Using the Rorschach Properly in Practice and Research

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Proper use of the Rorschach Inkblot Method (RIM) in practice and research requires (a) well-founded expectations concerning what the RIM should be expected to do, and (b) appropriate methods for examining its validity in achieving the purposes for which it is intended. The RIM is a personality-assessment instrument, and its validity should be judged from its substantial correlations with observed behaviors that are conceptually linked to personality processes. Knowledge about personality functioning gleaned from Rorschach data may contribute to diagnostic formulations, but associations between Rorschach indices and psychometrically shaky DSM diagnostic categories have little bearing on the utility of the instrument for achieving its intended purposes. Adequate conceptual formulation of this kind is as necessary as solid empirical verification in the development and use of psychological assessment instruments. J Clin Psychol 56: 435–438, 2000.

Proper use of the Rorschach Inkblot Method (RIM) in practice and research requires (a) well-founded expectations concerning what the RIM should be expected to do, and (b) appropriate methods for examining its validity in achieving the purposes for which it is intended. The article under discussion fails to meet these requirements by equating the validity of Rorschach assessment with how well it correlates with psychiatric disorders, as defined by versions of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), and with whether it correlates as well with DSM diagnoses as the MMPI. Given the nature of the RIM, these matters are of little import, and efforts to assess Rorschach validity in these ways lead along paths of little import. This is so because the RIM is not a diagnostic test, if diagnosis means DSM classification. The RIM is a personality-assessment instrument designed and intended to measure aspects of personality structure and dynamics. Associations between Rorschach indices and DSM categories accordingly have little bearing on the utility of the RIM for achieving its intended purposes.

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Sometimes, in some circumstances, Rorschach findings identify aspects of personality functioning that do prove helpful in correctly classifying people as demonstrating one of the conditions listed in the DSM. However, neither practitioners nor researchers should be much concerned if the RIM or any other personality-assessment instrument shows only modest correlations with DSM diagnoses. The DSM is, after all, an inferential classification scheme that constitutes an abstraction, rather than real behavior; that comprises diagnoses varying widely in their reliability and validity; and that treats as categorical a host of dimensional and overlapping conditions, including most of Axis II. As behavioral scientists, psychologists are concerned with understanding and predicting behavior, that is, how people are actually likely to think, feel, and act. Clinical psychologists are concerned more specifically with identifying adjustment problems and helping people overcome them. There is little to be gained in this process by pondering whether psychological tests can predict how someone will be classified by a psychometrically shaky, inferential nosological scheme involving criteria and definitions that change from one revision to the next.

As an example of faulty conceptualization in measuring the adequacy of personality-assessment instruments against DSM categories, Wood and Garb (2000) criticize the Rorschach Oral Dependency (ROD) scale for not correlating well with DSM-IV Dependent Personality Disorder. Why should scientists concerned with understanding and predicting human behavior worry about hitting such a moving target as an unreliable and unvalidated DSM-IV Axis II diagnostic category that overlaps with several other Axis II categories? Correlations of a personality-assessment scale with such psychometrically shaky variables should attract passing interest at most; these correlations should not be considered critical evidence pertaining to the scale's validity. Of further note with respect to the validity of the ROD, Wood and Garb (2000) not only criticize this scale on the basis of conceptually irrelevant findings, but also omit to mention that the ROD, in fact, has demonstrated substantial construct validity by showing significant correlations with actual observed dependent behaviors (see Bornstein, 1996, 1999). By overlooking the demonstrated behavioral correlates of the ROD, while focusing on its low correlation with DSM-IV Dependent Personality Disorder, the article (Wood & Garb, 2000) results in the unwarranted inference that the ROD is invalid and the misleading implication that Rorschach assessment in general serves little purpose.

Proper use of the RIM does not include validation studies in which DSM categories are employed as dependent variables, nor does it include clinical practice in which DSM diagnoses are inferred directly from Rorschach indices. As previously noted, shared personality variance at times may contribute to RIM–DSM correlations, but these correlations are meaningful only when researchers and practitioners can identify the particular personality characteristics that are being measured by the RIM, and that also are intrinsic to the diagnostic category. It is for this reason that RIM–DSM correlations by themselves are of little interest or import.

By contrast, what is interesting and important in clinical practice and research is whether Rorschach assessment can identify accurately personality strengths and weaknesses that have implications for treatment planning. As an example, the Rorschach Thought Disorder Index (TDI) developed by Johnston and Holzman (1979) consistently has demonstrated significant correlations with manifest thinking disorder (see Kleiger, 1999, chap. 5, for a review of this research). Identifying thought disorder does not provide a definitive DSM-IV diagnosis, given that disordered thinking occurs in people considered to have schizophrenia, paranoia, delusional disorder, bipolar disorder, and schizotypal personality disorder, among other possibilities. However, knowing that a patient is thought disordered usually proves helpful in planning his or her treatment and may contribute to

determining a DSM-IV diagnosis. What counts in such instances is the real behavior (thought disorder) that is being measured by the TDI, not the abstractions for which definitions change over time (DSM diagnoses), and it is against observed behavior that this and other Rorschach indices should be validated.

Turning to whether the RIM correlates less well than the MMPI with DSM diagnoses, findings in this regard have no more bearing than RIM–DSM correlations on the validity of Rorschach assessment in serving the purposes for which it is intended. Of course the MMPI shows higher correlations with DSM categories than the RIM. Unlike the RIM, the MMPI was derived empirically from comparisons among diagnostic groups, and it involves the same kind of self-report methodology that clinicians employ in using symptom descriptions to determine a DSM diagnosis. Wood and Garb (2000) cite a recent meta-analytic study indicating that, with psychiatric diagnosis as the criterion, the unweighted mean validity coefficients were .37 for the MMPI and .18 for the RIM (Hiller, Rosenthal, Bornstein, Berry, and Brunnell-Neuleib, 1999). Because of the substantial method variance shared by the MMPI and DSM, especially when structured interviews are used to establish a DSM diagnosis, these findings are not at all surprising.

What is surprising, however, is that Wood and Garb (2000), while apparently endorsing the Hiller et al. meta-analysis in using its findings on DSM correlations as a basis for challenging the validity of Rorschach assessment, fail to mention two other data sets in the Hiller et al. report. First, the overall unweighted mean validity coefficients found by Hiller et al. for all kinds of external criteria, *including* psychiatric diagnoses, were .30 for the MMPI and .29 for the RIM, and these values are not significantly different from each other. Second, whereas the MMPI was found superior to the Rorschach in predicting psychiatric diagnosis and scores on other self-report measures, the RIM was found by Hiller et al. to be superior to the MMPI in predicting behavioral outcomes, such as treatment attendance. Hiller et al., in fact, speak to whether the RIM is as valid as the MMPI by concluding that ". . . on average, both tests work about equally well when used for purposes deemed appropriate by experts" (p. 293). By selectively reporting the results of the Hiller et al. meta-analysis, Wood and Garb (2000) fall short of presenting an even-handed discussion.

More than anything else, the shortcomings in the article under discussion derive from insufficient attention to adequate conceptual formulation, as well as solid empirical verification in the development and use of psychological assessment instruments. The present author has been encouraging thoughtful conceptualization in psychodiagnostic practice and research in four decades (see Weiner, 1966, 1977, 1986, 1995). Fuller appreciation of the importance of proceeding on the basis of relevant concepts would render moot many concerns currently being raised about the utility of Rorschach assessment.

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