

AN EXPERIMENTAL EXAMINATION OF THE SZONDI TEST AS
A CLINICAL TOOL

by

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Submitted to the Department of
Psychology and the Faculty of the
Graduate School of the University
of Kansas in partial fulfillment
of the requirements for the de-
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September, 1951

[1952]

ACKNOWLEDGMENTS

The writer wishes to express appreciation to Drs. H. Sargent, M. Scheerer, J. Chotlos, and A. Baldwin, for their generous advice and help with this research. Grateful acknowledgement is due the Szondi judges, Drs. E. Fromm, M. Harrower, W. Klopfer, and W. Lemmon, who offered their experience, time and effort.

Particular thanks go to the writer's colleagues, psychologists and psychiatrists at Winter Hospital and the Menninger Foundation, many of whom served as judges in the research and the rest of whom continuously stimulated and helped him with the technical and extra-technical problems intimately associated with a study of this sort.

Last, and most important, the author wishes to acknowledge with gratitude the help of his wife without whom this research could never have been carried through.

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CHAPTER I

INTRODUCTION

The Szondi, a new projective test which has become quite popular with clinical psychologists, is being used more and more as part of a battery of psychological tests in clinical work. Literature on the test is beginning to appear in the journals and, at this writing, at least fifty research projects using the Szondi are in progress in this country.

There is reason for such popularity. Rapaport (50), discusses the "criteria of projective tests" as follows:

"Projective tests have the boldly proclaimed aim to elicit, to render observable, to record, and to communicate the psychological structure of the subject, as inherent to him at any given moment, and without study of historical antecedents." (p. 8)

He states that the eliciting procedure must be simple, not time-consuming, not requiring time to develop a complex relationship between patient and examiner; the test must have a standard set of stimuli and a limited and specific procedure; the behavior to be elicited must be easily and fully recorded and scored.

The Szondi test fulfills the formal criteria completely. Some of its most publicized values are the ease of administration and the very short time needed for administration of the test. Its scoring and recording is clear and accurate.

But there are more important reasons for the popularity of the test than the satisfaction of the formal criteria and these are concerned with the clinical psychological value of the test. The

Szondi test¹ is said by Deri to have the purpose of reflecting

" . . . the personality as a functioning, dynamic whole. More specifically, it conceives of the personality as consisting of a number of need-systems (or drives) and reflects the quantitative distribution of tension in these specific need-systems plus the way the person handles these need-tensions Because the Szondi test--more than any of the other projective technics reflects the personality as a dynamic process undergoing constant fluctuations through the accumulation and discharge of the various need-tensions, the test is particularly apt to follow up and make visible certain psychodynamic changes, such as the psychologic changes during a paroxysmal cycle of epilepsy, or the effects of various therapeutic procedures." (14, p. 7, 8)

This statement of purpose may well be of extreme importance to the clinical psychologist and psychiatrist. A difference from other projective tests is implied. If the test reflects changes in the distribution of tensions within a personality then it may be possible to study the processes rather than cross-sections of the personality. Measuring progress in therapy might help us to improve as well as to evaluate our therapeutic procedures. The absence of verbal requirements also suggests other potentialities; for example, something might be learned about the psychology of the aphasic with whom we could use few other projective techniques.

The purpose of the present study is, in general, to investigate whether the Szondi test can accomplish what is claimed for it or not. This introductory chapter will be concerned with: 1) the basis for the claims made apropos the validity of the Szondi test; 2) a brief critical review of the research referable to the validity of the

1 The materials, administration procedure, and principles of interpretation of the Szondi test have been described extensively in Szondi (70), and Deri (14).

Szondi test; and 3) the need for the research here undertaken.

Szondi, the originator of the test, and Deri, its chief proponent, used as bases for their validation data the "factorial association experiments", genetic and occupational normative studies, and their conviction that the test "works".

The beginning research was done, of course, by Szondi (70). The basis for his choice of the particular eight categories (homosexuality, sadism, epilepsy, hysteria, catatonia, paranoia, depression, and mania) lies in his genetic theory which he calls "fate-analysis".² Szondi used the "factorial association experiment" to choose the specific pictures for the test in the following manner. Using pictures, from various books, of patients in the eight diagnostic groups listed above, he showed the pictures to subjects and asked for their associations. It was assumed that the pictures would direct the associations of the subject "to different drive areas which correspond to the character of the exposed picture." Szondi reports, "It has been proved that each picture actually directs the association of the subject into the drive area which corresponds to its specific factor." He used those pictures for the test which were "factorially specific" and discarded the others which were not.

Deri (14), also discusses the experiment of factorial association, and quotes a few illustrative examples selected "practically at random." She states that although the associations

² An exposition of the fate-analytic theory can be found in Szondi (71).

are not "proof in the strict sense of the word. . . .the verbal material gained by the experiment of 'factorial association' supports our theory in regard to the specific valence character of the eight factors in a rather direct way." (p. 23) She adds that the fact that the test "works" has to be accepted anyway as some sort of pragmatic proof of the theory.

There appear to be many deficiencies, from a systematic point of view, in both Szondi and Deri's work with the Association Experiment. For one, associations which have no limit set on them other than the stimulus are difficult to categorize. The tendency to see what one wants to see is always present when one deals with such qualitative, somewhat vague material. Neither Deri nor Szondi tells us the size of the population from which they drew their samples. They do not set down their method of analysis beforehand nor are their hypotheses stated clearly so that they are put to the test, at least partially, through the "experiment". They do not present, or attempt to understand, those associations which do not fit their interpretation. Deri's use of the term "practically at random" also leaves her results open to criticism. The point of criticism here is not that the data from the factorial association experiment are useless and valueless in helping us to understand how the test works. They are valuable; but dealt with unsystematically they cannot conceivably serve as proof of anything. And, since such work was the basis for the choice of the particular pictures used, the question as to whether these pictures, i.e., the test, serve the purposes claimed, remains unanswered.

Deri (14), includes additional information which is pertinent to the problem of validation. Throughout her discussion of the principles of interpretation, which is the major part of the book, she presents comparative data on genetic and occupational groups. Deri also distributed in mimeographed form norms for 2250 subjects from which the data in the book seem to have been taken. These norms are presented with no comments and with little systematization, so that their adequacy is hard to evaluate.

Deri is fully aware of the absence of rigorous quantitative validating data. She finds it necessary to say, "As it is, the acceptance of practically any of my statements about the meaning of the various factorial constellations is left to the good-will of the reader." (14, p. xi) This last statement has been referred to by almost all those who have reviewed Deri's book. Schafer (57), Margolet (39), and Meehl (41), were extremely critical of Deri's attitude about validation material. They felt that hers was an unsophisticated attitude and one that asks too much of the clinical psychologist. One must agree with these critics although the agreement requires qualification.

Empirical proof, usefulness by experienced and respected clinicians, and clinical evidence are important in evaluating the validity of a projective test. Adequate methods for establishing the validity of projective tests to the satisfaction of most psychologists have not been developed yet. Most of the procedures that have been attempted suffer from basic methodological difficulties. Deri and others have developed confidence

in the Szondi test through using it. In her book Deri tells how she uses the test and lays the groundwork for further research. However, she realizes the weakness of her book in the area of validation and suggests that she would welcome systematic studies of validation. Rapaport (49), who also placed emphasis on the importance of clinical experience in evaluating a projective test, said that the Szondi test ". . . was developed on the only lines possible for a projective test."

Since the publication of Deri's book in 1949, results of a few studies have appeared in the journals, and there is a great deal of research in progress. Knowledge of some current researches has been gathered through the Szondi Newsletter, and through personal correspondence with people doing research in this area. Many of the researches now in progress are concerned with finding Szondi "patterns." Studies are being done on criminals, girls in a state school to find an "institutional" pattern, psychological interns, five to six year old children, patients with organic brain disease, social workers, medical students, arthritics, stutterers, hypertensives, people with peptic ulcer, and the physically handicapped. There are studies reported in progress giving Szondi tests pre-and-post surgery for facial disfigurement, psychodrama sessions, reading a frightening story, therapy for children with behavior problems, treatment for alcoholism, and group therapy. There are Szondi tests being given to find the difference or similarity between seven-year-olds in progressive schools and seven-year-olds in public schools, early and late onset of brain disease, and

early and late onset of physical handicap. The personalities of epileptics, manifest homosexuals, and out-patients at a mental hygiene clinic are being studied through the use of the Szondi test.

With all this research activity it is surprising to find that, in spite of the lack of systematic validation of the Szondi test, much of the research being done is not pointed towards validation and, in fact, implicitly assumes that the Szondi is a valid test. The following are some of the studies which illustrate this point.

One study has the purpose of testing the theories of child development of Anna Freud, Piaget, Buhler, and Gesell.

"The problem is to show changes in personality structure as described by the Szondi from the pre-school level to early adolescence, the basic assumption being that the changes revealed should fit one developmental theory more adequately than any others." (35, p. 7).

Another research project uses the Szondi test in combination with sociometric devices. "...to see if persons within a psychopathic hospital will tend to choose as friends others of a similar personality pattern."

It is reported that a psychologist working at a state village is using the Szondi and "...feels that from it she is beginning to get results that correlate better with the success of the girl on parole than does the I. Q., or Rorschach, or Social Quotient."

3

Michaeli writes that she has completed profiles on approxi-

3 Personal correspondence, 1950

mately fifty psychiatrically diagnosed paranoid schizophrenics.

"Some interesting findings thus far are: (1) Paranoids for the most part show a normal pattern in the sex vector (f_h, f_s). (2) -d is prevalent, indicating that the basic problem is fixation on the primary love object. (3) Patients showing bizarre behavior rather than delusional or hallucinatory phenomena have open e, open hy more than 50% of the time. . . . (4) Paranoid schizophrenics who avoid hospitalization until their early forties run a consistently high f_m ."

Otto Deri (11), used the Szondi in a study which was designed to test the personality differences of subjects of 'pure' classical musical taste and subjects of 'romantic' musical taste. He concludes that,

". . .major differences were in the sexual area, furthermore in the 'k' and 'p' factors. The results bear out the hypothesis that subjects with classical taste repress their primary sexuality and preference for strict classical form goes with tendency for narcissistic introjection. While subjects with romantic taste do not deny their primary sexual impulses and show a more expansive and fluid ego-organization."

All these studies are using Szondi test results as the basis for psychological conclusions. The validity of the conclusions is, of course, dependent upon the validity of the test itself. The fact that the researchers make conclusions about personality from the Szondi test results points up the implicit assumption of validity.

There are a number of completed studies which more or less directly refer to the validity of certain of the basic assumptions underlying the rationale of the Szondi test, or have tested some of the interpretive principles Deri set down in her book.

Paine (44), attempted to investigate the validity of Deri's statements about intertest change, while trying to find quantifiable and scorable variables which might be useful in the interpretation of the Szondi test. He gave a series of six Szondi tests to each

of thirty chronic psychotic patients and measured the behavior changes of these patients by means of a rating scale. Test change, and behavior change were quantified and correlated. He reports, "There is no significant relationship between test change and change in the behavior of psychotic patients." (p. 113).

Fosberg (18), attempted to test certain of Deri's principles of interpretation and raised the following questions:

"(a) Does the Szondi test administered to patients before and after electrically induced grand mal seizures show a difference in the paroxysmal vector? (b) Does the Sex Vector scores of the Szondi Test differ when the test is administered after a sexual episode as compared with the test administered when no orgasm has taken place?" (p. 326).

To study question (a), he gave five tests pre-and-post shock to ten male patients. For question (b), twenty normal married men and women were given the Szondi test ten times. Five of the administrations were within twelve hours of a sexual episode, and five were given with a time lapse of forty-eight hours or more since the last sexual episode. For control groups, Szondi tests were given to fifty men and fifty women who were "normal" and to fifty men and fifty women who were NP patients in mental wards (majority diagnosed paranoid schizophrenic). He reports his results as follows:

"No significant differences were found (1) on comparing the distribution of the Szondi Paroxysmal factors before and after shock; (2) between NP controls and NP experimental groups; (3) between sex vector scores of pre-and-post orgasm tests; or (4) between normal controls and normal experimental groups. Conclusion: Szondi theory of decrease in selection of specific vector cards with discharge of tension in such areas is not substantiated." (p. 326-7).

Holt (30), attempted a validation study of the Szondi test by giving one subject a series of ten Szondi tests, each

separated by a week. Two more Szondi tests were administered after a period of three months. On the occasion of each Szondi testing the subject filled out a revision of the Horn Repeated Questionnaire. Holt concluded that the obtained correlations, on the one hand, supported Deri's statements about the meanings of some of the Szondi factors; on the other hand, he suggested modifications and additions to Deri's interpretive principles.

In another study, Holt stated that the validity of the Szondi test rests on the assumption that a person consciously or unconsciously reacts to significant aspects of each picture, related to the pathology present in the person photographed. He posed the question whether a person acquainted with kinds of pathology could recognize them from photographs. For this purpose he asked psychologists and psychiatrists unfamiliar with the test to go through the Szondi pictures and to diagnose each of the pictures, choosing a diagnosis from the eight represented in the Szondi categories. He found that the group as a whole made correct judgments significantly above chance expectancy. The manics and the homosexuals were diagnosed correctly most often, and the catatonics and epileptics least often.

Rabin (47), in a similar study, used the Szondi pictures as experimental material in the investigation of the ability of subjects to identify psychiatric diagnoses of patients from their portraits. His subjects were undergraduates who had had psychology courses, and a group of experienced clinical psychologists. He concluded,

"The number of pictures correctly identified as to diagnoses was significantly better than chance for both groups. About one-half of the forty-eight pictures was identified by large enough percentages of students and psychologists that differed significantly above chance. With the exception of the homosexual category, the psychologists were consistently superior to the students in their ability to identify the diagnoses from the pictures. Manics and homosexuals were most frequently identified correctly. Hysterics, catatonics and epileptics were most difficult to identify." (p. 395)

As a follow-up to this last study Rabin (48) had students make judgments at the beginning of a course in abnormal psychology and at the end of the course. He found significant differences in the correctness of judgment and concluded, "that the Szondi pictures as stimuli have some meaning" but that more investigation is necessary.

Klopfer (33), investigated the problem of the properties of the pictures by testing a group of college students to see if they consistently responded to the stimulus pictures by giving certain associations which could be considered as related to the dynamics described by Deri. Klopfer developed, with the aid of experts, a descriptive paragraph for each of the eight Szondi categories. He had students match each of the Szondi pictures with the descriptive paragraph that best described the person pictured. Part of the first group of students gave associations to all of the Szondi pictures. The associations were classified into the eight Szondi categories by a group of three judges, familiar with the Szondi test, who first classified the associations independently and then, after discussion, reached a group decision. From his results Klopfer concluded,

"It seems evident from the results of this study that the Szondi test is, at present, in a rather ambiguous situation. The assumptions made concerning the stimulus pictures are correct to an extent which would make one very loath to discard the present test pictures. On the other hand, the associative valences of the pictures, although present in forty-four of the pictures, agree with Szondi's designations only 50% of the time. Furthermore.. ..many of the pictures to which an associative label has been assigned on the basis of the present studies do not consistently produce such associations among subjects. This would certainly imply that the test in its present form lacks sufficient validity to be used routinely in clinical practice. The idiosyncratic associations produced by schizophrenics reflect on the use of the test in its present form among hospitalized patients."

Deri (17), recently published a study about which she said,

"The results of this one study, paradoxical as it may seem, furnish more convincing answers to a few general questions about the test--mainly regarding its validity and reliability--than would any detailed description of the theory underlying this projective method and the practice of interpretation. One may make this assertion with some conviction, for this is the first systematic study to be carried out in this country, it utilizes widely employed statistical methods for the treatment of the data, such as the significances of differences and the establishment of reliability by test-retest methods, and it is a good example of how the Szondi test may be used in clinical psychological research." (p. 299).

She gave Szondi tests pre-and-post electric shock to nineteen patients whose pre-shock symptoms were: depressed mood, guilt feelings, and self-accusation. Two control groups were given Szondi tests at approximately the same times. One group consisted of ten hospitalized patients; another of ten "normals".

Deri's original "hunch" - "...that the artificial seizures serve to release the depressed patients accumulated introverted aggression" (p. 304), was based on clinical experience and psycho-analytic theory. In terms of the Szondi rationale, Deri predicted that the most significant changes after shock treatment should be in

the "s" factor. Also,

"The 's' factor was expected to show a strong negative tendency before shock, and a change towards the plus direction after shock treatment was finished. Change toward 'plus' includes the change of becoming simply less negative or closer to 'open' reaction." (p. 306).

The results of the study showed that there was greatest change in the 's' factor, as predicted. There was no direct demonstration of how many of the subjects had originally strong minus 's' which changed in a plus direction, or how many subjects did not. However, by algebraically adding and averaging the choices, the 's' column is shown to have moved from minus to plus for the group as a whole.

In her discussion of the results, Deri states,

"The specific changes occurring in the experimental group after shock proved more than just the general fact that the choices are not due to chance, and that groups of subjects varying in their degree of emotional stability react to it differently. These changes asserted the validity of the more specific theory in regard to the principles involved in reacting to the pictures in the testing situation as stated above in connection with the general description of the test. On the basis of this theory the greatest qualitative changes occurring in the 's' factor after shock were predicted. Actually the 's' factor turned out to be the most changing one so far as changes in direction are concerned. The theoretical reasons for having expected the changes in the 's' column have been described previously." (p. 318).

Deri then uses the results of this research to support her theory of what happens, psychodynamically, to a psychotic depressive patient who receives shock treatment.

In attempting to evaluate the foregoing studies of the validity of the Szondi test from an objective point of view, one must be aware

of the methodological limitations in dealing with clinical psychological material. It would not be difficult to destroy almost all clinical psychological studies with the objection that they are not crucial studies and do not prove their points conclusively. However, many of the studies have inadequacies which are important to keep in mind in evaluating their results. Paine's study (44), for example, used behavioral changes as a criterion. There is real doubt whether Deri, or any other Szondi expert, would expect behavioral changes concomitantly with test changes. His essentially negative results, therefore, do not necessarily speak badly for the Szondi test.

In Fosberg's study (18), one must question whether he was justified in assuming the existence of tension in his subjects, pre-shock and pre-intercourse. Certainly the pre-shock patient cannot be compared to the pre-seizure epileptic in terms of inner tension. As to the pre-and-post intercourse tests on married people, one must wonder how much the need for intercourse organizes and influences the ordinary married man. Tension unquestionably would be present at the foreplay period and there would be release after orgasm. But Fosberg tested his subjects twelve hours and forty-eight hours after the last sexual episode. The conclusions from this study must be carefully evaluated. Holt's more general study (30), although nicely demonstrating some important methodological principles, is not well enough organized to contribute either positively or negatively to the question of the

validity of the Szondi test. His criterion measure, the Horn Repeated Questionnaire, is itself, admittedly, of doubtful validity.

Klopfer's study (33), clearly points up the danger of generalizing from the conclusions of Szondi and of Deri. His conclusions, as he recognizes, suffer from a handicap in that his population was an extremely homogeneous one (composed of University of California students), and he grants that caution must be exercised in generalizing from his findings for other groups. Nevertheless, of all the studies, it appears that Klopfer's raises the most legitimate doubts about the validity of the Szondi test.

Deri's study (17), is not the model for research that she claims it to be. Her major error seems to be the use of inadequate results to support a rather general and all-inclusive theory. While she does predict the major changes in the 's' factor, - and this is encouraging, - she then finds it necessary to group her data and interpret the results of the group as she would an individual pattern.

Schafer's discussion on this point is appropriate:

"The majority of publications of test research takes for granted that traditional statistical techniques are adequate for the gathered test data. The techniques referred to center around establishing the significance of the difference between single score-averages (t-test) and the significance of the difference between single score-distributions (chi-square test). In both instances the single score is treated as the fundamental unit of the test results. Thus, there are many published studies comparing the average incidence of each of the Rorschach test scores in two or more groups. Significant differences between averages are then held to indicate significant and specific personality differences between the members of the groups involved. This procedure therefore implicitly assumes that a score retains the same significance regardless of the context in which it occurs.

Methodological confusion is further increased when the researcher tries to compensate for his initial disregard of individual score-pattern by interpreting the pattern of obtained averages. Thus the Rorschach test scores of a group may be averaged and the table of averages then interpreted as if it represented the individual scores of the 'typical' group member. Furthermore, how is one to establish the specific shading of meaning of a group average if not by the circular method of borrowing from current clinical theory about the personalities of members of the group? The faulty logic of this approach is so striking that it is difficult to see how it can be implicit in so many publications." (56, p. 331)

Another group of studies, the results of which bear less directly on validity, are concerned with the necessary assumption that the pictures within each group are of equal "stimulus value." It should follow from such an assumption that there would be no popular choices, and that cultural and sex differences do not influence the choices of the testee.

There seems to be little doubt among Szondi workers that certain pictures are more popular than others. Harrower, for example, showed that there were "virtually identical" choices in spite of differences in type of presentation of the test (group or individual), or the illness or normalcy of the testees. Gardner compared the choices of a group of doctors interested in psychiatry with those of hospitalized patients and found rank difference correlations ranging from .83 to .88. Borstelman, with Klopfer (33), decided that in order to control the factor of popularity it was necessary to regroup the pictures in presenting them to a subject. David (9), Rabin and Kassiff (46), and, at one point, Deri (16), all note the presence of popular choices.

Spitz (61), gave a series of ten Szondi tests to 110 children

five to seven years old. She reported that the children were easy to test and liked the photographs except that the people with beards "were nearly always disliked."

Gardiner⁴ reports cases where the patients chose all the women as "dislikes", some of whom verbalized this as the reason for their choices.

The results reported above throw serious doubt on the validity of the principles of interpretation suggested by Deri. It would seem to be necessary that the psychopathological dynamics of the persons pictured be communicated in some way to the testee and be the sole basis for his choices.

Still another group of studies attempts to compare Szondi data with case history data. In some cases Rorschach information was added. In her book (14), and in an article (15), Deri offers a number of Szondi interpretations with collateral clinical information. These samples are expressly selected to make a point. Calabresi (5), presents three cases for the purpose of illustrating the use of the Szondi test in the description of personality. Rapaport (49), approached this problem in a somewhat more controlled manner by presenting a "routine" test report, prepared without any knowledge on the part of the examiner of the psychiatric history of the patient, and a brief clinical summary supplied by the patient's analyst. A "blind" analysis of a Szondi record was done by Deri (16), and presented with "blind" analyses of many other experts using other projective techniques. In none of these more "clinical" studies was there any attempt to systematically compare

⁴ Personal communication, 1950

the descriptions from the different sources.

In light of the above review it seems safe to conclude that the validity of the Szondi test has not, as yet, been adequately demonstrated. Actually there is no one systematic study which can report unqualified support for the validity of any of the interpretive principles set down in the literature. On the contrary, the results of some of the researches seem to point toward the lack of validity. Yet, many competent clinical psychologists, who have used and have done research with the Szondi test, express confidence that the test "works" in practice. These clinicians include, Harrower (26), Guertin (24), Rapaport (49), and Deri (17). It seems clear that there is a strong feeling that the test "works" and that the test is useful.

The absence of systematically adequate validity studies coupled with the conviction that the test works and is clinically useful is as true of the Rorschach as it is of the Szondi test. Concern over the inadequacy of the methods for demonstrating the validity of projective tests has been expressed in much recent literature, and some writers, particularly Mensch (42), Cronbach (7, 8), and Zubin (75, 76, 77), have reviewed the methodological problems at length. It is conceivable in the case of the Szondi test, and taken for granted by many in the case of the Rorschach test, that the relative failure of the attempts at validating may well be due to methodological inadequacies rather than to the invalidity of the tests themselves.

The purpose of the present study is to attempt to approach the validity of the Szondi test with a relatively new method which promises the solution of some of the important methodological problems which have confronted the clinical psychologist in his research efforts.

In the attempt to evaluate the validity of the Szondi test this study proposes to investigate the following questions:

1. How do inferences about personality made on the basis of Szondi test results compare with inferences based upon sources of clinical judgment recognized generally as the "most useful" in the field, e.g., a battery of psychological tests, and clinical psychiatric knowledge?

2. Are inferences made on the basis of Szondi test results by different qualified and experienced psychologists adequately in agreement?

3. Are inferences made on the basis of Szondi test results relatively more effective with regard to some areas of personality structure or function than others?

4. Is it possible to draw more precise inferences about certain areas of personality structure or functioning on the basis of Szondi test results than on the basis of another single, more established, projective test?

CHAPTER II

METHOD AND PROCEDURE

The questions with which this study is concerned require particular characteristics of the method used. The method must be designed to deal with qualitative data since all our data will be "inferences about personality" rather than quantities, i.e., scores. It must allow for the comparison of one set of inferences with another. It must allow for the investigation of various aspects of personality structure and functioning, permitting these aspects to be viewed in the context of the total personality. And, of course, it must be capable of allowing all these with an acceptable degree of scientific rigor. These requirements are not easily satisfied, and all have been problems of major proportion for clinical psychological research.

The basic method used in the present study is the "Q"-technique, developed by William Stephenson (62, 63). The Q-technique appears to fulfill to a large extent the requirements of method stemming from our problem. Unlike the usual type of analysis where traits or tests are correlated, it allows one to correlate qualitative descriptions of persons. One can analyze personality traits viewing each trait in the context of the total personality.

Stephenson says,

"Relativity of parts is involved, and not a butcherlike pre-occupation with overall sizes as such. It is this matter of internal relationships that Q-technique represents in a systematic manner.

It does so by defining universes of observable characteristics, the significance of whose parts, relative to one another, makes it possible to describe personality, or aspects of it. . ." (67, p. 27)

To use the Q-technique a "trait-universe" must first be defined. "Trait-universes consist of innumerable 'units of behavior'", or, one might say, a definite group of statements used to describe people. A trait-sample is then randomly drawn from the trait-universe and this sample is used to describe the people to be studied. The trait-universe is, statistically speaking, the population. Stephenson states,

"Any personality can then be represented in terms of the sample, by giving high scores for traits which characterize it, and low for those which do not do so. If we assume that, for such a random sample, the mean score for the sample of traits will not differ much from personality to personality, and that the scores given to the large sample of traits will tend to be normally distributed, the conditions at once exist for the reduction of data to standard scores, and for applications of the product-moment correlation coefficient." (66, p. 215)

Two trait-universes were defined for the present study: First, one trait-universe was defined as all the statements descriptive of people made by Susan Deri in her book, "Introduction to the Szondi Test." More specifically, the experimenter extracted from Deri's discussion of the various factors and combinations of factors all statements which could be considered, on any level of abstraction, descriptive of personality. The wording of some of the statements was changed in order to clarify them and to correct those which were taken out of context. At all times the effort to retain Deri's exact meaning was maintained. After duplications were eliminated, the remainder of the statements were used as the Szondi

trait-universe.¹ The choice of the Deri book as a source for the first trait-universe allowed us to limit the study to those "traits" of personality about which it is claimed the Szondi test can contribute pertinent information.

The second trait universe was defined as all the statements descriptive of people made by Roy Schafer, in interpreting Rorschach tests, in his book, "The Clinical Application of Psychological Tests". (55) This Rorschach trait-universe² was developed in the same way as the Szondi trait-universe. A Rorschach trait-universe was felt to be necessary in order to compare the inferences from the Szondi and Rorschach tests. One of the basic questions raised in this study concerns the comparison of the Szondi with another test and the Rorschach was chosen as the test most similar in purpose. The choice of the Schafer book as a source of the Rorschach trait-universe stems, in part, from the background of the clinicians who were chosen to use the Rorschach as their basic data. All those psychologists were trained, or have worked for a long period at Winter Veterans Administration Hospital. Schafer, too, comes out of the Winter Hospital-Menninger Foundation environment.

A sample of seventy-six statements was drawn at random from each trait-universe and both trait-samples were used by all clinicians in describing each patient.³ Stephenson says,

1 Hereafter referred to as S.T.U.

2 Hereafter referred to as R.T.U.

3 The trait-samples are in Appendix A. The items of the S.T.U. were numbered 1 through 76; those of the R.T.U., 101 through 176.

" . . . where the distributions are acceptably normal, I follow the practice of requiring all assessments to conform to one frequency distribution, the standard deviation of which is fixed by the size of the sample of traits, so that the means and standard deviations are the same, respectively, in all the personalities under examination." (67, p. 30)

In the present study, the raters were asked to sort each sample of seventy-six statements into eight groups, and the judgments were weighted so as to normalize each distribution and to equate the means and standard deviations of each of the statistical personality descriptions.⁴

The raters were four groups of experienced clinicians, and each group used a different source of information about the persons whom they described. Group 1 was made up of four Szondi experts. Since the Szondi is the point of the study and a relatively new test, it was felt to be important that the Szondi data be interpreted by people who are generally recognized as experienced and skilled with the test. The four experts were asked to describe by the Q-sort method each of the four patients used in the study. The information from which they were to gain their knowledge of the patient was a series of ten Szondi psychograms and the age and sex of the patient.

In order to evaluate the usefulness of the Szondi test as a clinical tool it was felt necessary to compare the descriptions of personality made on the basis of Szondi test results with descriptions of personality which are considered to be the most useful descriptions of personality we have. The next two groups were

4 The instructions given the raters are in Appendix B.

chosen as these "criterion" groups. Group 2 was composed of psychiatrists who had known the patient through a group control for a period of six months.⁵ Each of the four patients was described by a different group of psychiatrists. Two of the groups were in their second year of training and two in their third, and last, year of training. For each patient all the members of the group control, including the therapist and the leaders, made descriptions. All of the leaders have had psychoanalytic training and two of them are training analysts.

The other criterion group, group 3, was made up of experienced psychologists who made their descriptions on the basis of the results of a battery of tests, including the Rorschach, Thematic Apperception, Wechsler-Bellevue, and Word Association tests. A total of nine psychologists participated in the research, seven of whom described two patients and two of whom described one. Of the nine psychologists there were three members of the Menninger Foundation psychology staff, three members of the Winter Hospital psychology staff, and three fourth year trainees of the Veterans Administration training program in psychology of Kansas University-Winter Hospital. All of the psychologists had extensive training

⁵ Group controls are part of the advanced training for psychiatrists of the Menninger Foundation School for Psychiatry. In group controls a psychiatrist presents notes of his therapeutic hours with a patient and the notes are discussed weekly with a group of the therapist's peers and a more experienced psychiatrist who is the leader.

and experience with the tests used in the battery.

Group 4 was the same people as group 3. Their descriptions, however, were made on the basis of a Rorschach test alone. The psychologists making up group 3 and 4 were given the battery of tests with the Rorschach test separated and were instructed to first describe the patient on the basis of the Rorschach test alone and then on the basis of the Rorschach plus the rest of the test battery. The use of the Rorschach test alone was for the purpose of having a single test with which to compare the ratings of the Szondi judges as well as to compare the different areas of personality best understood through the use of the two different tools.

The patients used in the study were four patients at Winter V.A. Hospital who were receiving intensive individual psychotherapy and whose therapy was being discussed and directed by group controls. The basis for choosing the patients was two-fold: first, that the patient should be known by many psychiatrists, and, second, that the patient should be available for testing. The four patients were Miss W.L., 31 years old; Mr. T.P., 33 years old; Mrs. M.V., 24 years old; and Mr. R.W., 33 years old.

All the tests were administered by the writer.⁶ The Szondi tests were administered in accordance with instructions given by Deri. For each patient Szondis were given on ten successive week days; the rest of the test battery was administered at the same time. The Rorschach, Thematic Apperception, Wechsler-Bellevue,

6 A fourth year trainee in the Kansas University-Winter V.A. Hospital clinical psychology training program.

and Word Association tests were administered and scored as suggested by Rapaport. There was no attempt at any particular standardization of the test situation. For one of the patients, Mrs. M.V., a request for testing had been made by her therapist and she was tested in line with this request. The other three patients were asked by their therapists if they would mind participating in some research. It is the examiner's evaluation that all the patients were strongly involved with the testing.

In this study, many different clinicians using a common set of concepts described patients, and their descriptions were to be compared. It seemed important that the question be raised as to whether these clinicians all had an adequately similar understanding of the statements, i.e., all meant the same thing when they used the same statements. Grayson and Tolman (23) in their recent study of psychological concepts used clinically, state, "The most striking finding is the looseness and ambiguity of the definitions of these terms." They add that "the semantic confusion is a product of the vagueness of our present grasp of deep psychological meanings, a vagueness shared alike by psychiatrists, psychologists and authoritative sources." (p. 229)

It should be recognized that, in our present state of knowledge, there can probably be no absolute agreement on the meaning of dynamic psychological terms. Grayson and Tolman do suggest, however, that the vagueness did not seem likely to result in

conflict between the psychiatrist and psychologist. This may indicate that in spite of the vagueness there is a general agreement about the meaning of psychological terms. In addition, all except the Szondi judges are part of the Menninger Foundation-Winter Hospital milieu and have an essentially psychoanalytic orientation. Second, Deri and Schafer both have a basic psychoanalytic approach and all the Szondi raters know and use Deri's formulations in dealing with the Szondi test. Third, some training of the new raters was attempted; all the clinicians, with the exception of the Szondi raters and the leaders of the group controls, were "trained" in the following way. The first time the experimenter saw the raters he gave them a list of all the statements in the two trait-samples, i.e., all the statements they would use in describing the patients. The raters were asked to read the statements and to mark any that had no meaning for them, or that they could not use or "emphathize" with. At a second meeting the experimenter discussed with the rater all of the statements the rater had questioned until the rater was satisfied that he could use the statement meaningfully. At this second meeting, too, the material and instructions for the description of the patients were distributed. An instruction sheet was left with the rater for his reference. It was felt that the basic similarity in orientation plus the training would bring about an adequate agreement as to the meaning of the statements.

To sum up the experimental design of the study: the trait-sample is the population; the judges are the variables; and each patient is a different experiment. Since all the raters used both the trait-samples, there were a total of eight experiments, each having a population of 76 and at least 16 variables.

CHAPTER III

RESULTS

Q-technique personality descriptions comprised all of the basic data of these experiments. These data were analyzed in two ways: correlational analysis; and item, or "trait" analysis. It was expected that the correlation analysis would throw light upon questions 1 and 2, namely, the comparison between the Szondi and the criteria, and the reliability of interpretation of the Szondi test. The results of the item analysis were to reflect upon questions 3 and 4: the areas of personality for which the judgments made on the basis of the Szondi results were closely and distantly related to the criteria judgments, and the comparison (in terms of areas of personality) of the Szondi and Rorschach tests. The correlational analysis would provide quantitative results while the item analysis was to add qualitative material.

Correlation Analysis:

Eight correlation matrices were obtained, there being two trait universes used for the description of each of the four patients. Each matrix was made up of the product-moment intercorrelations between all the raters for each of the eight patient-trait universe units. In Appendix C, these matrices are presented in Tables 8 to 15, with the means of each of the experimental groups of each matrix in Tables 16 to 23. Table 1, (p. 30) presents these means in summary form. For example, the

TABLE 1

Mean intercorrelations between rater groups										
Correlated Groups	Patient				Overall					
	W.L.		T.P.		M.V.		R.W.		Mean	
	S	R	S	R	S	R	S	R	S	R
Szondi- Clinical	14	25	09	13	09	11	08	12	10	15
Rorschach- Clinical	01	07	35	29	21	25	07	14	16	19
Szondi- Battery	05	13	25	33	17	12	10	20	14	20
Szondi- Szondi	28	27	24	40	33	26	25	38	28	33
Rorschach- Rorschach	03	31	31	19	25	34	30	34	22	30
Battery- Battery	22	23	47	43	38	44	30	33	34	36
Clinical- Clinical	42	44	45	46	46	51	36	33	42	44
Battery- Clinical	15	20	32	31	38	31	23	24	27	25
Rorschach- Szondi	06	11	07	12	19	18	02	22	09	16

1. S is Szondi trait universe; R is Rorschach trait universe.

Note: The decimal point has been omitted in front of all the figures, all figures being hundredths.

means of the intercorrelations between the Szondi and Clinical raters using the S. T. U. to describe patient W. L. is .14.

Table 1 shows that the overall mean intercorrelations between the Szondi judges and the Clinical judges are .10 and .15 for the two trait universes; the Szondi-Battery overall mean intercorrelations are .14 and .20. In and of themselves, these validity coefficients appear to be too low to give support to the claimed validity of the Szondi test. However, the overall mean intercorrelations between the Rorschach and Clinical groups are .16 and .19, which is strikingly similar to the Szondi correlations with the same criteria.²

For the individual experiments, the Szondi-Clinical intercorrelations for both trait universes were significantly higher than the Rorschach-Clinical intercorrelations for patient W. L.; while the opposite was true for patients T. P. and M. V.; there was no significant difference between the Szondi-Clinical and Rorschach-Clinical intercorrelations for patient R. W.³

2 The Rorschach-Battery correlations could not be used for comparative purposes since the Rorschach was part of the battery, and the same raters judged from the battery as did from the Rorschach alone, thus confounding the correlations. These correlations are reported, however, in Appendix C, Tables 8 to 23.

3 Significance of difference was tested by using formula 9 in Lindquist (37, p. 51), treating the z-transformations as scores. All significant differences reported are at the 1% level of confidence.

The reliability of interpretation of the Szondi test is represented by the intercorrelations between the Szondi raters themselves. The overall means of these intercorrelations are .28 and .33. The reliability coefficients for the Rorschach test were .22 and .30, not very different from the Szondi test reliability coefficients.⁴

Item Analysis:

The individual traits were analyzed in the following manner: for each trait-patient unit the mean of the judgments of each rating group, i.e., the Szondi, Rorschach, Battery, and Clinical rating groups, was obtained.⁵ For example, for patient W.L. trait 1 was given weights (from 1 to 8 in terms of its salience) by the four rater groups and the mean of each group's ratings was determined. Therefore, for each trait-patient unit there were four means, one for each rater group. These group means were used for all aspects of the item analysis.

To approach question 3, which concerns the relationship between the Szondi ratings and the criteria in terms of particular areas of personality, the trait mean ratings of the Szondi

4 It should be noted that the trait universes do not systematically influence the results. It had been expected that the S.T.U. would favor the judgments from the Szondi test and the R.T.U. the judgments from the Rorschach test. Actually, the R.T.U. produced, in general, higher correlations for all rating groups.

5 I.B.M. machines and service were used to obtain these means.

judges were compared with the trait mean ratings of the two criterion groups, the Clinical and Battery judges. The differences between the Szondi mean ratings and the Clinical mean ratings were obtained for each trait for each of the four patients. The four differences for each item were summed and the sums of the differences ranked. The same procedure was used for the comparison of the Szondi and Battery group ratings. Those nineteen items which had the smallest difference sum were considered as having closely related judgments, whereas those nineteen items with the greatest difference sum were distantly related.⁶ Tables 2 and 3 (pp. 34-36) list the items for which the Szondi group agreed with both of the criterion groups. The less significant results of this analysis are shown in Appendix D, Tables 24 to 26.

On inspection of Tables 2 and 3, there appeared to be dissimilarity in terms of two general psychological realms represented in the two tables. These areas of psychological commonality were identified as Impulse Discharge-Aggression, and Subjective Feelings. The procedure for the further analysis of these data was as follows: the experimenter and two members of the Winter Hospital staff abstracted from the total trait universe all the traits that, in their judgment, belonged in the psychological realms named above. Any trait that was included

⁶ Nineteen items are 25% of the total of seventy-six items in each trait universe. Thus the top and the bottom quartiles were used as points of differentiation.

TABLE 2

Items on which the mean Szondi group ratings were closely related to the mean ratings of both criterion groups.

1. He has feelings of helplessness.
26. He actively rebels against the "rigid resistance" of the environment.
32. His level of aspiration is higher than his level of achievement.
49. He is guilty and over-critical of himself.
55. He is both physically and psychically restless.
72. He has a tendency toward rivalry.
76. He is anxious with the fear that he will lose his material possessions.
105. He is apathetic in his object relations.
111. He has a subjective feeling of separation from the world.
121. He has a paranoid anticipation that others will unjustifiably question his sincerity and that he must therefore prove them wrong at once.
126. When his impulsiveness does appear, he is quick to defend himself but also careful not to get in deeper.
141. He overuses projective mechanisms.
160. He has feelings of inadequacy.
161. He has a basically terrified reaction to the world.
170. He suffers from a persisting anxiety state of the dull, oppressive, restless, vaguely uneasy variety.
176. He has feelings of worthlessness.

TABLE 3

Items on which the mean Szondi group ratings were distantly related to the mean ratings of both criterion groups.

5. He has doubts--perhaps even conscious--about his sexual identification.
6. He actively, even aggressively, goes after the things he wants.
8. He is passive, even "feminine", in his relation with love objects.
13. His aggressions are turned against himself. (masochistic tendencies) (depressive tendencies)
19. He is a rigid person in an over-controlled way.
21. He is an immature person.
24. He likes to help people, though one gets a feeling of hidden aggression (reaction formation).
37. He tends to be somewhat exhibitionistic--he likes to "play a role".
39. He has qualities of a moral masochist.
43. He has a low frustration tolerance.
73. He is passive and submissive in interpersonal relationships. (feminine identification)
103. He does things the easy way.
109. He directs his aggressiveness against himself.
110. He denies aggression.
119. He is moralistic.
128. He has a weak capacity for thoughtful delay of impulses.
143. He is overcautious in his object relations.

TABLE 3 (Cont'd)

- 145. He makes rigid, compulsive efforts to remain on an abstract, all-inclusive level of thinking.
- 148. Self-expressive responses are inhibited and pushed into the background in emotionally disturbing situations.
- 152. There is no basic impairment of reality testing but critical restraint is not applied extensively enough.
- 164. He is a self-assertive person.

by two or three of the judges was said to be part of the realm for the purposes of additional analysis.⁷ The Szondi mean ratings were closely related to the mean ratings of one or both of the criterion rater groups on 13.5% of the thirty-seven Impulse Discharge-Aggression items, and were distantly related on 64.9%; there was an equivocal relationship on the remaining 21.6% of the items. For the twenty-four Subjective Feeling items, the Szondi ratings were closely related to the criterion ratings on 70.9%, were distantly related on 8.3%, and had an equivocal relationship on the remaining 20.8%.⁸ These relationships, with other results, are summarized in Tables 6 and 7 (pp. 46-48).

In attempting to answer question 4, the comparison of the Szondi and Rorschach tests, two forms of analysis were used. First, the mean Rorschach trait ratings were compared with the psychiatrists ratings by the same method as that used in the Szondi-Clinical comparison. The results of this analysis (items on which the Rorschach ratings were closely and distantly related to the Clinicians ratings) are listed in Tables 4 and 5 (pp. 38-41). These listings were inspected but no striking

7 The items included in psychological realm labeled "Impulse Discharge-Aggression" were: 4, 6, 13, 19, 20, 24, 26, 27, 30, 34, 37, 39, 43, 46, 53, 54, 60, 67, 70, 72, 108, 109, 110, 112, 113, 114, 119, 126, 128, 138, 148, 149, 163, 164, 166, 173, 174. In the psychological realm labeled "Subjective Feelings" were items 1, 12, 17, 23, 29, 34, 35, 36, 49, 50, 62, 74, 76, 104, 111, 118, 120, 134, 136, 160, 170, 172, 176.

8 Use of the Chi Square technique demonstrated that both these distributions are significantly different from normal expectancy, and significantly different from each other, at less than the .01 level.

TABLE 4

Items on which the mean Rorschach group ratings were closely related to the mean ratings of the Clinical raters.

21. He is an immature person.
22. He resists change.
29. He does not display or act out his emotions but rather feels them as an inner, subjective experience.
32. His level of aspiration is higher than his level of achievement.
37. He tends to be somewhat exhibitionistic--he likes to "play a role".
38. His constant showing off is too obvious and tinged with anxiety.
40. He is hypochondriacal (in the popular sense).
43. He has a low frustration tolerance.
49. He is guilty and overcritical of himself.
51. He constantly has his need for passive recipiency of love gratified.
55. He is both physically and psychically restless.
57. He accepts his passive and submissive needs.
58. He is extremely sensitive in his reactions to even slight environmental cues.
59. He is adolescent-like.
61. He likes physical activity.
69. At times he recognizes and at times he denies his passive needs.
71. He seems to recognize his own emotional processes and is willing to face them.
72. He has a tendency towards rivalry.

TABLE 4 (Cont'd)

- 76. He is anxious with the fear that he will lose his material possessions.
- 102. His thinking tends to be circumstantial.
- 104. He rarely experiences an urgency about things.
- 106. He is unable to apply his assets constructively because of his passive, narcissistic orientation.
- 110. He denies aggression.
- 111. He has a subjective feeling of separation from the world.
- 116. He is a narcissistic person.
- 117. A good part of his phantasy is taken up with glorified images of himself.
- 121. He has a paranoid anticipation that others will unjustifiably question his sincerity and that he must therefore prove them wrong at once.
- 126. When his impulsiveness does appear, he is quick to defend himself but also careful not to get in deeper.
- 128. He has a weak capacity for thoughtful delay of impulses.
- 133. He is concretely oriented.
- 135. He is a naive person.
- 142. He is overalert.
- 146. Frivolity is alien to his self-conception.
- 147. He has doubts about his sexual identity.
- 149. He has a potentiality for depressive mood swings.
- 156. He is characteristically overcompliant in his interpersonal relationships.
- 160. He has feelings of inadequacy.
- 162. He is a sensitive person.

TABLE 5

Items on which the mean Rorschach group ratings were distantly related to the mean ratings of the Clinical raters.

4. He feels things strongly but he cannot express his feelings easily.
7. His attitudes are extremely negativistic.
13. His aggressions are turned against himself. (masochistic tendencies) (depressive tendencies)
16. His intellectual interests are too widespread and all-inclusive to allow the systematic development of one given problem.
27. His impulses lead to immediate action of some kind.
30. He is a domineering, aggressive person.
35. He is concerned about how his actions affect other people.
36. He longs to be taken care of.
39. He has qualities of a moral masochist.
41. He organizes the world in an autistically egocentric way.
42. He sees objects from the viewpoint of how much pleasure can be derived from them.
45. He is a moralistic person.
47. His "private" emotional life is inhibited and he is emotionally somewhat detached in everything he does.
50. He is very anxious with the fear that he will lose those who care for him.
52. He is a shy person.
54. He is guarded against emotional involvements.
60. He is capable of committing anti-social acts.
62. He constantly experiences free floating diffuse anxiety.

TABLE 5 (Cont'd)

74. He has a complex and relatively strong "character armor" which camouflages a great deal of subjectively felt anxiety.
101. He prefers to work with details rather than generalities.
115. He is a person whose thinking can be sharp and creative but who, consciously or unconsciously, is "holding back".
119. He is moralistic.
122. He is affectively labile.
124. He has strong oral needs.
125. He is a parasitic person.
127. There is a primitive quality about him.
137. He organizes the world in an arbitrary way.
144. It is difficult for him to cope with anxiety-arousing and affect-arousing situations.
150. He is an excitable person.
151. His critical controls are underemphasized or ineffectual.
154. He has obsessive characteristics.
163. He is an inhibited person.
164. He is a self-assertive person.
166. He has difficulty in coping with strong emotional experiences and tends to retreat to the safe and conventional in such situations.
167. He is often arbitrary in his attitudes and opinions.
168. He is a tense and anxious person.
172. He feels quite guilty.
173. His controls over aggressive phantasies are quite fragile and serve only to effect a slight delay.
174. He has sadistic tendencies.

dissimilarities appeared as in the case of Tables 2 and 3 (Szondi-Criterion relationship). In Tables 4 and 5 the data were analyzed, however, with reference to classification according to the categories Impulse Discharge-Aggression and Subjective Feelings. For 19% of the Impulse Discharge-Aggression items there was a close relationship between the mean Rorschach ratings and the criterion ratings, with a distant relationship on 32.4% of the items, and an equivocal relationship on the remaining 48.6%. For the Subjective Feeling items there were 20.8% close, 16.7% distant, and 62.5% equivocal. These data are also summarized in Tables 6 and 7.

In the second form of analysis, there were abstracted those items for which the mean Szondi rating was considerably closer to the Clinicians mean rating than was the mean Rorschach rating⁹; those other items for which the mean Szondi rating was considerably further from the Clinicians mean rating than was the mean Rorschach rating¹⁰; and those items on which the mean Szondi and Rorschach ratings were both in close agreement with the mean Clinical ratings¹¹. It is interesting to note that in this last form of analysis, in

9 Items 2, 4, 7, 12, 26, 47, 50, 52, 60, 101, 125, 136, 137, 138, 141, 163, 172.

10 Items 6, 8, 21, 24, 34, 37, 43, 73, 75, 109, 110, 119, 128, 139, 143, 146, 149, 174.

11 Items 11, 15, 25, 30, 32, 35, 36, 41, 48, 58, 69, 108, 112, 115, 118, 122, 126, 132, 153, 155.

which the Rorschach-Clinical relationship is used as a comparative measure for the Szondi-Clinical relationship, the close Szondi items are different from those for which the Szondi ratings had been closely related to the criterion ratings (Table 2). On the other hand, where the Szondi raters had differed with the criterion raters (Table 3), they continue to differ on many of the same items when the Rorschach-Clinical relationship is used for comparison.

One further type of item analysis was done with the purpose of attempting to isolate those traits which were not meaningful or useful to the various rating groups. Positively, an attempt was made to find a measure which would indicate that a rating group had used a trait with "confidence". For the purpose of such an analysis, a trait was said to have been used with confidence by a rating group if the mean rating of the rating group for the trait was below 3.00 or above 6.00, for at least one of the four patients described in the study. For example, if the mean of the Szondi raters for trait 1 fell in one of these extreme ranges for at least one patient, it was considered that the Szondi raters had used trait 1 with confidence, i.e., considered it useful for describing a salient characteristic of a patient.

There are a number of reasons for the adoption of such a criteria for "confidence". First, for the group mean to be so low or so high it was necessary that all four ratings cluster around the extreme rating with little variability. Second,

there was no way of evaluating whether an item rated between 3.00 and 6.00 was placed in this middle category because the rater felt that it belonged there or because the trait was ambiguous, meaningless, equivocal, etc. It remains possible that some of the items that never received an extreme mean rating may have been rated purposefully but there are many other factors which may have influenced such a rating.

The items which fulfilled the above-mentioned criteria of "confidence" for each rating group are listed in Appendix D, Table 27.

For the items in the psychological areas under particular examination, that is, items which refer to Impulse Discharge-Aggression and Subjective Feeling, the rating groups which demonstrated "confidence", in line with the above definition, are indicated in the summary Tables 6 and 7 (pp. 46-48). Results represented in Tables 6 and 7 may be summarized as follows: First, it is clear that for the Impulse Discharge-Aggression items there is a striking disagreement between the Szondi raters and the ratings of the criterion groups; and, for the Subjective Feeling items, the agreement is evident. For both these groups of items the results of the Rorschach-Clinical comparison are not as significant as the Szondi-Criterion comparison. Second, the "confidence" of the Szondi raters, as well as the psychiatrists, is loaded in the area of sharp disagreement, that is, on the Impulse Discharge-Aggression items. Of the thirty-seven Impulse Discharge-Aggression items, the Szondi raters were "confident"

on 78.4% of them and the Clinical raters 73% (Table 7). Consistent with this trend, where there is strong agreement between the Szondi and criterion judges, that is, on the Subjective Feeling items, "confidence" has been demonstrated on 25% of the items by the Szondi raters and 45.9% by the psychiatrists (Table 6).

TABLE 6

Subjective Feeling items analyzed by criterion agreement of Szondi and Rorschach ratings.

Trait No.	Szondi		Rorschach		"confidence" ¹²			
	A ¹³	D	A	D				
1.	x					r		c
12.	x						b	
17.	x						b	
23.	x							c
29.			x		s	r	b	
34.		x			s	r	b	c
35.	x				s	r	b	c
36.				x			b	c
49.	x		x		s			c
50.	x			x				
62.				x				
74.		x		x	s		b	c
76.	x							
104.	x		x			r	b	c
111.	x		x					
118.							b	c
120.	x							c
134.					s			
136.	x							
160.	x		x			r		c
161.	x							
170.	x							
172.	x			x				
176.	x					r		
Total-24	$\frac{x}{17}$	$\frac{\quad}{2}$	$\frac{\quad}{5}$	$\frac{\quad}{4}$	$\frac{\quad}{6}$	$\frac{r}{7}$	$\frac{\quad}{9}$	$\frac{\quad}{11}$

12 In indicating those groups which fulfill the requirements of "confidence" stated in the body of the paper, s, r, b, and c refer to the Szondi, Rorschach, Battery and Clinical ratings groups respectively.

13 The A (agreement) and D (disagreement) with the criteria are taken from the results of the analysis of the relationship of the two tests to the criteria. Only significant items (in the top or bottom quartiles) are plotted here.

TABLE 7

Impulse Discharge-Aggression items analyzed by criterion agreement of Szondi and Rorschach ratings.

Trait No.	Szondi		Rorschach		"confidence" ¹⁴		
	A ¹⁵	D	A	D	s	r	b c
4.		x		x	s	r	c
6.		x			s		c
13.		x		x	s		c
19.		x			s	r	b c
20.					s		b c
24.		x			s		c
26.	x					r	
27.				x	s		c
30.		x		x	s	r	b c
34.		x			s	r	b c
37.		x	x		s		
39.		x		x	s		
43.		x	x			r	b c
46.					s		c
53.						r	b c
54.		x			s	r	c
60.		x		x	s	r	c
67.					s		
70.		x			s	r	b
72.	x		x				
108.		x			s	r	c
109.		x			s		c
110.		x	x		s		
112.							b c
113.					s	r	
114.	x					r	b
119.		x		x	s		b c
126.	x		x				
128.		x	x		s	r	c
138.		x			s		
148.		x			s		c
149.		x	x		s	r	c
163.				x	s	r	b c
164.		x		x	s		c
166.	x			x			c

TABLE 7 (Cont'd)

173.		x		x			c
174.		x		x	s		c
Total-37	5	24	7	12	29	17	11 26

14 See foot note 12.

15 See foot note 13.

CHAPTER IV

DISCUSSION OF RESULTS

The results of this study will be divided, for purposes of discussion, into three parts. The first two parts will be concerned with the results of the correlational analysis and the item analysis, while the third part will consider some general implications of the earlier discussion for clinical psychological research. The discussion of the first two parts will be rather directly related to the results. The last portion will be more abstract, more distant from the actual data, and clearly speculative.

Correlational Analysis:

It seems justified to conclude from the results of the correlational analysis that the validity and reliability-of-interpretation of the Szondi test are no better and no worse than the validity and reliability of the Rorschach test. As Table 1 showed, the average validity coefficients of the Szondi test with the psychiatrists used as a criterion were .10 and .15 for the two trait universes; using the Battery raters as a criterion, the average validity coefficients were .14 and .20. The mean validity coefficients of the Rorschach test, using the psychiatrists as a criterion, were .16 and .19.¹ The differences between the Szondi and Rorschach validity coefficients were

¹ See footnote 2, Chapter 3, p. 31

obviously not significant. The coefficients of reliability of interpretation of the Szondi test were represented by the overall mean intercorrelations of all the Szondi raters. Those coefficients were .28 and .33 for the two trait universes. The Rorschach reliability of interpretation coefficients were .22 and .30, again not very different from the Szondi coefficients.

In studies of the validity of projective tests, a major problem is the adequacy of the criterion. The measures of the consistency of the criteria used in this study give some answer to this question. The overall mean intercorrelations of the Clinical raters was .43, and that of the Battery group, .35. However, the ratings of the Clinical groups were not independent. They had discussed the described patient with each other over a period of approximately six months. The Battery ratings, as well as the Szondi and Rorschach ratings, had been independent of discussion with the other raters. The results of an unpublished study² in which a group of thirteen psychologists, after having discussed a battery of tests weekly for over six weeks, had an average Q-technique intercorrelation of .48, may suggest the amount of inflation of the correlations between independent raters due to the factor of dependent judgments based upon group discussion. It would appear, then, that there is little difference between the measures of consistency of the two criterion groups,

2 By Greenbaum, N., Winter VA Hospital, 1950

and that the independent intercorrelations of either criterion might be represented by an average coefficient of about .35.

One cannot avoid being impressed with the low absolute values of the coefficients. Coefficients below .20 certainly do not satisfy one as supporting the validity of the Szondi test. However, certain qualifications should be made before these coefficients can be finally evaluated. First, although the Szondi coefficients are very low, they are not significantly different from the Rorschach coefficients. Second, the question must be raised as to how high a validity coefficient might have been expected in the present study. In examining the criteria it was seen that the consistency measures of the two most used sources of psychological knowledge about people are so low as to be hardly adequate for use as a criterion in a study of the validity of a psychological test by traditional means. If a coefficient of .35 represents the best relationship that can be expected under the conditions of the present study, then the average Szondi validity coefficient of .15 should be evaluated somewhat differently than when it is compared with the traditional aim of a (coefficient) of 1.00. In a relative sense, one might say that if the criterion approached a reliability of 1.00 then the Szondi validity coefficient would be considerably higher and would probably cause one to feel differently about the validity of the Szondi test than would a coefficient of .15.

Item Analysis:

The results of the item analysis of the data point up, in the first place, an important value of the Q-technique. For the items on which there was a particularly close or distant relationship between the Szondi and the criteria (Tables 2 and 3) there appeared to be consistent trends in terms of certain psychological areas (Tables 6 and 7). It was seen that for the area, Subjective Feelings, there was a significantly close relationship between the Szondi and the criterion raters; there was strikingly little agreement between the two rating groups for items concerning the area, Impulse Discharge-Aggression. These systematic relationships are, in one sense, a breakdown of the overall correlation coefficients. For example, if the trait universe included only statements referring to Subjective Feeling it is probable that the Szondi validity coefficients would have been considerably higher. On the other hand, traits concerned with Impulse Discharge-Aggression tended, in this study, to lower the validity coefficients considerably. More is also learned about the reliability-of-interpretation coefficients through the analysis of the items in which the raters demonstrated "confidence", since one of the requirements to fulfill the criteria of "confidence" was little variability among the rating group. Here the situation is reversed. There was much "confidence" in the ratings of items in the area, Impulse Discharge-Aggression, thus tending

to raise the reliability coefficients of the Szondi raters; the relative absence of "confidence items" in the area of Subjective Feeling suggests, but not definitively, that there was more variability among the ratings of these items, thus tending to lower the reliability coefficients. To summarize, the ratings of Subjective Feeling items tended to lower the reliability coefficients and raise the validity coefficients; the ratings of the Impulse Discharge-Aggression items did the opposite, raised the reliability coefficients and lowered the validity coefficients.

Further examination of these two important psychological areas might help one toward a better understanding of these unusual results. In the area of Subjective Feeling considerable agreement is found between the Szondi and Clinical raters with a relative absence of "confidence" in these traits. It seems to follow that this is necessarily based largely on agreement in the middle, possibly equivocal, range of ratings. This last conclusion is supported by the results of the analysis of the Szondi-Clinical Rorschach-Clinical comparison.³ Among the items on which the Szondi ratings are closer to the Clinical ratings than are the Rorschach ratings, we do not find many of the Subjective Feeling traits. Thus, in addition to the lack of "confidence", the ratings of the Subjective Feeling traits are not closely related to the Clinical ratings when the

³ See Chapter 3, p. 42.

Rorschach ratings are brought in as a comparative measure. The original close relationship (Table 6) must be evaluated with caution since it may be an artifact. On the basis of this discussion one could not feel too comfortable with the possible conclusion that one can have faith in judgments about Subjective Feelings made on the basis of Szondi test results, because the Szondi ratings agreed closely with the criterion ratings.

How then can one understand this significant close relationship between the Szondi and Clinical ratings of items referring to Subjective Feeling? One might speculate that there are special characteristics of these statements which may have helped to bring about this result. Subjective feelings are essentially phenomenological constructs and, it may be, that the clinicians in the present study have other than phenomenological orientations. It could follow that such traits might not be considered particularly salient in a personality description, might then be placed in the middle range of ratings, and we would discover agreement between the raters. Actually, most clinical psychologists and psychiatrists in America today do not hold to a phenomenological orientation and tend rather to describe a person from the viewpoint of an outside observer rather than from an attempt at identification with a person's feelings and view of the world.

The picture is different, however, in the area of Impulse Discharge-Aggression. Here, there is not only a striking difference between the Szondi ratings and the criteria, but

both groups have demonstrated considerable "confidence" in ratings of items in this area. This result might be interpreted in many ways. It might be said, for example, that one can put no faith in judgments about the psychological area Impulse Discharge-Aggression made on the basis of Szondi test results, since these judgments sharply disagree with the criterion judgments, and therefore the Szondi judgments are wrong. This conclusion seems to be questionable, particularly in the light of our inadequate criteria. More positively, it could be suggested that this area of sharp difference between the two rating groups sets the stage for a more intensive analysis. The differences help us toward action by sharpening the questions. Further and more concrete investigation of judgments in this area might offer an opportunity for a different sort of evaluation of the test. Study directed toward determining which group is "right" (a patient's future behavior could be predicted) may help to tell something about the basic validity of the Szondi test.

Some speculation about this clear difference in judgment in terms of clinical psychological experience suggests other ways of possible explanation. It may be that there is a real and important difference in the way that the psychiatrist and the tester perceive a patient. Their positions, or, one might say in Lewinian terms, the structure of their fields, are very different.

The psychiatrist is in direct contact with the patient. He is responsible for the patient in a direct way and is faced, again directly, with hospital management problems, e.g., passes, discharge, etc., or with similar problems when the patient is in treatment, e.g., termination. The tester has a responsibility which is radically different. This is particularly true if, as in the present study, the testers did not have any interpersonal contact with the patient. The tester can make recommendations and, in a sense, decisions but the action must be taken by the psychiatrist. To take a particularly critical example, the tester may say about a patient that there are suicidal potentialities present. To the psychiatrist directly responsible for the patient such a statement has many implications, e.g., should the patient be sent to a suicidal ward where he can be protected? How should he handle the patient's constant request for passes which, let us suppose, the patient has been receiving? After all, in the record, the test report, there is a warning about suicide and he, the psychiatrist, is responsible for the patient. It could easily be that these problems may not concern the tester. More elaboration is not necessary. Two clinicians, the psychiatrist and the psychological tester, are in different "fields." Their decisions about a patient do have different implications. They may see the patient quite differently.

It seems significant, too, to continue the discussion, that the area of particular difference is that of Impulse

Discharge-Aggression. Many clinicians feel that it is precisely in this general area that major conflicts exist for the psychiatrist who is directly responsible for the patient and also that in this area the most complex ego-involvement or counter-transference problems for the psychiatrist are found. This seems understandable. The management problems suggested previously cannot be satisfactorily answered without concern over such questions as: "Will this patient hurt somebody?"; "Will he hurt himself?"; "Can he control his impulsiveness?" etc. The question of suicidal potentialities is, as illustrated previously, a particularly critical one. In the light of the lack of real, certain knowledge of the answers to these questions it is conceivable that a responsible psychiatrist would have conflict about these questions. The aggressiveness or "acting-out" of a patient is said to create difficult counter-transference as well as management problems. The therapist may dislike the patient, be afraid of him, want to get rid of him, etc. But all these feelings are "not right." The "good" therapist controls such feelings and they are not supposed to interfere with his relations with the patient. Reaction formation is conceivable even in a psychiatrist. But, one might ask, if this area is the scene of such conflict and counter-transference then how can one explain the "confidence" demonstrated by the clinicians since this implies that the psychiatrists agreed quite well in

their evaluation of these items? Clinical experience suggests a possible answer. Often problems falling in this area of Impulse Discharge-Aggression are handled by rules. If a person is considered a suicidal threat he is sent, in most hospitals, to a special ward. If an open ward patient comes back to the hospital drunk he may be sent to a closed ward or discharged. The ways of handling "acting-out" of impulses are commonly codified.

Further Discussion:

Much of the above is speculative but the results demand some attempt at positive explanation. There are four points, implications of the above discussion, which seem worthy of further consideration. First, there is the suggestion that the "fields" of the psychiatrist and tester are structured differently so that, in a sense, they talk about different things when they say the same thing. Second, one might question whether the ego-involvement and conflict about problems falling in the area of Impulse Discharge-Aggression do not influence the psychiatrist's evaluation of and description of the patient. Third, it is suggested that it is in these areas of conflict, of question, that the psychiatrist asks the help of the psychological tester. The fourth point follows from the last, and it is that if one thinks this way, then the conclusions of the Szondi testers about problems falling in this critical area are useful if only they offer to the psychiatrist, who must take

action about the patient, the basis for new possibilities for action.

The first two suggestions may have important implications for research in clinical psychology, and particularly for validity studies like the one being discussed. Earlier, in outlining the method and procedure for the present study, it was argued that it was reasonable to believe that there would be adequate agreement among the different raters in their understanding of the various traits. If the speculations about the different field structure of the psychiatrist and tester are held to it would follow that, to the contrary, the description of a patient may be basically an individual one, depending upon interpersonal variables, and that any such direct comparison, as was done in the present study, is subject to severe limitations. But direct comparison of different views is the essence of traditional validity studies. It may be that the need in clinical psychology is, as many have said, new methods which allow us to deal with the complex problems of clinical psychology in a systematic and statistically precise way. But the solution may not lie in new statistical methods; methods that spring from our "scientific" heritage. It may be that what we call clinical can only be maintained as clinical under certain conditions which, when viewed from a point of view that demands exactness, looks like sloppiness and looseness. In other words, it may be that vagueness is one of the essential

qualities of clinical psychological concepts and that to destroy the vagueness would destroy the concept. If this were so then the scientific method for approaching clinical psychological problems would need be radically different from "the" scientific method which is traditionally accepted. But this idea is raised as a possibility which we are certainly not ready to accept yet but which should be recognized. One might say, with justification, that the suggestion of such a possibility is valueless unless it is accompanied by concrete suggestions as to the character of the "new" method. It is true that such a suggestion would be totally destructive if it led to an attitude of waiting till the new method comes along. But this is not a necessary consequence. We must continue to use the known methods having the best potentialities. We must not choose the path of waiting and doing nothing.

The third and fourth points, too, require further elaboration. It was suggested that in areas where conflict and doubt exist for the psychiatrist he tends to ask for help from the psychological tester. The area of Impulse Discharge-Aggression has been characterized as the scene of conflict. In this area, also, we found sharp disagreement between the Szondi raters and the criterion raters. Yet it is suggested in point four that the conclusions of the Szondi testers may be considered useful to the psychiatrist in helping him to take action.

It might be profitable to take what seems to be a round-about way to best elaborate this concept of "usefulness". It

has been proposed earlier, in evaluating the studies of the validity of the Szondi test, that the relative failure of these studies might be due to methodological difficulties rather than to a basic invalidity of the test itself. The results of the present study are similar to those considered previously. These results do not give support to the validity of the Szondi test, nor can one feel confident on the basis of these results that the Szondi is not a useful instrument. It may be, as our speculations might be taken to indicate, that our difficulties in research with projective tests go further than the methods themselves and reach into the methodology of the research.

The question has been raised as to whether direct comparisons, such as that between a test and a criterion, can justifiably be made. In the present case one possibility suggested was that the "fields" of the tester and the psychiatrist were structured differently. A further speculation, that description of a person is essentially individual, was added. The method of direct comparison can be examined from another point of view.

When one investigates the validity of a projective test such as the Szondi, as in the present study, the implicit aim is a validity coefficient of 1.00, inferences from the Szondi test results perfectly correlated with the criteria. If such a result had been attained, the Szondi test would

have been judged to be as adequate, and as inadequate, as our present day criteria. We would have reached a termination point, that of agreement. But considering that the setting in which clinicians work today is one of vague concepts and the absence of systematic methods to demonstrate the adequacy of these concepts, it is suggested that such agreement is not a sufficient end-point. In such a setting, where there is no demonstrated truth, one acts according to his convictions as to what is true. Actually, this is what one has to act on today; one has confidence in and convictions about certain methods, tools, and procedures, and one uses these convictions as the basis for action.

The recognition of such a setting, in which there is no truth and nothing worthy of being called a criterion, and where action is necessarily based upon what the clinician has confidence in, requires, it seems, a different aim than one of perfect relationship between the experimental tool and criterion. An examination of "what" clinicians have confidence in may be more profitable. And, in the evaluation of a projective test, a test from which competent clinicians can make conclusions in which they have confidence is a useful test, not only because it is used, but because the clinicians judgment and consequent convictions are the only practical signposts of what is useful in clinical psychological practice today. This conceptualization may appear to be some-

what dangerous in that it may seem to imply that the truth of the conclusions is not necessary and that the worker and not the conclusion is the basis for evaluation. It is dangerous, but this concept of usefulness springs from an appreciation of the current state of affairs in our field of study (which is illustrated by the results of the present experiments) and the need for progress. But, to say that the usefulness of a test depends on the confidence placed in it by competent clinicians would certainly not be enough of a basis for advancing this new concept. The earlier discussion of the results of the present study appears to lead us either toward such a conceptualization or toward a decision that the data from the study are valueless. Within the conceptual scheme developed in the discussion, such differences as appeared between the Szondi raters and criterion raters in the area of Impulse Discharge-Aggression set the stage for further intensive investigation and offer, to the one who must take action, new possibilities for action. This is useful. It appears that if we look at the data (of almost any of the validity studies) from the traditional point of view, we are left with much less.

Usefulness is offered not as an end-point but as a first step in the evaluation of a projective test. If we first establish "what" the clinicians have confidence in, then, particularly in areas of difference, we may be better able to evaluate whether his confidence can be justified as "right."

When and if there is more knowledge[®] as to where the truth lies and there is a "good" criterion, then validity would be an essential requirement for a good projective test. In general, the research aim has been changed to the point of being more consistent with the current state of knowledge and the peculiarities in the field of clinical psychology and it may now be possible to achieve a more systematic evaluation of a test in these new terms where we have been unable to do it with the old.

CHAPTER V

SUMMARY AND CONCLUSIONS

An examination of the validity of the Szondi test was attempted with the use of a relatively new statistical method, Stephenson's Q-technique. Four patients all were described, using two trait universes of 76 traits each, by four groups each having at least four members. The rating groups were differentiated on the basis of the source of information about the patient to be described. Thus there was the Szondi, Rorschach, Battery, and Clinical (psychiatric) rating groups, the latter two considered as criterion groups.

Correlation matrices were obtained for each patient-trait universe unit and the experimental divisions of the matrices were averaged. Thus, average consistency (reliability) measures for all four rating groups were obtained, as were average validity coefficients for the Szondi and Rorschach tests.

Item analysis was done by using mean group ratings of each trait and comparing the mean ratings of the various rating groups. In this way the traits for which the Szondi raters and the Clinical raters, for example, were closely or distantly related were abstracted. Another form of item analysis was undertaken in order to eliminate those traits which may not have been meaningful to one or all of the rating groups. For this purpose, a trait was said to have been used with "confidence" by a rating

group if the mean rating of the rating group for the trait was below 3.00 or above 6.00 for at least one of the four patients described in the study.

The main conclusions to be drawn from the findings in the experiments are as follows:

1. The validity of the Szondi test was as good as the validity of the Rorschach test.

2. The reliability-of-interpretation of the Szondi test was not very different from the reliability-of-interpretation of the Rorschach test.

3. The consistency measures of both the Battery and Clinical rating groups approximated .35, an extremely low reliability figure for criterion measures. In the light of this measure, it was felt that the low validity coefficients of the Szondi and Rorschach tests require qualification.

4. There was a significant agreement between the Szondi judges and the criterion raters in their ratings of items referring to Subjective Feelings. However, both groups fulfilled the criteria of "confidence" for few of these traits.

5. There was a significant disagreement between the Szondi raters and the criterion judges in their ratings of items concerning Impulse Discharge-Aggression. In addition, both groups demonstrated "confidence" in their ratings of these traits.

Some implications of the results for clinical psychological research were examined.

APPENDIX A - THE TRAIT UNIVERSES

Szondi Trait Universe:

1. He has feelings of helplessness.
2. He has the philosophy that if you don't worry too much about things everything will work out all right.
3. He reacts to trauma with withdrawal.
4. He feels things strongly but he cannot express his feelings easily.
5. He has doubts -- perhaps even conscious -- about his sexual identification.
6. He actively, even aggressively, goes after the things he wants.
7. His attitudes are extremely negativistic.
8. He is passive, even "feminine", in his relation with love objects.
9. He is an efficient, "busy" person.
10. His values are idealistic -- not pointed towards concrete, real objects.
11. He is inclined to collect things which are easily available.
12. He does not know what to expect from others.
13. His aggressions are turned against himself. (masochistic tendencies) (depressive tendencies)
14. He is likely to identify himself with more abstract forms of affection and love, such as: humanitarian love for all mankind, or other "conceptual" forms of tenderness.
15. Although he acts according to his latent needs, he is certain that his actions are determined purely by the objective characteristics of his environment.
16. His intellectual interests are too widespread and all inclusive to allow the systematic development of one given problem.

17. He feels as if he is going to explode at any moment.
18. His emotions organize his life for him.
19. He is a rigid person in an overcontrolled way.
20. He will face and fight rather than withdraw in the face of reality problems.
21. He is an immature person.
22. He resists change.
23. He has a general feeling of being somewhat apart from reality.
24. He likes to help people, though one gets a feeling of hidden aggression (reaction formation).
25. He explains his actions "objectively" rather than "subjectively".
26. He actively rebels against the "rigid resistance" of the environment.
27. His impulses lead to immediate action of some kind.
28. His "oral" passive needs are not adequately gratified.
29. He does not display or act out his emotions but rather feels them as an inner, subjective experience.
30. He is a domineering aggressive person.
31. He conforms with reality and accepts authority.
32. His level of aspiration is higher than his level of achievement.
33. He does all things "as if his very life depended on it."
34. He tends to be depressed at times.
35. He is concerned about how his actions affect other people.
36. He longs to be taken care of.
37. He tends to be somewhat exhibitionistic -- he likes to "play a role".

38. His constant showing off is too obvious and tinged with anxiety.
39. He has qualities of a moral masochist.
40. He is hypochondriacal (in the popular sense).
41. He organizes the world in an autistically egocentric way.
42. He sees objects from the viewpoint of how much pleasure can be derived from them.
43. He has a low frustration tolerance.
44. He is a "doer" rather than a "thinker".
45. He is a moralistic person.
46. He readily and steadily discharges aggressive emotions (though this discharge can be achieved through healthy or neurotic mechanisms.)
47. His "private" emotional life is inhibited and he is emotionally somewhat detached in everything he does.
48. He is a person who one would characterize as tense and anxious.
49. He is guilty and over-critical of himself.
50. He is very anxious with the fear that he will lose those who care for him.
51. He constantly has his need for passive recipiency of love gratified.
52. He is a shy person.
53. He strives to be self-sufficient and unemotional through the use of intellectualization and isolation.
54. He is guarded against emotional involvements.
55. He is both physically and psychically restless.
56. He "clings" to objects in order to derive security and thus pleasure from them.
57. He accepts his passive and submissive needs.

58. He is extremely sensitive in his reactions to even slight environmental cues.
59. He is adolescent-like.
60. He is capable of committing anti-social acts.
61. He likes physical activity.
62. He constantly experiences free-floating diffuse anxiety.
63. He is sensitive and somewhat detached from the physical, concrete aspects of reality.
64. He is overeager. He doesn't want to miss anything in life.
65. He wants many objects and never has enough to satisfy him.
66. His interpersonal relationships are numerous and superficial.
67. He has strong exhibitionistic needs which are frustrated although they may appear in actual behavior in some distorted form.
68. He is able to bear the coexistence of contradictory tendencies in consciousness without collapsing under the strain.
69. At times he recognizes and at times he denies his passive needs.
70. There is a martyr-like quality to his high frustration tolerance.
71. He seems to recognize his own emotional processes and is willing to face them.
72. He has a tendency toward rivalry.
73. He is passive and submissive in interpersonal relationships. (feminine identification)
74. He has a complex and relatively strong "character armor" which camouflages a great deal of subjectively felt anxiety.
75. He is a pessimistic person.
76. He is anxious with the fear that he will lose his material possessions.

Rorschach Trait Universe:

101. He prefers to work with details rather than generalities.
102. His thinking tends to be circumstantial.
103. He does things the easy way.
104. He rarely experiences an urgency about things.
105. He is apathetic in his object relations.
106. He is unable to apply his assets constructively because of his passive, narcissistic orientation.
107. He is not very involved in what is going on.
108. His continuous display of affect is shallow play-acting.
109. He directs his aggressiveness against himself.
110. He denies aggression.
111. He has a subjective feeling of separation from the world.
112. His impulsive acts are likely to be aggressive.
113. A good part of his aggression is likely to be absorbed in fantasy.
114. His first impulse is to oppose.
115. He is a person whose thinking can be sharp and creative but who, consciously or unconsciously, is "holding back".
116. He is a narcissistic person.
117. A good part of his phantasy is taken up with glorified images of himself.
118. Feelings of unreality are present.
119. He is moralistic.
120. Feelings of confusion are present.
121. He has a paranoid anticipation that others will unjustifiably question his sincerity and that he must therefore prove them wrong at once.

122. He is affectively labile.
123. His projective thinking makes its clearest appearance only when he is "on the spot", although traces of it are generally evident.
124. He has strong oral needs.
125. He is a parasitic person.
126. When his impulsiveness does appear, he is quick to defend himself but also careful not to get in deeper.
127. There is a primitive quality about him.
128. He has a weak capacity for thoughtful delay of impulses.
129. He is affectively bland.
130. He is unresponsive to common conventional ideas.
131. His reaction to reality problems is a generalized withdrawal.
132. His pretentiousness is intellectual in form.
133. He is concretely oriented.
134. He constantly experiences free-floating anxiety.
135. He is a naive person.
136. He seems overwhelmed by a pervasive fearfulness.
137. He organizes the world in an arbitrary way.
138. In the main he is able to delay the expression of impulses cautiously and truly impulsive acts occur only sporadically.
139. He is a careless person.
140. Much of his gaiety is feigned, put on for effect and used as cunningly as possible to gain an advantage in social situations.
141. He overuses projective mechanisms.
142. He is overalert.

143. He is overcautious in his object relations.
144. It is difficult for him to cope with anxiety-arousing and affect-arousing situations.
145. He makes rigid, compulsive efforts to remain on an abstract, all-inclusive level of thinking.
146. Frivolity is alien to his self-conception.
147. He has doubts about his sexual identity.
148. Self-expressive responses are inhibited and pushed into the background in emotionally disturbing situations.
149. He has a potentiality for depressive mood swings.
150. He is an excitable person.
151. His critical controls are underemphasized or ineffectual.
152. There is no basic impairment of reality testing but critical restraint is not applied extensively enough.
153. He is able to make only superficial relationships.
154. He has obsessive characteristics.
155. There is a quality of strained perfectionism in his behavior.
156. He is characteristically over-compliant in his interpersonal relationships.
157. His passive needs are quite strong.
158. His relationships are warm and spontaneous.
159. He is a critical person.
160. He has feelings of inadequacy.
161. He has a basically terrified reaction to the world.
162. He is a sensitive person.
163. He is an inhibited person.
164. He is a self-assertive person.

165. He has a tendency to dwell too long on the opposite side of the question.
166. He has difficulty in coping with strong emotional experiences and tends to retreat to the safe and conventional in such situations.
167. He is often arbitrary in his attitudes and opinions.
168. He is a tense and anxious person.
169. His capacity for rapport is minimal.
170. He suffers from a persisting anxiety state of the dull, oppressive, restless, vaguely uneasy variety.
171. He is dependent in a childish way.
172. He feels quite guilty.
173. His controls over aggressive phantasies are quite fragile and serve only to effect a slight delay.
174. He has sadistic tendencies.
175. He has morbid preoccupations.
176. He has feelings of worthlessness.

APPENDIX B - INSTRUCTIONS TO THE RATERS

Instructions for the description of the patient:

The materials that you have are two sets of 76 statements (in rubber bands), a set of cards numbered 1 to 8, and two score sheets. You are to deal with each group of statements separately. Take one group of 76 statements and sort them as follows: divide them roughly into two or three piles, those which are characteristic of the patient, and those which are not characteristic of him, then subdivide those groups as follows. Place the statement which you feel is most characteristic of the patient at the upper (8) end of the distribution, then the next five most characteristic statements in the next pile (7), the twelve third most characteristic cards in the third pile (6), and twenty cards into the next pile. Do the same for those you consider not characteristic of the patient. The one least characteristic statement is placed in pile number 1, etc. Thus, you will have eight piles of statements consisting of one, five, twelve, twenty, twenty, twelve, five, and one cards each. The cards numbered 1 to 8 are just an aid for you in sorting.

Record your ratings as follows: write the card numbers under the number of the pile in which you had sorted it. Be sure that the statement you choose as most characteristic is

in the column headed by the number 8. As you will see there are enough boxes, and only enough, in each column of the score sheet. This is to be sure that there are the correct number of statements in each group.

You are to do the same with the two groups of statements independently and record them separately.

ADDITIONAL INSTRUCTIONS TO THE RORSCHACH AND BATTERY RATERS

You have been given three envelopes two of which contain test batteries on two different patients and one which contains instructions, materials, and score sheets for the descriptions that you are being asked to do. You will find that in the envelopes containing the test batteries the Rorschach protocol is separated from the rest of the tests. For each patient you are asked to make two sets of descriptions: first on the basis of the Rorschach test alone, and second on the basis of the Rorschach test plus the rest of the battery (the Thematic Apperception Test, the Word Association Test, and the Wechsler-Bellebue Scale). Thus, for each patient you will duplicate the procedure outlined on the instruction sheets.

If there are any problems or questions that arise in your mind, please do not hesitate to call on me.

TABLE 8

Intercorrelations between raters of Patient W.L. using Szondi trait universe

		Szondi				Rorschach				Battery				Clinical					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Szondi	1																		
	2	56																	
	3	46	38																
	4	11	<u>02</u>	13															
Rorschach	5	02	15	09	<u>01</u>														
	6	29	<u>30</u>	08	<u>02</u>	18													
	7	41	<u>35</u>	<u>43</u>	03	26	<u>01</u>												
	8	27	21	11	<u>11</u>	<u>13</u>	<u>25</u>	15											
Battery	9	10	16	15	03	83	23	19	<u>26</u>										
	10	<u>22</u>	<u>20</u>	09	<u>12</u>	08	60	03	<u>29</u>	19									
	11	<u>13</u>	<u>05</u>	<u>42</u>	<u>05</u>	25	21	<u>61</u>	<u>17</u>	19	17								
	12	11	35	31	<u>03</u>	04	13	32	10	08	31	36							
Clinical	13a	07	25	10	11	<u>09</u>	<u>12</u>	24	11	04	<u>06</u>	08	23						
	14b	26	25	14	<u>01</u>	<u>21</u>	<u>09</u>	30	<u>27</u>	21	<u>24</u>	17	41	41					
	15	06	22	13	07	<u>13</u>	<u>04</u>	06	<u>23</u>	01	25	07	31	15	35				
	16	16	21	15	08	<u>02</u>	<u>07</u>	22	<u>19</u>	06	11	<u>07</u>	17	35	42	20			
	17	12	17	02	<u>12</u>	<u>05</u>	11	24	<u>19</u>	01	19	10	30	48	56	41	43		
	18	16	25	17	02	<u>29</u>	<u>10</u>	19	<u>23</u>	27	03	06	25	29	71	39	34	54	
	19	31	38	35	11	<u>04</u>	<u>07</u>	34	<u>00</u>	<u>01</u>	10	17	41	36	43	43	41	56	39

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 9

Intercorrelations between raters of Patient T.P. using Szondi trait universe

		Szondi				Rorschach				Battery				Clinical					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Szondi	1																		
	2	45																	
	3	58	42																
	4	00	<u>17</u>	03															
Rorschach	5	39	02	27	09														
	6	21	<u>01</u>	29	23	35													
	7	06	04	<u>03</u>	11	31	17												
	8	<u>11</u>	<u>43</u>	<u>07</u>	25	33	26	44											
Battery	9	33	18	46	14	62	58	44	09										
	10	28	35	29	17	30	67	17	<u>02</u>	53									
	11	35	50	35	13	34	46	25	<u>17</u>	53	56								
	12	02	<u>20</u>	14	38	36	56	34	<u>48</u>	53	39	25							
Clinical	13a	02	01	09	23	15	29	29	52	29	23	12	43						
	14b	<u>01</u>	<u>20</u>	<u>01</u>	27	15	43	19	47	28	21	06	52	58					
	15	<u>23</u>	<u>03</u>	<u>17</u>	39	31	65	24	29	52	52	40	62	48	50				
	16	16	00	25	29	32	54	42	35	43	44	36	56	36	47	58			
	17	03	29	08	30	24	25	41	54	13	<u>01</u>	04	45	44	41	33	38		
	18	<u>09</u>	<u>31</u>	09	40	17	22	23	59	15	<u>13</u>	<u>07</u>	52	48	37	35	40	52	

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 10

Intercorrelations between raters of Patient M.V. using Szondi trait universe

		Szondi				Rorschach				Battery				Clinical					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Szondi	1																		
	2	35																	
	3	28	44																
	4	15	31	44															
Rorschach	5	40	32	19	28														
	6	15	07	18	13	05													
	7	30	28	28	22	38	09												
	8	29	36	34	22	51	00	48											
Battery	9	35	34	25	36	78	02	42	48										
	10	11	22	15	08	54	18	04	27	38									
	11	21	25	35	29	38	13	72	42	50	15								
	12	28	17	02	09	55	11	26	66	49	46	26							
Clinical	13a	13	01	05	07	29	05	17	23	35	44	36	36						
	14b	33	15	07	10	44	02	30	32	51	42	52	41	46					
	15	12	03	17	01	40	05	18	25	37	48	20	36	52	44				
	16	20	04	05	09	40	09	10	28	45	38	23	39	51	42	51			
	17	29	09	12	18	37	12	16	35	44	29	28	32	44	41	50	41		
	18																		

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 11

Intercorrelations between raters of Patient R.W. using Szondi trait universe

		Szondi				Rorschach				Battery				Clinical						
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Szondi	1																			
	2	05																		
	3	20	11																	
	4	42	18	49																
Rorschach	5	13	01	04	06															
	6	03	09	09	06	19														
	7	02	12	18	06	52	23													
	8	01	07	07	19	40	17	24												
Battery	9	06	20	07	23	36	18	22	31											
	10	01	26	02	15	06	68	14	15	29										
	11	00	28	07	04	52	13	68	35	46	13									
	12	08	04	07	17	21	15	17	58	42	15	32								
Clinical	13a	05	18	02	00	17	09	05	18	39	17	16	07							
	14b	01	07	22	20	06	25	03	38	34	34	12	37	43						
	15	02	23	14	19	11	03	03	16	17	31	09	16	56	40					
	16	02	27	03	02	26	02	05	32	21	11	11	34	55	38	44				
	17	01	25	20	30	00	23	02	34	52	36	14	44	44	46	40	45			
	18	00	15	08	03	08	01	15	31	09	09	08	27	29	23	08	41	18		
	19	22	26	12	06	10	11	15	21	24	21	30	19	33	38	25	25	24	36	
	20	03	04	08	23	03	26	17	34	37	20	07	33	35	55	38	27	54	16	23

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 12

Intercorrelations between raters of Patient W.L. using Rorschach trait universe

		Szondi				Rorschach				Battery				Clinical					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Szondi	1																		
	2	48																	
	3	40	30																
	4	12	19	12															
Rorschach	5	05	04	21	15														
	6	13	10	04	<u>13</u>	31													
	7	38	23	22	<u>05</u>	42	17												
	8	17	18	<u>03</u>	<u>06</u>	32	18	44											
Battery	9	01	<u>02</u>	21	<u>20</u>	95	26	32	21										
	10	01	<u>09</u>	<u>14</u>	<u>15</u>	20	58	14	25	15									
	11	36	23	<u>22</u>	<u>05</u>	50	24	90	45	42	18								
	12	27	48	21	<u>19</u>	15	27	24	30	13	22	27							
Clinical	13a	17	17	25	25	09	30	15	<u>00</u>	08	20	17	17						
	14b	30	26	40	25	<u>01</u>	20	13	<u>13</u>	03	01	09	36	38					
	15	23	03	25	19	<u>08</u>	16	07	<u>05</u>	<u>04</u>	02	05	18	30	49				
	16	30	16	17	11	<u>00</u>	03	05	<u>01</u>	<u>00</u>	05	07	16	27	42	31			
	17	19	01	16	40	<u>01</u>	30	07	<u>07</u>	<u>04</u>	18	05	28	36	48	43	43		
	18	33	32	36	21	<u>04</u>	19	<u>10</u>	<u>14</u>	09	11	<u>07</u>	30	25	61	55	53	42	
	19	41	38	47	29	07	13	<u>17</u>	<u>08</u>	11	<u>06</u>	<u>21</u>	42	37	58	56	39	50	56

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 13

Intercorrelations between raters of Patient T.P. using Rorschach trait universe

		Szondi				Rorschach				Battery				Clinical					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Szondi	1																		
	2	40																	
	3	64	54																
	4	35	20	16															
Rorschach	5	05	02	00	30														
	6	37	<u>20</u>	<u>23</u>	34	32													
	7	04	13	01	17	19	03												
	8	<u>00</u>	<u>15</u>	<u>17</u>	41	33	<u>06</u>	26											
Battery	9	45	22	36	38	44	52	09	21										
	10	49	34	51	30	26	74	04	10	54									
	11	37	46	47	24	25	40	<u>48</u>	07	40	51								
	12	11	<u>05</u>	05	44	32	38	23	51	47	43	22							
Clinical	13a	27	19	28	24	04	13	46	27	20	23	44	38						
	14b	09	02	09	45	<u>28</u>	22	28	38	25	17	20	57	32					
	15	01	<u>19</u>	<u>14</u>	28	23	22	49	28	40	23	42	52	38	49				
	16	19	14	19	31	13	45	36	30	42	38	32	55	40	44	64			
	17	<u>12</u>	<u>19</u>	<u>24</u>	31	17	15	38	38	05	05	11	35	38	48	42	44		
	18	<u>00</u>	<u>05</u>	<u>05</u>	33	19	18	44	44	17	<u>19</u>	26	63	40	52	58	50	50	

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 14

Intercorrelations between raters of Patient M.V. using Rorschach trait universe

		Szondi				Rorschach				Battery				Clinical					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Szondi	1																		
	2	10																	
	3	14	47																
	4	07	31	42															
Rorschach	5	20	23	14	07														
	6	24	08	05	15	12													
	7	28	28	26	20	44	24												
	8	24	17	11	19	46	13	58											
Battery	9	20	24	28	21	85	24	52	53										
	10	03	03	17	06	42	23	38	55	52									
	11	10	23	36	21	30	25	75	57	50	37								
	12	18	10	07	00	29	07	34	64	33	57	35							
Clinical	13a	10	04	04	23	23	13	31	28	31	29	24	18						
	14b	15	32	25	35	26	14	40	32	42	24	41	24	44					
	15	02	02	27	02	34	03	38	30	31	44	23	38	58	32				
	16	15	04	16	14	16	05	35	26	19	30	19	30	60	39	57			
	17	25	26	08	28	37	16	38	41	46	36	36	32	58	46	53	61		
	18																		

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 15

Intercorrelations between raters of Patient R.W. using Rorschach trait universe

		Szondi				Rorschach				Battery				Clinical							
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
Szondi	1																				
	2	43																			
	3	38	14																		
	4	54	50	26																	
Rorschach	5	43	08	35	36																
	6	26	17	17	13	32															
	7	30	29	25	43	61	20														
	8	03	<u>24</u>	26	12	29	16	38													
Battery	9	23	11	25	26	66	15	48	30												
	10	28	22	16	18	19	74	21	19	12											
	11	25	23	36	28	50	15	72	36	50	28										
	12	09	01	21	12	23	21	36	73	35	28	44									
Clinical	13a	<u>11</u>	21	<u>11</u>	12	08	07	04	11	13	09	05	32								
	14b	<u>17</u>	17	<u>15</u>	01	<u>19</u>	<u>15</u>	23	25	42	23	26	41	52							
	15	11	03	05	01	06	24	<u>04</u>	11	11	34	<u>02</u>	19	32	34						
	16	01	11	07	03	11	11	<u>01</u>	15	14	08	<u>09</u>	30	38	42	36					
	17	24	29	26	32	32	40	<u>38</u>	24	36	38	45	40	23	54	21	38				
	18	16	29	09	29	05	17	19	11	24	23	29	24	35	30	29	42	36			
	19	33	43	07	26	14	25	22	09	30	36	28	21	34	43	17	38	45	39		
	20	01	01	11	<u>07</u>	<u>03</u>	09	06	27	11	16	05	30	29	38	30	15	19	14	11	

a--Leader of group therapy control

b--Therapist

Note: Underscored correlations are negative, and decimal points are omitted from the front of all figures.

TABLE 16

Mean intercorrelations between raters of Patient W.L. using Szondi trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.28			
Rorschach	.06	.03		
Battery	.05	.23	.22	
Clinical	.14	.01	.15	.42

TABLE 17

Mean intercorrelations between raters of Patient T.P. using Szondi trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.24			
Rorschach	.07	.31		
Battery	.25	.36	.47	
Clinical	.09	.35	.32	.45

TABLE 18

Mean intercorrelations between raters of Patient M.V. using Szondi trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.33			
Rorschach	.19	.25		
Battery	.17	.40	.38	
Clinical	.09	.21	.38	.46

TABLE 19

Mean intercorrelations between raters of Patient R.W. using Szondi trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.25			
Rorschach	.02	.30		
Battery	.10	.32	.30	
Clinical	.08	.07	.23	.36

TABLE 20

Mean intercorrelations between raters of Patient W.L. using Rorschach trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.27			
Rorschach	.11	.31		
Battery	.13	.44	.23	
Clinical	.25	.07	.12	.44

TABLE 21

Mean intercorrelations between raters of Patient T.P. using Rorschach trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.40			
Rorschach	.12	.19		
Battery	.33	.33	.43	
Clinical	.13	.29	.31	.46

TABLE 22

Mean intercorrelations between raters of Patient M.V. using Rorschach trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.26			
Rorschach	.18	.34		
Battery	.12	.46	.44	
Clinical	.11	.25	.31	.51

TABLE 23

Mean intercorrelations between raters of Patient R.W. using Rorschach trait universe.

	Szondi	Rorschach	Battery	Clinical
Szondi	.38			
Rorschach	.22	.34		
Battery	.20	.41	.33	
Clinical	.12	.14	.24	.33

APPENDIX D - ITEMS FOR WHICH SZONDI RATINGS ARE CLOSE OR DISTANT
FROM ONE CRITERION

TABLE 24

Items on which the Szondi group compared favorably with one criterion group and equivocally with the other.

2. He has the philosophy that if you don't worry too much about things everything will work out all right.
3. He reacts to trauma with withdrawal.
7. His attitudes are extremely negativistic.
12. He does not know what to expect from others.
17. He feels as if he is going to explode at any moment.
22. He resists change.
23. He has a general feeling of being somewhat apart from reality.
25. He explains his actions "objectively" rather than "subjectively".
33. He does all things "as if his very life depended on it".
35. He is concerned about how his actions affect other people.
40. He is hypochondriacal (in the popular sense).
42. He sees objects from the viewpoint of how much pleasure can be derived from them.
50. He is very anxious with the fear that he will lose those who care for him.
51. He constantly has his need for passive recipiency of love gratified.
56. He "clings" to objects in order to derive security and thus pleasure from them.
58. He is extremely sensitive in his reactions to even slight environmental cues.
63. He is sensitive and somewhat detached from the physical, concrete aspects of reality.

TABLE 24 (cont'd)

64. He is overeager. He doesn't want to miss anything in life.
65. He wants many objects and never has enough to satisfy him.
66. His interpersonal relationships are numerous and superficial.
68. He is able to bear the coexistence of contradictory tendencies in consciousness without collapsing under the strain.
69. At times he recognizes and at times he denies his passive needs.
102. His thinking tends to be circumstantial.
104. He rarely experiences an urgency about things.
106. He is unable to apply his assets constructively because of his passive, narcissistic orientation.
107. He is not very involved in what is going on.
114. His first impulse is to oppose.
120. Feelings of confusion are present.
123. His projective thinking makes its clearest appearance only when he is "on the spot", although traces of it are generally evident.
125. He is a parasitic person.
129. He is affectively bland.
131. His reaction to reality problems is a generalized withdrawal.
136. He seems overwhelmed by a pervasive fearfulness.
137. He organizes the world in an arbitrary way.
142. He is overalert.
144. It is difficult for him to cope with anxiety-arousing and affect-arousing situations.
159. He is a critical person.

TABLE 24 (cont'd)

165. He has a tendency to dwell too long on the opposite side of the question.
166. He has difficulty in coping with strong emotional experiences and tends to retreat to the safe and conventional in such situations.
172. He feels quite guilty.

TABLE 25

Items on which the Szondi group compared poorly with one of the criterion groups and equivocally with the other.

4. He feels things strongly but he cannot express his feelings easily.
9. He is an efficient, "busy" person.
14. He is likely to identify himself with more abstract forms of affection and love, such as: humanitarian love for all mankind, or other "conceptual" forms of tenderness.
30. He is a domineering aggressive person.
34. He tends to be depressed at times.
41. He organizes the world in an autistically egocentric way.
45. He is a moralistic person.
54. He is guarded against emotional involvements.
60. He is capable of committing anti-social acts.
70. There is martyr-like quality to his high frustration tolerance.
71. He seems to recognize his own emotional processes and is willing to face them.
74. He has a complex and relatively strong "character armor" which camouflages a great deal of subjectively felt anxiety.
75. He is a pessimistic person.
108. His continuous display of affect is shallow play-acting.
116. He is a narcissistic person.
122. He is affectively labile.
124. He has strong oral needs.
127. There is a primitive quality about him.

TABLE 25 (cont'd)

- 132. His pretentiousness is intellectual in form.
- 133. He is concretely oriented.
- 138. In the main he is able to delay the expression of impulses cautiously and truly impulsive acts occur only sporadically.
- 139. He is a careless person.
- 147. He has doubts about his sexual identity.
- 149. He has a potentiality for depressive mood swings.
- 150. He is an excitable person.
- 154. He has obsessive characteristics.
- 158. His relationships are warm and spontaneous.
- 167. He is often arbitrary in his attitudes and opinions.
- 169. His capacity for rapport is minimal.
- 171. He is dependent in a childish way.
- 173. His controls over aggressive phantasies are quite fragile and serve only to effect a slight delay.
- 174. He has sadistic tendencies.

TABLE 26

Items on which the Szondi group compared favorably with one criterion group and poorly with the other.

- 27. His impulses lead to immediate action of some kind.
- 47. His "private" emotional life is inhibited and he is emotionally somewhat detached in everything he does.
- 53. He strives to be self-sufficient and unemotional through the use of intellectualization and isolation.

TABLE 27

"Confidence" in the use of traits demonstrated by the four rating groups.

Trait No.	Rating Groups			
	Szondi	Rorschach	Battery	Clinical
1.		1*		1
2.			2	
3.				
4.	2	2		1
5.		1	2	1
6.	2			2
7.		1	1	1
8.	2		2	1
9.			3	1
10.			1	
11.				
12.			1	
13.	1			2
14.	3		2	1
15.		1	1	
16.		2	2	2
17.			1	
18.			1	
19.	1	1	1	1
20.	1		1	3
21.		2	2	2
22.				
23.				1
24.	1			1
25.				
26.		1		
27.	1			1
28.		1	1	2
29.	1	1	1	
30.	1	2	2	4
31.	1	1	1	
32.			1	
33.			1	
34.	1	1	2	3
35.	1	1	1	1
36.			1	2

* The numbers in the table represent the number of patients for whom the mean rating on the trait of the designated rating group fell in one of the extreme ranges.

TABLE 27 (Cont'd)

"Confidence" in the use of traits demonstrated by the four rating groups.

Trait No.	Rating Groups			
	Szondi	Rorschach	Battery	Clinical
37.	3			
38.		1		
39.	2			
40.			1	
41.		2	1	
42.				
43.		1	2	1
44.	2		1	1
45.			1	1
46.	2			1
47.		1	1	
48.	1	2	2	1
49.	1			1
50.				
51.	2		2	
52.		2	1	
53.		2	3	1
54.	1	1		1
55.	1		1	
56.				1
57.	1	1	1	
58.		1	1	
59.		1		1
60.	2	2		2
61.	1			
62.				
63.			1	
64.				
65.	1	1		
66.		1		
67.	1			
68.			1	
69.				
70.	2	2	3	
71.			2	1
72.				
73.	2	1		
74.	1		1	1
75.				
76.				

TABLE 27 (Cont'd)

"Confidence" in the use of traits demonstrated by the four rating groups.

Trait No.	Rating Groups			
	Szondi	Rorschach	Battery	Clinical
101.		1	2	
102.				
103.	1		1	
104.		1	1	2
105.	2		2	
106.				1
107.				1
108.	2	1		1
109.	2			1
110.	2			
111.				
112.			2	1
113.	2	1		
114.		1	1	
115.			1	1
116.			3	1
117.			1	
118.			1	2
119.	1		1	2
120.				1
121.				
122.	2	1	2	
123.				
124.	2	1	2	1
125.				1
126.				
127.	2	2	2	1
128.	3	1		1
129.	3	2	4	1
130.		2	2	1
131.				
132.		3	3	2
133.		1	1	
134.	1			
135.		1	2	
136.				
137.		1		
138.	1			

TABLE 27 (Cont'd)

"Confidence" in the use of traits demonstrated by the four rating groups.

Trait No.	Rating Groups			
	Szondi	Rorschach	Battery	Clinical
139.	1		1	1
140.		1		
141.				
142.			1	
143.	1			
144.	1	2	2	1
145.	2	2	2	2
146.			2	
147.	1	1	2	
148.	1			1
149.	2	2		2
150.	1	1	1	1
151.	1			
152.	1	1	1	
153.		1		
154.		1		2
155.	1	1	2	1
156.				1
157.	1	1	1	3
158.			2	2
159.				
160.		1		2
161.				
162.		1	1	1
163.	2	2	1	1
164.	1			2
165.				
166.				1
167.		1		1
168.	2	2		2
169.	1		1	1
170.				
171.	2		1	
172.				
173.	2	1		2
174.	1			1
175.				1
176.		1		

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