

A RORSCHACH STUDY OF
FIFTEEN WOMEN WITH TRICHOTILLOMANIA

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A RORSCHACH STUDY OF FIFTEEN WOMEN WITH TRICHOTILLOMANIA

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ABSTRACT

Fifteen adult women (mean age 34.5 years) participated in this exploratory study. The study aimed to identify commonalities in trichotillomania patients' personality structure and psychological functioning. Relevant historical data were obtained, the Massachusetts General Hospital Hairpulling Scale was completed, and a Rorschach test in terms of the Comprehensive System was administered. The results point to an innate vulnerability in the sample's personality structure that impedes their capacity for efficient problem-solving, decision-making, and coping behaviour. Other key findings include a distorted perception of themselves, a limited capacity for control and stress tolerance, difficulty in modulating and expressing emotions, the interference of primary process thinking in ideational activity, and the effects of these factors on their interpersonal relationships. Theoretical inferences are made about the probable aetiological roots of these findings. As the subjects' level of functioning was unexpectedly high in the light of their deep-rooted pathology, the dynamic role and function of self-induced hair pulling as a symptom were considered. Suggestions are made to improve the treatment prognosis of the disorder.

Keywords: Trichotillomania, hair pulling, Rorschach, Exner, Comprehensive System, personality structure, psychological functioning, adjustment, psychodynamic, aetiology, treatment

'N RORSCHACH-STUDIE OOR VYFTIEN VROU MET TRICHOTILLOMANIE

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SAMEVATTING

Vyftien volwasse vroue met trichotillomanie (gemiddelde ouderdom 34.5 jaar) het aan hierdie ondersoek deelgeneem. Die doel van die studie was om gemeenskaplike faktore in trichotillomaniepatiënte se persoonlikheidsstruktuur en psigologiese funksionering te identifiseer. Toepaslike historiese inligting is ingesamel, die 'Massachusetts General Hospital Hairpulling Scale' is voltooi, en 'n Rorschach-toets is volgens die 'Comprehensive System' afgeneem. Die resultate dui op 'n ingebore kwesbaarheid in die doeltreffendheid van die steekproef se probleemoplossings- en besluitnemingsvermoë, asook hoe hulle moeilike situasies hanteer. Ander sleutelbevindinge sluit 'n verwronge selfbeskouing in, beperkte beheer en strestoleransie, probleme met die modulering en uiting van emosies, die invloed van primêre prosedensie tydens denkbeeldvorming, en die uitwerking van hierdie faktore op interpersoonlike verhoudings. Teoretiese gevolgtrekkings word oor die waarskynlike etiologiese gronde vir die bevindinge gemaak. Aangesien die respondente se funksioneringsvlak bo verwagting positief in die lig van 'n diepgevoerde patologie was, is die dinamiese rol en funksie van selfgeïnduseerde harepluk as simptome oorweeg. Voorstelle ter verbetering van die behandelingsprognose vir die versteuring word gemaak.

Sleutelwoorde: Trichotillomanie, harepluk, Rorschach, Exner, Comprehensive System, persoonlikheidsstruktuur, psigologiese funksionering, aanpassing, psigodinamies, etiologie, behandeling

CHAPTER 1

INTRODUCTION

1.1 RATIONALE FOR RESEARCH

The term 'trichotillomania' was first used in 1889 by the French dermatologist Hallopeau (1889), to describe an affliction of chronic, self-directed hair pulling in the absence of any obvious skin disease.

More than a century later, the classification and criteria for trichotillomania remained contentious. Although currently considered one of the impulse control disorders, a number of alternative classification schemes have been proposed in an attempt to describe the condition better. Some of these schemes regard trichotillomania as a variant of obsessive-compulsive disorder (Tynes, White, & Steketee, 1990); an obsessive-compulsive 'spectrum' disorder (Jenike, 1989; Swedo & Leonard, 1992); a disorder of abnormal grooming (Swedo & Rapoport, 1991); one of the habit disorders (Mansueto, 1991); or an affective spectrum disorder (Christenson, Mackenzie, & Mitchell, 1991; McElroy, Hudson, Pope, Keck, & Aizly, 1992). The debate continues, but no alternative categorisation for trichotillomania is currently widely supported. A number of these issues are reviewed in Chapter 3 of this report.

Chapter 4 discusses current theories of which none seems to offer a sufficient explanation of the aetiological factors of the illness. The psychodynamic perspective considers the symptoms to be manifestations of unconscious dynamic processes and unresolved conflicts, but the limitations in anecdotal reports on treatment effectiveness render this model less useful in attempts to understand the condition. The cognitive-behavioural model, on the other hand, focuses on explaining what maintains hair pulling once it begins, and several treatment studies have reported effective results. However, the emphasis on specific behaviours associated with the

symptom sometimes leaves the impression that hair pulling and its associated features should be simple and straightforward - which is clearly not the case. In fact, people with trichotillomania often find the indirect psychosocial problems to be the more disturbing aspects of the disorder, and this might actually contribute to patient non-compliance and high relapse rates. From the psychiatric perspective, biological theories have specified a range of neurobiological abnormalities that could underlie trichotillomania, but pharmacological efforts to treat these and other physiological aspects of the disorder have produced inconsistent results. This model does not address the wider-ranging implications of psychological, behavioural, and interpersonal sequelae either.

Despite its high prevalence, trichotillomania has been the subject of relatively few studies. As it appears to be a heterogeneous condition with a range of divergent comorbid conditions, the methodological difficulties in studying the illness have made a generalisation of the available research results difficult and left gaps in both its conceptualisation and treatment. These factors present serious obstacles in the prognosis for the disorder, and it is clear that a more comprehensive understanding of this illness and the people who suffer from it is required to serve this population meaningfully.

The current study targeted a group of individuals who shared the same cluster of symptoms on the DSM-IV, which necessarily implies a medical system of thought. Although both psychiatry and psychology aim to apply unique, field-specific principles to adjustment problems, this study attempted to augment current theoretical conceptualisations of the disorder by describing a number of psychological aspects that accompany trichotillomania.

As described in Chapter 5, Exner's Comprehensive System for the Rorschach provides a well-validated basis for describing various aspects of personality structure and serves

as a rich source of hypotheses on numerous aspects of personality dynamics. Although not a predictive instrument, Rorschach trait variables do provide reasonably accurate longitudinal predictions of personality style. Also, the method has been demonstrated to aid in diagnosing various conditions that involve specific patterns of personality functioning. It has the potential to facilitate a diagnosis of any condition that is determined by or contributes to distinctive personality characteristics (Weiner, 1998). For instance, given trichotillomania's classification as an impulse control disorder, the research group's performance on the Rorschach variables deemed to be related to impulsivity (D, Adj D, FC:CF+C, M, and Lambda) would be interesting. The Obsessive Style (OBS) Special Index could also illuminate aspects of the continuing debate about the disorder's classification as an obsessive-compulsive spectrum disorder.

The Comprehensive System makes well-validated contributions to identifying treatment targets and potential obstacles to making progress in psychotherapy by selecting appropriate treatment modalities and monitoring change over time. It is hoped that this study would elucidate factors that could impact on the illness' relapse rate, and that recommendations for treatment alternatives might emerge from the data.

1.2 OBJECTIVES OF STUDY

In view of the above, the specific objectives of this study have been formulated as follows:

- To explore the personality structure and psychological functioning of a group of people who have been diagnosed with trichotillomania
- To identify commonalities in the cognitive style, self and interpersonal perceptions, capacity for control and stress tolerance, and the affective functioning of the participants in the study with the aid of the Rorschach Comprehensive System.

1.3 DEFINITIONS

For the purposes of the current study, personality structure is considered the relatively stable nature of people as can be inferred from their current thoughts and feelings. According to Weiner (1998), the thoughts and feelings elicited by specific situational circumstances constitute personality states. He regards people's abiding disposition to conduct themselves in certain ways, to constitute personality traits that comprise a broad range of fairly stable characteristics and orientations.

On the other hand, people's psychological functioning (or their personality dynamics) refers to the manner in which one's personality states and personality traits interact to influence each other. It also describes how a person's nature is affected by underlying needs, attitudes, conflicts, and concerns. These dynamic aspects influence people to think, feel, and act in certain ways at particular times and in particular circumstances (Weiner, 1998).

The Rorschach Comprehensive System describes people's personality structures and psychological functioning as they relate to specific characteristics of the components of the total personality, including:

- Their capacity for control and stress tolerance, which has to do with the available adaptive resources to cope with demands and to manage stress
- Information processing, which is how people pay attention to their worlds
- Cognitive mediation, which is how people perceive the objects of their attention
- Ideation, which is how people think about what they perceive
- Affective functioning, which is how people deal with emotional situations, and how they experience and express feelings

- Self-perception, which pertains to how people view themselves
- Interpersonal perception, which involves the way people perceive and relate to others.

The composite elements of these aspects are described in more detail in Chapter 5.

1.4 SCIENTIFIC CONTRIBUTION

It is envisaged that an exploration of trichotillomania patients' personality structures and psychological functioning would be particularly meaningful when cognisance is taken of the potential benefits of the outcomes of such a study.

It is believed that any project that explores the complex relationship between hair pulling and its associated features has the potential for immediate clinical application. People who seek help could benefit from validation of the commonalities across individuals with the same problem. This could in turn alleviate feelings of isolation and shame. Bearing such commonalities in mind, clinicians could conduct comprehensive, targeted assessments of how these factors manifest in individual patients' lives. Also, this study's outcome could facilitate adjustment of current psychotherapeutic modalities and interventions to accommodate common aspects.

Once the disorder is better understood, identification of commonalities could open doors for future research to determine, for example, if any of these factors remit after pulling; whether they have to be addressed directly or indirectly, concurrently or subsequently; and if specific treatments should be developed and/or implemented to address these issues.

CHAPTER 2

CHARACTERISATION OF TRICHOTILLOMANIA

2.1 INTRODUCTION

When Hallopeau (1889) first described the condition of chronic, self-directed hair pulling, he coined the term 'trichotillomania' from the Greek words thrix for hair, tillein that refers to the action of pulling out, and mania which means madness, to capture the essential characteristics of the disorder.

2.2 DIAGNOSTIC CLASSIFICATION AND CRITERIA

Trichotillomania entered the American Psychiatric Association's diagnostic classification system almost a century after Hallopeau's first case documentation when the third revised version of the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R) was published in 1987. At that time, it was grouped under Impulse Control Disorders Not Otherwise Specified.

The DSM-IV added a stipulation on the distress or impairment associated with the disorder, and classified trichotillomania with the other impulse control disorders (pyromania, kleptomania, pathological gambling, and intermittent explosive disorder) (American Psychiatric Association, 1994). A DSM-IV diagnosis of trichotillomania now requires that the following criteria be met:

- A. Recurrent pulling or failure to resist urges to pull out one's hair, resulting in noticeable hair loss
- B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behaviour
- C. Pleasure, gratification, or a sense of relief when pulling out hair

- D. The disturbance is not better accounted for by another mental disorder (e.g. those involving delusions or hallucinations where hair loss is self-induced) and is not due to a general medical condition (e.g. dermatological)
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other areas of functioning.

2.3 EPIDEMIOLOGY

Limited epidemiological research has been done on trichotillomania among the general population. Based on extrapolations from clinic referrals, it has initially been judged a rare condition (Diefenbach, Reitman, & Williamson, 2000). However, more recent epidemiological data suggest that hair pulling as a symptom and trichotillomania as a syndrome are relatively common.

In one of the first studies on the prevalence of trichotillomania in a non-clinical group, Christenson, Pyle, and Mitchell (1991) found a lifetime prevalence of 0.6% in a sample of 2,534 male and female college students. When less stringent DSM criteria were employed, 1.5% of these males and 3.4% of the females reported patterns of pathological hair pulling (Diefenbach, Reitman, & Williamson, 2000).

Trichotillomania is now considered a chronic condition, and is thought to be as common as schizophrenia. Its prevalence rate is conservatively estimated to be at least 1% of the total population (Soriano et al., 1996).

Swedo and Rapoport (1991) have suggested a bimodal age of onset for trichotillomania, with its typical occurrence either in early childhood or in adolescence. Swedo states that, in the majority of cases of early-onset trichotillomania, the symptoms appear before the age of two and often during infancy. Similar to thumb sucking and rocking, it occurs mainly at bedtime when the child is tired or bored, and during periods of separation or other stress.

In these cases the hair pulling is often associated with other self-soothing behaviours, and is considered more of a habit disorder that remits at school-going age (O'Sullivan, Keuthen, et al., 1997). On the other hand, 'classic' trichotillomania appears either in later childhood (after age eight) or early adolescence and older. The hair pulling is then more severe and resistant to treatment, and is often accompanied by a set of ritualised behaviours and considerable psychological distress.

Christenson, Mackenzie, and Mitchell (1991) found the mean age of onset for trichotillomania in a large sample of adult hair pullers to be 13 years.

Dawber (1985) found a male predominance (3:2) in early childhood trichotillomania. This ratio appears to change with later onset trichotillomania, with the predominance in females by a margin of 4:1. This finding was confirmed in a series of 145 sequential patients where males predominated in the preschool age group (Ratner, 1989).

Muller (1987) reported that 62% of the patients with onset before age six were boys, whereas 70% of the total distribution of chronic hair pullers were female. Although most patients who seek treatment for trichotillomania are women, especially in adolescent and adult populations, this unequal distribution could reflect underlying gender differences and the social acceptability of hair loss and help-seeking behaviour. Christenson, Mackenzie, and Mitchell (1994) suggest that although the lifetime prevalence of trichotillomania may be equal between men and women, men were perhaps more likely to seek treatment if other psychiatric problems were present, or if their hair pulling was more focused (see par. 2.5) or compulsive in nature.

No conclusive evidence on the long-term natural course of trichotillomania has been reported. Based on clinical history summaries and self-reports by patients who had sought help, O'Sullivan, Mansueto, Lerner, and Miguel (2000) report the course for typical patients (i.e. 40-year old, white, middle-class women with early adolescent

onset of the disease) to be chronic, with numerous remissions and exacerbations in the severity of their hair-pulling symptoms.

2.4 COMORBIDITY

Despite the clinical perception that patients who have been diagnosed with trichotillomania do not have significant secondary psychopathology (Winchel, 1992), research has established that other psychiatric disorders are more prevalent in groups diagnosed with trichotillomania than would be expected in the general population.

Christenson, Mackenzie, and Mitchell (1991) found a comorbid lifetime prevalence rate as high as 82% for Axis I disorders. Christenson, Chernoff-Clementz, and Clementz (1992) cite reports on trichotillomania that include cases of comorbid depression, psychotic disorders, eating disorders, and mental retardation. Diefenbach and colleagues (2000) state that comorbid mood, anxiety, and addictive disorders are most common on Axis I. They also cite studies where rates as high as a 20% lifetime prevalence for eating disorders and 23% for body dysmorphic disorders have been found. However, consistent with these and other studies that demonstrated a wide range of psychiatric comorbidity, no single Axis I diagnosis has consistently been associated with trichotillomania (Diefenbach et al., 2000).

Prevalence estimates of comorbid Axis II disorders are higher than have been found in the general population (Schlosser, Black, Blum, & Goldstein, 1994), but not higher than found in other psychiatric populations (Christenson, Chernoff-Clementz, & Clementz, 1992). Despite earlier findings of comorbidity with passive-aggressive and hysterical features (Sorosky & Sticher, 1980; Schnurr, 1988), obsessive-compulsive and schizoid personality disorders or features (Winnik & Gabbay, 1965; Chauhan, Jain, & Dhir, 1985) and borderline personality organisation (Galski, 1983; Greenberg & Sarner, 1965), no single personality disorder has been consistently associated with trichotillomania. Christenson, Chernoff-Clementz, and

Clementz (1992) also found that people with trichotillomania showed less Cluster A symptomatology than psychiatric controls, and there has been no difference in Cluster B and Cluster C pathology between the trichotillomaniac and nontrichotillomaniac groups.

Trichotillomania appears to be commonly associated with other problematic behaviours such as nail biting, skin picking, nose picking, picking at acne, lip biting, and cheek chewing (Christenson, Mackenzie, & Mitchell, 1991).

2.5 PHENOMENOLOGY

The unique experiences associated with this disorder vary across patients, but some common elements regarding its phenomenology have been documented.

Hair pulling occurs at any of one or more body sites. Christenson, Mackenzie, and Mitchell (1991) determined that the most common hair-pulling site was the scalp, followed by the eyelashes, eyebrows, and pubic hair. Most patients pull from more than one area.

The hair-pulling phenomenology is similar for men and women (Christenson, Mackenzie, & Mitchell, 1994). However, as with other psychiatric disorders where the symptoms increase during the luteal phase of the menstrual cycle, the hair pulling could exacerbate during the week prior to menstruation (Keuthen, O'Sullivan, Hayday, Peets, Jenike, & Baer, 1997).

A number of negative affective states and sedentary or contemplative activities have been identified as cues that frequently prompt or exacerbate hair pulling (Christenson, Ristvedt, & Mackenzie, 1993). Although many patients present with a mixed clinical picture that has elements of both types, O'Sullivan, Keuthen, and colleagues (1997) have identified two predominantly different styles of hair pulling. Christenson differentiates between them as follows:

- Focused hair pulling is phenomenologically similar to the rituals found in obsessive-compulsive disorder (OCD). It could incorporate the need for hair-pulling symmetry or attempts to pull hair with unique textures or qualities. Focusing on pulling often forfeits attention to necessary tasks. Focused hair pulling is associated with mounting tension before pulling or when attempting to resist the urge to pull, followed by a sense of relief. This is the dominant style of hair pulling among approximately a quarter of the patients (O'Sullivan, Keuthen et al., 1997).
- The other major style of hair pulling has been described as automatic or habitual, and it is not associated with a prodromal sensation or hair-pulling urge. Approximately three quarters of the patients with trichotillomania reported automatic pulling as their predominant style of hair pulling (O'Sullivan, Keuthen et al., 1997). Such pulling often occurs in the context of pensive leisure activities in which absorbed attention to a specific task is required while the patient is relatively inactive. These activities include watching television, speaking on the telephone, lying in bed at night in a state of anticipation or contemplation, reading, or driving.

Hair pulling is frequently ritualistic (Swedo & Rapoport, 1991). A hair that 'does not feel right' - too wiry, kinky, crooked, straight, or otherwise different - would be located, plucked out, and examined. Christenson, Mackenzie, and Mitchell (1991) found that about 48% of the people with trichotillomania would engage in some form of oral behaviour after pulling - running the hair across their lips, biting off the root, or eating the hair (trichophagy). Complete chewing of pulled hair occurs in 33% and hair ingestion in 10% of trichotillomania patients. This behaviour could give rise to serious medical conditions, including dental erosion, carpal tunnel syndrome, and skin infections. Hairballs (trichobezoars) in the stomach and large intestines could cause anorexia, stomach pain, anaemia, obstruction, peritonitis, and mortality if untreated (Christenson, Mackenzie, & Mitchell, 1991).

Hair-pulling sessions could vary from 4-5 hours during which several hundred hairs would be pulled, to brief episodes with only a few hairs pulled at a time. However, this could recur several times in the course of a day. Pulled hairs are sometimes piled before they are discarded.

Most trichotillomania patients do not experience pain during hair pulling. Christenson, Raymond, and Faris (1994) investigated the hypothesis that increased pain thresholds might serve a permissive function in the development and/or maintenance of trichotillomania, but found no significant difference in either pain detection or pain tolerance thresholds between the control group and trichotillomania patients.

Most of these patients take great pains to conceal the bald areas by clever use of make-up, hairstyle, or head coverings, and many avoid outdoor activities, interpersonal contact (social and occupational), intimate relationships, and scenarios where the problem might be exposed.

One destructive consequence of chronic hair pulling is the effect it has on the patient's appearance and sense of self-control. Others are the attendant secrecy and feelings of shame and humiliation, and the sense of isolation that negatively impacts on a patient's self-concept and self-esteem (O'Sullivan, Keuthen et al., 1997; Soriano et al., 1996; Townsley Stemberger, McCombs Thomas, Mansueto, & Carter, 2000).

Despite a better understanding of the disorder during the past decade, the pathology of trichotillomania seems to span several disciplines. Many of the complexities of its characterisation and phenomenology consequently remain unclear.

CHAPTER 3

CONTENTIOUS ISSUES IN TRICHOTILLOMANIA

3.1 INTRODUCTION

As mentioned before, trichotillomania is currently classified as an impulse control disorder. Some clinicians believe, however, that the criteria set by the DSM-IV could also identify individuals suffering from different psychopathological or pathophysiological conditions (Koran, 1999). This classification and criteria of trichotillomania have therefore remained contentious. Several approaches to the categorisation of trichotillomania have since been proposed in attempts to accommodate the divergence ascribed to the different components of the disorder.

This section highlights the main reasons behind the continuing debate about the diagnostic requirements for trichotillomania. A number of alternative classification schemes that are still under investigation are described.

3.2 TRICHOTILLOMANIA AS IMPULSE CONTROL DISORDER

According to Sue, Sue, & Sue (1994), impulse control disorders such as trichotillomania share three characteristics:

- Firstly, people with an impulse control disorder fail to resist an impulse or temptation to perform some act, knowing that the act is considered wrong by society or harmful to them. The impulse may or may not be consciously resisted, and its performance may or may not be premeditated.
- Secondly, most sufferers experience tension or arousal before the act referred to above.
- Thirdly, they experience a sense of excitement, gratification, or release after committing the act. Guilt or regret may or may not follow.

Despite generally fulfilling these requirements, controversy concerning the classification of trichotillomania and its diagnostic criteria persists. A significant percentage of hair pullers do not meet criterion A or B of the DSM-IV's characteristic symptoms of impulse control disorders - a mounting tension before and/or a tension-release or gratification cycle after having engaged in destructive behaviour. In a sample of 60 patients referred for treatment for hair pulling, Christenson and colleagues (cited in (Diefenbach, Reitman & Williamson, 2000) found that 5% did not report mounting tension before pulling, and 12% did not report tension release, pleasure, or gratification associated with pulling.

Based on these results, some researchers (cited in Diefenbach et al., 2000) argue that the current DSM-IV diagnostic criteria may be too restrictive, and that they cast some doubt on the classification of trichotillomania as an impulse control disorder.

Several alternative classifications have since been proposed.

3.3 TRICHOTILLOMANIA AS HABIT DISORDER

Based on resemblances between hair pulling and other nervous habits such as pathological nail biting (onychophagia) and skin picking, some authors believe that trichotillomania could be considered a habit disorder.

Analogous to previously mentioned aspects of trichotillomania's phenomenology, habit disorders mainly occur without conscious awareness, while the individual is attending to another task. These disorders seem to provide some kind of soothing function, but could also cause damage to one's own body (Ninan, Mansueto, Rothbaum, O'Sullivan, & Nemeroff, 1999). Similarities such as these suggest a degree of relatedness between hair pulling and prototypic habit disorders.

Friman (1992) refers to paediatric, behavioural, and dermatological literature on hair pulling to emphasise that it usually presents as a benign habit similar to thumb

sucking (another habit with which it often covaries in children). In these cases the hair pulling is easily treated with behaviour modification, counselling, or even placebo-type interventions (Friman, 1992; Friman & Hove, 1987).

Others do not view trichotillomania as simply a habit. After reviewing more than 40 people with trichotillomania, Mansueto (1991) noted that his data challenged the widespread impression that trichotillomania was a simple nervous habit, and that the problem was instead revealed as a complex disorder with great variation in individual expression.

The issue is complicated by the fact that some habit disorders involve 'empty' behaviours where symptom-oriented approaches are appropriate. Others, such as the trichotillomania case report cited by Oakley (1998), appear to be maintained by underlying anxieties and unresolved issues. In such cases, the habitual hair pulling seems to serve an important psychological function in the individual, but has distressing consequences.

No revised categorisation has therefore been reached to group trichotillomania as a habit disorder. However, a distinction between hair pulling as a behavioural symptom and trichotillomania as a clinical syndrome with substantial psychological sequelae could clarify debated aspects surrounding the disorder's classification as a habit disorder.

3.4 TRICHOTILLOMANIA AS DISORDER OF ABNORMAL GROOMING

Swedo and Rapoport (1991) suggested that trichotillomania could belong to a spectrum of unwanted repetitive species-typical behaviours, and that syndromes such as trichotillomania, compulsive feather picking in birds (Grindlinger & Ramsay, 1991), psychogenic alopecia in cats, and acral lick dermatitis in dogs (Goldberger & Rapoport, 1991) could represent pathological variants of normal

grooming behaviours. These authors believe that the phenomenological aspects of trichotillomania could intimate pathology in the neurobiological mechanisms responsible for grooming behaviours. Specifically, this neuroethological theory proposes that neurological dysfunction causes the preprogrammed grooming behaviours - that are normally under higher cortical control - to be released inappropriately as 'fixed action patterns'.

While Swedo and Rapoport (1991) admit that phenomenological similarities between hair pulling and some animal behaviours represent a provocative analogy, pharmacological studies in this regard imply homologous mechanisms or neural structures subserving these behaviours. In fact, Grindlinger and Ramsay (1991) found evidence of a link between dysfunctional serotonergic activity and repetitive grooming behaviour in animals, and suggested that this neurobiological approach could provide a model for trichotillomania. However, no conclusive evidence has as yet been proposed for this model.

3.5 TRICHOTILLOMANIA AS OBSESSIVE-COMPULSIVE SPECTRUM DISORDER

Based on the phenomenological overlap with obsessive-compulsive symptoms, it has been suggested that trichotillomania may be conceptualised as either a variant of obsessive-compulsive disorder (OCD) (Tynes et al., 1990), or that it may be a distinct disorder that shares a biological aetiology with the obsessive-compulsive spectrum disorders (Jenike, 1989; Swedo & Leonard, 1992; Hollander & Wong, 1995).

Hollander (1993) coined the umbrella concept of obsessive-compulsive 'spectrum' disorders to describe a group of disorders that share features with OCD in a range of domains, including phenomenology, family history, aspects of clinical course, treatment response, and possibly serotonergic mediation. The obsessive-compulsive spectrum disorders include certain neurological conditions (e.g. Tourette's syndrome, Huntington's disease, Sydenham's chorea, autism, epilepsy); certain eating and

somatoform disorders; variants of OCD; most of the impulse control disorders; depersonalisation disorder; borderline, antisocial, and obsessive-compulsive personality disorders; and the habit disorders of nail biting and skin picking (Hollander & Wong, 1995; McElroy, Phillips, & Keck, 1994).

Another hypothesis purported that obsessive-compulsive spectrum disorders vary along a continuum of compulsivity versus impulsivity, with compulsive disorders reflecting excessive harm avoidance and risk aversion, and impulsive disorders characterised by the minimisation of harm and risk (Stanley & Cohen, 2001). This proposed dimension of obsessive-compulsive spectrum disorders may be particularly relevant to the relationship between OCD and trichotillomania.

Despite suggestions of subclassifications, the general concept of obsessive-compulsive spectrum disorders has recently been criticised as vague, overinclusive, and lacking clear inclusive or exclusion criteria (Stanley & Cohen, 2001).

Notwithstanding the debate, the proposed relationship between trichotillomania and OCD stimulated numerous research investigations to compare the two patient populations. However, researchers have generally found more differences than similarities.

Specifically, trichotillomania and OCD differ phenomenologically in terms of the severity of obsessional symptoms and the perceived pleasure derived from the behaviour (Stanley, Borden, Bell, & Wagner, 1994). The disorders can also be distinguished with respect to stimulus cues (Mackenzie, Ristvedt, Christenson, Lebow, & Mitchell, 1995), attentional focus (Christenson, Mackenzie & Mitchell, 1991), and demographics (Himle, Bordnick, & Thyer, 1995; Mackenzie et al., 1995; Stanley, Swann, Bowers, Davis, & Taylor, 1992).

Himle and colleagues (1995) found that patients who met the criteria for OCD scored higher on measures of psychiatric symptomatology than patients with trichotillomania, including ratings of obsessions and compulsions, general and phobic anxiety, interpersonal sensitivity, depression, and psychoticism.

Stanley and Cohen (2001) report that, although both trichotillomania and OCD are affected by serotonin probes, serotonergic probes produce a euphoric effect in patients with trichotillomania but a dysphoric effect in OCD, as well as an altered response in OCD but not in trichotillomania. Also, trichotillomania (but not OCD) is responsive to pharmacotherapy with lithium (Christenson, Popkin, Mackenzie, & Realmuto, 1991).

Although higher rates of OCD were found in the families of trichotillomania patients relative to the general population (Lenane et al., 1992), OCD rates in families of OCD patients were still higher than in the families of trichotillomania patients (Stanley & Cohen, 2001).

Comorbidity as high as 27% has been reported between trichotillomania and OCD in samples reported by Christenson, Mackenzie and Mitchell (1991) and Schlosser et al. (1994). However, it has been significantly lower in a study conducted by Winchel, Jones, Stanley, Molcho, and Stanley (1992).

These and other results seem to support the validity of conceptualising trichotillomania and OCD as differing behavioural disorders. However, it is clear from all the above that the conceptualisation of the disorder remains undecided.

CHAPTER 4

THEORETICAL CONCEPTUALISATION OF TRICHOTILLOMANIA

4.1 INTRODUCTION

Some authors describe trichotillomania as “a disorder of unknown aetiology” (Peterson, Campise, & Azrin, 1994, p.434). While there is no consensus about the cause of trichotillomania, several aetiological models have been proposed from differing theoretical perspectives. A review of the literature reveals three main theoretical models namely psychoanalytic, behavioural, and biological.

4.2 PSYCHOANALYTIC MODEL

Aetiological theories of trichotillomania based on the psychoanalytic perspective explain the symptom of chronic hairpulling as a symbolic expression designed to relieve anxiety generated by some unresolved and/or unconscious conflict (Greenberg & Sarner, 1965; Tattersall, 1992).

The model assumes that the past leaves a living record within the personality that is dynamically related to the present. Bearing this in mind, the classic psychoanalytic literature ascribes multiple symbolic meanings to hair (Berg, 1936). It is considered a symbol of beauty, virility, and physical prowess (Kanner, 1959); a bisexual symbol (Sperling, 1954); and representing displaced sexual conflicts (Simmel, 1925; Zaidens, 1951; Andreasen, 1980). Hair cutting or plucking has also been associated with fears of castration (Barahal, 1940; Sperling, 1954).

Although childhood trauma, and specifically sexual abuse, has been said to play a role in the development of trichotillomania (Greenberg & Sarner, 1965; Singh & Maguire, 1989), more recent studies found the association between sexual abuse and trichotillomania to be unusual (Christenson, Mackenzie, & Mitchell, 1992).

Certain unconscious themes concerning the loss of hair appear repeatedly in the classical mythology and in anthropological studies. Hollander (in Stein & Christenson, 1999) refers to the Medusa myth, the goddess Athena, the Sirens, and other folklore to elucidate the sexual symbolism attributed to hair. The relation between hair plucking or hair cutting and the mourning process is also well documented. In the story of Rapunzel, the cutting of hair is symbolic of castration, loss of the mother, and separation. In various Hindu cultures, shaving of the scalp is associated with separation and the mourning process. In another culture the hair of the bereaved is laid beside the dead, and in others the widow's hair is thrown onto the funeral pyre of the dead husband. One community in India requires hair plucking before a person enters a life of penance. Similarly, Christian monastic life has traditionally been associated with shaving one's hair.

A number of psychodynamic case reports suggest that trichotillomania may be associated with poor object relations (Greenberg, 1969). Although the absence of a control group reduces the significance of this finding, Krishnan, Davidson, & Guajardo (1985) found a high frequency of actual or threatened object loss prior to the onset of hair-pulling symptoms. This fear is often associated with the absence of the mother. Krishnan and colleagues (1985) and Buxbaum (1960) concurred that hair pulling could be a means of working through real or perceived threats of object loss. Hollander (in Stein & Christenson, 1999) states that this fear of loss or abandonment may reflect unresolved dependency needs originating in earliest infancy, or represent feared punishment for forbidden sensual wishes or rebellious anger later in the child's development.

Many adult patients avoid heterosexual involvement as the loss of their feminine attractiveness signifies to them that they are not worth loving.

Greenberg and Sarner (1965) approached the problem as resulting from multiple fixation points at all levels of psychosexual development:

- At the oral level, pulling, saving, or eating hair could symbolise incorporation and identification with the mother, and reassurance against her loss.
- At the anal level, hair plucking could represent rage and frustration directed toward the object and the internalised superego, with the symptom becoming a depressive equivalent.
- At the genital stage, hair pulling in the female could demonstrate to her mother that the girl is willing to deny her femininity and give up the oedipal struggle. For both sexes, however, hairlessness symbolises a return to innocent childhood where the patient has renounced all claims to genital sexuality.

As the hair is pulled out by the individual personally, several authors have considered issues of autoaggression, autoeroticism, and masochism in relation to trichotillomania (Greenberg & Sarner, 1965; Mannino & Delgado, 1969).

Buxbaum (1960) considered the hair-pulling symptom as a fetish, multi-determined by a variety of unconscious conflicts. According to her formulation, hair pulling could represent transitional phenomena that are secondary to separation anxiety; autoaggression (anger turned inwards) that is secondary to feelings of ambivalence towards the parents; autoerotic activity designed to counter feelings of loneliness, insecurity, and anxiety; displacement of castration fears secondary to a wish to pull the parent's hair (especially the 'castrated' mother's for the girl); an amalgamation of painful and pleasurable sensations (early symptoms of masochism); signs of despair and mourning; and/or a means of reassuring the particular patient of his/her existence through the bodily sensations he/she experiences.

It is clear from the above why the psychodynamic model considers hair to be symbolic of an attempt to resolve conflict around a variety of sexual and aggressive issues, or as conflict in connection with dependency and the loss of loved ones.

Several case reports have been published of successful psychoanalysis or psychoanalytically oriented therapeutic interventions with adult patients (Monroe & Abse, 1963; Sorosky & Sticher, 1980), but few describe the specifics of the treatment model. Paul and Cunningham (2000) emphasised the need to explore the unique content and meaning of patients' hair-pulling behaviour to establish the connection between their life experiences and the symptom. In this case, treatment would involve the clarification and interpretation of transference and countertransference reactions that repeat early interaction patterns between the child and its primary caretaker(s). This process allows patients to work through early developmental conflicts until the function of the hair pulling has been resolved. Krishnan, Davidson, and Guajardo (1985) describe two cases in which the occurrence of trichotillomania was related to object loss. In these cases, the value of hair as transitional object was neutralised by working through fears of abandonment and associated rage.

The very nature of the psychoanalytic paradigm unfortunately precludes empirical evidence of the validity of its theoretical concepts and treatment strategies, and few modern clinicians acknowledge its potential contribution to the field of trichotillomania. Much of the recent discourse around trichotillomania consequently focused on what Tanquary (1994) refers to as "mechanistic and biologically reductionistic" (p.35) conceptualisations of the disorder.

4.3 COGNITIVE-BEHAVIOURAL MODEL

Behavioural perspectives on trichotillomania have traditionally focused on factors that maintained the chronic hair-pulling symptom. Azrin and Nunn (1973) proposed that the process by way of which trichotillomania is learnt is similar to other habit-forming

processes. Hair pulling is believed to develop as a coping behaviour in response to stress, reinforced by tension-reduction experiences or negative reinforcement. These may be pleasurable sensations derived from the pulling, and securing of desired hair or roots, and/or achieving a desired outcome such as the removal of unwanted hair. Other desirable outcomes could be the reduction or elimination of aversive conditions including the alleviation of tension, boredom, or other negative affective states, or an escape from undesirable tasks or thoughts (O'Sullivan et al., 2000). Cravings for the physical sensations associated with pulling could become conditioned (Friman, Finney, & Christophersen, 1984). Pulling episodes are often only ended by aversive sensations and cognitions experienced as punishment. Ultimately, through both classical and operant conditioning processes, the behaviour becomes associated with an increasing number of internal and external cues until it eventually becomes habitual - often occurring without the person being consciously aware of it. As can be expected, the patient's subjective experience of continued control over the hair-pulling behaviour decreases significantly once he/she finds him/herself with hands full of pulled hair without clearly remembering doing it.

Another hypothesis, response covariation, has proven useful for describing the aetiology of early-onset trichotillomania. The successful treatment of thumb sucking has also eliminated covariant hair pulling (Friman & Hove, 1987; Knell & Moore, 1988; Watson & Allen, 1993).

Appreciation of the diagnostic complexities and the limits of categorical diagnoses have prompted behavioural therapists to develop behavioural treatment models to accommodate the diverse subjective and behavioural phenomenology of hair pulling.

Habit-reversal techniques acknowledged and addressed the impact of environmental variables, motor habits, and affective states in hair pulling. Other techniques

highlighted the role of cognitive features and added cognitive-based treatment strategies for trichotillomania. These techniques include self-monitoring by means of hair collection, improving coping strategies by identifying preventive strategies for high-risk situations, motivation enhancement, changing the internal monologue, awareness training, competing response training, and relaxation skills training (Koran, 1999).

More recent developments in the cognitive-behavioural field favour a comprehensive conceptual and behavioural model that incorporates the behavioural, affective, and cognitive variables into the diverse and idiosyncratic features characteristic of trichotillomania (O'Sullivan et al., 2000). The integrative model organised all these variables into a functional analytic framework that incorporates the different antecedents that stimulate the urge to pull or facilitate pulling, the wide range of behaviours involved in the actual pulling of hair, and the full range of consequences of hair pulling.

4.4 BIOLOGICAL MODEL

A limited but growing body of literature hints at the structural and functional neurobiologic correlates of trichotillomania (Stein, 2000; Stein, O'Sullivan, & Van Heerden, 1998; Swedo & Rappoport, 1991), and differentiates subjects with trichotillomania from healthy controls and other groups with obsessive-compulsive spectrum disorders (O'Sullivan et al., 2000).

Somatosensory sensations, parasthesias, and prodromal urges (rather than obsessions) that precede hair-pulling episodes have become associated with the urge to pull (Diefenbach et al., 2000). Patients with trichotillomania sometimes describe a tingling or other sensation on the body area(s) from which they usually pull, and it is frequently these sensations that drive the pulling response. It is thought that this sensation approximates Tourette's syndrome, in which somatosensory urges also seem to drive

the motor tics. Certain neurological similarities have subsequently been noted between trichotillomania and Tourette's syndrome (O'Sullivan, Rauch et al., 1997; Stein & Hollander, 1992).

As for the possible neurobiological correlation of hair pulling (one of a number of unwanted repetitive motor behaviours), recently conducted controlled medication trials found that neurotransmitters such as serotonin and dopamine play an important role in mediating the neurons that affect trichotillomania and obsessive-compulsive spectrum disorders.

It is not yet clear to what extent the development of trichotillomania is influenced by genetic factors. Although some studies have found rates of between 4% and 8% of first-degree relatives who also pulled their hair (Christenson, Mackenzie, & Reeve, 1992; Lenane et al., 1992; Schlosser et al., 1994), it is difficult to generalise these findings.

Other biological theories ranged from dysregulated grooming (see par. 3.4) to complex autoimmune (Swedo, 1994) or neuroimmunocutaneous-endocrine interactions (O'Sullivan, Lipper, & Lerner, 1998).

Trichotillomania was initially treated with topical agents directed at the cutaneous sensations that might prompt hair pulling. The first drug treatment for trichotillomania was introduced in 1985, when Childers (cited in Paul & Cunningham, 2000) reported two long-standing cases that responded positively to chlorpromazine. Several studies were subsequently conducted to test the impact of clomipramine, desipramine, fluoxetine, and naltrexone. Trichotillomania has shown some responsiveness to serotonin re-uptake inhibitors, but not to noradrenergic re-uptake inhibitors (Stein et al, 1995).

However, the variety and inconsistency of the research findings and the inconsistent results produced by pharmacological treatments offer only tentative and incomplete biological explanations for phenomena associated with trichotillomania. Furthermore, these treatments do not address the many psychological, behavioural, and interpersonal sequelae of the disorder.

4.5 COMMENT

Researchers are currently investigating the possibility that the heterogeneous nature of trichotillomania could reflect subtypes of the disorder with differing aetiologies (Minichiello, O'Sullivan, Osgood-Hynes, & Baer, 1994). Although Du Toit, Van Kradenburg, Niehaus, and Stein (2001) have found that differences in the population could rather reflect greater severity in hair-pulling symptomatology than distinct subtypes, the aetiology of hair pulling in every individual client could well denote a complex interaction of biological, psychological, and social factors.

Diefenbach and colleagues (2000) point out that the continued elaboration of integrative conceptualisations that draw from multiple perspectives therefore presents an important tool in advancing the scientific understanding of trichotillomania. Furthermore, as each level of analysis approaches the disorder from a different perspective, they emphasise that the trichotillomania population would benefit most when these paradigms are used to complement each other.

CHAPTER 5

OVERVIEW OF THE RORSCHACH COMPREHENSIVE SYSTEM

5.1 NATURE OF THE RORSCHACH

The ten inkblots that constitute the stimuli of Herman Rorschach's inkblot test were first presented to the professional public in 1921 (Exner, 1993). Since then, the instrument has generated much interest, extensive use, and considerable research.

As a cognitive structuring task that comprises uniform stimuli, standard administration, formal coding, and specific interpretative guidelines, the Rorschach is in many ways an objective assessment technique. Weiner (1998) describes the Rorschach as an instrument that constitutes in part a problem-solving task to provide an objective assessment of a subject's cognitive structuring style. However, it also presents a stimulus to fantasy that provides a subjective assessment of thematic imagery. Weiner (1998) points out that the production of Rorschach responses involves processes of association, attribution, and symbolisation, which lead to the assignment of characteristics that go beyond the actual stimulus features of the blots.

Two key considerations in elucidating the nature of the Rorschach instrument are then relevant. The first of these, the projection process, occurs when people attribute their own internal characteristics to external stimuli without justification - and without being consciously aware that they are doing so. The second consideration, the role of ambiguity, is closely linked to the extent of inherent structure in the stimuli and the nature of the subject's task.

According to Weiner (1998), Schachtel (1966) and Exner (1989), responding to Rorschach stimuli may and often does involve projection, but may also happen independently. As the instrument embraces both ambiguous and clearly defined

stimuli and task elements, Weiner (1998) regards it a relatively unstructured technique among personality assessment techniques, rather than a merely projective method.

5.2 BACKGROUND TO THE COMPREHENSIVE SYSTEM

The Rorschach Research Foundation was established in 1968. Its principal aim was to conduct a comparative analysis of the five major approaches to the Rorschach method. The Foundation originally sought to validate the Rorschach method empirically by excluding aspects of other applications that were found to be unreliable or invalid and hence not of clinical value, and to introduce empirically sound contributions to the administration, scoring, and interpretation of the instrument.

Due to the scope of the original study, however, the development of a Comprehensive System was suggested and has expanded considerably since its introduction by Exner in 1974. It was motivated primarily by the need for a consistently administered, adequately normed, reliably scorable, and psychometrically sound method of Rorschach assessment.

The Comprehensive System rests on three pillars namely standardised administration, objective and reliable coding, and a representative norm base. It has become a reliable way to assess a subject's personality structure and psychological functioning. It has been used as an aid in the diagnosis of various conditions that involve specific patterns of personality functioning. It furthermore offers well-validated contributions to identifying treatment targets and potential obstacles to progress in psychotherapy, selecting appropriate treatment modalities, and monitoring change and improvement over time (Weiner, 1998).

5.3 APPROACH TO ANALYSIS

The Comprehensive System enables thorough analysis of a wide range of Rorschach data, including the interpretation of structural variables, content themes, sequence

analyses, and test behaviours. For the purposes of the current study, however, only the structural variables have been considered.

5.3.1 Clusters of variables

Seven groups of intercorrelated variables were identified for structural analysis after a formal examination of all the Rorschach data. These groups were designated Rorschach 'clusters' or sections.

Each of these seven clusters of intercorrelated structural variables were found to be related to a distinct aspect of personality functioning.

5.3.1.1 The control and stress tolerance cluster provides information about subjects' innate and current psychological resources, their ability to manage stress, and their capacity to cope consistently and effectively with life events.

Sufficient resources are needed to minimise subjectively felt distress and maintain a consistent coping style, in order to promote psychological well-being and successful adaptation to life demands. Exner and Weiner (1999) purport that the combination of inadequate resources, excessive stress, and inconsistent coping efforts are typical of lives marked by distress, disappointment and limited accomplishment. The relevant Rorschach findings help to identify the extent of the adaptive capacity subjects can muster in planning and implementing ways of dealing with their everyday experiences; the extent and kinds of stressful demands in their lives; how well they can tolerate their level of stress without becoming unduly upset and losing self-control; and the adequacy with which they can bring a cohesive personality style to bear in managing their affairs.

Situation-related stress is explored by an array of variables that have broad significance for the manner in which subjects use ideation, modulate affect, view themselves, and relate to others. Exner and Weiner (1999) state that, when

considered in combination, the situational stress variables provide information concerning the nature and sources of situational stressors that impinge on any subject's psychological organisation and functioning.

5.3.1.2 The information-processing section provides information about the manner in which subjects focus their attention on events in their lives, and how they organise perceptions that enter their awareness.

Exner and Weiner (1999) suggest that successful adaptation is promoted by an openness to experience and the efficient organisation of the impressions a person forms, whereas viewing the world from a narrow or disorganised frame of reference makes a person susceptible to various types of adjustment difficulties.

5.3.1.3 The cognitive-mediation section provides information about the manner in which subjects perceive their environments, and especially whether they perceive people and events the way most other people do.

According to Exner and Weiner (1999), the ability to perceive one's experience realistically and with a modicum of conventionality constitutes a personality strength that typically contributes to good adjustment. Conversely, they emphasise that subjects' difficulties in seeing themselves and their world in a realistic light represent a personality limitation that may cause adjustment problems. The same is true of inclinations that are unusually conforming or highly idiosyncratic in forming impressions of experiences.

5.3.1.4 The ideation section provides information about the way subjects think about the experiences they have and the impressions they form of events in their lives.

People adapt best when they are able to think about their experiences and impressions in a logical, flexible, coherent, constructive, and only moderately preoccupied manner. Conversely, being inclined to illogical, inflexible, incoherent,

overly fanciful, or excessively preoccupying ways of thinking, constitute a personality liability that interferes with psychological adjustment (Exner & Weiner, 1999).

- 5.3.1.5 The affective features section provides information about the manner in and comfort with which subjects process their emotional experiences, but specifically with how they deal with their own feelings, and how they respond to the feelings of others and to emotionally charged situations in general.

According to Exner and Weiner (1999), the relevant Rorschach findings help to identify whether people can experience and express emotion sufficiently, pleasurably, and in moderation, or whether instead they are prone to process affect in a constricted, dysphoric, or overly intense manner that leads to adjustment difficulties.

- 5.3.1.6 The self-perception cluster provides information about how subjects view themselves, particularly with respect to their self-esteem, the extent of their self-awareness, and the nature of their self-image.

The relevant Rorschach findings help to identify whether people feel satisfied and comfortable with themselves or if they are burdened by negative self-attitudes. They also recognise whether the subjects are excessively preoccupied with or paying little attention to themselves, and whether they have a clear and stable sense of their identity rather than an uncertain and unrealistic grasp of the kind of persons they are (Exner & Weiner, 1999).

- 5.3.1.7 The interpersonal perception section provides information about how subjects relate interpersonally, particularly in their attitudes to others, the degree of interaction they have with others, and the manner in which they approach and manage interpersonal attachments.

Exner and Weiner (1999) contend that the relevant Rorschach findings help to identify whether people are able to sustain a reasonable level of interpersonal interest,

involvement, and comfort, or are instead inclined to be disinterested, disengaged, or ill at ease in social situations; whether they anticipate intimacy and security in their interpersonal interactions, or whether they tend instead to regard interpersonal closeness as threatening to their well-being and therefore keep their distance from others; whether they can strike an adaptive balance between collaboration and tolerance on the one hand, and competitiveness and assertiveness on the other hand, or whether they tend instead to become excessively subservient or domineering in their interpersonal relationships. These findings also reveal whether they perceive people and social situations accurately and with empathy, or are instead prone to misinterpret the motives of others and to misconstrue the implications of interpersonal events (Exner & Weiner, 1999).

5.3.2 Sequential search strategy

The Comprehensive System features a routine for the optimal review of each of the above clusters. Exner and his team (1991) uncovered 12 key variables that, when set in order of dominance or priority, appear to define the optimal order of cluster review.

Six special indices were developed to aid diagnostic considerations. These include the Suicide Constellation (SCON), the Depression Index (DEPI), the Coping Deficit Index (CDI), the Hypervigilance Index (HVI), the Obsessive Style Index (OBS), and the Perceptual Thinking Index (PTI) which replaces the earlier Schizophrenia Index (SCZI)¹.

Most of these special indices form part of the 12 key variables. It is important to bear in mind that the presence of a key variable predicts which combination of clusters would yield the data sources that contributed to the most substantial information about a subject's core psychological features. In fact, the key variables are dominant elements in the personality structure and have a major impact on a person's psychological functioning.

¹ For the purposes of this study, only the PTI was considered.

The first six key variables ($PTI > 3$, $DEPI > 5$ and $CDI > 3$, $DEPI > 5$, $D\text{ Score} < Adj\ D$, $CDI > 3$, and $Adj\ D < 0$) deal with personality structure. They focus on the presence of psychopathology or the potential for functional disorganisation. The remaining six variables ($\Lambda > 0.99$, $Reflection > 0$, $EB = \text{Introversive}$, $EB = \text{Extravertive}$, $p > a + 1$, $HVI = \text{Positive}$) define the more basic personality styles - any of which may form the cornerstone of the individual's future organisation and functioning (Exner, 1993).

The identification of any of these key variables suggests the presence of strong, relatively fixed character traits or pathology. It was therefore, for the purposes of this study, relevant to determine whether and/or which key variables introduce individual subjects' search strategies.

TABLE 1: RECRUITMENT OF RESPONDENTS

Source	Number	Percentage
1. Newspaper article	2	3
2. Professional seminars, Conferences and symposia	14	19
3. Research institutes	1	1
4. Word of mouth	3	4

CHAPTER 6

METHODOLOGY

6.1 PARTICIPANTS

Fifteen people were selected for this project ($N=15$). As the purpose of the study was exploratory and the identification of participants proved exceptionally exigent, sampling was purposive rather than representative.

The participants were enlisted from various sources, including referrals from local psychiatrists and dermatologists, the Obsessive-Compulsive Disorder Association of South Africa, the Trichotillomania Learning Centre of South Africa, and printed media advertisements.

As demonstrated in Table 1, 53% ($N=8$) of the final sample were members of the Trichotillomania Learning Centre of South Africa who had indicated that they were willing to participate in research projects on the illness. A further 3 participants (20%) who were also involved with the Trichotillomania Learning Centre, were enlisted by word of mouth. Four participants (27%) responded to an article in the REKORD suburban newspaper. Participation in the study was voluntary and without remuneration.

TABLE 1: RECRUITMENT OF RESEARCH PARTICIPANTS

SOURCE	N	%
1. Newspaper article	4	27
2. Trichotillomania Learning Centre of South Africa	11	73
• Research volunteers	8	53
• Word of mouth	3	20

6.1.1 Selection criteria

In addition to having a DSM-IV diagnosis of trichotillomania, factors that determined the participants' inclusion in the study were i) gender; ii) age (18 to 65 years); iii) late onset of trichotillomania (after age eight); iv) the absence of organic impairment, mental retardation, or acute psychosis; and vi) the participants' outpatient status.

Although all the participants had a history of visible, self-induced hair loss, the actual hair-pulling sites were not physically examined to rule out differential diagnoses. However, the participants' condition was verified via a self-report version of the DSM-IV criteria for trichotillomania, and all the participants completed the Massachusetts General Hospital Hairpulling Scale (see par. 6.2.1).

Two participants (13%) did not experience the tension-release and/or gratification cycle required by the DSM-IV. As this criterion is still a matter of debate (see par. 3.2), however, their inclusion is consistent with the subject profile of other major studies (Christenson, Mackenzie, & Mitchell, 1991; Christenson, Chernoff-Clementz, & Clementz, 1992; Soriano et al., 1996; Ninan et al., 1999).

It was acknowledged that comorbid conditions would affect the results of this study. However, the scope of the project did not warrant a comprehensive, structured DSM-IV screening of all the participants. In order to limit the impact of unknown comorbid psychiatric diagnoses, it was decided to exclude those who had been admitted to a psychiatric hospital before. In other words, despite the possible presence of comorbid conditions, it was assumed that the participants' functioning would not be affected below a Global Assessment of Functioning (GAF) Scale of 51-60.

As personality structure is not a transient phenomenon that is significantly affected by the presence or absence of symptoms, the participants' current phase of acuity or

residual state was not considered for inclusion criteria. Also, although situational stress is an integral and probably unavoidable part of every person's psychological functioning, its potential for confounding effects on the participants' current level of functioning was nevertheless considered in the analysis of the Rorschach data.

6.1.2 Demographic variables

Table 2 reflects the demographic characteristics of the sample which consisted of adult Caucasian females only. All but one participant ($N=14$) (93%) were in their early adulthood (18-45 years). The participants' ages ranged from 23 to 51 years, with a mean age for the sample of 34.5 years.

Only 3 of the participants (20%) were unmarried. Of these, 1 participant has been in a serious relationship for the past two and a half years, another has been in a lesbian relationship for the past four years, and the other one has been single since school and has never had a serious relationship.

All but 3 participants (80%) had completed Std. 10. The majority of the participants (53%) had furthered their secondary education by means of finishing or technical diploma courses. Two participants (13%) had obtained a professional qualification at university level. The participants averaged 12.9 years of education, with a range of 8 to 17 years.

Most of the participants resided in Gauteng ($N=12$) (80%). Of these, 9 (60%) lived in metropolitan areas, 2 (13%) on smallholdings, and 1 (7%) in a rural town. Two of the participants (13%) were residents of rural towns in the North West Province and Mpumalanga, and another (7%) lived on a farm in Mpumalanga.

All the participants were fluent in either Afrikaans ($N=9$) or English ($N=6$). Both the structured interview and administration of the Rorschach were conducted in the participant's home language.

Written informed consent was obtained from all the participants. The participants' names were omitted from their records to ensure anonymity, and replaced with research codes. The usual ethical guidelines for the confidentiality of information applied.

TABLE 2: DEMOGRAPHIC VARIABLES OF SAMPLE

VARIABLE	N	%	VARIABLE	N	%	VARIABLE	N	%
RACE			MARITAL STATUS			AGE		
White	15	100	Married	12	80	18-25	3	20
			Single	3	20	26-35	5	33
						36-45	6	40
						46-55	1	7
EDUCATION			RESIDENCE			LANGUAGE		
Under 12 yrs	3	20	Urban	9	60	Afrikaans	9	60
12 yrs	1	7	Suburban	3	20	English	6	40
13-15 yrs	9	60	Rural	3	20			
16+ yrs	2	13						

6.2 DATA COLLECTION PROCEDURES

6.2.1 MGH Hairpulling Scale

The Massachusetts General Hospital (MGH) Hairpulling Scale was used to determine the participants' behaviours and/or feelings concerning their symptoms in the course of the week preceding assessment (attached as Appendix A).

The MGH Hairpulling Scale is one of the most well-known and accepted tests for the clinical assessment of trichotillomania. It has been shown to form a homogeneous scale for the measurement of severity (Keuthen, et al., 1995), and is used most often in view of empirical documentation on its acceptable reliability and validity (Keuthen, et al., 1995; O'Sullivan, Keuthen, et al., 1997).

The self-rated questionnaire consists of seven items that are rated on a 5-point scale (0=best; 4=worst). The items cover the frequency of urges, the intensity of urges,

the ability to control the urges, the frequency of hair pulling, attempts to resist hair pulling, control over hair pulling, and associated distress.

The participants' scores on the MGH scale ranged from 4 to 24, with the lowest score by a participant whose hair pulling is currently in remission. Figure 1 below displays the participants' actual scores as well the distribution of scores for the sample. The mean score for the sample was 13.

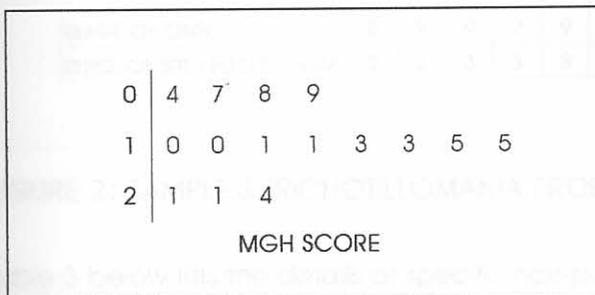


FIGURE 1: STEM-AND-LEAF DISTRIBUTION OF SCORES ON MGH HAIRPULLING SCALE

6.2.2 Structured clinical interview

A structured clinical interview was conducted with each participant prior to administering the psychometric test in order to obtain relevant historical data and limit interviewer bias. The Maudsley case history format was adapted for this purpose (attached as Appendix B). The questions covered aspects of the presenting problem, natal history, early development and education, family history, interpersonal relationships, sexual inclination and practices, occupation, hobbies and habits, treatment history, and significant life events.

The sample's trichotillomania profile was generally consistent with the findings of Christenson, Mackenzie, and Mitchell (1991). The mean age of onset for the illness was 12 years, with a range of 8 to 18 years and a mode of 13 years. The majority of the participants ($N=10$) (73%) pulled hair from more than one site. The number of sites ranged from 1 to 5, with 1 and 2 as modes. Figure 2 presents these particulars for each participant.

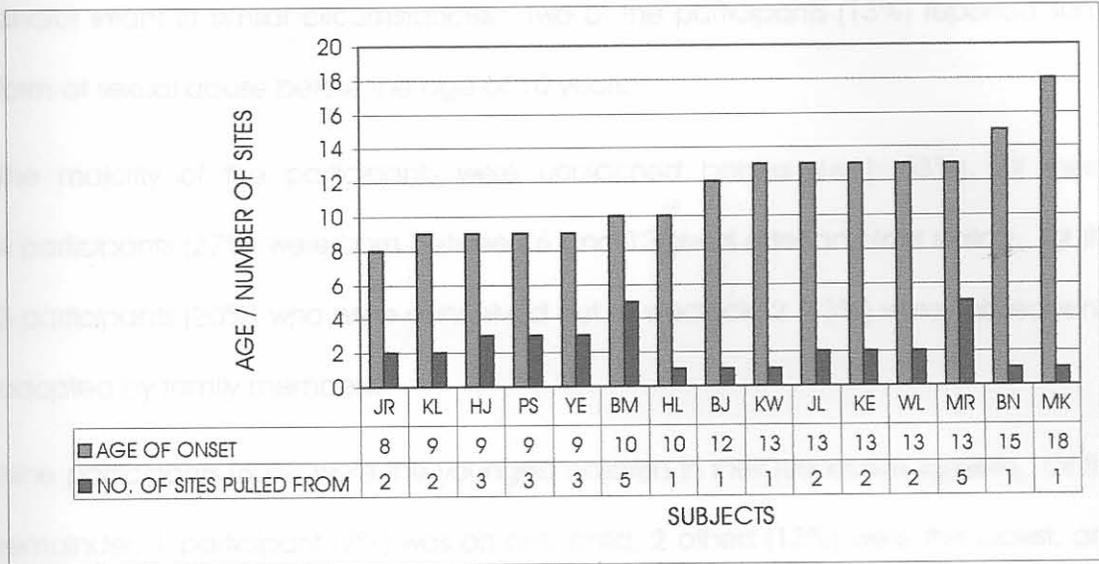


FIGURE 2: SAMPLE'S TRICHOTILLOMANIA PROFILE

Table 3 below lists the details of specific hair-pulling sites for each participant.

TABLE 3: PARTICIPANTS' HAIR-PULLING SITES

PARTICIPANT	SITES PULLED FROM
MK	Eyebrows
BJ	Scalp
BN	Scalp
HL	Scalp
KW	Scalp
JL	Scalp, pubic area
JR	Scalp, pubic area
KE	Scalp, pubic area
KL	Scalp, pubic area
WL	Scalp, pubic area
YE	Scalp, eyelashes, eyebrows
HJ	Scalp, pubic area, legs
PS	Eyebrows, eyelashes, legs
BM	Scalp, eyebrows, eyelashes, pubic area, upper lip
MR	Scalp, eyebrows, eyelashes, pubic area, legs

Four participants (27%) volunteered that they also suffered from trichophasia.

Furthermore, 87% ($N=13$) of the participants reported clearly traumatic or at least significant life events before the age of three years. For 8 participants (53%), these events included pregnancy, birth, or medical complications. Seven participants (47%) reported social factors that would be markedly stressful to almost any mother

and/or infant in similar circumstances. Two of the participants (13%) reported some form of sexual abuse before the age of 10 years.

The majority of the participants were unplanned babies (N=8) (53%). Of these, 4 participants (27%) were born between 6 and 12 years after an older sibling. Of the 3 participants (20%) who were conceived out of wedlock, 2 (13%) were subsequently adopted by family members.

Nine participants (60%) were the youngest children in their respective families. Of the remainder, 1 participant (7%) was an only child, 2 others (13%) were the oldest, and 3 (20%) were middle children.

Only 1 participant (7%) reported an unequivocally good relationship with both her parents since childhood. Five other participants (33%) reported that they preferred to discuss matters close to their hearts with their fathers rather than their mothers, and another 5 participants (33%) reported the opposite preference. Four participants (27%) reported not being emotionally close to either parent.

With regard to comorbid conditions, 6 participants (40%) were on psychiatric medication for anxiety and/or depression. Of these, only 1 (7%) participant had been formally diagnosed with a mood disorder after a suicide attempt. She was admitted to a (general) hospital for the condition in 1986¹, but her mood has been stable since. In 1987¹, another participant (7%) was admitted to the Sterkfontein psychiatric hospital for alcohol abuse. She has reportedly been in remission for the past three years, although she admits to regularly smoking marijuana.

Although 9 of the participants (60%) reported having consulted a psychologist before, none of them had been in psychotherapy for more than eight sessions. These sessions

¹ It was decided to include these participants as more than a decade had lapsed since hospitalisation.

included hypnotherapy, cognitive-behavioural therapy, and pastoral care. No one was in psychotherapy at the time of assessment.

Eleven participants (73%) had a history of nail biting to various degrees of severity, and 6 of them (40%) also reported skin-picking habits.

6.2.3 Rorschach Comprehensive System

All the participants' Rorschachs were administered directly on conclusion of the structured interviews. The basic instructions recommended by Rorschach and used in the Comprehensive System were followed. The participants were asked, 'What might this be?' upon presentation of each card, followed by 'Where do you see it?' and 'What made it look like that?' in the enquiry phase. All the responses were recorded verbatim.

As hypothesis testing did not form part of the research design, the principal researcher administered all the Rorschach tests.

All the research protocols contain a sufficient number of responses to provide reliable information and to support valid interpretations, with a range of 14 to 35 responses (mean=19.40; SD=6.26; median=16; mode=15).

The principal researcher followed the Comprehensive System's standard procedures to code all the responses, which were checked by the study leader. A blind, neutral third party proficient in the use of the Comprehensive System's rules and principles for coding, rescored the protocols to increase interscorer reliability and accuracy. The percentage of coding concurrence for the Location, Developmental Quality, \bar{z} score, Pair, and Popular categories was more than 95%, with agreement on Form Quality and Content scores slightly lower at 90%. Interscorer agreement on the Determinants and the Special Scores was lowest at 88%.

The data were subsequently tabulated by the Rorschach Interpretative Assistance Program-4 (RIAP-4) (Exner & Weiner, 1999). Although the RIAP-4 program is based on earlier versions of the Comprehensive System, interpretative inferences are based on the most recent primer for Rorschach interpretation (Exner, 2000).

Copies of the complete set of protocols of the sample, with their respective location sheets, structural summaries and constellation tables are included as Appendix C.

6.3 DATA ANALYSIS

Several factors were taken into account in the choice of data analysis. It was acknowledged that the small size of this purposive sample ($N=15$) probably rendered the results of the study preliminary at most. The potential impact of the non-normal distribution of many of the Rorschach variables rendered the use of parametric methods of data analysis precarious, and the concurrent potential for Type I and Type II errors was also borne in mind. It was decided, however, that the scope and exploratory nature of this study probably allowed for less conservative methods of data analysis. Both descriptive and inferential methods of analysis were therefore used to examine all of the Rorschach variables.

All participants' Rorschach protocols were examined individually. As the effect of predominant personality styles is a widely recognised factor, the participants' Lambda and EB variables were taken into account where analysis of the data indicated it.

The subsequent collective analyses of the sample's Rorschach data were generally qualitative (Exner, 2000). Descriptive statistics concerning central tendencies and/or the dispersion of scores were calculated for some variables. Analysis of the non-parametric variables relied, as far as possible, on the descriptive value of the frequency, range, median, and mode of the data. Where relevant, these were tabulated or displayed graphically for the sake of clarity of the data.

Inferential statistics were subsequently used to differentiate the trichotillomania sample from general psychiatric outpatient and non-patient populations by comparing the collective performance of the sample to normative expectations.

The potential implications of the study's small sample size compared to the Comprehensive System's normative populations (Exner, 2001) were acknowledged, but disregarded as the samples were matched in terms of age, education, and number of Rorschach responses (R). The mean value for these factors is shown in Table 4 below.

TABLE 4: MATCHED FACTORS BETWEEN CURRENT SAMPLE AND NORMATIVE POPULATIONS

MATCHED FACTORS (MEAN)	NON-PATIENT ADULTS (N=700)	OUTPATIENT ADULTS (N=440)	RESEARCH SAMPLE (N=12)
Age	31.73	33.81	33.53
Years Education	13.43	13.46	12.9
Number of Responses	22.32	20.25	19.40

The study results were subsequently compared to the normative data for adult non-patient and psychiatric outpatient populations (Exner, 2001) with the aid of SPSS-generated parametric statistics that were calculated for all the relevant variables of all the participants. Standardised z scores with the kurtosis and skewness for each variable, are cited in the relevant sections of Chapter 7. However, these scores were only considered where the distribution of scores could be expected to reflect normal-shaped curves.

To enhance the objectives of the study, the resultant findings are reported per variable or per group of variables, rather than per participant.

As the main aim of the study was the identification of commonalities in the research sample, only data suggesting a significant coalescence of findings (i.e. where more than 70% of the sample shared similar characteristics for a specific factor) were considered conclusive for inferences based on the Rorschach results.

CHAPTER 7

RESULTS

7.1 INTRODUCTION

As the results pertaining to methodological aspects of the study were included under the relevant sections of Chapter 6, this section reports on the quantitative and qualitative aspects of the Rorschach data.

The participants' performance on the special index constellation and the key variables is highlighted first, followed by the identification of sequential search strategies for this sample. The findings for the two variables on personality style, Lambda and Erlebnistypus (EB), are cited. The bulk of the chapter is devoted to data reflecting potential commonalities in the participants' personalities and psychological functioning. As far as practically possible, these data are reported per cluster.

7.2 SPECIAL INDICES

All but 4 participants' (74%) protocols featured one or more of the special indices. As graphically presented in Figure 3, 5 participants (33%) showed a positive Depression Index (DEPI), and the Suicide Constellation (SCON) of 3 participants (20%) was positive. Of the 7 participants who scored positively on the DEPI and/or the SCON scale, 4 (27%) were already on mood-related medication. Although 3 participants (20%) had a positive Coping Deficit Index (CDI), none of them had DEPI scores higher than the cut-off value. Of the 3 participants who scored positively on the old Schizophrenia Index (SCZI), only 2 (13%) showed a pathological level on the new Perceptual Thinking Index (PTI). Two participants (13%) scored positively on the Hypervigilance Index (HVI). Of most interest in view of the much-debated association between trichotillomania and obsessive-compulsive spectrum disorders, is that none of the participants in this sample scored positively on the Obsessive Style Index (OBS).

A positive OBS signals the inclination to be perfectionistic, overly preoccupied with details, indecisiveness, and often having difficulties with expressing emotions - especially negative ones. It also identifies people who are strongly influenced by their needs to be conventional.

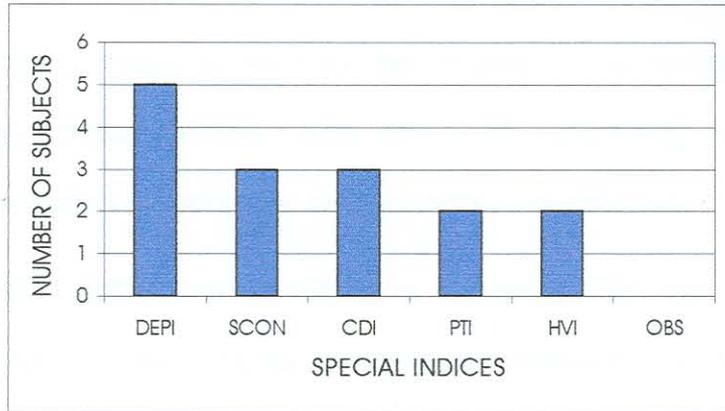


FIGURE 3: POOLED DISTRIBUTION OF SPECIAL INDICES ACROSS SAMPLE

The distribution of these special indices across the individuals in the research sample is detailed in Table 5 below.

TABLE 5: DISTRIBUTION OF SPECIAL INDICES PER PARTICIPANT

PARTICIPANT	POSITIVE SPECIAL INDICES
BJ	PTI & DEPI (SCZI)
BM	DEPI & HVI
BN	DEPI & SCON
HJ	HVI (SCZI)
HL	DEPI & CDI
JL	-
JR	-
KE	SCON
KL	-
KW	PTI (SCZI)
MK	DEPI
MR	SCON
PS	-
WL	CDI
YE	CDI

7.3 STYLE VARIABLES

7.3.1 Lambda

Interestingly, none of the participants rendered a Lambda value higher than the critical point ($L > 0.99$) to indicate an avoidant personality style. Although 6 participants (40%) had Lambda values below 0.30, the majority of the sample's ($N=9$) (60%) Lambda values ranged between 0.30 and 0.99, suggesting that most of the participants manifested an adaptive, balanced focus of attention.

On the other hand, rather than simplifying or narrowing down the stimulus field, the 6 participants (40%) whose Lambda values ranged between 0.08 and 0.27 showed an excessive openness to experience as characterised by an overly broad focus of attention.

Low Lambda individuals are usually highly sensitive to their experiences and acutely aware of events in their lives (Weiner, 1998). Given the combination of EA, Adj es, and Adj D score values, however, this style appears to represent a liability rather than an asset in at least 5 of the participants (33%). They probably tend to become overinvolved when they contemplate the underlying significance of events to sort out their feelings about them.

A summary of the sample's Lambda performance appears in Table 6 below.

TABLE 6: SAMPLE'S LAMBDA STYLE

DESCRIPTIVE DATA										
MEAN	S.D.	MIN	MAX	FREQUENCY	MEDIAN	MODE				
0.41	0.22	0.08	0.88	15	0.45	0.45				
NORMATIVE DATA										
NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)					
Z VALUE	S.E.	S.D.	KURTOSIS	SKEWNESS	Z VALUE	S.E.	S.D.	KURTOSIS	SKEWNESS	
-0.62	0.19	0.75	-0.49	0.36	-0.58	0.05	0.18	-0.49	0.36	

7.3.2 Erlebnistypus (EB)

As mentioned in Chapter 6 and graphically represented in Figure 4 below, the majority of participants ($N=9$) (60%) shows an ambivalent¹ style of problem solving and decision making. This finding proved significant, as Weiner (1998) points out that the inconsistent impact of emotions on ambivalent people's lives often results in inefficient coping efforts, unpredictable behaviour, and an uncertain self-image.

Except for 1 participant (7%) who is extratensive, the remainder of the sample (33%) shows an introversive style of ideational preference where emotions are kept more peripheral during decision-making and coping activities.

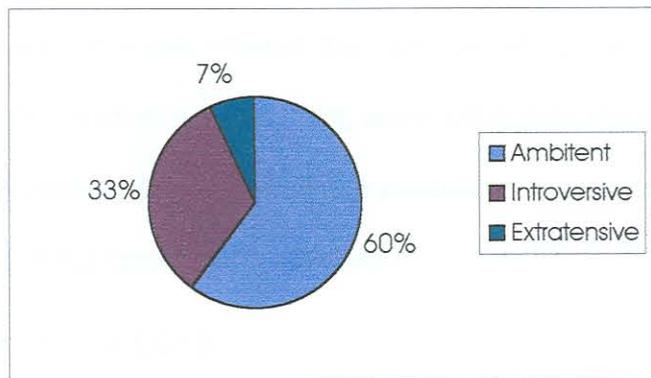
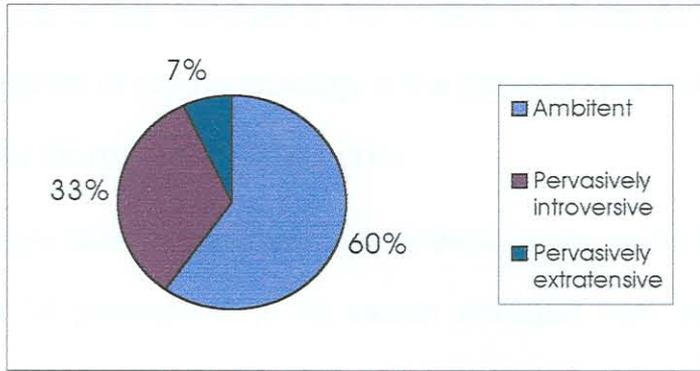


FIGURE 4: DISTRIBUTION OF EB STYLES

Bearing in mind that the majority of the sample (60%) is ambivalent, it is noteworthy that all the introversive participants (33%) and the one extratensive individual (7%) also show a pervasive EB style in coping with problem-solving or decision-making situations. Figure 5 below presents this finding graphically.

¹ A closer analysis of 2 participants' EB values indicated that the data designating their coping style might not be reliable. One participant's data are too sparse (2:1.5) to assure validity for any of the EB personality styles, whereas the massive containment of affect signalled by the other's EB data (4:0) could constitute a transient defensive reaction rather than part of a distinctive introversive coping style. Where relevant, however, these individuals' EB results were accepted at face value (unless otherwise indicated) to accommodate the limitations of a collective analysis of the sample's Rorschach data.

FIGURE 5: DISTRIBUTION OF PERVASIVE EB STYLES (EBPer)

Although the presence of a pervasive EB style is not necessarily a liability, it does indicate the likelihood of less flexibility in coping and decision making. The same applies to ambitents, whose inconsistent approach to problem solving and decision making often renders them less efficient than people with either an introversive or an extroversive style. This finding suggests that, even within their respective coping styles, the entire sample showed some kind of vulnerability in their characteristic problem-solving, decision-making, and coping behaviours.

7.4 SEQUENTIAL SEARCH STRATEGIES

Given the distribution of special indices in the sample, it is not surprising that one or more of the key variables initiated the search strategy for the majority of participants ($N=14$) (93%). In the only other protocol, the search strategy was introduced by the participant's high number of Critical Special Scores, with the relevant tertiary variable being $\text{Sum6} > 5$. Figure 6 presents these findings graphically.

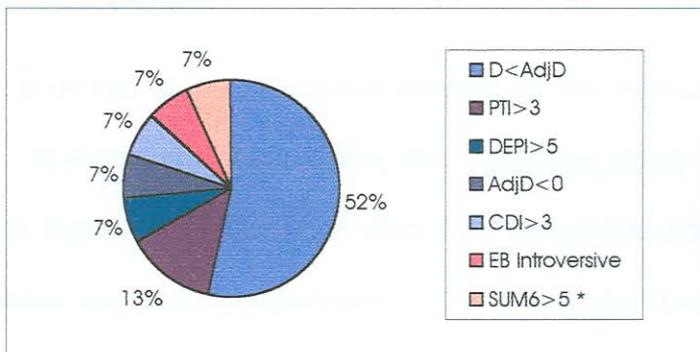


FIGURE 6: DISTRIBUTION OF KEY VARIABLES

The predominance of key variables in the choice of sequential search strategies confirms the presence of psychopathology or the potential for some kind of functional disorganisation for the majority of participants.

Given the disorder's DSM-IV classification under the impulse control disorders, it is also noteworthy that 10 participants' (67%) search strategies were introduced by the controls cluster, while clusters of the cognitive triad determined the search strategy for 4 participants (27%). Only 1 participant's search strategy was introduced by the affective cluster (7%). This is graphically illustrated in Figure 7 below.

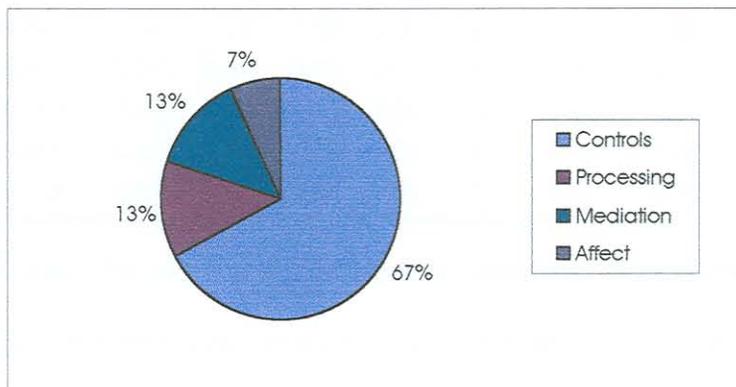


FIGURE 7: INTRODUCTORY SECTIONS IN CLUSTER ANALYSES

7.5 CLUSTER ANALYSES

7.5.1 Controls and stress tolerance

The fact that the controls cluster determined the majority of the sample's (67%) search strategies certainly suggests some unusual features regarding the sample's capacity for control and/or stress tolerance.

Table 7 below is a record of the descriptive statistics for the relevant variables in the controls cluster. In every section to follow, the collective results table groups the distribution of the individual participants' data into descriptive statistics in order to describe the entire sample's performance. These statistics include the mean,

standard deviation, frequency, range, median, and mode for each variable as it occurred in the sample.

TABLE 7: COLLECTIVE RESULTS FOR CONTROLS CLUSTER

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
D. Score	-1.93	1.84	-5.00	2.00	15	-2.00	-2.00
Adj D	-0.87	1.54	-4.00	3.00	15	-1.00	-1.00
EA	6.90	2.80	3.50	14.0	15	6.50	-
es	12.60	4.57	6.00	21.0	15	12.0	-
Adj es	10.13	2.24	5.00	16.0	15	9.00	-
FM	5.80	2.40	2.00	9.00	15	6.00	-
m	2.20	1.60	0.00	7.00	13	2.00	2.00
Sum C'	[1.93]	[1.65]	0.00	5.00	11	2.00	2.00
Sum T	[0.60]	[1.08]	0.00	3.00	4	0.00	0.00
Sum V	[0.27]	[0.57]	0.00	2.00	3	0.00	0.00
Sum Y	[1.80]	[1.90]	0.00	7.00	10	2.00	-
Pure C	[0.27]	[0.57]	0.00	2.00	3	0.00	0.00
MQual-	[0.47]	[0.62]	0.00	2.00	6	0.00	0.00

Based on the value for individual participants' variables, standardised scores were calculated for each participant. In every cluster, the sample's mean values for these z scores are represented in the table for standardised scores. For example, Table 8 below lists the standardised score (z) for each variable as it would have been distributed on a normal curve, to compare the sample's performance with that of the non-patient and outpatient adult populations listed in the Comprehensive System's normative tables (Exner, 2001). The standard error and standard deviation from the mean are listed, and the kurtosis and skewness (based on the standardised values) are given to elucidate the distribution of the standardised scores on a normal-shaped curve.

Where relevant, the values for non-parametric variables are shown in brackets. Care was taken not to assume the accuracy of statistics based on parametric analyses.

Highlighted figures indicate a significant deviance from the relevant norm population.

TABLE 8: STANDARDISED SCORES COMPARED TO NORMATIVE DATA - CONTROLS CLUSTER

VARIABLE	NON-PATIENT ADULTS (\bar{z})					OUTPATIENT ADULTS (\bar{z})				
	\bar{z} MEAN	S.E.	S.D.	KURTOSIS	SKEW	\bar{z} MEAN	S.E.	S.D.	KURTOSIS	SKEW
D Score	-1.96	0.51	1.97	0.11	0.10	-1.38	0.37	1.42	0.11	0.10
Adj D	-1.24	0.50	1.95	2.08	0.36	-0.96	0.36	1.38	2.08	0.36
EA	-0.74	0.31	1.22	1.74	1.31	0.10	0.22	0.84	1.74	1.31
Adj es	1.42	0.41	1.58	-0.85	0.41	1.38	0.29	1.13	-0.85	0.41
FM	1.57	0.49	1.90	-1.21	-0.22	1.75	0.35	1.34	-1.21	-0.22
m	0.93	0.43	1.67	4.75	1.59	0.72	0.34	1.30	4.75	1.59
Sum C'	[0.38]	[0.38]	[1.47]	[-0.51]	[0.61]	[0.74]	[0.35]	[1.37]	[-0.51]	[0.61]
Sum T	[-0.57]	[0.47]	[1.84]	[1.21]	[1.64]	[0.10]	[0.34]	[1.33]	[1.21]	[1.64]
Sum V	[-0.02]	[0.25]	[0.97]	[4.78]	[2.27]	[-0.23]	[0.20]	[0.77]	[4.78]	[2.27]
Sum Y	[1.24]	[0.53]	[2.05]	[2.28]	[1.42]	[0.68]	[0.45]	[1.73]	[2.28]	[1.42]
Pure C	[0.40]	[0.41]	[1.60]	[4.78]	[2.27]	[-0.30]	[0.17]	[0.67]	[4.78]	[2.27]
MQual-	[1.47]	[0.61]	[2.37]	[0.40]	[1.08]	[0.04]	[0.23]	[0.88]	[0.40]	[1.08]

Table 9 below lists the performance of individual participants in the sample for major elements in the controls cluster.

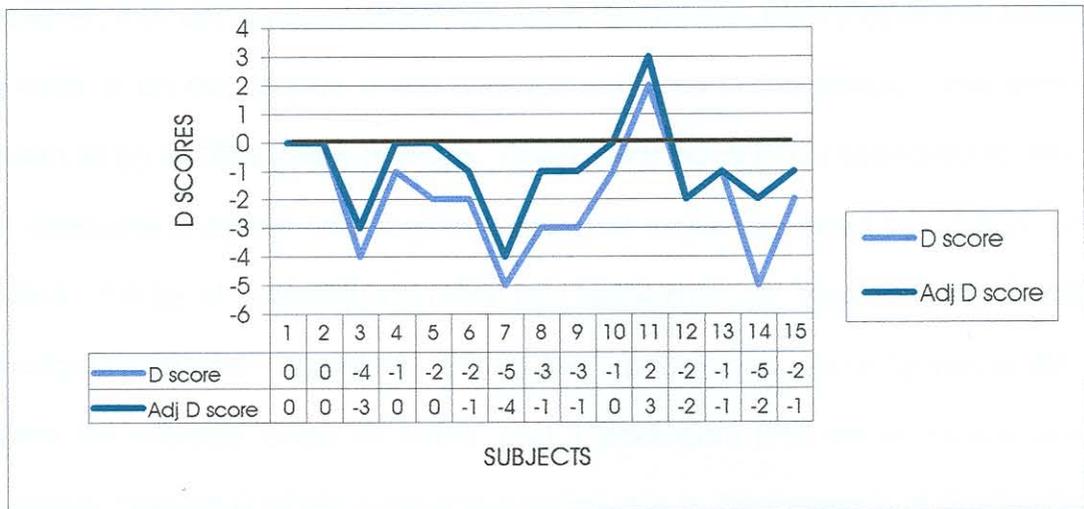
TABLE 9: DISTRIBUTION OF MAJOR VARIABLES IN CONTROLS CLUSTER PER PARTICIPANT

	BJ	BN	BM	HL	HJ	JL	JR	KE	KW	KL	MIR	MK	PS	WL	YE
D Score	-3	-5	-2	-5	-3	+2	0	-1	-3	0	-1	-2	-2	-2	-1
AdjD	-1	-2	-1	-4	-3	+3	0*	0	-1	0*	-1	-1	0*	-2	0*
EA	12.0	7.0	7.5	3.5	7.0	14.0	6.5	8.0	5.5	4.0	5.5	8.0	6.5	4.5	4.0
es	20	21	13	17	18	7	9	11	14	6	10	14	12	10	7
Adj es	16	14	11	16	16	5	9	8	9	5	9	13	6	10	5
CDI	1	3	2	5 [#]	3	1	2	2	3	2	3	3	2	4 [#]	4 [#]

One of the more pronounced factors to consider is the sample's D scores, as is evident from Figure 8 below.

* This is probably not a reliable or valid index for these participants, and the Adj D score most likely falls in the minus range. Where relevant for specific calculations concerning customary capacity for control and stress tolerance, these participants' value for Adj D was taken as -1.

[#] Positive CDI

FIGURE 8: DISTRIBUTION OF D Score AND Adj D

The sample's mean for the D Score is -1.93 , despite its range (-5 to $+2$). This is significantly low compared to both the non-patient ($z=-1.96$) and outpatient ($z=-1.38$) norm groups. Bearing the D Score's median (-2) and mode (-2) in mind, the sample's capacity for control and stress tolerance is currently significantly impaired. However, this finding does appear to have chronic implications, as the mean for the sample's Adj D is -0.87 . Although only in the low average range in comparison to the outpatient group norms ($z=-0.96$), it is still significantly lower than the norm for the non-patient norm group ($z=-1.24$).

Control and stress tolerance

The potential impact of the findings represented in Figure 8 is clearer if cognisance is taken of the fact that 13 participants (87%)² had an Adj D in the minus range, suggesting an inherent vulnerability in the personality profile of the research sample. Only 1 participant in the entire sample (7%), notably the extratensive one, had an Adj D in the high positive range.

It is remarkable that only 3 participants (20%) showed a positive Coping Deficit Index (CDI), and that one of them had a quite demanding professional career.

² Although 5 participants had an Adj D score of 0 (zero), this appeared to be a valid and reliable index for only one individual when the value for EA is taken into account.,

However, they did not cope better than expected with the demands of their worlds as a result of an abundance of the available resources in the sample. The sample's mean for EA (6.90) is below average. Only 2 participants (13%) appeared to dispose of adequate available resources that were not excessively taxed by environmental stimuli. The EA of 8 participants (53%) was below average, suggesting more limited available resources. Another 4 (27%) of the 5 participants whose EA values did fall within the average range for adults, and 1 participant (7%) whose EA was above average, had Adj D scores in the minus range due to the presence of unexpectedly elevated Adj es values.

Just more than half the sample ($N=8$) (53%) had elevated values for Animal Movement ($FM>5$), and another 3 participants (20%) had an FM value of 5. As the mean for this variable is significantly elevated compared to the normative data for both non-patient ($z=1.57$) and outpatient ($z=1.75$) groups, it suggests that the presence of ungratified needs that could be expected to interfere with participants' attention and concentration, is particularly strong in this sample.

It may then be significant that 11 participants (73%) had I-less protocols ($SumI=0$), while 3 other participants (20%) showed elevations in the texture variable ($SumI>1$). The potential negative implications of the former include a limited capacity to form close attachments and an aversion to intimacy. Weiner (1998) emphasises this aspect when he points out that $SumI=0$ occurs in only 11% of non-patient records and increases to 64% in outpatient populations. On the other hand, having more than one texture response sometimes also promotes the maladaptive behaviour that arises from efforts to alleviate subjective experiences of loneliness, distress, and emotional deprivation usually associated with $SumI>1$.

As the presence or not of a texture response in a record constitutes a relatively stable trait variable, either signifies chronic adjustment problems that were apparent in all but 1 participant (93%).

Moreover, 60% of the sample ($N=9$) showed an elevated value for SumC' (i.e. SumC'>1). In 4 of these participants (27%) this higher value indicated excessive internalisation of feelings that they would rather have externalised.

Only 3 participants (20%) had a Vista variable that exceeded the normatively prevalent score of 0 (zero). Only this small portion of the sample appeared to engage in ruminative, painful introspection about perceived negative features. Two of these participants also had positive scores on the DEPI.

Situational stress

Although impairment of the psychiatric participants' capacity for control and stress tolerance is not unexpected, the sample's low D Score value suggests a susceptibility for situational stress that surpasses that of the general psychiatric population. This is evident when the sample's D Score value is compared to that of the normative outpatient sample ($z=-1.38$).

At least 10 participants (67%) currently experience some situational stress (D<Adj D) and it can be assumed that their current stress tolerance is lower than usual. Consequently their typical capacities for control could be less sturdy than usual. This is cause for concern as in 8 of these participants (53%), the problem is being superimposed on an already limited capacity for control and stress tolerance.

According to Exner (200), situational stress usually creates considerable psychological discomfort, frequently increasing the potential for some form of impulsive behaviour. If true for the participants in this sample, their stress could have given rise to decisions

and/or behaviours that were less well organised than usual. This could in turn affect the conclusions based on other clusters' data.

Upon closer examination, however, the small difference between the values for Adj D and the D Score suggests that 8 participants (53%) currently experience only a mild to moderate form of psychological disruption. Only 3 participants (20%) are currently experiencing substantial levels of stress that could be expected to cause considerable interference in customary patterns of thinking and/or behaviour. Notably, 1 of these participants scored positively on both the DEPI and PTI scales, another featured a positive DEPI and SCON, and the third had a positive PTI. Surprisingly, these participants continued fulfilling their everyday functions without any readily apparent ineptitude.

Based on the values of m and SumY, it can be assumed that the psychological consequences of the stress tended to be diffused in 6 participants (40%), impacting on both their thinking and emotion, and having a substantial impact on 3 participants' (20%) ideational activity. Only 1 participant (7%) gave evidence that the stress had a considerable impact on her emotions.

The values of the participants' D Scores suggest that of 3 participants (20%), the impact of the situational stress was rather modest. One participant (7%) functioned adequately in environments that were familiar - especially those that were structured and well defined. However, she could be vulnerable to disorganisation and impulsive thinking or behaviour as situations became more complex or ambiguous.

Six participants (40%) had a D Score value of less than -1 , suggesting that in situations of increased situational stress, they would exhibit substantial potential for disorganisation and would be highly susceptible to control difficulties. This portion of

the sample also had to be highly vulnerable to ideational and/or behavioural (but not emotional³) impulsiveness under those conditions.

Except in situations that are very structured and routine, people with a D Score value of less than -1 are not expected to function adequately or effectively on a regular basis. What is surprising, however, is that all but one of these women had careers in which they functioned unexpectedly well.

The findings of the controls cluster emphasise the presence of persistent adjustment problems for the entire sample:

- Their innate, chronic vulnerability in the capacity for control and stress tolerance (AdjD) left the sample even more susceptible to the severely disruptive effect of situational stress (D Score).
- There could be a relation between the strong presence of ungratified internal needs (FM) and the limited availability of adequate resources (EA).
- Problems with attachment and intimacy are common (SumI).

7.5.2 Information processing

The first of the three clusters in the cognitive triad involves the mental procedures entailed in the input of information. The efficient organisation of information consists of an adaptive balance between the amount and quality of information taken in (scanning the environment), and the capacity to process that amount of information adequately (creating images or icons in the short-term memory).

The processing strategy in any given situation can be affected by many elements. Motivation and economy-related issues, achievement needs, defensiveness, and pre-established sets or preconceived attitudes can be inferred from the sample's performance on the Rorschach variables included in Table 10 below.

³ The absence of C responses in these participants' records contraindicates the potential for emotional impulsiveness.

TABLE 10: COLLECTIVE RESULTS FOR PROCESSING CLUSTER

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
DQ+	7.87	2.25	5.00	12.0	15	8.00	-
DQv/+	[0.00]	[0.00]	0.00	0.00	0	0.00	0.00
DQv	[0.27]	[0.44]	0.00	1.00	4	0.00	0.00
Zf	12.87	3.67	7.00	22.0	15	12.0	12.0
Zd	2.83	4.67	-8.00	9.00	15	2.50	2.00
M	4.00	1.41	2.00	7.00	15	4.00	4.00
W	7.40	2.68	3.00	12.0	15	73.0	7.00
D	7.60	4.50	2.00	18.0	15	7.00	-
Dd	[4.40]	[2.65]	1.00	11.0	15	4.00	-
PSV	[0.07]	[0.25]	0.00	1.00	1	0.00	0.00

Table 11 presents the sample's performance compared to the normative data. Except that the sample made less use of Usual Details (D), whose implications are discussed below, deviations from the normative group are statistically insignificant.

TABLE 11: STANDARDISED SCORES COMPARED TO NORMATIVE DATA - PROCESSING CLUSTER

VARIABLE	NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)				
	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW
DQ+	0.23	0.27	1.04	-1.24	0.22	0.55	0.19	0.72	-1.24	0.22
DQv/+	-0.64	0.00	0.00	-	-	-0.34	0.00	0.00	-	-
DQv	-0.57	0.09	0.36	-0.73	1.18	-0.64	0.08	0.31	-0.73	1.18
Zf	0.37	0.35	1.37	1.31	0.82	0.46	0.26	0.99	1.31	0.82
Zd	-0.66	0.11	1.62	0.27	0.91	-0.12	0.05	1.06	0.27	0.91
M	-0.15	0.19	0.75	0.97	0.95	0.06	0.15	0.58	0.97	0.95
W	-0.37	0.30	1.17	-0.79	0.26	-0.14	0.21	0.83	-0.79	0.26
D	-1.40	0.32	1.24	0.27	0.91	-0.29	0.23	0.89	0.27	0.91
Dd	[1.94]	[0.42]	1.64	[1.06]	[0.88]	[0.41]	[0.25]	0.98	[1.06]	[0.88]
PSV	[-0.01]	[0.27]	1.03	15.00	3.87	-0.23	0.11	0.45	15.00	3.87

Although the sample as a whole generally performed within expectations compared to the outpatient norms, analyses of individual participants' characteristic ways of information processing presented some interesting findings.

The mere fact that no one in the sample showed a high Lambda style of processing (mean=0.41) already alludes to the participants' tendency to become very involved in their worlds.

Most of the participants ($N=7$) (47%) scored within the average range for adults on the Z_f scale that assesses organising activity and frequency. A further 40% ($N=6$) of the sample invested considerably more into the processing effort than most adults, despite the fact that all but one of them were already under a continual threat of disorganisation (see par. 7.4.1). Only 2 participants (13%) were overly economical, almost lackadaisical, in establishing organising objectives for their approach to processing stimuli.

Despite the sample's varied organising activity, unusual inconsistencies existed within the context of their processing strategies and economy. An examination of the participants' individual scores for the relevant variables in the Economy Index elucidates this statement (see Table 12 below).

TABLE 12: INDIVIDUAL PARTICIPANTS' PERFORMANCE ON THE ECONOMY INDEX ($W:D:Dd$)

	BJ	BN	BM	PS	HL	HJ	JL	KE	KW	KL	MR	MK	JR	WL	YE
W	7	11	6	8	4	12	7	11	7	4	6	7	7	11	3
D	11	2	3	4	18	15	11	3	5	9	7	5	8	4	9
Dd	11	1	6	4	5	8	6	1	4	1	3	3	6	4	3

None of the participants in the sample showed a value for all three the variables in the $W:D:Dd$ ratio that is within the expected range (i.e. $1:1.3-1.6:Dd < 4$). This is not surprising in view of the frequency of $Dd > 3$, which indicates a kind of atypical processing for the majority of the sample.

Although 8 participants (53%) gave proportionally more D than W answers (where the latter usually suggests a more economical approach to information processing), 4 of these participants (27%) showed an elevation in their Dd responses. As Dd responses are only formed after considerable scanning that requires increased effort, the predominance of Dd responses by these participants actually neutralises the economy of their processing efforts.

Furthermore, W was proportionally greater than D for 7 participants (47%). The fact that 5 of these participants (33%) also gave higher frequencies of Dd answers reinforces the hypothesis that these participants tend to invest more effort in the processing of information than is customary.

The combined elevation in W and/or Dd responses therefore suggests that 80% of the sample invest in a kind of processing that is everything but economical – regardless of whether it is due to the predominance of W responses or elevations of the Dd responses in the Economy Index.

The Aspirational Index sheds more light on this finding. When the W:M ratio is considered against the backdrop of the group members' EB style, it is significant that all the ambitious participants ($N=9$) (60%) strive to accomplish more than is reasonable in the light of their current functional capacities. This is also true for 2 of the introversive participants (13%).

In view of these findings, one could expect that the majority of the participants (73%) have to work hard to achieve even everyday objectives.

Although the sample performed within the average range for Zd compared to both the non-patient ($z=-0.66$) and outpatient ($z=-0.12$) populations, its range (-8 to +9) draws attention to the individual differences in the sample's processing efficiency. Almost half the sample ($N=7$) (46%) are relatively proficient in examining their environments. However, the exaggerated Zd values of the majority ($N=8$) (53%) indicate such a pronounced style of overincorporative (46%) or underincorporative (7%) scanning that either may reasonably be considered a neurotic defence. Although intended as protection against the disturbing effects of too much or too little environmental stimuli, the extent of both these styles is such that it probably represents a liability for these participants. This is especially true in view of the chronic potential for psychological disorganisation in the sample (see 7.4.1).

The quality of the processing efforts of most of the sample appears to be within the average range, especially in comparison to the normative psychiatric population. However, in view of the above-mentioned overinvolvement in the stimulus field, however, it is not surprising that they gave less of the more common DQo responses than non-patient adults do. In fact, when the values for DQ+, DQv, and DQv/+ are examined against the background of each individual's EB style, the quality of 9 participants' (60%) processing efforts is more than merely adequate. The quality of the processing efforts of the remainder of the sample (N=6) (40%) is exceptionally good and probably rather complex. It is noteworthy that none of these participants is particularly well educated, and most of them completed only a short diploma course after completing their secondary education.

The findings of the processing cluster suggest that:

- The participants clearly tended to become very involved in organising their environments (Zf), regardless of their inherent vulnerabilities mentioned before.
- Many of them invested more energy than necessary in attempts to assess situations precisely, with varying degrees of accuracy (Lambda, W, and Dd).
- Not surprisingly, the quality of their processing efforts was generally more than sufficient (DQ+), but it was certainly not economical (W:D:Dd).
- Most of them aspired to more than what could reasonably be expected (W:M) in light of the serious limitations in their internal resources and capacity for stress tolerance.
- It seems possible that either the perfectionistic or the lackadaisical style of processing (Zd) of some constitutes a defence. Although in itself an adaptive process designed to relieve anxiety, the extent to which this processing style has become fixed now amounts to a maladaptive effort to control their environments.

7.5.3 Cognitive mediation

The second cluster in the cognitive triad is concerned with how the acquired mental images get translated or identified to be functional. The process requires some form of resolution between the newly attained images and previously stored icons. In addition to the degree to which such translations are accurate, common, or unique, the Rorschach data also provides information on the circumstances in which the accuracy of such translations falters. Table 13 below summarises the sample's presentation of mediational activity.

TABLE 13: COLLECTIVE RESULTS FOR MEDIATION CLUSTER

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
XA%	0.83	0.02	0.60	0.95	15	0.88	0.93
WDA%	0.85	0.03	0.67	1.00	15	0.85	-
FQx+	0.80	0.98	0.00	3.00	7	0.00	0.00
FQxo	9.60	3.65	4.00	17.00	15	9.00	8.00
FQxu	5.47	2.03	2.00	9.00	15	5.00	4.50
FQx-	3.47	3.18	0.00	11.00	14	2.00	1.00
FQx none	[0.07]	[0.25]	0.00	1.00	1	0.00	0.00
M-	[0.47]	[0.62]	0.00	2.00	6	0.00	0.00
X+%	0.54	0.10	0.34	0.67	15	0.57	-
X-%	0.17	0.11	0.00	0.38	14	0.13	0.07
Xu%	0.29	0.08	0.11	0.40	15	0.31	-
F+%	0.60	0.24	0.33	1.00	15	0.50	-
S-%	0.30	0.31	0.00	1.00	9	0.25	0.00
P	5.40	1.45	3.00	9.00	15	5.00	5.00

As is clear from Table 14, the sample shows some unusual characteristics in translating acquired environmental input, especially when the quality of the sample's X%s is taken into account. However, this is probably to be expected from a psychiatric population such as the current sample. The only significant deviation from the outpatient norms is that the sample exceeded the expected number of unusual form characteristics.

TABLE 14: STANDARDISED SCORES COMPARED TO NORMATIVE DATA - MEDIATION CLUSTER

VARIABLE	NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)				
	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW
FQx+	0.10	0.30	1.15	-0.35	0.93	0.16	0.19	0.75	-0.35	0.93
FQxo	-2.05	0.29	1.13	-0.23	0.59	-0.68	0.26	0.99	-0.23	0.59
FQxu	0.97	0.27	1.03	-0.65	-0.8	0.67	0.22	0.85	-0.65	-0.08
FQx-	1.59	0.71	2.74	1.28	1.42	0.12	0.37	1.44	1.28	1.42
FQx none	-0.12	0.18	0.70	15.00	3.87	-0.49	0.08	0.30	15.00	3.87
X+%	-2.51	0.30	1.18	-0.62	-0.68	-0.69	0.20	0.76	-0.62	-0.68
X-%	1.91	0.60	2.33	-0.95	0.57	0.05	0.30	1.17	-0.95	0.57
Xu%	1.98	0.32	1.24	0.22	-0.89	1.21	0.25	0.96	0.22	-0.89
M-	1.47	0.61	2.37	0.40	1.08	0.04	0.23	0.88	0.40	1.08
P	-0.85	0.28	1.08	1.11	0.80	-0.15	0.18	0.69	1.11	0.80

The majority of the participants ($N=10$) (67%) have the capacity for conventional reality testing. Four of them (27%) show an XA% and WDA% within the expected range, and a further 6 participants (40%), whose XA% and WDA% are higher than 0.90, make a special effort to translate situations accurately.

The remainder of the sample ($N=5$) (33%) experiences varying degrees of mediational problems. The XA% and WDA% of 1 participant (7%) suggest that her mediational translations, although generally appropriate in obvious situations, tend to become less appropriate in more ambiguous circumstances where she feels unsure of what is expected of her. The reality testing of another participant (7%) who also scored positive on the Perceptual Thinking Index (PTI), falters significantly in situations where the cues to appropriate translations are not obvious. Yet another (7%) showed a moderate mediational dysfunction, while 2 participants (13%)⁴ showed significant mediational impairments. The dysfunction of both is serious and their reality testing is often markedly affected.

Mediational distortions occur only occasionally for the majority of the sample ($N=9$) (60%). However, 6 participants (40%) gave more than the acceptable number of FQ- responses, increasing the sample's mean for X-% to 0.17. When the X-% of all

⁴ Interestingly, both participants featured a positive Schizophrenia Index but only one qualified for the Perceptual Thinking Index.

the participants is examined against the backdrop of the number of responses, the location of FQ- answers, and the use of space, 2 participants (13%) showed a moderate elevation in the incidence of mediational dysfunction, 3 participants (20%) experienced pervasive mediational difficulties, and the elevation in X-% of another 3 participants (20%) indicated the likelihood of even more prevalent and serious mediational impairments. This suggests that slightly more than half the sample (53%) experienced a form of mediational dysfunction at least some of the time.

Seventy-nine percent of all the FQ- responses produced were given on blots containing chromatic colour. However, only 32% of these represented S- answers, and only 3 participants (20%) had more than one Space response in their protocols. This is contra-indicative of trait-like anger and negativism in the sample. Twelve of the 14 participants (80%) who gave minus Form Quality answers gave these on Card IX and/or Card X. Thus, in addition to the disorganising effect of emotionally-laden situations for the majority of the sample, this effect seemed more prevalent in unstructured, complex situations.

The distribution of Popular responses in the sample confirms earlier findings that expected or appropriate responses are likely in situations when the cues for such responses are obvious and/or simple. The majority of the sample ($N=13$) (87%) performed within expectation compared to both the non-patient ($z=-0.85$) and outpatient ($z=-0.15$) populations. Only 1 person (7%) appeared overly concerned with detecting cues for socially accepted or expected behaviour. Another one (7%) showed very little regard for social convention, as is confirmed by her history of adultery and substance abuse.

Examination of the X+% and Xu% indicated that none of the participants were overly committed to conventionality. In fact, the majority of the sample ($N=9$) (60%) was able to disregard social demands or expectations more easily than most people, and

showed a tendency for unique decisions that reflected an emphasis on individualism. A further 5 participants (33%) went beyond mere unconventionality and behaved more atypically and even inappropriately at times. No one in the sample had an $X+%$ value that is associated with more obsessive and/or perfectionistic tendencies ($X+>0.85$), as might be expected from patients with an obsessive-compulsive spectrum disorder.

The findings of the mediation cluster confirm that:

- The majority of the sample had the inherent capacity to maintain adequate reality testing ($XA%$ and $WDA%$)
- They could be expected to respond realistically in situations where appropriate reactions were clear (P), regardless of a stronger emphasis on individualism ($Xu%$)
- The majority nevertheless experienced some degree of mediational impairment at least some of the time ($FQx-$ and $X-%$). They appeared to be especially vulnerable to emotionally laden situations that were more ambiguous and unstructured – conditions that are typical of interpersonal interaction.

7.5.4 Ideation

The third cluster in the cognitive triad is represented by a form of thinking where translations of input are conceptualised and used in individually meaningful ways. Table 15 below lists the sample's performance on the Rorschach variables that typically reveal characteristics of conceptual thinking.

TABLE 15: COLLECTIVE RESULTS FOR IDEATION CLUSTER

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
Intellect	2.13	1.67	0.00	6.00	15	2.00	-
a (active)	7.33	3.52	2.00	14.0	15	7.00	-
p (passive)	4.93	2.91	0.00	11.0	14	4.00	3.00
Ma	2.47	1.75	0.00	6.00	14	2.00	2.00
Mp	1.60	1.02	0.00	3.00	13	1.00	1.00
FM	5.80	2.40	2.00	9.00	15	6.00	-
m	2.20	1.60	0.00	7.00	13	2.00	2.00

TABLE 15: COLLECTIVE RESULTS FOR IDEATION CLUSTER (cont.)

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
MOR	[1.40]	[1.25]	0.00	4.00	11	1.00	1.00
Sum6SpSc	7.53	2.96	3.00	14.0	15	8.00	8.00
L2 SpSc	2.00	1.86	0.00	6.00	12	1.00	1.00
WSUM6	23.80	11.95	3.00	50.0	15	21.0	-
DV	[0.93]	[1.00]	0.00	3.00	9	1.00	-
DR	[1.00]	[1.21]	0.00	4.00	8	1.00	0.00
INCOM	[2.67]	[2.02]	0.00	7.00	13	2.00	-
FABCOM	[0.67]	[0.70]	0.00	2.00	8	1.00	0.00
ALOG	[0.27]	[0.68]	0.00	2.00	2	0.00	0.00
DV2	[0.27]	[0.57]	0.00	2.00	3	0.00	0.00
DR2	[0.33]	[0.60]	0.00	2.00	4	0.00	0.00
INCOM2	[0.60]	[1.14]	0.00	4.00	4	0.00	0.00
FABCOM2	[0.80]	[1.17]	0.00	4.00	6	0.00	0.00
CONTAM	[0.00]	[0.00]	0.00	0.00	0	0.00	0.00
MQual-	[0.47]	[0.62]	0.00	2.00	6	0.00	0.00
MQual none	[0.00]	[0.00]	0.00	0.00	0	0.00	0.00

In addition to the previously noted elevation on the FM variable, the sample's deviation from outpatient norms on the passive movement variable (p) could elucidate these patients' resistance against long-term adherence to alternative coping strategies aimed at reducing hair-pulling symptoms. Furthermore, as conceptual thinking forms a basis for reality testing, the sample's unexpectedly elevated values for the Critical Special Scores suggest some form of ideational peculiarity that must affect their decisions and deliberate behaviours. As is evident from Table 16 below, the extent of these difficulties clearly differentiates the sample not only from non-patients norms, but also from general psychiatric populations.

TABLE 16: STANDARDISED SCORES COMPARED TO NORMATIVE DATA - IDEATION CLUSTER

VARIABLE	NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)				
	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW
active	0.40	0.42	1.35	-0.81	0.38	1.16	0.35	1.35	-0.81	0.38
passive	1.24	0.47	1.22	0.18	0.80	0.59	0.32	1.22	0.18	0.80
Ma	-0.28	0.30	1.00	0.13	0.94	0.22	0.26	1.00	0.13	0.94
Mp	0.17	0.26	0.71	-1.17	0.12	-0.13	0.18	0.71	-1.17	0.12
Intellect	0.38	0.30	0.99	0.15	0.63	0.27	0.26	0.99	0.15	0.63
FM	1.57	0.49	1.34	-1.21	-0.22	1.16	0.35	1.34	-0.81	0.38
m	0.93	0.43	1.67	4.75	1.59	0.72	0.34	1.30	4.75	1.59

TABLE 16: STANDARDISED SCORES COMPARED TO NORMATIVE DATA - IDEATION CLUSTER (cont.)

VARIABLE	NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)				
	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW
MOR	[0.69]	[0.38]	[1.46]	[-0.64]	[0.70]	[0.26]	[0.25]	[0.98]	[-0.64]	[0.70]
Sum6SpSc	3.87	0.56	1.09	0.16	0.42	1.50	0.28	1.09	0.16	0.42
WSUM6	4.77	0.80	1.16	0.36	0.72	1.34	0.30	1.16	0.36	0.72
L2 SpSc	[7.76]	[1.99]	[1.49]	[-0.39]	[0.90]	[1.04]	[0.39]	[1.49]	[-0.39]	[0.90]
DV	[0.44]	[0.34]	[0.99]	[0.32]	[1.05]	[0.13]	[0.26]	[0.99]	[0.32]	[1.05]
DR	[0.88]	[0.47]	[1.63]	[0.95]	[1.26]	[0.96]	[0.42]	[1.63]	[0.95]	[1.26]
INCOM	[2.79]	[0.71]	[1.94]	[-0.51]	[0.65]	[1.58]	[0.50]	[1.94]	[-0.51]	[0.65]
FABCOM	[0.76]	[0.36]	[1.10]	[-0.65]	[0.63]	[0.39]	[0.28]	[1.10]	[-0.65]	[0.63]
ALOG	[1.13]	[0.91]	[1.68]	[4.35]	[2.40]	[0.33]	[0.43]	[1.68]	[4.35]	[2.40]
DV2	[4.44]	[2.55]	[1.98]	[4.78]	[2.27]	[0.59]	[0.51]	[1.98]	[4.78]	[2.27]
DR2	[2.94]	[1.45]	[0.83]	[2.63]	[1.79]	[0.26]	[0.22]	[0.83]	[2.62]	[1.79]
INCOM2	[4.46]	[2.35]	[2.52]	[4.24]	[2.11]	[0.91]	[0.65]	[2.52]	[4.24]	[2.11]
FABCOM2	[4.81]	[1.95]	[1.89]	[2.17]	[1.56]	[0.84]	[0.49]	[1.89]	[2.17]	[1.56]
CONTAM	[0.00]	[0.00]	[0.00]	-	-	[0.00]	[0.00]	[0.00]	-	-
MQual-	[1.47]	[0.61]	[0.88]	[0.40]	[1.08]	[0.04]	[0.23]	[0.88]	[0.40]	[1.08]
MQ none	[-0.13]	[0.00]		-	-	[0.00]	[0.00]	[0.00]	-	-

Against the backdrop of an ideational framework, the previously mentioned distribution of characteristic EB styles implies that the inconsistent role and impact of emotions render the thinking of the ambivalent participants (60%) psychologically inefficient. They would at times try to push their feelings aside to address issues logically, whereas emotions would significantly influence their decisions at other times. As neither approach is used consistently both are rather inefficient, and as a result these participants have to invest more time and effort in dealing with the demands of everyday life. Although the remainder of the sample showed some inflexibility in their preferred coping style, closer analysis revealed that this is especially true of 4 of the introversive participants (27%). They allowed their emotions to play a very limited role in their decision-making activity and also relied on this rigid style of thinking when a less cognitive approach would have been preferable. In other words, the participants' distinctive coping styles were employed in such a manner that the entire sample experienced some difficulty with problem solving and decision making.

When the $\alpha:p$ ratio is examined, the attitudes and values of 9 participants (60%) were reasonably well fixed with a concomitant effect on the conceptual process. Six of these participants (40%) showed ideational sets and values that were so inflexible that they would find it quite difficult to alter their attitudes and opinions or even consider alternative perspectives on issues. Such rigidity is usually rooted in an underlying sense of fragility.

The sample as a whole did not reflect ideational sets commonly associated with cognitive problems. Only 2 participants (13%) scored positively on the HVI scale. The anticipatory or hyperalert state indicated by this index suggests a long-standing, negative or mistrusting attitude that could provoke illogical or even paranoid-like patterns of thought. Although 11 participants gave MOR responses, the frequency of these responses indicated that only 4 participants' (27%) conceptual thinking was marked by a moderate but significant pessimistic set and a substantially lowered quality of conceptual thinking.

The sample's mean value for m, associated with a subtle awareness of external demand situations, is high but within expectations based on the norm groups. However, the sample scored significantly higher on the FM variable compared to both the non-patient ($z=1.57$) and the outpatient ($z=1.16$) norm groups, suggesting considerable need states among the participants in the sample.

In fact, of the 10 participants (67%) who scored higher than average on FM+m, the composite left-side eb value of 8 participants (53%) confirms earlier hypotheses on the presence of chronic rather than transient internal need states. The substantial level of peripheral mental activity due to these needs probably frequently interferes with these women's attention and concentration. The Form Quality of 9 participants' (60%) M responses has no interpretative usefulness. For 6 other participants (40%), however, the presence of MQ->1 confirms the presence of some thinking peculiarities.

Situation-related stress further increases this kind of peripheral activity for 2 of these participants (13%).

Twenty-six of the 58 M responses (45%) produced by the sample involved poor use of form (FQ-) or at least one of the Critical Special Scores. This result confirmed the presence of intrusive preoccupations that presented an immature, concrete quality of thinking.

Given all of the above, it is noteworthy that only 1 participant (7%) showed a reasonably flexible style of thinking, problem solving and decision making. Although this person's emotions played a predominant role in these activities, she was able to use more appropriate cognitive approaches to complement the demands of important situations.

Analysis of the six Critical Special Scores confirms that the participants' conceptual thinking clearly resulted in pervasive difficulties in containing or directing ideational activities adaptively, regardless of the unique source of its disruption.

Table 17 below lists the number of answers that warranted Critical Special Scores for all the participants. Only 1 participant (7%) presented an unquestionably clear conceptual thinking with a WSUM6 value of only 3. The value and composition of WSUM6 for the remainder of the sample (N=14) (93%) suggested that, as a group, these individuals tended to think in a disorganised, inconsistent manner, often marked by seriously flawed judgment.

TABLE 17: DISTRIBUTION OF CRITICAL SPECIAL SCORES PER PARTICIPANT

	BJ	BN	BM	PS	HL	HJ	JL	KE	KW	KL	MR	MK	JR	WL	YE
DV	1	2	0	0	1	1	1	1	1	2	0	0	0	0	3
INC	5	3	7	1	3	5	2	1	2	0	1	0	3	6	2
DR	0	2	0	1	3	1	1	2	0	0	0	4	0	1	0
FABC	1	1	2	0	0	1	0	1	0	0	1	0	2	0	1

TABLE 17: DISTRIBUTION OF CRITICAL SPECIAL SCORES PER PARTICIPANT (cont.)

	BJ	BN	BM	PS	HL	HJ	JL	KE	KW	KL	MR	MK	JR	WL	YE
DV2	0	0	0	0	0	1	2	1	0	0	0	0	0	0	0
INC2	4	2	0	0	0	0	2	0	0	0	0	0	0	0	1
DR2	0	0	0	1	1	0	0	2	1	0	0	0	0	0	0
FABC2	2	2	0	0	0	0	0	0	4	0	1	0	1	2	0
ALOG	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0
CONT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SUM6	13	14	9	5	8	9	8	8	8	3	3	4	6	9	7
WSUM6	45	50	22	21	22	20	20	27	39	3	13	12	21	29	15

Figure 9 illustrates the extraordinary frequency of conceptual slippages in the sample.

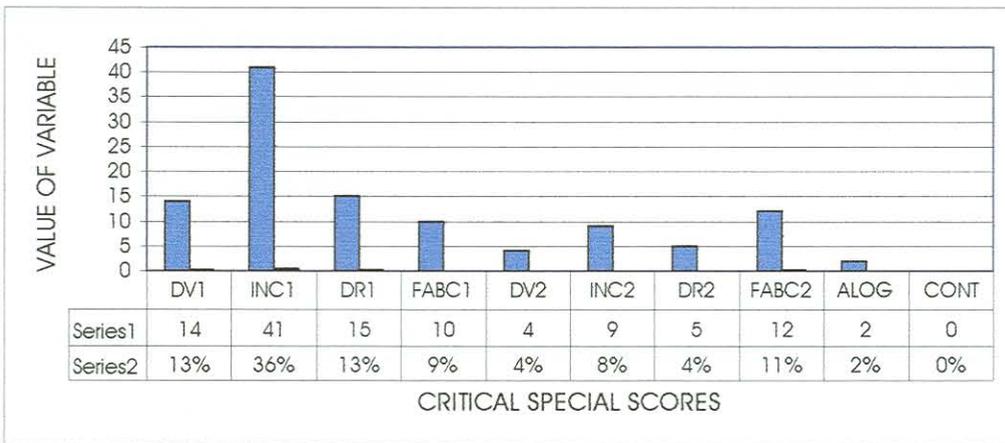


FIGURE 9: POOLED VALUE OF CRITICAL SPECIAL SCORES ACROSS SAMPLE

Figure 10 below indicates that the majority of these slippages (63%) represented mild forms of cognitive mismanagement (i.e. DV1, INCOM1, and DR1 answers), and that only 23% of the assigned Critical Special Scores represented more serious forms of cognitive dysfunction (FABCOM1, DV2, INCOM2, and ALOG answers). Only 13% of the sample's Critical Special Scores resulted from severely impaired conceptual thinking (DR2, FABCOM2, CONTAM). However, the latter involved 9 participants (60%), of whom 6 gave a FABCOM2 answer and 4 gave a DR2 answer. No one gave a CONTAM answer.

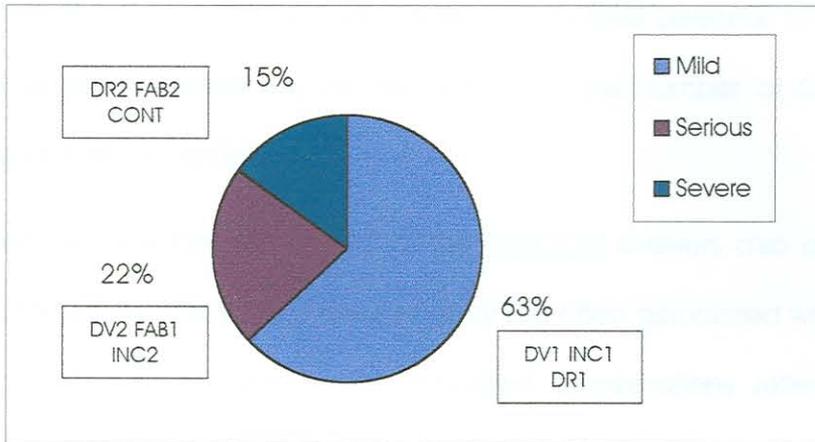


FIGURE 10: DEGREE OF COGNITIVE DYSFUNCTION INDICATED BY CRITICAL SPECIAL SCORES

A review of the standardised scores confirms that the mean for Sum6 is elevated compared to both the non-patient ($z=3.87$) and the outpatient ($z=1.50$) norms. Accordingly, the sample's mean value for WSUM6 (23.80) is also significantly elevated compared to the non-patient ($z=4.77$) and even the outpatient ($z=1.34$) norm populations.

When the value for WSUM6 rises to such levels as in this sample, there is usually an association with impaired reality testing. However, almost none of the answers containing Critical Special Scores were particularly bizarre. As mentioned above, the majority (63%) represented mild forms of cognitive mismanagement (i.e. DV1, DR1, and INCOM1), reflected by unexpected forms of flawed or immature logic for adults.

In fact, 41 of the 112 (37%) assigned Critical Special Scores comprised INCOM1 answers, in which the participants merged an unusual combination of details into a single object. According to Exner (2001), this kind of answer represents a conceptual failure to discriminate and/or a kind of concrete reasoning. What may be cause for concern, however, is that 7 participants (47%) gave more than two INCOM1 answers. Three of them (20%) also had more than one INCOM2 answer, reaching beyond the occasional, simple discriminatory failure. Although the nine INCOM2 answers in the sample were not truly bizarre either, they did reveal a loose form of logic that tended

to discount reality considerations and/or reflected marked personal preoccupations. The INCOM answers represented almost half (45%) the number of Critical Special Scores assigned for the sample.

Given the above, it is not surprising that the FABCOM answers also occurred at a higher frequency. Like the INCOM answers, they are often associated with less mature forms of ideation. More specifically, fabulised combinations reflect very loose conceptual associations and irrational forms of synthesising. In the sample, they represent a further 20% of the Critical Special Scores.

Only 2 participants (13%) gave ALOG answers to represent a form of strained reasoning where faulty cause-and-effect relationships are connected in a simplistic manner and maintained regardless of apparent flaws in the logic. It follows that, as these ALOG answers were more concrete than bizarre, they also indicated immature thinking and unexpectedly poor judgment.

These instances of unsophisticated, arbitrary connections constitute 78% of the assigned Critical Special Scores.

The 9 ambivalent participants produced all the DR responses in the sample, suggesting some form of indecisiveness or a defensive attempt to detach from the task. Although the DR responses in low frequencies simply reflect poor judgment, they could indicate a decline in control over the ideational impulses of the 2 participants (13%) who gave more than two Level 1 answers. On the other hand, the Level 2 responses indicate a more seriously impaired ability to 'stay on target'. They suggest the presence of impulsive and disjointed conceptual thinking in 4 participants (27%) who produced more than one DR2 answer. The DR answers comprise 17% of the sample's Critical Special Scores.

DV1 answers indicate brief moments of cognitive mismanagement, but none of the 5 participants (33%) who produced them scored high enough for the result to be interpretatively significant. However, 3 of these participants (20%) also gave a DV2 response which signalled the presence of intrusive preoccupations and a more serious form of cognitive mismanagement. The DV answers constitute 13% of the Critical Special Scores in the sample.

Given the presence of frequently impaired conceptual thinking in the sample, plus the fact that most of the participants appeared to be continually subjected to the disruptive effects of unmet internal need states, the previously raised question about their repertoire of defensive manoeuvres again becomes relevant. Analysis of the other variables in this cluster does not answer this question satisfactorily.

Based on the Ma:Mp ratio, 4 participants (27%) tended to revert to fantasy more often than is common for most people. Three of them (20%) presented with the 'Snow White Syndrome', routinely escaping from unpleasant situations by flights into fantasy in order to deny reality - often neglecting many of their own needs in the process.

Intellectualisation did not feature as a common defensive measure in this sample. This is clear from its mean on the Intellectualisation Index (mean=2.13) and its standardised scores for non-patients ($z=0.38$) and outpatients ($z=0.27$). Only 3 participants (20%) were slightly more inclined to intellectualise their feelings by accepting a distorted form of conceptual thinking in order to deny the true impact of a situation.

From the findings of the ideation cluster it is therefore evident that:

- Practically the entire sample's thinking is characterised by disorganised and inconsistent ideational activity, often marked by seriously flawed judgment (WSUM6).

- In addition to the psychologically ineffective coping styles of the majority of the sample (EB), many also showed some form of rigid inflexibility that pointed to an underlying sense of fragility (a:p).
- Chronic rather than transient need states frequently seemed to interfere with the participants' concentration and attention (FM+m).
- The sample clearly experienced pervasive difficulties in containing or directing their ideational activities adaptively (Sum6), regardless of the unique source of disruption in the individual participants' conceptual thinking.
- Attempts to make arbitrary connections between the elements of a situation frequently compromised their reality testing (INCOM, FABCOM, ALOG).

7.5.5 Affect

Emotions tend to permeate most psychological activity. When emotions interact with thinking, they affect judgments and decisions and impact on many other aspects of behaviour. The sample's performance on the Rorschach variables related to emotion is highlighted in Table 18 below. In addition to the characteristic EB styles referred to in paragraph 7.3.2, these variables provided information about the role and function of emotions in the participants' psychological functioning.

TABLE 18: COLLECTIVE RESULTS FOR AFFECT CLUSTER

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
FC	1.27	1.34	0.00	4.00	10.0	1.00	1.00
CF	1.87	1.89	0.00	7.00	11.0	1.00	1.00
Pure C	[0.27]	[0.57]	0.00	2.00	3.00	0.00	0.00
CP	[0.00]	[0.00]	0.00	0.00	0.00	0.00	0.00
Sum C'	[1.93]	[1.65]	0.00	5.00	11.0	2.00	2.00
Sum T	[0.60]	[1.08]	0.00	3.00	4.00	0.00	0.00
Sum V	[0.27]	[0.57]	0.00	2.00	3.00	0.00	0.00
Sum Y	[1.80]	[1.90]	0.00	7.00	10.0	2.00	-
Afr	0.61	0.16	0.36	0.88	15.0	0.00	-
Blends	5.73	2.57	2.00	10.0	15.0	6.00	6.00

With the exception of two variables (see Table 19 below), the sample generally performed within expectations in terms of both non-patient and outpatient norms. Although it is not unexpected for a psychiatric sample such as this one to perform below average on the FC variable, the significant elevation in Blends compared to the norms for the general psychiatric population is certainly worthy of consideration. One may reasonably expect similar experiences of environmental stress, unfulfilled needs, and unresolved conflicts in both these populations.

TABLE 19: STANDARDISED SCORES COMPARED TO NORMATIVE DATA – AFFECT CLUSTER

VARIABLE	NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)				
	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW
FC	-1.22	0.19	0.74	0.21	1.12	-0.08	0.27	1.03	0.21	1.12
CF	-0.41	0.39	1.50	2.00	1.33	0.49	0.38	1.48	2.00	1.33
Pure C	[0.40]	[0.41]	1.60	[4.78]	[2.27]	[-0.30]	[0.17]	[0.67]	[4.78]	[2.27]
CP	[0.00]	[0.00]	[0.00]	-	-	[0.00]	[0.00]	[0.00]	-	-
WSUMC	-0.82	0.32	1.24	3.26	1.41	0.10	0.30	1.16	3.26	1.41
Sum C'	[0.38]	[0.38]	1.47	[-0.51]	[0.61]	[0.74]	[0.35]	[1.37]	[-0.51]	[0.61]
Sum T	[-0.57]	[0.47]	1.84	[1.21]	[1.64]	[0.10]	[0.34]	[1.33]	[1.21]	[1.64]
Sum V	[-0.02]	[0.25]	0.97	[4.78]	[2.27]	[-0.23]	[0.20]	[0.77]	[4.78]	[2.27]
Sum Y	[1.24]	[0.53]	2.05	[2.28]	[1.42]	[0.68]	[0.45]	[1.73]	[2.28]	[1.42]
Afr	-0.36	0.26	1.02	-1.05	0.31	0.17	0.22	0.86	-1.05	0.31
Blends	0.28	0.33	1.28	-1.04	0.12	1.08	0.28	1.10	-1.04	0.12

Although the mean values for the achromatic colour (C) and the different shading determinants (I, V, and Y) are not interpretatively significant, analysis of individual differences proved useful. Unexpected elevations⁵ in the variables constituting the right-side eb suggest that 9 participants (60%) were suffering from some form of negative affective experience. Three of these participants (20%) featured an eb ratio with the value of the right side exceeding that of the left side, signalling the presence of intense emotional discomfort or even distress.

⁵ i.e. SumC'>2; SumI>1; SumV>0; SumY>2

As is evident from the distribution of the individual scores listed in Table 20 below however, the varied sources and extent of their discomfort complicate the formulation of individual hypotheses that would serve the purpose of the current study.

TABLE 20: DISTRIBUTION OF RIGHT-SIDE eb VALUES PER PARTICIPANT

VARIABLE	BJ	BN	BM	PS	HL	HJ	JL	KE	KW	KL	MR	MK	JR	WL	YE
<u>SumC</u>	4	2	2	0	3	5	2	1	2	0	0	5	2	0	1
<u>SumI</u>	1	2	0	0	3	0	0	0	0	0	0	3	0	0	0
<u>SumV</u>	2	0	1	0	0	0	0	0	0	1	0	0	0	0	0
<u>SumY</u>	4	2	0	7	2	2	0	2	4	0	1	1	0	0	2

Given their respective EB styles, the sample's Afr suggests that the majority ($N=9$) (60%) was as willing or interested as most other adults in processing emotional stimuli. One participant (7%) was very attracted by emotional stimulation and apparently quite interested in emotional exchange. However, her DEPI and CDI scores indicated that her personality organisation was vulnerable to frequent experiences of affective disruption. The remainder of the sample (33%) showed below average values for Afr. Four of these participants (27%), all ambivalent, preferred to be less involved with emotional stimuli. Given their control and modulation difficulties, this could signal some awareness of the problem and an inclination to avoid situations that could exacerbate it. Two of these participants tended to deal with feelings on an intellectual level more often than most people. Only 1 participant (7%) showed a marked tendency to avoid emotional stimuli, suggesting that she was uncomfortable with emotions. Not surprisingly, she was even more inclined to rely on a defensive use of intellectualisation to reduce or neutralise the true impact of emotions that were unavoidable.

Analysis of the FC:CF+C ratios in the group suggests that 87% of the sample ($N=13$) experienced some degree of difficulty with the modulation and expression of their emotions. This is illustrated in Figure 11, and described in more detail below.

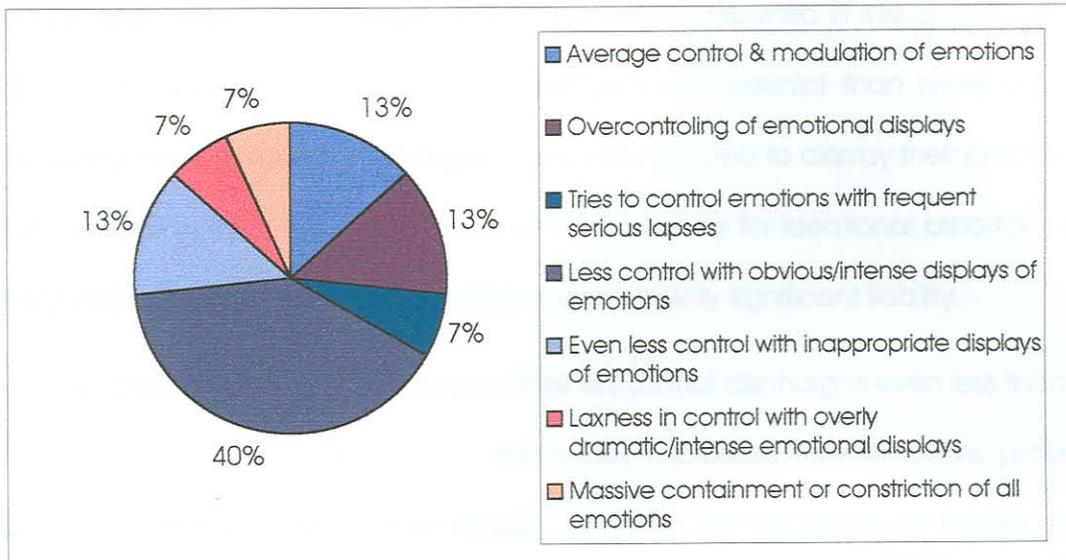


FIGURE 11: MODULATION AND DISPLAY OF EMOTIONAL DISCHARGES IN THE SAMPLE

As is evident from Figure 11, only 2 participants (13%) in the entire sample controlled or modulated their emotional discharges about as much as most adults do. Still, given the value of their EBs, one would have expected these two introversive participants to modulate any emotional displays quite tightly. In addition to featuring Adj D scores in the minus range, however, they might actually exert somewhat less control over their emotions than usual due to the present overload of situational stress (D Score > -1). It is then not surprising that both of them also had a positive DEPI.

Two other ambivalent participants (13%) were inclined to overcontrol their emotional displays much more than most people, suggesting a fearfulness or mistrust of being involved in intense emotional experiences. This deduction is confirmed by an unexpected elevation in the achromatic colour responses (SumC' = 5) of one of these two participants who also had a positive HVI. The other's SumY value of 7 clearly showed her frustration with the feelings of helplessness that arose from an inability to resolve a particularly stressful situation in her life.

One participant (7%) strove to modulate her emotional discharges effectively, but potentially serious lapses in modulation were nevertheless frequent.

Although probably not surprising in view of the findings reported in the controls cluster, most of the participants ($N=6^6$) (40%) exercised less restraint than most adults in modulating their emotional discharges. They were inclined to display their emotions in rather obvious or intense ways. In view of their proclivity for ideational distortions and control difficulties, this tendency constituted a potentially significant liability.

Two other participants (13%) modulated their emotional discharges even less than the above group, and the intensity with which they expressed their emotions probably frequently called attention to themselves. Although not necessarily a liability, these participants' impaired capacity for control and specific ideational problems left them at risk when their passionate emotional expressions were inappropriate under the given circumstances.

The 1 extratensive participant (7%) showed a unique way of dealing with affective experiences. Her FC:CF+C ratio of 1:8 suggests that she is by nature an emotionally immature person whose emotions are often shallow and superficial and relatively transitory. Rather than the more formal and reserved expression of relatively stable affects, she showed a significant laxness in modulating her emotions and tended to express her emotions in an overly dramatic and overly intense manner. However, as is evident from her positive D score (+2) and the apparent lack of experienced emotional difficulties (eb=5:2; DEPI=2; CDI=1; Afr=0.85), she is not incapable of exerting self-control and keeping her emotions in check. Rather, she chooses not to do so. Her childish tendency towards expansive or explosive, potentially inappropriate emotionality nevertheless creates a significant vulnerability in adjustment.

Finally, 1 participant (7%) had a SumC of 0 (zero). In combination with a left-side EB value of 4, this signalled a massive containment or constriction of affect. She currently uses considerable energy to ensure that her emotions are all strictly concealed and

⁶ Unexpectedly, two of these participants have a distinctively introversive EB style.

controlled. However, the combination of a positive CDI with a D score and (revised) Adj D in the minus range makes it particularly unlikely that she would be able to maintain this sort of extreme constriction over a lengthy period of time. In fact, if she does not allow for episodes of deliberate release, she is likely to become overwhelmed by the increasing intensity of her affects. These would thrust her into a labile state where her emotions dominate most of her psychological functioning. When this happens, her emotions would force her into decisions and behaviours that would bring relief, regardless of the realities of the situation.

TABLE 21 PARTICIPANTS' CURRENT AND USUAL LEVELS OF PSYCHOLOGICAL COMPLEXITY

An examination of the DEPI and CDI combinations in the sample elucidated the cost to some of the group members' affective vulnerabilities. Two participants (13%) had a DEPI value of 6 but a value for the CDI of less than 4. This signalled a significant and potentially disabling affective problem that probably promoted behavioural dysfunction. The DEPI and CDI values of 3 other participants (20%) confirmed the presence of a personality organisation that was vulnerable to frequent experiences of affective disruption. Both the DEPI and CDI of another participant (7%) had a value of 5, alluding to the potential for affective problems in response to social adjustment difficulties.

Analysis of the WSUMC':WSUMC ratio indicated that 6 participants (40%) tended to inhibit the release of their emotions much more frequently than most people, and they were burdened by more irritating affects than should normally be the case.

The frequency and sequence of Space responses by 7 participants (47%) are interpretatively insignificant. However, it indicated the likelihood of a somewhat negativistic set in 3 participants (20%). This could impair their ability to create and sustain rewarding social relationships. In another 5 participants (33%), the frequency of Space responses points to the presence of trait-like, considerable anger that had to affect their decision-making and coping activities. It is then significant that all but one

of these participants had an elevated value for SUMC', suggesting that they often internalised these emotions.

The sample showed an unusual complexity when the proportion and composition of Blends in each protocol were examined against the backdrop of the participants' EB style. Table 21 below lists each participant's performance in the Complexity Index as well as a revised index for which the calculations take the impact of environmental stress into account.

TABLE 21: PARTICIPANTS' CURRENT AND USUAL LEVELS OF PSYCHOLOGICAL COMPLEXITY

Level of Complexity	Ambitents (16-36%*)						Extratensive (19-33%*)				Introversives (13-26%*)				
Participant	BN	PS	HL	HJ	KE	KW	MK	JR	WL	JL	BJ	BM	KL	MR	YE
Blends/R (Current)	0.71	0.44	0.10	0.23	0.47	0.38	0.40	0.10	0.21	0.25	0.34	0.53	0.14	0.19	0.27
Blends/R (Usual)	0.57	0.31	0.07	0.23	0.47	0.19	0.40	0.10	0.21	0.21	0.28	0.47	0.14	0.13	0.27

* Average for EB style

It is clear from Table 21 that 2 of the ambitent participants, the 1 extratensive participant, and 2 of the introversive participants (33%) featured a current level of psychological complexity that is not unlike that of others with a similar style orientation. The psychological organisation of 2 other participants (13%), both ambitent, was most likely marked by some sort of immaturity or impoverishment. Given their other difficulties with controlling and modulating their emotions, they could be expected to manifest behavioural difficulties in complex emotional situations.

The remainder of participants (N=8) (53%) showed a more complex than expected psychological functioning. In at least 6 of these participants (40%), this unexpectedly high level of psychological complexity appeared to be characteristic.

What is unexpected, however, is that 10 participants' (67%) usual level of complexity appeared to be relatively unaffected by current stressors in their lives. Given the

extent of other difficulties previously reported for these participants, they could have found some means to absorb the effects of these stressors.

Figure 12 below illustrates the difference between the sample's current and usual levels of psychological complexity.

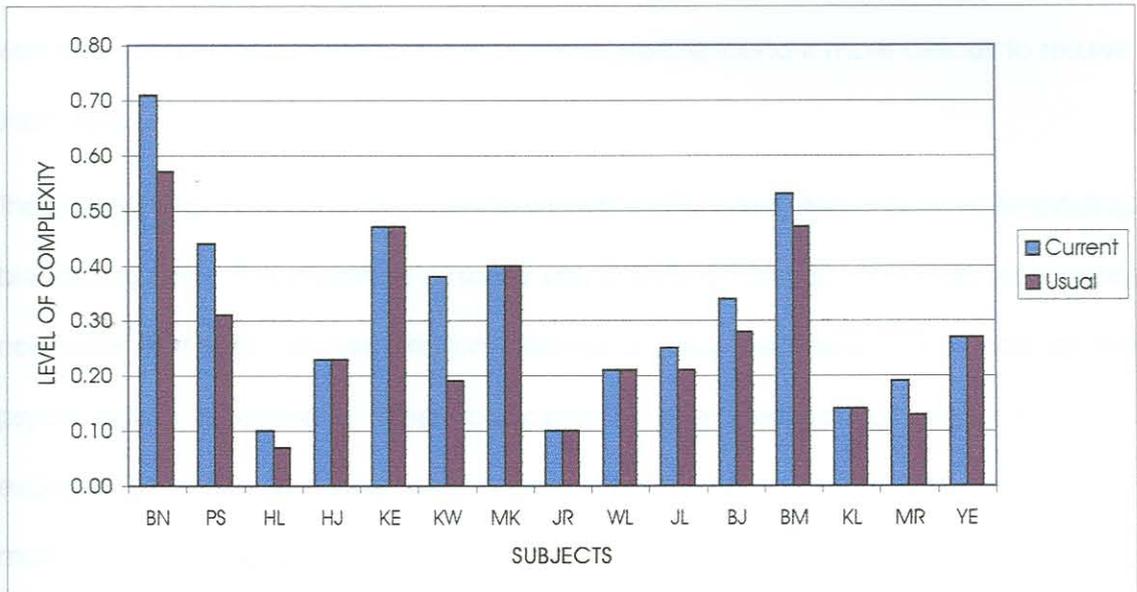


FIGURE 21: PARTICIPANTS' CURRENT AND USUAL LEVELS OF PSYCHOLOGICAL COMPLEXITY

The unexpectedly high number of determinants per blend suggests, regardless of the above findings, that the psychological functioning of almost all the participants ($N=12$) (80%) become inordinately complex at times. While not necessarily a liability, the sample's previously mentioned vulnerabilities regarding the availability of resources and problems with controlling and modulating their emotions could easily contribute to dysfunction.

Bearing the characteristics of the participants' distinctive EB styles in mind, the frequency and composition of colour-shading blends in 4 participants' (27%) protocols suggest that they are sometimes uncertain or confused by emotions or emotional situations. This is not unexpected of 3 of these participants (20%) who are ambivalent, and it probably contributed to their inconsistent approach to decision making and problem solving.

Two participants (13%) tended to experience feelings more intensely than most people. They were often confused by the impact of emotions and sometimes found it difficult to bring emotional situations to a close. The frequency of such confusing emotional experiences was exacerbated by situationally related events in both their lives. These experiences were particularly disruptive for the introversive participant, who was less accustomed to such situations and therefore found it more difficult to resolve such issues.

These 2 participants and 3 others in the sample (33%) presented one or more shading blends, signalling the presence of some very painful emotions. One may reasonably conclude that such intense irritation created a disruptive impact on almost all the psychological functions of these participants. The presence of such tormenting experiences would probably affect their attention and concentration and could markedly impair their judgment.

From the affect cluster's findings it can be inferred that:

- Most of the participants showed a willingness to deal with emotions (Aft), and few were uncertain or confused by emotions or emotional situations (colour-shading Blends).
- The majority of participants endured some form of negative affective experience (eb).
- The entire sample experienced some difficulty with controlling and modulating their emotions. Some exercised excessive control over these emotions, but the majority typically restrained their emotions much less than most people and often expressed their emotions in intense and/or dramatic ways (FC:CF+C).

- Most participants attempted to keep their emotions at a peripheral level, but the majority was nevertheless affected by the inconsistent impact of emotions on their decisions and the behavioural implementation of those decisions (EB).
- The majority of the sample was psychologically rather complex. Most participants' level of complexity appeared relatively unaffected by current situational stress (Blends/R).

7.5.6 Self-perception

This section deals with the image that members of the sample had of themselves, with impressions they had regarding their own characteristics. These may or may not be accurate and/or accessible to their conscious awareness. The extent to which these participants were involved with themselves in contrast to their concerns for the external world was examined.

The participants' performance on the Rorschach variables related to this aspect of their personalities and psychological functioning is listed in Table 22 below.

TABLE 22: COLLECTIVE RESULTS FOR SELF-PERCEPTION CLUSTER

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
3r+(2)/R	0.45	0.19	0.14	0.80	15	0.40	0.33
Fr+rF	[0.33]	[0.60]	0.00	2.00	4	0.00	0.00
FD	[1.87]	[1.36]	0.00	4.00	12	2.00	-
H	2.60	1.50	0.00	6.00	14	3.00	3.00
(H)	0.87	0.81	0.00	3.00	10	1.00	1.00
Hd	1.33	1.25	0.00	4.00	11	1.00	1.00
(Hd)	0.47	0.62	0.00	2.00	6	0.00	0.00
Hx	[0.20]	[0.54]	0.00	2.00	2	0.00	0.00
An	[2.00]	[2.19]	0.00	7.00	11	1.00	1.00
Xy	[0.13]	[0.50]	0.00	2.00	1	0.00	0.00
Sx	[0.27]	[0.57]	0.00	2.00	3	0.00	0.00
MOR	[1.40]	[1.25]	0.00	4.00	11	1.00	1.00
Sum V	[0.27]	[0.57]	0.00	2.00	3	0.00	0.00

It is evident from Table 23 below that the sample generally performed within expectations in a comparison with the normative groups, with the apparent exception

of anatomy responses. However, when this finding is interpreted, the non-parametric qualities of An should be borne in mind and descriptive properties of frequency data should be studied.

TABLE 23: STANDARDISED SCORES COMPARED TO NORMATIVE DATA – SELF-PERCEPTION

VARIABLE	NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)				
	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW
3r+(2)/R	0.53	0.57	2.21	-0.90	0.39	0.27	0.37	1.42	-0.90	0.39
Fr+rF	[0.52]	[0.37]	1.44	[2.63]	[1.79]	[0.23]	[0.25]	0.98	[2.63]	[1.79]
FD	[0.66]	[0.39]	1.52	[-1.40]	[0.23]	[0.87]	[0.36]	1.40	[-1.40]	[0.23]
H	-0.36	0.23	0.91	0.26	0.38	0.22	0.28	1.08	0.26	0.38
(H)	-0.35	0.21	0.82	1.96	1.13	-0.25	0.18	0.69	1.69	1.13
Hd	0.48	0.33	1.27	0.76	1.12	-0.08	0.22	0.84	0.76	1.12
(Hd)	0.51	0.33	1.28	0.40	1.08	-0.10	0.19	0.74	0.40	1.08
Hx	[0.74]	[0.63]	[2.44]	[8.39]	[2.92]	[0.81]	[0.69]	2.67	[8.39]	[2.92]
An	[1.90]	[0.76]	[2.95]	[1.72]	[1.53]	[1.01]	[0.48]	[1.87]	[1.72]	[1.53]
Xy	[0.35]	[0.56]	[2.15]	[15.00]	[3.87]	[0.04]	[0.40]	[1.56]	[15.00]	[3.87]
Sx	[0.33]	[0.33]	[1.26]	[4.78]	[2.27]	[-0.32]	[0.15]	[0.60]	[4.78]	[2.27]
MOR	[0.69]	[0.38]	[1.46]	[-0.64]	[0.70]	[0.26]	[0.25]	[0.98]	[-0.64]	[0.70]
Sum V	[-0.02]	[0.25]	[0.97]	[4.78]	[2.27]	[-0.23]	[0.20]	[0.77]	[4.78]	[2.27]

Despite the nondescript standardised scores, an examination of the individual records rendered potentially significant commonalities in the participants' views of themselves.

Four participants (27%) showed unexpected elevations in their reflection answers ($Fr+rF$), indicating that they were unusually self-centred and had an exaggerated sense of their personal worth. These characteristics could be basic personality features that dominated their perceptions of themselves and their worlds. As the need for reaffirmation and/or reinforcement of their exaggerated sense of personal pride would substantially impact on their decisions and behaviours, these participants would find it more difficult to establish deep and meaningful interpersonal relationships. This could in turn provoke introspection that might result in internal conflict due to some awareness that the high values they attributed to themselves may not be valid.

The Egocentricity Index ($3r+(2)/R$) of all but one of these participants ($N=3$) (20%) was also above average. This finding confirms that the above-mentioned narcissistic-like

features were strongly embedded in their psychology and provided some confirmation of their extensive self-involvement and inclination to assess themselves quite highly.

The result for another 4 participants (47%) whose Egocentricity Index was also above average signalled an unusually strong concern with themselves that could easily lead to neglect of the external world. Although such scores may indicate a high self-regard or estimate of personal worth, it was clear from the research interviews and/or other Rorschach findings that these participants' self-concepts rather involved a marked sense of personal dissatisfaction.

The Egocentricity Index of another 5 participants (33%) suggested a quite negative estimate of their personal worth. They regarded themselves less favourably in comparison with others. Not surprisingly, 3 of them scored positively on the DEPI.

Four participants (27%) presented a frequency of MOR answers that confirmed their self-image was noticeably marked by negative features. Their perceptions of themselves were consequently quite pessimistic. Another's result signalled the presence of some conflict between her self-image and self-value that might stem from perceived educational failure.

The value for An+Xy suggests that almost half the sample ($N=6$) (47%) experienced some unusual body concern. Although not necessarily significant in the case of 3 of the participants (20%), the combined presence with MOR and/or FQ- determinants suggests that it is a significant issue in at least 2 of these women's (13%) psychological organisation. The extent of body concern of the other 4 participants (27%) with an elevation on this scale in the absence of known physical problems, suggests the likelihood of a disconcerting sense of vulnerability that is prompted by rumination about their body and/or self-image.

Not surprisingly the majority ($N=8$) (53%) engaged in some unusual self-inspecting behaviour. For 1 of them (7%) this involved a constructive striving for self-improvement. The presence of a V score in 3 participants' records signified a preoccupation with perceived negative features, whereas the same result for the other participants merely represented some rumination about themselves.

The absence of FD or V answers in 3 other participants' (20%) records suggests that their view of themselves is unlikely to change due to increased self-awareness, as they seldom engaged in self-inspecting behaviour. In fact, only 4 participants (27%) routinely made use of introspection to promote the reevaluation of their self-image.

What is of more concern, however, is that an analysis of the H:(H)+Hd+(Hd) ratio and its content coding suggests that only 3 participants' (20%) self-image is based on real experience with real people instead of on their imagination. The majority of the sample's ($N=12$) (80%) self-image and/or self-value seemed largely based on imaginary impressions or distortions of real experiences. This implies that most participants were less mature, that their self-awareness was limited, and/or that they had more distorted notions about themselves.

This distorted notion is not surprising in 2 of the participants (13%) who were hypervigilant. As they were inclined to mistrust their environments and were preoccupied by the possibility of being degraded or manipulated, they invested considerable energy into maintaining a state of preparedness so that they could timeously identify potential threats to their self-esteem. Their personal integrity was particularly important to them, and they would defend it by attributing the causes of negative events to external forces, regardless of the realities of the situation.

From the above findings on self-perception, it is evident that:

- The participants had negative self-images, although some tried to deny this by employing narcissistic methods of defence (3r+(2)/R and Fr+rE).

- At least half the sample maintained an unusual body concern that could reflect a sense of their perceived vulnerabilities (An+Xy).
- The majority of the participants' image of themselves was rooted in imaginary impressions or distortions of real experiences (H:(H)+Hd+(Hd)).
- It is unlikely that introspection would markedly affect the majority of the sample's perception of themselves despite being quite involved with themselves (FD and V).

7.5.7 Interpersonal perception and behaviour

A number of factors affect how people perceive and relate to others. In addition to external elements that prescribe adherence to certain roles or expectations, internal factors such as needs, attitudes, emotional states, and coping styles also have a considerable impact on people's notions of their social environments.

Table 24 below lists the sample's Rorschach data for the variables related to interpersonal perception.

TABLE 24: COLLECTIVE RESULTS FOR INTERPERSONAL-PERCEPTION CLUSTER

VARIABLE	MEAN	S.D.	MIN	MAX	FREQ	MEDIAN	MODE
All H	5.47	2.50	3.00	12.00	15	5.00	5.00
H	2.60	1.50	0.00	6.00	14	3.00	3.00
(H)	0.87	0.81	0.00	3.00	10	1.00	1.00
Hd	1.33	1.25	0.00	4.00	11	1.00	1.00
(Hd)	0.47	0.62	0.00	2.00	6	0.00	0.00
Isolate/R	0.20	0.20	0.00	0.79	13	0,14	-
Sum T	[0.60]	[1.08]	0.00	3.00	4	0.00	0.00
Fd	[0.20]	[0.40]	0.00	1.00	3	0.00	0.00
COP	1.13	1.02	0.00	4.00	11	1.00	1.00
AG	0.60	0.88	0.00	3.00	6	0.00	0.00
PER	1.40	1.54	0.00	5.00	8	1.00	0.00
a (active)	7.33	3.52	2.00	14.00	15	7.00	-
p (passive)	4.93	2.91	0.00	11.00	14	4.00	3.00
GHR	2.87	0.63	1.00	5.00	15	3.00	3.00
PHR	3.13	1.92	0.00	11.00	15	2.00	2.00

The sample as a whole appeared to differ substantially from the normative samples on the Isolation Index, active and passive movement variables, and the quality of their human responses (see Table 25 below). It is not unusual for a psychiatric sample to differ substantially from the non-patient norms for the GHR:PHR ratio, and to be more inactive or isolated in their interpersonal relationships than people without a DSM-IV diagnosis. However, analysis of the individual records indicated that the standardised scores highlighted in Table 25 below should be interpreted with caution, as only a small portion of the sample actually scored positive variables that identified the presence of features that could negatively impact on interpersonal perceptions or behaviours, even in a comparison with outpatient norm populations.

TABLE 25: STANDARDISED SCORES COMPARED TO NORMATIVE DATA - INTERPERSONAL PERCEPTION

VARIABLE	NON-PATIENT ADULTS (z)					OUTPATIENT ADULTS (z)				
	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW	Z MEAN	S.E.	S.D.	KURTOSIS	SKEW
All H	0.06	0.38	1.46	1.44	1.31	0.06	0.24	0.92	1.44	1.31
H	-0.36	0.23	0.91	0.26	0.38	0.22	0.28	1.08	0.26	0.38
(H)	-0.35	0.21	0.82	1.96	1.13	-0.25	0.18	0.69	1.69	1.13
Hd	0.48	0.33	1.27	0.76	1.12	-0.08	0.22	0.84	0.76	1.12
(Hd)	0.51	0.33	1.28	0.40	1.08	-0.10	0.19	0.74	0.40	1.08
Isolate/R	1.01	0.63	2.44	0.55	0.94	1.08	0.41	1.57	0.55	0.94
Sum T	[-0.57]	[0.47]	[1.84]	[1.21]	[1.64]	[0.10]	[0.34]	[1.33]	[1.21]	[1.64]
Fd	[-0.01]	[0.14]	[0.54]	[0.90]	[1.67]	[-0.18]	[0.21]	[0.81]	[0.90]	[1.67]
COP	-0.63	0.20	0.77	2.83	1.36	0.15	0.25	0.96	2.83	1.36
AG	-0.44	0.20	1.93	2.36	1.63	-0.24	0.19	0.75	2.36	1.63
PER	0.53	0.45	1.75	-0.12	0.82	0.22	0.25	0.97	-0.12	0.82
active	0.40	0.42	1.63	-0.81	0.38	1.16	0.35	1.35	-0.81	0.38
passive	1.24	0.47	1.84	0.18	0.80	0.59	0.32	1.22	0.18	0.80
GHR	-1.16	0.18	0.70	-0.12	0.03	-0.34	0.18	0.71	-0.12	0.03
PHR	1.10	0.47	1.83	5.01	1.99	0.26	0.32	1.24	5.01	1.99

When the individual participants' a:p ratio is examined without consideration of other elements, the participants did not seem particularly passive in their interpersonal relations. This is contrary to expectations for psychiatric participants, but might cast some light on the sample's elevated standard score for active movement ($z=1.16$) when compared to the norms of another outpatient sample. In fact, the a:p ratio of

only 4 participants (27%) indicated that they would assume a passive role in their interpersonal relationships. The substantial frequency of passive movement answers produced by these participants confirmed that they would prefer to rely on others to take responsibility for decision making. They were less inclined to identify alternative solutions to problems or to initiate new patterns of behaviour.

The unexpected elevation in another 3 participants' Ed responses intimated that a further 20% of the sample could exhibit greater dependency behaviour than is typical for adults. These participants probably also relied on others for direction and support, and they tended to be rather naïve in their expectations concerning interpersonal relations.

Excessive dependency appears to be but one way in which the participants addressed their interpersonal needs.

Except for 1 participant (7%) who acknowledged and conveyed her need for closeness in ways similar to those of most people (SumI=1), the majority of the participants (N=11)⁷ produced no texture responses. This suggests that 73% of the participants were probably overly concerned with personal space and much more cautious about creating or maintaining close emotional ties with others.

Another 3 participants (20%) showed unexpected elevations in their texture responses (SumI>1), indicating the presence of very strong unfulfilled needs for closeness. As their histories were void of a recent emotional loss, it is doubtful whether these yearnings were merely reactive. It seemed likely that they had a more sustained experience of longing or loneliness which they felt unable to reconcile or satisfy.

When the issues around R and EB styles are considered, the relation of Pure H contents to all human contents in individual participants' protocols suggests that the sample as

⁷ Although the potential for a false positive finding was ruled out for 3 of the 4 participants' whose records were completely void of grey-black or shading responses, inferences based on their I-less protocols should be approached with caution.

a whole was quite interested in people. Figure 13 below illustrates the sample's characteristic interest in and conceptions of others (described in more detail below).

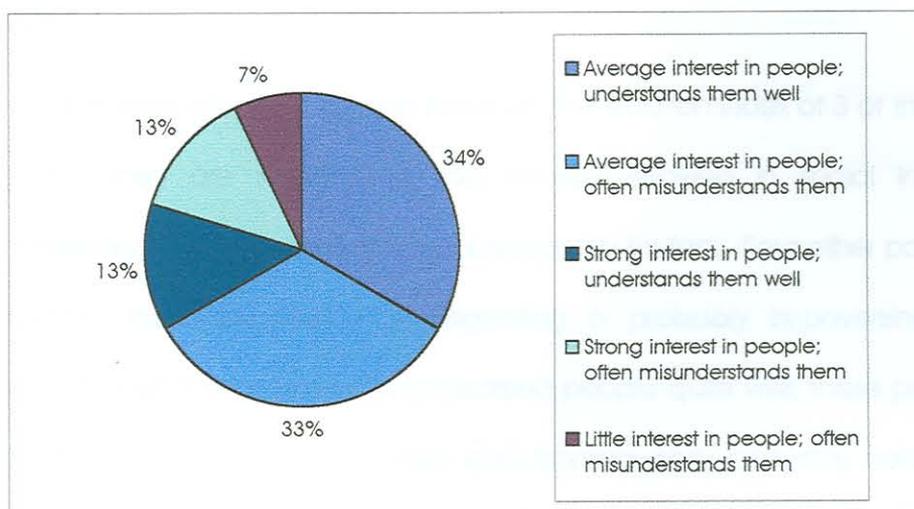


FIGURE 13: CHARACTERISTICS OF SAMPLE'S PERCEPTIONS OF OTHERS

The majority of the sample ($N=10$) (66%) were as interested in others as most people are. However, only half of them can be expected to conceptualise people in ways that are reality-based. The other 5 participants (33%) probably do not understand people that well and would tend to misinterpret social gestures to the detriment of interpersonal relationships. A similar ratio applies to the 4 participants (27%) who were strongly interested in others. The interest of 2 of them in others was based on an understanding of people that seemed to be grounded in reality, whereas the other 2 (13%) did not understand people very well - with similarly negative social consequences. Only 1 participant (7%) showed very little interest in others, and as she also failed to understand them, she was probably emotionally withdrawn, with few social contacts.

The presence of COP and AG responses in the sample occurred infrequently, with COP's median and mode at 1 and AG's even lower at 0 (zero). However, the combination and rate at which they appeared in the majority of the participants' ($N=10$) records, confirm that 67% of the sample seemed open to interpersonal exchanges and usually expected them to be positive.

Only 1 participant in the sample (7%) is likely to be regarded by others as likeable and outgoing. However, the $Bt+2Cl+Ge+Ls+2Na/R$ ratio suggests that she is socially quite isolated.

Despite the sample's interest in people however, the Isolation Index of 3 of them (20%) suggests that they are reluctant to be actively involved in social interaction. Their participation in social activities was subsequently limited. Four other participants' (27%) Isolation Index exceeds 0.33, signalling a probably impoverished social existence. Although they seemed to understand people quite well, these participants found it difficult to connect with others and consequently probably had few truly rewarding relationships.

Two participants (13%) did not routinely anticipate positive interaction between people. Although both reportedly had satisfying relationships with their spouses, they felt less comfortable in interpersonal situations and preferred to remain on the periphery of group interactions. Others were likely to regard them as distant and aloof, and this probably contributed to their sense of discomfort in the presence of strangers. Not surprisingly, one of them was positive on the CDI, whereas the other had a positive HVI.

Two other participants (13%) perceived aggressiveness to be a natural part of interpersonal relationships. This was cause for concern as they also tended to misunderstand social cues. Both of them were typically more negativistic or oppositional towards their environments. Despite these Rorschach findings, however, neither was perceived as particularly forceful or aggressive in their everyday interaction. Other findings suggest that they probably seldom voiced but rather internalised these negative affects. Both also scored positive on the DEPI.

Six other participants (40%) gave PER answers which suggest that they would be somewhat more defensive in their interpersonal relationships than most people. They

often relied on a display of knowledge as a way of reassuring themselves and to avoid having to contend with challenges from others. Only 1 participant (7%) was inclined to become defensively authoritarian when she felt insecure about her personal integrity in interpersonal relationships. Although usually adaptive, others probably regarded her as rigid or narrow-minded and she struggled to maintain close relationships.

The value for the GHR:PHR ratio of most participants ($N=9$) (60%) confirms that, regardless of their interpersonal strategies, their social activities were usually adaptive and regarded favourably by others. However, the opposite is true of 6 other participants (40%). Their GHR:PHR ratio suggests that they were prone to engage in interpersonal behaviours that were probably less adaptive to situations than might be desirable. They might subsequently be regarded more unfavourably by others.

From the above findings on the sample's interpersonal perceptions, it is clear that:

- People were important to them ($H:(H)+Hd+(Hd)$), and most of the participants expected social interactions to be positive (COP and AG).
- The sample suffered from chronic interpersonal deprivation that significantly impacted on their relationships (SumI).
- Some participants were excessively dependent on others (a:p and Fd), but the majority were quite guarded about establishing and maintaining close interpersonal relations (SumT=0). A few were even socially isolated (Bt+2Cl+Ge+Ls+2Na/R).
- The majority of participants behaved in adaptive, socially appropriate ways and others probably regarded them favourably (GHR:PHR).

CHAPTER 8

DISCUSSION

8.1 SYNOPSIS OF FINDINGS

The purpose of this study was to explore the personality structure and psychological functioning of a sample of patients with trichotillomania with the aid of the Rorschach inkblot method. The results of the Rorschach Comprehensive System indicated a number of commonalities in their capacity for control and stress tolerance, their perceptions of themselves, aspects of their affective functioning and cognitive style, and the effect of these factors on their interpersonal relationships.

The most outstanding of these common attributes was that the participants showed a notable impediment in their characteristics for problem solving, decision making, and coping behaviour, where the inconsistent impact of emotion left the majority psychologically inefficient (see par.7.3.2). This seemed to be the culmination of a number of confounding factors, as is evident from the commonalities in the personality structures and psychological functioning of the majority of participants. These are highlighted below:

- There was a strong presence of chronic rather than transient unmet need states in the sample. For several participants, these frequently interfered with their concentration and attention (FM+m, SumC', SumI, SumY, and SumV).
- These need states reflected a variety of early developmental issues pertaining to the fulfilment of needs, the capacity for interpersonal attachment and intimacy, and associated affective states, and left almost all participants with a chronic vulnerability in terms of their inherent capacity for control and stress tolerance (AdjD).

- The participants' also showed a susceptibility for situational stress that surpassed that of the general psychiatric population (D Score). This increased their potential for disorganisation and/or impulsive thinking and behaviour.
- The psychological consequences of the stress tended to affect both the participants' thinking and emotions (SumY and m). Regardless of its focus, however, the disruptive and/or disorganising impact appeared to be severe when it occurred (D Score < -1).
- Approached from a dynamic developmental perspective, the roots of this vulnerability could be identified in the participants' perception of themselves. As could be expected of a sample with such core structure impairments, the participants had quite a negative self-image (3r+(2)/R, Fr+rF, and MOR) - whether consciously acknowledged or denied by way of narcissistic defensive measures.
- Most of the participants' notion of themselves was based more on imaginary impressions or perversions of real experiences than on true interaction and/or identification with real people (H:(H)+Hd+(Hd)).
- Despite being generally quite preoccupied with themselves, the majority did not routinely engage in constructive introspective behaviour (FD and Y). It is therefore unlikely that their self-awareness would change substantially to exert a positive effect on their distorted images of themselves.
- Another concern was that most participants had limited available resources (EA and Adj_es) to minimise the pejorative impact of their subjective experiences of insecurity, dissatisfaction, negativity, overload, and failure.
- They routinely invested in a type of processing that was everything but economical (W:D:Dd), for example expending more energy than necessary in attempts to assess situations precisely. Their attention to details suggested a strong need for

control over every subtle cue from their environments, but also signalled a guardedness and fear of excessive involvement. Despite striving to accomplish more than what appeared reasonable in the light of their current functional capacities (W:M), however, the quality of their processing efforts was generally excellent (DQ+).

- None of the participants was overly committed to conventionality or social expectations (X+%). They nevertheless had an adequate capacity for reality testing (XA% and WDA%) and could be expected to respond appropriately in situations where the cues for acceptable behaviour were simple and obvious (P).
- However, the majority showed a decrease in mediational efficiency (X-%) in situations that were complex and ambiguous (see page 63). Although severely impaired conceptual thinking occurred occasionally (L2SpSc), most of the ensuing cognitive slippage represented benign forms of conceptual mismanagement (INCOM, FABCOM, and ALOG) that signify the rudiments of primary process thinking, for example instances of unexpectedly immature or flawed logic that allowed for unsophisticated and arbitrary connections between apparently unrelated elements. Despite the non-bizarre nature of these slippages, the participants showed such a high incidence of cognitive mismanagement (Sum6) and even instances of reduced reality testing that they were expected to be unable to contend persistently effectively with the demands of everyday living.

The small sample size unfortunately obviated a conclusive inference about the incidence of momentary failures in control that impaired the participants' ability to contain or direct their ideational focus adaptively. There were indications that their thinking was likely to become disorganised, inconsistent, and marked by seriously flawed judgment (WSUM6) in situations that were intensely emotional

and/or unstructured¹. This aspect substantiated the vulnerability posited about the participants' affective functioning.

- Although most of the participants attempted to keep their emotions peripheral (EB, WSUMC':WSUMC, and Intellectualisation Index), the majority experienced some degree of difficulty with modulating and expressing their emotions (FC:CF+C). They typically restrained their emotions much less than most people, and often expressed their feelings in intense and/or dramatic ways.
- The individual group members dealt differently with the presence of unresolved conflicts related to dependency. A few were overly reliant on important others for direction or support (a:p and Fd), but the majority of the sample were quite concerned with their personal space and much more cautious about creating or maintaining close emotional ties with others (SumI=0). Therefore, despite being quite interested in people (H:(H)+Hd+(Hd)+Hx), the majority preferred to keep others at an arm's length. Some were even socially isolated, with almost no rewarding interpersonal relationships (Isolation Index).

In view of the prevalence of situational stress in their lives, the majority of the sample's level of psychological complexity (Blends/R) appeared to be relatively unaffected by its impact. Also, despite numerous theoretical indications to the contrary, only a very small percentage of the sample featured truly significant deficits in coping with everyday demands (CDI). Regardless of the group's inherently vulnerable capacity for control and stress tolerance, their avoidance of close interpersonal contact, their impaired ability to cope with everyday problems and decisions, the interference of primary process thoughts and even the occasionally reduced reality testing, some means did exist to prevent complete disorganisation.

¹ Refer to page 63 and page 68

The question arises whether the symptom of chronic hair pulling represented an adaptive defence that prevented the imminent potential for disorganisation in the group. If so, the protective function served by this form of self-induced harm could be one of the reasons behind the disorder's poor prognosis. Before attempting to answer these questions, the aetiological roots that underpin the collective personality structure and psychological functioning of the sample have to be highlighted.

8.2 AETIOLOGICAL CONSIDERATIONS

The sample's collective performance in the Rorschach test was generally notable, but it was difficult to generalise the findings to the trichotillomania population due to individual differences in a relatively small sample. The near unanimous performance on the Rorschach indicators listed below nevertheless deserves further attention.

Without necessarily repeating the implications of their performance, these findings include the following:

- 8.2.1 The absence or unexpected elevation in 14 participants' I responses (93% of the sample) signified the presence of attachment difficulties and chronic adjustment problems for the majority of the sample.
- 8.2.2 The $H:(H)+Hd+(Hd)$ ratio of 12 participants (80%) indicated that the majority of the participants' self-image and/or self-value was based on imaginary impressions or distortions of real experiences.
- 8.2.3 The low value for $Adj\ D$ in 13 participants' records (87% of the sample) signalled a chronic vulnerability in their capacity for control and stress tolerance.
- 8.2.4 Thirteen participants (87% of the sample) showed some degree of difficulty in modulating and expressing affect, as indicated in their $FC:CF+C$ ratio.

8.2.5 The disruptive presence of primary process thoughts in 14 participants' (93% of the sample) conceptual thinking was indicated by the composition and elevated value of WSUM6.

From a psychodynamic perspective, the combination of these findings signalled a range of early experiences that probably influenced the development of the participants' personality structure and psychological functioning.

Winnicott (1960) emphasised the role of the environment in the formation of self. He pointed out that infants depended on the provisions of a facilitative environment to foster their maturational processes. This environment usually comes in the form of a good-enough primary caretaker (generally the mother) who adapts to the changing needs of the child during the different developmental periods in their relationship. If maternal care is optimal, the child learns to trust his environment to meet his emotional and physical needs, and to increasingly differentiate between me and not-me at a manageable pace. The way in which this environment responds to the developing infant and his needs teaches a child how to regard himself as wanted, worthy, loveable, or not. The mother's ability to identify, name, and accept the child's emotions accurately lays the foundation for how the child regards and deals with his future affective experiences. As the child grows older, the mother's continued but unobtrusive support allows him to discover his personal life, to feel real, and to develop the capacity to be alone without fearing loss or extinction. In other words, good-enough mothering allows a child to move from absolute dependence to relative dependence, and then towards independence. If successful, the adult child is able to enter intimate, interdependent, interpersonal relationships without having to fear engulfment or abandonment.

The interactional patterns laid during these first few years become the blueprint for a child's perception of himself and his world - and all his subsequent relationships.

In the early developmental years, cognitive processes are limited to primary process thinking that is not subject to the rules of logic or oriented to reality. Dudek (in Woody, 1980) points out that primary process thinking serves an adaptive function for the developing infant by providing tension reduction and wish fulfilment, and by organising and ordering his world into manageable portions. Only as the child matures does logical and reality-oriented secondary process thought gradually become dominant, to eventually supplant primary process thinking.

The child's needs are not met and implemented in the absence of a facilitative environment. Bearing in mind that a helpless infant is entirely dependent on its caretakers, it follows that repeated failure to attend to its most basic needs signals an imminent threat to continuation of the infant's very existence. Fried (in Lerner & Lerner, 1988) points out that the most appropriate emotion in case of such a threat is dread, and that any other feeling is likely to be defensive. Theoretically, the infant then has to employ a number of suitably adaptive defences to ensure its survival and to protect itself against the encompassing dread or anxiety associated with the threat.

Most people respond with submission in an environment that is not safe. Therefore, when the not good-enough mother overlooks or ignores her child's needs to replace them with her own, the infant conforms. Eventually, however, the child's compliance leads to the development of a false self that becomes isolated from its own spontaneous and life-giving core. For instance, when the child is left alone and unable to share intense emotions with a suitably responsive important other, or when the expression of these emotions is unwelcome, the child learns to isolate his affective responses from the external world. Anger also easily becomes projected or denied when the needs of the caregiver require that the child be without such emotions in order to be accepted.

According to Winnicott (1960), the origin of this false self therefore lies in the seduction of the infant into a compliant relationship with a non-empathic caretaker. The false self serves defensive needs to hide and protect the true self, by complying with external demands. When this happens, the cathexis of external objects remains incomplete, and spontaneity is repressed by a false set of relationships in which the individual reacts compliantly to environmental demands.

The findings of the current study strongly suggest that this sample's early environments were not optimal for the development of secure, contented, and truly independent adults (as signalled by the results of the Egocentricity Index, $Fr+rE$, FD , $SumV$, $SumC$, $SumY$, $SumT$), who would feel comfortable with emotional intimacy and/or intensity (contra-indicated by the results of the Isolation Index, $SumT$, $FC:CF+C$, COP and AG), and whose cognitive abilities would routinely promote logical, reality-oriented alternatives to problem solving and decision making – which is clearly not the case when the results of the ideation cluster is taken into account.

It is rather postulated that the development of a false self allowed these individuals to adjust relatively well to reality, despite a deep-rooted pathology. However, although the false self originally allowed them to remain in the primary relationship without being overwhelmed by the fear or rage that were kindled by their disparagement, the price was an immature, fragile core that is easily overwhelmed when the usual defensive measures designed to protect it inevitably fail.

8.3 DYNAMIC IMPLICATIONS

The early interpersonal deprivation these participants suffered appear to translate into massive attempts to seek stimulation. They achieve this stimulation by getting involved with people, but generally also by overly scanning their environments. This tendency to scan situations in-depth for even subtle nuances, in combination with their mostly accurate mediational abilities, seem to serve a dual purpose – it satisfies their need for

adequate stimulation and increases their control over the unexpected. In fact, this might well be one of the reasons why these patients continue to function relatively successfully, despite all indications to the contrary. The more acute their perceptions of fluctuation in their external environments, the less pathology is revealed.

However, beneath this frantic search for object contact is an empty dysphoria that only comes to the fore when the sheer amount of information or its content overwhelms the individual's normal defensive structures². It is hypothesised that this usually adaptive process would be particularly vulnerable to lapses in control when their environments become more ambiguous or emotionally laden and the cues for appropriate behaviour consequently become less clear (see page 63). Anxiety then overwhelms the individual and the underlying pathology becomes evident. Even in the adult who has basically achieved an adequate false self that functions reasonably well under ordinary circumstances, intense conflict that arouses a myriad irreconcilable emotions could reawaken the infantile dread of fragmentation. The data on the sample's ideational functioning suggest that these participants resort to primary process thinking³ under such circumstances.

Russ (in Lerner & Lerner, 1988) conceptualises primary process thinking as representative of affective content in cognition. She suggests that primary process content derives from the early developmental phases and that it comprises the contents around which the child experienced early intense feeling states - in other words, content which was at one time affect-laden. However, although some affect may remain, Russ proposes that primary process thinking also reflects a style of dealing with intensely affective material. The primary process could therefore refer both to current affective material and to a style of dealing with affective thoughts.

² Signalled by the findings for the D Score, Adj.D, and FC:CF+C ratio

³ Refer to page 68-71 of this report

If true, these trichotillomania participants seem to regress to primary process thinking in their attempts to reduce emotional tension related to a temporary loss in control, while at the same time reintroducing a means of organising and ordering their world. This would also support Exner's (2000) notion that most lapses in control are related to some homeostatic need in terms of which reduced control produces a sense of relief or gratification.

It is of special interest that the consequences of trichotillomania patients' lapses in control can be equated with the Isakower phenomenon (Isakower, 1938). Fried et al (in Lerner & Lerner, 1988) describes this phenomenon as encompassing regressive ego structure alterations, with a decathexis of the real external world, disintegration of the capacity for differentiated critical thinking and reality testing, and a hypercathexis of the body ego. In this state, physical sensations are intensified and the boundary between self and environment becomes so blurred that it is difficult to distinguish outer from inner or to localise the sources of sensations.

The question then arises whether, once in this state, the self-induced hair pulling constitutes a defensive operation. The arbitrary, seemingly illogical connection between self-inflicted, uncontrollable hair pulling and intense emotional disruption then almost concretely represents the dreaded damage to the self and its internalised objects that could result from actual loss of (emotional) control. At the same time, however, the symptom also protects both the self and its internalised objects from the feared destructive effect of rage (Klein, 1975; Fairbairn, 1954). The symptom also fulfils the need for a self-soothing capacity that protects the individual from being traumatised by spreading emotions that are especially associated with anxiety. This would constitute a more adaptive alternative to the patient's characteristic ways of emotional discharge. While the regressed part of the ego indulges in the abandonment of reality testing so that it may "conjure up lost objects and

submerged worlds" (Isakhower, 1938, p.345), the observing part continues to appraise the process to ensure that it remains adaptive. In this way a degree of control is maintained in order to prevent too deep a regression.

For some patients, the hair twirling and pulling associated with reducing tension quickly becomes a reassuring habit that is resorted to even in the absence of acute emotional discomfort.

8.4 PROGNOSTIC CONSIDERATIONS

The treatment objectives for trichotillomania directly or indirectly target a reduction of the hair-pulling symptoms, with attention to psychosocial and/or interpersonal concerns as secondary aims. However, against the backdrop of the above-mentioned dynamic factors, the findings of the current study do identify important factors that could reasonably be expected to affect the disorder's unremitting disease course.

Several confounding factors in the participants' personality structure and psychological functioning appear to impact on prognostic considerations:

- 8.4.1 The innate vulnerability in the patients' personality structure indicated by the Adj D scores and exacerbated by the limited available resources (EA and Adj es).
- 8.4.2 Either too much or too limited flexibility in coping behaviours, suggested by the distinctive EB style in combination with findings from the cognitive triad (a:p, Zd, W:M).
- 8.4.3 The predominance of unmet need states indicated by FM+m, and elucidated by the absence of or unexpected elevation in I responses.
- 8.4.4 The inconsistent impact of emotions on directed ideational activity indicated by the distinctive EB styles and the inordinately high level of psychological complexity signalled by the frequency and composition of their Blends.

- 8.4.5 The limited control and modulation of emotional discharges, indicated by the $\frac{FC}{CF+C}$ ratio in combination with other psychological vulnerabilities.
- 8.4.6 The frequency and extent of ideational interference posed by primary process thoughts, signalled by the value and composition of the Sum6 and WSUM6 variables.
- 8.4.7 The distorted self-image and limited potential for increased self-awareness signalled by the $\frac{H:(H)+Hd+(Hd)}{V}$ ratio and the value for the \underline{V} and \underline{FD} variables.

The factors listed above would contra-indicate the isolated use of cognitive-behavioural techniques in the treatment of trichotillomania patients. Such approaches tend to target the habitual resorting to hair pulling and associated environmental cues by predetermining coping strategies for high-risk situations. However, a major complication of the inconsistent impact of emotions on these patients' cognitive functioning is the associated tendency to regress to primary process thinking. It follows that patients cannot be expected to adhere to logical, reality-oriented coping strategies that were formulated prior to the re-emergence of especially anxiety-provoking situations. Such a treatment stance would obviously signal the potential for a higher relapse rate.

The findings of the current study therefore correspond with the envisaged benefits of the more recent, comprehensive conceptual and behavioural model that combines the behavioural, affective, and cognitive variables into the diverse and idiosyncratic features that are characteristic of trichotillomania (O'Sullivan, et al., 2000).

Regardless of the preferred treatment approach, however, it might prove beneficial to bear in mind that the predominance of secondary process thought does not seem well established in these patients, and that primary process thinking therefore easily takes over in more demanding situations. If access to primary process material is to become more adaptively employed as a creative resource

(Russ in Lerner & Lerner, 1988) instead of as a means to avoid constructive management of difficult situations, it has to become better integrated with secondary process thought. In this regard, psychodynamic theory predicts that patients who permit affect-laden material to surface in adaptive ways and who can cognitively integrate and master such material would be more open to ideas and more flexible in their problem-solving approach.

The hypothesis that access to primary process thinking and its integration into secondary process thought correlates positively with cognitive functioning, flexible problem solving and generally coping, has been repeatedly confirmed in studies with children. Russ (in Lerner & Lerner, 1988) found for example that well-integrated primary process content accounted for a large proportion of the variance in school achievement, independent of both intelligence and general integrating ability. The cognitive integration of affective material was found to be the important variable. It might therefore prove beneficial to also target the strengthening of secondary process thought and the necessary cognitive structures to integrate affect when trichotillomania patients are treated.

Another factor that should be taken into account for the treatment of these patients is that numerous studies have indicated a relationship between thought and object development (Blatt & Ritzler, 1974; Athey, 1974; Berg, Packer, & Nunno, 1993). The success of strengthening a patient's cognitive structure and secondary process thought would therefore probably be partially determined by his or her intrapsychic and interpersonal repertoire (i.e. the level of the patient's object relations). In order to remedy some of the deficiencies in this regard (the result of early developmental conflicts), Gilpin (1976) points out that it would be important for the therapist to remain a stable object that can be taken in slowly. The therapist must be predictable, consistent, and empathic, and has to become a trusted object to be able to help the

patient with his self/other differentiation and to separate fantasy from reality. The therapist has to serve as an auxiliary ego, helping the patient to establish accurate cause-effect relationships and to link outside triggering events with internal feeling states. These processes and interventions would promote the development and/or strengthening of internal structures and rewarding object relations. Only then can primary process thinking be better modulated and integrated to increase the patient's flexibility and general coping ability.

If future research should determine that unrealistic ambitions (as suggested by the sample's W:M ratio) were in fact a common characteristic of most trichotillomania patients, this finding might elucidate the prevalence of failed treatment interventions and/or recurrent relapses. It would also prompt treating clinicians to closely monitor the pace at which patients attempt to master the above-mentioned skills.

8.5 CONCLUSION

The findings of the current study confirm self-reports that, as a group, people with trichotillomania are highly vulnerable to loss of control and becoming disorganised under stressful conditions. Few of the participants in the current sample had sufficient adaptive resources to manage the stressors in their lives without feeling or manifesting undue distress, which in turn impacted on their sense of comfort, composure, and satisfaction. Most of the participants appeared to lead relatively stressful lives in which they frequently had to deal with demands to make decisions, solve problems, handle feelings, and take action. These demands were exacerbated by virtue of the occupations they filled, the goals to which they aspired, the responsibilities they assumed, and their interpersonal relationships. It was therefore not surprising that many of their histories were marked by instances of faulty judgment, emotional disruption, and/or behavioural ineffectiveness, with numerous remissions and exacerbations in their hair-pulling symptoms.

At face value, they could arguably benefit from leading lives in which neither the expectations they had of themselves nor the external requirements they confronted on a daily basis placed heavy psychological demands on them. They could probably also benefit from learning basic ways of dealing with problems, for example by thinking about them and responding to situations by expressing feelings about them.

However, these participants' life styles appeared to serve them well. They actually sought demanding situations, which in combination with their self-induced hair pulling appeared to fulfil an important psychological function for them. It is therefore unlikely that attempts at mere intellectual insight would markedly affect the quality of their lives or cause permanent remission of their symptoms.

The current study has indicated a number of factors to be taken into account in the treatment of trichotillomania patients. Firstly, more controlled access to primary process thinking would allow for increased efficiency in these participants' characteristic ways of problem solving, decision making, and general ability to cope with the demands of everyday life. A prerequisite, however, is tolerance and eventual integration of distressing emotional contents. This would in turn impact positively on their self-perception, and estimates of their self-worth, and their ability to enter into mutually satisfying interpersonal relationships. Attaining these objectives would theoretically also neutralise the adaptive need for the self-destructive hair-pulling symptoms of trichotillomania patients.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

In 1992, Christenson, Chernoff-Clementz, and Clementz assessed the personality and clinical characteristics of 48 female patients with trichotillomania. They were surprised to find that the entire mean MMPI-2 profile of their sample fell within the normal range. Based on the sample's mean Es scale of the MMPI-2, they also concluded that chronic hair pullers appeared to be better adjusted psychologically than outpatient psychiatric comparison groups.

Bearing the small sample size in mind, the findings of the current study did not support these conclusions. The research sample differed significantly from the normative outpatient sample with regards to the distractive presence of need experiences (FM) and external demand situations (m) that frequently interfered with their ideational focus and direction (Sum6 and WSUM6). In spite of being psychologically more complex (Blends) than expected from a psychiatric sample, they also showed a notable impairment in their capacity for control and stress tolerance when compared to other psychiatric populations (D Score and Adj D). In fact, the results of the current study point to an innate vulnerability in the participants' personality structure that notably impedes their efficiency in solving problems, making decisions, and coping with the demands of everyday life.

Based on the combination of key findings surrounding the majority of participants' distorted perception of themselves, their limited capacity for control and stress tolerance, their difficulty in modulating and expressing emotions, the interference of primary process thought on their ideational activity, and the effect of these factors on their affinity for close emotional contact with significant others, a number of theoretical inferences were made about the probable aetiological roots of these problems. These findings supported early

work with trichotillomania patients that suggested that hair pulling is associated with significant difficulties in psychological functioning (Greenberg & Sarner, 1965).

The postulated limitations in the participants' early facilitative environments elucidated the precincts associated with the development of a compliant - but false - self. However, it is acknowledged that the presentation of an apparently well-adjusted false self could well be one of the reasons why the extent of the pathology in this population has seldom been fully appreciated.

The culmination of research findings and aetiological considerations facilitated an appreciation of the dynamic interplay between different facets of the participants' personality structure and the characteristics of their psychological functioning. Against the background of the Isakhower phenomenon, the hypothesis was that the frequent instances of reduced control that resulted in regression to primary process thought actually constituted an adaptive defence. It presented an opportunity to release the strain associated with situational stress and/or cognitively unmanageable situations, and also introduced a means of reorganising and ordering their worlds. The symptom of self-induced hair pulling is then a last link in the intricate chain of defensive operations designed to protect the individual from severe disorganisation and/or fragmentation. Similar to other acting-out defences, it too serves a tension-reducing function and at the same time fulfils the need for a self-soothing capacity that protects the individual from being traumatised by the spreading of frightening emotions.

If the light of these findings it would seem that, on the proposed continuum of compulsivity (involving excessive harm avoidance and risk aversion) versus impulsivity, that is said to be characterised by the minimisation of harm and risk (Stanley & Cohen, 2001), people with trichotillomania would rather fall on the impulsive end of the compulsive-impulsive spectrum. However, the Rorschach variables associated with impulsivity (D, Adj D, M, Afr, X+%, FC: CF+C, and Lambda) relate more to psychological (internal) operations

and they therefore have few direct links with observed (external) behaviour. As such, it is difficult to obtain conclusive support from the present study's data to comment on the sample's impulse control.

The very nature of the psychodynamic paradigm's theoretical constructs unfortunately makes it difficult to verify the other postulated hypotheses empirically. Rather than a "mechanistic and biologically reductionistic" (Tanquary, 1994, p.35) conceptualisation of the disorder, however, this level of analysis takes early developmental failures and intrapsychic considerations into account when it presents a potentially valuable, complementary perspective on the aetiology, dynamics, and maintenance of the disorder.

Despite the fact that the research design served the extent and purpose of the current study, one obviously cannot generalise the findings of this study to the general trichotillomania population. The reasons for this conclusion are multiple. The participants were limited to females in early adulthood, and the findings might therefore not apply to younger or male patients with trichotillomania, or to others for whom menopause has become a factor. Sampling was furthermore purposive rather than representative. It is therefore also possible that the sample composition does not characterise most adult women with trichotillomania. The relatively small number of participants further limits the conclusions about the disorder that may be drawn from this study. A bigger sample would justify more rigorous statistical manipulations to verify the data and infer additional relationships between the different variables. A bigger sample would also allow for more conclusive inferences about the sample's performance compared to the Comprehensive System's normative samples.

Other confounding factors that may have impacted on the results obtained from this sample include the possible presence of comorbid (psychiatric) conditions. These were limited but not ruled out in the current study. Future studies could benefit from a comprehensive, structured DSM-IV screening of all participants.

The disorder's current phase of acuity or residual state was not deemed an important variable for the aims of this study. However, it is noteworthy that one participant who is currently in remission presented with more serious pathology on the Rorschach than most of the other participants. Although this aspect could actually support the postulate that patients need to pull their hair to prevent or at least minimise the threat of disorganisation, several other possible explanations for this finding could be more relevant. The severity of symptoms at the time of assessment might therefore be an element to take into consideration in future studies.

The MGH Hairpulling Scale is probably not the most suitable instrument for selecting potential participants, despite being the only psychometrically standardised measure instrument for trichotillomania. As it presents a reasonably accurate reflection of the disorder only if the patient is currently in an acute phase, patients in remission score low on this scale in spite of numerous acute phases in the past. A low MGH score could subsequently be misleading in terms of the extent of the clinical problem.

Bearing its aim and extent in mind, the insights generated from this study therefore rather aim to stimulate hypotheses for further research in order to realise the scientific contributions mentioned in the beginning of this report. Further work with bigger samples is necessary to confirm the pilot data.

Nevertheless, the current study's results did elucidate a number of potentially important prognostic implications. In essence, these centre around the conclusion that the symptom itself cannot be targeted effectively over the longer term without acknowledging the confounding structural, affective, and cognitive factors associated with the disorder. It is therefore recommended that the interplay of these factors be taken into account in the conceptualisation of treatment objectives and the formulation of individual treatment plans.

The reported commonalities open doors for further research. For instance, it would be interesting to explore the total absence of an obsessive-compulsive style (OBS) in a sample

expected to show obsessive-compulsive tendencies. Also, one wonders to what extent would factors such as situational stress and the participants' level of complexity be affected in the absence of hair-pulling symptoms. Finally, once it could be determined whether the symptoms have to be addressed directly or indirectly, concurrently or subsequently, further research could indicate the development and/or implementation of more specific treatment models to address the prognostic issues elucidated in this report.

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MASSACHUSETTS GENERAL HOSPITAL HAIR-PULLING SCALE

INSTRUCTIONS:

For each question, pick the one statement that most accurately describes your behaviour during the past week. If you cannot recall having done or done, try to estimate the average for the past week. Be sure to read all the statements in each group before making your choice.

QUESTIONS

1. I pulled my hair out.

2. I pulled my hair out a lot.

3. I pulled my hair out a little.

4. I pulled my hair out a great deal.

5. I pulled my hair out a great deal.

6. I pulled my hair out a great deal.

7. I pulled my hair out a great deal.

8. I pulled my hair out a great deal.

9. I pulled my hair out a great deal.

10. I pulled my hair out a great deal.

11. I pulled my hair out a great deal.

12. I pulled my hair out a great deal.

13. I pulled my hair out a great deal.

14. I pulled my hair out a great deal.

15. I pulled my hair out a great deal.

16. I pulled my hair out a great deal.

17. I pulled my hair out a great deal.

18. I pulled my hair out a great deal.

19. I pulled my hair out a great deal.

20. I pulled my hair out a great deal.

21. I pulled my hair out a great deal.

APPENDIX A

MASSACHUSETTS GENERAL HOSPITAL
HAIR-PULLING SCALE

MASSACHUSETTS GENERAL HOSPITAL HAIR-PULLING SCALE

INSTRUCTIONS:

For each question, pick the one statement in that group which best describes your behaviours and/or feelings over the past week. If you have been having ups and downs, try to estimate the average for the past week. Be sure to read all the statements in each group before making your choice.

NAME:

FOR THE FIRST THREE QUESTIONS, RATE ONLY THE URGES TO PULL YOUR HAIR.

1. Frequency and urges:

On an average day, how often did you feel the urge to pull your hair?

- 0 This week I felt no urges to pull my hair.
- 1 This week I felt the occasional urge to pull my hair.
- 2 This week I felt an urge to pull my hair often.
- 3 This week I felt an urge to pull my hair very often.
- 4 This week I felt near constant urges to pull my hair.

2. Intensity of urges:

On an average day, how intense or how "strong" were the urges to pull your hair?

- 0 This week I felt no urges to pull my hair.
- 1 This week I felt the occasional urge to pull my hair.
- 2 This week I felt an urge to pull my hair often.
- 3 This week I felt an urge to pull my hair very often.
- 4 This week I felt near constant urges to pull my hair.

3. Ability to control the urges:

On an average day, how much control do you have over the urges to pull your hair?

- 0 This week I could always control the urges, or I did not feel urges to pull my hair.
- 1 This week I was able to distract myself from the urges to pull my hair most of the time.
- 2 This week I was able to distract myself from the urges to pull my hair some of the time.
- 3 This week I was able to distract myself from the urges to pull my hair rarely.
- 4 This week I was never able to distract myself from the urges to pull my hair.

FOR THE NEXT THREE QUESTIONS RATE ONLY THE ACTUAL HAIR PULLING.

4. Frequency of hair pulling:

On an average day, how often did you actually pull your hair?

- 0 This week I did not pull my hair.
- 1 This week I pulled my hair occasionally.
- 2 This week I pulled my hair often.
- 3 This week I pulled my hair very often.
- 4 This week I pulled my hair so often it felt like I was always doing it.

5. Attempts to resist hair pulling:

On an average day, how often did you make an attempt to stop yourself from actually pulling your hair?

- 0 This week I felt no urges to pull my hair.
- 1 This week I tried to resist the urge to pull my hair almost all of the time.
- 2 This week I tried to resist the urge to pull my hair some of the time.
- 3 This week I tried to resist the urge to pull my hair rarely.
- 4 This week I never tried to resist the urge to pull my hair.

6. Control over hair pulling:

On an average day, how often were you successful at actually stopping yourself from pulling your hair?

- 0 This week I did not pull my hair.
- 1 This week I was able to resist pulling my hair almost all of the time.
- 2 This week I was able to resist pulling my hair most of the time.
- 3 This week I was able to resist pulling my hair some of the time.
- 4 This week I was rarely able to resist pulling my hair.

FOR THE LAST QUESTION, RATE THE CONSEQUENCES OF YOUR HAIR PULLING.

7. Associated distress:

Hair pulling can make people feel moody, "on edge," or sad. During the past week, how uncomfortable did your hair pulling make you feel?

- 0 This week I did not feel uncomfortable about my hair pulling.
- 1 This week I felt vaguely uncomfortable about my hair pulling.
- 2 This week I felt noticeably uncomfortable about my hair pulling.
- 3 This week I felt significantly uncomfortable about my hair pulling.
- 4 This week I felt intensely uncomfortable about my hair pulling.

STRUCTURED CASE HISTORY INTERVIEW

APPENDIX B

CASE HISTORY FORMAT FOR
STRUCTURED CLINICAL INTERVIEW

Name:

Age:

Sex:

Presenting Problem:

What was the age when first you became aware of the problem? How long has it been bothering you?

How did you first realize this was a problem?

How long has this been bothering you?

How long have you been seeing me?

History:

What was your first psychiatric episode? How long has this been bothering you?

How long has this been bothering you?

How did you perceive the mood of the episode? How long has this been bothering you?

What was the mood of the episode? How long has this been bothering you?

How long has this been bothering you? How long has this been bothering you?

How long has this been bothering you? How long has this been bothering you?

Development:

Stages of development:

1. How old were you when you could walk without aid?

2. How old were you when you learned to talk?

3. At what age did you start walking?

4. At what age did you start talking?

5. How old were you when you were fully toilet trained?

6. At what age did you start your primary school?

STRUCTURED CASE HISTORY INTERVIEW

Name:

Age:

Sex:

Marital status:

Education:

Occupation:

Presenting Problem

1. When was the first time that you became aware of the symptoms, that you noticed a change from your earlier behaviour?
2. When did you first realise this was a problem?
3. Is there anything that could have contributed to the situation?
4. Have you ever sought help for the problem? Describe.

Natal history

5. What was your mother's emotional state like during her pregnancy and your birth? Were there any factors causing trauma?
6. How did your parents feel about the pregnancy (planned or unplanned)?
7. What was the manner of birth (caesarean, epidural, natural)?
8. Were there any complications during birth process (medical, social)?
9. What was your mother's method of feeding (breast or bottle)?

Early Development

10. Milestones of development:

- 10.1 How old were you when you could sit without support?
- 10.2 How old were you when you started crawling?
- 10.3 At what age did you start walking?
- 10.4 At what age did you start talking?
- 10.5 How old were you when you were fully potty trained?
- 10.6 At what age did you reject your bottle/dummy?

11. Describe your health as a child:

- 11.1 Were you ever hospitalised?
- 11.2 Were you involved in any serious accidents?
- 11.3 Did you experience any head trauma?
- 11.4 Were there long separations that you remember? (i.e. holidays, hospitalisations)

12. Did you experience any of the following? If yes, describe the circumstances.

- 12.1 Did you suck your thumb?
- 12.2 Did you have temper tantrums?
- 12.3 Did you walk in your sleep?
- 12.4 Did you wet your bed?
- 12.5 Did you chew your nails? Do you pick at scabs?
- 12.6 Were you extremely afraid of something?
- 12.7 Did you regularly have nightmares?
- 12.8 Did you have any particular food fads?
- 12.9 Did you stutter when you spoke?
- 12.10 Would you describe yourself as a model child or a rebel?

Education

- 13. How old were you when you started school?
- 14. Did you ever change schools?
- 15. Describe your academic performance (mostly A's (80%), B's (70%), C's (60%), D's (50%), E's (40%))
- 16. Did you ever fail a grade?
- 17. What grade did you reach when you left school? How old were you?
- 18. Did you partake in extramural activities (sports, & hobbies) at school? If yes, what and at what level?
- 19. Did you further your training after school? If yes, describe.

Family History:

- 20. Describe your siblings in terms of their age, highest level of education, and occupation.
- 21. Describe your biological parents in terms of their age, highest level of education, occupation and marital status.
- 22. If you had to rate your relationship with your mother on a scale from 1 (very poor) to 5 (extremely close), how would you rate it? Motivate.

23. If you had to rate your relationship with your father on a scale from 1 (very poor) to 5 (extremely close), how would you rate it? Motivate.
24. Do you have any adoptive, foster or stepparents? How old were you when the relationship started? If you had to rate your relationship with them on a scale from 1 (very poor) to 5 (extremely close), how would you rate it? Motivate
25. If you had to rate your relationship with your grandparents on your mother's side on a scale from 1 (very poor) to 5 (extremely close), how would you rate it? Motivate
26. If you had to rate your relationship with your grandparents on your father's side on a scale from 1 (very poor) to 5 (extremely close), how would you rate it? Motivate
27. Did any of your family members experience serious medical problems? If yes, describe.
28. Did any of your family members have a psychiatric condition? If yes, describe.

Sexual Inclinations and Practices:

29. What is your sexual orientation?
30. How often are you sexually active?
31. At what age were your first exposure to people's sexuality and how did it happen?

Marriage / Relationship/Friendships

32. Do you have friends? How often do you see them? What do you do together?
33. With whom are you currently living and how do you find it?
34. Describe your partner in terms of his/her age, highest level of education, and occupation.
35. How long were you and your partner friends before you started a relationship?
36. Is your relationship a committed one? If so, for how long has it been?

Occupation

37. How old were you when you started working?
38. What were your dreams when you thought about a career?
39. How often have you changed jobs since you started working? On average, how long did you remain with a specific employer?
40. What were your reasons for resigning?
41. Are you currently satisfied in your job? If no, describe your dissatisfaction.

DEMOGRAPHICS SHEET

Hobbies & Habits

42. What do you do in your leisure time? (hobbies, sport)
43. Do you practice any religion? If yes, how often? What was your parents' attitude towards religion?
44. Do you smoke? If yes, how often?
45. What is your preferred alcohol and how often do you drink? How does it affect you?
46. Do you use any drugs? If yes, which drugs and how regularly?
47. How long do you sleep at night?
48. Describe your eating patterns (appetite, food fads, weight loss)

Medication

49. What medication are you currently using and how long have you been using it?

Previous Illness

50. Provide a detailed account of all illnesses experienced
- Medical (including illnesses, operations, accidents)
 - Psychiatric (include dates, duration, symptoms, where treated)
51. Have you received psychotherapy before? If yes, when and what for?

Significant Life Events:

52. When you think back on your life there must be some things which you regard as important influences; things that have had an impact on your life, or shaped your personality and values -
- Things that happened to you
 - Difficulties you had to overcome
 - People that played an important role
 - Other major influences.

Would you care to share some of these with me now?

53. Is there something of importance that I have not asked, or is there anything you would like to ask me?

DEMOGRAPHICS SHEET

Please mark the appropriate answer with an 'X':

NAME & SURNAME:

CONTACT NUMBER:

Area code: () Tel no.:

H	W	Cell
---	---	------

POSTAL ADDRESS

Code:

HIGHEST LEVEL OF EDUCATION:

AGE:

() Years () Months

SEX:

Male	Female
------	--------

MARITAL STATUS:

Single	Married	Divorced Separated	Widow/er
--------	---------	-----------------------	----------

LANGUAGES

	SPEAK	READ	WRITE
1.	Good / Fair / Poor	Good / Fair / Poor	Good / Fair / Poor
2.	Good / Fair / Poor	Good / Fair / Poor	Good / Fair / Poor
3.	Good / Fair / Poor	Good / Fair / Poor	Good / Fair / Poor

Have you ever before received psychotherapy?

YES	NO
-----	----

If yes, when and what for?

Have you ever received a formal psychiatric diagnosis?

YES	NO
-----	----

If yes, for what condition(s)?

1. _____
2. _____
3. _____

Have you ever been admitted to a psychiatric hospital?

YES	NO
-----	----

If yes, when?

What medication do you currently use?

	DOSAGE	TIMES PER DAY
1.		
2.		
3.		
4.		

At what age did you start pulling your hair?

() Years

From which site(s) do you pull hair from?

Scalp	Arm(s) / Underarm	Leg(s)
Eyelashes	Eyebrows	Pubic area
Other:		

Does your hair pulling result in noticeable hair loss?

YES	NO
-----	----

Do you feel mounting tension before you pull or when you try to resist pulling?

YES	NO
-----	----

Do you experience pleasure, gratification, or a sense of relief when pulling?

YES	NO
-----	----

Does your pulling cause distress or impact on your functioning at work or socially?

YES	NO
-----	----

Do you want to be notified of the outcome of the study?

YES	NO
-----	----

Are you interested in a self-help support group for trichotillomania sufferers?

YES	NO
-----	----

APPENDIX C

RORSCHACH PROTOCOLS

with

LOCATION SHEET

STRUCTURAL SUMMARY

CONSTELLATION TABLE

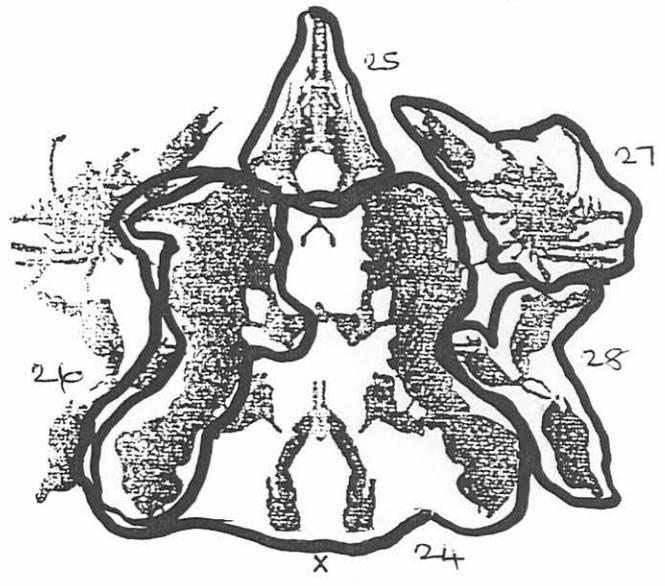
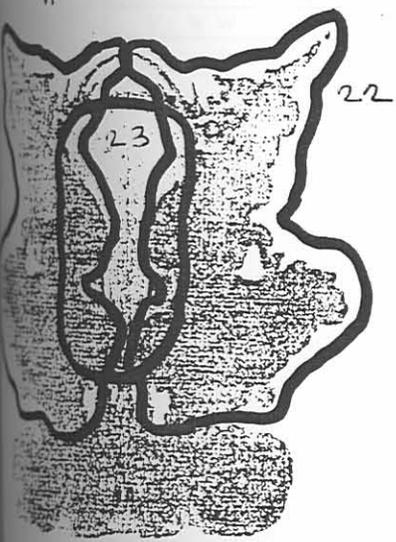
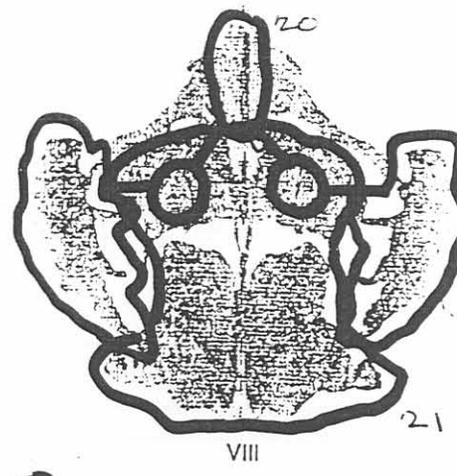
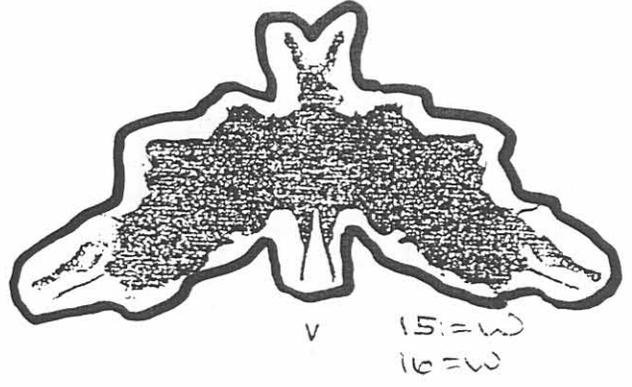
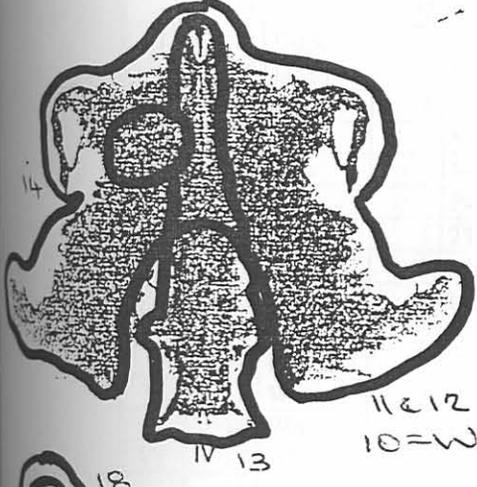
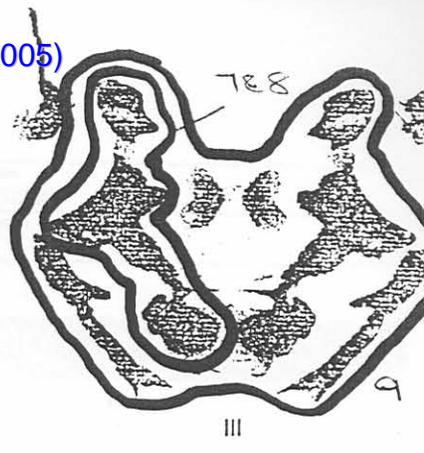
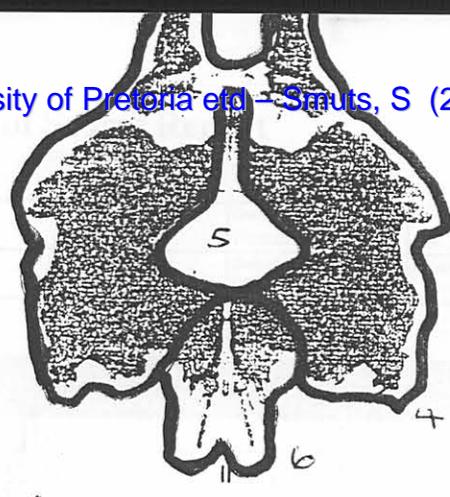
RORSCHACH PROTOCOL (BJ)		ENQUIRIES	
CARD	RESPONSE		
I	1. A butterfly. Hmm... Must I carry on? [Do you see anything else? Some people see more than one thing on these cards.] 2. Maybe a bat. 3. Or a dragon.	5" ^ ^ ^	[Repeats response] Yes, here is the main part of its body with the two wings. And even two little feelers coming out of the top here. [Repeats response] Once again, I saw the body, and the black wings up on the sides. [Repeats response] These parts look like a dragon, or the outline of a dragon (D2), with the wing coming out sharply at the left and the head at the top. [Sharply?] This part here (Dd34).
II	4. Oh! It could be a, like a man. 5. It could be a space rocket.	2" ^ ^	[Repeats response] I used the entire body, picture (excluding D3). Here are his head, or I imagined it to be here (DS2). Those two red parts are his eyes (D2). This little black part was his nose (D4), and these were his arms coming out at the side and his legs at the bottom (D1). [Repeats response] This would be the nose of the space rocket (Dd4) and this would be the body (DS5), and the red part would be the flame when it takes off (D3). [What on the card made it look like the 'flame'?] The shape and the colour. [What on the card made it look like a 'space rocket' to you?] The white part is like the shiny body of the space craft, and the lighter grey area would be the cone part of it, the top part of it. [What on the card makes it look 'shiny'?] The white, it sort of illuminates it.
	6. It could also be two animals. Two bears or something, or elephants. But two animals. That's all I see there.	^	[Repeats response] That would be the head of the one animal, and his neck coming down (D1). Although it's not his complete body. But here are the feet, so it's like a distorted animal. [You said it look like 'bears' or maybe 'elephants'?] Well, it now also looks like it could be rhino with the sharp pointed nose here, but I can't say that now can I? Or maybe elephant because of the long necks, I don't know. [What makes these noses look 'sharp' and 'pointed'?] The angle of that triangle, how the noses get together and sort of end up in a point. [You also mentioned there were two of them?] Yes, the other one is directly opposite it and they meet together, the two noses meet together here.
III	7. Two people sort of dancing. 8. It could be two ducks. 9. It could be somebody's face and neck.	3" ^ ^ ^	[Repeats response] Here are the heads, nose, neck, arms that come forward, and the legs - it's leaning forward at an angle (Dd), that's why I think they are dancing. The other one is a replica opposite it. The backside is sticking out with the foot (Dd31) sticking out at the bottom. Oh! Now I see that its legs could have rather gone down here (D5), that looks more like it! But I didn't see it like that before. [Repeats response] That's the same image. But instead of its back side this is its tail. With its beak here instead of its nose. And opposite it's the same. [Repeats response] It's only the lower half of the face, without the eyes (D1). This would be the neck here, attached below. This red, the orange bow, is the mouth (D3). I almost wants to say its throat (D8) has been cut open, but that's a bit... (laughs). It's like the inner view. [What on the card makes it look like that?] Because of these lines and pipes and things that are in there. [What made this look like the 'mouth'?] Because the sides are wide. It's almost the shape of a human mouth, and it's in the right position.

RORSCHACH PROTOCOL (BJ)		ENQUIRIES	
CARD	RESPONSE		
IV	10. This looks like a splat, like something that has died on the road you know – a blob.	1"	[Repeats response] Just because, I think it's just sort of one, almost like an insect that got squashed! The entire shape. I think the sort of different colour texture looks like something that's been splattered, and moved around. [Colour texture?] The light and dark make me think it's a different texture, like maybe thick and thin substances.
	11. It could also be a man, an angry man.	^	[Repeats response] Yes, it's got big feet, and sort of big, claw-type of hands. And he's sort of coming towards me, almost sort of very noisily [laughs]. I used the entire shape, although I don't know about this piece here in the middle (D1). It's almost as if you can see his spine. [A spine?] Yes, the way it runs, like a thick... how can I explain it? It looks like a bone, a backbone. [What on the card makes it look like that?] These little lighter grey lines coming down here [subs card].
	12. It looks like a scary monster.	^	[Repeats response] It's got a small head that's almost like a skull with sort of, what is it called? Like on of those dinosaur collars, like sort of a cowl neck. [What on the card made it look 'scary?'] Because you can't really see its body, it's just like a big thing coming at you. Its head looks like an animal skull.
	13. It could also be like part of a body, like a spine.	^	[Repeats response] This would be a close-up view of the spinal chord (D5). And then I see this main shaft going down here, and being the spine, the main column. And it's even got nerves at the bottom, these things here, coming out (Da28). The rest of the mass around that column I just see as part of the body.
	14. Then I saw also, that could be skulls. I see skulls in here. It is surrounded by these black things. There are the two skulls. That's all I think.	^	[Repeats response] Jis, I can't see it now! Where is it? [Take your time] It's one of these 3-D pictures so... It doesn't look like that anymore. I know I saw it here but it doesn't look like that, I can see one here but it's not a good image anymore. This little lighter grey area (Da22). It seems to have like a darker area around it where the eye sockets would be. But I can't see it clearly, it's really only the outer shape of it now. [You mentioned that the picture was '3-D'. What made it look like that?] I was scared that you would ask me that, I don't know! How can I say? I suppose the way it is made, it's not flat.
V	15. A butterfly.	1"	[Repeats response] These are the feelers, the little antennae at the top, with the centre line forming the centre of its little body, and then these are the two wings – here's the one wing with its little tail attached to it at the bottom. And then of course the other wing here. It was the shape of the wings, of what I see as the wings, that made it look like a butterfly wing.
	16. It could be a rabbit, with like wings. That's all.	^	[Repeats response] These two would be the ears at the top, and the two back legs sticking out below, with the main body between those two. Did I mention the head, under the ears here? These wings, I see them, looks almost like legs that allow him to fly along [laughs]. It's sort of like extended legs. [You said the legs were 'sticking out?'] Yes, because they are flat and extended, away from the body. I'm seeing it from a higher position, he is below me.

RORSCHACH PROTOCOL (BJ)		ENQUIRIES	
CARD	RESPONSE		
VI	<p>17. I don't know! [Take your time] Okay, what do I see? A face on the side... This could be a totem pole with, like an ugly face at the top.</p>	8"	<p>[Repeats response] It's got a face, with eyes, and the nose, and a down-curved mouth (inner detail of Dd23), with two whiskers on either side (Dd26). I can see the shape of his hair on top of his head, and he's also frowning. He's got a thin, very serious thin face, not something that I would... not a happy, jovial face. The pole (D5) extends all the way down to the bottom of the picture. At the top, below the head, it's got like wing-like decorations (Dd22). [What on the card made it look like that?] The different colour lines there, the dark and light. [What on the card made it look like a 'totum pole?'] The head at the top. [What made that look like a 'head?'] The middle path with the sides, and there's actually a part that has fallen over its forehead. Now I can see two more faces, two profiles, where the ears are supposed to be (D6 edge detail)</p>
	<p>18. It could be like those strange gods that they pray to. [Do you regard that as a separate response, or as part of the totem pole?] No, it's separate.</p>	^	<p>[Repeats response] Yes, it was separate, but that is actually what those totem poles are, isn't it? [What on the card made it look like a 'strange god?'] It's almost like a stone god, a stone image that those wild tribes used to pray to. [What made it look like a 'stone' god?] Because it's hard. [Hard?] Yes, it's not friendly. [I'm not sure that I understand what on the card made it look 'hard', like 'stone', to you?] It's just lifeless. It looks like it's carved. [Carved?] Oh, I don't know! [laughs] Just because they carve those things out of stone.</p>
VII	<p>19. It's two people. Two children, and they're separated and they're trying to reach the other to touch maybe, but there's this gulf between. That's all I see there.</p>	14"	<p>[Repeats response] Yes, a little boy. I can see his profile here, the lighter part of that dark (inner detail of D8s). And his hand is stretched out to the end of that rock (D8). On the opposite side it's a little girl's profile, also with her hand stretched out. It's as if this shape at the bottom has caused the split between the two of them, that the rocks have actually split apart and it's too far to come back together. [What made it look like a little 'boy?'] There's his face. The little darker part is his hair, as if he's got a hat on. And his hand is sticking out, holding the rock. [What on the card made it look like 'rock?'] The shape and the colour. [The colour?] It's grey, like rock. The girl, it's definitely a girl, has like curly hair hanging down. [What made it look like that?] It looks like those locks, like in the olden days, those locks that used to hang like that. The funny thing about their hands, their hands... it looks like skeleton-like arms. [What made it look like that?] Because there's bone sticking out, like the skin is too thin and there's no flesh.</p>
VIII	<p>20. It's a, two pink lions. They're reaching up to this man in the middle, who seems to be suspended because his legs are hanging. Below the man there are some horrible faces.</p>	12"	<p>[Repeats response] The lions are red and on the sides, and they are... The man is up in the middle. He's not clear but his two feet are hanging out. In this sort of blue colour there are like dark, sort of, what would you call those kinds of faces? Like sort of Halloween kind of faces and they're laughing. Here are the eyes and the round mouth. There are two of them actually. It has got hair on the head and they have a little hat on. [What makes it look like that?] Because the hair is covered up in that area, so it must be by a hat.</p>
	<p>21. It could also be two moths. A blue one and an orangy-pinky moth, one flying above the other.</p>	^	<p>[Repeats response] That would be the blue moth at the top (D5), the other one is below him (D2). That's the body down the centre again, and it's got markings on their wings. [Markings?] These smudges here and up there next to my heads [laughs], there are the other marks. [What makes it look like it's 'smudged?'] The paint, it's like someone's finger print. The darker and lighter areas are like veins, it's vein-like shapes.</p>

CARD		RESPONSE		ENQUIRIES
IX	22.	8"	Two unicorns at the top. And they're on top of two elephants.	[Repeats response] [Do you see these as one response, or two separate images?] No, they are together. The elephants are the green (D1), and they are almost leaning out from the centre at an angle. They are like holding up these unicorns (D3). They are, the unicorns are orange-coloured. They've got their mouths open and they are touching in the centre. [What made it look like 'unicorns'?] The horns in the centre. [And the elephants?] They've got trunks and big ears and little tails. [You mentioned that they were 'holding up' the unicorns?] The unicorns are not a complete body, it's only the head and part of the neck. There's the horn on top, the nose and open mouth.
	23.	^	I can see an African mask.	[Repeats response] This lighter colour is actually behind these other colours, the mask actually goes here (traces outline of 'mask'). [What on the card made it look like a 'mask'?] It's got two eyes, elongated eyes, and a long nose (D8) like, uhhmm... I don't know what you call it. The top of the mask's head is light, a lighter shade, and it gets darker as it comes down to the eyes, until at the bottom it is actually very dark.
X	24.	6"	Here's a man with a long moustache. Not a whole man, just his face. He's got a very elaborate sort of hairdo.	[Repeats response] The pink is his hair, he's got pink hair. And two bright, daisy-like eyes, and a nose with a long green moustache. [What made the eyes look 'bright'?] The colour, the yellow colour. [You also mentioned that he has an 'elaborated' sort of hairdo?] Because it's very high above his actual face.
	25.	^	It could also be a space ship taking off, shooting off.	[Repeats response] Wow, there are faces here as well...! Anyway, it's the sort of grey colour at the top with the long shape of a space ship (D1.4), and the grey part below that's almost smudged. That would be the fire and I suppose the smoke (D8s). [What on the card made it look like that?] Just the shape of it. [You mentioned that it looks 'smudged'?] It looks like a blob of ink that someone has put on and allowed to just run. [What on the card made it look like a 'space ship'?] The steel colour and the shape. [The 'steel' colour?] Yes, it's a metal colour. [What on the card makes it look like a 'metal' colour?] It is grey, dirty grey.
	26.	^	Two sea horses.	[Repeats response] These pink shapes on the sides (D9), facing each other. They can be blowing on a trumpet (D6), and I can see their facial features and their tails. [Their 'facial features?'] They almost have human faces – eyes, nose, little foreheads. Gee, I see faces all over, there also. It's like a nightmare! [You mentioned they were blowing on a 'trumpet'?] That blue part in between, because it is attached to their mouths.
	27.	^	I also see things here that look like scorpions that are flying, and they've got like green flames in their hands.	[Repeats response] These crabby-like creatures on the side seem to have lots of legs and a head, with eyes, and a very thick tail (D1). [A 'thick' tail?] That part there, that comes back, it's like folded back against their body, holding it in the air. [What on the card made it look like that?] The shape and the use of the colours – the dark and light. [You also said they were 'flying'. What made it look like that?] Because they're not really on the ground so they're higher up. [And you mentioned the green 'flames'?] Yes, like those old-fashioned torches, like a stick with fire, that's green (D12). They do look angry, I can tell by their eyes.

CARD	RESPONSE		ENQUIRIES
28.	^	And also next to them some brown scorpions.	[Repeats response] Yes, those were just, not very significant, below them. I don't know if they are actually scorpions but I would say a creature in three shades, three colours, and they are touching the sea horses. [What on the card made it look like that?] The yellow, brown, and orange.
29.	^	Last of all I see like quite a fat boy. His whole body. And he is surrounded by all these things around him.	[Repeats response] His body is this white (Dds29). His hands are stretched up, next to his head, and I would say he is jumping up in the air because his feet are not stretched out or touching the ground. He's got almost, it looks like a chicken's wish bone (D3), which could be symbolic of his ribs. And I almost feel like he could be a sailor, a sailor boy with a sailor's hat on. Those white parts are his big shoes coming out around him. [You said he was 'surrounded' by those other things?] Yes. I still see all those other images that we've talked about.



IX

RIAP™ Sequence of Scores Report

Client Information

Client Name: B J	Gender: Female	Test Date: 10/27/2001
Client ID:	Date of Birth: 01/01/1956	Description:

Sequence of Scores

Card	Resp. No	Location and DQ	Loc. No.	Determinant(s) and Form Quality	(2)	Content(s)	Pop	ZScore	Special Scores
I	1	Wo	1	Fo		A	P	1.0	
	2	Wo	1	FC'o		A	P	1.0	
	3	Do	2	F-		A			
II	4	DdSo		F-		H		4.5	
	5	DdS+		CF.FC'.mau		Fi,Sc		4.5	
	6	D+	6	FMpo	2	A	P	3.0	MOR
III	7	Ddo		Ma-	2	H			
	8	Ddo		F-	2	A			
	9	Dd+		F-		Hd,An		4.0	MOR
IV	10	Wv	1	TF-		A			MOR
	11	Do	7	Mao		H,An	P		AG, FAB2
	12	Do	7	FMao		(A),An			DV
	13	Do	5	Fo		An			
	14	Ddo	22	FV-		An			
V	15	Wo	1	Fo		A	P	1.0	INC
	16	Wo	1	Fu		(A)		1.0	INC2
VI	17	Ddo		Mp.FY+	2	Ay,Hd			
	18	Ddo		Fu		(H)			
VII	19	W+	1	Ma.FY.CF+		H,Ls,Cg,An		2.5	INC2
VIII	20	Dd+		FMa.Map.FD.FC-	2	A,H,(Hd),Cg	P	3.0	FAB, INC
	21	D+		FC.FMa.FYo		A		3.0	INC
IX	22	D+		FMa.FC-	2	(Ad),A		2.5	FAB2, INC
	23	DSo	8	FD.FYu		Hd		5.0	
X	24	Ddo		FCu		Hd			INC
	25	D+	11	ma.FC'u		Fi,Sc		4.0	
	26	D+		Mau	2	A,Sc		4.0	INC2
	27	D+		FMa.CF.FVu	2	A,Fi		4.0	INC2, AG
	28	Dd+		CF.FMa-		A		4.0	
	29	WS+	1	Mau		H,An,Cg		6.0	AB

Summary of Approach

I: W.W.D	VI: Dd.Dd'
II: DdS.DdS.D	VII: W
III: Dd.Dd.Dd	VIII: Dd.D
IV: W.D.D.D.Dd	IX: D.DS
V: W.W	X: Dd.D.D.D.Dd.WS

W = 14.1	Sum = 11	1	2	18	100% = 0.2
W = 8.2	INC = 6	2	2	17	100% = 0
W = 2	W = 4.2	3	2	16	100% = 2
W = 2	W = 0	4	2	15	100% = 7
		5	2	14	100% = 1

Client Information

Client Name: B J	Gender: Female	Test Date: 10/27/2001
Client ID:	Date of Birth: 01/01/1956	Description:

Location Features	
Zf	= 18
ZSum	= 58.0
Zest	= 59.5
W	= 7
(Wv)	= 1
D	= 11
Dd	= 11
S	= 4

DQ	
(FQ-)	
+	= 12 (4)
o	= 16 (5)
v+	= 0 (0)
v	= 1 (1)

Form Quality				
	FQx	FQf	MQual	SQx
+	= 2	0	2	0
o	= 8	3	1	0
u	= 9	2	2	3
-	= 10	4	2	1
none	= 0	----	0	0

Determinants	
Blends	Single
CF.FC'm	M = 4
M.FY	FM = 2
M.FY.C'F	m = 0
FM.M.FD.FC	fc = 1
FC.FM.FY	CF = 0
FM.FC	C = 0
FD.FY	Cn = 0
m.FC'	FC' = 1
FM.CF.FV	C'F = 0
CF.FM	C' = 0
	FT = 0
	TF = 1
	T = 0
	FV = 1
	VF = 0
	V = 0
	FY = 0
	YF = 0
	Y = 0
	Fr = 0
	rF = 0
	FD = 0
	F = 9
	(2) = 8

Contents	
H	= 5, 1
(H)	= 1, 0
Hd	= 3, 1
(Hd)	= 0, 1
Hx	= 0, 0
A	= 12, 1
(A)	= 2, 0
Ad	= 0, 0
(Ad)	= 1, 0
An	= 2, 5
Art	= 0, 0
Ay	= 1, 0
Bl	= 0, 0
Bt	= 0, 0
Cg	= 0, 3
Cl	= 0, 0
Ex	= 0, 0
Fd	= 0, 0
Fi	= 2, 1
Ge	= 0, 0
Hh	= 0, 0
Ls	= 0, 1
Na	= 0, 0
Sc	= 0, 3
Sx	= 0, 0
Xy	= 0, 0
Idio	= 0, 0

S Constellation	
<input checked="" type="checkbox"/>	FV+VF+V+FD > 2
<input checked="" type="checkbox"/>	Col-Shd Blends > 0
<input checked="" type="checkbox"/>	Ego < .31 or > .44
<input type="checkbox"/>	MOR > 3
<input type="checkbox"/>	Zd > ±3.5
<input type="checkbox"/>	es > EA
<input checked="" type="checkbox"/>	CF + C > FC
<input checked="" type="checkbox"/>	X+% < .70
<input checked="" type="checkbox"/>	S > 3
<input type="checkbox"/>	P < 3 or > 8
<input type="checkbox"/>	Pure H < 2
<input type="checkbox"/>	R < 17
6	Total

Special Scores		
	Lvl-1	Lvl-2
DV	= 1 x1	0 x2
INC	= 5 x2	4 x4
DR	= 0 x3	0 x6
FAB	= 1 x4	2 x7
ALOG	= 0 x5	
CON	= 0 x7	
Raw Sum6	= 13	
Wgtd Sum6	= 45	
AB	= 1	CP = 0
AG	= 2	MOR = 3
CFB	= 0	PER = 0
COP	= 0	PSV = 0

RATIOS, PERCENTAGES, AND DERIVATIONS

R = 29	L = 0.45	

EB = 7 : 5.0	EA = 12.0	EBPer = N/A
eb = 9 : 11	es = 20	D = -3
	Adj es = 16	Adj D = -1

FM = 7	C' = 4	T = 1
m = 2	V = 2	Y = 4

AFFECT	
FC:CF+C	= 4 : 3
Pure C	= 0
SumC' : WSumC	= 4 : 5.0
Afr	= 0.53
S	= 4
Blends:R	= 10 : 29
CP	= 0

INTERPERSONAL	
COP	= 0
AG	= 2
Food	= 0
Isolate/R	= 0.03
H : (H)+Hd+(Hd)	= 6 : 6
(H)+(Hd):(A)+(Ad)	= 2 : 3
H+A : Hd+Ad	= 22 : 6

IDEATION		
a:p	= 14 : 3	Sum6 = 13
Ma:Mp	= 6 : 2	Lvl-2 = 6
2AB+(Art+Ay)	= 3	WSum6 = 45
M-	= 2	M none = 0

MEDIATION	
P	= 6
X+%	= 0.34
F+%	= 0.33
X-%	= 0.34
S-%	= 0.10
Xu%	= 0.31

PROCESSING	
Zf	= 18
Zd	= -1.5
W : D : Dd	= 7 : 11 : 11
W : M	= 7 : 7
DQ+	= 12
DQv	= 1

SELF-PERCEPTION	
3r+(2)/R	= 0.28
Fr+rF	= 0
FD	= 2
An+Xy	= 7
MOR	= 3

<input checked="" type="checkbox"/> SCZI = 6	<input checked="" type="checkbox"/> DEPI = 6	<input type="checkbox"/> CDI = 1	<input type="checkbox"/> S-CON = 6	<input type="checkbox"/> HVI = No	<input type="checkbox"/> OBS = No
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CONSTELLATIONS TABLE

S-Constellation (Suicide Potential)
<input type="checkbox"/> Positive if 8 or more conditions are true: <i>NOTE: Applicable only for subjects over 14 years old.</i>
<input checked="" type="checkbox"/> $FV+VF+V+FD [4] > 2$
<input checked="" type="checkbox"/> Col-Shd Blends [3] > 0
<input checked="" type="checkbox"/> Ego [0.28] < .31 or > .44
<input type="checkbox"/> MOR [3] > 3
<input type="checkbox"/> $Zd [-1.5] > \pm 3.5$
<input checked="" type="checkbox"/> $es [20] > EA [12.0]$
<input type="checkbox"/> $CF + C [3] > FC [4]$
<input checked="" type="checkbox"/> $X+% [0.34] < .70$
<input checked="" type="checkbox"/> $S [4] > 3$
<input type="checkbox"/> $P [6] < 3$ or > 8
<input type="checkbox"/> Pure H [6] < 2
<input type="checkbox"/> $R [29] < 17$
6 Total

SCZI (Schizophrenia Index)
<input checked="" type="checkbox"/> Positive if 4 or more conditions are true:
<input checked="" type="checkbox"/> $((X+% [0.34] < 0.61) \text{ and } (S-% [0.10] < 0.41))$ or $(X+% [0.34] < 0.50)$
<input checked="" type="checkbox"/> $X-% [0.34] > 0.29$
<input checked="" type="checkbox"/> $(FQ- [10] \geq FQu [9])$ or $(FQ- [10] > FQo [8] + FQ+ [2])$
<input checked="" type="checkbox"/> $(\text{Sum Level 2 Special Scores [6]} > 1)$ and $(FAB2 [2] > 0)$
<input checked="" type="checkbox"/> $(\text{Raw Sum of 6 Special Scores [13]} > 6)$ or $(\text{Weighted Sum of 6 Special Scores [45]} > 17)$
<input checked="" type="checkbox"/> $(M- [2] > 1)$ or $(X-% [0.34] > 0.40)$
6 Total

DCPI (Depression Index)
<input checked="" type="checkbox"/> Positive if 5 or more conditions are true:
<input checked="" type="checkbox"/> $(FV + VF + V [2] > 0)$ or $(FD [2] > 2)$
<input checked="" type="checkbox"/> $(\text{Col-Shd Blends [3]} > 0)$ or $(S [4] > 2)$
<input checked="" type="checkbox"/> $(3r + (2)/R [0.28] > 0.44 \text{ and } Fr + rF [0] = 0)$ or $(3r + (2)/R [0.28] < 0.33)$
<input type="checkbox"/> $(Afr [0.53] < 0.46)$ or $(\text{Blends [10]} < 4)$
<input checked="" type="checkbox"/> $(\text{SumShading [11]} > FM + m [9])$ or $(\text{SumC' [4]} > 2)$
<input checked="" type="checkbox"/> $(MOR [3] > 2)$ or $(2xAB + Art + Ay [3] > 3)$
<input checked="" type="checkbox"/> $(COP [0] < 2)$ or $([Bt+2xCl+Ge+Ls+2xNa]/R [0.03] > 0.24)$
6 Total

CDI (Coping Deficit Index)
<input type="checkbox"/> Positive if 4 or more conditions are true:
<input checked="" type="checkbox"/> $(EA [12.0] < 6)$ or $(AdjD [-1] < 0)$
<input type="checkbox"/> $(COP [0] < 2)$ and $(AG [2] < 2)$
<input type="checkbox"/> $(\text{Weighted Sum C [5.0]} < 2.5)$ or $(Afr [0.53] < 0.46)$
<input type="checkbox"/> $(\text{Passive [3]} > \text{Active} + 1 [15])$ or $(\text{Pure H [6]} < 2)$
<input type="checkbox"/> $(\text{Sum T [1]} > 1)$ or $(\text{Isolate/R [0.03]} > 0.24)$ or $(\text{Food [0]} > 3)$
1 Total

HVI (Hypervigilance Index)
<input type="checkbox"/> Positive if condition 1 is true and at least 4 of the others are true:
<input type="checkbox"/> (1) $FT + TF + T [1] = 0$
<input checked="" type="checkbox"/> (2) $Zf [18] > 12$
<input type="checkbox"/> (3) $Zd [-1.5] > +3.5$
<input checked="" type="checkbox"/> (4) $S [4] > 3$
<input checked="" type="checkbox"/> (5) $H + (H) + Hd + (Hd) [12] > 6$
<input checked="" type="checkbox"/> (6) $(H) + (A) + (Hd) + (Ad) [5] > 3$
<input checked="" type="checkbox"/> (7) $H + A : Hd + Ad [22:6] < 4 : 1$
<input type="checkbox"/> (8) $Cg [3] > 3$

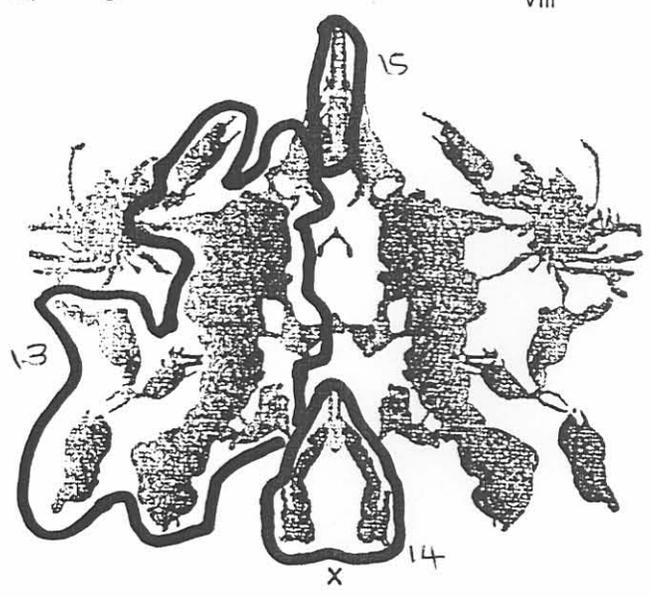
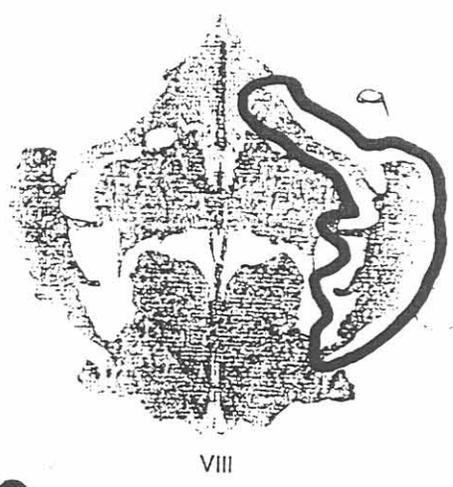
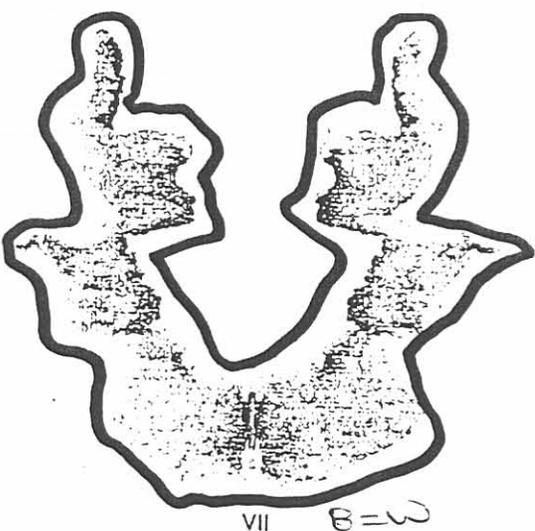
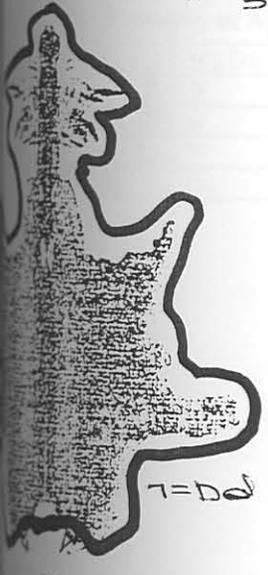
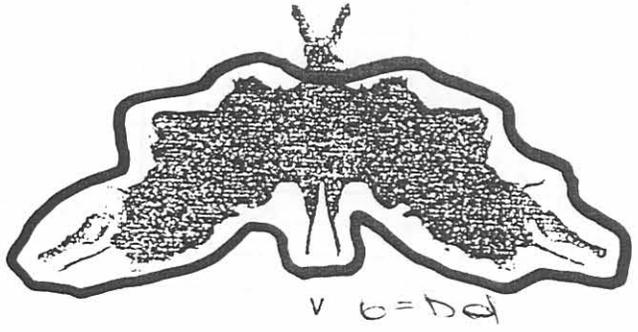
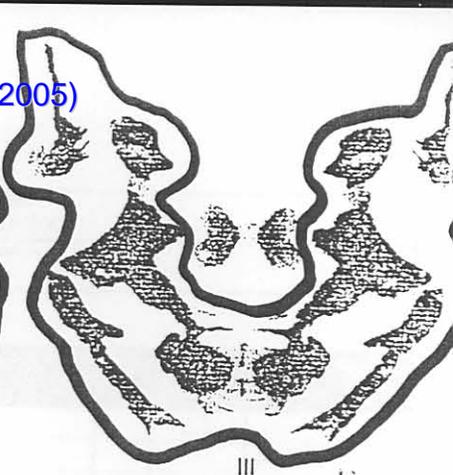
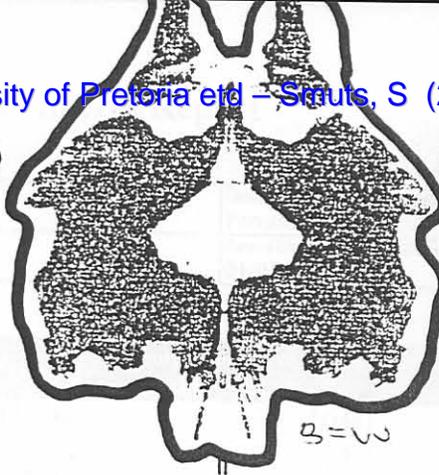
OBS (Obsessive Style Index)
<input checked="" type="checkbox"/> (1) $Dd [11] > 3$
<input checked="" type="checkbox"/> (2) $Zf [18] > 12$
<input type="checkbox"/> (3) $Zd [-1.5] > +3.0$
<input type="checkbox"/> (4) $\text{Populars [6]} > 7$
<input checked="" type="checkbox"/> (5) $FQ+ [2] > 1$
<input type="checkbox"/> Positive if one or more is true:
<input type="checkbox"/> Conditions 1 to 5 are all true
<input type="checkbox"/> Two or more of 1 to 4 are true and $FQ+ [2] > 3$
<input type="checkbox"/> 3 or more of 1 to 5 are true and $X+% [0.34] > 0.89$
<input type="checkbox"/> $FQ+ [2] > 3$ and $X+% [0.34] > 0.89$

NOTE: '*' indicates a cutoff that has been adjusted for age norms.

KAART	1.	6"	^	RESPONS	NAVRAE
I	1.	6"	^	(Huiwering om kaart te neem) [Hier, vat die kaart aab!] (8") (Neem kaart) (5") Dit lyk soos 'n duiwelgestiggle. Hy lyk gemeen. As ek langer lyk sien ek nou meer...	[Herhaal respons] Dit lyk so oor die driehoekige ogies hier (Dd330) en die skerp hoekies (buiteleyn). Dit lyk ook of dit skerp punte het hieronder (Dd329). Dit lyk soos sy tande en hy lyk onvriendelik.
	2.		^	As ek dit so bekijk lyk dit hier bo of dit twee handjies is wat gryp. Dan lyk die goed wat eers ore was soos vletke. Hmm, dis omtrent al.	[Herhaal respons] Hierdie (D1) lyk soos 'n duim met die ander vingers so bymekaar (demonsteer). Dan is die middel (D4) sy lf, en die vlerke hierso (Dd) – dan is dit nie meer ore nie – en die arms hierso so boontoe. [Arms?] Wel, ek reken maar so oor die hande hierso moet die arms omtrent hier lewers wees.
II	3.	6"	^	Hierdie is twee olifantjies met hulle slurpe teen mekaar, wat na mekaar toe kyk. Die rooi goed maak ek nie lekker uit nie. Dit lyk of hulle iets stukkend trap hieronder. Dit lyk of hierdie rooi hier bo goggatjies is wat van die olifante se koppe af spring.	[Herhaal respons] Hier's die slurpies, boud, agterbeen (D1). Die voorbeen lyk of dit iets stukkend trap (D3) want dit bars hier met die goed wat so spat. Hier's die goggatjies (D2) – die koppie bo, voorkop mondjie, neusie se silhoeët, en dit lyk soos 'n voeljie hier. Die ligrooi laat dit lyk of dit gesping het van die olifant se kop af. Dis 'n goggatjie oor dit hier by sy voorkop iets het wat lyk soos 'n voelertjie.
III	4.	1"	^	Gmpfl! (lag) Dit lyk soos twee ousies by 'n pappot. Dit lyk of hulle dit uitmekaar uit trek. Die rooi kalle agter hulle koppe is iets wat vir hulle sê wat hulle moet doen, dit lyk of hulle vir hulle iets fluister.	[Herhaal respons] Hier's die neus, kop, boude, been, borste, arms hier (D9). Dit lyk of hulle die pot (D7) uitmekaar trek oor die strepe – dit lyk of dit weg van mekaar af trek. Hierdie (D2) lyk soos 'n handjie neusie, mondjie – dit lyk of sy mondjie so tuit is, en of hy so fluister agter sy handjie [Agter sy handjie?] Oor sy mondjie so naby aan sy handjie is. Dit lyk nie of hy hard praat nie want dit lyk of sy mondjie toe is, so amper asof hy sê, 'sjuut, saggies!' [Wat op die kaart het dit vir jou soos 'ousies' laat lyk?] Wel die swart kop, lf... seker maar oor dit swart is, en dit lyk of hulle nie klere aanhet nie. Die wit [bokant D5] lyk soos 'n voorskoot-dingetjie wat wit is. Hulle staan so half gebukkend.
IV	5.	10"	^	Dit lyk soos iets wat sit op moederveroor se vlakke, met sy ore wat so hang. Dit lyk ook soos 'n olifant. Tot sy slurp hang! Hy lyk moeg, die ou ding (sit kaart neer).	[Herhaal respons] Hier's die kop bo (Dd), met die ore (D4) wat so hang. Dit lyk of hy sit met sy been (D6) wat so uitkom. Hier's die voet en die slurpie (D1) wat so hang, dit lyk of dit somer so op die vloer hang. Dit lyk of sy skouerfjies (Dd) ook hang. [Wat laat dit so lyk?] As hy regop sou sit sou mens mees van sy nek gesien het. Nou lyk dit of die armpies en goed somer hier by sy nek uitkom. [Jy't gepraat van 'die ou ding'. Hoe bedoel jy?] Hy lyk moedeloos, alles hang net. Hy lyk definitief nie op en wakker en lewendig nie!
V	6.	12"	^	O, ek sien net olifante - ek weet nie hoekom nie! Hulle druk met hulle koppe teen mekaar. En elke ding wat hang lyk vir my soos 'n slurp (sit kaart neer).	[Herhaal respons] Hier's die slurpe (Dd32). Hulle koppe is plat teen die muur, hier's die oor se hobbel, en die agterfjies (D4). [Hulle koppe is plat teen 'n muur?] Teen mekaar, ja. En dit lyk of die slurpies hang. Hulle lyk ook nie baie 'happy' nie.
VI	7.	7"	^	Dit lyk soos daai Sylvester-kat op die TV. Dit lyk of hy sulke snorre het. Hy's platgetrap. Ja, 'n platgetrapte kat (sit kaart neer).	[Herhaal respons] Sylvester het mos sulke baardhare wat so uitstaan (Dd22). Daai is sy snoet (Dd23), sy snobbaarde weerskante (Dd26), en sy nek. Sy lyk so platgetrap – dis van bo af gesien, sy maag is onder. Hier's sy agterbene en voorpote, amper soos 'n afgeslagte ding. Dis die hele ding, maar sonder die uitsteekseljies hieronder (Dd33).

KAART	RESPONS	NAVRAE
VII	8. (Hulwerig om kaart te neem) Dit lyk soos twee kabouterfjies wat 'n dansie doen op 'n klip. Dis ou/kabouterfjies!	[Herhaal respons] Hier's die hoedjies (D5), die koppie van die hoed, kulif, oogwimper, neuse, kakebeen. Hulle lyk oud oor die kakebeen lyk of dit nie tande in het nie. Hier's die een armple wat agtertoe wys (Dd21) – dis wat my laat dink het hulle dans. Hier's die voet, op die klip (Dd23). Elkeen het 'n klip. [Wat op die kaart het dit soos 'n klip' laat lyk?] O, hierdie en hier (wys buitelyne). [Wat laat dit lyk of hulle nie 'tande' het nie?] Oor die kaak wat so naby aan die neus is, dit lyk of hulle so vorentoe leun - dis nie 'n jong profiel nie. Die gebuigde nekke en skouers het hulle ook ouerig laat lyk.
VIII	9. Aan die kante lyk dit of daar twee rooi diere aan iets opklim. Dit lyk armpers soos bere. Of rotte. Dit lyk of daar bo iets is wat hulle aan die poot vat, maar wat nie optrek of wegfoot nie. Ek bedoel dit lyk of die beer opgetrek word maar die ding lyk of hy hom wegfoot - sy hand is oop. Die beer hou sy hand vas, maar sy hand vat nie die beer s'n nie.	[Herhaal respons] Hier's die kop, rug, agterpoot (D1), en die ander poot is besig om op te klim. Dié een trap vas en die ander een vat dit vas wat lyk soos 'n hand. Dis dalk 'n rot oor die lyf so lank is. Maar hy't nie 'n stert nie, dis hoekom ek dink dis dalk 'n beer. Dan die ding bo (Dd22) – die arm, vingerfjies. Maar die hand vat nie, die vingers is net so oop. Dis net die arm, nie alles (van D4) nie.
IX	10. (Sug) Dit lyk soos 'n sprinkaan of 'n ding se kop. Groot kake, voelers, skerp tande.	[Herhaal respons] Die twee lyk soos oë (DdS29). Daai lyk soos voelers (D3). Dit het ge lyk of dié deel van die sprinkaan se kakebeen is oor dit so vierkantig is (D6), en dan't dié soos tandjies ge lyk (Dd21). Dié sal omtrent sy neusgate wees (DdS23). [Wat het dit soos 'kake' laat lyk?] Oor die oë hier is het ek gedink die kaak moet hier wees. Dit lyk nogal bedreigend. [Bedreigend?] Oor die skerp tandjies, die breë vierkantige kaak, skerp voelerfjies, en die oë wat so driehoekig is. [Wat laat die voelerfjies skerp lyk?] Oor die punte hierso (wys buitelyne).
	11. Anders lyk die groen dele soos varkies wat iets eet.	[Herhaal respons] Hier's die stertjie (Dd31), pootjies, kop en ore (Dd24), nek. Hier kom sy handjie wat iets in sy mond insit (Dd29). Dit lyk of hulle so agteroor leun. Dis varkies oor hulle sulke lekker vet lyfied het. [Wat laat hulle lyfies 'ver' lyk?] Die skaduwees hier en hier. Dit lyk of sy nek sulke rolle het. En die kepie hier wat so 'n skaduwee maak hierso.
	12. Die boonste oranje goedjies kan lyk soos iets wat vir mekaar vinger wys. Met een hand wys hulle vir mekaar vinger en met die ander hand hou hulle mekaar vas, met 'n tou.	[Herhaal respons] Hier's die koppe, die agterkop hier. Magies. Die bene gaan daar af. Hierdie lyk soos 'n armple met 'n vingerfjie wat vorentoe wys, daai kant ook. Die donkerder oranje lyk soos nog 'n armple met vingerfjies. Die ligoranje lyk soos die toue. [Wat het dit soos toue laat lyk?] Die ligoranje streep moet 'n tou wees wat hulle trek. Of stoot, want die boonste een maak so 'n kurwe. Dit lyk soos twee toue.

<p>KAART X</p>	<p>13.</p>	<p>7</p>	<p>Dis twee mense wat met hulle voorkoppe teen mekaar staan, en met hulle een hand iets vashou en met die ander hand iets weghou van mekaar af. Agter elkeen is 'n mannetjie - hy's kleiner, dit lyk soos 'n kind of iets - wat aan hulle stoot, na mekaar toe. Maar dit lyk so half of die twee mekaar wil bykom of iets hierso met 'n bokshandskoen. Dit lyk of hier in die middel, voor die mannetjies, is hier twee goedjies wat lyk soos verkleurmannetjies.</p>	<p>[Herhaal respons] Hier's sy kop (D8), skouers en bene tot onder (D9). Die blou (D6) lyk soos soos arms wat uit hulle kiere uit kom. Dit hou iets saam vas. Hier's die arm wat agtertoe wys (Dd) met iets in die hand wat weggehou word agter hom. [Agter' horn?] Want sy gesig wys vorentoe en hierdie hand wys vorentoe - dit lyk of hy iets weghou in die ander hand. Dié (D12) is 'n bokshandskoen in sy handjie wat dié kant om kan gaan.</p> <p>Die kind... Hier's die kop, die geel is die hare (D15), hier's die armpie wat soontoe stoot, met die onderlyf hier (D13), dit lyk soos 'n rokkie of iets. Hy stoot oor die kuwe in die been - dié een stoot soontoe, en die ander een soontoe (wys). [Wat laat dit soos 'n rokkie' lyk?] Die oranje deel. Dit lyk nie of hy bene het het nie, so dis seker 'n lang rokkie. [Ek is nog nie seker ek weet wat op die kaart het dit so laat lyk nie?] Dis 'n vroulike kind of ding oor die hare, die lang hare hierbo, so dit moet 'n rokkie wees. Dit lyk of die rokkie op die grond sleep hieragter. [En wat op die kaart het dit soos 'hare' laat lyk?] Net oor dit bokant die koppie is.</p> <p>Die geel goeterfjies hier (D2), dit lyk of hulle boontoe klim. Die oranje kol is sy oog. Daar's sy voeterfjies of oorjie of iets. [Wat het dit vir jou soos 'verkleurmannetjies' laat lyk?] Die groot kop en klein lyfie, en die groot ronde ogle. [Is dit deel van die mense, of 'n aparte respons?] Wel, dit lyk of hulle hier bo teen die mense opklim, so dit is deel van die prentjie.</p>
<p>14.</p>	<p>^</p>	<p>^</p>	<p>Dit lyk of hier 'n hasie sit in die middel van die prentjie tussen hulle.</p>	<p>[Herhaal respons] [Sien jy dit as deel van jou eerste antwoord, of as 'n aparte respons?] Ek weet nie eintlik wat maak die hasie daartoe nie. Ek dink dis deel van die hele storie, maar sê maar dis apart. Dit lyk soos 'n vet hasie (DS10). ['n vet' hasie?] Hierdie hele groot oop deel lyk soos sy maglie (spasie) wat miskien wit is, met sy pote en ore hierso. Die liggroen is sy kop en oorjies. En sy mondjie, dit lyk of hy lag.</p>
<p>15.</p>	<p>^</p>	<p>^</p>	<p>En daar's 'n mier tussen hulle (i.e. die mense se) koppe. Dis omtrent di.</p>	<p>Hierdie ding hier bo (D14) lyk soos 'n mier. [Wat het dit vir jou soos 'n mier laat lyk?] Want dis reguit en glad en plat. [Hoe bedoel jy 'glad'?] Dit lyk egdlig, dit het nie kurweyne nie.</p>



Client Information

Client Name: BM	Gender: Female	Test Date: 07/28/2001
Client ID:	Date of Birth: 01/01/1962	Description:

Sequence of Scores

Card	Resp. No	Location and DQ	Loc. No.	Determinant(s) and Form Quality	(2)	Content(s)	Pop	ZScore	Special Scores
I	1	WSo	1	Mau		(Hd)		3.5	
	2	Ddo		Mau		(Hd)			
II	3	W+	1	FMa.mau	2	A	P	4.5	INC AG, MOR,
	4	W+	1	Ma.FC'o	2	H,(H),Cg,Hh	P		5.5
IV	5	Wo	1	FMp.FDo		A		2.0	INC, MOR
	6	Dd+		FMpu	2	A			2.5
VI	7	Ddo		Fo		(A)			MOR
	8	W+	1	Mao	2	(H),Ls,Cg			2.5
VIII	9	Dd+		FMa.Mp.FCo	2	A,Hd	P	3.0	INC
	10	WSo	1	F-		Ad			5.5
IX	11	Ddo		FMa.FV-	2	A			INC
	12	D+	3	Ma.mau	2	(H),Sc	P		2.5
X	13	Dd+		Ma.FD.mp.FMa+	2	H,Cg,A		4.5	AG, FAB
	14	DSO	10	FMa.FC'u		A			6.0
	15	Do	14	F-		A			

Summary of Approach

I: WS.Dd	VI: Dd
II: W	VII: W
III: W	VIII: Dd
IV: W	IX: WS.Dd.D
V: Dd	X: Dd.DS.D

RAIUS, PERCENTAGES, AND DERIVATIONS

<p> $R = 1.33$ $L = 0.22$ $RA = 1.33$ $LA = 1.1$ $LDer = 7.0$ $RA = 1.33$ $LA = 1.1$ $D = -1$ $AG = 1.1$ $AGD = -1$ </p>	<p> $RA = 1.33$ $LA = 1.1$ $LDer = 7.0$ $RA = 1.33$ $LA = 1.1$ $D = -1$ $AG = 1.1$ $AGD = -1$ </p>
<p> $R = 1.33$ $L = 0.22$ $RA = 1.33$ $LA = 1.1$ $LDer = 7.0$ $RA = 1.33$ $LA = 1.1$ $D = -1$ $AG = 1.1$ $AGD = -1$ </p>	<p> $R = 1.33$ $L = 0.22$ $RA = 1.33$ $LA = 1.1$ $LDer = 7.0$ $RA = 1.33$ $LA = 1.1$ $D = -1$ $AG = 1.1$ $AGD = -1$ </p>

Client Information

Client Name: B M	Gender: Female	Test Date: 07/28/2001
Client ID:	Date of Birth: 01/01/1962	Description:

Location Features	
Zf	= 11
ZSum	= 42.0
Zest	= 34.5
W	= 6
(Wv = 0)	
D	= 3
Dd	= 6
S	= 3

DQ	
	(FQ-)
+	= 7 (0)
o	= 8 (3)
v/+	= 0 (0)
v	= 0 (0)

Form Quality				
	FQx	FQf	MQual	SQx
+	= 1	0	1	0
o	= 5	1	3	0
u	= 6	0	3	2
-	= 3	2	0	1
none	= 0	---	0	0

Determinants		Contents
Blends	Single	
FM.m	M = 3	H = 2, 0
M.FC'	FM = 1	(H) = 2, 1
FM.FD	m = 0	Hd = 0, 1
FM.M.FC	FC = 0	(Hd) = 2, 0
FM.FV	CF = 0	Hx = 0, 0
M.m	C = 0	A = 7, 1
M.FD.m.FM	Cn = 0	(A) = 1, 0
FM.FC'	FC' = 0	Ad = 1, 0
	C'F = 0	(Ad) = 0, 0
	C' = 0	An = 0, 0
	FT = 0	Art = 0, 0
	TF = 0	Ay = 0, 0
	T = 0	Bl = 0, 0
	FV = 0	Bt = 0, 0
	VF = 0	Cg = 0, 3
	V = 0	Cl = 0, 0
	FY = 0	Ex = 0, 0
	YF = 0	Fd = 0, 0
	Y = 0	Fi = 0, 0
	Fr = 0	Ge = 0, 0
	rF = 0	Hh = 0, 1
	FD = 0	Ls = 0, 1
	F = 3	Na = 0, 0
	(2) = 8	Sc = 0, 1
		Sx = 0, 0
		Xy = 0, 0
		Idio = 0, 0

S-Constellation	
<input checked="" type="checkbox"/>	FV+VF+V+FD > 2
<input type="checkbox"/>	Col-Shd Blends > 0
<input checked="" type="checkbox"/>	Ego < .31 or > .44
<input type="checkbox"/>	MOR > 3
<input checked="" type="checkbox"/>	Zd > ±3.5
<input checked="" type="checkbox"/>	es > EA
<input type="checkbox"/>	CF + C > FC
<input checked="" type="checkbox"/>	X+% < .70
<input type="checkbox"/>	S > 3
<input type="checkbox"/>	P < 3 or > 8
<input type="checkbox"/>	Pure H < 2
<input checked="" type="checkbox"/>	R < 17
6	Total

Special Scores		
	Lvl-1	Lvl-2
DV	= 0 x1	0 x2
INC	= 7 x2	0 x4
DR	= 0 x3	0 x6
FAB	= 2 x4	0 x7
ALOG	= 0 x5	
CON	= 0 x7	
Raw Sum6	= 9	
Wgtd Sum6	= 22	
AB	= 0	CP = 0
AG	= 3	MOR = 3
CFB	= 0	PER = 0
COP	= 0	PSV = 0

RATIOS, PERCENTAGES, AND DERIVATIONS

R = 15	L = 0.25	
EB = 7 : 0.5	EA = 7.5	EBPer = 7.0
eb = 10 : 3	es = 13	D = -2
	Adj es = 11	Adj D = -1
FM = 7	C' = 2	T = 0
m = 3	V = 1	Y = 0

AFFECT	
FC:CF+C	= 1 : 0
Pure C	= 0
SumC' : WSumC	= 2 : 0.5
Afr	= 0.88
S	= 3
Blends:R	= 8 : 15
CP	= 0

INTERPERSONAL		
COP	= 0	AG = 3
Food	= 0	
Isolate/R	= 0.07	
H : (H)+Hd+(Hd)	= 2 : 6	
(H)+(Hd):(A)+(Ad)	= 5 : 1	
H+A : Hd+Ad	= 14 : 4	

IDEATION		
a:p	= 13 : 4	Sum6 = 9
Ma:Mp	= 6 : 1	Lvl-2 = 0
2AB+(Art+Ay)	= 0	WSum6 = 22
M-	= 0	M none = 0

MEDIATION	
P	= 4
X+% = 0.40	
F+% = 0.33	
X-% = 0.20	
S-% = 0.33	
Xu% = 0.40	

PROCESSING	
Zf	= 11
Zd	= +7.5
W : D : Dd	= 6 : 3 : 6
W : M	= 6 : 7
DQ+	= 7
DQv	= 0

SELF-PERCEPTION	
3r+(2)/R	= 0.53
Fr+rF	= 0
FD	= 2
An+Xy	= 0
MOR	= 3

<input type="checkbox"/> SCZI = 2	<input checked="" type="checkbox"/> DEPI = 5	<input type="checkbox"/> CDI = 2	<input type="checkbox"/> S-CON = 6	<input checked="" type="checkbox"/> HVI = Yes	<input type="checkbox"/> OBS = No
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CONSTELLATIONS TABLE

S-Constellation (Suicide Potential)

Positive if 8 or more conditions are true:
NOTE: Applicable only for subjects over 14 years old.

- FV+VF+V+FD [3] > 2
- Col-Shd Blends [0] > 0
- Ego [0.53] < .31 or > .44
- MOR [3] > 3
- Zd [7.5] > ±3.5
- es [13] > EA [7.5]
- CF + C [0] > FC [1]
- X+% [0.40] < .70
- S [3] > 3
- P [4] < 3 or > 8
- Pure H [2] < 2
- R [15] < 17

6 Total

SCZI (Schizophrenia Index)

Positive if 4 or more conditions are true:

- ((X+% [0.40] < 0.61) and (S-% [0.33] < 0.41)) or (X+% [0.40] < 0.50)
- X-% [0.20] > 0.29
- (FQ- [3] ≥ FQu [6]) or (FQ- [3] > FQo [5] + FQ+ [1])
- (Sum Level 2 Special Scores [0] > 1) and (FAB2 [0] > 0)
- (Raw Sum of 6 Special Scores [9] > 6) or (Weighted Sum of 6 Special Scores [22] > 17)
- (M- [0] > 1) or (X-% [0.20] > 0.40)

2 Total

DEPI (Depression Index)

Positive if 5 or more conditions are true:

- (FV + VF + V [1] > 0) or (FD [2] > 2)
- (Col-Shd Blends [0] > 0) or (S [3] > 2)
- (3r + (2)/R [0.53] > 0.44 and Fr + rF [0] = 0) or (3r + (2)/R [0.53] < 0.33)
- (Afr [0.88] < 0.46) or (Blends [8] < 4)
- (SumShading [3] > FM + m [10]) or (SumC' [2] > 2)
- (MOR [3] > 2) or (2xAB + Art + Ay [0] > 3)
- (COP [0] < 2) or ((Bt+2xCl+Ge+Ls+2xNa)/R [0.07] > 0.24)

5 Total

CDI (Coping Deficit Index)

Positive if 4 or more conditions are true:

- (EA [7.5] < 6) or (AdjD [-1] < 0)
- (COP [0] < 2) and (AG [3] < 2)
- (Weighted Sum C [0.5] < 2.5) or (Afr [0.88] < 0.46)
- (Passive [4] > Active + 1 [14]) or (Pure H [2] < 2)
- (Sum T [0] > 1) or (Isolate/R [0.07] > 0.24) or (Food [0] > 0)

2 Total

HVI (Hypervigilance Index)

Positive if condition 1 is true and at least 4 of the others are true:

- (1) FT + TF + T [0] = 0
- (2) Zf [11] > 12
- (3) Zd [7.5] > +3.5
- (4) S [3] > 3
- (5) H + (H) + Hd + (Hd) [8] > 6
- (6) (H) + (A) + (Hd) + (Ad) [6] > 3
- (7) H + A : Hd + Ad [14:4] < 4 : 1
- (8) Cg [3] > 3

OBS (Obsessive Style Index)

- (1) Dd [6] > 3
- (2) Zf [11] > 12
- (3) Zd [7.5] > +3.0
- (4) Populars [4] > 7
- (5) FQ+ [1] > 1

Positive if one or more is true:

- Conditions 1 to 5 are all true
- Two or more of 1 to 4 are true and FQ+ [1] > 3
- 3 or more of 1 to 5 are true and X+% [0.40] > 0.89
- FQ+ [1] > 3 and X+% [0.40] > 0.89

NOTE: '' indicates a cutoff that has been adjusted for age norms.*

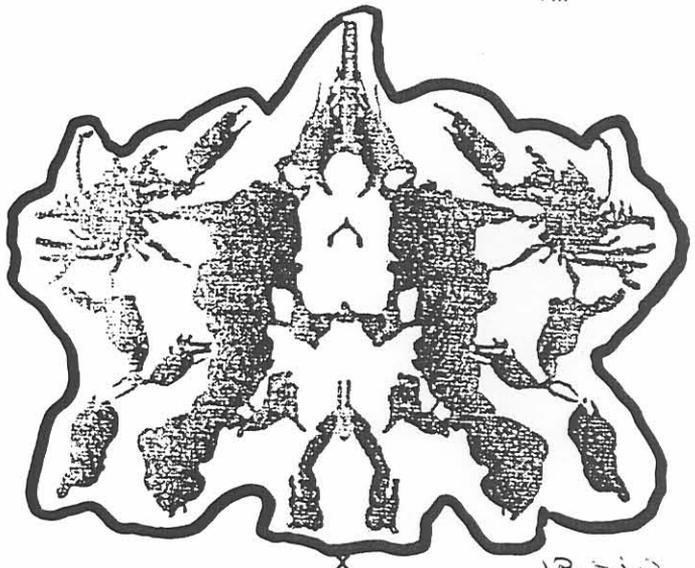
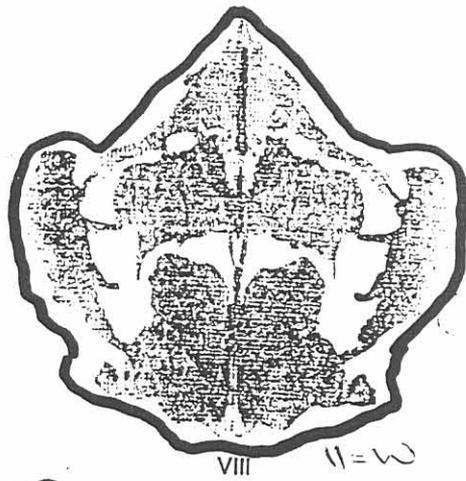
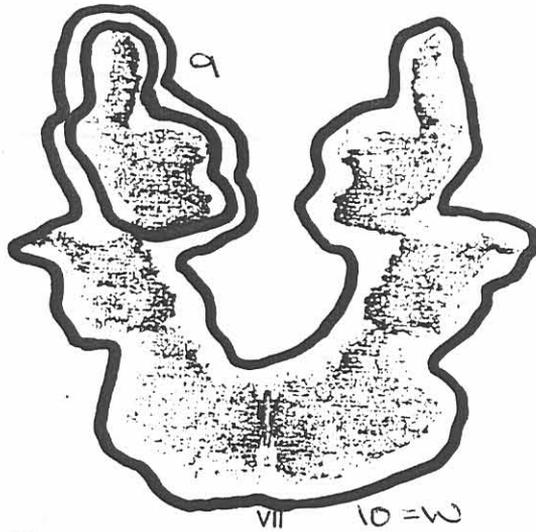
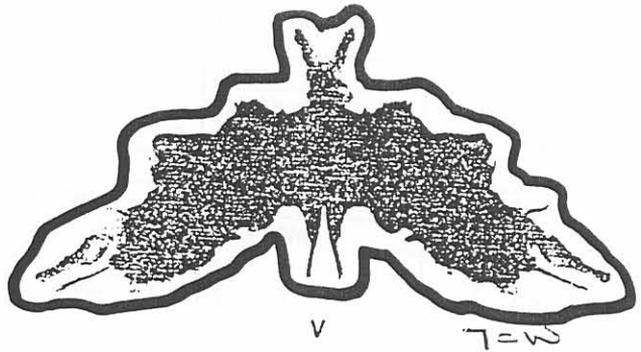
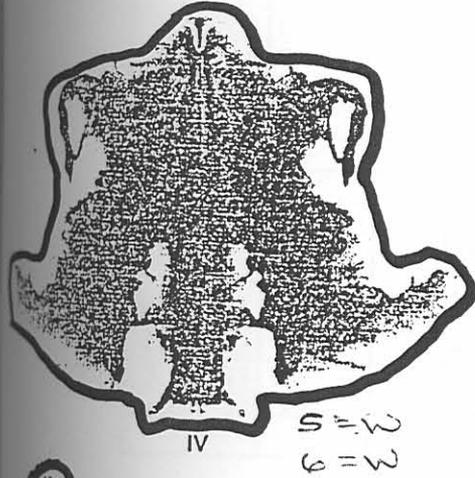
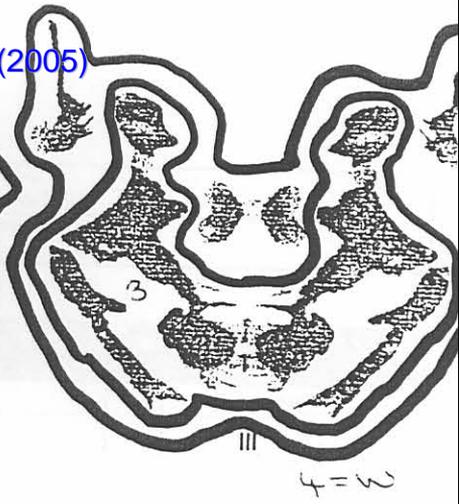
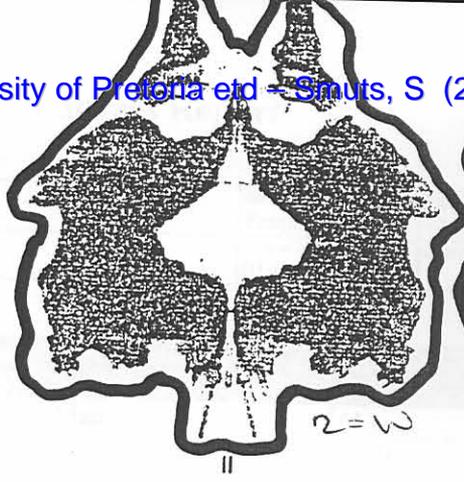
Iwende afname van toets agv onvoldoende antwoorde met eerste afname. Tyd in hakies is responstyd met eerste afname.

I	1.	6" (10")	^	Dit lyk soos 'n kombinasie tussen... 'n bal... Maar ook 'n spinnekop wat op iets afvlieg, want hy's gereed om iets te vang of te byt of iets soos dit. [Sien jy dit as een of twee aparte response?] Nee, dis so 'n 'bal' spinnekop, dié ding... Hy kan amper die leier wees, omdat sy lyf redelik groot is.	[Herhaal respons] Hier's die vlerke, die oë van 'n spinnekop, en sy 'pinchers'. Hier's sy lyf, waar 'n 'bal' ook so tipe boud het. Daai (Da26) is net 'markings' op sy vlerke. Die lyf hier lyk nie in proporsie na... dit lyk amper groot in verhouding met die vlerke dis hoekom ek gesê het dit lyk of hy die leier kan wees. Die kolleffies hier (Da32) kan aandui dat hy besig is om te vlieg.
II	2.		^	Dit lyk nog steeds soos twee olifante wat hulle neuse so teenmekaar het. Maar dis so 'n sirkusatmosfeer, 'n gelukkige atmosfeer. Hulle speel amper saam. Dis asof hulle weet hulle gaan nou werk doen, maar later gaan hulle eet. En speel, want hulle is nog babatjies. <td data-bbox="134 1935 174 2127">[Herhaal respons] Olifante, met hulle neuse wat saam is. Hier's die voorste pote wat aan mekaar raak. Hulle oorjies is nog klein. Dit kan aandui dat hulle is nog babatjies. Die rooi... kan amper balonne wees in 'n sirkus. Omdat jy gewoonlik sien, dier wat toerjies doen is gewoonlik in die sirkus. Hier en daai rooi kan ook aandui die sirkusatmosfeer, want dis 'n helder, vriendelike kleur. Daar's hulle oë, hulle kyk so vir mekaar.</td>	[Herhaal respons] Olifante, met hulle neuse wat saam is. Hier's die voorste pote wat aan mekaar raak. Hulle oorjies is nog klein. Dit kan aandui dat hulle is nog babatjies. Die rooi... kan amper balonne wees in 'n sirkus. Omdat jy gewoonlik sien, dier wat toerjies doen is gewoonlik in die sirkus. Hier en daai rooi kan ook aandui die sirkusatmosfeer, want dis 'n helder, vriendelike kleur. Daar's hulle oë, hulle kyk so vir mekaar.
III	3.	2" (3")	^	In die een lig kan dit vrouens wees wat oor 'n pot hang en kosmaak. <td data-bbox="174 1935 215 2127">[Herhaal respons] Dit lyk soos Boesmanvrouens met hulle hande wat hier uitgesteek is (D1). Hier's die pot (D7). Hier's hulle kop, hulle lang nek, lyf, en daar's die bene. En al twee hande wat om die pot besig is. [Wat op die kaart het dit soos 'Boesman' vrouens laat lyk?] Die boudte wat so uitgedruk is, hulle het gewoonlik sulke 'protruding' boudte. [En wat het hierdie soos 'n 'pot' laat lyk?] Daar's amper 'n sitkel (buitely), daar's die rand van die pot en daar's die boonste 'rim'.</td>	[Herhaal respons] Dit lyk soos Boesmanvrouens met hulle hande wat hier uitgesteek is (D1). Hier's die pot (D7). Hier's hulle kop, hulle lang nek, lyf, en daar's die bene. En al twee hande wat om die pot besig is. [Wat op die kaart het dit soos 'Boesman' vrouens laat lyk?] Die boudte wat so uitgedruk is, hulle het gewoonlik sulke 'protruding' boudte. [En wat het hierdie soos 'n 'pot' laat lyk?] Daar's amper 'n sitkel (buitely), daar's die rand van die pot en daar's die boonste 'rim'.
IV	5.	3" (2")	^	Maar dit kan ook twee mense wees wat dans by 'n klub. Amper 'n verliefde paartjie. Amper asof die rooi kan wees – almal sien liefde as 'n hart – hulle hartjies wat bymekaar is, een word. Dis amper of hulle, tipies verliefdes, maar hulle aandag is net op mekaar gevestig. Ander dinge wat om hulle aangaan, maar hulle het net oë en aandag vir mekaar. <td data-bbox="215 1935 255 2127">[Herhaal respons] Daar's die paartjie (D9). Daai gedeelte wat so uitsteek kan hulle neuse wees, en hulle kyk net na mekaar. Die rooi kan ligte wees in 'n jolplek, of klub. Dit bly agter hulle want hulle sien net vir mekaar. Amper of hulle harte uitgesping het uit hulle bors uit, en die twee harte kom so bymekaar. Daai vorm (Da2?) kan amper soos 'n fiese hart wees. Daar smelt hulle so saam (D3). [Wat op die kaart laat dit so lyk?] Elkeen het 'n eie vorm van 'n hart, maar in die middel is 'n gedeelte wat saamsmelt. Hulle kan moontlik, hier waar hulle arms is lyk dit of hulle hande vashou. [Jy' gesê die ligte is 'agter' hulle?] Hier kyk hulle, en die ligte is agter hulle (D2). Die rooi laat my dink aan daai ligte, glasballe wat so hang in klubs. [Glasballe?] Oor die feit dat dit so hang en dit so rond, sirkelvormig is soos 'n bal. [Wat het hierdie soos hulle 'harte' laat lyk?] Daai vorm, dit lyk amper soos 'n menslike hart. [Wys net weer vir my wat jy alles gebruik het?] Alles. Hierdie kan dan 'n tafeltjie wees (D7), met hulle hande wat so uitgestrek is.</td>	[Herhaal respons] Daar's die paartjie (D9). Daai gedeelte wat so uitsteek kan hulle neuse wees, en hulle kyk net na mekaar. Die rooi kan ligte wees in 'n jolplek, of klub. Dit bly agter hulle want hulle sien net vir mekaar. Amper of hulle harte uitgesping het uit hulle bors uit, en die twee harte kom so bymekaar. Daai vorm (Da2?) kan amper soos 'n fiese hart wees. Daar smelt hulle so saam (D3). [Wat op die kaart laat dit so lyk?] Elkeen het 'n eie vorm van 'n hart, maar in die middel is 'n gedeelte wat saamsmelt. Hulle kan moontlik, hier waar hulle arms is lyk dit of hulle hande vashou. [Jy' gesê die ligte is 'agter' hulle?] Hier kyk hulle, en die ligte is agter hulle (D2). Die rooi laat my dink aan daai ligte, glasballe wat so hang in klubs. [Glasballe?] Oor die feit dat dit so hang en dit so rond, sirkelvormig is soos 'n bal. [Wat het hierdie soos hulle 'harte' laat lyk?] Daai vorm, dit lyk amper soos 'n menslike hart. [Wys net weer vir my wat jy alles gebruik het?] Alles. Hierdie kan dan 'n tafeltjie wees (D7), met hulle hande wat so uitgestrek is.
		17" (7")	^	Dit lyk nog steeds soos 'n tipe eksperiment wat verkeerd gegaan het, 'n monsteragtige tipe dier. Ek kyk te veel fillers, ek weet dit! Met groot voete en die arms wat so misvorm is, en die kop wat nie in proporsie met die lyf is nie. <td data-bbox="255 1935 295 2127">[Herhaal respons] Hieronder is die groot voete, die bene, na die lyf toe. Hier's die arms wat so oorang. [Oorang?] Hulle 'dangle' omtrent, hang net. Hier bo is die klein gesiggie, maar dis helemaal uit proporsie van die lyf. Hier kan amper hare of leisie wees wat langs die gesig is. [Hare?] Dis omtrent om die gesig en agter die nek. [Agter' die nek?] Hier sien ek die nek, en dit gaan agter om. Dit spreit so uit, maar dis agter die nek.</td>	[Herhaal respons] Hieronder is die groot voete, die bene, na die lyf toe. Hier's die arms wat so oorang. [Oorang?] Hulle 'dangle' omtrent, hang net. Hier bo is die klein gesiggie, maar dis helemaal uit proporsie van die lyf. Hier kan amper hare of leisie wees wat langs die gesig is. [Hare?] Dis omtrent om die gesig en agter die nek. [Agter' die nek?] Hier sien ek die nek, en dit gaan agter om. Dit spreit so uit, maar dis agter die nek.

KAAFT	6.	RESPONS	MAAR IN DIE ANDER OÊ (LAG), DIT KAN OOK WEES 'N TIPE 'ROCKET' WAT OPGESTYG HET, EN HIERONDER IS DIE 'YUMES' OF DAAR STAF – EK WEEF NIE WAT MENS DIT NOEM NIE? HIER HEELBO IS WAAR DIE 'SPACE SHIP' ONTKOPPEL VAN DIE GROTE, WAAR DIT NET DIE KLEINFIE IS WAT OPGAAN MAAN TOE. DIE KANTE HIER IS DIE ANDER GEDEELTE VAN DIE SKIP, VAN DIE 'SPACE SHIP', WAT NOU AFGEVAL HET VAN JOU HOOFDING WAT NOU OPGEGAAN HET. DIE RES VAN... DIE OORMEERDERHEID SWART IS DIE 'YUMES' VAN DIE 'SPACE SHIP' WAT OPGAAN.	[Herhaal respons] Hieronder sal wees wanneer die 'rocket ship' opgaan die eerste keer. En hier's die 'Yumes' wat so uitgaan asof dit so uitspat, en dan gaan dit weer op. [Uitspat?] Die manier hoe dit nle in een vorm is nie. Dit lyk of dit so afgedruk word soos die 'rocket' opgaan en dan's dit donkerder, en soos dit met gewone lug meng word dit ligter. Hier's die dele wat afgekom het (D4) en terug oarde toe gaan kom.
V	7.	58" (14")	Dit lyk, dit kan 'n voël wees wat haar vlerke so afskud van die water. En die grootste swart gedeelte is water wat van die vlerke afkom. Maar sy't haar rug teen my, haar rug is na my.	[Herhaal respons] Dis amper soos of dit 'n 'slow motion' prentjie is wat jy sien hoe val die water af met die vlerke, en soos sy haar vlerke skud is daar net meer water wat afval. [Water?] Die gedeelte hier. Dit lyk soos iets wat vloei, wat weggaan van die grootste gedeelte af. [Wat op die kaart het dit soos 'water' wat 'afval' laat lyk?] Waar die gedeelte donkerder is, dis swart en die goed word so grys. Hier sien ek die voete. En bo is die kop. Dit kan amper 'antennae' wees, alhoewel voëls nie 'antennae' het nie. Maar hier kom die skouers uit en daar kom die vlerk. [Jy't ook gesê sy staan met haar 'rug' na jou toe?] Dit lyk of dit plat is, so dit kan net die rug wees want dit is plat – jy kan nie die voorste gedeelte van die lyfie sien nie. [Wat op die kaart laat dit 'plat' lyk?] Dit lyk net plat! Dit voel of daar niks is wat uitsteek, waar die swart bieffie ligter word, wat iets aan kan dui nie - dis net plein swart.
VI	8.	4" (15")	Dit is, lyk nog steeds soos 'n vel wat so uitgestit is op die grond. Dit lyk amper of dit 'n leeu, 'n leeuvel kan wees. Hierso kan die 'whiskers' wees, en die maanhare. Die vel is nie volledig nie, oor die voorste twee voete wat nie helemal daar is nie, alhoewel die agterste twee voete daar is... Die stert is ook nie daar nie... Dit kan mistkien wees dat die dier mistkien betrokke was in 'n ontploffing oor die gesig nie helemal daar wys nie, en die voorvoete ook nie. En die skouers lyk amper of dit iets kort daar.	[Herhaal respons] Hier's die agtervoete omdat hier die vorm is van 'n boud. En die gedeelte wat regdeur gaan is die rugsting. Hierdie kan die maag- of lyfgedeelte wees. Hier sou die voorpote gewees het. Hier kan die skouers begin, maar dis amper of hulle rond moet gaan, nie skuins indulk nie. Daar sal die nekgedeelte wees, en hier's die kop. Maar dit lyk of die kop so uitgeskeur is, hy's nie ovaal soos hy moet wees nie. Hier voor is die neusgedeelte met sy 'whiskers' op die kant. [Wat op die kaart het dit vir jou soos 'n 'vel' laat lyk?] Die bene, en die boonste lip lyk soos 'n neus. En dan kan jy uitmaak – bene, boud, nek, kop.
VII	9.	14" (32")	Dit lyk soos twee 'eetknies', die boonste gedeelte, wat op 'n rots sit. Hulle lyk na mekaar en is besig om te eet. Met hulle sterte wat so waal in die lug.	[Herhaal respons] Daar's sy lyfie, sy koppie met die oorjie. Daar's amper, soos 'n inhammetjie, vir sy mondjie. En die handjie oor dit naby aan sy mondjie is. En sy stert oor 'eetknies' sulke bossterte het. Hier's die rots waarop hulle sit. [Die rots?] Oor die feit dat dit amper hoekig hier is soos 'n baksteen (buitelyne). [En wat op die kaart laat dit soos 'bossterte' lyk?] Dit lyk 'puffy', soos wafle. [Puffy?] Waar die swart en die wit so meng lyk dit of dit fluffy is.

FAAKT	10.	RESPONS	NAWRAE
	Die onderste deel kan, is soos die 'stem of a tree'. En hier is die "branches" wat so uitkom met die blare op dit. Dis kan twee eëtkorings wees (Dd21) wat verdwyn tussen die blare en takke, tussen dit afklim met die boom. Hier kan amper hulle ingang wees waar hulle 'n nes hef in die boom, daai oop gedeelte waar hulle ingaan tussen die 'branches' - wat is dit in Afrikaans? - die takke, en die blare (buitelyn van Dd23). Daai punte (op D3) kan amper 'n ander 'eëtkoring' se gesig wees. Al twee punte is twee verskillende 'eëtkorings' se gesigte.		[Herhaal respons] Hieronder waar die wit is, kan amper die 'stem' wees. Hieragter kan die 'bark' wees van die boom (Dd25), en die is die takke en die blare (Dd22). [Wat op die kaart laat dit so lyk?] Oor dit lyk of dit los is, die blare hang aan iets, terwyl die 'stem' van die boom agter dit is. Daai deel wys iets wat growwer as wat dit hier is. [Growwer?] Oor dit donkerder is, basies swart, en langs dit die grys wat ligter word, sien? [En wat het dit laat lyk of die 'stem' agter' die ander goed is?] Omdat mens net 'n klein stukkie daarvan sien en dit nie duidelik sigbaar is nie, so hy moet agter wees. Daar's die sterfjies (Dd21), mens sien net die sterfjies. Ek assosieer dit met sterfjies oor daai (D5) ook soos sterfjies lyk. En oor dit tussen die blare en takke is. Daai deel dui aan 'n opening (spasie). [n Opening?] Want hier lyk dit soos 'n bebosde gedeelte, en die spasie kan aandui 'n opening vir hulle. Daai (op D3) kan die 'tip of a nose' wees, 'n klein ogie. Dit lyk of hy so uitkyk.
VIII	11. 2'25" " (1'5")	Dit lyk nog steeds soos twee bokke wat opklim om na 'n boonste punt van 'n berg te kom. Amper asof hier, dit vat hulle 'n rukkie om tot bo te kom, maar hieronder waar die pienk en oranje is dui hy somer aan, en dan die blougedeelte waar dit herfs raak, en dan die boonste gedeelte die berg met die sneeu bedek. Miskien is die somergedeelte groter want dis makliker om op te klim? Maar met die herfs- en wintergedeelte word die prentjie kleiner wat aandui die moeilikheids wat saam met die seisoene kom. Dan kom die winter tot 'n punt, en dan begin dit van onder af weer boontoe.	[Herhaal respons] Ja, hier's die bokkies oor die vier pote (D1), en ek dink aan berg en jy assosieer 'n bok met 'n berg. Hier's amper die oor, rug, en been. Die oranje-pienk is vollike kleure (D2). Dit dui aan die blomme - soos as jy lyk na rose, dit het pienk-oranje - en dit lyk vollik. Dit lyk so na 'n sagte kleur. [n 'Sagte' kleur?] Dis sag op die oë. Die pienk is 'n sagte pienk, met die oranje wat so saamsmelt. Die blou gedeelte dui aan dit gaan kouer raak (D5). Die blou het amper bietjie groenerigheid in - die blare val af. Sê maar, as dit 'n boom was, begin dit anders te lyk, dat dit bietjie meer van 'n harder kleur is. [n 'Harder' kleur?] Dis 'n donkerder kleur wat lyk of dit gemeng kan wees met 'n groen en 'n swart. [Wat het hierdie (D4) soos 'n 'berg met sneeu' laat lyk?] Want hy's witgrys. [Witgrys?] Die kleure se kombinasies van wit en grys. En oor dit so 'n punt bereik lyk dit soos die punt van 'n berg. Die grys saam met die wit gemeng lyk amper soos koue - as ek aan sneeu dink dink ek aan winter. Tussen die somer en die winter is dit herfs. Daai kan bloeisel wees. Tussen-in is waar dit kouer raak - die blomme val af en die bome begin leeg raak. Waar dit kon groen gewees het is dit nou blou, leeg. Dit lyk net soos 'n goetie vergelyking van somer wat geleidelik oorgaan na winter toe.
IX	12. 28" (40")	Hieronder kan 'n kerstendelaar wees, met die kers wat in die middel boontoe gaan. Die kers brand wel, dis hoekom dit so wit is hier om hom is. Langs die kerstendelaar kan daar skulpies wees wat so teen hom lê, teen die kerstendelaar lê. Die blou, of groen, en die oranje kan die wind wees wat ingewaai het, en die wind kom van al twee kante af. Maar die kers brand nog steeds, hier bo gloei hy. Die wind se sterkste punt is waar die vuur is, maar die vuur blok amper die wind. Maar onder waar die vuur nie is nie is die wind sterker en hy's nader aan die kers.	[Herhaal respons] Hier's die kerstendelaar (Dd35), die kers (D5), en dit kan die vlam aandui (bopunt van D5). [Wat op die kaart het dit vir jou so laat lyk?] Dit lyk amper soos 'n pot dié, 'n 'belly' pot waar jy die kers insit, en dan't hy so 'n pens. [n Pens?] Die vorm wat so uitkom hier van bo af. Hierdie lyk dan soos daai skulpe (D4). Ek dink mens noem hulle 'curly's', dis so gedraai tot op die punt. Daai ene ook. [Wat het dit soos 'curly's' laat lyk?] Die 'curly'-gedeelte, dit gaan so hobbelgedeelte (randdetail). Hier kan jy was sien wat afkom (Dd30) teen die kers. [Wat op die kaart het dit soos 'was' laat lyk?] Omdat dit wit is, en dit lyk amper soos 'n traan. Soos dit drup en afgly dan word dit mos hard en lyk amper soos 'n traan. Die boonste gedeelte van die wind, die oranje gedeelte, sien ek as die warm lug, want warm lug is mos alyd bo en koue lug onder. Dis hoekom die blougedeelte die koel lug kan wees. Hier onder kom die koue nader aan die kers as wat die warm lug doen. Hierdie lyk amper of dit so 'n sitkel kan wees, soos as 'n kers brand, daai 'flame' rondom dit. En dan druk dit daai lug weg. Daai boonste deel kan die tip van die vlam wees.

KAART	13.	7" (36")	<	Dit lyk nog steeds of dit binnegoed kan wees, met jou are wat so uitgaan na jou organe toe. En elkeen het 'n eie kleur wat aandui dat dit 'n ander funksie het, dis 'n ander gedeelte.	[Herhaal respons] Die blou het amper gelyk soos are. [Are?] Ja, omdat dit op jou lyf blou lyk, en oor dit gekoppel is aan verskillende organe. Ek kan nie spesifiek sê soos watter organe lyk dit nie, maar dit lyk soos organe.
X	13.	7" (36")	<	Hm, die pienk is 'sea horses' (D9). Dit lyk amper of hulle trompette blaas (D6). Die pers, of die blou, kan 'n seekat wees (D1). Die bruin hieronder kan krappe wees (D7) en hulle hou vas aan iets oranje. Hierbo kan amper mikrofone wees (D11) om die musiek op te vang van die 'sea horses'. Hieronder is een van die 'eels' wat oor 'n skulp hang wat so vas is teen 'n rofs (D10). Die geel tussen die 'sea horses' kan hulle babatjies wees (D2). Dis amper of hulle so konseft hou vir die kleintjies, en al die diere 'n instrument gebruik om musiek te maak. Die krap, of die bruin gedeelte - sal ek maar sê 'die krap'? Dit lyk of hy met twee simbole, hy't 'n simbaal in elke hand (D13 & D15), dan speel hy so musiek.	[Herhaal respons] Ons was onlangs by die dieretuin, so ek weet presies! Daar's die gesigdeel - dis mos so 'pointed', the nose. Hulle lyfies hang so in die water. En dit kan hulle vinne wees (buitelyne), en daar's ook deel van die vin. Hierdie lyk soos, of dit snackse trompette kan wees wat uit die mond uit... en dan word dit geblaas. [Wat het hierdie soos 'n 'seekat' laat lyk?] Omdat, daar kan sy lyf wees en al die goed wat so uitkom hier kan die 'tentacles' wees. [En wat het hierdie soos 'n krap laat lyk?] Daar kan die lyf wees van die krap met sy 'antennae' bo, met 'n baie beenjies of aimpies wat so uitspat. [Uitspat?] Hoe kan ek sê - dis amper, hy staan so uit. [Ja] Ja, kan amper hier die handjie sien en dan die vingers wat so enjifie van mekaar af is. [Jy't ook gesê hierdie lyk soos 'mikrofone'?] Met die musiekvideos wat ek gesien hulle gemaak het het hulle so ding wat hang van die dak af en so mikrofoon. Die punt kom af (D14) en dan's die twee mikrofone daar (D8). [Wat het hierdie soos 'n 'eel' wat oor 'n skulp hang laat lyk?] Dit lyk of dit so 'u-shape'-skulp kan wees. En dan hang die 'eel' so daaroor. So heilte van sy lyf is daar agter die skulp en dan hang die res van sy lyf net so af. [Jy't ook gesê die skulp is 'vas teen 'n rofs'?] Ja, anders sal hy nie oor hom kan hang nie. [En wat het die soos 'n 'eel' laat lyk?] Dis 'n aanhoudende lyn. En ek weet 'n 'eel' is omtrent die enigste vis wat een lyn dier is. [Wat op die kaart het hierdie soos die 'sea horses' se 'babatjies' laat lyk?] Die oë, die rooi gedeelte, die neuse - as hulle so klein is is hulle neuse langer. Daar's die kop, lyfies, en vinneffies. [Jy't ook gesê die krap het twee 'simbole'?] Ja, dit lyk of die krap simbole het al is dit nie helemal rond nie, kon dit rond gewees het vir simbole. [So jy't alles gebruik?] Alles behalwe hierdie deeltjie (D3). Ek het daaraan gedink maar weet waar om dit in te pas nie.
	14.		<		



Client Information

Client Name: B N	Gender: Female	Test Date: 10/06/2001
Client ID:	Date of Birth: 01/01/1974	Description:

Sequence of Scores

Card	Resp. No.	Location and DQ	Loc. No.	Determinant(s) and Form Quality	(2)	Content(s)	Pop	ZScore	Special Scores
I	1	WSo	1	FMAu		(A)		3.5	INC2
II	2	W+	1	FMa.CF.Mpu	2	A,Hx	P	4.5	COP, AB, DR
III	3	D+	1	Mao	2	H,Hh	P	3.0	COP
	4	W+	1	Mp.mp.FD-	2	H,Hh,Sc,Hx,An	P	5.5	FAB2, COP, AB
IV	5	Wo	1	Fmp.FDo		(A)		2.0	DR
	6	W+	1	map.YFu		Sc,Fi		4.0	
V	7	W+	1	FMa.mp.YFo		A,Na		2.5	INC
VII	8	Wo	1	Fo		Ad,An	P	2.5	MOR, INC
	9	D+	1	FMa.FTu	2	A,Na		3.0	DV, INC
VIII	10	WS+	1	FMa.mp.FT.FD+	2	Ad,Bt		4.0	DV
	11	WS+	1	FMa.CF.mp.C'Fu	2	A,Na	P	4.5	ALOG, AB
IX	12	WS+	1	map.C'F+	2	Hh,Fi,Na		5.5	ALOG, FAB
	13	W+	1	CF-		An		5.5	
X	14	Dd+		FMap.FD.mp.Ma+	2	A,Sc,Na		4.5	PER, INC2, FAB2, COP

Summary of Approach

I: WS	VI: W
II: W	VII: D.WS
III: D.W	VIII: WS
IV: W.W	IX: WS
V: W	X: W.Dd

RATIOS, PERCENTAGES, AND DERIVATIONS

<p>EA = 70</p> <p>W = 21</p> <p>Ad = 14</p> <p>C = 2</p> <p>V = 0</p>	<p>EA = 70</p> <p>W = 21</p> <p>Ad = 14</p> <p>C = 2</p> <p>V = 0</p>	<p>EA = 70</p> <p>W = 21</p> <p>Ad = 14</p> <p>C = 2</p> <p>V = 0</p>	<p>EA = 70</p> <p>W = 21</p> <p>Ad = 14</p> <p>C = 2</p> <p>V = 0</p>
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Client Information

Client Name: BN	Gender: Female	Test Date: 10/06/2001
Client ID:	Date of Birth: 01/01/1974	Description:

Location Features	
Zf = 14	
ZSum = 54.5	
Zest = 45.5	
W = 11	
(Wv = 0)	
D = 2	
Dd = 1	
S = 4	

DQ	
	(FQ-)
+ = 11 (2)	
o = 3 (0)	
v/+ = 0 (0)	
v = 0 (0)	

Form Quality				
	FQx	FQf	MQual	SQx
+ = 3 0 1 2				
o = 4 1 1 0				
u = 5 0 1 2				
- = 2 0 1 0				
none = 0 ---- 0 0				

Determinants	
Blends	Single
FM.CF.M M = 1	
M.m.FD FM = 1	
FM.FD m = 0	
m.YF FC = 0	
FM.m.YF CF = 1	
FM.FT C = 0	
FM.m.FT.FD Cn = 0	
FM.CF.m.CF FC' = 0	
m.CF C'F = 0	
FM.FD.m.M C' = 0	
FT = 0	
TF = 0	
T = 0	
FV = 0	
VF = 0	
V = 0	
FY = 0	
YF = 0	
Y = 0	
Fr = 0	
rF = 0	
FD = 0	
F = 1	
(2) = 8	

Contents	
H = 2, 0	
(H) = 0, 0	
Hd = 0, 0	
(Hd) = 0, 0	
Hx = 0, 2	
A = 5, 0	
(A) = 2, 0	
Ad = 2, 0	
(Ad) = 0, 0	
An = 1, 2	
Art = 0, 0	
Ay = 0, 0	
Bl = 0, 0	
Bt = 0, 1	
Cg = 0, 0	
Cl = 0, 0	
Ex = 0, 0	
Fd = 0, 0	
Fi = 0, 2	
Ge = 0, 0	
Hh = 1, 2	
Ls = 0, 0	
Na = 0, 5	
Sc = 1, 2	
Sx = 0, 0	
Xy = 0, 0	
Idio = 0, 0	

S Constellation	
<input checked="" type="checkbox"/> FV+VF+V+FD > 2	
<input checked="" type="checkbox"/> Col-Shd Blends > 0	
<input checked="" type="checkbox"/> Ego < .31 or > .44	
<input type="checkbox"/> MOR > 3	
<input checked="" type="checkbox"/> Zd > ±3.5	
<input checked="" type="checkbox"/> es > EA	
<input checked="" type="checkbox"/> CF + C > FC	
<input checked="" type="checkbox"/> X+% < .70	
<input checked="" type="checkbox"/> S > 3	
<input type="checkbox"/> P < 3 or > 8	
<input type="checkbox"/> Pure H < 2	
<input checked="" type="checkbox"/> R < 17	
9 Total	

Special Scores		
	Lvl-1	Lvl-2
DV = 2 x1 0 x2		
INC = 3 x2 2 x4		
DR = 2 x3 0 x6		
FAB = 1 x4 2 x7		
ALOG = 2 x5		
CON = 0 x7		
Raw Sum6 = 14		
Wgtd Sum6 = 50		
AB = 3 CP = 0		
AG = 0 MOR = 1		
CFB = 0 PER = 1		
COP = 4 PSV = 0		

RATIOS, PERCENTAGES, AND DERIVATIONS

R = 14	L = 0.08

EB = 4 : 3.0	EA = 7.0
eb = 15 : 6	es = 21
	Adj es = 14
	Adj D = -2

FM = 8	C' = 2
m = 7	V = 0
	T = 2
	Y = 2

AFFECT	
FC:CF+C = 0 : 3	
Pure C = 0	
SumC' : WSumC = 2 : 3.0	
Afr = 0.40	
S = 4	
Blends:R = 10 : 14	
CP = 0	

INTERPERSONAL	
COP = 4	
AG = 0	
Food = 0	
Isolate/R = 0.79	
H : (H)+Hd+(Hd) = 2 : 0	
(H)+(Hd):(A)+(Ad) = 0 : 2	
H+A : Hd+Ad = 9 : 2	

IDEATION		
a:p = 11 : 11		
Ma:Mp = 2 : 2		
2AB+(Art+Ay) = 6		
M- = 1		
Sum6 = 14		
Lvl-2 = 4		
WSum6 = 50		
M none = 0		

MEDIATION	
P = 5	
X+% = 0.50	
F+% = 1.00	
X-% = 0.14	
S-% = 0.00	
Xu% = 0.36	

PROCESSING	
Zf = 14	
Zd = +9.0	
W : D : Dd = 11 : 2 : 1	
W : M = 11 : 4	
DQ+ = 11	
DQv = 0	

SELF-PERCEPTION	
3r+(2)/R = 0.57	
Fr+rF = 0	
FD = 4	
An+Xy = 3	
MOR = 1	

<input type="checkbox"/> SCZI = 3	<input checked="" type="checkbox"/> DEPI = 6	<input type="checkbox"/> CDI = 3	<input checked="" type="checkbox"/> S-CON = 9	<input type="checkbox"/> HVI = No	<input type="checkbox"/> OBS = No
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CONSTELLATIONS TABLE

S-Constellation (Suicide Potential)	SCZI (Schizophrenia Index)
<p><input checked="" type="checkbox"/> Positive if 8 or more conditions are true: NOTE: Applicable only for subjects over 14 years old.</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> $FV+VF+V+FD [4] > 2$ <input checked="" type="checkbox"/> Col-Shd Blends [1] > 0 <input checked="" type="checkbox"/> Ego [0.57] < .31 or > .44 <input type="checkbox"/> MOR [1] > 3 <input checked="" type="checkbox"/> $Zd [9.0] > \pm 3.5$ <input checked="" type="checkbox"/> $es [21] > EA [7.0]$ <input checked="" type="checkbox"/> $CF + C [3] > FC [0]$ <input checked="" type="checkbox"/> $X+% [0.50] < .70$ <input checked="" type="checkbox"/> $S [4] > 3$ <input type="checkbox"/> $P [5] < 3$ or > 8 <input type="checkbox"/> Pure H [2] < 2 <input checked="" type="checkbox"/> $R [14] < 17$ <p>9 Total</p>	<p><input type="checkbox"/> Positive if 4 or more conditions are true:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> $((X+% [0.50] < 0.61) \text{ and } (S-% [0.00] < 0.41))$ or $(X+% [0.50] < 0.50)$ <input type="checkbox"/> $X-% [0.14] > 0.29$ <input type="checkbox"/> $(FQ- [2] \geq FQu [5])$ or $(FQ- [2] > FQo [4] + FQ+ [3])$ <input checked="" type="checkbox"/> (Sum Level 2 Special Scores [4] > 1) and (FAB2 [2] > 0) <input checked="" type="checkbox"/> (Raw Sum of 6 Special Scores [14] > 6) or (Weighted Sum of 6 Special Scores [50] > 17) <input type="checkbox"/> $(M- [1] > 1)$ or $(X-% [0.14] > 0.40)$ <hr/> <p>3 Total</p>
<p>DEPI (Depression Index)</p> <p><input checked="" type="checkbox"/> Positive if 5 or more conditions are true:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> $(FV + VF + V [0] > 0)$ or $(FD [4] > 2)$ <input checked="" type="checkbox"/> $(Col-Shd Blends [1] > 0)$ or $(S [4] > 2)$ <input checked="" type="checkbox"/> $(3r + (2)/R [0.57] > 0.44 \text{ and } Fr + rF [0] = 0)$ or $(3r + (2)/R [0.57] < 0.33)$ <input checked="" type="checkbox"/> $(Afr [0.40] < 0.46)$ or $(Blends [10] < 4)$ <input type="checkbox"/> $(SumShading [6] > FM + m [15])$ or $(SumC' [2] > 2)$ <input checked="" type="checkbox"/> $(MOR [1] > 2)$ or $(2xAB + Art + Ay [6] > 3)$ <input checked="" type="checkbox"/> $(COP [4] < 2)$ or $([Bt+2xCl+Ge+Ls+2xNa]/R [0.79] > 0.24)$ <p>6 Total</p>	<p>CDI (Coping Deficit Index)</p> <p><input type="checkbox"/> Positive if 4 or more conditions are true:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> $(EA [7.0] < 6)$ or $(AdjD [-2] < 0)$ <input type="checkbox"/> $(COP [4] < 2)$ and $(AG [0] < 2)$ <input checked="" type="checkbox"/> $(Weighted Sum C [3.0] < 2.5)$ or $(Afr [0.40] < 0.46)$ <input type="checkbox"/> $(Passive [11] > Active + 1 [12])$ or $(Pure H [2] < 2)$ <input checked="" type="checkbox"/> $(Sum T [2] > 1)$ or $(Isolate/R [0.79] > 0.24)$ or $(Food [0] > 0)$ <hr/> <p>3 Total</p>
<p>HVI (Hypervigilance Index)</p> <p><input type="checkbox"/> Positive if condition 1 is true and at least 4 of the others are true:</p> <ul style="list-style-type: none"> <input type="checkbox"/> (1) $FT + TF + T [2] = 0$ <input checked="" type="checkbox"/> (2) $Zf [14] > 12$ <input checked="" type="checkbox"/> (3) $Zd [9.0] > +3.5$ <input checked="" type="checkbox"/> (4) $S [4] > 3$ <input type="checkbox"/> (5) $H + (H) + Hd + (Hd) [2] > 6$ <input type="checkbox"/> (6) $(H) + (A) + (Hd) + (Ad) [2] > 3$ <input type="checkbox"/> (7) $H + A : Hd + Ad [9:2] < 4 : 1$ <input type="checkbox"/> (8) $Cg [0] > 3$ 	<p>OBS (Obsessive Style Index)</p> <ul style="list-style-type: none"> <input type="checkbox"/> (1) $Dd [1] > 3$ <input checked="" type="checkbox"/> (2) $Zf [14] > 12$ <input checked="" type="checkbox"/> (3) $Zd [9.0] > +3.0$ <input type="checkbox"/> (4) $Populars [5] > 7$ <input checked="" type="checkbox"/> (5) $FQ+ [3] > 1$ <hr/> <p><input type="checkbox"/> Positive if one or more is true:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conditions 1 to 5 are all true <input type="checkbox"/> Two or more of 1 to 4 are true and $FQ+ [3] > 3$ <input type="checkbox"/> 3 or more of 1 to 5 are true and $X+% [0.50] > 0.89$ <input type="checkbox"/> $FQ+ [3] > 3$ and $X+% [0.50] > 0.89$

NOTE: '**' indicates a cutoff that has been adjusted for age norms.

CARD	1.	22"	REINFORCE	ENCUIRES
I	1.	^	It could look like, hmmm... some kind of a beast. Here is the eyes, this looks like tusks... It could be a face, it looks like a bush pig's.	[Repeats response] Yes, there are the eyes (DdS30), the tusks (DdS29) – they come out. [Come out?] Yes like a bush pig's (demonstrates). [What on the card made it look like the face of a 'bush pig'?] The shape of the eyes and these jagged pieces on the side (outline). It just looks like it could be the face of an animal.
	2.	^	Here I see a face as well – the eyes, mouth.	[Repeats response] Yes, the shape of the head, the eyes (Dd30) and the mouth (DdS29). [What on the card made it look like a 'face'?] Well, part of it is not filled in here at the top (referring to DdS32) of the head, but the ears... I don't know what kind of a face it is. Is it an animal...? No definitely an animal!
	3.	^	It could also be like a goggo, like an insect, a moth. Can I explain what I see inside in there as well? [As you like] That looks like the thorax (Dd21) and the abdomen (Dd24).	[Repeats response] Here's the head. This piece running down the middle is the thorax, I mean the abdomen, and the thorax. [What on the card made it look like an 'insect'?] There, see the shadow of the centre (referring to the middle line), the shape going up the head, a strange head though. [Just show me again where you saw it] Just this middle part.
	4.	^	There's something of a spider here (circles Dd22), you know – like the spincarettas.	[Repeats response] Yes, those two little bumps there in the middle. [What on the card made it look like 'spincarettas'] I suppose from the shape of the body in the middle. But a spider isn't normally this shape...
	5.	^	Also a bat.	[Repeats response] The wings and the two little hands (demonstrates), the little... and the hmmm... It could also have been the head. But his wings are not complete. [What makes it look 'not complete'?] Because of these, it's not finished off.
	6.	v	Can I turn them? [Any way you prefer] A UFO. Like that Space Invaders that the kids play on the TV games, that you have to shoot down.	[Repeats response] Here (Dd) and this is something. It could be a cloud. [What on the card made it look like a 'UFO'?] The shape, and these (DdS26) look like windows. [What made it look like 'windows'?] The shape. This could be a bit of a cloud it's on, and these could be its landing things. Or it could be its feet. Yes. You know these UFO things, when they land these feet come out. This must sound very stupid! I suppose today you find out what a mad person sees!
II	7.	^	There's a butterfly.	[Repeats response] Yes, the red shape (D3) - inside, the wings, the head, and the abdomen in the centre. [What on the card made it look like a 'butterfly'?] The shape.
	8.	^	It makes me think of the hips with the hole that the baby comes through – what is it called? The pelvis!	[Repeats response] Here are the hips (D6) and the ... (shows D65), and the two bones that come together in the middle. [What on the card made it look like a 'pelvis' to you?] The dark area here, the dark shading. And this piece here is where the spine would go up at the back. [I see where you see it. I'm not sure if I understand what on the card made it look like that to you?] The shape of the dark shadow.
	9.	v	And kind of a face here, eyes, nose and teeth. Like horror, a vampire... I don't know if it's because of the colours, the red and the black.	[Repeats response] Here are the eyes (inner red detail), nose (D4), and these red things are his canines (D2). [You mentioned something about the colours?] Yes, the black face and the red canines, the red teeth, and the red eyes made me think of that.

ENQUIRIES

CARD	10.	V	A mask.	RESPONSE
	11.	^	A dog. The eyes here. This might be a patch on the face (DS5), the nose, and the ears. Although half is bitten off.	[Repeats response] Yes, the black, the eyes (inner red detail), the nose. What's it like, those mask balls you know, you know the masks that they would hold, the men? This (D3) could signify something of colour, or feathers on the mask. [Feathers?] Hmm, not feathers. But something at the centre of the mask. [Repeats response] It looks more like a staffie kind of face. Eyes (inner red detail), it's got a patch on its nose. [What made it look like a 'patch'?] The white, the white shape. This bottom red in the black would signal the nose. But there's no mouth. Only the top part of its face. And it's got no ears.
III	12.	2"	This looks like two black men standing over a pot. Looks like two Zulus. Maybe there's a heart in the middle - they love one another, I don't know! (v) (^) ... Both these are female actually, with the breasts here. You know what that is (referring to a sound a few metres away)? That must be a bull frog! (leaves the table to go and look for it). Where were we? Hmm yes, and they're both wearing high-heeled shoes.	[Repeats response] Yes, the black men (D9). Their heads, they're exactly the same. Remember later I said they're female? It reminds me of that abstract art. They're bending over something, a pot (D7). [What makes it look like a 'pot'?] The round shape. [You also mentioned a 'heart'?] Yes, the red pattern in the middle (D3), the red shape made me think of a heart.
	13.	^	Over here I see a face. It looks like a person wearing sunglasses. Or glasses. (v) (^) (v) (^)	[Repeats response] Yes (shows D7), the shape of the face and the two dark, very dark things over the eyes, over the head made me think of that.
IV	14.	2"	It looks like a bat. Especially the face. Okay, the wings aren't really finished off, but the head and body of a bat.	[Repeats response] This (D1) is the bat's head. And here are the top of its wings. It's like this (demonstrates) and there's its head and its wings - it has brought the wings up and over like this. But it's more the head - the two eyes, and the ears on the side, and these things here could be whiskers or feelers or I don't know what you call them. [Just show me again where you see the bat?] I don't really see the body, actually it's just the head and the shoulders around the head, and the wings are incomplete. I see the head as if sticking out from under the wings as they are folded over the head. The space here should be the rest of the wings.
	15.	<	Also, the head of a ... dandy lion. [A dandy lion?] Yes, it's an insect that goes into the sand where it hides, and it catches insects walking over the trap. I think it's called a dandy lion.	[Repeats response] Yes, it's the shape of this part (D1) in the middle of the card that made me think of that.
	16.	^	This can also be some kind of beast. Here's his head, arms, feet, and tail. (v) (^)	[Repeats response] Yes, there's the head - a very small, undistinguished head, the body, two feet, and between the two legs behind it his tail. [You said it looks like a 'beast'?] Yes, I've seen a lot of horror movies in my life. I used to love it, but I don't enjoy it anymore - it disturbs me now.
V	17.	3"	This looks like a bat to me again. It's flying - it's wings are down and there are his feet.	[Repeats response] Yes, it's flying off. Here are the ears, the back of its head. It's the body of a bat. Here's its tail and its wings. [What made it look like the 'back' of the bat?] Because the wings are down.
	18.	v	And these look like two birds together, the heads and the beaks.	[Repeats response] Yes, they're lying together like that. There's the head and beak. It is lying with its wings open on either side. They are lying side by side, stomach to stomach.

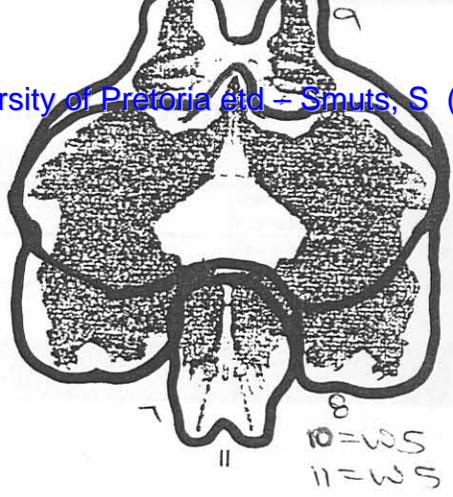
CARD	VI	17"	RESPONSE	ENQUIRIES
19.	^		This could be a wolf's head – the whiskers, the head, nose, and ears.	[Repeats response] Yes, here (D3) because of the snout, whiskers, ears and maybe by the shape of the hair on... underneath its chin, his neck [Underneath] its chin, its neck? Yes, I look at it from above. The hair is from underneath its head, but you can see it from above. I would say like from these cartoon characters – bleep bleep! (laughs) – that wolf!
20.	v		This could be a buck skin, you know, when you kill an animal. (^) (v) (<)	[Repeats response] Yes, this part here (D1). I had a couple here myself. [What on the card made it look like that?] The shape again, and maybe the colouring. [The colouring?] The greys and the blacks...
VII	^	7"	It looks like two people again, looking at one another. Both have got long hair. (sighs) (v) (^) Both are standing on something here, I don't know what it is.	[Repeats response] Yes, these top parts here (D2). The hair is doing, standing up. Maybe the wind is blowing, I don't know. The shape of the heads, nose, chins. 'Got one head up... Maybe she's looking at herself in the mirror, not her (shows). And standing on a rock, or something. [What makes it look like a 'rock?'] The shape.
22.	v		A butterfly – body, with the head and thorax.	[Repeats response] Here are the wings, body and the head (D4).
VIII	^	15"	This is like a big fish. One of those that you get in the ocean with those big teeth, it looks like razor blades here. Here's the fin and the side fins, and the one (fin) at the back on the top.	[Repeats response] Yes, it's the top blue part (D4). You're looking the fish full in the face – there are his eyes, the fin at the back, and the mouth with the teeth, and the side fins. And there's a very distinguished line on its nose up to its back. [What on the card made it look like a 'fish?'] The shape. [And what made the teeth look like 'razorblades?'] Because it looks very thin and fine and sharp. [What on the card made it look 'sharp?'] The needle-like things in its mouth.
24.	<		This looks like some kind of animal. Like, I would say, some kind of mongoose or something. There are two of them.	[Repeats response] Yes here (D1). He's actually standing in a ... There's the front and the back legs. The animal is looking down.
IX	v	28"	(<) (v) I would say that part there, a fish. I can see the two eyes and the mouth.	[Repeats response] Here are the eyes and the mouth. The mouth is open as well, but I can't see teeth or anything. I'm also looking the fish full in the face (DdS8). [What on the card made it look like a 'fish?'] The eyes and mouth.
26.	>		This over here! It looks like somebody on a motorbike, some kind of machine, like a motorbike or 3-wheeler. There's his face. It's quite a big person, quite fat.	[Repeats response] Yes, here's the man on the bike (D1). [What on the card made him look 'fat?'] Because of the shape of the motorbike to the size of the person sitting on it. He's travelling because his scarf is flying open at the back like that.
27.	v		And a face here. I don't know what kind of face it is. This looks like two eyes.	[Repeats response] The head, you can't see the head only the eyes (DdS22). Maybe an octopus'.
28.	^		Over here I see a face of some kind, of a buck... it could be a springbuck. I see its eyes, its nose, and - I don't know what it's called, the different colour on its nose – its mane? You know when it's brown and it's got – colour!	[Repeats response] Here are the eyes, nose, and it's got the – what do you call it, the mane, and also the colour here, the brown orange. [So what on the card made it look like a 'buck, a 'springbuck?'] The shape of the eyes and the colour, I suppose (DdS).
29.	v		This could be a bird, an owl, and it's opened its wings. You can see its eyes and its beak.	[Repeats response] It's an owl because of the shape. This could be its two eyes, its beak, and its two wings – it's open.

ENQUIRIES

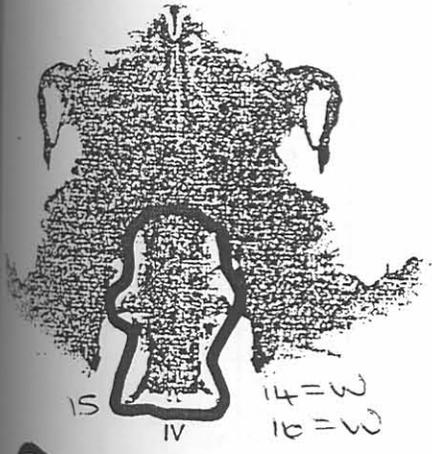
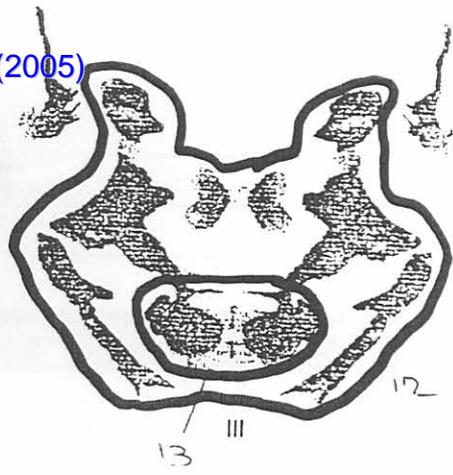
CARD	RESPONSE	V	ENQUIRIES
30.	Also some kind of face, with a hat on. A green hat on its head. And on top of the man's head he's got a bird.	V	[Repeats response] The person is the orange (D3). There are the man's eyes, and the lighter shade is his hair, but there is no form of mouth or nose. This (DdS32) could be his chin. [You said there was a 'bird' on the man's head?] Yes, it's the owl (referring to response 29) standing on the man's head (D6).
X 31.	Wow, pretty colours! (laughs) I like the blue. (V) (< (V). Here I see a body with wings (D10).	V	[Repeats response] Here is the body, the two legs. This looks like a head, with the wings. [What on the card made it look like that?] The shape and the colouring. [The colouring?] The wings are darker than the inner colour.
32.	I see a face – I see the eyes, mouth, and the nose (variation of DdS22).	V	[Repeats response] Here are the eyes (D2), this spot is the nose (Dd34), and this is the mouth (D3). This here is the face (part of D9). It would be a smiling face.
33.	Another face. This one has a moustache. The eyes, nose, and moustache.	^	[Repeats response] Yes, the eyes (D2), nose (D5), and moustache (D10).
34.	This looks like two insects again, like those big black beetles - dung beetles.		[Repeats response] Yes, these things here (D8). [What made it look like 'dung beetles'?] The colouring, the legs, and the antennae. Maybe it's not a dung beetle, but some other kind of goggo. There are two of them, looking at one another. I see the mouth and eyes.
35.	These could be spiders, carrying something in its hand, in its mouth. It could be an ant in its mouth.		[Repeats response] Yes, I would see an ant (D1) carrying a leaf (D12) because of the green. I can see the mouth and the pinchers here, it is carrying in its pincher.



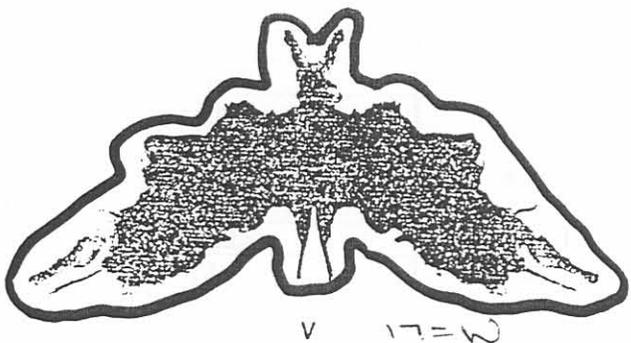
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2=WS
5=W
6=WS



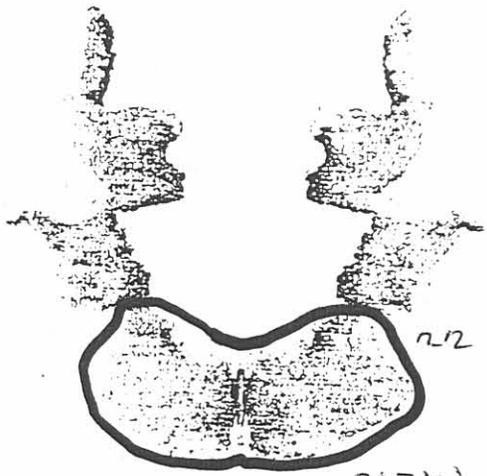
10=WS
11=WS



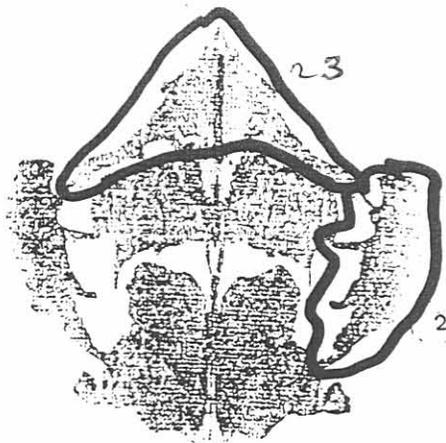
14=W
15=W



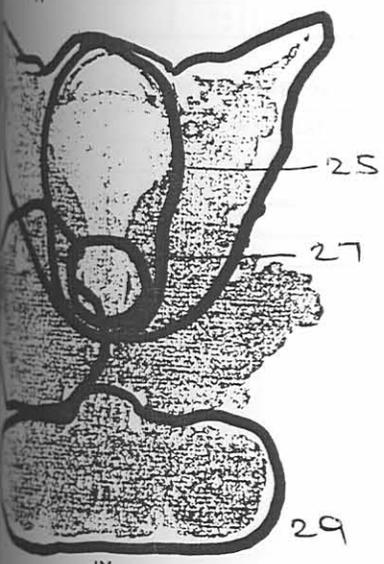
17=W
18=W



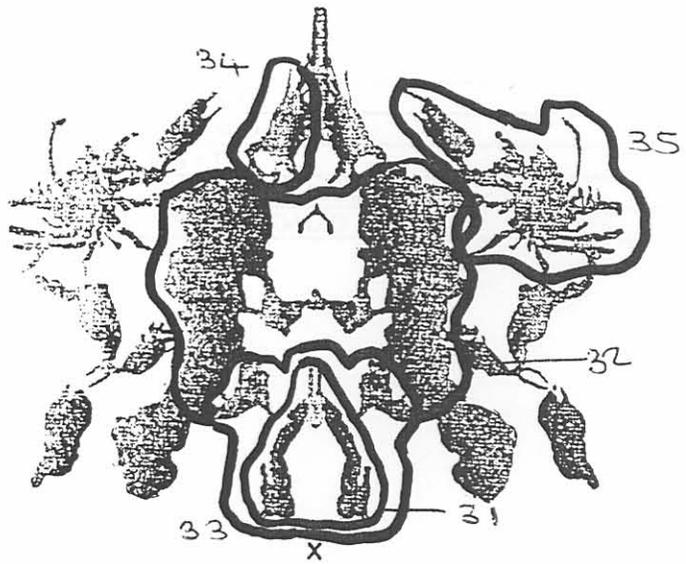
21=W



VIII



30=W



X

Client Information

Client Name: H J	Gender: Female	Test Date: 09/08/2001
Client ID:	Date of Birth: 01/01/1966	Description:

Sequence of Scores

Card	Resp. No	Location and DQ	Loc. No.	Determinant(s) and Form Quality	(2)	Content(s)	Pop	ZScore	Special Scores
I	1	WSo	1	Fu		Ad		3.5	
	2	WSo	1	Fo		Ad		3.5	
	3	Do	4	Fo		A			
	4	Ddo	22	Fu		Ad			
	5	Wo	1	Fo		Ad		1.0	INC
	6	WS+	1	mau		Sc		4.0	PER, DR
II	7	Do	3	Fo		A			
	8	DSO		FYu		An		4.5	
	9	Ddo		FC'.FC-		(Ad)			INC
	10	WSo	1	CF-		(Hd)		4.5	
III	11	WSo	1	FC'-		Ad		4.5	MOR
	12	Dd+		Mp.FC'o	2	H,Hh,Hx,An,Cg,A rt	P	4.0	AB
	13	D+	7	FDu		Hd,Sc		3.0	
IV	14	Wo	1	FMa.FDu		Ad		2.0	INC
	15	Do	1	Fu		Ad			DV
V	16	Wo	1	FDo		(A)		2.0	PER
	17	Wo	1	FMao		A	P	1.0	
VI	18	W+	1	FMpo	2	A		2.5	
	19	Do	3	FDo		(Ad)			
VII	20	Do	1	FC'o		Ad	P		PER
	21	W+	1	Mp.Fro		H,Ls	P	2.5	
VIII	22	Do	4	Fo		A			
	23	Do	4	F-		A			
IX	24	Do	1	FMpo	2	A	P		
	25	DdSo		FMp-		Ad		5.0	
	26	D+	1	Ma.mp+		H,Sc,Cg		2.5	
	27	DdSo	22	F-		Ad		5.0	
	28	DdSo		FC-		Ad		5.0	DV2
	29	Do	6	FMa-		A			
X	30	WS+	1	FC.FMp-		Hd,Cg,A		5.5	FAB
	31	D+	10	FYo		(H)		4.0	INC
	32	Ddo		Mp-		Hd			
	33	Ddo		F-		Hd			
	34	D+	8	FMp.FC'o	2	A		4.5	
	35	D+		FMa.FCo	2	A,Bt	P	4.0	INC

Summary of Approach

I: WS.WS.D.Dd.W.WS	VI: D.D
II: D.DS.Dd.WS.WS	VII: W.D
III: Dd.D	VIII: D.D
IV: W.D.W	IX: DdS.D.DdS.DdS.D.WS
V: W.W	X: D.Dd.Dd.D.D