	0.55	0.46	0.29	0.42
FD	1.63	1.95	0.87	1.34	1.46	1.67	0.88	1.26	1.54	1.79	0.87	1.30
F	8.57	8.40	11.78	9.96	7.55	8.28	13.08	9.97	8.06	8.33	12.42	9.97
Pair	5.96	7.45	7.75	6.97	6.06	5.64	9.33	7.33	6.01	6.40	8.53	7.15
3r+(2)/R	0.34	0.38	0.34	0.35	0.36	0.37	0.37	0.37	0.35	0.37	0.35	0.36
Lambda	0.88	0.84	1.33	1.07	0.71	0.81	1.31	0.98	0.79	0.83	1.32	1.02
PureF%	0.39	0.38	0.47	0.42	0.35	0.40	0.48	0.41	0.37	0.39	0.47	0.42
FM+m	4.66	5.93	5.36	5.16	4.72	4.64	5.80	5.15	4.69	5.18	5.58	5.15
EA	6.20	7.25	5.48	6.04	6.63	6.14	6.21	6.36	6.42	6.61	5.84	6.20
es	11.35	11.17	7.66	9.69	12.18	8.41	8.52	9.94	11.77	9.57	8.09	9.82
D Score	−1.71	−1.29	−0.73	−1.21	−1.78	−0.69	−0.68	−1.11	−1.75	−0.94	−0.71	−1.16
AdjD	−0.75	−0.38	−0.35	−0.52	−0.93	−0.17	−0.32	−0.53	−0.84	−0.26	−0.34	−0.52
a (active)	4.23	4.12	5.32	4.69	4.04	3.74	5.97	4.78	4.13	3.90	5.64	4.74
p (passive)	3.25	5.81	2.91	3.48	4.32	4.33	3.22	3.87	3.79	4.95	3.06	3.68

(continued)

Table 5.1 (continued)

	Age 11–14				Age 15–18				Age 11–18			
	Italy	Israel	Iran	Int.	Italy	Israel	Iran	Int.	Italy	Israel	Iran	Int.
Ma	1.53	1.86	1.76	1.68	1.44	1.67	2.16	1.78	1.48	1.75	1.96	1.73
Mp	1.28	2.10	1.10	1.32	2.15	1.74	1.21	1.68	1.72	1.89	1.15	1.51
Intellect	0.86	2.74	2.44	1.84	1.56	1.69	2.17	1.84	1.21	2.13	2.31	1.84
Zf	12.96	11.55	8.31	10.70	11.11	10.91	9.15	10.26	12.03	11.18	8.73	10.47
Zd	−2.31	0.83	−0.80	−1.18	−1.42	1.80	−1.58	−0.86	−1.86	1.40	−1.19	−1.01
Blends	5.28	5.36	3.18	4.36	5.44	3.78	3.06	4.13	5.36	4.44	3.12	4.25
Blends/R	0.23	0.23	0.14	0.19	0.25	0.18	0.11	0.18	0.24	0.20	0.13	0.18
Col-Shd Blends	0.91	1.02	1.06	0.99	1.04	0.48	1.21	1.00	0.98	0.71	1.13	1.00
Afr	0.46	0.53	0.50	0.49	0.48	0.53	0.51	0.50	0.47	0.53	0.50	0.50
Populars	4.53	3.86	3.73	4.08	4.20	3.97	4.40	4.24	4.36	3.92	4.06	4.16
XA%	0.81	0.84	0.76	0.79	0.81	0.80	0.77	0.79	0.81	0.81	0.76	0.79
WDA%	0.82	0.86	0.78	0.81	0.83	0.83	0.80	0.82	0.83	0.86	0.79	0.82
X+%	0.39	0.43	0.43	0.41	0.39	0.46	0.44	0.42	0.39	0.45	0.43	0.42
X−%	0.19	0.15	0.22	0.20	0.18	0.19	0.20	0.19	0.18	0.17	0.21	0.19
Xu%	0.41	0.41	0.33	0.37	0.42	0.34	0.32	0.36	0.42	0.37	0.33	0.37
Isolate/R	0.29	0.18	0.21	0.24	0.25	0.19	0.17	0.21	0.27	0.18	0.19	0.22
H	2.44	2.52	2.54	2.50	2.37	2.22	2.78	2.51	2.40	2.35	2.66	2.50
(H)	1.12	1.07	1.18	1.14	1.24	0.90	1.23	1.17	1.18	0.97	1.20	1.15
Hd	1.54	2.17	1.12	1.45	2.00	1.55	1.30	1.62	1.77	1.81	1.21	1.54
(Hd)	0.73	0.48	0.12	0.42	0.73	0.71	0.27	0.54	0.73	0.61	0.19	0.48
Hx	0.38	0.81	0.58	0.53	0.66	0.28	0.88	0.68	0.52	0.50	0.73	0.61
H, (H), Hd, (Hd)	5.82	6.24	4.97	5.51	6.33	5.38	5.60	5.84	6.08	5.74	5.28	5.68
A	8.04	8.50	8.98	8.52	6.99	7.59	9.41	8.10	7.51	7.97	9.19	8.31
(A)	0.25	0.40	0.47	0.37	0.35	0.52	0.46	0.43	0.30	0.47	0.47	0.40

Ad	1.90	2.24	1.92	1.96	1.91	1.52	2.4	2.04	1.91	1.82	2.16	2.00
(Ad)	0.23	0.29	0.07	0.17	0.22	0.16	0.08	0.15	0.22	0.21	0.07	0.16
An	0.47	0.60	0.56	0.53	0.41	0.71	0.97	0.70	0.44	0.66	0.76	0.62
Art	0.34	0.86	1.05	0.73	0.34	0.83	0.95	0.69	0.34	0.84	1.00	0.71
Ay	0.34	0.60	0.06	0.25	0.27	0.45	0.05	0.21	0.30	0.51	0.06	0.23
Bl	0.21	0.21	0.20	0.21	0.15	0.33	0.21	0.21	0.18	0.28	0.20	0.21
Bt	1.52	1.21	1.18	1.32	0.94	1.02	1.37	1.13	1.23	1.10	1.27	1.23
Cg	2.03	1.90	1.87	1.94	2.13	1.79	1.32	1.73	2.08	1.84	1.60	1.83
Cl	0.15	0.14	0.16	0.15	0.14	0.16	0.16	0.15	0.14	0.15	0.16	0.15
Ex	0.35	0.21	0.22	0.27	0.21	0.16	0.18	0.19	0.28	0.18	0.20	0.23
Fi	0.70	0.29	0.24	0.44	0.53	0.21	0.14	0.31	0.13	0.59	0.37	0.31
Food	0.10	0.60	0.50	0.35	0.16	0.59	0.23	0.27	0.61	0.24	0.19	0.37
Ge	0.04	0.02	0.12	0.07	0.17	0.22	0.71	0.40	0.11	0.14	0.41	0.24
Hh	0.57	0.74	0.99	0.78	0.61	0.76	0.47	0.58	0.59	0.75	0.73	0.68
Ls	1.37	0.67	0.92	1.07	1.23	0.57	0.81	0.93	1.30	0.61	0.87	1.00
Na	1.57	0.93	1.13	1.28	1.36	0.93	0.99	1.12	1.46	0.93	1.06	1.20
Sc	1.65	2.07	1.56	1.67	1.60	1.78	1.43	1.56	1.62	1.90	1.50	1.62
Sx	0.02	0.12	0.02	0.03	0.08	0.10	0.08	0.08	0.05	0.11	0.05	0.06
Xy	0.03	0.00	0.02	0.02	0.06	0.14	0.08	0.08	0.05	0.08	0.05	0.05
Idiographic	1.53	0.43	0.65	0.98	1.78	0.40	0.86	1.13	1.66	0.41	0.75	1.06
An + Xy	0.51	0.45	0.58	0.53	0.47	0.71	1.00	0.73	0.49	0.60	0.79	0.64
DV	2.00	0.93	0.54	1.20	1.04	0.71	0.39	0.71	1.52	0.80	0.47	0.95
INCOM	0.38	0.81	1.16	0.79	0.36	0.67	1.02	0.69	0.37	0.73	1.09	0.74
DR	0.21	0.21	0.13	0.18	0.09	0.29	0.13	0.15	0.15	0.26	0.13	0.16

(continued)

Table 5.1 (continued)

	Age 11–14				Age 15–18				Age 11–18			
	Italy	Israel	Iran	Int.	Italy	Israel	Iran	Int.	Italy	Israel	Iran	Int.
FABCOM	0.19	0.14	0.31	0.24	0.17	0.31	0.28	0.24	0.18	0.24	0.30	0.24
DV2	0.02	0.00	0.01	0.01	0.00	0.00	0.00	0.00	0.01	0.00	0.01	0.01
INC2	0.14	0.17	0.11	0.13	0.15	0.10	0.14	0.14	0.15	0.13	0.12	0.13
DR2	0.01	0.02	0.08	0.04	0.01	0.00	0.02	0.01	0.01	0.01	0.05	0.03
FAB2	0.14	0.38	0.06	0.14	0.05	0.16	0.04	0.07	0.09	0.24	0.05	0.10
ALOG	1.36	0.05	0.33	0.71	0.19	0.02	0.35	0.22	0.77	0.03	0.34	0.46
CONTAM	0.04	0.00	0.05	0.04	0.02	0.00	0.07	0.04	0.03	0.00	0.06	0.04
Sum6 Sp Sc	4.48	2.71	2.77	3.46	2.08	2.26	2.47	2.28	3.27	2.45	2.62	2.85
Lv2 Sp Sc	0.30	0.57	0.20	0.30	0.21	0.26	0.17	0.20	0.25	0.38	0.19	0.25
WSum6	12.85	7.48	7.60	9.73	4.79	5.76	7.21	5.98	8.80	6.41	7.41	7.79
AB	0.10	0.64	0.66	0.43	0.48	0.21	0.58	0.47	0.29	0.39	0.62	0.45
AG	0.18	0.74	0.52	0.41	0.21	0.66	0.45	0.40	0.20	0.69	0.49	0.40
COP	0.41	1.31	0.28	0.49	0.35	0.53	0.49	0.44	0.38	0.86	0.38	0.46
CP	0.00	0.00	0.00	0.00	0.00	0.03	0.00	0.01	0.00	0.02	0.00	0.00
Good HR	3.47	3.50	2.98	3.26	3.89	2.88	3.39	3.49	3.68	3.14	3.18	3.38
Poor HR	2.73	3.48	2.48	2.73	3.02	2.97	3.01	3.01	2.88	3.18	2.74	2.87
MOR	0.91	1.40	0.79	0.93	0.69	1.52	0.91	0.94	0.80	1.47	0.85	0.94
PER	0.88	0.83	0.74	0.81	0.51	0.93	0.47	0.58	0.69	0.89	0.61	0.69
PSV	0.35	0.36	0.23	0.30	0.27	0.24	0.21	0.24	0.31	0.29	0.22	0.27

Table 5.2 Weighted means of T Scores for CS variables in the combined international sample of nonpatient adolescents and in a sample of patient adolescents from the USA (McGrath et al., 2005)

	Weighted means of T Scores for the combined international sample of nonpatient adolescents			T Scores for the sample of patient adolescents from the USA
	Age 11–14	Age 15–18	Age 11–18	
R	51	51	51	46
W	47	47	47	48
D	51	53	52	45
Dd	54	53	54	50
S	49	47	48	47
DQ+	46	46	46	**44**
DQo	52	52	52	47
DQv	54	**56**	55	51
DQv/+	54	**56**	55	49
FQx+	49	48	49	47
FQxo	45	**46**	45	**40**
FQxu	**57**	**57**	**57**	50
FQx–	51	51	51	52
FQxNone	47	49	48	52
MQ+	48	49	48	47
MQo	45	46	45	**43**
MQu	53	54	53	51
MQ–	49	50	50	50
MQNone	49	49	49	49
SQual–	48	47	48	50
M	47	49	48	46
FM	49	50	49	**43**
m	53	52	53	46
FC	48	48	48	**43**
CF	50	48	49	47
C	52	53	52	53
Cn	49	50	49	49
Sum Color	49	48	48	**44**
WSumC	50	49	49	47
Sum C′	51	53	52	49
Sum T	49	48	48	45
Sum V	54	54	54	48
Sum Y	49	49	49	48
Sum Shading	50	51	50	47
Fr+rF	50	50	50	47
FD	53	52	52	48
F	52	52	52	51
Pair	50	51	50	49
3r+(2)/R	48	49	49	49

(continued)

Table 5.2 (continued)

	Weighted means of T Scores for the combined international sample of nonpatient adolescents			T Scores for the sample of patient adolescents from the USA
	Age 11–14	Age 15–18	Age 11–18	
Lambda	52	51	52	**58**
PureF%	52	51	52	NA
FM + m	51	51	51	**43**
EA	48	49	48	45
Es	51	52	51	**44**
D Score	46	47	47	53
AdjD	47	47	47	51
a (active)	49	49	49	**44**
p (passive)	49	51	50	**44**
Ma	48	48	48	46
Mp	48	50	49	47
Intellect	48	48	48	**43**
Zf	46	45	46	45
Zd	49	50	49	48
Blends	51	50	51	**44**
Blends/R	51	50	50	46
Col-Shd Blends	54	54	54	48
Afr	48	49	48	48
Populars	**43**	**44**	**43**	**43**
XA%	50	50	50	**43**
WDA%	49	50	50	49
X + %	**42**	**43**	**42**	**40**
X–%	51	50	50	**57**
Xu%	**59**	**58**	**59**	55
Isolate/R	53	50	52	48
H	50	50	50	48
(H)	49	50	49	49
Hd	50	51	50	48
(Hd)	48	49	48	49
Hx	51	53	52	46
H, (H), Hd, (Hd)	49	50	50	47
A	53	51	52	52
(A)	49	50	50	54
Ad	48	48	48	47
(Ad)	50	50	50	49
An	46	47	46	47
Art	47	46	46	**44**
Ay	47	46	47	46
Bl	49	49	49	50

(continued)

Table 5.2 (continued)

	Weighted means of T Scores for the combined international sample of nonpatient adolescents			T Scores for the sample of patient adolescents from the USA
	Age 11–14	Age 15–18	Age 11–18	
Bt	49	48	49	47
Cg	50	49	50	45
Cl	49	49	49	48
Ex	52	50	51	49
Fi	48	47	48	48
Food	52	50	51	48
Ge	47	52	50	48
Hh	49	47	48	46
Ls	52	51	51	46
Na	55	53	54	49
Sc	54	53	54	NA
Sx	45	46	46	45
Xy	47	48	47	47
Idiographic	51	52	51	51
An + Xy	45	46	45	NA
DV	**56**	51	53	49
INCOM	51	50	50	49
DR	47	46	47	48
FABCOM	47	47	47	49
DV2	50	49	50	**71**
INC2	51	51	51	55
DR2	49	48	49	53
FAB2	52	50	51	**56**
ALOG	**62**	51	**57**	52
CONTAM	51	51	51	50
Sum6 Sp Sc	53	48	50	50
Lvl2 Sp Sc	51	49	50	**57**
WSum6	53	48	50	52
AB	51	52	52	46
AG	49	48	48	47
COP	45	45	45	46
CP	49	49	49	49
Good HR	48	49	48	45
Poor HR	49	51	50	48
MOR	48	48	48	47
PER	51	50	51	47
PSV	51	50	51	51

Note: T Scores in bold are significantly elevated or lowered in comparison to the international sample of nonpatient adults (Meyer et al., 2007)

table are T Scores of a patient adolescents sample from the USA (McGrath et al., 2005). These T Scores were computed by scaling a variable to set its mean at 50 and its standard deviation (SD) at 10. Thus a T Score of 40 is 1SD below the mean, a T Score of 60 is 1SD above the mean, and so on. Meyer et al.'s composite international sample of adults is used as a benchmark for computing the T Scores for the current adolescent sample, because considerable variability was found among their international samples of children and adolescents. This procedure makes it possible to evaluate the current combined sample of Italian, Israeli, and Iranian adolescents against the standard established for nonpatient adults and to highlight and quantify any developmental differences that might be present.

In addition, a weighted mean T Score is presented for both the younger and older adolescent groups. In occurrences of missing values (e.g., the *S-CON* for younger adolescents to whom it is not applicable), the T Score calculations are based on the weighted means for the age group in which these values are available (15–18). Deviations are noted in bold when the value of a variable exceeds a cutoff point of 5 (T < 45 or > 55), which is equal to 1/2 SD below or above the mean of the value of this variable in the Meyer et al. (2007) composite international sample of adults. Deviations in T Scores allow clinicians and researchers to determine how much a person or a sample differs from an expected norm.

Data presented in Table 5.2 show that if cutoff points of T < 45 or > 55 are applied, deviations (indicated in bold) of the current international sample of nonpatient adolescents aged 11–18 from the norms established by the composite adult sample of Meyer et al. (2007) occur in the following variables: *FQu*, *popular* (*P*) responses, *X* + %, *Xu%*, and *ALOG*, with T Scores of 57, 43, 42, 59, and 57, respectively. However, whereas the lowered *X* + % commonly characterizes nonpatient adolescents in both age-based groups of all three countries, deviations in *FQu*, *P*, *Xu%,* and *ALOG* appear to be more culture specific, with the Italian younger group showing normative *P* and elevated *ALOG*, the Israeli older group showing normative *FQu* and *X* + %*,* and the Iranian younger group showing normative *FQu* and *Xu%*.

With respect to the elevated *ALOG* in the Italian younger group, as suggested by Wenar and Curtis (1991), this CS marker of psychopathological thinking, which represents a departure from conventional logic into circumstantial ideation, might be elevated in normative children and is expected to decline with cognitive development. It might therefore represent a childish pattern of ideation characterizing the Italian sample aged 11–14, rather than evidence of disordered thinking (see Chap. 2). However, this and other cultural specific differences should be further explored.

The main finding in the cross-cultural analysis is that, with rare exception, the T Scores for CS variables in the combined international sample of adolescents commonly fall in a narrow range from 45 to 55, reflecting 1/2 SD, with many of the scores falling in an even narrower range from 47 to 53. These close to average T Scores indicate substantial similarity between the present reference data for adolescents and the international composite data for nonpatient adults. The most notable exception in this regard is the elevated T Score for *Xu%*, with a T Score of 59 (based on the composite nonpatient adult sample). As an index of nonconventional percep-

tion, *Xu%* can nevertheless be interpreted as reflecting age-appropriate tendencies toward individuation. This finding indicates that the existing CS reference data for perceptual accuracy in adults are adequate for adolescents (the T Score for *X-%* = 50), but should probably not be used to evaluate conventionality of perception in young people.

On the other hand, the current data provide essential evidence that nonpatient adolescents are unlikely, and no more likely than nonpatient adults, to show deviations of more than 5 T Score points in CS markers of cognitive deficiencies and perceptual distortions. These findings differ notably from those derived from the McGrath et al. (2005) study of patient adolescents. Whereas the age-based current international sample of nonpatient adolescents show T Scores of 51 for age group 11–14 and 50 for age group 15–18 on *X-%*, which is similar frequency to adults (Meyer et al. 2007), the adolescent patients of McGrath et al. show a T Score of 57 on this perceptual variable, as indicated in bold in Table. 5.2.

With respect to the clinical implications of these findings, it is commonly accepted among researchers that only a T Score difference of ten points (1SD) or more should be considered likely to cause at least minor adjustment difficulties, but may not warrant a formal clinical diagnosis. However, a T Score above 65 (M + 1.5 SD) or below 35 (M −1.5 SD) deviates markedly from normative standards and is likely to cause major adjustment difficulties. Applying these benchmarks, none of the variables in the combined international sample that is used in this volume for providing cross-cultural reference values deviates markedly from the normative standards.

For reasons that are not clear, the old CS norms for adolescents (Exner, 2003; Exner & Weiner, 1995) showed a surprisingly low frequency of inaccurate perception. When T Scores are computed for these old reference data in two age groups, 11–14 (N = 470) and 15–16 (N = 250), the protocols collected from adolescent nonpatients about 30 years ago show much lower *X-%* (T = 39) than the current sample of adolescents and Meyer et al.'s (2007) currently collected international sample of nonpatient adults. These low T Scores in the old CS norms are not shown in CS markers of disturbed thinking (e.g., *LV2*), with T Scores of 50 in the 11–14 and 47 in the 15–16 age-based samples of nonpatient adolescents from the USA. In this regard, the current data derived from the international sample of adolescents are very similar to those of the old CS norms.

These data have important implications for clinical practice. The older CS norms suggest that adolescents could be expected to have a frequency of inaccurate perceptions as measured by *X-%* that is more than 2 SDs lower than what is average for contemporary adults. In contrast, the current combined sample of adolescents shows a level of inaccurate perception that is similar to what is average in adults (i.e., T Score of 50). These are dramatically different benchmarks for understanding what is typical or normal for adolescents, in that the older norms and the contemporary combined samples provide different expectations for how much perceptual lapse or distortion is expected to be found in nonpatient adolescents.

Many authors support the basic approach of CS users to focus interpretation on psychometrically superior dimensional scores rather than categories formed by arti-

ficially dichotomized cutoff scores (e.g., MacCallum, Zhang, Preacher, & Rucker, 2002; Meyer et al., 2007). However, to facilitate clinical inferences based on the presence or absence of certain CS scores, Table 5.3 provides frequency data for the traditional classifications found in Exner's reference tables. Using the same procedures described for compiling the weighted mean T Scores, we computed the average proportion of participants in the three nonpatient samples of adolescents in each classification category.

Table 5.3 compares age-based weighted frequencies for selected CS variables in the combined sample of nonpatient adolescents from Italy, Israel, and Iran with Meyer et al.'s (2007) composite international sample of nonpatient adults. The data presented in the table indicate that differences between the Rorschach data of the nonpatient adolescents in the current composite sample and those of the nonpatient adults in the international composite sample of Meyer et al. (2007) occur particularly with respect to two related FQ variables, $X+\% < 0.55$ and $Xu\% > 0.20$. The data also show a substantially higher percentage of $P < 4$ in the adolescent sample, which, like low $X+\%$ and high $Xu\%$, has implications for nonconformity. These differences between the current adolescent sample and the adult composite international sample could be interpreted as reflecting expected developmental tendencies to pursuit individuality (see Chap. 2).

Analyzing CS norms of children aged 5–16, Wenar and Curtis (1991) found several longitudinal Rorschach changes consistent with predictions from developmental psychological data, including increases over time in cognitive complexity, precision of thinking, and conformity to socially acceptable patterns of thinking and perception. As shown in Tables 5.1, 5.2, and 5.3, the new composite norms are very similar to the adult composite norms, which means not only that the Rorschach does not overpathologize adolescents with respect to their cognitive functioning, but also that examiners can interpret CS variables such as *X*-% similarly for adolescents and adults, without any age adjustment. For example, $X\text{-}\% > 0.30$, and with greater confidence $X\text{-}\% > 0.42$, which is the mean in the current international sample of adolescents, can be used as a benchmark for distinguishing between healthy and psychopathological functioning. Consistent with this recommendation, an $X\text{-}\% > 0.29$ receives one point on the Perceptual Thinking Index (*PTI*), and an $X\text{-}\% > 0.40$ receives two points.

Aside from cognitive functioning, two examples of unique adolescent features in the affect and self-perception domains are worth noting. First, the normal maturational tendency for adolescents to become emotionally more reserved and less intense would be reflected, as previously noted, in a decreasing number of color form (*CF*) and no-form color (*Pure C*) responses that are considered a corollary of relatively unmodulated patterns of emotional expressiveness, compared to form-dominated color responses (*FC*) that are considered a corollary of relatively modulated patterns of emotionality. As evidence in this regard, the traditional *CS* norms point to $CF + C$ responses that substantially outnumber *FC* responses in the reference groups for children aged 5–8 and $CF + C$ responses that are a bit more frequent than *FC* responses among older children and young adolescents (aged

Table 5.3 Frequencies for selected CS variables in the combined international sample of nonpatient adolescents as compared to the composite international sample of nonpatient adults (Table 2, Meyer et al., 2007)

	Int. adolescents			Int. adults
Variables	11–14 M%	15–18 M%	11–18 M%	M%
Styles				
Introversive	16 %	23 %	20 %	26 %
Pervasive introversive	10 %	14 %	12 %	16 %
Ambitent	26 %	28 %	27 %	31 %
Extratensive	18 %	13 %	15 %	16 %
Pervasive extratensive	10 %	6 %	8 %	9 %
Avoidant	40 %	36 %	38 %	28 %
D Scores				
D Score > 0	8 %	8 %	8 %	12 %
D Score = 0	41 %	40 %	40 %	46 %
D Score < 0	51 %	53 %	52 %	41 %
D Score < −1	30 %	32 %	31 %	23 %
Adj D Score > 0	14 %	13 %	13 %	19 %
Adj D Score = 0	49 %	47 %	48 %	52 %
Adj D Score < 0	38 %	40 %	39 %	30 %
Adj D Score < −1	18 %	20 %	19 %	13 %
Zd				
Zd > +3.0 (overincorp)	15 %	20 %	18 %	19 %
Zd < −3.0 (underincorp)	31 %	32 %	31 %	29 %
Form quality				
XA% > 0.89	16 %	13 %	14 %	19 %
XA% < 0.70	18 %	15 %	16 %	18 %
WDA% < 0.85	53 %	61 %	57 %	49 %
WDA% < 0.75	23 %	20 %	22 %	20 %
X + % < 0.55	87 %	84 %	85 %	55 %
Xu% > 0.20	90 %	88 %	89 %	68 %
X − % > 0.20	47 %	41 %	44 %	41 %
X − % > 0.30	15 %	12 %	14 %	14 %
FC:CF + C ratio				
FC > (CF + C) + 2	16 %	12 %	14 %	13 %
FC > (CF + C) + 1	29 %	28 %	28 %	22 %
(CF + C) > FC + 1	32 %	29 %	30 %	24 %
(CF + C) > FC + 2	24 %	16 %	20 %	15 %
Constellations				
S-Constellation positive	N/A	11 %	11 %	4 %
HVI positive	8 %	8 %	8 %	12 %
OBS positive	0 %	0 %	0 %	0 %
PTI =5	0 %	0 %	0 %	0 %

(continued)

Table 5.3 (continued)

	Int. adolescents			Int. adults
Variables	11–14 M%	15–18 M%	11–18 M%	M%
PTI =4	2 %	0 %	1 %	2 %
PTI =3	7 %	3 %	5 %	6 %
DEPI =7	1 %	2 %	1 %	2 %
DEPI=6	9 %	6 %	7 %	10 %
DEPI=5	21 %	24 %	23 %	19 %
CDI=5	8 %	10 %	9 %	11 %
CDI=4	35 %	34 %	34 %	25 %
Miscellaneous variables				
R<17	18 %	19 %	18 %	25 %
R>27	27 %	26 %	26 %	20 %
DQv>2	26 %	29 %	27 %	16 %
S>2	35 %	29 %	32 %	40 %
Sum T=0	66 %	68 %	67 %	57 %
Sum T>1	11 %	10 %	11 %	15 %
3r+(2)/R<0.33	46 %	40 %	43 %	39 %
3r+(2)/R>0.44	26 %	30 %	28 %	30 %
Fr+rF>0	26 %	27 %	26 %	25 %
Pure C>0	31 %	34 %	33 %	25 %
Pure C >1	9 %	14 %	12 %	7 %
Afr<0.40	26 %	26 %	26 %	27 %
Afr<0.50	50 %	51 %	50 %	47 %
(FM+m)<Sum Shading	38 %	43 %	40 %	35 %
(2AB+Art+Ay)>5	8 %	8 %	8 %	11 %
Populars<4	41 %	31 %	36 %	16 %
Populars>7	4 %	2 %	3 %	12 %
COP=0	70 %	70 %	70 %	42 %
COP>2	6 %	4 %	5 %	13 %
AG=0	70 %	72 %	71 %	64 %
AG >2	2 %	2 %	2 %	4 %
MOR>2	11 %	10 %	10 %	16 %
Level 2 Sp.Sc.>0	20 %	15 %	17 %	17 %
GHR>PHR	56 %	55 %	56 %	57 %
Pure H<2	34 %	39 %	37 %	35 %
Pure H=0	11 %	13 %	12 %	11 %
p>a+1	25 %	29 %	27 %	21 %
Mp>Ma	31 %	41 %	36 %	32 %

Note: S-CON data for adolescents are based on the Italian and Israeli samples only

9–12 years old). The 13- to 16-year-old adolescents in the CS reference sample gave fewer *CF* + *C* than *FC* responses. As shown in Table 5.3, the current reference data of the combined adolescent sample are much more similar to those of adult sample of Meyer, Erdberg, and Shaffer (2007) although contemporary normative adolescents,

particularly those in the 11–14 age group, are still more likely than adults to have *CF* + *C* dominant color use.

Second, with respect to their self-perception, the data in Table 5.3 show approximately the same frequency of an elevated *Egocentricity Index* (> 0.44) in the combined adolescent sample (28 %) and Meyer et al.'s composite adult sample (30 %). On the other hand, the adolescent sample shows a higher percentage with reflection responses (*Fr* + *r*F > 0 = 32 %) than the adult sample (*Fr* + *rF* > 0 = 25 %). This difference between adolescents and adults is consistent with the expected engagement of adolescents in self-focused mental functioning, as mentioned in Chap. 2 and as measured by reflection responses. However, the difference between these two measures of self-focused functioning (i.e., the *Egocentricity Index* and *Fr* + *rF* > 0) might raise question about the traditional CS interpretation of the *Egocentricity Index*, which includes pair responses (*2*) in addition to the *Fr* + *rF* (see Chap. 6).

As has been noted in Chap. 2, developmental changes in personality characteristics do not call for corresponding changes in the interpretation of related Rorschach indices. Accordingly, a predominance of *CF* + *C* over *FC* responses typically characterizes young people who show emotional intensity and limited affect modulation, whatever the age of the child or adolescent. However, the implications of such a finding would be age related, with limited affect modulation suggesting normative development in children but emotional immaturity in older adolescents and adults, with possible related adjustment difficulties.

Further analyses of the current data have shown that, with respect to color use, the expected developmental pattern might be culturally dependent. Thus, whereas the percentages of nonpatient adolescents who show more color-dominated (*CF* + *C*) than form-dominated (*FC*) color responses become a bit lower in the older age group (15–18) as compared to those in the 11–14 age group in both the Israeli and the Iranian samples, the percentages of Italian adolescents who provide more color-dominated responses are higher in the older age group. These findings show that Italian adolescents may exhibit a curvilinear pattern throughout adolescence in which a larger portion of them demonstrate a less mature style of modulating affect when they are 15–18 than when they are 11–14 years of age.

Because the traditional CS reference data on nonpatient adolescents were collected over 30 years ago and refer to samples solely from the USA, differences between these data and the current composite adolescent sample data could reflect cultural variation or cultural change over time. As previously suggested by Tibon-Czopp, Rothschild-Yakar, and Appel (2012), these changes might also be related to advances in modern technology, including the impact of the internet and Facebook revolution on how people interact with their environment. The possible patterns in which modern technology translates into adolescents' manner of responding to the Rorschach is an intriguing area for investigation, and the question of whether response differences over time are due to exposure to environmental changes or to substantial changes in patterns of mental functioning, particularly in adolescence, should be further explored. On the other hand, even though Rorschach age-based reference data are of considerable importance for evaluating the extent to which obtained scores deviate from expected values in certain age groups, normative data should be interpreted cautiously. Statistical norms should not be equated with

psychological normality, and uniqueness should not automatically be taken to indicate psychopathological functioning.

Although the normative reference CS data for adolescents, presented in this chapter, have been drawn solely from three countries, the findings have some substantial implications with respect to clinical practice with adolescents. Particularly important in this regard is the evidence that the Rorschach does not show diagnosable psychopathology when it is not present and that, except for some adolescent inclination toward nonconventional and individualistic perception, there are no normative differences between adolescent and adult patterns of cognitive functioning. In clinical practice, this finding may call for reconsideration of the cutoff scores in the CS textbooks to make them congruent with the currently updated norms.

To recapitulate the recommendations in this chapter, T Scores lower than 40 (M– 1SD) and higher than 60 (M+ 1SD) on Rorschach markers of psychopathology should be considered indicative of some degree of disturbance but do not necessarily warrant a formal clinical diagnosis. For example, the upper limit for *X*-% as established by M + 1SD in the composite international sample of adults would be 0.19 + 0.11 = 0.30 (see Table 1 in Meyer et al., 2007). When a protocol shows an X-% that exceeds 0.30, it is likely to be demonstrating disturbed mental functioning probably manifest in distortions of reality and inaccurate perception of people and events. Rorschach data in which T Scores on CS markers of psychopathology exceed the upper limit of 65 should be interpreted as providing substantial evidence for disturbed functioning.

To facilitate Rorschach work in clinical practice with adolescents, Chap. 6 provides updated cutoff scores for CS markers of disturbed functioning. Overall, the current data offer ample evidence that the Rorschach does not overpathologize adolescents. Rorschach protocols of nonpatient adolescents do not provide any evidence, and no more than those of nonpatient adults, of distorted perception or disturbed thinking, and they can be interpreted by using the same cutoff points as are applicable for adults.

Conclusion

Whereas the previous chapter was concerned with theoretical conception of how and why the Rorschach works, the present chapter addresses empirical research concerning whether it works. Whether the Rorschach or any other personality assessment instrument works is a function of the dependability and utility of its findings, which constitute its essential psychometric properties. To be psychometrically sound, personality assessment instruments should (a) employ standardized procedures for data collection, (b) generate consistent findings over time for stable phenomena or changing findings that parallel changes in these phenomena, (c) measure accurately the phenomena they are designed or intended to measure,

and (d) have comparison data that provide a basis for qualitative judgments about the obtained information.

For the Rorschach and personality assessment instruments in general, standardized administration and coding make possible the accumulation of the results of Rorschach research studies to provide dependable large-sample information about the stability, accuracy, and applicability of Rorschach variables. Consistency over time is demonstrated by substantial test–retest reliability coefficients for Rorschach variables that are presumed to measure stable personality characteristics. For variables presumed to measure situational characteristics, on the other hand, or among individuals known to have undergone some personality change, retest coefficients may be minimal.

The accuracy of Rorschach findings, in common with the results of other personality assessment measures, consists of their validity for serving relevant purposes. Several aspects of relevance are particularly important in evaluating Rorschach validity. First, the numerous variables that comprise the Rorschach are likely to differ in their relevance for certain purposes, and it is these variables, not the Rorschach as a whole, that can be found more or less valid in research studies. The number or percentage of Rorschach variables that are validated in particular studies may justify referring to the entire measure as being more or less valid, but such global reference to the Rorschach or to any other multiple variable assessment instrument has little relevance to what certain test variables may contribute to answering particular referral questions. Second, the validity and utility of Rorschach variables should be assessed by how they relate to conditions or events in which personality characteristics are assumed to play an important part and not for how they delineate conditions or predict events in which personality characteristics are of little relevance. Third, Rorschach validation research should compare the obtained findings with relevant observed behaviors and objective characteristics of people, not with the findings of other personality assessment instruments that, like the Rorschach, are inferential themselves and more or less valid for certain purposes. Fourth, Rorschach research should emphasize construct validation, which is more likely to generate relevant information than studies that are limited to criterion validation. Criterion validation relates Rorschach findings to certain conditions or events, whereas construct validation seeks in addition to explain why such relationships exist. Construct validation thus speaks to the complementary roles of conceptualization and empiricism in advancing knowledge, as discussed in the previous chapter.

As for comparison data that provide a basis for qualitative judgments, normative reference information is necessary for investigating how groups of people resemble or differ from each other and for distinguishing between normal and abnormal test findings. For these purposes, normative reference samples should be as large as is feasible to compile; they should include representative groups of nonpatients differing in age, nationality, and as many other demographic characteristics for which sufficient data can be collected; and these data should be collected by examiners trained in administering and coding whatever measures are being studied.

Similar scores among reference subsamples on a variable indicate that a single composite score for this variable can be used for comparisons with individuals being examined. Differences among subsamples in certain variables may call for using separate age-based, national, or other subsample demographic normative values for comparison purposes. With respect to qualitative judgments in clinical applications of normative data, findings similar to the reference data delineate normal range personality functioning, whereas deviations from normative expectations suggest maladaptive personality functioning or psychological disorder.

As reviewed in this chapter, Rorschach assessment meets each of these criteria for psychometric soundness. The CS provides standardized guidelines for administration and coding that are used around the world, as reflected in the published literature. Intercoder agreement among adequately trained administrators ranges from good to excellent, as does the retest reliability of variables that are presumed to measure stable personality characteristics. An extensive literature demonstrates the validity of the Rorschach when used for its intended purposes of personality assessment. Large international reference samples of nonpatient adults show sufficient similarity to warrant using composite values to delineate deviations from CS norms without the necessity of culture-specific reference data. Combined contemporary reference samples of nonpatient adolescents closely resemble the composite adult sample in their Rorschach data. There are nevertheless some differences in Rorschach scores that reflect expected developmental changes from childhood to adulthood. The developmental change, as reflected in the structural variables, exemplifies the construct validity of Rorschach assessment. These developmental changes that call for somewhat different cutting scores that delineate psychopathological functioning in adolescents are presented in the next chapter.

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Chapter 6
The Rorschach Inkblot Method: Practice

Following the conceptual and methodological issues discussed in Chaps. 4 and 5, this chapter provides guidelines for administration, coding, and interpretation that promote effective use of the Rorschach Inkblot Method in the clinical assessment of adolescents. These guidelines are presented in the form of a workbook designed for practitioners who use the Rorschach Interpretation Assistance Program (RIAP; Exner & Weiner, 2003) for computing the ratios, percentages, indices, and constellations of the CS and the new CS-based variables that are included in the revised Structural Summary, presented in this volume.

The chapter emphasizes that the essence of Rorschach assessment resides in its standardized administration as a free association task. Additionally, Rorschach coding procedures should follow CS guidelines with only minor adaptations. On the other hand, interpretive procedures can vary according to the theoretical perspective of the practitioner. The interpretive process consists of drawing on structural variables, especially multivariable constellation indices, thematic imagery, behavioral clues, and response sequence. In line with the PDM (PDM Task Force, 2006), this process yields valuable information concerning adaptive development (Bleiberg, 2001), risk factors, and the subjective experience of symptom patterns.

Administration

The CS workbook (Exner, 2001) delineates specific guidelines for Rorschach administration to be followed around the world, with some minor adaptations dictated by individual needs or cultural constraints. These minor adaptations might include avoiding a second administration when $R < 14$, accepting more than five responses to a card while coding five responses only, sitting at a 90-degree angle from the person being examined instead of the side-by-side seating recommended by the CS workbook, or in exceptional circumstances conducting the inquiry during

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the response phase of the administration. As has been noted, preservation of the standardized common procedures of data collection, with minimal allowance for necessary adaptations, enhances the cross-cultural applicability of whatever normative reference data are obtained. With respect to the testing-the-limits (TL) procedure for evaluating whether popular responses (*P*) can be given to Cards III, V, and VIII, our clinical experience indicates that this procedure is particularly helpful in distinguishing between psychotic and nonpsychotic disorders in adolescents.

Coding

Each Rorschach response should be scanned for the following features: Location (which part of the blot or the background was used?); Developmental Quality (how much organizational activity is involved?); Determinants (what made the blot look like it did?); Form Quality (does the shape of the object seen in the response realistically resemble these objects?); Pairs (is there reference to symmetrical objects?); Contents (what is seen?); Popular (*P*) responses (is the object commonly seen by other individuals?); Special Scores (does the response include some unusual features related to cognitive functioning?); and *Z* score (how much organizational activity is invested in the response?).

The CS workbook (Exner, 2001) delineates specific instructions to guide the Rorschach coding process. Two additional sources, Viglione (2002) and Scaria, Weiner, and Ritzler (2014), provide coding guidelines that clarify Exner's instructions and suggest solutions to various coding problems. We recommend reliance on these sources in the coding of Rorschach protocols. Further attention would be helpful in differentiating between sometimes contradictory types of responses that have the same code (e.g., "soft" and "rough" texture responses) and clarifying the guidelines for coding Form Quality (*FQ*) and some Special Scores, especially perseveration (*PSV*). As noted in Chap. 5, on the other hand, accumulated research has shown that the CS codes can be used reliably and provide empirically valid and clinically meaningful information either as individual variables or as elements of global indices.

Interpretation

Interpretation is the most complex facet of Rorschach work, involving as it does the integration of structural, thematic, behavioral, and sequential data. Whereas the perceptual nature of the Rorschach task illuminates the potential contribution of CS structural variables, its associational and interpersonal nature require analyzing the thematic imagery, the response sequence, as well as transference and countertransference issues. Many clinicians rely on the Rorschach as an assessment tool for helping to distinguish between healthy and psychopathological functioning in adolescents. As a standardized behavioral task that does not require respondents to engage in conscious reflection, it is well-suited for this purpose, if properly used. The present

discussion focuses on the interpretation of 50 CS-based structural variables. However, to generate a comprehensive picture of an individual's personality functioning, the interpretation of these 50 variables must be combined with inferences derived from the full range of Rorschach structural, content, and sequential data and with information gleaned from self-report measures and behavioral observations.

As has been noted, Rorschach protocols of adolescents should be analyzed in relation to age-based, cross-cultural normative data. Tables 6.1–6.4 present 45 CS-based structural variables and the reference values of each of these variables for distinguishing between healthy and psychopathological functioning in adolescents. Specific forms of psychopathology associated with these reference values are discussed

Table 6.1 Selected CS and CS-based variables and reference values for assessing impaired cognitive functioning in adolescents[a]

Variables	Reference Values	Implications of Deviant Scores
General Indices		
PTI	*PTI* > 3	Disturbed thinking and distorted perception
RFS-P	*RFS-P* < − 0.30	Reality collapse into fantasy; lowered capacity for relating to outer world
	RFS-P > + 0.92	Fantasy collapse into reality; lowered capacity for relating to internal experiences
RFS-S	*RFS-S* > 2.67	Proneness to dissociation
EII-2	*EII-2* > 0	Likelihood to maladaptive functioning
Attention (Processing)		
L	*L* < 0.30	Excessive openness to experience; over involvement in contemplating the underlying significance of events or sorting out feelings about them
	L > 0.99	Limited openness to experience; narrow frame of reference; tendency for detachment from thoughts and feelings
W:D:Dd	*W* > .50 *D* < .50 *Dd* > .15	Inordinate attention to global or unusual aspects of experience rather than to what is ordinary and commonplace; often associated with unconventional attitudes or behavioral tendencies
Zd	*Zd* > + 3.0	Attending to more information than can be organized efficiently and examining experience more thoroughly than is necessary
	Zd < − 3.0	Taking in too little information and examining experience less thoroughly than would be advisable
DQv	*DQv* > 2	Impressionistic, poorly defined, and concrete style of processing information

(continued)

Table 6.1 (continued)

Variables	Reference Values	Implications of Deviant Scores
Perception (Mediation)		
XA%	*XA%* < .70	Impaired reality testing; inaccurate perception of people and events
WDA%	*WDA%* < .75	Inaccurate perception when attending to usual and apparent stimuli in the environment
X-%	*X-%* > .30	Distorted perception associated with instances of poor reality testing and faulty judgment
Xu%	*Xu%* < .10	Proneness to being strongly committed to conventionality
P	*P* < 4	Notable idiosyncratic view of the world; inability or unwillingness to recognize conventional reality
	P > 7	Notable endorsement of conformity and conventionality
Thinking (Ideation)		
WSum6	*WSum6* > 17	Illogical and incoherent thinking
Lv2	*Lv2* > 0	Likelihood of thinking disorder
M-	*M-* > 1	Strange ideas about what people are like and how they are likely to act
FM + *m*	*FM* + *m* > 6	Intrusive thoughts; often associated with difficulties in concentration
INTELL	*2AB* + *Art* + *Ay* > *5*	Excessive reliance on intellectualization as a way of minimizing affective experience

[a]*Note*. The CS variables that correspond to the codes in each of the sections of the first column are as follows: *General indices. PTI* = *Perceptual Thinking Index*. A constellation index composed of five conditions involving the critical special scores (*DV, DR, INC, FAB, ALOG, CONTAM*) and form quality variables. *RFS-P* and *RFS-S* = mean and SD scores on the *Reality–Fantasy Scale Version 2.0* (*RFS-2*; Tibon-Czopp, et al., 2015), a CS-based index, calculated by the *RFS Software,* according to a flowchart. Because the reference values for the *RFS-P* is different in adults (*RFS-P* < –0.51; *RFS-P* > +0.65), the reference values presented in the table should be applied only to adolescents (11–18); *EII-2* = *Ego Impairment Index*, which refers both to cognitive and interpersonal functioning; *Attention* (Processing cluster). *L* = *Lambda*, the relative number of pure form (*F*) responses divided by to the number of responses with determinants other than pure form (*F/R-F). W:D:Dd* = the number of whole blot (*W*), usual detail (*D*), and unusual detail (*Dd*) responses. *Zd* = a difference score calculated by subtracting an estimated total *Z* Score for the responses in a protocol (*Zest*) from the total assigned *Z* scores (*ZSum*). *DQv* = number of responses with vague developmental quality (*DQv*). *Perception* (Mediation cluster). *XA%* = percentage of total responses with ordinary, ordinary-elaborated, or unusual form quality (*FQo;FQ+;FQu*). *WDA%* = percentage of responses to common areas of the blot (*W* or *D*) that have accurate form quality (*+, o, u*). *X-%* = percentage of responses with minus form quality (*FQ-*). *Xu%* = percentage of responses with unusual form quality (*FQu*); *P* = number of Popular (*P*) responses. *Thinking* (Ideation cluster). *WSum6* = weighted sum of critical special scores; *Lv2* = number of responses coded with Level 2 Special Scores; *M-* = sum of human movement (*M*) responses with distorted form (*FQ-*); *FM* + *m* = sum of animal movement (*FM*) and inanimate movement (*m*) responses; *INTELL* = *Intellectualization Index*, computed as the sum of *2AB* + *Art* + *Ay*. An additional variable that has implications for cognitive functioning is *MOR* (see self-perception, Table 6.4). When interpreted as a cognitive variable, *MOR* > 2 is often indicative of pessimistic thinking. Based on Table 2 in Meyer et al. (2007), which shows that the traditional reference value of *Xu%* > 0.20 was found to be applicable for more than a half of the international nonpatient adult sample, this value was not included in the table for distinguishing between healthy and psychopathological functioning

Table 6.2 Selected CS and CS-based variables and reference values for assessing impaired affective experience in adolescents[a]

Variables	Reference Values	Implications of Deviant Scores
DEPI	*DEPI* = 5 or higher	Subjectively felt distress
S-CON	*S-CON* = 8 or higher	Self-destructive or suicidal tendencies
D Score	*D Score* < −1	Current experience of stress overload and insufficient coping abilities
	D Score > 0	Current minimization of stressful experience; consistency over time, even when the consistency involves being emotionally unstable, with little sense of needing to change, and with ego-syntonic rather than ego-alien symptom formation
AdjD Score	*AdjD Score* < −1	Persistent experience of stress overload and insufficient coping abilities
	AdjD Score > 0	Persistent tendency to minimize stress
AdjDMD	*AdjDMD* > 0	Likelihood of experiencing overwhelming affective or cognitive symptoms of anxiety
FC: CF + C	*FC* > (*CF* + *C*) + 2	Disposition to well-modulated and reserved processing of affect; feelings tend to be mildly to moderate in their intensity while they are present
	(*CF* + *C*) > *FC* + 2	Disposition to unmodulated and spontaneous processing of affect; feelings tend to be transitory but intense while they are present
Pure C	*Pure C* > 1	Likelihood of uncontrolled, intense, and explosive emotional reactivity
Cons. Index	*Sum C'* > *WSumC*	Likelihood of emotional blocking that is preventing feelings from being experienced or expressed
eb	(*FM* + *m*) < *SumShd*	Likelihood of dysphoric, unpleasant, and maladaptive affect
Col-Shd	*Col-Shd* > 1	Limited capacity to experience and enjoy positive feelings
S	*S* > 3	Negativistic attitudes; sometimes associated with oppositional behavior or underlying feelings of resentment
Afr	*Afr* < 0.40	Aversion to affective involvement or interchange; often an indicator of social or emotional withdrawal
	Afr > 0.89	Greater than average interest in emotional stimulation and exchange

[a]*Note*. The CS variables that correspond to the codes in the second column are as follows: *DEPI* = *Depression Index*. A constellation index composed of seven conditions associated with affective states. *S-CON* = *Suicide Constellation*. A constellation index composed of twelve conditions relating to all four dimensions of personality functioning. Two of these conditions (*FV* + *VF* + *V* + *FD* > 2 and *Color-Shading Blend* > 0) are particularly likely to be associated with suicidality, and their endorsement lowers the cutoff score that should be considered. *D Score* = a difference score that converts the raw score difference between *EA* and *es* into a scaled

(continued)

Table 6.2 (continued)

score; *AdjD Score* = an adjusted difference score, calculated by subtracting variables indicating situational stress (*m* and *Y* determinants) from the *D Score*. *AdjDMD* = *AdjD Score – D Score*. A CS-based index computed by subtracting the *D Score* from the *AdjD Score* (Weiner, 2003); *FC: CF + C* = ratio between the number of form-dominated color responses and the sum of color form and no-form color responses; *Pure C* = no-form color responses; *WSumC* = weighted sum of color responses; *Constriction Ratio* = ratio between sum of achromatic color responses (*SumC′*) and weighted sum of chromatic color (*WSumC*); *SumShd* = sum of texture (*SumT*), vista (*SumV*), diffuse shading (*SumY*), and achromatic (*Sum C′*) responses; *eb* = ratio between the sum of animal movement (*FM*) and inanimate movement (*m*) responses and *SumShd. Col-Shd Blend* = *Color-Shading Blend*. Number of responses coded with both color and shading determinants; *S* = *Space*. Number of responses coded with *S* for location (*WS; DS; DdS*). Based on more recent findings (Exner, 2003; Meyer et al., 2007), the traditional cutoff score of *S* > 2 has been changed to *S* > 3; *Afr* = *Affective Ratio*. Computed by dividing the number of responses to Cards VIII, IX, and X by the number of responses to Cards I–VII. An additional variable that should be interpreted in relation to affective functioning is *MOR* (see self-perception, Table 6.4). When interpreted as an affective variable, *MOR* > 2 implies dysphoric feelings, as may be indicated by the content of the response

in the following three chapters (7, 8, 9). Five additional variables that are indicative of personality style rather than psychopathology should also be examined when interpreting a Rorschach protocol. These five variables are the total number of responses (*R*), the *EB* ratio between human movement (*M*) responses and the weighted sum of color responses (*WSumC*), the ratio between active and passive movement responses (*a:p*), the ratio between active and passive human movement responses (*Ma:Mp*), and the *Complexity Index* (*Comp. Index = Blends:R*), which refers to the relative number of responses having more than one determinant.

These stylistic variables provide a contextual framework for interpretation. For example, *EB* is an indicator of personality style, not psychopathology, which is not included in Tables 6.1, 6.2, 6.3, and 6.4, but it can be useful in differentiating the presence of certain kinds of disorder or susceptibility to them. As a case in point, being extratensive can help to differentiate the presence of or susceptibility to bipolar disorder or borderline personality disorder, whereas being introversive makes the presence or susceptibility to these primarily affective disorders unlikely. In general, *R* is usually indicative of a person's openness, energy level, and productivity; *Blends: R* speaks to the relative simplicity or complexity of an individual's personality style; a surplus of passive movements suggests a deferential style in interpersonal relationships and a preference for being a follower rather than a leader; and a surplus of passive human movement points to a problem-solving style based more on thinking than on taking action. Although descriptive of style, none of these variables is likely to be a CS marker of psychopathological functioning.

Tables 6.1, 6.2, 6.3, and 6.4 present selected Rorschach variables for distinguishing between healthy and psychopathological functioning in the four domains of cognitive functioning, affective experience, interpersonal relatedness, and self perception. Some of these variables have implications for more than one domain and should be interpreted accordingly. The selected variables provide a basic platform for interpreting the data presented in the eight clusters of the CS Structural Summary.

Table 6.3 Selected CS and CS-based variables and reference values for assessing impaired interpersonal relatedness in adolescents[a]

Variables	Reference Values	Implications of Deviant Scores
CDI	*CDI* > 3	Deficits in capacity for coping with ordinary aspects of interpersonal and emotional situations
EA	*EA* < 6	Limited adaptive resources
HVI	*HVI* positive	Interpersonal distance, mistrust, and suspiciousness; excessive concern about sources of danger in the environment
Human Content	*H* + *(H)* + *Hd* + *(Hd)* < 2	Limited capacity to form adaptive identifications with other people
Pure H	*Pure H* = 0	Limited capacity to form a stable sense of identity through reference to mental representations of realistic human figures
Fd	*Fd* > 0	Dependency and passivity in interpersonal relationships
Sum T	*Sum T* > 1	Subjective experience of lacking attentiveness to one's needs for intimacy; often associated with feelings of being emotionally deprived and interpersonally unfulfilled
COP	*COP* = *0*	Incapacity to anticipate and engage in collaborative activities with other people
AG	*AG* > *2*	Proneness to being physically or verbally expressive; more likely to be associated with competitive than collaborative interpersonal attitudes and expectations
PER	*PER* > *0*	Defensive, authoritative, or narcissistic interpersonal style

[a]*Note*. The CS variables that correspond to the codes in the second column are as follows: *CDI* = *Coping Deficit Index*. A constellation index measuring impaired interpersonal functioning. *EA* = *Experience Actual*. Sum of human movement responses (*M*) and the weighted sum of color responses (*WSumC*). *HVI* = *Hypervigilance Index*. A constellation index composed of eight conditions related to cognitive and interpersonal dimensions of personality functioning. When the first condition of no texture (*T* = 0) and four of the other conditions are present, the *HVI* is likely to be clinically meaningful. The index can be also be interpretively significant when *HVI* > *4,* regardless of whether the first condition is present. *Human Content* = number of responses with human content, not including *Hx*. *Pure H* = number of responses with whole realistic human figures. *a:p* = ratio between the number of active movement and passive movement. *Sum T* = number of responses with one of the texture codes (*FT, TF, T*). *COP* = *Cooperative Movement*. A special score assigned to movement responses in which two or more objects are engaged in a positive or cooperative interaction. *AG* = *Aggressive Movement*. A special score assigned to movement responses involving aggressive actions. *PER* = *Personalized*. A special score for responses in which the subject refers to personal knowledge or experience. *PER* also has implications for self-perception. An additional variable that has implications for interpersonal functioning is human movement with distorted form quality (*M*-). This variable is included in the CS Ideation cluster as an indicator of strange ideas about people. As an interpersonal variable, it is associated with inaccurate impressions of people and interpersonal events. Based on Table 2 in Meyer et al. (2007), which shows that the traditional reference values of *T* = 0 and *AG* = 0 were found to be applicable for more than a half of the international nonpatient adult sample, these values were not included in the table for distinguishing between healthy and psychopathological functioning

Table 6.4 Selected CS and CS-based variables and reference values for assessing impaired self perception in adolescents[a]

Variables	Reference Values	Implications of Deviant Scores
Reflections	*Fr* + *rF* > 0	Narcissistic traits, involving preoccupation with one's own needs, usually associated with self-admiration, sense of entitlement, externalization of responsibility, and adjustment problems
Egoc. Index	*[3r* + *(2)]/R* < 0.33	Paying insufficient attention to one's self and avoiding self-focusing, usually associated with low self-esteem
	[3r + *(2)]/R* > 0.44	Inordinate preoccupation with oneself; minimal attention to others
Sum V	*Sum V* > 0	Excessive self-criticism, often associated with guilt feelings
FD	*FD* = 0	Lack of self-awareness; limited psychological mindedness
	FD > 2	Excessive introspection; proneness to being maladaptively self-conscious
MOR	*MOR* > 2	Negative attitudes toward one's body and its functions; Dysphoric feelings
H: (H) + *Hd* + *(Hd)*	*H* < *(H)* + *Hd* + *(Hd)*	Tendency to identify with partial or imaginary human figures

[a]*Note*. The CS variables that correspond to the codes in the second column are as follows: *Reflections* = number of responses with *Fr* or *rF*; *Egocentricity Index* = *[3r* + *(2)]/R* represents the proportion of reflection and pair responses in a protocol, with each reflection response (*Fr* or *rF*) being weighed as three pair responses. An elevated *Egocentricity Index* is likely to be clinically meaningful only if *Fr* + *rF* > 0. *Sum V* = number of responses that with one of the vista codes (*FV, VF, V*); *FD* = *Form Dimensionality*. Number of responses that involve impressions of depth or dimensionality that are not based on shading; *MOR* = *Morbid*. *MOR* is a special score for objects perceived as dead, destroyed, damaged, dysfunctional, or as experiencing dysphoric feelings. Whether an elevated number of *MOR* responses have implications for self-perception, ideation, or affective experience depends on the contents of these responses. *H: (H)* + *Hd* + *(Hd)* = ratio between *Pure H* and all the other human figure responses. An additional variable with implications for self-perception is *PER* which is included in the CS Interpersonal cluster

As has been noted, we recommend adding to this platform the five stylistic variables *R*, *EB*, *a:p*, *Ma:Mp*, and *Complexity Index*. Attention to other CS structural variables that appear relevant to a case under consideration and have values that deviate markedly from those found in nonpatient samples (see Chap. 5) may enrich the psychodynamic formulation of the adolescent's personality functioning.

The variables presented in the first column of Tables 6.1, 6.2, 6.3, and 6.4 and grouped by domain of personality functioning are drawn mostly from the eight CS variable clusters. These are variables that have a solid conceptual basis and have proved reliable and valid in cross-cultural research and in clinical applications (Exner, 2003; Exner & Weiner, 1995; Weiner, 2003; Weiner & Greene, 2008; Meyer et al., 2007). Also included in the tables are two CS combinations of variables (*FM* + *m* and *Col-Shd Blend*) and the CS-based indices used in this volume (*RFS-P*, *RFS-S*, *EII-2*, and *AdjDMD). RFS-P* and *RFS-S* are derivations of the *Reality–Fantasy Scale*

Version 2.0 (*RFS-2*; Tibon-Czopp, Appel, & Zeligman, 2015) that have been validated as measures of psychotic thinking and dissociation proneness, respectively; the *Ego Impairment Index EII-2* (Viglione, Perry, & Meyer, 2003) is a theoretically derived measure of maladaptive functioning that has been validated in a meta-analysis encompassing both adult and adolescent samples (Diener et al., 2011); and the *AdjDMD* index (Weiner, 2003), is a measure of anxiety, which has been validated among adolescents (Stokes et al., 2013). The *EII-2* and the *AdjDMD* can be derived directly from the RIAP Structural Summary, and the *RFS* derivations can be computed by transporting the data from the RIAP to the *RFS Software Version 2.0* (Tibon & Suchowski, 2015).

The reference values presented in the second column of Tables 6.1, 6.2, 6.3, and 6.4 correspond to the traditional cutoff scores for adults suggested by Exner (2003), except for his recommending on the basis of his most recent reference data (Exner, 2007) that the cutoff score for white space should be increased from $S > 2$ to $S > 3$. Tables 6.1, 6.2, 6.3, and 6.4 accordingly show $S > 3$ as the white space reference value. There are also eight variables for which traditional CS tables provide two optional reference values. Based on the international composite reference data reported by Meyer et al. (2007, Table 2), Tables 6.1, 6.2, 6.3, and 6.4 applies the least strict (i.e., most liberal) cutoff score, as defined by its being exceeded by a lower percentage of nonpatient adults, in these eight variables as follows: $X\text{-}\% > 0.30$; *D Score* < -1; *AdjD Score* < -1; $FC > (CF + C) + 2$; $(CF + C) > FC + 2$; *Pure C* > 1; $Afr < 0.40$; and *Pure H* $= 0$.

Research findings indicate that many of the traditional cutoff scores for adults presented in Tables 6.1, 6.2, 6.3, and 6.4 are applicable in contemporary assessment of both adults and adolescents (see Chap. 5). In particular, this means that, for most of the variables listed in Tables 6.1, 6.2, 6.3, and 6.4, the traditional reference values for distinguishing between healthy and psychopathological functioning can be applied to Rorschach protocols of contemporary adolescents. With respect to three variables, however, some adjustment of the reference value should be considered, given that more than 50% of the nonpatient adults in the composed international sample of Meyer et al. (2007) exceeded the traditional cutoff point. These three values are $Xu\% > 0.20$, $T = 0$, and $AG = 0$.

In addition, the interpretation of adolescents' Rorschach CS data should be guided by the percentages of nonpatient adolescents in the combined normative samples from Italy, Israel, and Iran (see Chap. 5) who exceed the traditional normative range. These updated reference data provide a benchmark for what is typical or atypical for contemporary adolescents and how youth differ from adults on certain variables. Integration of these cross-cultural empirical findings with psychodynamic developmental conceptualization is used for demonstrating which deviant values in the case illustrations presented in this volume should be considered clinically meaningful, thus distinguishing between healthy and psychopathological functioning.

As has been noted (see Chap. 2), clinically useful classification of psychopathological manifestations must begin with an understanding of healthy mental processes that involve a person's overall resources and capacities. Although no profile can encompass the full range of mental functioning, Tables 6.1, 6.2, 6.3, and 6.4 provide a handy guide for assessing personality strengths and weaknesses and describing the

adequacy of an adolescent's functioning in four major domains: *C*ognitive *Functioning*, *Affective Experience*, *Interpersonal Relatedness*, and *Self-Perception*. When sufficiently elaborated, these four domains of personality functioning serve well the purposes of capturing the richness and individuality of an adolescent's mental functioning and internal experience and providing a psychodynamic structural diagnosis, which distinguishes among healthy, neurotic, and lower (i.e., borderline and psychotic) levels of personality organization (PDM Task Force, 2006). The focus in this chapter is on adequacy of mental functioning rather than on specific psychopathological manifestations. Such manifestations are discussed in the following chapters.

Distinguishing between Normative and Psychopathological Rorschach Protocols of Adolescents

As noted in Chap. 2, healthy reactions to developmental crises may temporarily interrupt an adolescent's maturation without there being any obvious external stimulus to this interruption. Such reactions typically follow a stable period of adjustment and are characterized by a brief crisis in which the adolescent shows some regression to a prior developmental phase. The impact of this developmental crisis might be manifest in a young person's cognitive functioning, affective experience, interpersonal relatedness, or self-perception, and it can at times be exacerbated by changes in an adolescent's family structure or other situations in which the adolescent is involved. Nevertheless, in mentally healthy adolescents facing a variety of normal developmental challenges, the capacity for relationships is preserved and age appropriate (PDM Task Force, 2006). Although the notion of age-appropriate behavior has recently been challenged (Hollenstein & Lougheed, 2013), extreme deviations from Rorschach CS normative data can be particularly helpful in distinguishing between healthy and psychopathological reactions to developmental challenges.

Case Illustration: A Normative Rorschach Protocol

A 12-year-old boy was referred for evaluation prior to his entrance to middle school because his sixth grade elementary school teacher had noticed some recently developed attention problems. He is a physically attractive boy of average size for his age, born and reared in Israel. He has two older brothers age 19 and 16 and a younger sister age 10. He has received high grades in school and maintained close relationships with his peers, among whom he is considered a social leader. His extended family relationahips on both sides are close, and the grandparents take an active part in bringing up the children. The family also has a close group of friends with whom they frequently go on trips and enjoy other collaborative activities. Both parents are college graduates. His father is an independent industrial engineer, and his mother, who originally graduated in business administration and for more than 10 years has had high-level positions in her field, decided 2 months prior to this referral to begin

working on a degree in education, in preparation for a major change in her career. At the same time, the older brother left home for his military service in the Israeli Defense Forces (IDF). These family changes, although viewed positively by both the parents and the children, apparently caused some tension and created some uncertainty with respect to the potential effects of the new circumstances on the family relationships and the boy's place within the family.

The referral based on the boy's teacher noticing some attention problems raises two possibilities to consider. The first possibility is whether he might have an ADHD

Table 6.5.1 Normative Rorschach CS data in a protocol of a 12-year-old boy: Structural Summary

			Affect	**Interpersonal Relatedness**
R = 17	***L = 0.42***			
EB = 5:2.5	***EA = 7.5***	*EBPer = 2.0*	***FC:CF + C = 1:2***	***COP = 2 AG = 1***
eb = 7:2	*es = 9*	***D = 0***	***Pure C = 0***	*GHR:PHR = 8:2*
	Adjes = 7	***AdjD = 0***	***Const. = 1:2.5***	***a:p = 8:4***
			Afr = 0.42	***Fd = 0***
FM = 4	***SumC' = 1***	***SumT = 0***	***S = 4****	***SumT = 0***
m = 3	***SumV = 0***	***SumY = 1***	***Complex. = 4:17***	***Human Content = 10***
			CP = 0	***Pure H = 7***
				PER = 0
				Isolation Index = 0.35
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 8:4	*Sum6 = 3*	***XA% = .94***	*Zf = 16*	***Egoc. Index = 0.35***
Ma:Mp = 4:1	***Lv2 = 0***	***WDA% = .93***	***W:D:Dd = 12:3:2****	***Fr + rF = 0***
INTELL = 3	***WSum6 = 9***	***X-% = .06***	*W:M = 12:5*	***Sum V = 0***
MOR = 0	***M- = 0***	*S- = 0*	***Zd = +3.5****	***FD = 2***
	Mnone = 0	***P = 4***	*PSV = 0*	*An + Xy = 0*
		X + % = .41	*DQ + = 10*	***MOR = 0***
		Xu% = .53	***DQv = 0***	***H:(H) + Hd + (Hd) = 7:3***
PTI = 0	***DEPI = 4***	***CDI = 2***	***S-CON = N/A***	***HVI = No*** *OBS = No*
FM + m = 7*	***Col-Shd = 1***			
RFS-P = −0.24	***RFS-S = 1.73***	***EII-2 = −1.10***	***AdjDMD = 0***	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R, EB, a:p, Ma:Mp, Complexity Index*). Apart from cases in which either or both sides of the *EB* or the number of *Blends* in the *Complexity Index* is zero, the stylistic variables should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure described in this chapter. These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see chap. 5). For interpretation of deviant scores, see Table 6.1–6.4

Table 6.5.2 Normative Rorschach CS data in a protocol of a 12 year-old boy: Sequence of Scores

Card	Resp.								*RFS-2*
I	1	Wo	FMao		A	P	1.0		1
	2	WSo	Fu		(H)		3.5	GHR	−1
II	3	W+	Mao	2	H		4.5	COP, GHR	0
	4	Wo	FMau	2	A		4.5		−1
III	5	DS+	Ma.FDo	2	H, Cg	P	4.5	AG, GHR	0
IV	6	Do	Fo		(H)	P		GHR	3
	7	Dd+	FYu		Bt		4.0		1
V	8	Wo	FMao		A	P	1.0		1
	9	Wo	Ma.mpu		H		1.0	INC, PHR	−1
	10	W+	F-		A, H		2.5	FAB, PHR	−5
VI	11	W+	Mpu	2	H, Cg, Hh		2.5	GHR	−1
VII	12	W+	Mao	2	H,Ls	P	2.5	COP, GHR	0
VIII	13	W+	FMa.mp.CF.FDo	2	A, Ls	P	4.5		1
	14	D+	CFu		Bt		3.0	DR, AB	−2
IX	15	WSo	Fu		(H)		5.5	GHR	−1
X	16	DdS+	mp.FC.FC'u		H, Cg, Art		6.0	GHR	−1
	17	W+	Fu		A, Na		5.5		2

Note: The *RFS-2* column refers to the score of each response on the *Reality-Fantasy Scale version 2.0*

problem for which he should be treated with such behavioral procedures as allowing him more time to complete examinations or such medical procedures as prescribing Ritalin. The second possibility is whether the attention difficulties might mask underlying psychopathology for which psychotherapy or psychotropic medication would be indicated. The Rorschach was administered in the course of his evaluation, and Table 6.5.1 presents in bold his scores on the 45 basic variables delineated in Tables 6.1, 6.2, 6.3, and 6.4 as distinguishing between healthy and psychopathological functioning and the additional five stylistic variables that provide the empirically based platform for interpretation. Table 6.5.2 presents the Sequence of Scores.

As shown in Table 6.5.1, this 12-year-old boy gave a valid Rorschach protocol with 17 responses. Overall, the personality profile shown by his Rorschach is that of a mentally healthy adolescent who exhibits high-level, adaptive, and age-appropriate cognitive capacities, reads and responds to emotional signals flexibly and accurately even when under stress, has considerable capacity for consistent and empathic interpersonal relationships and for self-observation, uses internal representations to experience a sense of self and others and to regulate his impulses and behavior, and demonstrates a well-developed talent for differentiation and integration that enables him to create bridges between reality and fantasy in a playful manner. Nevertheless, if we apply the traditional CS reference values, with the exception of three reference values ($Xu\% > 0.20$; $T = 0$; and $AG = 0$), previously noted as characterizing 50% of nonpatient adults (Meyer et al., 2007, Table 2), the protocol of this adolescent points out deviant scores on the following variables: *S*, *Zd*, and $FM + m$. These findings, noted with an asterisk (*) in Table 6.5.1, require further consideration. In order to explore the meaning of these deviations, we suggest applying a two-step procedure for interpretation. This procedure for analyzing deviations is illustrated with the

present case of a normative adolescent and recommended in the evaluation of any adolescent Rorschach protocol.

For this purpose, the interpretive significance of any deviant score should be assessed by making the previously recommended comparisons with contemporary reference norms. As a first step in this procedure, an adolescent's Rorschach scores that deviate from traditional CS reference values should be compared to the mean (M) and standard deviation (SD) for these scores in the composite international reference data reported by Meyer et al. (2007, Table 1). Although many CS variables are not normally distributed, the distribution of the Ms and SDs becomes increasingly normal as the size of the samples increases, and the scope of the international composite sample (4704 nonpatient adults from 17 countries around the world) warrants using these Ms and SDs to define a normative range. Accordingly, adolescent deviations from traditional CS reference values that fall within 1 SD of the mean value for the international composite sample should be considered unlikely to constitute a psychopathology marker.

In the case of this 12-year-old boy, four of his five scores that deviate from the traditional CS values ($S=4$; $T=0$; $Zd=+3.5$; and $FM+m=7$) are within 1 SD of the contemporary international composite mean and should thus be considered within the normal range. However, they are not indicative of impaired psychological functioning. As for his *Xu%* of 0.53 exceeding the international mean by more than 1 SD, note should be taken of the previously discussed findings that more than half (68 %) of the international adult respondents exceeded the $Xu\%>0.20$ cutoff score. The elevated *Xu%* in this boy's protocol may thus have some interpretive significance, together with his *S*, *Zd*, and $FM+m$ scores, but these scores should not be considered as pointing out psychopathological functioning.

However, should any of an adolescent's Rorschach scores deviate from the contemporary international composite mean as well as the traditional CS reference value, a second step in this interpretive procedure consists of comparing it with the contemporary nonpatient adolescent reference data in Tables 5.3. This table shows a much higher mean value for *Xu%* than the contemporary adults, with 90 % exceeding the $Xu\%>0.20$ cutoff score. Also of note is that the majority of the contemporary adolescent sample showed $T=0$ with the 11–14 age group differing somewhat more than the 15–18 age group from the adult composite sample in both the *Xu%* and *T* variables. These findings indicate that the $Xu\%>0.20$ and $T=0$ cutoff scores should not be used as cutoff scores for distinguishing between healthy and psychopathological functioning in contemporary adolescents.

Another consideration in this interpretive process concerns those deviant scores that exceed the normative range in contemporary nonpatient adult samples and are not presented in the traditional CS tables. In the present case, none of the deviant scores exceeds the normative range. However, because the normative range for *W:D:Dd* is not presented in the traditional tables, the deviant score on this variable (*W:D:Dd* = 12:3:2) should be compared to the reference value displayed in Tables 6.1, 6.2, 6.3, and 6.4 ($W>0.50$; $D<0.50$; $Dd>0.15$) and interpreted accordingly. This comparison shows that the boy is attending to experience in a highly global fashion at the expense of attention to conventional details, which can sometimes facilitate a grasp of complex relationships. Elevated *W* frequency has in fact

been found in highly intelligent people. Nevertheless, as noted by Weiner (2003), the locations people choose for their Rorschach responses provide some indication of whether they pay attention and perceive events conventionally. Preoccupation with the global picture can preclude adequate attention to commonly noted but important details of situations. With respect to the present case illustration, the elevated *W* responses might reflect the high-level intelligence of this 12-year-old boy or some attention problems or both. Additionally, his heightened *FM* + *m,* might be associated with intrusive thoughts that sometimes interfere with his concentration. All things considered, however, Tables 6.5.1 and 6.5.2 present a Rorschach normative protocol of a high-functioning adolescent who currently shows some attention problems, either of a neuropsychological type (ADHD) or as a reaction to a healthy developmental crisis.

As has been noted, attention problems might nevertheless mask various psychopathological manifestations, and the Rorschach can be particularly useful for distinguishing them from healthy patterns of functioning. What follows is another illustration of how to apply the two-step interpretive procedure in an 11-year-old boy with attention problems (Tibon & Rothschild, 2009). The data derived from this adolescent's Rorschach protocol served as an example of assessing psychopathology in children and adolescents in the twenty-first century, and it was used to illustrate an interim solution for the variability found with young nonpatient samples by Meyer et al. (2007). This boy, who was medicated with Ritalin, was referred to an outpatient clinic because of impulsive, violent, and self-harmful behaviors. His Rorschach protocol showed many deviations from the CS traditional reference data, including CS constellation indices of *PTI* = 4, *DEPI* = 6, *CDI* = 4, and *HVI* = Yes.

Noteworthy in his record was the *WSum6* of 31, which we can use to illustrate new suggested guidelines for interpretation. This score is well beyond the normative range as delineated by the traditional cutoff score of *WSum6* > 17. Accordingly, we should first compare the elevated score on this variable to the normative range in the contemporary nonpatient adult samples (Meyer et al., 2007, Table 1). The *WSum6* of 31 is far beyond the contemporary cutoff score as established by M + 1SD (7.63 + 7.75 > 15 when rounded off), which is even lower than the traditional value of *WSum6* > 17. We should therefore evaluate in the second step of interpretation whether the elevated *WSum6* is also deviant in comparison with data collected from contemporary nonpatient adolescents (see Tables 5.1–5.3).

As previously noted (Tibon & Rothschild, 2009), to evaluate the score of *WSum6* = 31, we should convert the raw score into T Score using the M and SD of the international adult nonpatient sample (Meyer et al., 2007, Table 1). We found the use of adult means and standard deviations to generate the T Scores for children and adolescents to facilitate more accurate interpretation of developmental issues if they exist. The corresponding value of *WSum6* is 80 when rounded off. This value should be compared to the T Score of *WSum6* in contemporary nonpatient adolescents aged 11–14, which is 53 (Table 5.2). The *WSum6* T Score in this case is clearly elevated, at more than 1 SD beyond the Mean T Score, which indicates that this boy is showing much more cognitive disorganization than would normatively be expected and that his attention and behavioral problems are likely to reflect impaired psychological functioning.

Conclusion

Effective practice of personality assessment requires careful attention to four considerations including what measures are selected for the assessment, how these measures are used, and when and with whom they should be used. With respect to the first of these considerations, the measures that are selected for a personality assessment should be psychometrically sound, which consists of their being reliable, valid, and normatively referenced. Their reliability should be demonstrated by retest data showing similar findings for variables that are presumed to measure stable personality characteristics. Their validity should be confirmed by statistically significant and clinically meaningful associations with phenomena they are expected to be associated with or to predict and their normative reference data should be sufficient to provide dependable benchmarks for recognizing deviations from what is average or ordinary. With relevance to the focus of the present volume, research reviewed in Chap. 5 documents that the Rorschach is a reliable and valid assessment instrument with extensive age-based and cross-cultural normative reference data.

In common with other personality assessment measures, however, the psychometric soundness of the Rorschach depends on its proper use, beginning with how examinations are conducted. To conduct personality assessments with psychological tests properly, examiners should follow established guidelines for their administration, coding, interpretation, and comparison with normative reference data. Administration in particular should adhere as closely as possible to standardized procedures. Only when tests are consistently administered according to standardized guidelines can sets of results be compared to each other or be combined for research purposes. Strict compliance with published guidelines for the coding of test responses similarly facilitates comparisons among test protocols and with normative data. Although precise coding may be more difficult to achieve with performance-based measures than with self-report inventories, the research reported in Chap. 5 indicates that adequately informed Rorschach examiners can show substantial intercoder agreement.

With respect to interpretation, personality assessors should be familiar with the suggested or demonstrated implications of certain test variables for certain personality characteristics. Unlike administration and coding, there is no fixed strategy for approaching the interpretive process, and legitimate differences of opinion may arise concerning which features of the test data should be emphasized what particular test scores or response contents may signify. However, while interpreting the data, examiners should recognize that their inferences and conclusions are likely to vary in certainty. Some of their impressions may be quite definite, some may consist of alternative possibilities, and some may be more speculative than they are absolute. Each level of certainty can contribute to effective assessment practice, provided that examiners distinguish among them when they report their findings.

Most important in conducting proper personality assessments, obtained findings should be compared with normative reference data. Such comparisons are necessary for examiners to determine the extent to which an individual's personality characteristics resemble or differ from those of most other people. In clinical practice, how

people differ from normative expectation in their personality characteristics has important implications for differential diagnosis and treatment planning. To facilitate such comparisons, the available Rorschach normative data include contemporary norms for several thousand nonpatient adults from 17 countries in North and South America, Europe, and. In Chap. 5 of the present volume we provide contemporary norms for adolescents based on non-patients samples from three countries.

Concerning when the Rorschach should be used, the answer to this question derives directly from its being a personality assessment instrument. Whenever personality characteristics have a bearing on decisions being made, Rorschach findings are likely to provide useful information. Effective applications of Rorschach assessment in clinical diagnosis, forensic evaluations, and therapeutic interventions are discussed in the next three chapters of this volume. With respect to these and other possible applications, however, the Rorschach should not be expected to serve purposes for which it is not intended. Practitioners asked for a consultation should think through the personality characteristics that have prominent implications for answering the question they are being asked. Should they conceive of few such implications or none at all, they should refrain from including Rorschach assessment in whatever evaluation they may conduct.

As for with whom the Rorschach can be applied effectively, when used for its intended purposes of personality assessment, the method has few limitations, provided that the examiner can communicate clearly the findings as describing personality dynamics and the subjective experience of the person being tested. With adequate attention to the age-based normative reference data, the Rorschach can be used with patients of almost any age, from young children to the elderly. As noted in Chap. 5, there are numerous changes in normative Rorschach findings from childhood to adolescence, there are slight Rorschach differences between younger and older adolescents, and there are small differences between older adolescents and adults. With respect to nationality, the international data for adolescents presented in Chap. 5 are notable much more for their similarities among countries than their differences, which indicates the cross-cultural applicability of Rorschach assessment.

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Part III
Applications of Rorschach Assessment of Adolescents

Chapter 7
Diagnostic Applications: Delineating Psychotic and Affective Disorders

The Rorschach was designed as a form-interpretation test, and it is aimed primarily at furnishing clinicians with a tool that is useful for obtaining a clinical diagnosis (Rorschach, 1921/1942). Rorschach assessment assists in diagnosis by providing information about perceptual and associational processes from which personality structural dispositions and dynamic processes can be inferred. Contemporary personality researchers perceive these two facets of personality functioning, the structural and the dynamic, as forming a single system that accounts for the variability in normative and psychopathological behavior (e.g., Mischel and Shoda, 1998). The Rorschach has sometimes been defined either as a measure of personality structure or as a measure of personality dynamics, when in fact it is both and the data it generates speak broadly to the entire personality system. As a standardized behavioral task that does not ask respondents to engage in conscious self-reflection, the Rorschach is well suited for capturing non-observable personality characteristics and distinguishing between healthy and psychopathological personality functioning.

In practice, this distinction between healthy and psychopathological personality functioning is facilitated by attention to Rorschach deviations from normative data that have diagnostic implications (see Chap. 6). Deviations on Rorschach CS markers of thinking disturbances, such as frequent severe cognitive special scores (*Lv2*), is a case in point. In such cases, the CS marker would be useful both for assessing the presence of psychopathology and for pointing to a specific diagnostic category among the psychotic disorders. Schizophrenia and other psychotic disorders, as defined by the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*; American Psychiatric Association, 2013), involve disordered thinking, and the CS special score indices of thinking disorder (see Table 6.1) accordingly suggest a psychotic disorder. Similarly, Rorschach CS markers of disturbed emotionality (see Table 6.2) can prove helpful in detecting the presence of an affective disorder.

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Nevertheless, apart from cases of psychotic and affective disorders, the Rorschach should not be considered a diagnostic test, particularly not one that can delineate the presence or type of a neurotic or personality disorder. Moreover, personality characteristics and their behavioral manifestations do not necessarily show a direct correspondence. In line with this conception, psychodynamic conceptualization is necessary for accurate interpretation of Rorschach markers of psychopathology. In particular, some seeming inconsistencies and puzzling contradictions in behavior can be considered healthy or adaptive at certain developmental stages or in certain circumstances but regarded as psychopathological or maladaptive in other developmental stages and contextual factors. Rather than being dismissed as noise, the differential impact of developmental stages and contextual factors far from obscuring personality, contribute to the coherence of personality functioning by capturing a person's distinctiveness and subjective experience.

As a further consideration in assessing psychopathology, mental health should be viewed as comprising more than merely the absence of symptoms. Rather, mental health involves both subjective experience and the overall quality of an individual's personality functioning, including cognitive, affective, relational, and self-observing capacities. Each of these capacities are located on a dimensional continuum from least to most adaptive, and they interact with developmental and contextual factors to produce healthy or psychopathological functioning. In searching for Rorschach CS indices that delineate the adolescent's capacities in the different realms of functioning (see Chap. 6), the key concern is not whether these indices are associated with any categorical classification but how they correlate with observed behaviors.

The present chapter and the two following chapters provide a psychodynamically oriented perspective on symptom patterns along the lines of the Child and Adolescent Symptom Patterns (SCA) axis of the *Psychodynamic Diagnostic Manual* (*PDM* Task Force, 2006). The SCA axis describes the symptom patterns most commonly observed in children and adolescents with psychological difficulties. Some of these symptom patterns are described only in the adult sections of the *DSM,* but they need to be considered as well with respect to how they are expressed in young people and how they influence their level of adaptive functioning and subjective experience. The discussion addresses special considerations in the diagnostic assessment of adolescents, particularly concerning psychotic and affective disorders, by exploring age-based normative reference data, elaborating CS markers of psychopathology, and showing how Rorschach data, when used properly in relation to updated age-based norms, can point to the presence, nature, and severity of these disorders. Two case illustrations are presented.

With respect to age-based normative data, Meyer et al. (2007) noted wide variability across nonpatient samples of children and adolescents, included in the CS international project. This variability was in contrast to the normative data for adults, which showed considerable similarity across samples from many different cultures and countries. Moreover, given that some CS variables are highly correlated with the total number of responses in the protocol (*R*), and more so in children and adolescents than in adults, *R* should be taken into account in using normative data for evaluating an adolescent's protocol. This is particularly the case with

respect to the cognitive special scores that are known to occur more frequently in young people than in adults (Exner & Weiner, 1995; Leichtman, 1996). Viglione and Meyer (2008) have suggested in a similar vein that greater variability in CS data calls for applying wider confidence intervals, that is, broader ranges for expected scores in a healthy protocol.

The following case illustrations describe two diagnosable disorders seen in adolescents, sometimes with a neuropsychological disorder (e.g., ADHD). The first refers to thinking and perceptual disorder in an 18-year-old girl (Case Illustration 7.1) and the second to major affective disorder in a 17-year-old boy (Case Illustration 7.2). Our approach for interpreting the data in the case illustrations starts with pointing out the deviant scores, followed by discussing the implications of these deviant scores for certain types of disorder, for certain personality characteristics, and for treatment planning, while considering the specific symptom patterns from an experiential perspective. The reader should keep in mind what has been already noted, namely, (a) that the Rorschach is not a diagnostic test and (b) that the Rorschach can provide test patterns that help to delineate psychotic and affective disorders but is infrequently useful for differentiating among the broad range of neurotic or personality disorders.

Case Illustration 7.1: Thinking and Perceptual Disorder in an 18-Year-Old Girl

Psychotic symptom patterns are characterized primarily by cognitive impairment involving disordered thinking and distorted perception. Disordered thinking consists of an incoherent disconnected ideas, illogical reasoning about relationships between events, and inappropriately abstract conceptualization of experience. Distorted perception consists of inaccurate impressions of people and situations resulting in impaired reality testing and poor judgment. These primary characteristics of psychosis may appear with affective instability, disrupted interpersonal relatedness, and a faulty sense of self and body boundaries. In clinical practice the diagnosis of psychotic disorders in adolescents is typically based on a combination of positive symptoms (delusions, hallucinations, and incoherent speech) and negative symptoms (flat affect, anhedonia, inability to function in daily tasks, poor self-care). Although cognitive symptoms could reflect brain dysfunctions, they might also be understood from a psychodynamic perspective as representing maladaptive patterns of functioning and failure to establish a sense of self-cohesion.

Because cognitive functioning develops and matures over time in young people, its possible disruptions should be evaluated in the context of an adolescent's level of maturation. In particular, thought disorders might not become apparent until or sometimes even beyond adolescence, which is when the capacity for formal operational thought normally emerges. The developmental achievement of formal operational thinking enables healthy adolescents to form and use thinking in a higher-level organization, which is characterized by the capacity to construct internal representations

and the capacity for differentiation and integration between self and object representations and between reality and fantasy (*PDM* Task Force, 2006).

The utility of certain Rorschach CS-based indices for distinguishing between psychotic and nonpsychotic personality functioning in adolescents has been empirically demonstrated in cross-cultural research studies. Six of the variables presented in Tables 6.1–6.4 have proved particularly effective with respect to this diagnostic distinction: *PTI*, *RFS-P*, *RFS-S*, *EII-2*, *WSum6*, and *Lv2*. Normal range scores on these variables make the presence of psychotic disorder unlikely, whereas prominent deviant scores provide strong support for a diagnosis of schizophrenia spectrum and other psychotic disorders.

Case Illustration 7.1: Symptom Patterns

This adolescent is an 18-year-old highly intelligent girl who entered college a few months prior to the present assessment. She reports preoccupation with intrusive thoughts about world catastrophes, pessimistic ideation, and mood fluctuations. At the time of the referral, her parents were questioning her contact with reality. They reported that she had been one of the top students in her class during grade school and junior high, was considered an obedient student, who did not get into trouble with teachers. However, during high school she began drinking heavily and using LSD, and she developed severe behavioral problems involving "pushing the limits," particularly in her relationships with adults. The patient reports that she is currently avoiding contact with her parents, apparently because she is involved with people and in activities that they would not approve. She describes some events of perceptual distortion, which she relates to her substance use. Tables 7.1.1 and 7.1.2 present the structural data and the sequence of scores for her Rorschach protocol.

Case Illustration 7.1: Interpretation of Rorschach Data

In accord with the main complaints on referral, inferences about this adolescent's personality functioning should focus on her cognitive scores. Tables 7.1.1 and 7.1.2 show deviant scores on the six ideational variables that have proved effective for distinguishing between psychotic and nonpsychotic functioning: *PTI* = 4, *RFS-P* = −1.10, *RFS-S* = 2.92, *EII-2* = +3.06, *WSum6* = 43, and *Lv2* = 5. Marked deviations also appear on the following cognitive variables: *M-, FM + m, INTELL,* and *W:D:Dd*. These deviations provide well-validated evidence of psychotic functioning. What follows is a description of each of these variables and the inferences that can be drawn from the deviant scores about this adolescent's cognitive functioning.

Table 7.1.1 Thinking and perceptual disorder in an 18-year-old girl: Structural Summary

			Affect	**Interpersonal**
R = 30	***L = 1.14****			
EB = 6:1.5	***EA = 7.5***	*EBPer = 4.0*	***FC:CF + C = 1:1***	***COP = 1 AG = 1***
eb = 9:6	*es = 15*	***D = −2****	***Pure C = 0***	*GHR:PHR = 5:9*
	Adjes = 12	***AdjD = −1***	***Const. = 4:1.5****	***a:p = 7:8***
			Afr = 0.36*	***Fd = 0***
FM = 5	***SumC' = 4***	***SumT = 0***	***S = 7****	***SumT = 0***
m = 4	***SumV = 1****	***SumY = 1***	***Complex. = 6:30***	***Human Content = 12***
			CP = 0	***Pure H = 3***
				PER = 0
				Isolation Index = 0.10
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 7:8	*Sum6 = 12*	***XA% = .70***	*Zf = 16*	***Egoc. Index = 0.50****
Ma:Mp = 2:4	***Lv2 = 5****	***WDA% = .86***	***W:D:Dd = 8:13:9****	***Fr + rF = 0***
Intell = 8*	***WSum6 = 43****	***X-% = .30***	*W:M = 8:6*	***Sum V = 1***
MOR = 3*	***M- = 3****	*S- = 3*	***Zd = +2.5***	***FD = 2***
	Mnone = 0	***P = 7***	*PSV = 0*	*An + Xy = 2*
		X+% = .33	*DQ+ = 12*	***MOR = 3****
		Xu% = .37	***DQv = 0***	***H:(H) + Hd + (Hd) = 3:9****
PTI = 4*	***DEPI = 7****	***CDI = 3***	***S-CON = 6***	***HVI = Yes**** *OBS = No*
FM + m = 9*	***Col-Shd = 1***			
RFS-P = −1.10*	***RFS-S = 2.92****	***EII-2 = + 3.06****	***AdjDMD = 1****	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R, EB, a:p, Ma:Mp, Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index* is zero, the stylistic variables should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4.

Table 7.1.2 Thinking and perceptual disorder in an 18-year-old girl: Sequence of Scores

Card	Resp.								*RFS-2*
I	1	W+	Ma.mpu	(2)	(H), Id		6.0	AG, MOR, PHR	−1
	2	DS+	Mp.FC'o	(2)	H, Cg		4.0	DV1, GHR	−1
	3	Ddo	Fu	(2)	Ad				+2
	4	WSo	Fo		(Ad)		3.5		+2
II	5	W+	FMa.mp.CF. C'F.VFu	(2)	A, Bl	P	4.5	FAB1, INC1, MOR	−5
	6	DdSo	F-	(2)	A			DV2	−3
	7	DSo	Fo		Sc				+3
	8	Do	Fo		Sc				+3
III	9	WS+	Mp.C'F.FMa-	(2)	H, A, Sc, Cg	P	5.5	FAB2, AB, PHR	−5
IV	10	Wo	FDo		(H)	P	2.0	GHR	+2
V	11	Wo	Fo		A	P	1.0	INC2	−5
	12	DdS+	Mp.FC'.FD-	(2)	H		4.0	AB, DR1, PHR	−5
VI	13	Do	Fu		Bt				+2
	14	Do	Fo		A				+3
	15	D+	FMpu	(2)	A		2.5	COP, GHR	−1
	16	W+	Mpu		Ay, Cl		2.5		−1
	17	Do	Fu		A				+2
	18	Ddo	F-		Ad				−3
	19	Ddo	Fu	(2)	Hd			PHR	+2
VII	20	D+	Mp.FYo	(2)	Hd, Cg, Art	P	3.0	MOR, INC	−1
	21	Do	Fu	(2)	(Ad)			PHR	−1
	22	Do	F-		Sx, Hd			PHR	−3
VIII	23	D+	FMao	(2)	A, Id	P	3.0		+1
	24	Ddo	F-		(H)			PHR	−3
	25	Ddo	Ma-	(2)	A			INC1, PHR	−5
IX	26	Ddo	F-		An			DR1	−3
	27	D+	ma-	(2)	Ay, Hd, An		2.5	FAB2, PHR	−5
	28	DdSo	Fo		(Hd), Art		5.0	GHR	+2
	29	D+	FCu		(H),Cg		2.5	GHR	−1
X	30	W+	FMau	(2)	A	P	5.5	DR2	−5

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality–Fantasy Scale Version 2.0*

PTI The Perceptual Thinking Index (*PTI*) is a constellation index composed of five conditions involving the critical special scores and form quality variables. An elevated *PTI* (*PTI*>3) is likely to indicate a psychotic disorder although neither this nor any other diagnosis should be inferred solely on the basis of Rorschach findings. On the other hand, various circumstances can produce a false negative *PTI*, and clinicians should not rule out a psychotic disorder on the basis of *PTI*<4 (Dao & Prevatt, 2006; Smith, Baity, Knowles, & Hilsenroth, 2001).

Proceeding with the interpretation of the *PTI* of 4 in this adolescent's protocol requires examining the specific conditions of the index that are met in this case. This examination shows that all of the *PTI* markers of disordered thinking (*Lv2*>2 and *FAB2*>0; *R*>16 and *WSUM6*>17; *M*->1) are in evidence, which supports a

diagnostic hypothesis of schizophrenia or other psychotic disorder. With regard to her perceptual functioning, her *X-%* of 0.30 is within the normative range (see Table 6.1). This form quality finding, considered jointly with her *P* = 7, indicates that she is able to perceive the world accurately for the most part and that her reality testing is not nearly as impaired as her ability to think clearly and logically.

It should nevertheless be stressed that psychopathological manifestations other than those reflected in the *PTI* might characterize psychotic disorders. Accordingly, diagnostic validity of the *PTI* depends not only on its sensitivity (i.e., that most psychotic individuals would manifest an elevated *PTI)* but also on its specificity (i.e., that relatively few nonpsychotic individuals would show a deviant score on this index). In this regard, it is notable that only 1% of the combined international sample of nonpatient adolescents used in this volume (see Table 5.2) and only 2% of the international nonpatient adult sample (Meyer et al., 2007) showed a deviant score of 4 or 5 on the PTI. This minimal frequency of nonpatients with *PTI* > 3 supports the inference of probable schizophrenia or other psychotic disorder.

RFS-P and RFS-S The *RFS-P* and *RFS-S* are two derivations of the *Reality–Fantasy Scale Version 2.0* (*RFS-2*; Tibon-Czopp, Appel, & Zeligman, 2015). The *RFS-2* was aimed at operationalizing Winnicott's (1971) construct of potential or transitional space between reality and fantasy and its application to Rorschach work, as described by Smith (1990). Theoretically, the scale is based on a relational view of mind and assumes a dialectic conception of what constitutes healthy personality functioning. Following Ogden's (1986) model of different psychopathological states as forms of collapse of potential space, the 11-point scale ranges from −5, which represents extreme reliance on fantasy, to +5, which represents extreme reliance on reality. The mean (*RFS-P*) and standard deviation *(RFS-S*) scores are derived by reviewing each Rorschach response on a given protocol according to specific steps, as presented in a flowchart. The *RFS-2* derivations can be computed by transporting the data from the *RIAP* (Exner & Weiner, 2003) to the *RFS Software* (Tibon & Suchowski, 2015). By scoring each response individually, the *RFS-2* provides clinicians with a tool for conducting a sequence analysis of a protocol, which can measure consistency in cognitive functioning when confronting different kinds of stimuli (e.g., colored vs. non-colored blots). An *RFS-2* sequence analysis can also be applied in exploring the extent to which the use of escape into fantasy as a defense strategy is effective and how long in terms of Rorschach responses it takes for a person to get back in contact with reality.

In the present case, the *RFS* derivations are particularly useful, because the main referral question was the patient's contact with reality. An *RFS-P* lower than 0.30 in an adolescent's protocol is a psychotic marker showing collapse of reality into fantasy, whereas an elevated *RFS-S* (higher than 2.67) is a dissociative marker indicating extreme fluctuations between reality and fantasy. The *RFS-P* and the *RFS-S* shown in this adolescent's protocol exceed the normative range, indicating collapse of potential space with both psychotic and dissociative features (*RFS-P* = −1.10; *RFS-S* = 2.92). Adolescents who exceed the normative range for the *RFS-P* or the *RFS-S* (see Table 6.1) show lowered capacity to differentiate and integrate inner and outer experiences. Although this girl can for the most part perceive events

accurately when she is attending to reality, as shown by her previously noted normative scores on the perceptual variables (CS Mediation cluster), she has considerable difficulty separating reality and fantasy and preventing her fantasy experiences from intruding on her attention to reality.

Specifically, the lowered *RFS-P*, which falls in the negative range of the *RFS-2* and her elevated *RFS-S* delineate this adolescent's substantial difficulties in relating to the outer world. The deviant *RFS-P* and *RFS-S* scores might reflect a schizophrenia spectrum and a dissociative disorder, respectively. Although neither the lowered *RFS-P* nor the elevated *RFS-S* should be considered a diagnostic criterion for a specific condition, their combined presence in the protocol of an adolescent calls for further consideration with respect to differential diagnosis and possible comorbidity of schizophrenia and a dissociative disorder.

EII-2 The Ego Impairment Index (*EII-2*; Viglione, Perry, & Meyer, 2003) has emerged as a dependable measure of psychological impairment and thinking disorder. The current version of the index comprises five components of Rorschach variables that are entered with different weights into an equation. In line with the theoretical perspective from which the index was derived, ego psychology, these variables are assumed to indicate deficits in ego functions that lead to impaired adaptation to external reality. In the present case, this girl's deviant score on the index (*EII-2* = + 3.06) demonstrates significant impairment of her adaptive capacities.

Although a deviant score on the index (*EII-2* > 0) indicates maladaptation to external reality, there are adolescents who demonstrate apparently adaptive functioning (*EII-2* < 0) but yet show psychopathological symptom patterns (e.g., somatization), in which the underlying disorder might be masked and go unnoticed when measured solely by the *EII-2*. In these cases the *RFS-P* and the *RFS-S* can be particularly useful in delineating psychopathology of subjectivity.

WSum6 The weighted sum of the six critical special scores (*DV, DR, INC, FAB, ALOG, CONTAM*) reflects the extent to which a person's thinking is illogical and incoherent. The *DV* and *DR* are coded for dissociative ideas that emerge out of sequence and produce strange, rambling, tangential, and sometimes incomprehensible verbalizations, and *INC, FAB, ALOG,* and *CONTAM* are coded for arbitrary reasoning in which various objects, ideas, and impressions are integrated, combined, or assumed to be interrelated, resulting in disturbed or bizarre thinking. The lower the *WSum6,* the less likely people are to form incoherent and illogical concepts and ideas, except in the case of an extremely guarded protocol with elevated *Lambda* (*L* > 0.99), which may produce a lowered *WSum6* because underlying thinking disturbances are obscured.

The *WSum6* of 43 shown in the present protocol exceeds the traditional normative range (see Table 6.1). Following the suggested interpretive guidelines that are applied in Chap. 6, this elevated score should first be compared to its normative range in the international nonpatient adult sample (Meyer et al., 2007, Table 1). The *WSum6* in this adolescent's protocol is far beyond the contemporary cutoff score as established by *M* + 1*SD* (7.63 + 7.75 > 15 when rounded off), which is even lower than the traditional cutoff value of *WSum6* > 17. As the second step of interpretation,

her *WSum6* should be compared to the reference value based on the combined international sample of nonpatient adolescents used in this volume. If her raw score (*WSum6* = 43) is converted to a T Score using the *M* and *SD* presented in Meyer et al., Table 1, the corresponding value is 100 when rounded off.

This value should be compared to the mean T Score of *WSum6* in contemporary nonpatient adolescents aged 15–18, which is 48 (see Table 5.2). The extremely elevated *WSum6* T Score of 100 therefore indicates that this adolescent is showing much more cognitive disorganization than would normatively be expected and that her cognitive functioning is impaired and dominated by severe thinking disorders. Of further note is the variety of the *WSum6* components in the present case (*DV1* = 1; *DV2* = 1; *DR1* = 2; *DR2* = 1; *INC1* = 3; *INC2* = 1; *FAB1* = 1; *FAB2* = 2). This range of critical special scores would appear to suggest a schizophrenia spectrum disorder with marked thinking disturbances involving both dissociative ideas (*DV* and *DR*) and arbitrary conceptions (*INC* and *FAB*).

Lv2 Responses coded with severe level special scores (*Lv2*) typically reflect disordered thought processes. A Rorschach protocol with *Lv2* > 0 is much more likely to characterize psychotic than non-psychotic disorders, and the presence of more than two such severe special scores is considered to appear quite unfrequently in other than individuals with schizophrenia (Weiner, 1997). From a psychoanalytic perspective, such bizarre responses involve imposing primary thought processes onto the inkblot stimulus.

The Rorschach protocol of this highly intelligent adolescent shows five responses coded with *Lv2* special scores. The nature and frequency of these bizarre responses indicates that she tends to indulge in language that would be inappropriate in any context (*DV2*), to make remarks that would be inappropriate within specific contexts (*DR2*), and to draw arbitrary and illogical inferences about relationships between objects and events (*INC2, FAB2*). The severity and heterogeneity of the thought disorders reflected in these responses further strengthen the hypothesized presence of a schizophrenia spectrum disorder.

In addition to analyzing the specific features of *Lv2* responses, examiners should consider as well the sequence in which they occur. This sequence analysis can yield important information about the context in which a person's *Lv2* responses appear (e.g., on a colored blot, following undistorted preceding responses) and about whether the problem of disordered thinking is resolved in the responses that follow. As shown in this adolescent's sequence of scores (see Table 7.1.2), her *Lv2* responses are distributed throughout the protocol with no consistent pattern related to the characteristics of the outer stimulus (the blot). This distribution suggests that she is at risk for showing impaired thought processes regardless of the situation she is in, which is a characteristic usually associated with a schizophrenia spectrum disorder.

Nevertheless, it is noteworthy that her first *Lv2 r*esponse occurs as the second response to Card II, following four relatively adaptive, although not particularly conventional, responses to Card I and an extremely complex and morbid initial response to Card II. This fifth response has *W*+ for location and *DQ*, five determinants in a *blend*, which includes an infrequently found and dysphoric combination of color-shading and shading-shading determinants in the same response, a content

representing primitive and usually unpleasant thoughts (*Bl*), and three special scores. The implications of blood content for concerns about being damaged or harmed raise the possibility of her having experienced a traumatic event. With regard to differential diagnosis, these complex findings call for consideration of comorbidity of a schizophrenia spectrum disorder with major affective and dissociative symptoms as in schizoaffective disorder or in PTSD.

M- The sum of human movement (*M*) responses with distorted form (*FQ-*) is another indicator of impaired thought processes. Its implications are particularly important for evaluating thought processes related to people activity, as measured by perceptual accuracy and realistic interpretation when human figures are seen in the blot. Adolescents, as well as adults, who give *M-* responses, are showing interest in people but a propensity for inaccurate and unrealistic interpretation of interpersonal situations, which typically contributes to poor social judgment and awkward or strained relationships. The frequency of *M-* responses in the present case (*M-* = 3) exceeds the cutoff score of *M-* >1. However, to evaluate the severity of thinking disturbance, each *M-* response should be considered with respect to its content and other coding features (e.g., special scores) and in relation to its place in the sequence of scores.

For example, the *M-* in the ninth response, which is the only response to Card III, can be considered to represent personality functioning within the context of interpersonal relationships: *I remember this one. Two people. The butterfly between them. Leaning on an Ouija board. Got like animal coming out of their chests. Genitals here. Animals coming out, like a spirituality thing. Heads, legs, skirts.* This *WS+* response changes an apparently developed pattern of four-sequence responses to the first two cards, with two *M* responses, coded with unusual and ordinary *FQ*, on Card I. The response begins with a comment (*I remember this one*) by which this adolescent is apparently aiming to sooth herself by referring to an already familiar outer stimulus, followed by the common (*P*) percept of two people. She specifies that the two people are involved in a spiritual, passive, and noncooperative activity (*leaning on an Ouija board*). This percept of isolated, distanced, and noncooperative human activity is followed by the accurate percept of a butterfly that is *between them*, which emphasizes even more the experience of distance in interpersonal relationships.

However, these two seemingly adaptive percepts of human figures and a butterfly gradually change into impaired thought processes (*Got like animal is coming out of their chests*), as coded with *FAB2*. The impaired thinking manifestation is followed by some explicit sexual content (*Genitals here*) and a kind of perseverative return to a threatening percept (*Animals coming out)* against which she defends with intellectualization, by becoming overly abstract and locating the percept in fantasy (*…like a spirituality thing*). However, this defensive operation does not appear particularly effective, and she abruptly changes her attention back to reality (*Heads, legs, skirts*), with accurately perceived details, but seemingly without her previously shown capacity to integrate these details into a whole human figure. This *M-* response, which starts with an appropriate acknowledgement of the human interpersonal context, is spoiled by some perceived threat that activates defensive operations

(intellectualization, distancing) aimed at reducing the perceived threat in the stimulus but resulting in a response notable for its fragmentally perceived reality.

FM + m The sum of animal movement (*FM*) and inanimate movement (*m*) responses represents intrusive ideas that resist conscious control. *FM* is typically associated with disturbing awareness of unsatisfied needs, and *m* indicates concerns about being helpless when confronting threatening events. The occurrence of *m* in this adolescent's first response to Card I provides substantial information about her psychological state when faced with the ambiguous nature of the Rorschach task. How does she cope with this anxiety-provoking threat? How are the other codes assigned to this response explaining her coping style when exposed to an external or internal threat? The coding of the first response (*W+ Ma.mpu (2) (H), Id 6.0 AG, MOR, PHR*) and the three subsequent responses to Card I provide some clues to answering these queries. When confronting the outer stimulus, she tends to respond initially by using ideational rather than affective coping strategies and by escaping into fantasy while preserving reasonably adequate although somewhat idiosyncratic contact with reality. With respect to her ideation, however, the human representation in her fantasy is a fictional and not a real human figure, and the contents are aggressive (*AG*) and loaded with pessimistic ideation (*MOR*).

The elevated score of $FM + m = 9$ shown in the protocol typically indicates, however, maladaptively excessive thinking involving lowered capacity to prevent conscious awareness of disturbing thoughts and concerns. This adolescent is in all likelihood preoccupied with intrusive and anxiety-provoking thoughts that make it difficult for her to concentrate and against which she employs a variety of defense strategies that are ineffective in preventing impaired cognitive functioning.

Intellectualization Index (INTELL) The variables that compose the Intellectualization Index (*INTELL*), which is computed as the sum of $2AB + Art + Ay$, represent an inclination to maintain some distance between oneself and the Rorschach stimuli. Although intellectualization is usually considered a relatively mature and high-order defensive strategy (McWilliams, 1994), excessive reliance on it can sometimes reflect a lower level of personality organization in which pseudo-intellectualized responses, and overly abstract thinking (*AB*) in particular, dominate a person's copying style.

The extremely elevated score on this index ($INTELL = 8$) in the present protocol, including two *AB* responses, is a further indication of this girl's impaired cognitive functioning. Using intellectualization as a major defensive strategy creates distance from troubling experiences and reduces the felt anxiety they might otherwise promote. This defense might prevent her from being overwhelmed by emotions and thus provide a safeguard against distress. However, relying excessively on intellectualization, as indicated by $INTELL > 5$, represents an immoderate use of ideation that is likely to have maladaptive consequences (Weiner, 2003). Her deviant score on the index shows that she is vulnerable to becoming markedly upset when faced with affective stimuli that exceed her capacity to use her intellectualizing defense effectively. As a further indication in this regard, her maximum score of 7 on the *Depression Index* (*DEPI*) is usually associated with a diagnosable affective disorder.

The elevated *INTELL* and *DEPI* indicate the presence of underlying distressing affect, against which she has activated vigorous but ineffective defenses including denial and dissociation. These findings lend further weight to the hypothesized comorbidity of schizophrenia spectrum disorder with major affective and dissociative symptoms.

W:D:Dd This ratio between responses given to the whole blot (*W*), frequently selected areas (*D*), and rarely selected areas of the blot (*Dd*) provides location choice information about selective focusing of attention. Impaired ability to focus on essential elements of the external stimulus, either because of overinclusion (*W*) or because of excessive attention to peripheral or infrequently noted details (*Dd*), might indicate thinking disturbances.

The extremely elevated number of *Dd* responses in the present protocol indicates that this highly intelligent and distressed adolescent cannot attend adequately and keep her attention focused on the obvious and important aspects of situations. Although highly intelligent obsessive individuals may also give numerous *Dd* responses, they would also be likely to display an organized and systematic approach to the Rorschach task that is intended to take all of the blot areas into consideration without being distracted by any of them. However, this girl seems to be easily distracted by irrelevant external and internal clues, often consisting of deviant thoughts and associations that prevent her from maintaining an adaptive focus of attention and further impair her functioning.

Case Illustration 7.1: Summary and Conclusions

This highly intelligent adolescent, whose Rorschach protocol is presented as a case illustration of impaired cognitive functioning, produced numerous markers of distorted thinking that are usually seen in schizophrenia and other psychotic-spectrum disorders ($PTI > 3$; $RFS\text{-}P < -.30$; $RFS\text{-}S > 2.67$; $EII\text{-}2 > 0$; $WSum6 > 17$; $Lv2 > 0$; $M- > 1$; $FM + m > 6$; and $INTELL > 5$). In addition, she shows considerable difficulty in keeping her attention focused on prominent details in her environment ($Dd = 9$). Nevertheless, when she does attend to reality, she is able to perceive objects and events accurately and conventionally ($XA\% = 0.70$; $WDA\% = 0.86$; $X\text{-}\% = 0.30$; and $P = 7$).

On the other hand, her severely impaired thought processes ($WSum6 = 43$; $Lv2 = 5$) are notable indications of limited capacity to separate and integrate reality and fantasy ($RFS\text{-}P = -1.10$; $RFS\text{-}S = 2.92$). This problem, coupled with intrusive thoughts ($FM + m = 9$) that are usually associated with difficulties in concentration, points to her inclination to rely excessively on fantasy. Her thinking is sometimes quite strange, and she disregards obvious reality clues much more than would be expected in her age group. She is consequently prone to faulty judgment, based on partial and overly imaginative views of objects and events in the environment particularly within an interpersonal context as shown in $M- = 3$, *HVI* positive, and $H < (H) + Hd + (Hd)$.

Her cognitive impairment appears jointly with marked indications of subjective distress (*DEPI*=7), with a *Col-Shd Blend* and a *Shading-Shading Blend* in the same response, elevated anxiety (*AdjDMD*=1), and pessimistic thinking (*MOR*=3). However, because her personality style is introversive (*EB*=6:1.5), complex (*Blends:R*=6:30), and passive (*a:p*), these concerns might go largely unnoticed, even when she is confronted with emotionally arousing stimuli (*Afr*=0.36) and interpersonal situations, due to her limited openness to experience (*L*=1.14) and inclination to block emotional expression (*Constriction index*=4:1.5). These characteristics put her at risk for episodes of depression.

As noted in Chap. 6, *EB* as an indicator of personality style can be useful in differentiating the presence of certain kinds of disorder or susceptibility to them. In the case of this adolescent, being introversive increases the likelihood of the presence or susceptibility to schizophrenia spectrum disorder. In response to her subjective distress, she resorts to defensive strategies of withdrawal into fantasy, intellectualization, and dissociation that further exacerbate her propensity to distance herself from reality. As a result, her adaptation to the outer world is severely impaired as shown by the elevated *EII-2*.

The surprising coupling of relatively accurate perception with substantially impaired thought processes (which is shown in the positive *PTI* that does not include the perceptual criterion of *XA%*<0.70 and *WDA%*<0.75) supports a hypothesized psychotic condition marked by peculiar verbalization (*DV2*), associational fluidity (*DR2*), and arbitrary thinking (*INC2* and *FAB2*). This variety of markers indicating severely impaired thinking processes point more specifically to a schizophrenia spectrum disorder. As a further consideration, accumulated clinical research has shown that the presence of severely disturbed thinking processes with relatively preserved perception of reality is often indicative of a delusional disorder. However, this adolescent appears quite motivated to communicate her distress (*R*=30) and to get professional help apparently to let *wired bug… things climbing up* (Card X, Resp. 30). Her preserved reality testing and her apparent motivation to communicate her subjective distress have important implications for treatment recommendations.

Case Illustration 7.2: Major Affective Disorder in a 17-Year-Old Boy

Affective disorders are widely considered to occur in two major forms of a unipolar affective disorder, which consists of episodes of depression, and a bipolar affective disorder, which involves manic and depressive episodes. In both depressive and manic symptom patterns, the disturbances can be observed in moods, attitudes, energy level, and physical states. While depressive mood symptom patterns are manifested by dysphoric affect, sadness, and irritability, manic symptom patterns are manifested by irritability coupled with a euphoric and playful mood. Changes in

appetite or weight, sleep, and psychomotor activity, along with somatic complaints that sometimes mask depression, frequently appear jointly with the depressive or manic mood states.

From a psychodynamic perspective, depression is the core factor in affective disorders, and the symptom patterns in mania are aimed at warding off depression. Of further note, developmental changes may produce variations in the manifestations of affective disorders. For example, adolescents diagnosed with phobic or avoidant disorders frequently meet diagnostic criteria for depressive disorder. Similarly, adolescents with conduct disorders often show symptom patterns of bipolar disorder. In both cases, the depressed adolescent is at risk for suicidality, substance abuse, early sexual involvement, and eating behavior problems (*PDM* Task Force, 2006).

The intense emotions that characterize adolescents with a diagnosable affective disorder, whether unipolar or bipolar, typically exceed their capacity to regulate. When depressed, adolescents may experience helplessness, vulnerability, fragility, and severe self-criticism. They are easily provoked by emotional stimuli and utilize a variety of defenses to avoid being overwhelmed. Depression also has substantial negative effects on interpersonal relationships. Adolescents with affective disorders have strong needs for being supported and helped to manage their distressing mood, while at the same time their needs for separation and individuation may strain their family relationships and minimize the support and help they receive. Overall, untreated depression in adolescence can severely impair social and emotional development and may lead to a poor adult adjustment.

Distinguishing between psychopathological and normal depressive states in adolescents can be a challenging task. Unlike schizophrenia and other psychotic disorders, depression is a familiar psychological state, particularly in adolescents. It is when normal episodes of depression, arising as a reaction to developmental crises or as a response to external threatening events, become prolonged or substantially impair the adolescent's personality functioning that they constitute a diagnosable depression.

Nevertheless, assessing the presence of a major affective disorder, differential diagnosis requires first evaluating whether the disorder is unipolar or bipolar. In this regard, Rorschach deviations on other than affective variables, particularly those referring to impaired cognitive or interpersonal functioning, may serve as indicators. For example, Rorschach markers of impaired attention (e.g., elevated *Dd* and *DQv*) or grandiosity (e.g., *PER*) can be useful in the differential diagnosis of mania. Some markers of manic defenses may appear in the protocol even when the adolescent being tested is in a depressive state, which can be helpful in differentiating between unipolar or bipolar disorder.

When symptom patterns raise a question of affective disorder, differential diagnosis also requires consideration of possible schizophrenia (see Case Illustration 7.1) or antisocial personality disorder, both of which have some symptoms in common with affective disorders. Additionally, of primary importance in the personality assessment of adolescents is the risk of self-destructive behaviors, as can be demonstrated by the *S-CON* for those who are 15 or older. These issues of differential

diagnosis and risk factors are explored in the present case illustration. As in the case of schizophrenia, the following discussion assumes familiarity of Rorschach users with the manifestations and origins of the condition. Accordingly, the inferential process focuses on the informed utilization of the test data.

Case Illustration 7.2: Symptom Patterns

This adolescent is a 17-year-old boy, a college student who was referred for assessment of the presence of affective disturbances. On referral, he reported multiple somatic symptoms (e.g., abdominal pain, diarrhea, and irritable bowel syndrome), frequently exacerbated under stress, as well as depressive mood, sadness, chronic fatigue, and irritability. According to his report, he had always been preoccupied with his physical health, which led to his developing cautious and avoidant patterns of behavior when involved in pleasurable activities, such as playing outside with his peers or eating non-healthy food. The patient described his mother as a very anxious person who is particularly concerned about health problems in the family and consequently seeks frequent medical consultation.

Tables 7.2.1 and 7.2.2 present the Structural Summary and the Sequence of Scores of this boy's Rorschach protocol.

Case Illustration 7.2: Interpretation of Rorschach Data

In line with the conception that somatic complaints may sometimes mask depression, the analysis of this adolescent's Rorschach data focuses on variables that have been found to distinguish between healthy and psychopathological affective functioning. Among the variables delineated as measuring affective functioning (see Table 6.2), the following deviations are shown in this adolescent's protocol: *DEPI* = 6; *S-CON* = 9; *AdjDMD* = 1; *eb* = 0:9; *Col-Shd Blend* = 2; *S* = 6; and *Afr* = 0.33. These deviations provide well-validated evidence of impaired affective functioning. What follows is a description of each of these variables and the inferences that can be drawn from their deviations with regard to this adolescent's affective functioning.

DEPI The *Depression Index* (*DEPI*) is a CS constellation composed of seven criteria involving achromatic color and shading determinants plus other structural variables assumed to be related to dejection or subjective distress. An elevated *DEPI* of 5 is likely to indicate subjectively felt distress, and a value of 6 or 7 is usually related to diagnosable depression. It should nevertheless be stressed that psychopathological manifestations other than those reflected in the *DEPI* may characterize major affective disturbances. Accordingly, the diagnostic validity of the *DEPI*, particularly in adolescence, depends not only on its sensitivity, which means that most adolescents

Table 7.2.1 Major affective disorder in a 17-year-old boy: Structural Summary

			Affect	Interpersonal
R = 24	***L = 1.18****			
EB = 0:4.0*	***EA = 4.0****	*EBPer = 4.0*	***FC:CF + C = 2:3***	***COP = 0**** ***AG = 0***
eb = 0:9*	*es = 9*	***D = −1***	***Pure C = 0***	*GHR:PHR = 2:3*
	Adjes = 5	***AdjD = 0***	***Const. = 3:4.0***	***a:p = 0:0***
			Afr = 0.33*	***Fd = 1****
FM = 0	***SumC' = 3***	***SumT = 1***	***S = 6****	***SumT = 1***
m = 0	***SumV = 0***	***SumY = 5***	***Complex. = 3:24***	***Human Content = 5***
			CP = 0	***Pure H = 0****
				PER = 4*
				Isolation Index = 0.13
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 0:0	*Sum6 = 1*	***XA% = .63****	*Zf = 8.0*	***Egoc. Index = 0.04****
Ma:Mp = 0:0	***Lv2 = 0***	***WDA% = .72****	***W:D:Dd = 10:8:6****	***Fr + rF = 0***
Intell = 2	***WSum6 = 3***	***X-% = .33****	*W:M = 10:0*	***Sum V = 0***
MOR = 5*	***M- = 0***	*S- = 3*	***Zd = +1.5***	***FD = 0****
	Mnone = 0	***P = 2****	*PSV = 0*	*An + Xy = 4*
		X+% = .38	*DQ+ = 3*	***MOR = 5****
		Xu% = .25	***DQv = 6****	***H:(H) + Hd + (Hd) = 0:5****
PTI = 2	***DEPI = 6****	***CDI = 5****	***S-CON = 9****	***HVI = No*** *OBS = No*
FM + m = 0	***Col-Shd = 2****			
RFS-P = + 0.17	***RFS-S = 2.51***	***EII-2 = + 0.59****	***AdjDMD = 1****	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R, EB, a:p, Ma:Mp, Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index* is zero, the stylistic variables should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4.

with *DEPI* of 6 or 7 would meet a diagnosis of depression, but also on its specificity, which means that relatively few nonpatient adolescents would show these values on the index. In this regard, data presented in Table 5.3 show that 29% of the nonpatient adolescents in the combined international sample used in this volume scored 5 on the

Table 7.2.2 Major affective disorder in a 17-year-old boy: Sequence of scores

Card	Resp.								*RFS-2*
I	1	Wo	Fo		An		1.0	PER	+3
	2	WS+	Fo		A	P	4.0	MOR	+4
	3	WSo	Fo		(Hd)		3.5	GHR	+2
II	4	Do	Fu		Sc				+2
	5	DS+	C′Fo		Na, Hh		4.5		+2
	6	Dv	CFo		(Hd), Bl			MOR, DR, PHR	+1
III	7	DdS+	FC′.FC-		(Hd), Cg		5.5	PHR	−3
	8	Do	Fu		(Hd)			GHR	−1
	9	Ddo	Fu		Ad				+2
IV	10	Do	FYo		An				+2
	11	Wv	Y		Sc				−2
	12	DdSo	F-		(Ad)				−3
V	13	Wo	FC′o		A	P	1.0		+3
	14	Ddo	F-		Hd			PHR	−3
VI	15	Wv	YF.TF-		Ay			MOR, PER	−3
	16	Wo	YF-		Xy		2.5	PER	−3
VII	17	DSv	F-		Id			MOR	−3
	18	Wv	Fu		Fd			MOR	+2
VIII	19	Wo	CF-		A		4.5		−3
	20	Ddo	Fu		Cg				+2
IX	21	Do	Fu		A				+2
	22	Ddo	F-		An			PER	−3
X	23	Wv	CF.YFo		Art				+2
	24	Do	FCo	2	Bt				+2

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality-Fantasy Scale Version 2.0*

DEPI, whereas 12% and 2% scored 6 and 7, respectively. Although the frequency of *DEPI*=5 is higher in nonpatient adolescents as compared to adults (19%) in the international project of Meyer et al. (2007), the age-based differences disappear with respect to *DEPI* of 6 or 7 (10% and 2%, respectively, in Meyer et al.'s sample). The lower frequency of nonpatients with *DEPI*=6 supports the inference of probable affective disorder when *DEPI* > 5, as in the present case.

S-CON The *S-CON* is a constellation index composed of 12 criteria relating to all four realms of personality functioning (cognitive, affective, interpersonal relatedness, and self-perception). When *S-CON* is 8 or higher, risk of self-destructive or suicidal tendencies is inferred. Two of the *S-CON* conditions (*FV* + *VF* + *V* + *FD* > 2 and *Color-Shading Blend* > 0) are particularly likely to be associated with suicidality, and their endorsement lowers to 7, the cutoff score that should be of concern.

The positive *S-CON* of 9 in this adolescent's protocol should be considered a risk factor for self-destructive and suicidal behaviors. Research findings and clinical experience have shown that suicidal behavior in adolescents typically involves long-standing distress, dissolving social relationships, and other maladaptive behavioral manifestations. It is particularly important to assess dispositions for self-destructive

acts when the presence of affective disorder is evident. The positive *DEPI* as well as other markers of impaired affective functioning in this adolescent's protocol further strengthen the hypothesis of suicidality shown by the *S-CON*.

AdjDMD The *AdjDMD* is a CS-based index computed by subtracting the *D Score* from the *AdjD Score* (Weiner, 2003). The index has been validated in a sample of patient children and adolescents as a measure of experienced anxiety (Stokes et al., 2013). When the value of *AdjDMD* is 1 or more, the person being tested is quite likely to be experiencing persistent affective or cognitive symptoms of anxiety.

The deviant score of 1 shown on *AdjDMD* in the present case suggests that the experienced anxiety of this adolescent, which is beyond his capacity to regulate, is not a result of a current crisis but rather should be viewed as a marker of an enduring affective disorder. The overall impaired ego functioning, as shown in his elevated *Ego Impairment Index* (*EII-2* = +*0.59*), indicates that, in addition to his constantly heightened subjective distress, he may be prone to maladaptive behaviors.

eb This ratio between the number of nonhuman movement responses (*FM* + *m*) and the number of achromatic color and shading responses (*SumShd*) provides an indication of experienced emotional stress. The *eb* enables clinicians to predict if stress symptoms are more likely to be reflected in the cognitive or the affective domain of functioning. As noted in Table 6.2, a Rorschach protocol in which *SumShd* exceeds *FM* + *m* indicates a likelihood of dysphoric, unpleasant, and maladaptive affect. Nevertheless, in respondents who show an introversive style and tend excessively to use intellectual defenses that blunt stressful emotional impact, this affective experience may not be consciously recognized or directly expressed, and relatively elevated *SumShd* can in particular impede pleasurable modulation of affect.

In the present case illustration, this adolescent is not stylistically oriented to use ideation for coping with reality (*M* = 0), which increases the likelihood that the substantial shading deviation shown in his protocol (*SumShd* = 9) is indicative of maladaptive affective functioning. The presence of five diffuse shading (*Y*) and three achromatic color (*C'*) responses as the major components of his *SumShd* speaks to feelings of paralysis and hopelessness and strengthens the inference of a substantially impaired affective experience.

Col-Shd Blend Rorschach protocols with *Col-Shd Blend* > 0 indicate at all ages limited capacity to experience and enjoy positive feelings, and even one such response suggests dysphoric tendencies. Respondents whose protocol includes one or more *Col-Shd Blends* frequently have difficulties sorting out their feelings and for the most part are likely to be upset. For respondents who show extratensive style, a more conservative cutoff score (*Col-Shd Blend* >1) should be used to support this inference.

The two *Col-Shd Blend* responses in this adolescent's protocol exceed even the conservative reference value used for respondents with an extratensive personality style. As noted, this deviation indicates limited capacity to experience and enjoy positive feelings. In addition, he has a *Shading-Shading Blend*, which is an infrequent finding at any age and further supports the inferred painful and dysphoric feelings that

are beyond his capacity to manage. Question might be raised whether any particular type of stimulus provokes these feelings. This question can be explored with a sequence analysis of his blend responses, each of which includes a shading code.

For example, the first blend (*FC. FC'*) appears when he confronts Card III, which is often considered to represent one's functioning within an interpersonal context (Resp. 7): *Tuxedo …a man in a tuxedo*. The location code of this response (*DdS*) indicates that he detaches himself, consciously or unconsciously, from the major feature of the blot, probably as a defensive operation to avoid being involved in the outer context of human interaction. Nevertheless, this defensive operation has impaired his perception of reality (*FQ-*). Although he managed to improve his perceptual accuracy in the two following Card III responses, neither of them includes the popular (*P*) percept of human figures.

White Space (S) When referring to the white space instead of the blot itself, individuals are doing just the opposite of what has been asked of them in the Rorschach instructions. Showing some autonomy by referring to the white space may indicate adaptive capacity for individuation, which is frequently observed in adolescents. However, an elevated number of *S* responses ($S > 3$) often indicates negative attitudes and irritability sometimes associated with oppositional behavior that goes beyond adaptive autonomy. In some cases, elevated *S* responses, particularly when referring to the central part of Cards II, III, VII, and IX, might indicate a defensive flight from emptiness, a denial of deficiency, or separation anxiety, either of which could be provoked by the gulf between the figures represented in the blot.

The relatively high frequency with which this adolescent uses the white space ($S = 6$) rather than the blot itself is likely to reflect generalized maladaptive oppositional tendencies that are associated with underlying feelings of anger or resentment. Such oppositional tendencies and underlying feelings could have a negative impact on his interpersonal functioning. Nevertheless, the occurrence of *S* in Cards II, III, and VII also raises the hypothesis that this adolescent is extremely invested in denying deficiency and coping with separation anxiety.

Afr The *Affective Ratio* (*Afr*) is an index that compares the number of responses given by the person being tested to Cards I–VII with the number given to Cards VIII–X. This index speaks to a person's inclination to become involved in or to avoid affective interchange. An *Afr* below .40, with the exception of protocols with a well-synthesized whole (*W*) response as the only response to Card X, indicates aversion to affective involvement or interchange and is often an indicator of social or emotional withdrawal.

The protocol of this boy shows a low *Afr* of .33 and does not include a particularly well-integrated sole response to Card X. Because close interpersonal relationships usually involve exchanging feelings and ideas, this adolescent is at risk for being socially as well as emotionally withdrawn. He is likely to feel inconvenience with affective displays, especially if he is expected to respond accordingly. Such aversion to emotionality might limit his social attractiveness, because his peers are likely to perceive him correctly as being distant and reserved.

Indeed, many deviations on the interpersonal functioning variables do appear in his protocol. These include deficits in the capacity for coping with ordinary aspects of interpersonal and emotional situations (*CDI* = 5), limited adaptive resources (*EA* = 4), limited capacity to form a stable sense of identity through reference to mental representations of realistic human figures (*Pure H* = 0), and to anticipate and engage in interpersonal relationships (*COP* = 0 and *AG* = 0), and a defensive or narcissistic interpersonal style (*PER* = 4). What follows is a description of the *PER* variable in relation to this deviant score.

PER Personalized (*PER*) responses are responses in which the individual refers to personal knowledge or experience as part of the basis for justifying or clarifying a response. The presence of one or more *PER* responses in a protocol indicates a guarded, defensive, and self-aggrandizing style in interpersonal relationships, often reflecting feelings of insecurity and limited self-confidence.

Applying the method described in Chap. 6 for converting the raw score of *PER* = 4 shown in this adolescent's protocol to a T Score using the *M* and *SD* presented in Meyer et al. (2007 Table 1), the corresponding value is 79 when rounded off. Compared to the mean T Score of *PER* in contemporary nonpatient adolescents aged 15–18, which is 50 (see Table 5.2), this value is extremely elevated. This elevation suggests that he is prone to use his personal knowledge and experience in interpersonal relationships in a self-aggrandizing style, probably as an element of a narcissistic injury defensive strategy.

Marked deviations in this boy's protocol also appear on some cognitive variables and indicate an unusual focus of attention (*W:D:Dd* = 10:8:6; *DQv* = 6), inaccurate perception (*XA%* = 0.63; *WDA%* = 0.72; *P* = 2), and pessimistic thinking and attitudes, particularly with respect to his body and bodily functioning (*MOR* = 5). Impaired ego functioning is less notable in the cognitive than in the interpersonal domain, but it is nevertheless significant that this distressed adolescent appears susceptible to being easily distracted by irrelevant external clues (*Dd* = 6). This might impair his capacity of maintaining an adaptive focus of attention.

His extremely low self-esteem as shown in the *Egocentricity Index* (*Egoc. Index* = 0.04) indicates that he is paying insufficient attention to himself and avoids self-focusing; he appears to lack self-awareness and have limited psychological mindedness (*FD* = 0); and he tends to identify with partial or imaginary human figures, as shown by the *H:(H) + Hd + (Hd)* ratio of 0:5. Taken together, these self-perception findings provide further support for a differential diagnosis that rules out the thinking disorder factor of a schizophrenia spectrum or other psychotic disorder and increases the likelihood of a major affective disorder.

Case Illustration 7.2: Summary and Conclusions

This 17-year-old boy produced a Rorschach protocol containing numerous markers of dysphoric emotionality and subjectively felt distress that exceed his capacity to manage comfortably and put him at risk for self-destructive behaviors (*DEPI* = 6,

S-CON = 9, *AdjDMD* = 1, *eb* = 0:9, *Col-Shd Blend* = 2, *S* = 6, and *Afr* = .33). Adding the infrequent finding of a *Shading-Shading Blend*, these markers are consistent with the diagnostic category of major affective disorders. As has been noted, inferring the presence of an affective disorder calls for further differentiation of whether the disorder is unipolar or bipolar. Although developmental variations in the manifestations of affective disorders do not alter the basic dimensions of depression and mania, they do influence the Rorschach protocol that adolescents are likely to produce. Indeed, some markers of reliance on manic defenses that might appear in the protocol even when the person being tested is in a depressive state are found in this boy's protocol. These include markers of an impaired focus of attention (*W:D:Dd* = 10:8:6; *DQv* = 6), unconventional perception (*P* = 2), and the use of both avoidance (e.g., *Afr* = .33) and manic-like defenses (*PER* = 4) in his interpersonal functioning.

Among adolescents who are characterized by depressive mood and negative self attitudes, those who are able to formulate and express this mood are eager to do so and respond differently from those who cannot grasp their own attitudes and who express their dysphoric feelings through somatization. Based on the conceptualization of manic defenses as a strategy to ward off depression, Rorschach manifestations of affective disorders are often influenced by a dynamic interplay between depressive and manic symptom patterns. In accord with this conceptualization, a bipolar disorder cannot be ruled out in the present case.

Furthermore, this boy's Rorschach protocol points to substantial interpersonal difficulties and negative self attitudes that are frequently associated with major affective disorders. These include deficits in capacity for coping with ordinary aspects of interpersonal and emotional situations, limited adaptive resources, little capacity to form a stable sense of identity through reference to mental representations of realistic human figures, inability to anticipate and engage in collaborative activities with other people, insufficient assertiveness, and a defensive, self-aggrandizing, or narcissistic style of relating to other people that probably derives from low self-esteem. Secondary to the affective domain deviations in this boy's protocol, marked deviations appear as well on some cognitive variables and indicate an unusual focus of attention, inaccurate perception, and pessimistic thinking, particularly with respect to his bodily functioning.

As noted in Chap. 6, the *EB* as an indicator of personality style can be useful in differentiating between affective and schizophrenia spectrum disorder or assessing susceptibility to these disorders. In the case of this adolescent, his being extratensive and lacking capacity to use ideation in coping with his experience (*M* = 0) increases the likelihood of his having or being susceptible to an affective disorder. In light of this boy's marked distress and apparent self-destructive tendencies, recommended treatment for him might couple medication with individual psychotherapy. He seems to be quite helpless and at high risk for further decompensation if his currently impaired ego functioning is not reversed. He is bewildered by his feelings and sees no options for managing his subjective distress other than holding it tightly inside. His maladaptive affective functioning is probably having a negative impact on his interpersonal relationships, self-perception, attention capacities, and perception of reality.

Conclusion

The Rorschach is a personality assessment instrument that facilitates differential diagnosis by delineating personality characteristics that are associated with particular types of psychological disorder. This diagnostic application of Rorschach assessment consists of drawing inferences from diverse personality characteristics about a person's likelihood of having a particular disorder or being susceptible to it; about the maladaptive impact of any present symptoms of the disorder on the person's ability to function; and about the person's subjective experience of having become symptomatic and unable to function as usual.

Rorschach findings are especially useful in helping to assess disorders that are marked by distinctive cognitive or affective personality characteristics as described in this chapter. With respect to cognitive characteristics, disordered thinking and impaired reality testing are distinctive hallmarks of schizophrenia spectrum disorders and are demonstrated by such Rorschach CS and CS-based indices as an elevated *PTI* and its key components of elevated *WSum6*, *Lv2*, and *X-%,* the two derivations of the *Reality–Fantasy Scale Version 2.0* (*RFS-2*), and the *EII-2*. With respect to affective characteristics, dysphoric mood and disparaging views of oneself and the world are distinctive hallmarks of affective disorders and are shown on the Rorschach by an elevated *DEPI* and such key component as numerous *C'* and *MOR* responses. Nevertheless, the presence of either cognitive or affective disorder would probably have a negative impact on the adolescent's interpersonal relationships, self-perception, attention capacities, and perception of reality.

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Chapter 8
Delineating Internalized Symptom Patterns

As has been noted in Chap. 7, Rorschach findings can be useful for demonstrating the presence of psychotic and affective disorders in the two categories of thinking and perceptual disturbances and major affective disturbances, but it cannot delineate or rule out the presence of any other disorder. What Rorschach findings can do in other than psychotic and affective disorders is to delineate people's susceptibility to a particular disorder and the maladaptive impact of the disorder on their psychological functioning. In this regard, personality characteristics shown in the Rorschach protocol of adolescents with adjustment symptom patterns may presage development of a personality disorder in adulthood, and clinical attention to these characteristics would be consistent with the central focus of this volume on promoting positive adolescent development.

Being addressed at classifying symptom patterns according to the *PDM*, the discussion in this and the following chapter reflects a dimensional approach to developmental psychopathology in adolescents (Widiger & Edmundson, 2011). Assuming that each personality system is characterized by a distinctive organization, it is the development of this organization that becomes the focus of the inquiry. The effects on observable behavior of personality system changes due to developmental and/or contextual factors are assumed to be mediated by the unique structural and dynamic facets of the adolescent being assessed. Interventions that are designed only to change contextual factors or observable symptoms, without addressing these mediating facets, run the risk of making maladaptive personality structural and dynamic factors still capable of becoming activated. The activation of these factors can result from self-generated internal experience (e.g., ruminations) or encounters with contextual factors (e.g., exposure to trauma) similar to those that originally induced the problematic behaviors. Such renewed contextual factors are particularly likely to produce symptom patterns and maladaptive behavioral manifestations in young people who are highly vulnerable to stress-inducing events. In these cases, the adolescent is still likely to be experiencing subjective distress that may continue to influence the nature and severity of psychopathological manifestations.

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In this regard, the cutting edge of Rorschach CS assessment is its ability to describe the structural and dynamic personality characteristics that underlie observable psychopathological manifestations while providing practitioners with a glimpse of the adolescent's subjective experience of symptom patterns. Furthermore, just as adolescence is likely to involve exacerbated environmental reactivity and instability, young people are also more susceptible than adults to examination context and examiner influences. Nevertheless, because of individual differences in adolescent emotional reactions to developmental tasks, comparison should take into account not only the aggregate normative data but also the relative changes within the individual (Hollenstein & Lougheed, 2013).

It has long been known that adolescents who show impaired psychological functioning are at increased risk for showing psychopathology in adulthood (Drabick, 2009; Mash & Wolfe, 2013; Weiner, 1992). With respect to the type of psychopathological manifestations that might develop in adulthood, examiners should attend to differences in personality style (i.e., internalized vs. externalized) among adolescents with the same disorder, because members of a diagnostic group who differ in personality style may differ as well in the etiology and phenomenological manifestations of their disorder. The following case illustrations describe four symptom patterns most frequently seen in adolescents. These include anxiety symptoms in a 12-year-old girl (Case Illustration 8.1), avoidant behavior in a 15-year-old boy (Case Illustration 8.2), obsessive–compulsive symptoms in a 16-year-old boy (Case Illustration 8.3), and somatization in an 18-year-old boy (Case Illustration 8.4). Our approach for interpreting the data in these case illustrations starts with pointing out the deviant scores, followed by discussing the implications of these deviant scores for certain personality characteristics, for certain types of internalized disorders, and for treatment planning, should treatment planning be part of the referral question, while considering the specific symptom patterns from an experiential perspective.

Case Illustration 8.1: Anxiety Symptom Patterns in a 12-Year-Old Girl

Manifestations of anxiety include a variety of affective states and a heightened level of alertness, which might impair the adolescent's adaptive functioning. Persistent severe anxiety manifestations can interfere with sleep, eating, learning, and peer relations, and they may also disrupt cognitive processes. Performance anxiety, for example, may include apprehension about submitting a class assignment that becomes paralyzing and prevents its being completed. When their experience of anxiety is chronic, rather than only situational, adolescents are likely to be described as tense, irritated, and markedly distressed (*PDM* Task Force, 2006). The subjective experience of anxiety is basically characterized by a sense of danger to which the adolescent responds by resorting to a variety of defense mechanisms (e.g., denial, dissociation). When defenses are ineffective, the resulting overwhelming anxiety may lead otherwise well-adjusted adolescents to manifest poorly controlled behaviors.

Case Illustration 8.1: Symptom Patterns

This adolescent is a bright 12-year-old girl who was referred for assessment because of night fears, high anxiety, and complaints about having "bad things" in her mind that she "can't get them out." She is the younger of two children of a couple who have been married for 18 years. Both parents have a college degree. The father operates a business, and the mother is a homemaker. There is no family history of emotional or learning difficulties. The girl is described by her parents as being overly emotional, easily frustrated, and "melting down" if things do not go her way at home. These poorly controlled behaviors do not occur at school. As an infant, she had some medical problems that further required diagnostic tests and minor surgical procedures. In school, she has always shown considerable test anxiety, and she had some reading difficulties in the second grade. Nevertheless, she has usually been considered a bright child (FIQ = 123) who is highly motivated to satisfy academic requirements.

She has recently applied to a private school that her brother attends, but she was not accepted. In an evaluation conducted prior to her entering middle school, she was described by the examiner as being extremely invested in the tasks that were set for her, unusually apprehensive about her ability to do well, and incapable of enjoying her successful performances. In contrast to her behavior in an academic context, both parents describe her as a very sociable girl who enjoys playing with children of all ages. However, she does seem to be especially attracted to younger children, perhaps because they might be less challenging with respect to her competitiveness and need for control.

Case Illustration 8.1: Interpretation of Rorschach Data

The Rorschach data presented in Tables 8.1.1 and 8.1.2 indicate that this bright 12-year-old girl is overwhelmed by anxiety to an extent that impairs her ability to function adequately. In this regard, her deviant score on the *Ego Impairment Index* (*EII-2* > 0) demonstrates ego function deficits that impair her adaptation to external reality (see Case Illustration 7.1). The following discussion focuses on specific markers of impairment in each of the four domains of personality functioning delineated in Tables 6.1–6.4. Inferences concerning her cognitive functioning are derived primarily from her deviations on the *RFS-S* and *Lambda* (*L*). Inferences about her affective experience are based on the unbalanced index of *FC*:*CF* + *C*, in which the only response is coded with *Pure C*, the *Complexity Index* with no blend responses, and the relatively elevated number of space (*S*) responses.

These inferences are analyzed in the context of her heightened reactivity to emotion-provoking stimuli (elevated *Afr*) and her rigid and concrete style of processing other stimuli (elevated *Lambda*). Her limited capacity for adequate functioning in interpersonal relationships is inferred from deviations shown on *EA*,

Table 8.1.1 Anxiety symptom patterns in a 12-year-old girl: Structural Summary

			Affect	Interpersonal
R = 23	***L = 2.83****			
EB = 1:1.5	***EA = 2.5****	*EBPer = N/A*	***FC:CF + C = 0:1***	***COP = 0*** ***AG = 1***
eb = 4:0	*es = 4*	***D = 0***	***Pure C = 1***	*GHR:PHR = 2:2*
	Adjes = 4	***AdjD = 0***	***Const. = 0:1.5***	***a:p = 2:3***
			Afr = 1.09*	***Fd = 0***
FM = 4	***SumC' = 0***	***SumT = 0***	***S = 4****	***SumT = 0***
m = 0	***SumV = 0***	***SumY = 0***	***Complex. = 0:23****	***Human Content = 3***
			CP = 0	***Pure H = 3***
				PER = 1*
				Isolation Index = 0.17
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 2:3	*Sum6 = 3*	***XA% = .70***	*Zf = 12*	***Egoc. Index = 0.30****
Ma:Mp = 0:1	***Lv2 = 0***	***WDA% = .76***	***W:D:Dd = 9:12:2****	***Fr + rF = 0***
INTELL = 0	***WSum6 = 10***	***X-% = .26***	*W:M = 9:1*	***Sum V = 0***
MOR = 1	***M- = 1***	*S- = 1*	***Zd = +1.5***	***FD = 0****
	Mnone = 0	***P = 4***	*PSV = 0*	*An + Xy = 2*
		X+% = 0.46	*DQ+ = 4*	***MOR = 1***
		Xu% = .43	***DQv = 1***	***H:(H) + Hd + (Hd) = 3:0***
PTI = 0	***DEPI = 4***	***CDI = 3***	***S-CON = N/A***	***HVI = No*** *OBS = No*
FM + m = 4	***Col-Shd = 0***			
RFS-P = + 0.30	***RFS-S = 3.03****	***EII-2 = + 0.36****	***AdjDMD = 0***	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R*, *EB*, *a:p*, *Ma:Mp*, *Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index* is zero, the stylistic markers should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4.

COP, and *PER*, which contrasts with the interest in people shown by her normative sum of *Human Content* and *Pure H* responses. Problems in self-perception are inferred from the absence of *FD* coupled with a low *Egoc. Index*.

As described in relation to thinking disturbances in Case Illustration 7.1, the *RFS-S* is a derivation of the *Reality–Fantasy Scale Version 2.0* (*RFS-2;* Tibon-Czopp,

Table 8.1.2 Anxiety symptom patterns in a 12-year-old girl: Sequence of Scores

Card	Resp.								*RFS-2*
I	1	Do	Fu		H			GHR	+2
	2	Wo	Fo		A	P	1.0	INC	+4
II	3	DSo	Fu		Sc				+2
	4	Dv	C	2	Bl				−2
III	5	Ddo	F-		An				−3
IV	6	WSo	Fu		Ad		5.0	PER	+2
V	7	Wo	Fo		A	P	1.0		+4
VI	8	Mp-			H		2.5	PHR	−5
	9	Fu			Hh		2.5		+2
VII	10	WSo	Fo		Hh		4.0		+3
	11	WSo	Fu		Hh		4.0		+2
VIII	12	W+	FMao	2	A, Ls	P	4.5		+1
	13	Dd+	FMa-	2	A		3.0	AG, MOR, PHR	−4
IX	14	Do	Fu	2	A				+2
	15	D+	FMp-	2	A, Ls		2.5		−4
X	16	Do	Fo	2	A	P			+4
	17	Wo	F-		Ad		5.5	DR	−3
	18	Do	Fo		An				+3
	19	Do	Fu		Ge			ALOG	−5
	20	Do	FMpu		A				+1
	21	D+	Fu	2	H, Cg		4.0	GHR	+2
	22	Do	Fu		Sc				+2
	23	Do	F-		Ge				−3

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality–Fantasy Scale Version 2.0*

Appel, & Zelgman, 2015), a Rorschach marker of an individual's inclination to dissociate. The *RFS-S* is based on the scatter of the *RFS-2* scores through the protocol, with particular attention to marked fluctuations between reality-bound and fantasy-derived responses. Such marked fluctuations often characterize dissociative disorders associated with trauma (Tibon-Czopp, Zeligman, Kedem, & Hadar, 2014).

In the present case, the elevated *RFS-S* of 3.03 suggests that this girl is highly likely to dissociate reality from fantasy. Most of the time she sticks to reality and avoids withdrawal into fantasy, as reflected in her positive range location on the reality–fantasy continuum (*RFS-P* = +0.30). However, when she experiences reality as excessively threatening and anxiety provoking, she tends to activate dissociative defenses that produce abrupt fluctuations between reality and fantasy, as well as over-reactive and unmodulated emotional manifestations (elevated *Afr* and *Pure C*, respectively). These manifestations contrast with her more commonly over-controlled and avoidant cognitive and affective functioning that might explain her normative *D* and *AdjD* scores and the resulting *AdjDMD* of 0, which shows that, by sticking to reality and applying dissociation, she defensively reduces symptoms of anxiety. In this regard, the following sequence analysis of circumstances surrounding her *Pure*

C response to Card II illuminates some psychodynamic processes that may underlie her symptom patterns.

The most distinctive feature of Card II is its red-colored areas. The upper- and lower-center red areas on the card can readily be seen as blood, which for many people elicits associations of being physically harmed. For this reason, responding to Card II can prove difficult for people who are concerned about being vulnerable to bodily damage, sometimes because of having had a traumatic experience that threatened their bodily integrity. When confronted with Card II, this girl responded with *an arrow in the middle* (Resp. 3) followed by *blood on the outside* (Resp. 4). She apparently experienced the blot as threatening, perhaps to the point of becoming overwhelmed by paralyzing anxiety. She was subsequently unable to function effectively on Card III, despite having in front of her the easily and commonly seen Card III popular (*P*) human figures. Instead, she gives as Resp. 5 *your rib cage*, which integrates the blot and the surrounding white space into an unusually located (*DdSo*) and inaccurately perceived (*F*-) percept. Seemingly overwhelmed with anxiety, she dissociated herself from reality by failing to attend to the prominent Card III feature of the two human figures.

She continues with a poor Card IV response of *snakeskin*, which she justifies by her personal experience (*PER*), and she is unable to get fully back to reality until Card V, with her *butterfly* response. This sequence exemplifies the effects of using dissociation as a defense (elevated *RFS-S*) to cope with overwhelming anxiety, perhaps in the face of threatening, intrusive, and aggressive acts directed at her. Given her history of medical examinations in early childhood, her current anxiety symptom patterns might be a reaction to having been exposed to these uncontrolled threats to her sense of safety.

In addition to the deviant *RFS-S* score, deviations are shown on variables distributed across all four domains of functioning. The interpretive significance of three of these variables (*S*, *Afr*, and *PER*) is described in the discussion of Case Illustration 7.2. What follows is a description of the other variables on which this adolescent shows deviant scores: *Lambda* (*L*), *Complexity Index*, *FC*:*CF* + *C*, *EA*, *COP*, and *FD*. The *Egocentricity Index*, which is low in this case, is described further in Case Illustration 8.2.

Lambda (L) This CS index measures openness to experience and a balanced focus of attention. People who maintain a balanced focus of attention tend to be aware of both internal and external events and are capable of tolerating ambiguity and coping with reality in a flexible manner. An elevated *Lambda* ($L > 0.99$) points to a lack of openness and an inclination to view the world with an overly narrow focus of attention. Adjustment can be served well when a narrow focus of attention is appropriate to the nature of particular situations and events, without oversimplification of those that are truly complex. However, when narrowness becomes a general pattern of functioning, especially in individuals who have usually been open and flexible in how they attend to experience, adjustment is likely to be impaired, often with indications of depression. In these cases, the elevated *L* does not reflect an ego-syntonic stylistic feature but rather an ego-alien defensive strategy of coping with

anxiety-provoking events in the outer world that increases the risk of psychopathological manifestations.

The elevated *L* of 2.83 in this adolescent's protocol indicates that she currently tends to deal with external events in a detached and avoidant manner, taking them at their face value, and probably does so as a defensive strategy. If the raw score of *L* = 2.83 is converted to T Score, the corresponding value is 71 when rounded off. This T value is far beyond the mean T Score of 52 in contemporary nonpatient adolescents aged 11–14 (see Table 5.2). The substantially elevated *L* demonstrates a single-minded approach, which makes her a narrowly focused adolescent, but can also delineate her becoming intensely devoted to tasks she chooses to pursue, perhaps to her benefit. However, this inclination toward a narrow focus of attention and single-minded devotion can be maladaptive when, as in her case, it leads to overinclusive and simplistic processing patterns (*W:D:Dd* = 9:12:2; *Blends:R* = 0:23). As noted, her narrow focus might constitute a defensive strategy by which she seeks to avoid becoming upset or disorganized by limiting her awareness of external threats to her well-being. Wearing psychological blinders may thus serve a constructive and self-protective purpose for her, even though such shutting down of awareness exacts the price of diminishing her sensitivity to what is going on around her.

FC:CF + C The ratio between form-dominated (*FC*) and the sum of color-dominated (*CF*) and pure color (*C*) responses reflects the capacity for adaptive modulation of affect. An unbalanced *FC:CF + C* ratio provides not only a marker of impaired affective functioning but also a likely indication of impaired interpersonal relatedness. *FC* responses are associated with relatively stable, well-modulated, and reserved processing of emotions, with respect both to how feelings are experienced and how they are expressed, which facilitates positive interpersonal behaviors. *CF* and *C* responses are associated with relatively unmodulated and spontaneous processing of affect in which feelings tend to be more intense than those associated with *FC* responses but also more likely to be superficial and transitory. The color continuum from *FC* to *CF* and *C* represents a range of human emotionality from mature to immature expression and can be described in terms of degree of rational control over emotion.

Generally speaking, good adaptation is fostered by an age-appropriate balance between *FC* and *CF + C* responses that demonstrates capacities for both reserved and spontaneous emotionality. However, a finding of *FC > (CF + C) +2* reflects an excessive disposition to overly modulated and reserved processing of affect, at the expense of spontaneity, and a finding of *(CF + C) > FC + 2* is a marker of excessive disposition to unmodulated and spontaneous processing of affect, characterized by easily elicited, intense, and rapidly changing emotional states. Adolescents who give only *FC* responses tend to be inordinately reserved in their interpersonal relationships, whereas those who give only *CF + C* responses are prone to be labile and emotionally immature in how they relate to their peers, especially if they give *Pure C* responses. In this regard, predominance of *FC* over *CF + C* can be considered to reflect self-other relatedness, whereas predominance of *CF + C* over *FC* points to feeling-centered relatedness.

In the present case illustration, the use of color in forming responses is limited to a single occurrence in which the emotional expression is unmodulated (*Pure C*). Considered in light of other notable deviations in this girl's protocol (e.g., $L = 2.83$; $Afr = 1.09$), this finding has implications for defensive operations aimed at coping with her over-reactivity to emotion-provoking stimuli and for the degree to which this mode of affective functioning can disrupt her interpersonal relationships. Her limited and unbalanced $FC:CF + C$ ratio is even more striking when interpreted within the broader context of her interpersonal functioning, given that some frequent markers of interpersonal difficulties (e.g., $CDI > 3$; $H < 2$) are not present in her record.

To sustain an adequate level of adaptation, however, she invokes rigid and avoidant defensive operations that can be quite effective for managing stress in usual circumstances but are less so in anxiety-provoking situations. Overall, the findings indicate an inclination to flatten her emotional tone, whether negative or pleasurable, in keeping with her generally narrow approach ($L > 0.99$) and her probable awareness that confronting threatening situations is likely to evoke extremely stressful and unmodulated emotionality. Even if effective in minimizing distress, her shutting down of awareness thus limits her accessibility to subjective experience.

EA The *EA* index measures the ideational (*M*) and emotional (*WSumC*) resources that are consciously controllable and available for planning and implementing deliberate strategies of coping with external demands and events. Consistent with its implications for coping skills, *EA* is a developmental variable. Normative maturation consists of gradual acquisition of a broad repertoire of adaptive capacities. In this regard, assessing personality functioning in adolescents should distinguish between limited available resources that indicate regression from a previously higher level of maturity, resulting from external circumstances, and limited coping resources that indicate developmental arrest and overall premature functioning.

Whether people are introversive or extratensive, they should produce at least two *M* responses and a *WSumC* of 2.5 to be considered as having minimally adequate capacities to reflect on their experience and process their emotions. The degree to which the available resources are used adaptively can be inferred from the *FQ* of the *M* responses and the components of the *WSumC*. The better the form level of their *M* responses and the more balanced their $FC:CF + C$ ratio, the more likely people are to be making effective use of the resources available to them.

This adolescent's protocol contains just one human movement (*M*) response and just one color response (*Pure C*), which indicates very limited psychological resources. These minimal indications of available coping resources may well be associated with the narrowly focused and limited openness to experience as reflected in her elevated *Lambda,* in which case her shutting down of awareness could be preventing her from drawing fully on coping resources that might otherwise be available to her. This would mean that the limited resources she can bring to bear in dealing with events should not be viewed as a developmental arrest but rather as a result of defensive operations that are curtailing her subjective experience.

COP and *AG* Cooperative movement (*COP*) and aggressive movement (*AG*) responses indicate responsiveness to people, as reflected in anticipation of collaborative and/or competitive interactions with other people. The *COP* responses reflect positive interpersonal attitudes and receptiveness to collaborative engagement with people. Respondents with *COP* > 2 are usually people who are well liked by others and enjoy rewarding social relationships. Their popularity appears to derive from their commitment to being agreeable and cooperative, their anticipation of friendly and positive interactions, and their interest in seeking interpersonal relationships.

In contrast, the absence of *COP* points to a maladaptive deficiency in the capacity to anticipate and engage in collaborative activities with other people. Adolescents in whom *COP* = 0 typically convey to others that they are reluctant to collaborate in shared endeavors and disinterested in doing so. Although they may not be actively disliked, they are rarely among the most popular or favorite members of their peer group. Nevertheless, the personality characteristics indicated by *COP* = 0 do not necessarily preclude adolescents' forming close interpersonal relationships, especially if they show normative *Human Content* responses that include numerous whole and real human figures. The combination of *COP* = 0 and *Human Content* = 3 in this adolescent's protocol points to a maladaptive deficiency in her capacity to anticipate and engage in positive interpersonal relationships but does not necessarily mean that she is incapable of forming relationships and identifying with other people. Indeed, the three responses of whole and real human figures indicate good capacity to draw on identifications with other people that contribute to developing a stable sense of identity in adulthood. This capacity, if not undermined by troubling external circumstances, can help to promote good psychological adjustment in the future.

Aggressive movement (*AG*) responses indicate reality-bound expectations that interpersonal relationships are more likely to be assertive or competitive than collaborative. Although *AG* responses often involve expressions of anger and hostility, they do not necessarily signify hostile patterns of behavior. Aggression is usually considered to imply anger, but it is preferable to interpret *AG* responses as relating to assertive behavior. Like anticipation of collaborative interpersonal relationships, as indicated by *COP* responses, the presence of one or two *AG* responses is normative. However, a. finding of *AG* > 2 may indicate adjustment problems.

On the other hand, *AG* is a unidirectional variable, in that a finding of *AG* = 0 may have no interpretive significance. It should be noted that *AG* = 0 was found in more than 50% of adult nonpatients in the international sample of Meyer et al. (2007), and the absence of *AG* may sometimes indicate insufficient assertiveness. As a further consideration, examiners should be cautious about ruling out aggressive traits or behaviors on the basis of a zero-order score on this unidirectional variable. In particular, *AG* = 0 should not be interpreted to contradict violence risk, because violent people may be so unconcerned about their aggressive impulses that they can and do act on them freely and have no need to express them in fantasy.

FD The Form Dimensional (*FD*) variable measures self-awareness, psychological mindedness, and capacity for introspection. Being sufficiently introspective to recognize one's personal characteristics promotes good psychological adjustment. Consistent with developmental expectations, young children rarely give *FD* responses, and the absence of *FD* responses should be considered indicative of maladaptive capacity for self-awareness only in adolescents and adults. The limited psychological mindedness of adolescents who give no *FD* responses reflects incapacity to represent behavior in terms of mental states or to have *A Theory of Mind* (Fonagy & Target, 1996), which puts them at risk for difficulties in developing adaptive interpersonal relatedness and self-organization.

In the present case, this girl's failure to provide any *FD* suggests little capacity to understand internal subjective experiences and to examine herself in a critical manner. Her limited self-awareness could derive from a defensive strategy that results in immature functioning in general and lack of psychological mindedness in particular. This indication of limited self-awareness is consistent with the implication of her low *Egocentricity Index* for not paying much attention to herself, but both of these findings diverge from the positive significance of her mature human representations. Such apparent inconsistency probably reflects discrepancies and discontinuities in how she experiences herself.

Moreover, in common with previously noted Card II content of an *arrow in the middle* and *blood on the outside*, these inconsistencies may provide further clues to her self-state, specifically with respect to fears about bodily integrity that might have resulted from traumatic experiences and are not easily expressed or communicated. However, her limited self-awareness, coupled with her rigid and concrete approach to reality, might be a substantial obstacle to progress in psychodynamic psychotherapy, unless she has been helped to recognize and modify her predominant defense strategy of dissociation.

Case Illustration 8.1: Summary and Conclusions

This bright 12-year-old girl, whose Rorschach protocol is presented as a case illustration of anxiety symptom patterns, appears to be overwhelmed by anxiety to an extent that impairs her ability to function adequately (*EII-2* > 0). Her protocol includes psychopathological markers in each of the four domains of functioning examined in this volume (see Chap. 6). These include cognitive difficulties in integrating reality and fantasy (*RFS-S* = 3.03); a rigid, concrete, and avoidant style characterized by a narrow frame of reference (*L* = 2.83) and an over-inclusive and simplistic pattern of attending to outside reality (*W:D:Dd* = 9:12:2 and *Blends:R* = 0:23, respectively); problems in affect modulation with minimal channels for experiencing or expressing feelings (*FC*:*CF* + *C* = 0:1 with *Pure C* = 1 and *S* = 4) and over-reactivity to emotion-provoking stimuli (elevated *Afr*); limited capacities for sustaining adaptive interpersonal relationships (*EA* = 2.5; *COP* = 0), which runs counter to her interest in people (*Human Content* =3) and capacity for

integrative human representations as shown by the ratio *H:(H) + Hd + (Hd)* = 3:0; and problems in maintaining appropriate self-awareness and positive attention to herself (*FD* = 0; *Egoc. Index* = 0.33).

This girl's problems are not impairing her ability to see the world accurately. When she attends to reality, she usually perceives objects and events accurately and conventionally (*XA%* = 0.70; *WDA%* = 0.76; *X-%* = 0.26; and *P* = 4). Nevertheless, she achieves this relatively accurate perception of the world by extensive use of dissociative defenses that enable her to focus narrowly on situations without being distracted by intrusive thoughts or unpleasant feelings but that also enter her into a detached self-state that allows only limited personal involvement. Although her wearing of psychological blinders can serve a constructive and self-protective purpose, by preserving her adaptive cognitive capacities, it also limits her openness to experience and her ability to form subjective impressions of events. Regarding her ideation, she is generally able to think clearly and coherently. However, when she is distressed by anxiety-provoking stimuli, she may at times resort to illogical reasoning (*ALOG*) to justify her conclusions, as in her response to Card X (Resp. 19): *A state, Florida… The shape and the crabs and stuff you might see…you might see crabs and stuff in Florida*.

Case Illustration 8.2: Avoidant Behavior in a 15-Year-Old Boy

Adolescents are frequently observed on referral as being quite avoidant. Some of these adolescents are described as being generally constricted or "slow to warm up", while others appear to have been overwhelmed by internal or external experiences to an extent that has led them to develop constricted patterns of behavior in order to avoid further stimulation. Such constricted patterns of behavior may constitute a commonly observed psychological state in adolescence, when young people confront difficulties in coping with developmental tasks, but they can also reflect a type of internalized diagnosable disorder.

Avoidant behavior in adolescents is typically shown by a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. They may become extremely anxious and frightened and consequently withdraw from their environment, which further limits their ability to develop social skills (*PDM* Task Force, 2006). In their interactions with others, they seek to avoid conflict and tend to respond to aggressive attitudes and behaviors by inhibiting their own aggression. These avoidant symptom patterns can usually be observed not only in their interpersonal functioning but also in how these adolescents think about and interpret their world. Their thinking focuses on the idea that they are not good enough and that others reject them. They think of themselves as unappealing and socially inept. Thinking in this way creates intense feelings of anxiety in social situations, along with fears of being ridiculed, criticized, and abandoned.

An important question to consider in cases of avoidant symptom patterns is whether these patterns are ego syntonic or ego alien. If they are ego alien, they are likely to be transient, situationally reactive, and relatively responsive to treatment. If, on the other hand, they are ego syntonic, these symptom patterns are likely to be enduring and inflexible regardless of the context and relatively resistant to treatment. Should ego-syntonic avoidance become prolonged and coupled with extreme subjective distress and marked functioning impairment (e.g., in interpersonal relationships), consideration should be given to the possibility of a schizophrenia-spectrum or affective disorder. The present discussion of the Rorschach given by a 15-year-old boy following one year of therapy focuses on the issue of therapeutic change. The current Rorschach findings are compared to those obtained at the time of his referral and provide a basis for exploring issues of differential diagnosis.

Case Illustration 8.2: Symptom Patterns

This 15-year-old boy was referred for therapy a year before the current Rorschach assessment. On entering therapy, he appeared markedly frightened, anxious, depressed, and avoidant. He reported being excluded from his father's extended family, which he described as being very traditional and rigid, after he was involved "in some kind of behavior the family disapproved." He is the only son of a couple who had divorced 10 years before the referral. Both parents are remarried, and the boy reports he has not forgiven his father for the divorce and that he does not like his father's wife. The father was quite embarrassed by his son's inappropriate behavior, which reportedly impaired further what had already been problematic relationships. The boy was not allowed to participate in family events or to stay with them on weekends and holidays. He feels he has been abandoned, although his father does keep in constant contact with him and is very concerned about his affective state. With regard to his mother, the boy reported that he admires her, but he seemed to be quite ambivalent about their relationships and her attitudes of exerting control over him. Tables 8.2.1 and 8.2.2 present the structural data and the sequence of scores of this boy's Rorschach protocol following one year of psychodynamic psychotherapy.

Case Illustration 8.2: Interpretation of Rorschach Data

The data presented in Tables 8.2.1. and 8.2.2 are interpreted through comparisons of deviant scores shown on the structural variables following 1 year of therapy with the scores on his first protocol administered at the time of his referral. These comparisons provide information useful for differential diagnosis, for showing changes that occurred during treatment, and for understanding psychodynamic processes that might explain the avoidant symptom patterns. To begin with this

Table 8.2.1 Avoidant behavior in a 15-year-old boy: Structural Summary

			Affect	**Interpersonal**
R = 28	***L = 1.80****			
EB = 0:0.0*	***EA = 0****	*EBPer = N/A*	***FC:CF + C = 0:0****	***COP = 0** AG = 0***
eb = 2:10*	*es = 12*	***D = −4****	***Pure C = 0***	*GHR:PHR = 2:3*
	Adjes = 11	***AdjD = −4****	***Const. = 6:0.0****	***a:p = 2:0***
			Afr = 0.56	***Fd = 1****
FM = 2	***SumC' = 6****	***SumT = 0***	***S = 3***	***SumT = 0***
m = 0	***SumV = 2****	***SumY = 2***	***Complex. = 3:28***	***Human Content = 4***
			CP = 0	***Pure H = 1***
				PER = 0
				Isolation Index = 0.21
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 2:0	*Sum6 = 0*	***XA% = .75***	*Zf = 5*	***Egoc. Index = 0.21****
Ma:Mp = 0:0	***Lv2 = 0***	***WDA% = .74****	***W:D:Dd = 6:17:5****	***Fr + rF = 0***
INTELL = 3	***WSum6 = 0***	***X-% = .21***	*W:M = 6:0*	***Sum V = 2****
MOR = 1	***M- = 0***	*S- = 1*	***Zd = +2.0***	***FD = 1***
	Mnone = 0	***P = 4***	*PSV = 0*	*An + Xy = 2*
		X+% = .46	*DQ+ = 1*	***MOR = 1***
		Xu% = .29	***DQv = 1***	***H:(H) + Hd + (Hd) = 1:3****
PTI = 0	***DEPI = 6****	***CDI = 5****	***S-CON = 5***	***HVI = No*** *OBS = No*
FM + m = 2	***Col-Shd = 0***			
RFS-P = + 0.96*	***RFS-S = 2.5***	***EII-2 = −0.68***	***AdjDMD = 0***	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R*, *EB*, *a:p*, *Ma:Mp*, *Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index* is zero, the stylistic markers should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4

adolescent's current cognitive functioning as compared to his functioning on referral, five deviant scores shown in the first administration disappeared and a sixth moderated. Specifically, *Zd* changed from +9.0 to +2.0; *DQv* decreased from 3 to 1; *XA%* increased from 0.70 to 0.75; *Lv2* decreased from 2 to 0; *FM + m* decreased from 7 to 2; and *W:D:Dd* changed from 12:11:4 to 6:17:5. These changes suggest improvement in his capacities for a balanced focus of attention,

Table 8.2.2 Avoidant behavior in a 15-year-old boy: Sequence of Scores

Card	Resp.								*RFS-2*
I	1	DdSo	Fo		(Hd)				+2
	2	W+	FC’		A	P	4.0		+3
II	3	WSo	FC’-		Hd		4.5		−3
III	4	Do	Fo	2	H	P			+4
	5	Do	Fo		An				+3
	6	Do	F-	2	Fd				−3
	7	Do	FC’u		A				+1
	8	Do	Fu		Sc				+2
IV	9	Wo	FC’o		A		2.0		+2
	10	Ddo	FC’.FYu		Na				+1
V	11	Do	FMa-		Ad				−4
	12	Wo	Fo		A	P	1.0		+3
	13	Wv	C’		Hx			AB, MOR	−3
VI	14	Do	Fu		Ad				+2
	15	Do	F-		Ge				−3
	16	Do	Fo		Hd				+3
VII	17	WSv/+	FD.FYo		Ls		4.0		+2
	18	Do	Fo		Ad				+3
VIII	19	Do	Fo		Na				+3
	20	Do	Fo	2	A	P			+4
	21	Ddo	F-		Ad				−3
IX	22	Ddo	Fu		Ad, Art				+2
	23	Do	Fu	2	Ad				+2
	24	Do	FMa.FVo	2	A				+1
	25	Do	FVu		Ad				+1
X	26	Do	F-		An				−3
	27	Ddo	Fu		Sc				+2
	28	Do	Fo	2	A				+3

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality–Fantasy Scale Version 2.0*

accurate perception, and logical and non-intrusive thinking, probably as a result of the therapeutic process.

However, his improved cognitive functioning has been achieved at the expense of narrowing his openness to experience, as reflected in his *Lambda* (*L*) increasing from 0.42 in the first administration to 1.80 in the current protocol. This finding suggests that he currently tends to deal with external events in a detached and avoidant manner, taking them at their face value and not forming many subjective thoughts or feelings about their meaning. As has been noted (see Case Illustration 8.1), this apparent objectivity might take the form of a generally single-minded approach that enables him to become narrowly but intensively devoted to various tasks in ways that serve him well in functioning adaptively.

On the other hand, noticing less than he should of the subtleties and nuances of situations puts him at risk for behaving awkwardly or inappropriately in interactions

with other people and inclined to avoid such interactions. Moreover, he currently tends to invest less energy than he did previously, prior to entering therapy, in processing information, as shown in his reduced score on the *Complexity Index,* with *Blends* = 3:28 as compared to 10:27 in the first administration. These changes might reflect a defensive strategy in which he resorts to a narrow approach and lack of openness to external stimuli so as to avoid becoming upset or disorganized by constant awareness of frustrating circumstances.

Consistent with his narrow approach and lack of openness to external stimuli, the elevated positive mean score on the *RFS*-2 (*RFS-P* = +0.96) on this adolescent's protocol indicates overly concrete and excessively realistic cognitive functioning, which shows that he currently tends to stick to reality and allow only minimal fantasy production. Although such patterns of cognitive functioning can be stylistic and ego syntonic, more often they reflect a defensive operation against anxiety-provoking stimuli, in which the collapse of fantasy into reality may hide a major affective disorder. Overall, being supported by therapy appears to have improved this adolescent's capacities for concentration at the expense of limiting his thinking to only concrete and realistic matters.

The CS affective variables in this boy's protocol exceed the normative range in both the first and the second administration. The *DEPI* of 6 found in the second administration is likely to indicate the presence of a depressive disorder. Depressive features were found on referral (*DEPI*=5) as well but following 1 year of therapy his depressive mood is quite prominent. Specifically, he is experiencing considerable distress, even more so than previously (*D* = −4 and *AdjD* = −4, as compared to *D* = −3; *AdjD* = −1, in the first administration). The elevated score of *SumShading* = 10 also points to excessive dysphoric feelings. Most importantly, these intense emotions appear to be bottled up inside (*Constriction Index* = 6:0.0) and consist of unpleasant and dysphoric feelings that are beyond his capacity to manage (*C′* = 6; *Shading-Shading Blend* = 1). This adolescent is in all likelihood overwhelmed by negative emotions that make it difficult for him to function and against which he employs a variety of defense strategies that are ineffective in preventing maladaptation to external reality, although his inclination is to stick to reality. On the other hand, the heightened subjective distress that he showed on referral has become more moderate (*AdjDMD* = 0 and *eb* = 2:10, as compared to *AdjDMD* = +2 and *eb* = 7:12 in the first administration).

Simultaneously with developing some self-inspection capacities that were not observed on referral (*FD* = 1 and *SumV* = 2, as compared to *FD* = 0 and *SumV* = 0, respectively), the nature of the impairment in this adolescent's affective functioning has also changed substantially. Whereas the depressive features seemed to be previously externalized, stormy, relatively unmodulated, and suffused with anger and conflicting emotions (*FC:CF* + *C* = 1:7; *Pure C* = 1; *Constriction index* = 8: 8.0; *S* = 5; *Col-Shd Blend* = 3), the current depressive episode is, presumably as a consequence of the therapeutic process, internalized in nature. In this regard, the notably lower *D Score* and *AdjD Score*, as well as the elevated *C'* and lack of color responses (*WSum C* = 0), resulting in the deviant score on the *Constriction Index* (*C':WSumC* = 6:0), are particularly meaningful for understanding this adolescent's subjective experience. What follows is a description of each of these three major psychopathological markers (*D Score*, *AdjD Score*, and *Constriction Index*) of the current depressive

episode and the inferences about his affective experience that can be drawn from these deviations.

D Score The *D Score* derives from conjoint consideration of all of the determinants coded in the CS except for *Form Dimensionality* (*FD*) and *Reflection* (*Fr; rF*) responses. It is therefore one of the most broadly based and interpretively meaningful indices that can be calculated from Rorschach data. If the *D Score* of an adolescent's protocol does not exceed the cutoff score of −1 (see Table 2) and its two components (*EA* and *es*) are within the normative range, the adolescent is usually well adjusted and is not showing overt symptoms of anxiety, tension, or irritability.

The raw *D Score* in this adolescent protocol (*D* = –4) was converted to a T Score using the M and SD of the *D Score* as presented in Meyer et al., (2007), the resulting value when rounded off is 28. This value falls far below the mean T Score of the *D Score* in contemporary nonpatient adolescents aged 15–18, which is 47 (see Table 5.2). The low T value indicates that this adolescent is showing much more affective disturbance than would normatively be expected and that his affective functioning is severely disordered.

AdjD Score The *AdjD Score* is useful for distinguishing between a relatively persistent stress overload and mostly situational experienced stress. Of the six determinants that compose the *es*, which is one of the *AdjD* components, four are reasonably stable (*FM, T, C',* and *V*), whereas the other two (*m* and *Y*) vary in response to contextual circumstances. The *AdjD* is produced by reducing the *es* by the number of *m* and *Y* greater than one (with one of each of these variables being the normative expectation) and subtracting this reduced *es* from the *EA*.

The *AdjD* of −4 in this adolescent's protocol points to a stress overload that is persistent and reflects long-standing incapacity to cope effectively with external demands and events without becoming unduly distressed by them. Interestingly, in contrast to this currently deviant score, his *AdjD Score* of −1 in the first administration did not exceed the cutoff point for distinguishing between healthy and psychopathological functioning, probably because he had been using his coping resources in a less defensive manner prior to entering therapy. It may be, however, that his previous externalization limited his felt distress but also created cognitive impairments, which have now lessened.

Constriction Index The *Constriction Index* (*SumC′:WSumC*) points to the capacity to experience and express affect pleasurably. The likelihood that feelings are being internalized and kept bottled up inside increases the more that *SumC′* exceeds *WSumC*. As distinct from the *Affective Ratio* (*Afr*), which indicates an individual's receptivity to or avoidance of becoming emotionally involved in affective interchange, the *Constriction Index* demonstrates an inclination either to internalize or externalize affective experience. The total absence of color responses in the presence of the six achromatic responses (*C′*) in this adolescent's protocol is of particularly concern. However, although the extremely unbalanced *Constriction Index* (*SumC′:WSumC* = 6:0), together with the deviations on the *DEPI, D* and the *Adj*D scores and on other affective variables as well, delineates a depressive episode, the relatively high proportion of form-dominated *C′* responses (*FC′* = 5) suggests that the

dysphoric feelings are now more moderated cognitively than they were on referral, when only half of his achromatic responses (*SumC′* = 8) were form dominated (*FC′* = 4). If so, this change during the course of his therapy reflects transformation from relatively uncontrolled dysphoria to an over-controlled depressive state.

As shown by the sequence of responses (see Table 8.2.2), Card IV was particularly likely to elicit dysphoric feelings, with two *FC′* responses: *Not defined* (turns the card)... *it reminds me of a bat* (Resp. 9)... and *a mountain… I don't know which mountain it is, but it is a mountain* (Resp. 10). Because Card IV is known to evoke associations to big, strong, massive, powerful, and sometimes threatening human or humanlike figures, which are looked up to as a dominant authority, it is often seen as reflecting one's internal representations of an authority figure. Furthermore, with the depressive tone created by its dark color and heavy shading, Card IV may be upsetting for people who are depressed or trying to avoid dealing with gloomy affect. In the case of this avoidant and frightened adolescent, Card IV must have evoked dysphoric affect, as shown in his two *FC′* responses to the card, coupled with a flight into ambiguous rather than precise description of the object seen in this card.

Following his exposure to Card IV, this boy appears to have difficulty preserving his previous relatively adaptive functioning. When shown Card V, he initially responds with an inaccurately perceived and partial object of *a dog. Just half of it…* (Resp.11). Although this response is followed by an accurately perceived whole object of *a butterfly* (Resp. 12), he is able to focus his attention on this commonly seen object only by manipulating the outer stimulus, which he does by turning the card upside down. His concluding response to this relatively unambiguous card, which provides strong representation of reality, is quite surprising. The third response to Card V, coded with *Wv C' Hx AB*, *MOR,* indicates subjective experience of even less clearly defined outer reality. The sequence analysis thus provides valuable information concerning how this depressed adolescent experiences reality, particularly when encountering difficulties in coping with an authority figure (Card IV), and it can illuminate the major symptom patterns shown in the interpersonal domain. Indeed, following 1 year of therapy, this adolescent appears to show substantial difficulties in interpersonal relationships that are more prominent than those shown on referral (*CDI* = 5; *EA* = 0; and *COP* = 0) compared to *CDI* = 4, *EA* = 10, and *COP* = 0. What follows is a description of the *CDI* as a psychopathological marker of relatedness. The *EA* and *COP* are described in relation to another case illustration of anxiety symptom patterns (see Case Illustration 7.3).

CDI The *Coping Deficit Index* (*CDI*) is a well-validated Rorschach measure of adaptive capacities for interpersonal relatedness. By combining *EA* with several other variables related to coping adequately with stress, affect, and interpersonal relationships, the *CDI* provides a broadly based measure of adaptive resources that has specific implications for differential diagnosis and treatment planning as well as for personality description.

The elevated *CDI* in this adolescent's protocol (*CDI* = 5) points to adjustment difficulties and limited capacity to cope effectively with ordinary demands. Furthermore, coupled with an elevated *DEPI* of 6 and an extremely low *EA* of 0, the deviant *CDI* provides further indication of this boy's impaired affective and

interpersonal functioning and his susceptibility to becoming markedly distressed when faced with situations that exceed his ability to cope with them effectively. As noted in Case Illustration 7.3, *CDI* is a developmental variable, and the combination of his normative *EA* on the first administration with his currently elevated *CDI* suggests a regressive state rather than a developmental arrest, as is also reflected in the previously noted changes in his affective functioning.

The absence of both *AG* and *COP* responses in this adolescent's protocol lends further weight to the previously noted implications of his *CDI* and *EA* scores for substantial difficulties in interpersonal relationships. With *COP* = 0 and *AG* = 0, he is not anticipating either collaborative or competitive interactions with other people, and avoids even contemplating them. Of further note in this regard is the absence of human-figure responses in Cards VIII–X. When confronted with these emotion-provoking stimuli, he seems particularly likely to respond with interpersonal avoidance. On the other hand, his relatively high number of responses involving human figures (*Human Content* = 4) suggest normal rather than limited interest in being involved in interpersonal relationships. Despite this normal degree of interest in people, however, he is currently avoiding interpersonal engagement in order to minimize the subjective distress it would cause him.

Interestingly, following 1 year of therapy, this adolescent currently coping with a depressive episode is less assertive (*AG* = 0) than he was on referral (*AG* = 1 in the first administration). The lack of assertiveness is likely to be a factor in his detaching himself from interpersonal events, which he sees as necessary to avoid being manipulated or injured by other people. This resulting maladaptive passivity seems to be ego alien, since he normatively gives active movement responses (*a:p* = 2:0) and did so even more prominently on referral (*a:p* = 8:1 in the first administration). On the other hand, he previously showed mistrust, suspiciousness, and excessive concern about sources of danger in interpersonal relationships (*HVI* positive in the first as compared to insignificant *HVI* in the second administration). He may thus be quite distant and avoidant in social interactions not because he is hypervigilant but as a defensive strategy aimed at protecting himself from being criticized or demeaned by other people.

The changes in this adolescent's interpersonal relationships are mirrored in his self-perception. He was already showing a low *Egocentricity Index* on referral, but other current deviations in the self-perception domain (see Table 6.1–6.4) were not present in the first protocol. Specifically, the elevated *SumV* and the unbalanced ratio of *H:(H) + Hd + (Hd)* appear only in the second administration. What follows is a description of these three deviant self-perception variables.

Egocentricity Index The *Egocentricity Index* is computed by dividing the sum of 3× (*Fr* + *rF*) and the number of *Pair* (2) responses by the total number of responses (*R*) in the protocol. The index is a marker of the extent to which people balance their attention between focusing on themselves and giving consideration to others in their environment. Adolescents whose *Egocentricity Index* falls below the reference value of 0.33 avoid self-focusing, often as an aspect of having a low estimate of their personal worth, whereas those with an elevated score on the index (*Egoc. Index* > 0.44) tend to show inordinate preoccupation with themselves while paying

minimal attention to other people. An elevated *Egocentricity Index* usually includes at least one *Reflection* response, and the absence of Reflection responses in an elevated *Egocentricity Index* usually indicates inordinate self-focusing or self-consciousness that is not pleasurable.

Of further importance with respect to the implications of the *Egocentricity Index* for adjustment difficulties is its stability over time and across situations in people older than 15. This stability means that a low *Egocentricity Index* in adolescents age 16 and above may not show much change during therapy even when positive changes occur in domains of functioning other than self-perception. In the present case illustration, a low score on the *Egocentricity Index* in both administrations indicates that this adolescent was paying insufficient attention to himself when he began his treatment and now, after 1 year of psychotherapy, is still avoiding self-focusing and continues to compare himself unfavorably to other members of his family and to his peers, whom he apparently is likely to look at as being more able, attractive, talented, and generally more worthwhile than he is. This negative view of himself is likely to exacerbate his subjective experience of loneliness, which constitutes a major component of his current depressive episode and should be considered a risk factor for self-destructive behaviors.

Sum V Vista (*V*) responses indicate self-criticism and are particularly likely to occur in people who manifest depressive symptom patterns involving feelings of guilt. Interestingly, a notable frequency of $SumV > 0$ has been found among narcissistic, psychopathic prison inmates with an externalizing and self-centered personality style that would ordinarily be expected to preclude lack of self-criticism. Further investigation suggested that these inmates remained narcissistic but were upset with themselves (i.e., self-critical) for having been caught and imprisoned for their offense.

Consistent with what is known about normative developmental processes (see Chap. 2), *Vista* responses rarely occur in the records of children under age 11, and the percentage of nonpatients exceeding the cutoff point of $Sum\ V > 0$ gradually increases from adolescence to adulthood. The particular psychopathological and adjustment implications of $Sum\ V > 0$ in adolescents should be considered in light of the sum of $Fr + rF$ responses then score on the *Egocentricity Index* in the protocol as well as current contextual factors.

In line with this conceptualization, the change shown in this adolescent's protocol ($Sum\ V = 2$ as compared to $SumV = 0$ on referral) can be attributed to both normative developmental processes and to his recent history. Following 1 year of psychotherapy, interaction between developmental processes and the evolution of some capacities for self-inspection ($FD = 1$ as compared to $FD = 0$) has led to this boy becoming much more self-critical than before. These findings of current negative attitudes toward himself, possibly involving guilt feelings, are consistent with the deviant scores on affective variables (e.g., *Constriction Ratio*) that reflect a substantial change in the type of his emotional functioning, from an externalized, stormy, and unmodulated mood disorder to an internalized depressive episode.

H:(H) + Hd + (Hd) The ratio between whole and real human-figure responses and all the other human-figure responses provides information about a person's ability to identify with other real persons and has implications for interpersonal functioning

and self-perception. Children under age 11 tend to give fewer whole and real human-figure responses than adolescents and adults, which is consistent with developmental expectations concerning identity formation, but the number of *H* responses normatively exceeds the number of *(H) + Hd + (Hd)* responses at every age. To adjust adequately to their circumstances and feel satisfied with themselves, adolescents need to be comfortable in interpersonal relationships and have a sense of what kind of person they are. Fewer *H* than *(H) + Hd + (Hd)* responses, on the other hand, usually signifies social discomfort and difficulty developing a sense of identity and self-integrity. So it is with this boy, whose surplus of *(H) + Hd + (Hd)* over *H* responses, as shown in the *H:(H) + Hd + (Hd)* ratio of 1:4, suggests not only deficient capacity for identifying with real human figures but also maladaptive uncertainty about himself and unpleasant interpersonal experience regardless of the context. As has been noted, the imbalance in his human representations was not shown on referral. This difference lends further support to the inference of a regressive depressive state emerging during the therapeutic process.

Case Illustration 8.2: Summary and Conclusions

Comparing the Rorschach data of this 15-year-old boy to his protocol when first referred makes it clear that, following 1 year of psychotherapy, his cognitive functioning is now more adaptive than it was previously. In particular, the overly inclusive processing style he demonstrated in the protocol administered on referral has disappeared. This change in his processing style and his lessen susceptibility to intrusive thoughts have probably contributed to his improved capacity for accurate perception of people and events. On the other hand, his currently more adaptive cognitive functioning by concentrating on reality occurs to have been achieved at the expense of limited access to fantasy.

Of further note, the changes in this adolescent's cognitive functioning appear jointly with a prominent change in his affective experience. Previously, the depressive features in his avoidant behavior patterns involved externalized affect, stormy and unmodulated and loaded with anger and conflicting emotions. By contrast, and apparently influenced by the therapeutic process, his current depressive state is characterized by internalization of affect.

Together with this change from an externalizing to an internalizing affective style, he has developed some capacities for self-inspection that were not evident on referral and probably reflect some positive impact of his therapy. As a further consideration, the marked transformation in just 1 year from an unmodulated externalizing coping style to his current over-controlled internalizing style constitutes a substantial fluctuation in functioning that may raise a question about possible emerging of bipolar disorder. Nevertheless, despite his improved functioning, Rorschach CS markers of psychopathology still appear in the interpersonal and self-perception as well as the cognitive and affective domains. The findings derived

from the two protocols of this adolescent boy illustrate personality characteristics underlying avoidant behavior and support the impression that his avoidance is not ego syntonic and should instead be considered part of a depressive episode.

Case Illustration 8.3: Obsessive–Compulsive Symptom Patterns in a 16-Year-Old Boy

Obsessive–compulsive symptom patterns include two groups of phenomena: obsessive thoughts and compulsive acts. Obsessions consist of recurrent ideas and fears (e.g., urges to perform socially disruptive or even assaultive actions, images of a distressing event) that intrude on conscious awareness despite being unwelcome and experienced as unpleasant. This intrusive ideation rarely serves any constructive purpose. Instead, it risks generating ruminations that may paralyze the person's ability to come to definite conclusions or make decisions. Compulsions consist of repetitive, nonproductive acts and rituals (e.g., handwashing, checking behaviors) that a person feels required to do even in the face of realistic judgment that they are inappropriate and unnecessary. These compulsive acts are aimed at neutralizing intrusive ideation and reducing the emotional distress it causes. Failure to comply with these compulsions can fill the person with an overwhelming sense of anxiety and dread. Clinical studies of adolescents with Obsessive–Compulsive Disorder (OCD) indicate that most are likely to present with some combination of both obsessions and compulsions.

Recent findings in brain research have suggested a neurobiological etiology of OCD and delineate brain regions that may play a role in the development of obsessive–compulsive symptom patterns, including the frontal basal ganglia–thalamic circuits and the thalamus (e.g., Hofer et al., 2013). These findings add important information to the existing OCD etiological literature, which speaks to genetic, cognitive behavioral, and psychodynamic–experiential factors that have an interactional effect on the development of obsessive–compulsive personality patterns. It should be stressed, however, that the emergence of obsessions or compulsions does not necessarily imply the presence of an obsessive–compulsive style. Moreover, many adolescents with obsessive–compulsive traits will not develop OCD, and normative adolescents often show some obsessions and compulsions in response to episodes of subjective distress. This being the case makes it essential to distinguish between normative and psychopathological OCD symptom patterns.

The *Diagnostic and Statistical Manual of Mental Disorders*-Fifth Edition (*DSM-5*; American Psychiatric Association, 2013) removed OCD and PTSD from the section on anxiety disorders and placed them in separate sections on obsessive–compulsive and related disorders and on trauma and stress-related disorder, respectively. These changes resulted from emerging research and clinical evidence demonstrating common threads running through these two types of disorder and thereby raising issues of comorbidity and differential diagnosis. With respect to differential diagnosis of OCD, clinicians should investigate whether the adolescent recognizes

that the obsessions or compulsions are definitely or probably not anchored in reality and are thus ego alien and not ego syntonic. Should an adolescent be thoroughly convinced that obsessive–compulsive symptom patterns are true, these patterns may reflect a psychotic disorder.

In general, obsessive–compulsive symptom patterns can be conceived as constituting defensive operations activated against anxiety provoked by threat from either internal sources (e.g., guilt) or external sources (e.g., exposure to traumatic situations). Although intended to diminish anxiety, however, these defensive symptom patterns are themselves likely to cause substantial distress. The present case illustration focuses on the utility of the Rorschach in providing differential diagnosis in a 16-year-old boy whose symptom patterns of compulsive behaviors meet the *DSM-5* criteria for OCD.

As previously noted, the Rorschach was not designed to provide a psychiatric diagnosis but has proved to be a valid measure for helping to differentiate among major cognitive and affective types of disorder and among other symptom patterns that constitute a diagnosable DSM category (e.g., OCD and PTSD). The Rorschach can additionally serve as a validated tool for delineating possible comorbid psychopathological states, particularly those in which observed symptom patterns, such as obsessive–compulsive or psychotic-like behavioral manifestations, are trauma induced (e.g., Viglione, 1990).

Case Illustration 8.3: Symptom Patterns

This 16-year-old boy was referred for assessment due to parental concerns about his compulsive behaviors, sleeping difficulties, and social withdrawal. He is the youngest son of two physicians and was born and raised with his two older brothers, age 19 and 21 at the time of referral, in a wealthy neighborhood of a large city. He complains about urges to perform repeated checking acts, particularly at nighttime, such as verifying that the windows are closed and the doors and drawers all in their proper place. Only after performing these time-consuming and tiring rituals can he go to bed, but he frequently has difficulty falling asleep. The boy regards these rituals as not making any sense, but he sees them as reducing the anxiety he experiences when thinking about some dread-provoking events. He reports that as a young boy he was afraid of the dark and of being alone, and he would consequently wake his mother up during the night.

He perceives his mother as harsh, emotionally unavailable, and sometimes abusive. As an example, he reports an event at age 6 in which she locked him in his room in tears, in order to curtail his “childish and immature” habit of crying at nights. The clinician was impressed by his introspective capacity, as demonstrated by reporting that, when he sleeps with one of his brothers, his fears disappear, and he does not need to perform the compulsive acts. Based on this impression, she recommended that antidepressant medication aimed at reducing his subjective distress and need to perform the problematic behaviors should be provided jointly

with psychodynamic psychotherapy. To illuminate his psychodynamic processes and gain some understanding of his subjective experience, she administered the Rorschach. Tables 8.3.1 and 8.3.2 present the structural data and the sequence of scores for this boy's Rorschach protocol.

Table 8.3.1 Obsessive–compulsive symptom patterns in a 16-year-old boy: Structural Summary

			Affect	**Interpersonal**
R = 31	***L = 0.55***			
EB = 3:3.0	***EA = 6.0***	*EBPer = N/A*	***FC:CF + C = 0:3****	***COP = 0** AG = 0***
eb = 11:6	*es = 17*	***D = −4****	***Pure C = 0***	*GHR:PHR = 3:4*
	Adjes = 16	***AdjD = −3****	***Const. = 2:3.0***	***a:p = 8:6***
			Afr = 0.63	***Fd = 1****
FM = 9	***SumC' = 2***	***SumT = 0***	***S = 5****	***SumT = 0***
m = 2	***SumV = 3****	***SumY = 1***	***Complex. = 9:31***	***Human Content = 6***
			CP = 0	***Pure H = 0****
				PER = 1
				Isolation Index = 0.23
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 8:6	*Sum6 = 3*	***XA% = .65****	*Zf = 10*	***Egoc. Index = 0.45****
Ma:Mp = 0:3	***Lv2 = 2****	***WDA% = .75***	***W:D:Dd = 7:17:7****	***Fr + rF = 4****
INTELL = 2	***WSum6 = 7***	***X-% = .35****	*W:M = 7:3*	***Sum V = 3****
MOR = 3	***M- = 1***	*S- = 1*	***Zd = +4.0****	***FD = 3****
	Mnone = 0	***P = 4***	*PSV = 0*	*An + Xy = 0*
		X+% = 0.39	*DQ+ = 5*	***MOR = 3***
		Xu% = .26	***DQv = 2***	***H:(H) + Hd + (Hd) = 0:6****
PTI = 1	***DEPI = 4***	***CDI = 4****	***S-CON = 8****	***HVI = Yes**** *OBS = No*
FM + m = 11*	***Col-Shd = 0***			
RFS-P = −0.71*	***RFS-S = 2.49***	***EII-2 = + 0.60****	***AdjDMD = 1****	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R*, *EB*, *a:p*, *Ma:Mp*, *Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index* is zero, the stylistic variables should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4

Table 8.3.2 Obsessive–compulsive symptom patterns in a 16-year-old boy: Sequence of Scores

Card	Resp.								*RFS-2*
I	1	Wo	FC'.FD-		Ad		1.0	DV2, INC2	–5
	2	WSo	Mpo		Hx, (Hd)		3.5	PER, GHR	–1
	3	Ddo	Fo		Art				+3
II	4	WSo	FD.CFu		(Hd), Bl		4.5	MOR, PHR	–1
	5	D+	FMpo	2	A	P	3.0	DV	+1
	6	Ddo	F-		(Ad)				–3
III	7	Do	Mp-		Hd			PHR	–5
	8	Do	Fo		Cg				+3
	9	Ddo	FY.FMa-		Ad				–4
IV	10	Ddo	FV-		(Ad)				–3
	11	WSo	Fr.mpu		Ls		5.0	MOR	–1
V	12	Wo	FMao		A	P	1.0	MOR	+1
	13	Ddo	FC'.FMao		A				+1
	14	Do	FMpu		Ad				–1
VI	15	Do	Fu		(Ad)				–1
	16	Do	FV-		A				–3
	17	Wv	Fro		Na				+2
VII	18	Do	FMao		Ad				+1
	19	Do	Fo		Hd	P		GHR	+4
VIII	20	D+	FMao		A, Na	P	3.0		+1
	21	Do	F-		Fd				–3
IX	22	Do	FMa.Fr-		A				–4
	23	Do	F-		Ge				–3
	24	Do	Mp.Fr.FVo		Hd, Art			PHR	–1
X	25	DdSo	F-		(Ad)				–3
	26	Wv	ma.CFu		Ex				–1
	27	D+	Fu		Sc		4.0		+2
	28	Do	Fu		A				+2
	29	DS+	FD.CFo		Sc, Bt		6.0		+2
	30	Ddo	F-		(Hd)			PHR	–3
	31	D+	FMau	2	A, Hx		4.0	GHR	–1

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality–Fantasy Scale Version 2.0*

Case Illustration 8.3: Interpretation of Rorschach Data

The analysis of this adolescent's Rorschach data (see Tables 8.3.1 and 8.3.2) focuses on deviations shown in his protocol with respect to two types of CS variables: the 45 basic variables presented in Tables 6.1–6.4 as distinguishing between healthy and psychopathological functioning and the five additional variables (*R*, *EB*, *a:p*, *Ma:Mp*, and *Complexity Index*) indicating personality style (see Chap. 6). With respect to the psychopathological markers, most important is the positive *S-CON* in which the condition $FV + VF + V + FD > 2$ is endorsed. The positive *S-CON*, which

is a well-validated CS marker of self-destructive tendencies (see Case Illustration 7.2), points to a high risk of self-destructive behavior in an extremely distressed and anxious boy ($D = -4$; $AdjD = -3$; $Sum\ V = 3$; $AdjDMD = 1$) with narcissistic-like traits ($Fr + rF = 4$; *Egoc. Index* = 0.45; $PER = 1$), who is currently preoccupied by intrusive ideation ($FM + m = 11$), which is likely to impair his functioning ($EII\text{-}2 = +0.60$). It might be hypothesized that he experiences these intrusive thoughts as threatening his capacity to preserve self-cohesion, and they consequently provoke overwhelming subjective distress. In order to cope with the intrusive thoughts, he uses compulsive acts. What follows is a description of the $Fr + rF$ variable and the implications of its deviation for recognizing this adolescent's narcissistic vulnerability as a key factor in his subjective distress and functioning difficulties.

Fr + rF The presence of one or more reflection responses in a Rorschach protocol of an adolescent age 16 or more is usually associated with narcissistic traits involving preoccupation with one's own needs, self-admiration, a sense of entitlement, externalization of responsibility, and resulting adjustment problems. The inclination to articulate either one or more *Reflections* or none at all is a stable phenomenon. Accordingly, like narcissistic behavioral manifestations in general, $Fr + rF > 0$ is a marker of a personality trait that is unlikely to change over time, although people who give *Reflections* may fluctuate in the number they give on different occasions. Nevertheless, there appears to be no direct relationship between the number of *Reflections* people produce and how narcissistic they are likely to be. A deviant score on the $Fr + rF$ variable commonly appears jointly with an elevated *Egocentricity Index* and other possible indications of narcissistic traits (e.g., $PER > 0$).

In addition to the narcissistic vulnerability shown in the deviant scores on CS self-perception structural variables ($Fr + rF$; *Egoc. Index*; and *PER*), as well as some narcissistic-like contents in his responses (e.g., crown), this adolescent shows substantial difficulties in interpersonal relationships ($CDI = 4$; *HVI* positive; $COP = 0$ and $AG = 0$; $Food = 1$; and $Pure\ H = 0$). These CS markers of impaired interpersonal functioning and the absence of whole real human figures, which is particularly meaningful when compared to the six fragmented or fictitious human figures, provide a basis for understanding his obsessions and compulsions as compensatory narcissistic defenses aimed at preserving a cohesive sense of self.

To adjust adequately to external circumstances and feel satisfied with himself, this adolescent needs to be comfortable in interpersonal relationships and have a sense of what kind of person he is. However, his 0:6 ratio of *H* to *(H) + Hd + (Hd)* responses suggests just the opposite, namely, that social discomfort and difficulty developing a sense of identity are probably contributing to his substantial subjective distress. In line with these findings, his deviant scores on self-perception variables are probably not delineating primary personality characteristics. Rather, they seem to represent a compensatory defensive strategy for coping with distress that consists in part of an experienced threat of self-fragmentation.

This conceptualization is based on integrating Weiner's (2003) interpretation of elevated CS markers of narcissistic inclination with Silverstein's (2007) self-psychology approach for understanding narcissistic-like personality functioning.

The integration of these two perspectives can illuminate hypothesized psychodynamic processes that are responsible for this boy's obsessive–compulsive symptom patterns. Like his narcissistic inclinations, his obsessive–compulsive symptoms can be understood as being aimed at forestalling fragmentation of his sense of the self, to which he appears vulnerable. Applying this time-consuming defensive strategy may reduce his anxiety, but it also impairs his level of adjustment.

His adjustment difficulties can also be traced in part to the insufficiently modulated and childish affective functioning shown by his deviant scores on the *FC:CF + C* ratio (0:3). The elevated number of space responses (*S* = 5) also suggests adjustment problems. As has been noted, frequent use of the white space instead of the blot itself in forming responses is likely to reflect maladaptive oppositional tendencies associated with underlying feelings of anger or resentment (see Table 6.2). This boy's frequent attention to the white space may reflect a generally negative affective state that interferes with effective interpersonal functioning, and it might also indicate feelings of emptiness and self-depletion (e.g., Smith, 1990). Thus, his *FC:CF + C* ratio and *S* frequency may speak not only to problems in affective functioning but also to maladaptive interpersonal behaviors that elicit negative reactions from other people and exacerbate his experience of loneliness and subjective distress (*D Score* = –4).

To evaluate how much a CS score deviates from normative expectation, the deviations shown in this adolescent's protocol (e.g., *D Score*) should be transformed into T Scores as described in Chap. 6. A large *D Score* should be compared to its normative range in the contemporary nonpatient adult samples (Meyer et al., 2007, Table 1). The *D Score* of this adolescent's protocol falls far below the contemporary cutoff score as established by M + 1SD.

As the second step of interpretation, his *D Score* should be compared to the reference value of the T of *D Score* in the combined international sample of nonpatient adolescents used in this volume, which is 47 (see Table 5.2). If the raw score of –4 is converted to a T Score, using the M and SD presented in Meyer et al., the corresponding value is 28 when rounded off. This T Score value indicates extreme subjective distress and severe affective problems at a level infrequently seen in normative adolescents. In general, the deviant values in this adolescent's Rorschach protocol make it quite likely that he is experiencing persistent anxiety symptoms and that this experienced anxiety is beyond his capacity to regulate and is not a result of a current crisis but rather a marker of an enduring disorder involving anxiety and depressive symptom patterns.

Turning to the cognitive domain, this adolescent's protocol shows lowered capacity for relating to outer world (*RFS-P* = -0.71) with specific difficulties in attention (*W:D:Dd* = 7:17:7; *Zd* = +4.0), perception (*XA%* = 0.65; *X-%* = 0.35), and thinking (*Lv2* = 2; *FM + m* = 11). These cognitive deviations from normative expectancy point out problems in functioning adaptively and indicate that, in addition to his persistently elevated subjective distress, he may be prone to maladaptive behaviors. Although impaired coping capacities are less notable in the cognitive than in the interpersonal domain, it is nevertheless the case that this distressed

adolescent appears easily distracted by intrusive ideation ($FM + m > 6$) and irrelevant external clues ($Dd > 0.15$) that are preventing him from maintaining an adaptive focus of attention.

However, the deviant scores in the different domains of functioning must be considered in relation to his personality style. The relatively high number of responses ($R = 31$) indicate that this boy was motivated to cooperate with the Rorschach task. Given the interpersonal aspects of the Rorschach assessment process, his responsiveness seems contrary to the difficulties in interpersonal relationships suggested by CS markers in the personality domain. This apparent contradiction, which probably provoked some distress, could have been less had he been stylistically oriented to make more use of either ideation or emotion in coping with his experience. Instead, however, however, he is inclined to use these two coping styles interchangeably ($EB = 3{:}3.0$), without emphasizing one or the other in coping with reality.

Furthermore, although he shows reasonable capacity to think flexibly ($a{:}p = 8{:}6$), his complex style of processing external stimuli (*Complexity Index* = 9:31) creates a risk of his having difficulty in making even minor decisions. Particularly important in this regard are the deviations on $FM + m$ and $FC{:}CF + C$ that delineate intrusive thoughts and relatively unmodulated emotionality, respectively, and raise question about the effectiveness of his decision-making strategies. Taken together, the CS findings support a diagnostic impression that rules out the thinking disturbances of a schizophrenia-spectrum or other psychotic disorder and increases the likelihood of a highly distressed anxious and vulnerable adolescent who may be at risk for developing a borderline personality organization (*PDM* Task Force, 2006).

Question might be raised whether any particular type of stimuli provokes his problems in adaptive functioning. As shown in the sequence of scores (see Table 8.3.2), this adolescent's first response to the newly encountered stimulus of the Rorschach task *a spider, mixed with a bat* is characterized by impaired cognitive functioning, as coded with FQ- and two *Lv2* special scores (*DV2* and *INC2*) as well as dysphoric affect (*FC'*). The inappropriate combination in his first response constitutes an arbitrary mode of perception (Lerner, 1998) that is more likely to occur in younger children (Leichtman, 1996). The word *base*, which he uses in describing a bat and a spider in the inquiry, is quite bizarre in the boy's native language (Portuguese) and was coded with *DV2*. This beginning response demonstrates some cognitive slippage and disordered thinking, neither of which is prominent in his record ($PTI = 1$; *WSum6* = *7*) but which may be indicative of how he is likely to respond initially when confronted with a new situation or demand.

Because of this boy's substantial difficulties in interpersonal relationships, his responses to Card III, which is the card most likely to elicit associations to interpersonal interactions, seem particularly meaningful. Notably, none of his three responses to Card III is the popular (*P*) percept of two human figures (see Table 8.3.2, sequence of scores). However, the common location (*D*) of his first response to this card (Resp. 7) indicates that he does not detach himself from the contour of the blot, and he does provide a human movement (*M*) response, which can be a

marker of underlying motivation to be involved in human interaction. Awareness of this underlying interest in interacting with people appears to be a source of distress for him that has the effect of distorting his perception of reality (*FQ*-). He managed to improve his perceptual accuracy in his next response to Card III (Resp. 8), coded with *FQ*o, but turned to maladaptive functioning with an *FQ*- in his third response to this card (Resp. 9).

Case Illustration 8.3: Summary and Conclusions

This 16-year-old boy, who reported compulsive behaviors and sleeping difficulties, produced a Rorschach protocol containing numerous markers of impaired functioning in the cognitive, affective, interpersonal, and self-perception domains. With respect to his cognitive functioning, he shows some maladaptive modes of coping with reality (*RFS-P* = −0.71; *EII-2* = +0.60) as well as specific difficulties in attention, perception, and thinking, particularly with respect to intrusive ideation. His considerable subjective distress exceeds the psychological resources he can bring to bear in managing reality demands and puts him at risk for self-destructive behaviors. His Rorschach protocol points additionally to substantial interpersonal and self-perception difficulties. These include deficits in capacity for coping effectively with ordinary aspects of interpersonal and emotional situations, limited capacity to form a stable sense of identity through reference to mental representations of realistic human figures, incapacity to anticipate and engage in collaborative activities with other people, insufficient assertiveness, and narcissistic-like patterns of relating to other people that are associated with extreme vulnerability to becoming distressed by their actions toward him.

The maladaptive effect of these psychopathological manifestations is exacerbated by some stylistic modes of behavior that jointly provide a personality picture of a highly distressed, anxious adolescent who has strong needs to ponder all aspects of outer stimuli before coming to any conclusions about them. His thorough, cautious, reflective, ruminative, and indecisive approach to forming judgments appears to reflect a chronic and conflictual uncertainty, which is unresolved in his mind even if someone else—especially his parents, whom he experiences as impatient and emotionally absent—has made a decision for him. Coupled with his narcissistic vulnerability, his pedantic cognitive style probably contributes to his substantial difficulties in interpersonal relationships and exacerbates his feelings of loneliness and neediness.

The literature suggests that multiple factors are involved in the etiology of OCD. Despite this multiplicity, the primary responsibility of traumatic experiences in childhood for the emergence of OCD is a possibility that cannot be ruled out. In line with this conception, his intense anxiety when being exposed to traumatic events, his inability to comfort himself at these times, and his related susceptibility to intrusive thoughts may well be a source of this boy's obsessive–compulsive

symptom patterns. Because emotional neediness and expression have been criticized by his parents as being immature, he has resorted to apparently more mature ideational defenses that he uses to control his childish-like emotionality. Nevertheless, most frequently he fails to use ideation in a realistic fashion and to keep himself task oriented. His complex style of processing external stimuli additionally puts him at risk of having difficulty making even minor decisions. This inability to arrive at definite conclusions about events renders him quite helpless at times and exacerbates his subjective distress. His marked subjective distress and helplessness, together with his self-destructive tendencies, make him highly susceptible to further decompensation.

This case illustration of a 16-year-old boy with obsessive–compulsive symptom patterns demonstrates how psychodynamically oriented assessment of diverse symptom patterns can play an important and beneficial role in Rorschach assessment, particularly for adolescents. Instead of regarding Rorschach findings as confusing because observed personality characteristics do not point to a clearly recognizable disorder, consideration of possible broader and underlying meanings of the overt symptoms and personality characteristics, even though speculative, can often serve to clarify the clinical picture. Although psychodynamic reconstructions cannot substitute for reliable and valid criteria for arriving at meaningful diagnoses, conceptual formulations, whatever form they may take, can facilitate clinical thinking about complex and atypical presenting pictures that do not fit familiar patterns and may thereby extend diagnostic understanding beyond categorical classifications based on self-report inventories.

Case Illustration 8.4: Somatization in an 18-Year-Old Boy

Somatic symptoms are observed quite frequently in adolescents. These types of symptoms (e.g., headache, stomachache) may arise either as a normative reaction to developmental crises or as a response to threatening internal or external experiences. When the symptoms become prolonged or impair personality functioning, they constitute a diagnosable disorder. The *Diagnostic and Statistical Manual, Fifth Edition* (*DSM-5*; American Psychiatric Association, 2013) similarly characterizes somatic symptom disorder (SSD) as consisting of symptoms that are either very distressing or that result in significant disruption of functioning. The symptoms may or may not have a medical explanation. However, adolescents with somatic complaints are usually brought or referred to nonpsychiatric medical settings, and clinicians in these settings should be alert to possible mental health problems. The denial or lack of recognition of such problems can exacerbate the typical resistance among adolescents seen in clinical practice to cooperating with the personality assessment process.

Viewed from a psychodynamic perspective, somatizing adolescents appear to feature a personality structure in which bodily symptoms are used to express ideas and affects. Clinical experience suggests that habitual tendencies to express

dysphoric affect by somatic symptoms is quite common among these adolescents, and progressive use of the symptoms as a pattern of avoiding unpleasant affect may evolve. Somatizing adolescents complaining of physical symptoms are usually preoccupied with these symptoms and with the details of external events while being detached from their own subjective experience (*PDM* Task Force, 2006). Most often, however, somatizing adolescents present a confusing personality picture in which general adaptive functioning is interrupted by apparently justified physical symptoms. In these cases, the main question is whether the somatic symptom patterns hide psychopathological states.

Two major psychodynamic models have been suggested for explaining the link between personality characteristics and somatic symptom patterns. One is the conflict model, derived from classical psychoanalytic theories of neurotic symptom formation, and the other is the deficit model, derived from modern psychoanalytic thinking based on clinical experience with somatizing patients. Whereas the conflict model emphasizes the role of unconscious conflicts in producing persistent states of emotional arousal that impair physiological functions, the deficit model attributes psychosomatic symptoms to deficits in personality organization rather than to neurotic defenses and focuses on what has been described by Nemiah and Sifneos (1970) as the Alexithymia construct.

Alexithymia is a multifaceted personality construct that encompasses a cluster of cognitive and affective characteristics associated with various psychiatric disorders. These characteristics include difficulties in describing, naming, recognizing, containing, or working through subjective feelings; problems in distinguishing between feelings and the bodily sensations of emotional arousal; impoverished and constricted imaginative capacities; and a concrete and reality-oriented cognitive style (Taylor, Bagby, & Parker, 1991). From a psychodynamic perspective, these difficulties are attributable to a developmental arrest in which affects are expressed through body sensations that are undifferentiated precursors of states of distress.

The particular type of individuals whose affects are channeled through body sensations has been described as normotic, meaning that they are well-adapted individuals whose personality functioning is "abnormally normal" (Bollas, 1987). These normotic individuals seem to be "disaffected" (McDougall, 1989; Ogden, 1989), in that they are detached from their subjective experience to the point of being inordinately stable, secure, comfortable, and socially extroverted. Alexithymic individuals are inclined to reflect mainly on material objects and phenomena, and they have little interest in feelings, fantasy, speculation, or aspects of their subjective experience. With respect to adjustment, this firm commitment to external reality often becomes a problem, rather than the solution (Winnicott, 1971).

As would be expected from their generally normative functioning, alexithymic adolescents may provide a normative Rorschach protocol with no prominent deviations. A disorder that is being masked by somatization (e.g., depression) might go unnoticed and the presence of a diagnosable disorder might be difficult to delineate. Clinicians who use the Rorschach in evaluating adolescents with somatic complains should accordingly look for any discrepancies between indices pointing to adaptive functioning and those showing difficulties associated with subjective experience. In line with this conception, the present case illustration explores the Rorschach data of

a well-adjusted 18-year-old boy, a computer technician, whose main complaint on referral was chronic headaches that had recently begun to interfere with the adequacy of his functioning at work. The analysis of his Rorschach protocol focuses on the question of whether his somatic symptoms hide a diagnosable disorder.

Case Illustration 8.4: Symptom Patterns

This is an 18-year-old boy, employed as a computer technician, who was referred for assessment because of a 5-year history of recurrent headaches. He lives with his parents, an older sister age 25, her sister's husband, and their two children, all of them in the same house. When returning home from work, he would usually go to his room and stay there until joining his family for dinner. During dinner they usually talk mainly about sports and political news. Recently, however, problems related to his work have also been discussed. He describes the family relationships as "good and normal." He experiences his parents as preserving the private space of each of the family members in the household. He is very much preoccupied with his health, easily becomes anxious about it, and spends hours reading about medical issues on the internet.

This health preoccupation appears to have led to some avoidant behavior with phobic and compulsive features. He does not eat some "risky" foods, particularly chocolate, nor does he go to crowded places (e.g., stadium, shopping malls) for fear they might trigger his headaches. He also avoids entering particular places or automobiles that are not in compliance with certain criteria (e.g., being in a non-smoking area), because of concerns about their being contaminated. Despite being thus highly anxious and easily distressed, he reports a stable romantic relationship with a girl aged 17, whom he met about 3 years prior to the present referral. He describes their intimate relationships and social activities as relaxed, satisfactory, and supportive, with no specific problems. He states that he feels "understood by her," particularly because she agrees to stay with him in his room, without talking, when his headaches prevent them from socializing with their friends. Tables 8.4.1 and 8.4.2 present the structural data and the sequence of scores for this boy's Rorschach protocol.

Case Illustration 8.4: Interpretation of Rorschach Data

The most prominent finding in the Rorschach protocol of this 18-year-old boy is his negative score on the *Ego Impairment Index* (*EII-2* = −1.37), which indicates well-adapted normative functioning. His score on the *EII*-2 falls within the optimal range, which is any score less than −0.3, and gives no evidence of impaired functioning or psychopathology (Viglione, Perry, & Meyer, 2003). The apparent ability of this adolescent to adjust himself successfully to external demands is quite puzzling, given his limited adaptive resources (*EA* = 2.5). Applying the interpretive guidelines described in Chap. 6 further consideration of his low *EA* starts with

Table 8.4.1 Somatization in an 18-year-old boy: Structural Summary

			Affect	**Interpersonal**
R = 19	***L = 1.71****			
EB = 1:1.5	***EA = 2.5****	*EBPer = N/A*	***FC:CF + C = 1:1***	***COP = 2 AG = 0***
eb = 4:2	*es = 6*	***D = −1***	***Pure C = 0***	*GHR:PHR = 4:0*
	Adjes = 5	***AdjD = 0***	***Const. = 1:1.5***	***a:p = 3:2***
			Afr = 0.58	***Fd = 0***
FM = 2	***SumC' = 1***	***SumT = 0***	***S = 2***	***SumT = 0***
m = 2	***SumV = 0***	***SumY = 1***	***Complex. = 1:19***	***Human Content = 4***
			CP = 0	***Pure H = 2***
				PER = 0
				Isolation Index = 0.11
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 3:2	*Sum6 = 1*	***XA% = .95***	*Zf =*	***Egoc. Index = 0.32****
Ma:Mp = 1:0	***Lv2 = 0***	***WDA% = .95***	***W:D:Dd = 13:6:0****	***Fr + rF = 0***
INTELL = 2	***WSum6 = 4***	***X-% = .05***	*W:M = 13:1*	***Sum V = 0***
MOR = 0	***M- = 0***	*S- = 0*	***Zd = +1.5***	***FD = 0****
	Mnone = 0	***P = 8****	*PSV = 1*	*An + Xy = 0*
		X+% = .79	*DQ+ = 6*	***MOR = 0***
		Xu% = .16	***DQv = 0***	***H:(H) + Hd + (Hd) = 2:2***
PTI = 0	***DEPI = 3***	***CDI = 2***	***S-CON = 2***	***HVI = No*** *OBS = No*
FM + m = 4	***Col-Shd = 1***			
RFS-P = + 1.53*	***RFS-S = 2.33***	***EII-2 = −1.37***	***AdjDMD = 1****	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R*, *EB*, *a:p*, *Ma:Mp*, *Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index* is zero, the stylistic markers should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4

comparing it to its normative range in the contemporary nonpatient adult reference samples (Meyer et al., 2007, Table 1). The *EA* in this adolescent's protocol is lower than the contemporary cutoff score as established by *M*—1SD (6.84–3.76 > 3 when rounded off.

Table 8.4.2 Somatization in an 18-year-old boy: Sequence of Scores

Card	Resp.								*RFS-2*
I	1	Wo	FMao		A	P	1.0		+1
	2	WSo	Fo		(Hd)		3.5	GHR	+2
II	3	W+	Mao	2	H		4.5	COP, GHR	0
	4	WSo	Fu		(Ad)		4.5		−1
III	5	Do	Fo		Cg				+3
	6	Wo	F-		Ad		5.5		−3
IV	7	Wo	Fu		A		4.0		+2
	8	Wo	Fo		(H)	P	2.0	GHR	+3
V	9	Wo	Fo		A	P	1.0		+4
	10	Wo	FC'o		A	P	1.0		+3
VI	11	D+	Fo		Ay		2.5		+3
VII	12	W+	Mpu	2	H, Id	P	2.5	COP, FAB, GHR	−5
VIII	13	D+	ma.CF.FYo		Ls, Fi		3.0		+1
	14	W+	FMpo	2	A, Ls	P	4.5		+1
IX	15	Wo	FCo		Art		5.5		+2
	16	Wo	Fo		(Ad)		5.5		+2
X	17	Do	Fo		A	P			+4
	18	Do	Fo		A	P		PSV	+4
	19	Do	Fo		A				+3

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality–Fantasy Scale Version 2.0*

The next step in the interpretation consists of comparing his *EA* with the reference value based on the combined international sample of nonpatient adolescents provided in Chap. 5 of this volume. If his raw score (*EA* = 2.5) is converted to a T Score using the M and SD presented in Meyer et al., Table 1, the corresponding value is 38 when rounded off, which is more than 2SD lower than the mean *EA* of nonpatient adolescents in his age group. Nevertheless, as just noted, he has apparently been able to preserve his well-adjusted functioning despite his limited coping resources. Notable in this regard has been his ability to minimize the experienced stress when confronting external demands and keep it within limits he can manage (*D* = −1; *AdjD* = 0).

This adolescent's well-adapted functioning is additionally evident in CS scores indicating accurate and conventional, or even overly conventional, perception (*XA%* = 0.95; *WDA%* = 0.95; *X-%* = 0.05; *P* = 8) and coherent and logical thinking (*WSum6* = 4; *Lv2* = 0). His appropriate adjustment to external demands is evidenced further by his adequate, although restricted and simplistic, affective functioning (*FC:CF* + *C* = 1:1; *Complexity Index* = 1:19); his ability to identify with other people (*Human Content* = 4); his capacity of relating to mental representations of realistic human figures (*Pure H* = 2); and his anticipation of engaging in collaborative activities with other people (*COP* = 2), although he may be lacking in assertiveness (*AG* = 0).

What is apparent, however, is that this adolescent's well-adjusted functioning is maintained by a coping strategy that adheres closely to reality and limits his ability

to relate to internal experience (*RFS-P* = +1.53). This strategy is reflected as well in other deviant scores that point to a narrow frame of reference in dealing with experience and a preference for detachment from thoughts and feelings (*L* = 1.71), little capacity for self-inspection (*FD* = 0), and minimal attention to himself (*Egoc. Index* = 0.32). Whatever positive purposes this strategy may serve for him, it does not prevent him from showing some affective and cognitive indications of oversimplification (*Complex.* = 1:19), experienced anxiety (*AdjDMD* = 1), and dysphoria (*Col-Shd Blend* = 1) to an extent that has probably been responsible for the recent impairment of his usually adaptive functioning. The discussion that follows focuses on this adolescent's normative score on the CS-based *Ego Impairment Index* (*EII-2*) and its association with his deviant score on the *Reality–Fantasy Scale* (*RFS-2*).

EII-2 The *EII-2* (Viglione, Perry, & Meyer, 2003) was developed as a measure of psychological impairment and thought disorder. The index comprises five component variables that are derived from the CS and entered with different weights to form an equation. This index reflects the ego psychology model, and its variables are assumed to indicate deficits in ego functions that impair adaptation to external reality. Numerous studies have demonstrated replicable factorial validity and good interrater reliability for the index (see Chap. 6). With respect to its statistical distribution, individuals who are well adapted are expected to have an *EII-2* score less than −0.3, which indicates high functioning, even in people who show substantial difficulties related to their subjective experience. Consequently, psychopathological states in which the disturbance is masked by areas of apparently normal functioning, such as those characterized by somatic symptoms, might not be captured when measured solely by this index.

To explore these states, Tibon, Porcelli, and Weinberger (2005) have suggested using the *RFS-P* and the *RFS-S* (see Table 6.1) jointly with the *EII-2*. As has been noted (see Chap. 6), the two CS-based derivations of the *Reality–Fantasy Scale Version 2.0* (*RFS-2*) are aimed at describing psychopathological states in terms of collapse of potential or transitional space between reality and fantasy (Winnicott, 1971). In keeping with the application of Ogden's (1989) model in Rorschach work, a deviant score on the *RFS-P* pointing toward the reality pole (*RFS-P* > +0.65 in adults and *RFS-P* > +0.92 in adolescents) speaks to conditions in which reality robs fantasy of its vitality and the capacity to imagine is impaired. These conditions include cases of Alexithymia or normotic functioning (Bollas, 1987), as frequently observed in patients with somatic symptom patterns.

In Rorschach terms, individuals experiencing this form of collapse of the dialectical process toward the reality pole may have difficulty generating responses. They may begin their response to a card by insisting that it is just an inkblot and claiming that they are unable to see it as anything else. When they do give responses, most frequently only after being prompted, their explanations in the inquiry are often limited to a cataloging of the parts of the percept and are based on form only. Some of these respondents are nevertheless keen observers and would note what details are missing from Card V that would make it look like a real bat (Smith, 1990). Given that the Rorschach stimuli do bear some concrete resemblance to real

objects, which they can be assumed to represent, these respondents do not adapt to the basic task of the test, which is to "misperceive" the stimulus as being something more than an inkblot (Exner, 2003). Instead, they are not able to cross the threshold where perception as recognition becomes perception as interpretation (Leichtman, 1996).

As an illustration of this conception, the elevated *RFS-P* in this adolescent's protocol, which substantially exceeds the normative range of this index, points to a reality-bound approach. This approach, which is also evidenced by some of his other CS scores (e.g., low number of color and shading responses, low *Complexity Index*), delineates a markedly narrow and reserved pattern of functioning and experiencing, which is apparently justified by the somatic symptoms. Further consistent with his excessively reality-bound approach is the frequency of his poor quality, childish-like, mostly common, and unelaborated contents ("a bat," "a butterfly," "insects"), with a high *Lambda* and 13 percepts referring to animals, most of them as a single content of the response.

Worth noting, however, is Resp. 13, which is his first response to Card VIII *a volcano* and stands out with its complex coding (*D+ ma. CF. FYo Ls, Fi*). It is reasonable to consider that this relatively ambiguous colored card may have provoked associations to a volcano explosion over which one has no control. Such associations may have threatened his internal sense of stabilized self-cohesion, either because of unresolved neurotic conflicts or because of substantial deficits in his capacity to process emotions. This threatening association apparently activated a strategy of coping with the outer stimulus (the blot) that differed from his customary narrow frame of reference and was characterized instead by a complex and integrative emotional style (*D+*, *CF*, multiple determinant *Blend*). Interestingly, this highly unusual style of coping, although experienced as quite distressful (*m, FY*), did not impair his thinking or perception.

Case Illustration 8.4: Summary and Conclusions

This 18-year-old boy, who was referred for assessment because of somatic symptom patterns that had recently begun to impair his otherwise well-adapted functioning, produced a Rorschach protocol that looks normative, with no evidence of impaired ego functioning or psychopathology (*EII-2* < –0.3). His limited availability of psychological resources for coping with situations (*EA* < 6) made assessment of his personality functioning in general and his inner experience in particular quite challenging. As has been noted, somatization can be an elusive symptom pattern in which underlying psychopathological states may not be reflected in maladaptive functioning. Assessing the quality of personality functioning in well-adapted adolescents being evaluated for somatic complaints may illuminate implicit psychopathological phenomena, and exploring their inner experience may provide clues to the effectiveness of their physical symptoms in neutralizing subjective distress.

With respect to the quality of this adolescent's functioning, the Rorschach protocol in the present case revealed a personality picture of a young person who is preoccupied with searching for concrete, reality-bound facts and establishing an accurate perception of the external world while persistently avoiding any internal imagery or affect that might "contaminate" this perception with his subjective experience. In this regard, the finding of an extremely elevated *RFS-P* suggests a severe impairment in his ability to preserve a dialectical tension between reality and fantasy.

Some authors (e.g., McDougall, 1989; Ogden, 1989) propose that somatic symptom patterns and psychosis might hide similar cognitive impairments. Most notable among these are difficulties in concept formation, as represented in either concrete or overly inclusive thinking (e.g., Weiner, 1992). This comparison may seem incongruous, in that few adolescents appear more bizarre than those with psychotic symptoms, and few seem as well adapted as those who show somatic symptom patterns, as is the case with this 18-year-old adolescent. This similarity is not limited to the dynamic force of unconscious fears concerning contact with external objects but also includes fears of the damage that emotional states are thought to cause.

Although located at two opposite poles of the reality–fantasy continuum, both somatic reactivity and psychotic symptoms point to impairment cognitive functioning and also to impaired experience of one's self-state. Whereas in psychosis, there is an attack on the psychological capacities by which meanings are created and contemplated, in somatic reactivity, there is an attack on the psychological capacity to capture affect and use it for thought. Adolescents with somatic symptom patterns deflect the self from subject to object. External reality and object relationships are thereby drained of their meaning, and, instead of delusions produced by thoughts, it is the somatic symptom that represents delusional thinking.

The present findings suggest that, in the evaluation of well-adapted adolescents with somatic symptom patterns, the *EII-2* should be used jointly with the *RFS-2* as complementary indices. In general, the *EII-2* might be more sensitive to problems of adaptation to external reality, whereas the *RFS-2* is more useful in assessing adolescents in whom the very adaptation to external reality is regarded as the problem, not the solution. In these cases, the *RFS-2* would enable clinicians to detect aspects of personality that would not be captured if the *EII-2* were used alone. However, in adolescents whose major symptom patterns are somatic, abnormality is most often masked by extremely concrete and reality-oriented experience. Using the *EII-2* jointly with the *RFS-2* can be essential for differential diagnosis and for understanding their subjective experience.

Conclusion

The distinctive characteristics of anxiety and personality disorders are less uniform and more varied than those of schizophrenia-spectrum and affective disorders, and Rorschach protocols of adolescents with these disorders are accordingly likely to be more diverse and less directly suggestive of any particular disorder, as described

in this chapter that explores case illustrations of adolescents with internalized symptom patterns. Even without implications for a specific disorder, however, Rorschach CS findings can provide diagnostically useful information about (a) the adequacy or limitations of an adolescent's cognitive, affective, relational, and self-observational capacities; (b) the overall state of the adolescent's psychological health; and (c) whether the adolescent needs and would benefit from some form of psychotherapy. With regard to psychotherapeutic treatment, a Rorschach protocol may demonstrate risk factors that call for immediate intervention, as in the case of suicidal risk delineated by an elevated *S-CON*. With more general respect to meeting an adolescent's psychological needs with psychotherapy, Rorschach assessment can play an important role in treatment planning and outcome evaluation, as elaborated in Chap. 11.

In formulating diagnostic impressions, the distinction between healthy and psychopathological personality functioning is substantial. This distinction should be based on comparisons of obtained findings with normative reference data. Recognizing developmental differences and their implications for disorder is essential. The Rorschach CS reference data presented in Chap. 5 indicate that early adolescent nonpatients differ in several factors from older nonpatient adolescents, who in turn differ in some factors from nonpatient adults. An adolescent Rorschach protocol should accordingly be evaluated with attention to level of maturity and the degree to which the test findings correspond to normative data.

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Chapter 9
Delineating Externalized Symptom Patterns

In line with the conception explored in the previous chapter concerning internalized symptom patterns, this chapter explores the utility of the Rorschach for delineating susceptibility of adolescents who show externalized symptom patterns to developing a particular disorder and the maladaptive impact of the disorder on their psychological functioning. As noted, it has long been known that adolescents who show impaired psychological functioning are at increased risk for showing psychopathology in adulthood. Accordingly, personality characteristics shown in the Rorschach protocol of adolescents with adjustment symptom patterns may presage development of a personality disorder in adulthood.

What follows are two case illustrations that describe the two externalized behavioral manifestations most frequently seen in adolescents. One is adjustment symptom patterns in a 15-year-old girl (Case Illustration 9.1) and the other is eating behavior problems in a 14-year-old girl (Case Illustration 9.2). Like the previous analysis of the externalized type cases, the present one begins with pointing out the deviant scores, followed by discussing the implications of these deviant scores for certain personality characteristics, for certain types of externalized disorders, and for treatment planning. Particularly important in these cases are issues of continuities and changes and their impact on adaptation in adulthood.

Case Illustration 9.1: Adjustment Disorder in a 15-Year-Old Girl

Adjustment symptom patterns are stress-related, short-term, nonpsychotic disturbances that have a substantial impact on one's functioning. The specific diagnostic criteria for adjustment disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*—Fifth Edition (*DSM-5*; American Psychiatric Association, 2013), include three major factors: (a) emotional or behavioral symptoms that

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develop in response to a stressor; (b) marked distress that is out of proportion to the severity or intensity of the stressor, even when external threatening events that might influence symptom severity are taken into account; and (c) significant impairment in functioning. Adjustment disorder can occur in the context of mood or conduct symptom patterns.

Adolescents with adjustment disorders can show a wide range of subjective states. They might be observed as being anxious, depressed, angry, or impulsive. Their relationships may become more dependent and clinging or more distant and detached, in accord to their basic personality dispositions. Because adolescents' cognitive functioning, affective states, relational patterns, and self-perception are quite varied, no single pattern characterizes those who show adjustment problems. However, impairment in one or more of the domains is usually evident and may exacerbate the adolescent's subjective distress to the extent of posing potential risky consequences, including self-destructive and violent behaviors. Although the subjective states in adjustment disorders are similar to those of other mental disorders, the major difference is that, in adjustment disorders these states are temporary and related to specific events (*PDM* Task Force, 2006). This conception makes it essential to assess the extent to which the symptom patterns are primarily reactive or instead constitute an enduring characterological pattern that would indicate faltering personality development.

During adolescence, when personality patterns become increasingly stable, some problems in personality organization start to be established. Most frequently, adolescents who show adjustment symptom patterns are more likely to be having problems in personality development rather than temporary maladaptive reactive states. In particular, adjustment symptom patterns are commonly found in adolescents who are functioning at the borderline level of personality organization (*PDM* Task Force, 2006).

Borderline adolescents are characterized by persistent ways of viewing and coping with events that seem out of step with their peers and often cause them to falter markedly in their daily functioning. They are vulnerable to psychotic-like episodes, inclined to overly intense and unstable emotionality and poor self-control, and likely to have strained interpersonal relationships and negative perceptions of themselves. However, these patterns of impaired functioning may appear only in specific stress-provoking circumstances, such as unstructured settings that provide few guidelines for what they should do or are expected to feel.

The only stable feature of adolescent borderline functioning is an unstable, inconsistent, and labile pattern of coping with reality, as demonstrated by abrupt fluctuations between reality and fantasy, between polarized affective states, between closeness and distance in interpersonal relationships, and between self-deprecating and grandiose views of themselves (Weiner, 1992). Because of their limited ego strength, they have little anxiety tolerance and are prone to diffuse free-floating anxiety that is particularly likely to disrupt their functioning in unstructured and emotion-laden settings (Lerner, 1998; Sugerman, 1980). Accordingly, the ambiguous nature of the Rorschach task makes it particularly suitable for capturing the marked fluctuations that characterize this personality organization.

When conducting Rorschach assessment addressed at delineating borderline conditions in adolescents, clinicians should be aware that conceptual issues related

to these conditions are far from settled and that consideration should accordingly be given to defining the phenomena to be diagnosed. In particular, there is no well-established Rorschach profile that discriminates among characterological disturbances. This limitation is quite evident in the assessment of adolescents, because of the variability with which they are developing physically and psychologically. Difficulties shown on the Rorschach of adolescents at one point of time may disappear, particularly if they have had the benefit of some psychotherapy.

The Rorschach can nevertheless provide clues to an adolescent's personality structure and processes and to the person's level of subjective distress. Along with considering the possibility of borderline disorder in an adolescent with adjustment problems, this Rorschach information can help to identify young people whose problem behavior is associated with the emergence on an antisocial personality disorder that is likely to persist into adulthood. What follows is a case illustration of a 15-year-old girl who was referred by her school and the Department of Social Services to evaluate whether she is under sufficient control to return to school, following her arrest for threatening her 18-year-old boyfriend with a weapon when she felt being humiliated by him. The discussion focuses on her deviant scores on the 45 CS and CS-based variables delineated in this volume for distinguishing between healthy and psychopathological personality functioning, within the context of her scores on the five stylistic variables (see Chap. 6). Attention is paid in particular to indications of whether the behavioral symptom patterns of this girl meet criteria for a diagnosable adjustment disorder or instead point to characterological problems.

Case Illustration 9.1: Symptom Patterns

This 15-year-old girl was referred by her school and the Department of Social Services to evaluate if she is under sufficient control to return to school. Approximately three months prior to referral, she was hospitalized in a psychiatric unit because of depressive symptoms. Two weeks following her hospitalization, she heard her boyfriend saying something about her mental state, which made her feel humiliated by him. She went out to the parking lot where his car was parked and used a pocket knife to slash the tires. When she came back inside, she announced to the people who were there that she was going to kill him. She approached her boyfriend, took out the knife, and waved it in his face in a threatening manner. She was subsequently arrested and charged with criminal behavior. She stated that this behavior was a reaction to her distressed mental state following the suicide of her favorite relative, which made her extremely depressed. Her parents were skeptical of her statement of having close relationships with this relative, because he had been in and out of prison, and she had hardly ever seen him. There is no history of substance abuse. Psychotropic medications were being considered, but she was not on any medications at the time of her Rorschach evaluation.

The girl is a physically attractive, healthy-looking adolescent. She is the only child of a couple who relocated 4 years prior to referral from another state, due to a back injury to her father that forced him to quit his job as a construction manager.

Table 9.1.1 Adjustment symptom patterns in a 15-year-old girl: Structural Summary

			Affect	Interpersonal
R = 16	***L = 1.29****			
EB = 0:1.5*	***EA = 1.5****	*EBPer = N/A*	***FC:CF + C = 1:1***	***COP = 0* AG = 0***
eb = 4:5*	*es = 9*	***D = −2****	***Pure C = 0***	*GHR:PHR = 1:2*
	Adjes = 6	***AdjD = −1***	***Const. = 3:1.5****	***a:p = 2:3***
			Afr = 0.45	***Fd = 3****
FM = 1	***SumC' = 3***	***SumT = 0***	***S = 4****	***SumT = 0***
m = 3	***SumV = 0***	***SumY = 2***	***Complex. = 3:16***	***Human Content = 3***
			CP = 0	***Pure H = 0****
				PER = 0
				Isolation Index = 0.06
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 2:3	*Sum6 =*	***XA% = .63****	*Zf = 11*	***Egoc. Index = 0.00****
Ma:Mp = 0:0	***Lv2 = 1****	***WDA% = .67****	***W:D:Dd = 11:4:1****	***Fr + rF = 0***
INTELL = 0	***WSum6 = 7***	***X-% = .31****	*W:M = 11:0*	***Sum V = 0***
MOR = 2	***M- = 0***	*S- = 3*	***Zd = −1.5***	***FD = 0****
	Mnone = 0	***P = 3****	*PSV = 1*	*An + Xy = 0*
		X+% = .38	*DQ+ = 4*	***MOR = 2***
		Xu% = .25	***DQv = 1***	***H:(H) + Hd + (Hd) = 0:3****
PTI = 2	***DEPI = 5****	***CDI = 5****	***S-CON = 6***	***HVI = No*** *OBS = No*
FM + m = 4	***Col-Shd = 0***			
RFS-P = −0.25	***RFS-S = 3.01****	***EII-2 = + 0.59****	***AdjDMD = 1****	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R*, *EB*, *a:p*, *Ma:Mp*, *Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index*, the stylistic variables should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4.

This event altered the family's pattern of functioning. Her mother found a job as an administrative assistant in a local hospital, and she entered the local school, where she has done well. She has a history of being a good student and a good athlete, with no history of family problems. Tables 9.1.1 and 9.1.2 present the structural data and the sequence of scores for her Rorschach protocol.

Table 9.1.2 Adjustment symptom patterns in a 15-year-old girl: Sequence of Scores

Card	Resp.							*RFS-2*
I	1	WSo	Fo	A	P	3.5		+4
	2	Wo	Fo	A		1.0		+3
II	3	DSo	F-	Fd			MOR	–3
III	4	DS+	FC′-	Ad, Cg		4.5	FAB2	–5
IV	5	W+	map.C′F.YF-	Sc, Fi		4.0		–4
V	6	Wo	Fo	A	P	1.0		+4
	7	Wo	Fo	A	P	1.0	PSV	+4
VI	8	W+	Fu	(Hd),Id		2.5	GHR	–1
	9	Do	Mpu	Fd		2.5	MOR	–1
VII	10	Wv	mp.C′Fu	Fi				–1
	11	Wo	Fu	Ad		2.5		+2
VIII	12	Do	FCo	Bt				+2
IX	13	Wv/+	Y	Id				–3
	14	DdSo	F-	(Hd)			PHR	–3
X	15	Do	F-	(Hd)			PHR	–3
	16	W+	FMa.CFo	A, Fd		5.5		+1

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality–Fantasy Scale Version 2.0*

Case Illustration 9.1: Interpretation of Rorschach Data

In keeping with the referral question concerning this adolescent's adjustment problems, the following discussion of her Rorschach protocol begins with noting her deviant scores on markers of impairment in each of the four domains of personality functioning delineated in Tables 6.1–6.4. Inferences concerning her cognitive functioning are derived primarily from the deviations shown on two of the general cognitive indices (*RFS-S* = 3.01; *EII-2* = +0.59), which indicate a proneness to dissociate and impaired ego functioning, respectively. Further evidence of attention problems is provided by the elevated *Lambda* (*L* = 1.29) and the unbalanced *W:D:Dd* ratio (*W:D:Dd* = 11:4:1), indicating limited openness to experience and inordinate attention to global aspects of outer stimuli and perceptual problems are evident in her low perceptual accuracy and limited conventionality (*XA%* = 0.63; *WDA%* = 0.67; *X-%* = 0.31; and *P* = 3).

As noted previously (see Case Illustration 7.1), an elevated *RFS-S* (*RFS-S* > 2.67) shows limited capacity to differentiate and integrate inner and outer experiences. This limitation points to abrupt fluctuations between reality and fantasy and between progressive and regressive functioning, and it also suggests the excessive use of dissociative defenses often found in adolescents who have been exposed to traumatic events. She accordingly appears vulnerable to dissociative episodes that could occur without advance warning, particularly in the context of an ambiguous anxiety-provoking experience, and that put her at risk for maladaptive functioning.

These findings suggest that, in a structured and predictable environment with minimal precipitating stress, maladaptive symptoms might disappear and her

cognitive functioning be within the normative range. This particular feature of her personality functioning was demonstrated as well by her scores on structured psychological tests such as the Wechsler Intelligence Scale for Children (*WISC*), which indicated coherent, logical, and realistic thinking. In this regard, the data are consistent with the expectation that relatively intact performance on the *WISC* contrasting with a clearly deviant performance on the Rorschach may well indicate the presence of a borderline disorder.

Inferences about the affective experience of this girl can be derived from the deviant *D Score* of −2, indicating current experience of stress overload and insufficient coping capacities to deal with events in her life without becoming unduly distressed by them. The *AdjDMD* of +1 delineates the likelihood of prevailing distressful experience with marked anxiety symptoms, and she additionally gives evidence of emotional blocking (*const.* = 3:1.5), dysphoric and unpleasant affect (*eb* = 4:5), and negative attitudes sometimes associated with oppositional behavior or underlying feelings of resentment and faulty judgment (*S* = 4, three of them coded with *FQ*-). These markers of psychopathological affective functioning coupled with the previously noted elevated *Lambda* (*L*), the formless diffuse-shading response (*Y*), and the rarely found *Shading-Shading Blend* point to a prevalent affective experience of anger and depression that may at times be discharged in maladaptive and poorly controlled behavior associated with outbursts of temper and violence.

Impaired interpersonal functioning can be inferred from this girl's deviant score on the *Coping Deficit Index* (*CDI* = 5) and her low *EA* (*EA* = 1.5). These deviations point to substantial deficits in her capacity for coping with ordinary aspects of interpersonal and emotional situations as well as her generally limited adaptive resources. In addition, the absence of *Pure H* responses, which is particularly meaningful in light of the heightened dependency needs indicated by the 3 *Food* (*Fd*) responses, put her at risk of being persistently angry and frustrated at not receiving the attention and nurturance she would like to have.

As described in previously presented case illustrations, the extent to which CS scores deviate from normative expectation can be evaluated by transforming them into T Scores. In this girl's record, her elevated number of responses with *Food* (*Fd*) content exceeds the cutoff score established as M + 1SD in the contemporary nonpatient adult samples (Meyer et al., 2007, Table 1). The *Fd* frequency in her protocol can be compared to the reference value of the T Score for *Fd* in the combined international sample of nonpatient adolescents used in the present volume, which is 50 (see Table 5.2). If the *Fd* raw score of 3 is converted to a T Score, using the M and SD presented in Meyer et al., the corresponding value rounds off to 90. This T Score value, compared to the customary mean value of T Scores at 50, provides indication of her extremely heightened dependency as compared to her peers.

An inclination toward strained interpersonal relationships is also reflected in the absence of human movement (*M*) responses and any cooperative movement responses (*COP*) in her protocol. These findings point to her incapacity to develop empathic relationships and to anticipate and engage in collaborative activities with other people, respectively. Accordingly, although she might be able to handle superficial relationships with other people, she cannot deal effectively with close or intimate

relationships. Furthermore, her apparently very low self-esteem (*Egoc. Index* = 0.00), coupled with limited psychological mindfulness (*FD* =0) and a tendency to identify with partial or imaginary human figures, as shown by the unbalanced ratio of *H* < (*H*) + *Hd* + (*Hd*), might explain her vulnerability to having difficulties in interpersonal relationships.

The nature of her internalized object relations induces this adolescent to relate to others as part objects whose purpose in life is either to serve or to attack her. She may consequently be inclined to suspect the motives of those with whom she develops an apparently close relationship and to misperceive their attitudes and the intent of their actions. Despite such concerns, her dependency needs may lead her at times to become over-involved with certain people and form an intense and clinging attachment to them. As a result, she is prone to interpreting even a slight suggestion of inattention to her needs as an empathic failure that threatens her self-integrity, as in taking a paranoid-like stance toward the world. This likely approach-avoidance pattern, together with her limited anxiety tolerance and insufficient adaptive coping resources, support the hypothesis of mixed characterological problems, with dependent, narcissistic and paranoid features, that have crystallized at a borderline level of personality organization.

It should be noted that, contrary to a common expectation, CS markers of distress in adolescents do not preclude the presence of characterological problems, including the evolution of antisocial personality characteristics. Adolescents functioning at the borderline level who become overwhelmed by subjective distress may well produce Rorschach protocols with a positive *CDI* but a minimally elevated *DEPI*. Such a finding can often help to differentiate adolescents at the borderline level who are depressed, withdrawn, and socially inept from their depressed peers who are at the neurotic level of personality organization and who more often display a positive *CDI* and a markedly elevated *DEPI* (Exner & Weiner, 1995). The pattern of minimally elevated *DEPI* and positive *CDI* shown in this case thus supports the hypothesis of characterological problems.

Of further note, the content of this adolescent's responses featured recurrent images of small, unspecified animate or inanimate objects (e.g., *Some kind of a bug…not any kind in particular…*, Card I, Resp. 2) that are perceived as being damaged (*A broken doughnut…*, Card II, Resp. 3), melting (e.g., *A popsicle*, Card VI, Resp. 9), or extinct (e.g., *A roach*, Card III Resp. 4). In contrast, she also reported some powerful and explosive objects (*Looks like a rocket that's blasting off*, Card IV, Resp. 5). She additionally tended to experience objects as intrusive (*A scarecrow…somebody put on a stick out there*, Card VI, Resp. 8) and lacking boundaries (*Looks like ink somebody spilled on paper…blended together here…blotchy… Its different colors, blended together*, Card IX, Resp. 13).

The sequence of scores (see Table 9.1.2) shows some interesting impact of "card pull." When responding to a relatively structured stimulus, such as the Card V blot, she sticks to its shape in a perseverative fashion: *Wo Fo A P 1.0 RFS-2* = +4 (Resp. 6); *Wo Fo A P 1.0 PSV RFS-2* = +4 (Resp. 7), and provides two accurately perceived and common percepts. By contrast, when confronted with a stimulus considered to be ambiguous and emotionally arousing, such as Card IX, she can provide only a

vague, formless, anxiety-laden, and idiosyncratic percept followed by an inaccurately perceived object, both of which reflect reality collapse into fantasy: *Wv + Y Id*; *RFS-2* = −3 (Resp. 13); *DdSo F- (Hd) RFS-2* = −3 (Resp. 14).

These findings paint a picture of diffuse identity and disturbed object relations, marked by object splitting and extremely ambivalent feelings and alternating between excessive clinging and prominent withdrawal and between blocked and explosive behavioral manifestations. These characteristics appear to be ego syntonic, and strongly suggest borderline-level personality organization. She is able to cope adaptively in relatively structured settings, but she is prone to becoming overwhelmed by anxiety and fears of falling apart when she is confronted with the demands of dealing with ambiguous and emotionally charged settings. It is thus reasonable to suggest that the current crisis does not represent a reactive adjustment problem but is instead a manifestation of faltering personality development. Her apparent susceptibility to becoming overwhelmed by her own impulses or affective states puts her at continued risk for losing self-control and engaging in repeated delinquent or self-destructive acts.

Case Illustration 9.1: Summary and Conclusions

This 15-year-old girl was referred for evaluation following her hospitalization in a psychiatric unit and her subsequent arrest for threatening her boyfriend with a pocket knife. Her Rorschach protocol does not show evidence of disordered thinking, but it does point to her proneness to dissociate (*RFS-S* > 2.67) and impaired of ego functioning (*EII-2* > 0). In addition to these two markers of maladaptive cognitive functioning, an elevated *Lambda* (*L* > 0.99) and a high percentage of whole responses (*W%* > 0.50) point to a rigid, concrete, and narrow frame of reference and an over-inclusive pattern of attending to outside reality, respectively. Deviations on some affective variables (*D Score* < −1; *AdjDMD* > 0; *C′* > *WSumC*; (*FM+m*) < *SumShd*>; and *S* > 3), coupled with the elevated *L* and a rarely found *Shading-Shading Blend*, delineate prevalent dysphoric affective experience involving anxiety, depressive mood, oversensitivity to nuances, and resentment that can sometimes be discharged in maladaptive and poorly controlled behavior, including outbursts of temper and violence.

In addition to this susceptibility to conduct problems, she is experiencing a troubling disparity between her impaired capacity for positive interpersonal relatedness (*CDI* > 3; *EA* < 6; *Pure H* = 0) and her needs to depend on and be nurtured by others (*Fd* > 0). Frustration at not getting her dependent needs met is likely to be exacerbated by her lack of empathic interest in people (*M* = 0) and limited anticipation of engaging in collaborative activities with others (*COP* = 0), as well as by her apparently low self-esteem (*Egoc. Index* = 0.00), minimal psychological mindfulness (*FD* = 0), and tendency to identify with partial or imaginary human figures, with minimal capacity to form a stable sense of her own identity, as shown by the unbalanced ratio of *H*:(*H*) + *Hd* + (*Hd*) with *Pure* H = 0. Her poor social skills, combined

with resentment toward other people for failing to recognize and minister to her needs, put her at risk for developing a paranoid-like stance, social isolation, and feelings of loneliness and being unsupported.

Measured against the understanding that a major developmental task in adolescence is associated with the separation–individuation process, in which young people move toward psychological independence from their parents and form a sense of identity, the present protocol contains numerous markers of faltering personality development. The inferences drawn from the protocol thus support the likelihood of a characterological disorder and suggest a psychodynamic diagnosis of borderline level of personality organization (*PDM* Task Force, 2006).

This girl's impaired interpersonal relatedness provides an illustration of her functioning at the borderline level of personality organization. In normative adolescents, object representations become more articulated and more cohesive from mid-adolescence onward. In line with this conception, mature internal objects are reflected by a predominance of whole and real human percepts that are well articulated and involve people who are accurately perceived, actively motivated, fully differentiated from each other, engaged in mutual activities, and show an integration of positive and negative characteristics. This type of response indicates a capacity to perceive objects as constant, multidimensional, and differentiated yet interrelated.

In contrast, adolescents at the borderline level of personality organization typically report Rorschach percepts that are mainly of animal and inanimate objects and suggest concern about object integrity. The threat of self-fragmentation and intrusive interpersonal relationships appears in damaged object representations that lack integration, complexity, and boundaries. These types of nonhuman responses suggest defensive strategies of these adolescents to distance themselves from experiencing their social ineptness and loneliness (Blatt et al., 1976; Exner & Weiner, 1995; Kelly, 1997; Leichtman, 1996; Sugerman, 1980; Weiner, 1992).

It should be noted that adolescents at the borderline level of personality organization may show different types of characterological problems that influence their style of coping with reality demands. Most often, however, these problems present in a mixed pattern consisting of two or more prominent styles of confronting reality. Such a mixed pattern is apparent in this adolescent's Rorschach, which points to marked dependency needs, narcissistic vulnerability, and a paranoid-like stance, interacting in ways that are manifested in her unpredictable, uncontrolled, destructive, and dramatic behaviors aimed at obtaining attention and support from other people. These maladaptive behaviors seem particularly likely to occur in ambiguous and emotionally charged conditions that are stress provoking and less so in relatively structured settings.

Characterological problems aside, Rorschach data are also useful for evaluating whether a current crisis with severe symptom patterns may mask underlying psychotic disorders, depressive disorders, anxiety disorders, or disruptive behavior disorders (*PDM* Task Force, 2006). In this regard, the present findings point to a depressive crisis characterized by feelings of emptiness and a self-perception of being weak, helpless, and vulnerable. Adolescents at the borderline level of

personality organization who are depressed usually provide constricted, banal records with uncomplicated responses, elevated *Lambda*, and prominent attention to white spaces (S) to which they attribute contents of emptiness.

In conclusion, this highly dependent adolescent, who persistently functions at the borderline level of personality organization, is currently in a depressive crisis that underlies and is masked by her adjustment symptom patterns. Her depression is experienced in fears of self-fragmentation and feelings of self-depletion (Silverstein, 2006) with which she is coping in a paranoid-like fashion. This coping style can help adolescents maintain boundaries in their interpersonal relationships and find a coherent sense of identity during a developmental phase that typically involves identity diffusion.

Case Illustration 9.2: Eating Behavior Problems in a 14-Year-Old Girl

The *Diagnostic and Statistical Manual of Mental Disorders*—Fifth Edition (*DSM-5*; American Psychiatric Association, 2012) presents a revision of the eating disorder classification. In the *DSM-IV-TR* (American Psychiatric Association, 2000), eating disorders were characterized by severe disturbances in eating behavior and included two specific diagnoses, anorexia nervosa (restricting and binge eating/purging) and bulimia (purging and nonpurging). The distinguishing criterion between the two disorders was based largely on body weight, in the assumption that they are mutually exclusive. However, accumulated clinical experience has demonstrated that these two disorders have some similar cognitive, emotional, and behavioral symptom features. For example, although binge eating was the main criterion for diagnosing bulimia, it is a common symptom in anorexia. Furthermore, many patients move between these two diagnostic categories at different points of time, and binge-eating symptoms have been found to account for the majority of cases categorized as eating disorders, not otherwise specified. In this regard, the body weight threshold appears to be quite arbitrary and challenges the validity of the *DSM-IV-TR* classification.

The *DSM-5* has accordingly preserved the two major types of eating disorders but added a third category, binge-eating disorder. This disorder is defined as recurring episodes of eating substantially more food in a short period of time than most people would eat under similar circumstances, with the episodes marked by feelings of lack of control and considerable subjective distress. Binging is accordingly viewed as a qualitative criterion for distinguishing between different subtypes of eating disorders. Eating disorders usually first develop in adolescence and can be readily recognized by their behavioral manifestations. However, these disorders constitute more than simply a problem with food. Rather, they are complex psychological disorders with aspects that are often not overtly manifested (*PDM* Task Force, 2006). In addition to the severely disturbed eating behaviors, these underlying symptom patterns may include cognitive distortions, impaired affective functioning (e.g., depressive mood), social withdrawal, and negative self-attitudes.

Consistent with psychodynamic formulation, empirical research has demonstrated that patients with restricting anorexia are more inhibited than those with binging disorders, who are more likely to have difficulties with affect modulation. Additionally, although both groups manifest concrete, reality-bound thinking, binge-eating patients are more likely to fluctuate between reality and fantasy, which might indicate their proneness to dissociate. In this regard, such dissociative phenomena as amnesia, derealization, depersonalization, and withdrawal from reality by substance use are most often observed in patients with binge eating, particularly in those who have been exposed to traumatic events. Active bulimic processes and episodes of binge eating can therefore be conceived as related to the use of various levels of dissociation, with consequent difficulties in distinguishing between physical and emotional reactions and between reality and fantasy (e.g., Fowler, Brunnschweiler, & Brock, 2002).

Based on theoretical formulation and empirical data supporting the notion that eating disorders fall on a continuum of levels of personality organization, patients with eating disorders are frequently viewed as functioning at the borderline level but also at a higher or lower level. Eating disorders, particularly those involving binging, should accordingly be evaluated as a cluster of symptoms associated with varying psychopathological conditions and different levels of personality organization. Binging patients who are functioning at the neurotic level of personality organization can be viewed as using their binging to avoid conscious awareness of inner conflicts and stress-evoking experiences. On the other hand, binging patients who are functioning at a severely disturbed borderline level or a psychotic level of personality organization can be viewed as using vomiting and other concrete strategies that serve them as a bridge back to reality.

In accord with this conceptual framework, clinicians assessing adolescents with eating disorders should be alert to the possibility that these disorders may hide underlying psychopathology marked by impaired cognitive functioning, affective experience, interpersonal relatedness, or self-perception and may occur at different levels of personality organization. Because empirical evidence and clinical experience have shown that eating disorders often develop in response to trauma, clinical evaluations should investigate the presence of comorbidity with posttraumatic stress disorder (PTSD), in addition to exploring at what level of personality organization (i.e., neurotic, borderline, or psychotic) the disorder has developed. What follows is a case illustration of a 14-year-old with eating behavior problems (Tibon & Rothschild, 2009).

Case Illustration 9.2: Symptom Patterns

This patient is a 14-year-old girl who was hospitalized with mixed symptomatology involving binge eating, self-destructive behavior, and obsessive–compulsive manifestations. She is the second child in a three-daughter family. Her parents are

divorced but remain living in the same house. When she was 2 years old, her mother was diagnosed with a chronic disease resulting in functioning difficulties and dysthymic mood. The patient's father was reported as having severe impulse control problems, as evidenced by violent outbursts toward his wife, and he is known to be involved in gambling. The patient was hospitalized after several months of noticeable weight gain with which she had initially coped by extreme restriction of her food intake. The staff of the psychiatric unit in which she was placed described her as an intelligent girl who is sociable and generally well accepted by other patients but has on occasion shown outbursts of rage toward them and also physically harmed herself. Tables 9.2.1 and 9.2.2 present the structural data and the sequence of scores for her Rorschach protocol.

Case Illustration 9.2: Interpretation of Rorschach Data

The Rorschach data of this intelligent 14-year-old girl contain numerous psychopathological markers, particularly in the domain of cognitive functioning. These include deviant scores on the general cognitive indices (*PTI* = *4*; *RFS-P* = −1.47; *RFS-S* = 3.38; *EII-2* = +3.90), indicating psychotic-like functioning, proneness to dissociate, and severely impaired ego functioning. Additional evidence of cognitive impairment emerges in her deviant scores on attention variables, including an elevated *Lambda* (*L* = 1.11) and an unbalanced *W:D:Dd* ratio (*W:D:Dd* = 9:5:5), as well as on perception variables (*XA%* = 0.58; *WDA%* = 0.64; *X-%* = 0.42) and ideation (*Lv2* = 2 and *WSum6* = 50) variables.

The psychotic-like functioning of this adolescent emerges clearly when the interpretive guidelines described in Chap. 6 are applied. For example, when compared with the normative range of *WSum6* in the contemporary nonpatient adult samples (Meyer et al., 2007, Table 1), her *WSum6* of 50 is far beyond the contemporary cutoff score established by M + 1SD (7.63 + 7.75 = 15 when rounded off), which is even more stringent than the traditional CS cutoff score of *WSum6* > 17. If the raw score (*WSum6* = 50) is converted to a T Score using the M and SD presented in Meyer et al., Table 1, the resulting value when rounded off is 105. In comparison to the mean T Score of *WSum6* in contemporary nonpatient adolescents aged 11–14, which is 53 (see Table 5.2), the T Score of 105 makes it quite apparent that this adolescent is showing marked cognitive disorganization and that her cognitive functioning is pervaded by severe thinking disorder. A similar analysis demonstrates the severity of her perceptual distortions. When her deviant score on *X-%* is converted to T Score, the corresponding rounded off value far exceeds the T Score in nonpatient adolescents aged 11–14 (see Table 5.2).

As described in Chap. 6, the *RFS-P* and the *RFS-S* are two derivations of the *Reality–Fantasy Scale Version 2.0* that measure psychotic thinking and dissociation proneness, respectively. The elevated *RFS-S* in her protocol, coupled with her low *RFS-P,* speaks to this adolescent's limited capacity to differentiate and integrate inner and outer experiences adaptively. These *RFS* scores delineate proneness to

Table 9.2.1 Eating behavior problems in a 14-year-old girl: Structural Summary

			Affect	Interpersonal
R = 19	***L = 1.11****			
EB = 2:2.0	***EA = 4.0****	*EBPer = N/A*	***FC:CF + C = 2:1***	***COP = 0* AG = 0***
eb = 6:2	*es = 8*	***D = −1***	***Pure C = 0***	*GHR:PHR = 1:6*
	Adjes = 6	***AdjD = 0***	***Const. = 2:2.0***	***a:p = 2:6***
			Afr = 0.46	***Fd = 0***
FM = 3	***SumC′ = 2***	***SumT = 0***	***S = 4****	***SumT = 0***
m = 3*	***SumV = 0***	***SumY = 0***	***Complex. = 4:19***	***Human Content = 6***
			CP = 0	***Pure H = 3***
				PER = 0
				Isolation Index = 0.26
Cognitive Functioning				**Self-Perception**
Thinking (Ideation)		**Perception (Mediation)**	**Attention (Processing)**	
a:p = 2:6	*Sum6 = 15*	***XA% = .58****	*Zf = 14*	***Egoc. Index = 0.47****
Ma:Mp = 2:1	***Lv2 = 2****	***WDA% = .64****	***W:D:Dd = 9:5:5****	***Fr + rF = 0***
INTELL = 0	***WSum6 = 50****	***X-% = .42****	*W:M = 9:2*	***Sum V = 0***
MOR = 6*	***M- = 1***	*S- = 2*	***Zd = −1.0***	***FD = 2***
	Mnone = 0	***P = 4***	*PSV = 0*	*An + Xy = 2*
		X+% = .21	*DQ+ = 10*	***MOR = 6****
		Xu% = .37	***DQv = 0***	***H:(H) + Hd + (Hd) = 3:3***
PTI = 4*	***DEPI = 3***	***CDI = 5****	***S-CON = N/A***	***HVI = No*** *OBS = No*
FM + m = 6	***Col-Shd = 1***			
RFS-P = −1.47*	***RFS-S = 3.38****	***EII-2 = + 3.90****	***AdjDMD = 1****	

Note: The format of the table is derived from the RIAP. The scores in bold are those of basic variables used for distinguishing between healthy and psychopathological personality functioning and the five stylistic variables (*R*, *EB*, *a:p*, *Ma:Mp*, *Complexity Index*). Apart from cases in which either or both sides of the *EB,* or the number of *Blends* in the *Complexity Index*, the stylistic variables should not be checked as psychopathological markers in themselves. Noted with asterisk (*) are scores that exceed the normative range according to the two-step interpretive procedure (see Chap. 6). These scores should be reconsidered in relation to the data of the composite international sample of nonpatient adolescents (see Chap. 5). For interpretation of deviant scores, see Tables 6.1–6.4

Table 9.2.2 Eating behavior problems in a 14-year-old girl: Sequence of Scores

Card	Resp.								*RFS-2*
I	1	Wo	Fo		A	P	1.0		+4
	2	DdSo	FC′.FD-		An			MOR	−3
II	3	WSo	F-		H, Ad		4.5	INC2, PHR	−5
	4	WS+	mp.CF.C′o		Sc, Bl, Ex, Fi		4.5	MOR, PHR	0
III	5	D+	FMp-	2	A, Bt		3.0	FAB, ALOG	−5
	6	DdS+	mp.FDu		(H), Bl, An		4.5	DR, FAB, MOR, PHR	−5
IV	7	Do	Fo		(H)	P		GHR	+3
	8	Wo	Fu		A		2.0		+2
V	9	Wo	Fu		A		1.0	DV	+3
	10	Dd+	Mp-		A, Hd		2.5	FAB2, PHR	−5
VI	11	D+	F-	2	H, A		2.5	FAB, PHR	−5
VII	12	W+	FMpu	2	A, Ls		2.5		−1
	13	W+	F-	2	Ad, Ls		2.5	FAB, INC, MOR	−5
VIII	14	W+	FMau	2	A, Sc	P	4.5	FAB	−5
IX	15	W+	Ma.mp.FCu	2	H, Sc, Fi		5.5	INC, MOR, PHR	−1
X	16	Do	F-	2	Bt				−3
	17	Ddo	Fu		A			INC	+2
	18	Do	Fo	2	A			INC	+4
	19	Dd+	FC-	2	Ad, Bt		4.0	INC, MOR	−3

Note: The *RFS-2* column in the sequence of scores refers to the score of each response on the *Reality–Fantasy Scale Version 2.0*

dissociate as well as psychotic-like functioning. This adolescent's inclination to fluctuate between reality and fantasy is illustrated by her shifts from reality-bound responses such as *a bat …because of its shape* (Card I, Resp. 1), coded *Wo Fo A P* 1.0, to fantasy-derived percepts as an incongruous combination (*INC2*) of *a person with a bug's face* (Card II, Resp. 3).

In contrast to this adolescent's substantial deviations on numerous cognitive variables, her affective functioning appears much less impaired. It should be noted in this regard that the contents of her six *MOR* responses appear to reflect negative self-attitudes and concerns about vulnerability to harm rather than her emotional experience (e.g., depressive mood). Similarly, the deviant score of 1 on her *AdjDMD* indicates a susceptibility to excessive anxiety and subjective distress that is probably manifest cognitively (e.g., obsessive–compulsive ideation) rather than through affective symptom patterns. The elevated *S* of 4, which often indicates negative attitudes associated with oppositional behavior, can contribute further to aspects of her impaired cognitive functioning and additionally cause problems in her interpersonal functioning.

With respect to this adolescent's interpersonal functioning, her deviant score on the *Coping Deficit Index* (*CDI* = 5) and her low *EA* (*EA* = 4.0) indicate limited adaptive resources and deficient capacity to cope effectively with ordinary aspects of

interpersonal and emotional situations. As further evidence of likely difficulties in interpersonal relationships, the total absence of cooperative (*COP*) and aggressive (*AG*) responses in her protocol suggests limited anticipation of or capacity to engage in either collaborative or competitive activities with other people and to her being insufficiently assertive to seek out such engagements in a productive fashion.

Nevertheless, despite her likely interpersonal difficulties, her capacities to identify with other people, form adaptive relationships with them, and establish a stable sense of her own identity are preserved. The key evidence in this regard is her reference to mental representations of realistic human figures, as shown in three *Pure H* responses and an adequate *H:(H) + Hd + (Hd)* ratio of 3:3. Of further note, her elevated *Egocentricity Index* of 0.47 might be seen as indicating a degree of self-centeredness that would exacerbate her interpersonal difficulties. In the present case, however, the absence of *Reflection* responses makes problematic narcissism unlikely. Instead, an elevated *Egoc. Index* with no *Reflections* usually indicates people who are paying a lot of attention to themselves but not taking much pleasure in doing so. Such unpleasant self-focusing would be consistent with the previously noted elevated frequency of *MOR*, all of them reflecting negative attitudes to the body and its functions, and would support the inference of impaired self-perception.

Case Illustration 9.2: Summary and Conclusions

This 14-year-old girl who was hospitalized because of binge–purge behaviors provided a Rorschach protocol with numerous psychopathological markers with respect to her cognitive functioning. Particularly prominent are her abrupt fluctuations between reality and fantasy, which reflect a propensity for extensive use of dissociation involving withdrawal from reality. In this sense, dissociation refers to Winnicott's (1971) conceptualization of mental health as including the capacity to preserve potential or transitional space between reality and fantasy and to Ogden's (1985) model for defining psychopathological states, including dissociation, in terms of a collapse of this potential space. Accordingly, dissociative states can be considered to occur when reality and fantasy fail to enrich each other and are experienced as two disconnected realms of experience.

Following Smith (1990), who suggested operationalizing Winnicott's (1971) construct of potential space with Rorschach variables, the CS-based measure *Reality–Fantasy Scale Version 2.0* (*RFS-2*) was developed. Lerner (1998) subsequently noted that no conventional Rorschach markers had emerged as indicative by themselves of dissociative processes. Since then, however, the *RFS-S* derivation of the *RFS-2* has provided an efficient tool for differential diagnosis. The original version of this scale has proved effective in delineating dissociative disorders (Zeligman, Smith, & Tibon, 2011) and psychotic-like dissociative phenomena in eating disorders (Tibon & Rothschild, 2009).

As for the present adolescent's protocol, the combination of an elevated *RFS-S* and a low *RFS-P* points to a dissociative component in her problematic eating behaviors, perhaps to an extent that might produce psychotic-like functioning. This raises a question of whether the disordered thinking has been developed in response to trauma. In light of the increasing empirical research that led the authors of the *DSM-5* to add the diagnostic category of dissociative PTSD disorder, PTSD with prominent dissociative functioning cannot be ruled out in this case. Nevertheless, the extent of cognitive impairment in her personality functioning calls for follow-up evaluation of the possibility of an emerging schizophrenia-spectrum disorder.

This case illustration shows that interpretation of CS Rorschach findings should be based on the premise that people with the same *DSM* diagnosis (e.g., eating disorders) may vary in the extent to which certain basic personality characteristics (e.g., dissociation proneness) are involved in the disorder. The present findings additionally confirm the value of using a *DSM* diagnosis jointly with a *PDM* psychodynamic diagnosis (*PDM* Task Force, 2006). Treatment approaches should similarly be selected in light of each person's particular personality characteristics, as opposed to inflexible application of uniform therapeutic methods to all cases that fit into a specific diagnostic category.

Conclusion

The Rorschach is particularly useful for assessing adolescents with externalized symptom patterns, who are most frequently diagnosed with conduct disorder (CD). As noted in Chap. 8, the distinction between healthy and psychopathological personality functioning should be based on comparisons of obtained findings with normative reference data. An adolescent Rorschach protocol should be evaluated with attention to level of maturity and the degree to which the test findings correspond to normative data.

The issue of continuities and change from adolescence to adulthood has clinical implications for all types of youth referrals but it is particularly important in assessing adolescents with externalized symptom patterns. Adolescents with externalized symptom patterns are at risk for developing antisocial behavior in adulthood. Nevertheless, although being similar from a phenomenological perspective, CD and antisocial externalized behavioral manifestations might reflect diverse psychodynamic processes, character problems, and psychopathological states. It is essential to assess thoroughly the personality structure of these adolescents for pursuing diagnostic clarity, especially as to the presence of psychopathic dispositions, including deficits in capacity of forming empathic interpersonal relationships. The Rorschach can point to the maladaptive impact of their symptoms regarding their psychological functioning, advancing responsible adolescent development. The advantages of using the Rorschach to achieve broadly based diagnostic inferences are related to the possibilities it allows assessors to comprehend and communicate why observed relationships exist, why accurate predictions hold true, and what

dynamic processes underlie different presentations of the same diagnostic category. With specific respect to eating disorders, predictions can be formulated in terms of personality characteristics (i.e., dissociation proneness) that appear to account both for a particular Rorschach marker and for particular psychopathological manifestations (i.e., eating disorder) that reflect these characteristics.

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Chapter 10
Forensic Applications of Rorschach Assessment

As a personality assessment instrument, the Rorschach can play an important role in forensic cases in which personality characteristic are relevant to decisions that are being made. Rorschach examiners can assist judges and juries by delineating personality characteristics that are pertinent to the issues in a case and drawing on the test data to point to the presence or absence of these personality characteristics. When adequately conceived in this regard and properly implemented, Rorschach assessment can be applied effectively in forensic cases involving various issues including child custody decisions, evaluation of trial competence, and resolution of personal injury claims.

Rorschach examiners assessing young people can enhance the value of their consultations by becoming knowledgeable about developmental issues characterizing adolescents and the normative expressions of these issues on the Rorschach. They can further enhance the value of their forensic consultations by presenting their conclusions in incisive and effective written reports. Forensic Rorschach specialists should, however, defend their testimony by documenting that the Rorschach is a widely used, informative, and psychometrically sound instrument and that Rorschach findings meet criteria for admissibility into evidence in the courtroom and are largely resistant to impression management.

With these considerations in mind, the present chapter addresses the utility of Rorschach assessment for resolving psycholegal issues. The discussion focuses specifically on adolescents seen in the criminal justice system and describes the application of Rorschach assessment with respect to five aspects of courtroom proceedings: (a) evaluating trial competence, (b) assessing criminal responsibility, (c) detecting prospective changes in antisocial behaviors from adolescence to adulthood, (d) investigating impression management, and (e) providing incremental validity for inferences drawn from other tests. Recognizing that not all CS variables are relevant to the assessment of psycholegal issues (e.g., Gacono, Evans, & Viglione, 2002), the chapter draws on selected variables used in this volume (see Chap. 6) to present forensic evaluators with a set of empirically validated CS

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markers that can be used effectively as a basis of courtroom testimony. The discussion also reviews published data confirming the acceptance of Rorschach assessment in forensic cases and offers some guidelines for effective reporting of Rorschach findings in the criminal justice courtroom.

Evaluation of Trial Competence

Numerous authors have pointed out the benefits of Rorschach assessment in forensic cases with particular respect to the evaluation of trial competence (e.g., Gacono, Evans, & Viglione, 2002; Weiner, 2013). Competence to stand trial is a legal matter that is debated by attorneys and decided by the court. Nevertheless, whether a criminal defendant shows capacity to proceed to trial is a psychological matter that should be assessed by qualified mental health professionals.

In legal terms, competence to proceed to trial consists of being able to consult with one's lawyer with a reasonable degree of rational understanding and having a factual and rational understanding of the offenses with which one is charged. The implications of these two basic elements of competence include such considerations as whether defendants can appreciate the nature of the charges and the possible penalties they are facing, grasp the nature of the adversarial process and courtroom proceedings, disclose pertinent facts to their attorney, testify adequately in their own behalf, and conduct themselves appropriately in the courtroom (e.g., Stafford & Sellbom, 2013; Zapf, Roesch, & Pirelli, 2014). Forensic psychological evaluations in which there is a question of trial competence require investigation of the defendant's current cognitive functioning. This investigation should be based on constructs referring to what constitutes impaired cognitive functioning and the application of clinical measures and assessment tools that provide valid data with respect to such impairment (e.g., Melton et al., 2007).

Inability to satisfy the criteria for competence typically derives from such psychotic-like manifestations as impaired reality testing, disordered thinking, poor judgment, and peculiar behavior. As noted in Chap. 7, indications of impaired cognitive functioning commonly characterize severe psychological disturbances, particularly schizophrenia-spectrum and major affective disorders, but they may also appear in traumatized people or in those with substance use and borderline personality disorders. On the other hand, immature cognitive functioning, which might have a substantial effect on trial competence, is quite frequently observed in adolescents. Establishing an accurate differential diagnosis is therefore highly important in evaluating the current and prospective trial competency of an adolescent alleged to have committed a crime.

The Rorschach can be particularly helpful in delineating cognitive functioning impairments that could prevent criminal defendants from understanding the charges they are facing. The following CS reference values are likely to be applicable in this regard: *PTI* > 3; *RFS-P* < −0.30; *RFS-S* > 2.67; *XA%* < 0.70; *WDA%* < 0.78; *X-%* > 0.30; *P* < 4; *WSum6* > 17; *Lv2* > 0; and *M-* > 1 (see Table 6.1). As is the case for

all the CS deviations, none of these variables can be interpreted accurately without attention to other structural and content variables that may enhance or attenuate its interpretation. The implications of a high *X-%* for impaired reality testing, for example, vary with the levels of *XA% and WDA%*, with the number of *Popular* (*P*) responses and with any repetitive association of *FQ* responses with particular content categories or embellishments.

Similarly, with regard to the implications of an elevated *WSum6* for disordered thinking, adequate Rorschach assessment of severity of thought disorder calls for considerations that go beyond the magnitude of this particular score. These considerations include the frequency of indicators of severe cognitive slippage (*DV2*, *DR2*, *INC2*, *FAB2*, *ALOG*, *CONTAM*), the distribution between these indicators and those of mild slippage (*DV1*, *DR1*, *INC1*, *FAB1*), and several variables including *R*, number of contents, *Blends*, *Zf*, *FC* + *FC*', *FT* + *FV* + *FY* + *FD*, and *H*+(*H*) that are assumed to measure an individual's capacity for *Integrative Complexity* (Tibon-Czopp, Appel, & Zeligman, 2014).

Nevertheless, as elaborated by numerous authors (e.g., Gray & Acklin, 2008), Rorschach findings of disordered thinking and impaired reality testing do not necessarily preclude a person's being legally competent. Whether defendants have an adequate grasp of courtroom procedures should be evaluated by asking them directly about courtroom procedures rather than by looking at whether they exceed certain cutoff scores on CS cognitive variables. However, when defendants cannot give an adequate account of the adversarial process, Rorschach evidence of cognitive dysfunction can help an examiner inform the court of likely reasons for their inability to meet this competency requirement.

Assessing Criminal Responsibility

Unlike trial competence, criminal responsibility concerns a defendant's mental state at some previous time, not at the time of the current examination. Assessment of criminal responsibility addresses the sanity of defendants at the time of their alleged offense as may be defined by their awareness of the wrongfulness of their conduct or their capacities for impulse control and refraining from the alleged criminal conduct. These criteria are often referred to as the cognitive and volitional prongs of sanity. Depending on the jurisdiction forensic cases vary with respect to whether an insanity plea must be presented on the basis of cognitive incapacity of the defendant or can alternatively be based on volitional incapacity. In formulating opinions about criminal responsibility, examiners need to supplement Rorschach indications of either cognitive or volitional incapacity with information about the defendant's mental state and behavior prior to the test administration.

Assessing cognitive incapacity at the time of the offense involves reconstruction of the defendant's thought processes before and during the alleged crime. Of substantial forensic import is the fact that cognitive impairment resulting in psychotic-like functioning may lead individuals to act on their experiences as if they were real,

when they are not (e.g., Melton et al., 2007; Zapf, Golding, Roesch, & Pirelli, 2014). Suggesting that a defendant shows psychotic-like functioning with an impaired sense of reality, on one hand, and was unable to appreciate the wrongfulness of the alleged offense at the time it was committed, on the other, links the legal concept of sanity with the psychological concept of psychosis.

With respect to CS cognitive markers related to the issue of criminal responsibility, deviations on *PTI* and *RFS-P* are essential to consider (see Table 6.1). If $PTI = 5$ and $RFS\text{-}P < -0.30$, examiners can with reasonable certainty infer current severe thinking and perceptual disturbances and limited capacity to differentiate between reality and fantasy. Adolescents who produce Rorschach protocols with $PTI = 5$ and $RFS\text{-}P < -0.30$ are at considerable risk for being consistently prone to faulty judgments concerning the meaning of events and the nature of people, and they may frequently act on their internal experience as if it represents an outer stimulus.

The assessment of volitional incapacity focuses on test indications of limited resources for coping with stress. These indications, combined with obviously stressful circumstances at the time of the alleged offense, increase the likelihood that a defendant might have experienced a transient episode of loss of impulse control, or perhaps of impaired cognitive functioning as well. Conversely, the more coping resources shown by current test responses, and the less stress defendants appear to have been experiencing prior to and during the commission of an alleged offense, the less likely they would have been at previous time to show loss of cognitive or volitional capacities. The evaluation of volitional incapacity is particularly important when defendants who appear to be functioning fairly well at present are claiming temporary insanity at the time of an alleged offense. Nevertheless, forensic psychologists should not present these or other conclusions with unwarranted certainty. Rather, they should use the overall strength of their assessment data as a basis for qualifying the certainty of their impressions. In commenting on criminal responsibility, for example, they may report that their findings make it likely ("strongly suggestive," "somewhat suggestive," or "inconclusive") that a defendant was legally insane at the time of an offense.

Although Rorschach CS variables do not directly measure the previous mental states of an individual, some CS indicators of personality traits can point to maladaptive personality characteristics that are quite stable and unlikely to change over time. Evidence of chronicity and stability increases the likelihood that psychologically disturbed people have had previous episodes of a specific disorder. The key Rorschach finding in this regard is D Score > 0, which in an unguarded record is usually associated with consistency over time, even when the consistency involves being emotionally unstable, with little sense of needing to change and with ego-syntonic as opposed to ego-alien symptom formation.

The chronicity and stability associated with $D > 0$ may suggest but does not warrant inferring legal insanity at the time of an offense from presently obtained test findings. Nevertheless, should a defendant who appears to be functioning fairly well when examined be claiming temporary insanity at the time of an alleged offense, Rorschach findings may bear on this possibility. Specifically, the less stressful a

defendant's circumstances appear to have been at the time of an alleged offense and the more stable and effective the person's coping resources as presently reflected in the test data, the less susceptible this person would have been at the previous time to a psychological breakdown involving loss of cognitive or volitional capacities. Conversely, the more limited the coping resources suggested by test findings and the more seemingly stressful the circumstances surrounding an alleged offense, the stronger the possibility that a person did in fact experience temporary insanity (Weiner, 2013).

In addition to $D > 0$, deviations on certain other CS variables (*AdjD* < 0; *CDI* > 3; *EA* < 6; *EII-2* > 0; *Pure C* > 1) can suggest that volitional incapacity currently shown in the test was present at the time of the offense. These CS markers indicate chronic stress overload and limited coping resources, which can result in susceptibility to problems of self-control and are commonly associated with poor frustration tolerance, intemperate outbursts of affect, and episodes of impulsive behavior. However, the interpretive significance of these variables is a function of their interaction with other variables in the protocol, and attention to these interactive influences, as elaborated in the texts by Exner and Erdberg (2005) and Weiner (2003), is essential to adequate interpretation of Rorschach data.

As suggested in Chap. 6, recently collected normative data call for revising three traditional cutoff points for of CS variables: *Xu%* > 0.20; $T = 0$; and $AG = 0$. These revisions would change slightly what is considered to indicate conventional perception of reality, capacity for close relationships, and risk for predatory violence, respectively. In general, Rorschach examiners should present their conclusions in terms of individualized assessment, which is person oriented rather than test oriented and describes a respondent without reference to normative data. Accordingly, apart from these three variables, deviations from the traditional reference values mean what they mean with respect to maladaptive functioning, regardless of trends appearing in contemporary normative data. Deviations from the traditional cutoff scores on *AdjD*, *CDI*, *EA*, *EII-2*, and *Pure C*, for example, as specified in Table 6.1, should therefore continue to be regarded as indicators of limited frustration tolerance, impulsivity, and poorly controlled emotional discharge, with their implications for volitional incapacity, even if many nonpatient adolescents show these deviations.

As noted by Weiner (2013), the critical evidence in evaluating criminal responsibility comes from defendants' recollections of their mental state before, during, and following an alleged offense and from observers' reports of how a defendant was behaving at the time. Should evidence from these sources suggest cognitive or volitional incapacity during the commission of an offense, Rorschach indications of such incapacity would provide supplementary information that might strengthen an insanity plea, with reference to a defendant's history of psychological disorder. Overall, despite the limitations of the Rorschach with respect to assessing a person's mental state at the time of an alleged offense, which is common to all personality assessment instruments, test indices of chronicity and stability can sometimes guide an estimation of previous functioning capacity from presently obtained data.

Detecting Prospective Changes in Antisocial Behaviors from Adolescence to Adulthood

The issue of continuities and changes from adolescence to adulthood has implications for interpretation of Rorschach findings in many types of youth referrals. This issue is particularly important in cases of adolescents with conduct disorder (CD) who are alleged to have committed a crime. In these cases examiners must often attend to risk factors for developing antisocial personality disorder (ASPD) in adulthood (Tibon-Czopp, 2012). Research studies indicate that ASPD in adulthood is most often predicted by CD in adolescence (Piquero, 2011). However, although both CD and ASPD involve psychopathic-like behaviors that are frequently related to criminality, they do not necessarily overlap and should be assessed with this consideration in mind.

Theoretically, contemporary psychoanalytic thinking regards failure to develop a mature and cohesive sense of self-representations and object representations as a core issue in maladaptive behaviors. This failure has been described in terms of a person's incapacity to preserve the space between the thought and the object of thought, the symbol and the symbolized, and the reality and the fantasy (Aron, 1996; Mitchell, 1988; Ogden, 1986). In accord with this conception, we suggest that adolescents who fail to develop and preserve the interplay between subjectivity and intersubjectivity will be prone to showing repetitive maladaptive, psychopathic-like, and sometimes criminal behaviors. In assessing adolescents in the criminal justice system, evidence of underdeveloped internal representations can serve as an important criterion for evaluating whether maladaptive patterns of functioning are probably chronic and therefore likely to be repetitive or should rather be considered slippage in otherwise usually adaptive behavior patterns.

Studies exploring common psychological deficits among adolescents who have committed a severe crime have noted their clinical diversity, particularly with respect to observable psychopathic traits, even in small samples (e.g., Cornell, 1990; Ewing, 1990). Many authors have called for a more differentiated approach to the classification and investigation of violent youth, based on the conception that distinct groups would be characterized by different psychological deficits). Rorschach comparisons of psychopathic and non-psychopathic young people have usually showed greater deficits in object relations in the psychopathic group (e.g., Greco & Cornell, 1992; Smith, Gacono, & Kaufman, 1997). It has been suggested that adolescent murderers are particularly likely to show object-relations deficits reflected in an immature and narcissistic conception of other people and failure to experience their victims as independent, feeling, and thinking human figures. Accordingly, the impulse to kill might be facilitated by an adolescent's tendency to dehumanize the victim as merely a frustrating object rather than a person with whom the adolescent could have a mutual empathic relationship (e.g., Greco & Cornell, 1992).

However, accumulated empirical evidence indicates that impaired object relations in adolescents with CD can reflect diverse psychodynamic processes, character problems, and psychopathological states (e.g., McConville & Cornell, 2003). It is accordingly essential to assess thoroughly the underlying object representations in adolescents who have committed a criminal act, to pursue diagnostic clarity, and to detect prospective continuities and changes. In healthy developmental processes, internal representations that are fragmented, vague, or split turn progressively into complex, articulated, differentiated, integrated, and cohesive representations of self and others. During adolescence, these processes occur within the context of developmental tasks that reactivate the earlier separation–individuation conflict and involve searching for a balance between autonomy and relatedness, renegotiating the threat of regressing to dependence and reintegrating new cognitive, social, biological, and familial factors (see Chap. 2).

As has been noted, the key Rorschach finding for evaluating consistency over time is *D Score* > 0, which in an unguarded record is usually associated with minimal motivation for change and ego-syntonic symptom formation. In order to evaluate prospective continuities and changes in maladaptive object relations, examiners should look for a *D Score* > 0 and also scan deviations on such CS markers of volitional incapacity as *AdjD* < −1, *CDI* > 3, *EA* < 6 *EII-2* > 0, and *Pure C* > 1. In addition, deviations on some CS variables in each of the four dimensions presented in Tables 6.1–6.4 (cognitive, affective, interpersonal, and self-presentation) might relate meaningfully to prospective continuities and changes from adolescence to adulthood. These include *M-* > 1; *S* > 3; *HVI* positive; *Human Contents* < 2; *Pure H* = 0; *COP* = 0; *AG* > 2; *PER* > 0; *Fr+rF* > 0; *Egocentricity Index* > 0.44; *FD* = 0; *MOR* > 2; and *H* < (*H*) + *Hd* + (*Hd*). Some of these variables (e.g., the *Egocentricity Index*) have been found to distinguish between psychopathic and non-psychopathic adults (Gacono & Meloy, 1994). However, with respect to the issue of prospective continuities and changes, it should be stressed that exceeding the age-based normative range on these variables does not necessarily indicate proneness to developing psychopathic tendencies in adulthood, and all of them should be considered jointly with other CS variables.

The use of Tables 6.1–6.4 in evaluating prospective continuities and changes in antisocial behaviors can be illustrated with the Rorschach protocol of a 15-year-old boy, whose evaluation was addressed to pointing out markers of uncontrolled impulsivity and delineating factors for developing antisocial behaviors in adulthood. This adolescent was considered to be a normative adolescent but was charged with having killed a friend of his in the course of a dispute they were having. The dispute took place in the defendant's house, where they were gathered with some other friends. The defendant was not claiming insanity and, except for *PER* = 2, none of the structural variables considered to indicate risk factors for developing antisocial behaviors in adulthood exceeded the normative range in his protocol.

This one deviation was interpreted as possibly a defensive style of communication that was serving as a compensating strategy to cope with some narcissistic

sensitivity exacerbated within the context of a developmental crisis. However, no substantial deficiencies were found in his self-representations and object representations or in his empathic capacity (*Human Contents* = 7; *Pure H* = 3; *M-* = 1). In accord with empirical evidence (e.g., Greco & Cornell, 1992), these findings were interpreted as indicating good capacity for adaptive interpersonal functioning and were taken into account in recommending the type of correctional framework that would be most appropriate for this defendant. He was assigned to a correctional program established specifically for juvenile youth who are considered capable of changing current maladaptive behavior patterns.

In addition to evaluating structural data, examiners should also conduct content and sequence analyses to help estimate likely continuities and changes from adolescence to adulthood (see Chap. 6). With respect to content analysis, it is particularly important to take notice of responses reflecting internal representations in protocols with a predominance of part and/or humanlike objects, as measured by the *H:* (*H*) + *Hd* + (*Hd*) ratio. This finding increases the probability of continuities in maladaptive behaviors from adolescence to adulthood, as do human and humanlike objects that are poorly articulated, inaccurately perceived, and deformed, distorted, or destructive and are engaged in malevolent interactions that lack mutuality. The shift from whole to part figures is consistent with the conception that a person who develops a personality disorder tends to defend against anxiety by splitting object representations into good ones and bad ones and failing to integrate apparently contradictory characteristics in the same object. This type of splitting response identifies a failure to perceive other objects as constant, multidimensional, and differentiated from the self.

Maladaptive interpersonal functioning likely to continue into adulthood would additionally be indicated by Rorschach responses that describe relationships as being chaotic and featuring raw and dramatic aggressive content (e.g., *Two people cutting each other and you can see the blood on their hands*). This extreme extent of aggression may sometimes reach the point of a collapse of potential space (Winnicott, 1971) in which there is no differentiation between the symbol and the symbolized (Ogden, 1986), and the blot is experienced as a real object: *It's a vicious bat, swooping down to fasten its fang on someone's throat*. As has been noted, such collapse would be identified by an *RFS-P* < −0.30 (see Chap. 6).

Sequence analysis conducted in Rorschach protocols with impaired human representations usually reveals that these representations tend to deteriorate along the protocol. This deterioration could indicate an adolescent's proneness to repetitive maladaptive interpersonal functioning in adulthood (Blatt, Brenneis, Schimek, & Glick, 1976; Blatt, Tuber, & Auerbach, 1990; Erdberg, 2007; Exner & Weiner, 1995; Kwawer, 1980; Lerner, 1998; Leichtman, 1996; Viglione, Perry, & Meyer, 2003). Accordingly, instead of evaluating prospective criminal acts as if they were a unitary, homogeneous mode of behavior, examiners should consider empirical evidence that distinguishes between subtypes or syndromes of violent adolescents and should interpret Rorschach findings in relation to these subtypes.

Assessing Issues of Impression Management

The possibility of impression management is an important issue in forensic evaluations. In this regard the face validity of an instrument tends to be directly related to its ability to capture different aspects of impression management. The more obvious the reason for a task or the meaning of a test item, the easier it is for people to respond according to how they wish to be seen. As noted in Chap. 3, the Rorschach usually provides little opportunity for people to sense the implications of the responses they are giving. The relatively ambiguous nature of the stimulus, the minimal instructions on how to proceed, and the absence of clues to what responses might signify combine to make the Rorschach difficult to fake.

Rorschach respondents who want to portray themselves as more disturbed or impaired than is actually the case, typically produce data that are internally inconsistent or show extreme deviations in CS structural variables. This is not uncommon in criminal defendants pleading insanity. By contrast, impression management intended to conceal psychological difficulties, which is unlikely to characterize criminal cases, usually results in a guarded Rorschach protocol consisting of a few brief, vague, unelaborated, and form-only responses. In both instances, however, impression management rarely succeeds in deceiving experienced examiners (e.g., Ganellen, Wasyliw, Haywood, & Grossman, 1996).

The detection of impression management may become challenging if defendants have obtained some prior information concerning the kinds of Rorschach responses that would serve their purpose of appearing disturbed or making a good impression. This information may have come from Rorschach texts that are available in bookstores or from various websites. Nevertheless, because of the complexity of the CS structural summary and the interactive manner in which responses are interpreted, website advice concerning specific responses one should give or avoid does not approach the level of sophistication necessary for respondents to deliver a convincingly malingered or deceptive Rorschach protocol.

Providing Incremental Validity

An additional feature of the Rorschach that enhances its utility in forensic assessments is its potential for providing incremental validity. As noted in Chap. 3, because the Rorschach is an implicit and indirect performance-based measure of personality, it can often contribute incremental validity by adding information beyond what can be gleaned from self-report inventories. Implicit traits, motives, and tendencies that can be inferred from Rorschach findings can help to predict how an individual is likely to function outside the spotlight of conventional expectations concerning explicit attitudes and overt behavioral manifestations (Bornstein, 2002; Hilsenroth & Stricker, 2004; McGrath, 2008). Research studies confirm the incremental validity of Rorschach assessment in providing information that would not

have otherwise been obtained (see Chap. 5). Forensic assessors who limit their instruments to just one type of measure, whether self-report of performance based, risk failing to obtain information that might be crucial to psychodynamic case formulation (Masling, 1997; Weiner, 1999).

Instead, in every type of case, Rorschach findings will be only one of many sources of data in an adequate forensic psychological evaluation. Consistent with general principles of integrative psychological assessment, interpretations based on Rorschach data must typically be considered in light of information from such other sources as self-report inventories, behavioral observations, collateral reports, and school records. Allegations in the literature that the Rorschach lacks adequate psychometric properties may influence some psychologists who would not include Rorschach assessment in their forensic evaluations. The fact is, however, that extensive research has affirmed the psychometric soundness of the Rorschach CS (see Chap. 5) and its incremental validity when used in conjunction with other psychological tests.

Acceptance of Rorschach Assessment in Forensic Cases

Widespread use of psychological tests in general and the Rorschach in particular in evaluations performed to assist legal decision-makers calls for examination of the appropriate parameters for their forensic applications. The primary legal criterion for the admissibility into evidence of psychological test findings is their relevance to the legal issue at hand or to some underlying psychological construct (Heilbrun, 1992). Forensic examiners should attend studiously to this relevance criterion in selecting their assessment instruments, along with their customary concern with general acceptance in the professional community of the utility of these instruments. General acceptance in this context does not require a procedure to be universally practiced or endorsed, which is a standard met by few if any assessment or treatment methods in psychology. Less stringently, general acceptance of a procedure is demonstrated when many professionals are using it in their practice, which is the case with regard to Rorschach assessment (e.g., Clemence & Handler, 2001; Mihura & Weinle, 2002).

Despite extensive information concerning the scientific respectability, general acceptance, and utility of Rorschach assessment in forensic cases, some critics have asserted that the CS Rorschach does not show sufficient reliability and validity to provide an admissible basis for courtroom testimony and that testimony based on Rorschach findings is therefore unlikely to be admitted into evidence in courts of law. To the contrary, however, available evidence concurs with the present chapter in documenting how and why a properly conducted Rorschach assessment satisfies applicable legal standards for admissibility (e.g., Hilsenroth & Stricker, 2004).

Specifically in this regard, a large body of empirical research demonstrates that the Rorschach is a standardized, testable, valid, reliable, and extensively peer-

reviewed instrument that is associated with a reasonable error rate, validated by substantial scientific evidence, and relevant to a wide range of forensic issues (Erard, 2005, 2007; Hilsenroth & Stricker, 2004; McCann, 1998; Ritzler, Erard, & Pettigrew, 2002; Weiner, Exner, & Sciara, 1996). These characteristics of the instrument fully satisfy the criteria for admissibility elaborated in the federal rules of evidence and are in accord with the central thrust of the Frye standard of being commonly used (*Frye v. United States*, 1923) and the Daubert standard of scientific respectability (*Daubert v. Merrell Dow Pharmaceuticals*, 1993). Also of note is a large international community of Rorschach scholars and practitioners who use the instrument in forensic evaluations.

Survey data confirm that Rorschach assessment has an established place in forensic cases and that the admissibility of its findings are seldom challenged in the courtroom (e.g., Bow, Quinnell, Zaroff, & Assemany, 2002; Budd, Felix, Poindexter, Naik-Polan, & Sloss, 2002; Meloy, 2008; Weiner, Exner, & Sciara, 1996). Forensic examiners can accordingly depend on being able to include in their courtroom testimony impressions based on properly obtained Rorschach data. This testimony should be presented clearly and in language that can be easily understood by attorneys, judges, and jurors, as well as by other forensic practitioners who have not been trained in Rorschach assessment.

Guidelines for Effective Presentation of Rorschach Data in Forensic Cases

Forensic examiners who use the Rorschach must be familiar not only with the nature of the instrument but also with how to present the testimony effectively, defend challenges to the Rorschach admissibility and import their testimony to the courtroom. As a general principle in explaining the nature of the Rorschach task in courtroom proceedings, examiners should avoid any implication that the test is a mysterious measure that can be understood only after years of study. Instead, it should be presented as a straightforward way of sampling how people look at their world, in the expectation that how people look at the world conveys considerable information about how they are likely to cope with different events under various circumstances. The Rorschach administration, coding, and interpretive procedures can and should be described briefly in nontechnical, jargon-free language. Specific guidelines for presenting Rorschach testimony in the courtroom are elaborated by Hilsenroth and Stricker (2004), Weiner (2013), and other authors.

Although the thematic imagery in Rorschach responses can provide clinically useful clues to a respondent's underlying attitudes (Lerner, 1998; Schafer, 1954; Weiner, 2003), the clinical utility of content and sequence analysis rarely extends to case presentations in the courtroom. The inferences derived from Rorschach thematic imagery are primarily symbolic and consequently more speculative and less conclusive than inferences based on the structural data. Compared to structural

based interpretations, those based on thematic imagery are less likely to be empirically supported, more likely to involve alternative possibilities, and more complex and difficult to explain in the courtroom.

As an illustration, consider the response to Card VII in the case of the 15-year-old boy whose Rorschach protocol is presented in this chapter: *Two faces looking at each other. They have something in their head. A kind of hair.* By saying "They have something in their head," the defendant used an inappropriate verbalization, coded with *DV1*, to describe an accurately perceived part of the blot. This *DV* phrase could be interpreted as a translation of the notion of "Having something in mind" into a concrete percept, which might suggest some underlying thoughts that the defendant was unaware of or unwilling to reveal (e.g., a potential aggressive act). As noted, however, such interpretive implications of thematic variables are much more speculative than those derived from most of the CS structural variables and are therefore not recommended for inclusion in a forensic report.

Rorschach examiners are also advised to avoid presenting impressions or conclusions based on a single response or answering questions at the level of the individual response. If asked about the meaning of any individual response, they should stress that the interpretive significance of Rorschach findings resides in the summary scores and indices in the structural summary. Relying mainly on the structural data provides a strong foundation for expert witness testimony with respect to the available research support (see Chap. 5) and also in responding to challenging cross-examination.

As an exception to avoiding thematic imagery in forensic reports, repetitive content themes in a Rorschach protocol may sometimes be relevant in a particular case and sufficiently compelling to strengthen an expert's testimony. Thus, noting several responses in which a human figure is seen as bleeding, having been seriously injured, or being beaten might bolster an inference that the respondent is unusually fearful of encountering physical harm. Nevertheless, courtroom testimony should stress that the Rorschach interpretations are based on the summary scores and that each response is important for what it contributes to the total scores but cannot be taken out of context and considered the sole basis for any inference.

Along with emphasizing the structural data and their relationship to available norms, forensic examiners can increase the effectiveness of their testimony by presenting their conclusions in terms of individualized assessment. Individualized assessment is person oriented rather than test oriented and describes a respondent without reference to normative data. In addition to or instead of comparing an adolescent to reference data, for example, "He has more difficulties than most adolescents at his age in thinking logically and coherently", Rorschach examiners should consider describing an adolescent's symptom patterns and subjective experience, as following: "His ability to think logically and coherently is quite limited, and this limitation appears to be causing him considerable subjective distress". By applying such individualized descriptive statements examiners can readily refer to observable features of a person's present behavior, which usually makes them as easy to explain and understand as statements based on normative data.

Rorschach examiners can additionally strengthen their testimony by using appropriate qualifiers in phrasing their impressions, as in saying that the data "are fully consistent with," "strongly suggest," "contain some indications of," or "raise the possibility of" some conclusion. Even at their most accurate, Rorschach inferences are not absolute and should not be presented as being definitive. Using qualifiers does not prevent examiners from distinguishing among conclusions with low, high, or intermediate probability, nor does it preclude their being able to satisfy a common courtroom request to affirm that a conclusion has been drawn with reasonable probability. Such qualifiers should not be considered merely as a hedge against challenging cross-examination, nor do they detract from the effectiveness of test-based testimony. Instead, qualifying statements that accurately describe the probability of the findings and reflect the limits of the conclusions are likely to convey caution, thoughtfulness, and an appropriate degree of humility on the part of an expert witness.

Conclusion

Using the Rorschach in the criminal justice courtroom can assist in decision-making processes by translating test findings from the language of personality functioning into psycholegal concepts. Forensic Rorschach examiners can enhance the effectiveness of their expert witness testimony in cases of adolescents evaluated in the criminal justice system by explaining in clear and uncomplicated terms how the Rorschach captures a respondent's personality characteristics. They should base their conclusions mainly on the structural rather than the thematic features of a Rorschach protocol, state their conclusions in both normative and individualized terms of reference, and frame their conclusions with qualifiers that accurately reflect the certainty of the data and the limits of the psychologist's expertise. Skilled examiners with substantial knowledge of Rorschach theory, research, and practice can contribute effectively to the resolution of legal issues, including correctional decision-making, in which a defendant's personality functioning is a relevant consideration.

In summary, the Rorschach is limited in how much it can reveal about what respondents actually are aware of or likely to act. Although Rorschach findings of psychotic-like functioning provide information about susceptibility to incompetence, they do not document its presence. Nevertheless, when direct inquiry appears to suggest legal incompetence, Rorschach evidence of immature or impaired cognitive functioning can be useful for examiners testifying in court, to point out why a defendant is having difficulties demonstrating competence. It is in this testimony that Rorschach findings of immature or impaired cognitive functioning can prove useful in evaluating trial competence. Some authors have noted their dissatisfaction with the juvenile justice system and offered proposals for reform while according youth some procedural and substantive protections not offered to adults. Specifically, with respect to rehabilitation issues, to be effective, interventions must address the

multiple causes of antisocial behavior in adolescent offenders (Levesque, 1996, 2002, 2008). However, this requires application of suitable tools, including the Rorschach, for evaluating the level of maturation as reflected in the adolescent's personality functioning.

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Chapter 11
Therapeutic Applications

Personality assessment has traditionally been perceived as being incompatible with the therapeutic process. Assessment and therapy have commonly been conducted in sequence by two different clinicians and perceived as two separate tasks. Most academic clinical programs have embraced this traditional distinction. In many programs around the world, students have become accustomed to perceiving assessment as an island separate from the mainland of other topics of clinical psychology and to viewing learning about psychological testing as an unpleasant obligation, to be dismissed as soon as possible, to allow them to concentrate in becoming proficient in psychotherapy.

People generally enter psychotherapy in order to be known, understood, recognized, viewed, and accepted. This is evident when we talk about therapy, but less obvious with respect to assessment. Nevertheless, what is evident about assessment is that getting the person being assessed to cooperate in the assessment process must be therapeutic. Assessors must accordingly offer an experience of mirroring and acceptance, which is particularly important in the assessment of adolescents. Adolescents are usually reluctant to recognize and admit to their difficulties and to cooperate with an adult authority figure whose role is to observe them through testing. Typically it is the parents or school teachers who have initiated the referral for an evaluation. As a result, many adolescents seen in clinical practice do not cooperate fully with the assessor, which can make the assessment process more complicated than it is with children or adults.

This chapter explores theoretical foundations and practical implications of integrating Rorschach assessment with the therapeutic action in adolescents by applying concepts derived from relational psychoanalysis, which has become the dominant alternative to classical theorizing within the contemporary American psychoanalytic scene (see Chap. 4). As noted in previous chapters, CS data can be very helpful for understanding symptom patterns and a patient's experience of these patterns, as well as in formulating treatment goals. The discussion in this chapter is addressed at demonstrating how a Rorschach protocol, when used for drawing

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inferences collaboratively with the patient, can become a therapeutic tool. In contrast to the traditional paradigm, which aims the assessment process solely at collecting information, the therapeutic assessment approach applies the Rorschach task in clinical settings with the context of the therapeutic action.

The discussion that follows elaborates the theoretical and therapeutic implications of standardized–individualized Rorschach assessment and the effects of intersubjective aspects of the assessment relationships on Rorschach interpretation. The text uses an illustration of therapeutic assessment in the case of a 15-year-old boy who was referred for evaluation because of avoidance symptom patterns, depressive mood, and somatization (see Tibon & Rothschild, 2007).

Standardized–Individualized Rorschach Assessment

As described in Chap. 1, the introduction of the CS initially divided the field into two seemingly contradictory perspectives. One is the standardized, empirically based CS and the other the individualized psychoanalytically oriented approach to interpretation. While applying the standardized approach, we score the Rorschach protocol, compute various indices based on these scores, and draw inferences derived from the empirical correlates of these indices. While applying the individualized approach, we look at the sequence of scores and the precise verbalizations, translate the verbalizations into psychological constructs, based on our theoretical propositions, and derive conclusions from these. If the two approaches are considered mutually exclusive, assessors may become estranged from the original data. However, defining perception as a mediator of experience, enables assessors integrating the two approaches into one standardized–individualized assessment process that is both test and person oriented and that provides an experience-near personality picture to be used as a therapeutic tool.

The concept of Rorschach therapeutic assessment refers to different types of approaches that involve a variety of technical procedures (e.g., Handler, 2007). Common to all of these techniques is the notion that any assessment procedure is potentially therapeutic. Reflecting this notion, the present approach suggests using a Rorschach protocol not only for obtaining collaboration and enhancing initial interventions, but also for developing an individualized and mutual but asymmetric therapeutic dialogue. With respect to the standardized–individualized conception, this approach preserves both the test-oriented standardized CS guidelines for administration and coding of the Rorschach (Exner, 2001) and the person-oriented experiential perspective (Lerner, 1998) on Rorschach interpretation.

As noted in Chap. 6, Rorschach CS assessment should be conducted along a bipolar continuum consisting of standardized procedures on one pole and individualized adaptations on the other. These two poles are integrated into a dialectic model of assessment in which two opposing concepts create, inform, preserve, and negate each other while standing in a dynamic changing relationship between them and

proceeding toward synthesis (e.g., Ogden, 1986). To think and speak in dialectical terms is sometimes confusing. However, many Rorschach concepts other than the standardized–individualized polarization also imply dichotomous thinking and paradoxical combinations (e.g., reality–fantasy; perception–projection). Although these polarities can be viewed as constituting mutually exclusive opposites, clinicians thinking in dialectic terms face the challenge of describing the effects of each pole on the other and aspects of each pole that are represented within the other (Hoffman, 1998). In keeping with this dialectic perspective on the Rorschach task, assessors should apply both test-oriented discipline and person-oriented adaptations involving intersubjective features.

The standardized Rorschach task enables adolescents to gain some distance from themselves and consequently to communicate associations that are mediated by the inkblot stimuli. At the same time, combining the CS basic guidelines (Exner, 2001) with acceptable adaptations based on the adolescent's special needs and cultural commitments (see Chap. 5) recognizes the young person's subjective experience and inevitably provides clues to the clinician's subjectivity. When patients perceive the clinician as departing from a convention of some kind, they have reason to feel recognized by the clinician's becoming personally involved in their subjectivity. Deviating from a standard technical stance in favor of immediate and individualized responsiveness to the person being examined reflects an emotional engagement on the examiner's part that can strengthen the working alliance between them. Conversely, strict adherence to standardized assessment procedures preserves the authoritarian and asymmetric aspects of the clinical encounter, and mechanical conformity to particular methods at the expense of individualized responsiveness can transform a patient's initial participation in the encounter into an oppositional stance.

The Effect of Intersubjective Aspects of Assessment on Rorschach Interpretation

The individualized–standardized approach to Rorschach assessment calls for consideration of the intersubjective relationships that evolve between the examiner and the person being tested and their effect on the Rorschach task. The examiner thus becomes a *participant–observer* (Sullivan, 1953) whose subjective experience in the assessment setting is likely to influence the adolescent's responses and the clinician's interpretations of these responses. Some practitioners might argue that viewing the examiner as a *participant–observer* is inconsistent with the preferable image of being an objective interpreter. However, personal involvement of the clinician in the assessment process is not only inevitable, but is also a useful source of information with respect to the complex personality structure and processes in people being examined.

The intersubjective aspects of the therapeutic encounter and their effects on both a patient's association products and the inferences drawn from them have been elaborated by authors who endorse the *relational psychoanalysis*. However, with some exceptions (e.g., Schachtel, 2001), this intersubjectivity has not been noted in the Rorschach assessment literature. In describing the therapeutic action from a relational perspective, Aron (1992) refers to the *Squiggle Game*, an assessment technique used by Winnicott (1958) as part of the initial interview with children to explore the mutual and subjective aspects of interpretation. Winnicott asserted that, while focusing on gaining understanding of a patient's difficulties, clinicians must also be able to tolerate not knowing and engage the patient in helping to understand.

Similarly, collaborative exploration of Rorschach data with the adolescent being assessed turns the test into a means of communication and thereby changes the authoritarian aspect of the assessment process into a mutual but still asymmetric encounter. Like the *Squiggle Game*, the Rorschach provides information about a person's current emotional difficulties and often about the roots of these difficulties in developmental and structural realities. Also in parallel to the therapeutic process, however, issues of transference and countertransference and their effect on Rorschach responses should be considered in the process of interpreting, communicating about, and working through the data in a Rorschach protocol.

The basic transference-evoking condition in Rorschach assessment derives from the testing situation, which is commonly felt as having been imposed, particularly by adolescents. Preserving the testing standardized procedures can reduce the effect of such issues on Rorschach responses. However, as described in Chap. 6 and in keeping with the discussion in this chapter of individualized assessment, there are cases in which some deviations from standardized procedures may be appropriate and beneficial. Wisely chosen deviations can be crucial for obtaining sufficient cooperation to result in an interpretable Rorschach protocol, particularly in working with adolescents. The inferences drawn from a Rorschach protocol constitute explanations that convey authoritative knowledge about a person's internal experiences. Exploring these inferences collaboratively with an adolescent being tested emphasizes mutual aspects of the encounter, even within the asymmetric context in which one person (i.e. the examiner) is the authority. The ongoing dialectic process between the adolescents' perception of the clinician as an authoritative figure with superior knowledge, judgment, and power and as a peer with whom they are engaged in a mutual even though asymmetric relationship can be most constructive, especially if the clinician's authority is sufficiently authentic and the authenticity is sufficiently authoritative.

This interactive approach closely resembles what is described in relational psychoanalysis terms as the interplay in the analytic encounter between the "principle of mutuality" and the "principle of asymmetry" (Aron, 1996). However, these relational principles raise a question that should be answered in the daily clinical practice. If we appreciate the shortcomings of an uncritical systematic application of standardized procedures in Rorschach assessment, and we recognize the potential benefits of a spontaneous personal engagement with the person being examined,

why not abandon the standardized procedures entirely and simply enter into personal relationships with the patients while focusing on the Rorschach as a therapeutic tool? The answer to this question should take into consideration the merits of the previously elucidated standardized–individualized approach in Rorschach assessment, particularly with respect to preserving the standard CS guidelines for administration and coding.

Returning to the importance of acknowledging and making constructive use of the clinician's personal involvement in the Rorschach assessment encounter, this involvement can be optimized by establishing treatment goals only within the context of clinicians' awareness and critical scrutiny of their participation in the process. Without discarding standardized guidelines, clinicians can put them temporarily in the background while taking into account the potential effect of the intersubjective encounter on the assessment data they collect. Correspondingly, when the standard, formal, and detached examiner stance is in the foreground, aspects of the relationships that reflect personal engagement should be in the background.

This conception is in accord with psychodynamic theories of assessment specifying that, regardless of how standardized an assessment procedure might be, the obtained data also reflect the intersubjective relationships between the examiner and the person being examined (Lerner, 1998; Schafer, 1954). In line with this conception, the impact of transference and countertransference issues on test results should be considered thoroughly in the process of interpreting these results. Current relational perspectives on therapeutic assessment suggest the simultaneous occurrence of interpretive and relationship factors, with the two being inseparably linked (e.g., Hoffman, 1998). This perspective acknowledges as well aspects of the relationship that derive from features of the assessment process itself (e.g., the presence of the inkblot stimuli) and the effect that examiners have on the assessment data even without any special efforts on their part to have some particular effect. An important interaction also characterized this process. Communication of inferences drawn from the Rorschach responses to the person being tested is maximally effective when received within a context of positive relationships, and positive relationships are nurtured by communication and collaborative exploration of these inferences.

Case Illustration of Rorschach Therapeutic Assessment in a 15-Year-Old Boy with Avoidant Symptom Patterns

Adolescents with avoidant symptom patterns typically show social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. They may appear overwhelmed by internal or external experiences, and they are prone to becoming extremely anxious, frightened, and withdrawn to an extent that limits their interpersonal functioning (see Case Illustration 8.2). Although these symptom patterns can reflect normative difficulties in coping with developmental tasks, they may also indicate a type of internalized diagnosable disorder. Avoidant adolescents are likely to be preoccupied with the idea that they are not good enough and that others

reject them. They think of themselves as unappealing and socially inept. An important question to consider in these cases is whether the observed behavioral manifestations of avoidance are ego-syntonic or ego-alien. To the extent that they are ego-alien, these symptom patterns are likely to be transient, situational, reactive, and responsive to psychodynamic treatment.

Background and Reason for Referral

This 15-year-old boy was referred for evaluation because of mixed depressive, somatic, and avoidant symptom patterns. Both parents are in their 40s and work in the high-tech industry. They appeared to be highly ambitious and demanding with respect to the academic performance of this boy and his two sisters, who were 18 and 8 years old at the time of referral. The father was diagnosed with ADHD in childhood as has been this boy, who is a talented musician. When first seen, he presented himself as being anxious and depressed and as feeling vulnerable. He reported being quite distressed, having problems with attention and concentration, feeling worthless and unsuccessful, and lacking social skills. He denied thoughts about harming himself, but the parents expressed concerns about his depressed mood. They also reported that, unlike his sisters, he has continually felt rejected by his peers and would rather play with his younger sister than get involved in peer-group activities. As a further deviation from typical adolescent behavior, he initiated the present evaluation by asking his parents to find a clinician with whom he could talk about his difficulties, and he was highly motivated to begin therapy.

Rorschach Structural Data

This adolescent provided a short protocol ($R = 14$) with a low *Lambda* ($L = 0.08$). This combination of a short record and a low *Lambda* often delineates an avoidant defensive strategy, which in this boy's case might have been a major source of his considerable subjective distress. Of greater concern, however, is his elevated *S-CON* of 9, along with which he has deviant scores on two other CS constellation indices (*DEPI* = 6; *CDI* = 4) and on numerous affective, interpersonal, and self-perception variables: $D = -5$; $AdjD = -5$; $FC:CF + C = 0:5$; $Afr = 0.27$; *Complexity Index* = 8:14; $COP = 0$; $Food = 3$; *Sum T* = 3; *Human Contents* = 0; *Egocentricity Index* = 0.00; $SumV = 2$; $FD = 3$; and $H:(H) + Hd + (Hd) = 0:0$.

Also apparent are some cognitive difficulties in the area of attention ($W:D:Dd = 13:1:0$; $Zd = +7.0$), probably related to his experiencing intrusive thoughts ($FM + m = 13$). Taken together, these structural data point to considerable subjective distress and defensive avoidance in a lonely, interpersonally alienated, and self-derogating boy whose difficulties are internalized and who is unlikely to

show any externalized behavior problems (for further discussion of the background and structural data in this case, see Tibon & Rothschild, 2007).

Treatment Goals

Treatment goals have been widely discussed and debated in the literature (e.g., Barlow, 1996). Some psychoanalytic authors have questioned whether therapeutic goals should be explicitly defined. However, psychodynamically oriented clinicians generally agree that treatment goals should be discussed between the patient and therapist at the beginning of their work together, and relevant research confirms that better outcomes are associated with patient–therapist agreement on the treatment goals. There is also widespread belief that clinical interviews and various personality assessment instruments, including the Rorschach, can be useful in defining these goals (Bram & Peebles, 2014; Weiner, 2004).

The utility of the Rorschach in defining treatment goals is particularly evident in adolescents who show self-destructive tendencies. In this adolescent's protocol the elevated *S-CON* pointed out an immediate and urgent need to address and attenuate his self-destructiveness. It should be noted in this regard that suicidal behavior in adolescents might gradually emerge in an unfolding process that can involve numerous types of internalized and externalized symptom patterns. Personality characteristics disposing adolescents to self-destructive acts must accordingly be evaluated at the very beginning of establishing treatment priorities.

The very rich and complicated responses together with his low *Lambda (L),* confirmed this adolescent's intense involvement in the Rorschach task and served as a clue to the potential effectiveness of conducting a therapeutic assessment guided by a psychodynamic perspective on Rorschach data. With this consideration in mind, the clinician who conducted the assessment applied guidelines for therapeutic assessment as originally designed for enhancing cooperation in treatment of adults. This application has been developed further into a new approach to therapeutic assessment, as presented in this chapter as part of the *Rorschach Psychoanalytic Science and Practice (RPSP)* model (see Chap. 12).

The Therapeutic Assessment Process

Following the coding of the responses and the computation of the Structural Summary, the clinician in this case compared her observations on the assessment process to inferences derived from the Rorschach structural data, the thematic imagery, and the response sequence, as recommended by Weiner (2003). This comparison provided the basis for formulating some hypotheses that she brought to the first feedback session, which was conducted jointly with the boy and his parents.

The clinician began this first feedback session with some observations on the boy's strengths, as revealed in the assessment process. She focused on his apparently high intelligence, creativity, rich language usage, breadth of knowledge, agreeableness, and openness to experience. She noted the apparent contradiction between his observed emotional restriction and social withdrawal, as indicated by some of the Rorschach findings (e.g., *Afr* = 0.27; *Human Contents* = 0), and intense affectivity suggested by some other Rorschach findings (e.g., *L* = 0.08; *FC*:*CF* + *C* = 0:5). She commented that these joint findings paint a personality picture of a shy and sensitive boy who searches for meaningful emotional relationships but is extremely fearful of the outside environment. Based on these findings, the clinician raised the hypothesis that being constantly alert to threatening clues from the environment (elevated number of shading responses) may have led him to develop an avoidant defensive strategy that has the negative effect of exacerbating his fears of the outside world. As part of this initial feedback, she also called attention to the elevated *S-CON*, saying that she is mostly concerned about his potential for self-destructiveness, as delineated by a Rorschach index that has been proved to be a valid measure of suicidal tendencies.

It should be noted that the use of "self-destructiveness" to describe an elevated *S-CON* can be helpful for communicating suicidal risk data, particularly with people who deny or are not aware of suicidal thoughts. In the present case illustration, the clinician felt that using these terms put the presence of suicidal thoughts in a broad context that would preserve the mutual trusting relationships already starting to develop between her and the boy. She offered to continue the feedback in further sessions in which they could explore together the test responses themselves, as a window into his subjective experience. The boy enthusiastically agreed, and they proceeded with a therapeutic assessment treatment.

In the subsequent sessions, that were conducted solely with the boy, the clinician read through the Rorschach responses together with him. She presented these responses as free-association products, in their original sequence, without reference to the specific cards that elicited these responses. They discussed together the overwhelming fears of being controlled, blocked, stuck, and dominated that were reflected in his Rorschach percepts of *A monster-animal which swallowed a butterfly* (Card III); *An animal that took control* (Card IV); *A crab that came about to eat the butterfly and the butterfly has no way to escape* (Card VIII); and *Fish that are searching for a way to go out but they are blocked from all the sides… trapped…* (Card X).

The clinician raised the hypothesis that, like the fish he saw in the blot, needy and dependent, looking for friends, he finds himself in an environment that he sees as hostile, dangerous, and threatening. Experiencing a constant threat in the environment, he can barely stand on his own feet independently, like the butterfly he saw on Card V that lacks *the two feathers that would fix him in the air.* She suggested that, being caught between the conflicting feelings of desiring nurturance yet fearful of being blocked and controlled, he regresses to immature relationships. Within the context of these relationships, it is likely that he allows himself to experience helplessness and becomes psychologically paralyzed, unable to function effectively or to resolve his feelings of

inadequacy, instability, and exposure to external threat. This observation was quite effective to create a mutual yet asymmetric basis for further discussion.

The main issues that were discussed further were related to this boy's extreme sense of vulnerability and his apparently resourceful adaptation to it by filtering out interpersonal connections and emotional involvement. In this regard, they concluded in collaboration that he avoids emotional involvement as a defensive strategy of keeping his affective experience muted and under control. In addition to providing affirmation of his concerns and defensive avoidance, the collaborative work on this adolescent's Rorschach protocol appeared to have the therapeutic effect of increasing his openness to developing close interpersonal relationships and helping him to be more self-confident. These treatment results reflect constructs proposed in several theories based on psychodynamic developmental conceptualization (e.g., Winnicott, 1958, 1971). In accord with this conceptualization, using Rorschach therapeutic assessment to help this boy view himself more positively served to alter his negative self-perception. Additionally, by treating him as an expert and engaging him as a partner in the assessment process, the clinician demonstrated that she considered him a worthy and capable individual.

As shown in this case illustration, establishing a secure working alliance during the assessment process can help alleviate the discouragement, interpersonal discomfort, feelings of aloneness, and subjective distress that frequently characterize adolescents who enter psychotherapy. With the focus of assessment expanded in this collaborative work, both the adolescent and the clinician gain knowledge about issues that are likely to arise in the treatment. The case illustration illuminates the process by which analyzing collaboratively the Rorschach protocol can open lines of further therapeutic communication.

Conclusion

Rorschach assessment can be therapeutic in its own right, and it can also enrich therapeutic assessment. The therapeutic benefit of being assessed derives from some common features between assessment and psychotherapy. Most people search for opportunities to be listened to, understood, and accepted as they are, and they usually appreciate the assessor's interpretations of the test data. Although the therapeutic benefit of such positive attitudes is more apparent in psychotherapy than in assessment, both procedures provide a relationship with a mental health professional whose sole purpose is to learn more about and be helpful to the person being seen. As previously noted, adolescents are usually referred for assessment by their parents, teachers, or other mental health professionals rather than applying on their own, and they are inclined to regard the Rorschach test as a task being imposed on them by adult authority. Nevertheless, in common with adults, young people referred for evaluation are likely to derive benefit from the assessor's undivided attention, nonjudgmental stance, and commitment to being helpful.

Assessors can facilitate making the Rorschach examination a positive experience and enhance the potential therapeutic benefit of being examined by employing a standardized–individualized assessment process. A standardized–individualized assessment process combines standard procedures for administering and coding the Rorschach with individually tailored adaptations to the needs and style of the person being examined. These adaptations derive from recognizing that Rorschach assessment is an interactive process in which the clinician and the patient form different kinds of impressions of each other. Sensitivity to this intersubjective process helps examiners monitor and adjust their conduct of the examination in ways that fit individual's pattern of functioning. Without sacrificing necessary standards or clinging to them mechanically, examiners can indirectly enhance the potential therapeutic benefit of taking the Rorschach with such minor adaptations. Such minor adaptations may involve the examiner's general manner of relating to the person being tested; the examiner's tone of voice, choice of words while explaining the testing procedures; and extra-test comments that respond to indications of distress (e.g., "You're doing just fine"; "Do you want to take a break?").

In addition to the indirect therapeutic benefit of providing a positive and potentially helpful experience, Rorschach assessment contributes directly to the welfare of the person being tested through its utility in treatment planning. For adolescents and people of all ages, the presence and severity of Rorschach markers of psychological disturbance can help to indicate (a) whether a person is functioning reasonably well or is in need of psychotherapy; (b) whether a person who needs psychotherapy can be treated adequately on an outpatient basis or requires inpatient treatment; and (c) whether a person's apparent suicidal tendencies, overwhelming distress, or other emerging difficulties call for crisis intervention. For people who have decided to seek psychotherapy, Rorschach findings can suggest which types of therapy are most likely to prove beneficial for a person with their personality characteristics. For people who have already entered psychotherapy, Rorschach information concerning their personality style and the nature of the underlying psychopathological manifestations can be useful to them and their therapist in establishing the goals of their work together.

Therapeutic assessment is an extended feedback process in which the examiner and the patient collaborate in reviewing the test findings and discussing their implications. These discussions serve as a springboard of further exploration of the personal issues and prior experiences that have caused the person psychological distress; how the person has coped with these issues and experiences; whether certain means of coping have been more or less helpful in alleviating the person's psychological distress; and what ways of understanding and coping with this distress might be beneficial. Thus, in contrast to the traditional focus of Rorschach assessment on collecting information, therapeutic assessment applies the Rorschach task in clinical settings as part of the therapeutic action as well as the diagnostic action. With full attention to the structural data and the thematic imagery, the Rorschach provides a rich source of conclusions, hypotheses, and speculations for discussion in the course of a therapeutic assessment. A case illustration in this chapter demonstrates how collaboration in drawing inferences from a Rorschach protocol can become a therapeutic tool.

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Part IV
Toward Empirically Based Psychodynamic Assessment of Adolescents

Chapter 12
The Rorschach Psychoanalytic Science and Practice (*RPSP*) Model

The problems affecting adolescents in the twenty-first century are enormous and complex. Current research concerned with aspects of adolescent development comprises a wide range of empirical studies of both normative and clinical age-based samples. This research provides new insights into adolescence as a unique developmental stage and updated empirical data to assist in evaluating cognitive, emotional, social, and self-perception developments in adolescence and distinguishing between healthy and psychopathological personality functioning. To make valid, sensitive, and specific diagnoses, clinicians must consider what is known about multiple sources of influence on proneness to develop psychopathological manifestations in adolescence and utilize multiple methods of assessment.

This volume provides practitioners with a handbook that elaborates the main principles of Rorschach work with young people, as described in the CS Volume 3 (Exner & Weiner, 1995) and adapts these principles to contemporary theoretical thinking and accumulated empirical findings derived from CS research. The present discussion draws on the preceding chapters to explore the application to adolescents of a new twenty-first century model for Rorschach assessment, the *Rorschach Psychoanalytic Science and Practice (RPSP)* model. The model is derived from recently developed perspectives on research in psychoanalytic science (e.g., Wallerstein, 2009) and integrates new developments in neuroscience and developmental psychology with contemporary psychoanalytic thinking.

The *RPSP* provides an empirically based Rorschach assessment model that is designed along the lines of the *Psychodynamic Diagnostic Manual* (*PDM* Task Force, 2006) applied to various psychopathological syndromes. Similarly to the *PDM,* the *RPSP* is based on the assertion that mental health comprises more than simply absence of symptoms. It involves a person's overall mental functioning, including cognitive, affective, relational, and self-observing capacities and should therefore be assessed by applying a continuous rather than a categorical approach. Being addressed to classifying psychopathological manifestations according to the *PDM*, the *RPSP* reflects a dimensional approach to developmental psychopathology

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(Hudziak et al., 2007) and accordingly enables clinicians to demonstrate the presence or absence of psychopathology in a Rorschach protocol and the degree to which any disorder is manifested, in addition to exploring it from an experiential approach. In this regard, the model applies a standardized–individualized conception of Rorschach assessment.

Basically, the *RPSP* resembles Weiner's (2003) ego psychology perspective on the interpretation of the Rorschach protocol that has been administered and coded according to CS guidelines (Exner, 2003). While applying additional psychodynamic perspectives, particularly those of object relations, self-psychology, and relational psychoanalysis, the *RPSP* model can be viewed as a revision of Weiner's interpretive approach, which suggests examining CS findings within the context of a pluralistic psychoanalytic paradigm. The model is novel in applying contemporary psychodynamic constructs that have usually been applied exclusively in a therapeutic context to the assessment field. By transporting these constructs to Rorschach assessment, the model suggests viewing the two aspects of clinical practice, assessment and therapy, as being connected and frequently overlapping, consequently calling for common concepts.

What follows is a description of the main topics discussed in the four parts of the volume as providing an overview of the *RPSP* model. The volume opens with placing the model on the historical continuum of the main developments in Rorschach assessment since its inception in 1921, particularly with respect to its suitability for assessing adolescents and its advantages when applied jointly with self-report inventories. This introductory part is followed by a discussion relating the *RPSP* to a pluralistic psychoanalytic theory, to the extensive Rorschach research, and to psychodynamically-oriented practice. The discussion of Rorschach theory, research, and practice in the second part is further explored by illustrations of *RPSP* clinical, forensic, and therapeutic applications, as described in the third part of the volume. The fourth part of the volume concludes with an overview of the new developments in Rorschach assessment.

The Development of the *RPSP*: Building Bridges in Rorschach Assessment

As noted in Chap. 1, critics of Rorschach assessment have argued that it lacks sufficient empirical evidence to support the inferences drawn from the data it provides. The CS standardization helped to resolve many of the earlier methodological issues, and over time it became the most widely used system for administering and coding the Rorschach. However, the application of the CS with its predominantly statistical emphasis gradually diminished appreciation for conceptual foundations of Rorschach assessment. The development of the CS, however, presented a distinct challenge of how empirically based, structurally derived interpretations can be counterbalanced and enriched by theoretical concepts and qualitative analysis of thematic imagery.

This question is particularly intriguing with respect to personality assessment of young people, which requires attention to developmental issues that are likely to affect personality functioning. Indeed, recent neuropsychological findings, derived from studies that apply new imaging techniques, have confirmed that adolescence constitutes a particularly complex developmental stage in which endocrine effects on the central nervous system can foster intense emotions, impulsivity, lessened self-control, and preference for actions that offer immediate rewards. Changes in ongoing brain development may accordingly result in emotional turmoil and poor impulse control manifest in maladaptive behaviors, including addictions and acts of violence. These advances have broadened the understanding of the interactional effect that neurological and personality factors, as measured by the Rorschach CS, can have on faltering development and point to the system being a useful neuropsychoanalytic tool for assessing personality functioning during adolescence (e.g., Zillmer & Perry, 1996).

Neuropsychological findings have in particular been consistent with psychoanalytic views of adolescence as constituting a qualitatively new developmental stage of individuation (Bleiberg, 2001) in which outside demands frequently induce internal regressive experiences and primitive defensive reactions (see Chap. 2). Additionally, the evolution of Rorschach research and practice in the twenty-first century has seen changed from previous splits between empirical and theoretical approaches to more integrative approaches that encompass both empirical evidence and psychodynamic conceptualization. At the same time, empirical investigation of the Rorschach has enhanced its scientific status in the field of personality assessment and demonstrated psychometric properties equivalent to those of self-report inventories (see Chap. 3).

Also in contemporary times, psychoanalytic thinking has given rise to numerous new CS-based measures, including the *AdjDMD* (Weiner, 2003), the *Ego Impairment Index* (*EII-2*; Viglione, Perry, & Meyer, 2003), and the *Reality–Fantasy Scale Version 2.0* (*RFS-2*; Tibon-Czopp, Appel, & Zeligman, 2015), all of which are applied in the present volume. Given these developments, the complaint sometimes heard that the CS is incompatible with psychoanalytic thinking about personality functioning is neither warranted nor relevant for analyzing specific Rorschach data. Accordingly, starting with Exner and Weiner (1995) and applied in other books (e.g., Exner & Erdberg, 2005), CS data have been merged with various psychodynamic perspectives. This approach has gradually become the dominant strategy in interpreting a Rorschach protocol (e.g., Bram, 2010; Silverstein, 2013).

The *RPSP*: Theory, Research, and Practice

Psychoanalysis has become increasingly diverse over the years and pluralistic with respect to theoretical perspectives. A unified paradigm for conceptualizing all people and situations has not proved satisfactory for capturing the many nuances of personality functioning. Unified paradigms have been based on assumptions in

psychoanalytic practice of a homogeneity principle according to which unity of the psyche derives from a global organizing principle that is the same for all of its components. However, even complex single-mechanism theories are unlikely to prove useful in clinical practice. The dominant theoretical conceptualization in psychodynamic psychotherapy changed during the 1990s from a monistic approach toward a more pluralistic one, but this transformation has not characterized Rorschach assessment. Instead, diverse theoretical perspectives on interpreting Rorschach data have been applied separately. Psychodynamically oriented authors have usually interpreted these data from some particular theoretical perspective. Weiner (2003), for example, proposed a model based on ego psychology. Additional models have integrated concepts derived from other theoretical perspectives (see Chap. 4). The present volume provides a modular psychodynamically oriented paradigm for interpreting Rorschach CS findings. This modular paradigm stems from conceiving the mind as constituted by the articulation of systems that function according to different rules, evolve in parallel and asynchronous patterns, and are linked through complex relationships that call for multiple interpretive strategies.

Empirically, the *RPSP* fits well with the accumulated research findings concerning the CS, which has proved to be a reliable and valid method of Rorschach assessment. As discussed in Chap. 5, there are some notable differences between the adolescent normative data derived from the international project of Meyer et al. (2007) and those collected in the USA about 30 years ago and presented in Exner (2001) with the recent samples apparently looking less adjusted. Although these differences could be considered to have implications for psychopathology, it is also quite possible that they reflect cultural changes worldwide related to advances in modern technology. Whether the differences are due to exposure to environmental changes or to substantial changes in patterns of mental functioning, particularly in adolescence, is a question for further exploration. Whatever the answer to this question might be, practitioners using the international CS database to establish a benchmark between healthy and psychopathological functioning should follow the CS procedures of administration and coding (Exner, 2003; Exner & Weiner, 1995). The *RPSP* model assumes preservation of these procedures, which enable clinicians and researchers to compare their Rorschach data to the large reference database now available.

When applying the *RPSP* in distinguishing between healthy and psychopathological functioning in adolescents, clinicians should be aware of cross-cultural issues that might contribute to deviations from age-based normative data. For example, empirical evidence demonstrates a striking similarity between the Rorschach data of African Americans and White Americans. Nevertheless, African Americans give fewer responses (*R*) and fewer cooperative movement (*COP*) responses, particularly when the Rorschach is administered by a White examiner (e.g., Presley, Smith, Hilsenroth, & Exner, 2001). Because available normative reference data have until recently been somewhat skewed toward Western culture, international practitioners should focus their interpretations on CS deviations that differ substantially from traditional cutoff scores and are therefore likely to be clinically meaningful in any population (e.g., $PTI = 5$).

To assist practitioners, this problem is addressed in the present volume by drawing on the data of three nonpatient adolescent samples, from Italy (Lis, Salcuni, & Parolin, 2007), Israel (Tibon-Czopp, Rothschild Yakar, & Appel, 2012), and Iran (Hosseininasab, Mohammadi, Weiner, & Delavar, 2015), to create a combined international sample of nonpatient adolescents. Analysis of the data from the three participating countries confirmed the cross-cultural transportability of these CS norms and also made it possible to provide a composite set of international norms for adolescents that can serve as a benchmark in clinical evaluations (see Chap. 5).

Rorschach practitioners can additionally appreciate knowing that CS empirical data have proved consistent with a pluralistic psychodynamic perspective on interpretation of these data. Although not homogeneous, this psychodynamic perspective fits well with psychoanalytic science. It should nevertheless be stressed that a pluralistic psychodynamic perspective pertains only to the interpretive phase of Rorschach assessment. As has been noted, the administration phase of the Rorschach as a free-association task requires strict conformity with the CS administration guidelines delineated by Exner (2000).

The *RPSP* model assumes that a conceptual integration of developmental, neurobiological, and psychodynamic considerations with cross-cultural normative data is essential to understanding how neurobiological changes during adolescent development interact with patterns of personality functioning. The key challenge for Rorschach assessment in this regard is building bridges across diverse disciplines and disparate approaches to link their concepts and empirical data so as to enhance understanding of personality functioning in adolescence. It is worth noting that the Rorschach has sometimes been viewed either as a measure of personality structure or as a measure of personality dynamics. In fact, it is both, and the data it generates speak broadly to the different facets of personality functioning and subjective experience as delineated in Chap. 6 of this volume.

The *RPSP* Model for Assessing Adolescents: Diagnostic, Forensic, and Therapeutic Applications

Applications of the *RPSP* model derive from the basic nature of the Rorschach task, which consists of looking at an inkblot and formulating a response to the examiner's question, *What might this be?* The blot is something that is "out there," separate from the person, and the respondent's task is to misperceive it, because in fact it is only an inkblot. Accordingly, Rorschach responses are created within the intermediate space between self and other and between reality and fantasy. It involves both perception and projection and the integration of subjective and intersubjective experiences.

In line with this conception, Smith (1990) has applied to Rorschach interpretation Winnicott's (1971) construct of potential space and Ogden's (1986) model delineating different types of psychopathological conditions as forms of collapse of potential space. The construct of potential or transitional space between reality and

fantasy as a major concept in modern psychoanalytic thinking, which describes how people organize their experience. In this formulation, meaningful human experience is generated by a mutual, dialectical, and enriching tension between reality and fantasy (e.g., Mitchell, 2000). Healthy psychological functioning is accordingly demonstrated by individuals who can separate their own psychic reality from that of other people while adequately maintaining an intermediate, transitional space where reality and fantasy are perceived as separate yet interrelated.

Assuming that Rorschach responses are located on the continuum between reality and fantasy, the *RPSP* model can be useful for distinguishing between healthy and psychopathological personality functioning; it can assist in delineating different types of psychopathological manifestations; and it can facilitate an experience-near understanding of individuals who show these psychopathological manifestations.

Some critics of Rorschach assessment have called attention to CS indices that do not correlate well with the *DSM* diagnoses. This is not a surprising finding, because the Rorschach is not a diagnostic test; it was not designed as a diagnostic test, nor was it intended to fit into *DSM* diagnoses (Weiner, 1999). Rather, the Rorschach is a personality assessment instrument that provides information about what people are like and how they are likely to think, feel, and act. Such information about personality functioning drawn from a Rorschach protocol can often assist in differential diagnosis, and this information provides an alternative to describing conditions solely only by their externally observable aspects with little attention to the subjectively experienced features of these conditions.

Consistent with this conception of the Rorschach as a personality assessment instrument, applying the *RPSP* in assessing adolescents enhances its utility for evaluating their proneness to developing a disorder and for delineating the type and severity of that disorder if it has already developed. As an example, Rorschach CS indices of disordered thinking and impaired reality testing are helpful in diagnosing schizophrenia, because schizophrenia, despite its heterogeneity, is a disorder characterized by cognitive dysfunction. For the most part, however, a direct relationship between CS markers of psychopathology and other *DSM* diagnoses is less likely than in this example, primarily because *DSM* diagnoses emphasize observable symptom patterns, not underlying personality characteristics (see Chaps. 7–9).

In particular, differential assessment of types of personality disorder as defined by whether specific personality traits are present or absent has not been validated. It is worth noting that the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*; American Psychiatric Association, 2013) includes a proposed model for dimensional rather than categorical classification of personality disorders. This dimensional approach would increase the effectiveness of the Rorschach CS as a means of distinguishing between healthy and psychopathological functioning and delineating diagnosable personality disorders. It seems likely that, based on the *DSM-5*, new classifications of various disorders usually seen in young people (e.g., disorders on the autistic spectrum, eating disorders) would further bridge the gap between Rorschach assessment and *DSM* diagnoses.

However, practitioners should not assume that empirically supported interpretations of Rorschach CS data describe the personality organization of all people with the same symptom patterns, irrespective of their cultural norms and regardless of whether they are disposed to being anxious or depressed, introverted or extroverted, or self-centered or interpersonally oriented in their subjective experience of these symptom patterns. To the contrary, individuals with similar symptoms but different personality styles cannot be given a "one-size-fits-all" description in an assessment report.

Clinical psychology has a long-standing tradition of attention to individual differences in the people who receive their services. Despite considerable empirical evidence concerning such individual differences, some Rorschach practitioners tend to regard symptom patterns as entities in their own right, rather than as expressions of a person's complex and unique individuality. Rorschach assessment also runs the risk of excessive reliance on a detailed manual or computer printout in formulating interpretations. Well-designed and validated manuals and printouts provide information that describes groups of people, but they do not capture individual uniqueness. Adequate attention to individual differences does not detract from the importance of basing Rorschach assessment on scientific research. With this consideration in mind, examiners applying the *RPSP* model in the assessment of adolescents should formulate personality descriptions that are based on well-validated CS variables but that also capture the dimensionality, multiplicity, and subjective experience of psychopathological conditions. Some case illustrations of the *RPSP* diagnostic applications are provided in Chaps. 7–9 of this volume.

Forensic applications of the *RPSP* involving adolescents should recognize the common gap in young people between their intellectual and their emotional maturation, which is relevant to the various psycholegal issues discussed in Chap. 10. As noted, specific structural changes occur in the brain during adolescence, as do changes in how the brain works. From adolescence into adulthood, activity in brain systems involving self-regulation is strengthened and functional MRIs have shown that reward centers in the brain are activated more readily in adolescents than in children or adults. Heightened sensitivity to anticipated rewards can motivate adolescents to engage in risky acts, such as unprotected sex, fast driving, or drug use, in which they anticipate pleasure without sufficient awareness of the risks involved. This hypersensitivity to reward is particularly pronounced when adolescents are in the company of friends.

These emerging findings from neuroscience research could have a substantial effect on how adolescents are treated in the courtroom. Many adolescents have not yet developed the same control over their actions as mature adults and should therefore be treated differently. Clinicians applying the *RPSP* in criminal cases involving adolescents may find this developmental conception helpful in evaluating control capacities and other personality characteristics relevant to the psycholegal issues in a particular case.

The potential application of the *RPSP* model extends beyond such diagnostic and forensic considerations. Contemplating the psychodynamic meaning of symptoms and personality characteristics may help to clarify how the two are related. Thus, when a clinical picture seems confusing because the observed personality

characteristics do not point to a clearly recognizable disorder, the possible broader meanings of these personality characteristics and of certain disorders may lend some clarity. Nevertheless, psychodynamic reconstructions cannot substitute for reliable and valid criteria for obtaining empirically based meaningful diagnoses.

There may, however, be inherent difficulties in resolving diagnostic threshold problems with extended explanations of symptoms and personality characteristics. To help resolve such difficulties, we recommend applying Rorschach inferences features derived from ego psychology (Exner & Weiner, 1995; Weiner, 2003) jointly with other psychodynamic perspectives integrated within psychoanalysis dialectic models. This joint application can facilitate formulation of complex and atypical clinical pictures that do not fit familiar patterns. Such an approach can provide diagnostic understanding that goes beyond grouping observed symptoms into categories. This interpretive approach should nevertheless be based on a foundation consisting of psychometrically sound CS variables.

As described in Chap. 11, Rorschach assessment serves more than diagnostic purposes and can also constitute a therapeutic intervention. Adolescents experience being assessed idiosyncratically, depending on their individual cognitive capacities, attachment styles, preferred defenses, family and social context, previous experiences with other practitioners, and a variety of other factors. Clinicians applying the *RPSP* model can use the standardized–individualized approach as an opportunity to develop and maintain psychodynamic therapeutic assessment with adolescents and to work collaboratively with them in exploring the implications of their Rorschach responses.

As shown in the case illustrations provided in this volume, establishing a secure working alliance in the assessment phase of treatment can help alleviate the discouragement, interpersonal discomfort, feelings of aloneness, and subjective distress that frequently characterize adolescents who enter psychotherapy. Within the context of therapeutic assessment, both the adolescent and the clinician gain knowledge about issues that are likely to arise in the treatment. In this regard, the *RPSP* enhances application of contemporary psychoanalytic constructs that are usually reserved for ongoing psychotherapy to psychological assessment. By transporting these constructs to Rorschach assessment, the model embraces the conception that the assessment and therapy aspects of clinical practice are interrelated, basically connected, and frequently overlapping, and they consequently call for a common theoretical frame of reference. However, because adolescents have often been compelled to be evaluated or see a therapist and may be filled with shame for needing or seeking help, practitioners should interpret Rorschach markers of psychopathological manifestations in light of such personal and contextual considerations.

Our conception of this volume and the information we provide include several contemporary developments. Of particular importance among these developments is the presentation of new composite adolescent reference norms, based on international sampling, and the translation of these norms into T Scores. To facilitate personality description, the traditional CS clusters of variables are reorganized into the four domains of cognitive functioning, affective experience, interpersonal relatedness, and self-perception. Protocol interpretation is focused on 45 CS and

CS-based variables that distinguish between healthy and psychopathological functioning in adolescents and five variables (*R*, *EB*, *a:p*, *Ma:Mp*, *Complexity Index*) that are indicative of personality style but are largely independent on the level of psychological functioning. The 45 diagnostic and five stylistic variables are listed in a revised version of the RIAP (Exner & Weiner, 2003) Structural Summary that facilitates presentation of the data.

Beyond these developments of the CS, we outline a new conceptual model for interpreting Rorschach data, the *Rorschach Psychoanalytic Science and Practice* (*RPSP*) model that is discussed in this chapter. This model refers to the Rorschach as a free-association task and integrates structural, thematic, sequential, and behavioral data. By referring to developmental considerations and applying some new CS-based variables in addition to the traditional CS variables, the *RPSP* model points to the CS as an evolving system that is suitable for Rorschach assessment in the twenty-first century, particularly with adolescents. In addition to differentiating normal from psychopathological functioning, the *RPSP* model provides clinicians with a psychodynamic tool that allows them to conduct standardized-individualized Rorschach assessment.

Conclusion

In conclusion, based on a standardized–individualized approach, the *RPSP* model assumes that conceptual integration of developmental, neurobiological, psychodynamic and contextual considerations with cross-cultural normative data is essential to understanding how neurobiological changes during adolescent development interact with patterns of personality functioning. In accord with this conception, personality descriptions are based on well-validated CS variables but also capture the individual uniqueness of adolescents' subjective experience of their psychological problems. By combining ego psychology concepts with those of other psychodynamic perspectives on personality functioning in Rorschach interpretation, the *RPSP* model facilitates formulation of complex and atypical clinical pictures that do not fit familiar patterns. Clinicians applying the *RPSP* model can also use the standardized–individualized approach for developing therapeutic assessment with adolescents and exploring collaboratively with them the implications of Rorschach data.

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Glossary

The glossary is designed to provide the reader with the list of CS and CS-based variables used in this volume as illustrated by Rorschach protocols of adolescents with various symptom patterns (see Chaps. 7, 8, and 9). In some of the variables codes assigned at the response-level use the same abbreviation at the protocol-level score. The glossary presents the abbreviation and a general description for each of the variables. With the exception of the five stylistic variables (*R, EB, a:p, Ma:Mp, Complexity Index*), the reference values for all the variables are presented in Tables 6.1–6.4.

Abbreviation	Description	Cases
AdjD Score	*Adjusted D Score*. An index, based on determinants, which provides information about persistent stress tolerance and control, and is calculated by subtracting situational stress scores ($m > 1$ and $Y > 1$) from the *D Score*	8.2; 8.3
AdjDMD	*AdjD* minus *D*. A CS-based index calculated by subtracting the *D Score* from the *AdjD Score*, which delineates tendencies to develop anxiety symptoms in response to situational stress	7.1; 7.2; 8.2; 8.3; 8.4; 9.1; 9.2
Afr	*Affective Ratio*. A ratio, which compares the number of responses given to cards VIII–X to those of cards I–VII and relates to interest in emotional stimulation	7.1; 7.2; 8.1
AG	*Aggressive Movement* responses. Sum of responses coded with *AG* special score (e.g., *Two people fighting*), in which $AG > 2$ indicates proneness to be physically or verbally aggressive and $AG = 0$ points to impaired interpersonal functioning	8.2; 8.3; 8.4; 9.1; 9.2
a:p	*Active-Passive Ratio*. A ratio based on the number of active (*a*) as compared to passive (*p*) movement responses, which is associated with flexibility in thinking and active or passive attitudes	7.1; 7.2; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2

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Abbreviation	Description	Cases
Blends:R	*Complexity Index*. A ratio between the number of responses with multiple blot qualities (*Blends*) and the total number of responses (*R*), which delineates degree of complexity as compared to simplicity in functioning	7.1; 7.2; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2
CDI	*Coping Deficit Index*. Constellation index, based on 5 conditions, which reflects impaired interpersonal relatedness	7.2; 8.2; 8.3; 9.1; 9.2
Col-Shd	*Color-Shading Blend*. A response with color and shading determinants, which is included in both the *DEPI* and the *S-CON* as indicating lowered capacity to enjoy positive emotional experiences	7.2
COP	*Cooperative Movement*. Sum of responses, coded with *COP* special score (e.g., *Two people dancing*), in which a value of zero suggests difficulties in perceiving interpersonal relationships as positive and cooperative	7.2; 8.1; 8.2; 8.3; 9.1; 9.2
Const.	*Constriction Index*. A ratio based on the number of achromatic color responses (*C'*) as compared to the weighted sum of color responses (*WSumC*) and indicates excessive internalization of affect	7.1; 8.2; 9.1
D Score	*Difference Score*. An index, based on determinants, which provides information concerning the relationship between available resources (*EA*) and stimulus demands (*es*) as representing current stress tolerance and capacity for stress tolerance and control	7.1; 8.2; 8.3; 9.1
DEPI	*Depression Index*. Constellation index, which is based on 7 conditions referring to affective functioning and self-perception, and reflects elevated subjective distress if five of the conditions are checked, and psychopathological affective functioning if six of the conditions are checked	7.1; 7.2; 8.2; 9.1
DQv	*Developmental Quality Vague*. Sum of responses coded with v or v/+, in which the objects have no specific form demand and the articulation does not introduce a demand (e.g., *a cloud*), associated with lack of precision in attending to external reality	7.2
EA	*M+WSumC*. An index based on the sum of *Human Movement* (*M*) responses and the *Weighted Sum of Color responses* (*WSumC*), which indicates available resources for coping with experience	7.2; 8.1; 8.2; 8.4; 9.1; 9.2
EB	*M:WSumC*. A ratio between the number of *Human Movement* (*M*) responses and the *Weighted Sum of Color responses* (*WSumC*), indicating coping style	7.1; 7.2; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2;
eb	*Experience Base*. A ratio between the number of *Nonhuman Movement* (*FM+m*) responses, and those of shading and achromatic color, which indicates cognitive and affective experienced distress evoked by the stimulus derived from the stimulus	7.2; 8.2; 9.1

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Abbreviation	Description	Cases
Egoc. Index	*Egocentricity Index*. An index based on the proportion of *Reflections (Fr + rF)* and *Pair* (*2*) responses in the protocol, which relates to self-focusing	7.1; 7.2; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2
EII-2	*Ego Impairment Index 2nd Version*. A CS-based index, composed of 7 cognitive and interpersonal variables that are multiplied by empirically-based coefficients, which distinguishes between healthy and impaired personality functioning	7.1; 7.2; 8.1; 8.4; 9.1; 9.2
FC:CF+C	*Form-Color Ratio*. A ratio between the number of form-dominated color responses (*FC*) and the sum of color-dominated and *Pure Color* responses (*CF+C*), which indicates capacity of affect modulation	8.2; 8.3
Fd	*Food* responses. Sum of responses, coded with *Fd* content, which indicates dependency needs	7.2; 8.1; 8.3; 8.4; 9.1
FD	*Form Dimension*. Sum of responses coded with *FD* determinant, for perceiving the blot as indicating dimensionality based on form features, which relates to one's capacity for introspection and psychological mindedness	7.2; 8.1; 8.3–9.1
FM+m	*Animal Movement* (*FM*) and *Inanimate Movement* (*m*) responses. Sum of responses coded with *Nonhuman Movement* determinants, indicating intrusive thoughts and internal tension respectively	7.1; 7.3
H:(H)+Hd+(Hd)	A ratio based on the proportion of whole and realistic human figures seen across cards as indicating an integrative view of people	7.1; 7.2; 8.2; 8.3; 9.1; 9.2
Human Content	*Human figure responses*. Sum of *H*, (*H*), *Hd*, and (*Hd*) contents, indicating interest in people	
HVI	*Hypervigilance Index*. Constellation based on absence of Texture (*T*) responses, and 7 other conditions, which indicates when positive a paranoid-like frame of reference	7.1; 8.3
INTELL	*Intellectualization Index*. Sum of *Abstract* (*AB*) special score multiplied by 2, plus *Art* and *Ay* contents, indicating the use of intellectualization as a defensive strategy	7.1
L	*Lambda = F/(R-F).* A score based on the number of pure form (*F*) responses, divided by the number of responses with determinants other than *F*, representing openness to experience	7.1; 7.2; 8.1; 8.2; 8.4; 9.1; 9.2
Lv2	*Level 2 Special Scores*. Sum of responses coded with *DV2*, *DR2*, *INCOM2*, or *FABCOM2*, indicating disordered thinking	7.1; 8.3; 9.1; 9.2
M-	*M minus* responses. Sum of *Human Movement* (*M*) responses coded with *Form Quality minus* (*FQ-*), indicating misperception of people and interpersonal relationships	7.1

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Abbreviation	Description	Cases
Ma:Mp	A ratio based on comparison between the number of *Active* (*a*) to *Passive* (*p*) *Human Movement* (*M*) responses, which represents the dominate style of thinking (active vs. passive) about one's own experience	7.1; 7.2; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2
MOR	*Morbid* responses. Sum of responses coded with *MOR* special score, which refers to images of dysphoric emotions and/or damaged objects, representing pessimistic thinking and/or lowered self-perception	7.1; 7.2; 9.2
P	*Popular* responses. Sum of responses coded as *Popular* (*P*), which indicates the extent of conventional perception	7.2; 8.4; 9.1
PER	*Personalized* responses. Sum of responses coded with *PER* special score, which communicates personal experience in formulating a response, and reflects defensive, authoritarian, or narcissistic dispositions	7.2; 8.1
PTI	*Perceptual Thinking Index*. Constellation index, which is composed of 5 conditions involving the cognitive Special Scores and *Form Quality* variables, and has implications for psychotic-like functioning	7.1; 9.2
Pure C	*Pure Color* responses. Sum of responses in which the percept is based on color only, representing affective intensity and limited control of emotions	
Pure H	*Pure Human* responses. Sum of responses coded for real and whole human figures, indicating presence of integrative human representations	7.2; 8.3; 9.1
R	Total number of responses in a given protocol, which indicates avoidance when lowered, and overwhelming mental states when elevated	7.1; 7.2; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2
Reflections	*Reflection* responses. Sum of responses in which symmetry is involved and the object is reported as being reflected (e.g., *A person looking in the mirror*), suggesting narcissistic dispositions	8.3
RFS-2	*Reality-Fantasy Scale Version 2.0*. A CS-based index, which operationalizes the psychoanalytic construct of potential or transitional space between reality and fantasy and provides the user with two derivations, *RFS-P* and *RFS-S* that delineate different psychopathological states	7.1; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2
S	*Space* responses. Sum of responses with *S* location code given to objects in which the white parts of the blot are used, representing oppositional attitudes and behaviors and/or internal emptiness	7.1; 7.2; 8.1; 8.3; 9.1; 9.2
S-CON	*Suicide Constellation*. Index based on 12 conditions ranging across different CS clusters, which delineates self-destructiveness	7.2; 8.3

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Abbreviation	Description	Cases
Sum T	*Sum Texture*. Sum of responses in which nuances of dark and light are used to indicate tactile qualities interpreted as indicative of attitudes toward interpersonal closeness and degree of dependency	
Sum V	*Sum Vista*. Sum of responses in which nuances of dark and light are used to indicate dimensionality and are interpreted as being related to self-criticism and low self-regard, frequently associated with guilt for one's own actions	7.1; 8.2; 8.3
W:D:Dd	*Economy Index*. A ratio, which presents the proportion of each of the location codes (*W, D, Dd*), associated with patterns of attention or processing the stimulus	7.1; 7.2; 8.1; 8.2; 8.3; 8.4; 9.1; 9.2
WDA%	*Form Appropriate Common*. The proportion of responses given to *W* and *D* areas of the blot, in which there is appropriate use of form features (*FQ* +, *o*, or *u*), associated with accuracy in perceiving commonly attended parts of reality	7.2; 8.2; 9.1; 9.2
WSum6	*Weighted Sum of 6 Special Scores*. Sum of all *Level 1* and *Level 2 Special Scores* plus *ALOG* and *CONTAM*, indicating disordered thinking	7.1; 9.2
X-%	*X-percentages*. Frequency of responses with *FQ-*, which refers to percepts that do not resemble the blot area or are uncommon in nonpatient samples, and indicates accuracy of perception and adequacy of reality testing	7.2; 8.2; 9.1; 9.2
XA%	*Form Appropriate Global*. The proportion of responses in which there is appropriate use of form features (*FQ* +, *o*, or *u*), associated with perceptual accuracy of both commonly and uncommonly attended parts of reality	7.2; 8.3; 9.1; 9.2
Xu%	*Unusual FQ percentages*. Frequency of responses with *FQu*, in which the appropriate use of form features includes uncommon object definitions, associated with one's commitment to conventionality	
Zd	*Processing Efficiency*. A difference score based on the frequency of responses in which organizational activity occurs (*Zf*), representing level of cognitive activity in organizing the stimulus field	8.3

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