

Original Article

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Data of a Sample of 212 Adult Nonpatients From Italy

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Abstract. The aim of this study was to collect a Rorschach Comprehensive System (RCS) adult nonpatient sample from Italy using more stringent exclusion criteria and controlling for psychopathology, taking into account the methodological suggestions of Ritzler and Sciara (2008). The authors hypothesized that: (a) adult nonpatient samples are not truly psychologically healthy, in that a high number of psychopathological symptoms are experienced by participants, particularly anxiety and depression, although they have never been in psychological treatment; (b) significant differences emerge between healthy and nonhealthy groups on Rorschach variables, particularly on CS psychopathological indexes; (c) RCS psychopathological indexes are significantly correlated in the expected direction with scores on psychopathological scales. The results confirmed the hypotheses, indicating the need to collect psychologically healthy samples in addition to normative and nonpatient samples. Because differences were found in the comparison between Exner's sample (2007) and the healthy group in this study regarding form quality and coping styles, the authors suggest that future research should investigate the construct validity of ambient style and culturally specific influences on form quality. Moreover, the Rorschach scientific community needs to have more extensive form quality tables, enriched with objects that are currently not included.

Keywords: Rorschach test, Comprehensive System, nonpatient sample, psychologically healthy sample

In the last 20 years, substantial international effort brought together more than 20 adult nonpatient or normative studies for the Rorschach Comprehensive System (RCS). In 2007 the *Journal of Personality Assessment Special*

Supplement on International Reference Samples for the Rorschach Comprehensive System included studies from 16 different countries. As Shaffer, Erdberg, and Meyer (2007) stated, although the samples included in the supplement were mostly composed of nonpatients, psychological difficulties were evident in all the studies.

Positive scores on the Depression Index (DEPI) ranged from 14% (Exner, 2007) to 55% (Greenway & Milne, 2007), positive scores on the Coping Deficit Index (CDI) ranged from 9% (Exner, 2007) to 55% (Nascimento, 2007), positive scores on the Hypervigilance Index (HVI) ranged from 2% (Lunazzi et al., 2007) to 22% (Mormont, Thommensen, & Kever, 2007; Sanz, 2007), and scores on the Perceptual-Thinking Index (PTI) of ≥ 3 ranged from 0% (Exner, 2007) to 20% (Nakamura, Fuchigami, & Tsugawa, 2007). Shaffer et al. (2007) commented that (a) a portion of participants in the studies should have been in treatment and (b) these results were in line with epidemiological statistics about mental disorders.

Only three studies on adult nonpatients (Ivanouw, 2007; Shaffer, Erdberg, & Haroian, 2007; Sultan et al., 2004) used tests to evaluate the presence of psychopathology and its extent in the normative or nonpatient samples. Sultan et al. (2004) administered the General Health Questionnaire (GHQ-12; Goldberg, 1978) and excluded from their study people who reported at least three items at level 3 or three items at level 2 if the individuals also reported psychological distress when answering the other three supplementary questions. Ivanouw (2007) used the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), a Danish version of the Symptom Checklist-90-Revised (SCL-90-R; Olsen, Mortenson, & Bech, 2006), and other tests, but he used them neither to exclude cases in the clinical range nor to report the results of these tests extensively in his paper. He reported only that the women in the sample were psychologically healthier than the men. Shaffer et al. (2007) administered the revised form of the Wechsler Adult Intelligence Scale (WAIS-R; Wechsler, 1981) and the MMPI-2 (Butcher et al., 1989) to investigate the presence of psychopathology in their sample. Globally, they found normative mean scores, but 44.54% of the men and 49.70% of the women had at least one scale elevation in the clinical range on the MMPI-2. They did not exclude these cases because they intended to collect a normative and representative sample, not a psychologically healthy one. Therefore, it was not surprising that 8% of their study participants scored 6 or more

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on the DEPI, 4% scored positively on the Suicide Constellation (S-CON), and 6% had a score of 4 or more on the PTI.

Thus, it would seem that data published in the supplement about non-patient samples were related to individuals who did not seek treatment rather than to psychologically healthy individuals. In addition, as psychopathological scales were not administered in most of the studies, it is not clear which psychopathologies were present in the different samples and to what extent. Furthermore, the impact of the different selection procedures on the level of psychopathology in the samples is unknown. Previously, it was noted that Exner's selection procedures could have played a part in showing a healthier sample (Meyer, 2001).

Meyer, Erdberg, and Shaffer (2007) used the adult samples included in the supplement and a French normative sample (Sultan et al., 2004) to create international normative reference data for the CS. Furthermore, they observed that the scores of variables reported for the international norms were in the lower section of the structural summary and different from the CS nonpatient reference data (Exner, 2001); furthermore, the results reported with international norms were about equal to those reported for the CS outpatients (Exner, 2001). Nevertheless, they noted that the new CS norms (Exner & Erdberg, 2005; Exner, 2007) were more similar to the international norms.

In our opinion, the latter statement downplayed the differences between the new CS norms and the international norms, particularly regarding the psychopathological indexes. For instance, in the international norms the DEPI was positive in 31% of the subjects, while in Exner's new sample DEPI was positive in 14% of the subjects.

Meyer, Viglione, Mihura, Erard, and Erdberg (2011) probably refer to Exner's new sample when they express concerns about "overpathologizing normative reference data" (p. 2). Ritzler and Sciara (2008) instead are concerned that in the international studies some of the consistency seen across countries may be the result of common methodological defects. Above all, they underlined the lower complexity levels (e.g., lower mean *Lambda*) and the lower number of color responses reported in the international studies compared with Exner's new sample. They supposed that "at least some of the simplicity can be attributed to the lack of examiner experience" (p. 3).

Sciara and Ritzler presented detailed cautionary notes for clinicians to consider when using the international norms. The authors underlined that a majority of the studies used graduate students as examiners,

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

sampled from large urban areas, relied on word-of-mouth selection procedures to procure participants, showed a considerable variability in exclusion criteria, had undersized samples without stratification, had different warm-up procedures, and did not evaluate the accuracy of administration procedures.

These serious methodological deficiencies had a strong impact on the international norms, and therefore Ritzler and Sciara (2008) suggested not using them. They state:

While the data presented in the Supplement are impressive, they clearly do not constitute appropriate norms for the Comprehensive System. If professional choose to utilize the data included in the international norms for evaluation and treatment, it is inappropriate to indicate that the CS has been used for the evaluation. (p. 5)

Therefore, Ritzler and Sciara's suggestions for future normative studies are: (a) to collect protocols from large urban, suburban, and rural areas; (b) to not use word-of-mouth selection procedures; (c) to define clearly and uniformly exclusion criteria; (d) to collect samples with adequate stratification and size; (e) and to not use students to collect normative data.

Thus, in the scientific Rorschach community there are currently two main points of view: Some researchers assume that international norms are valid and could serve as a basis for clinical interpretation of the Rorschach test, which implies notable changes, while others consider that international norms are not valid and clinical interpretations do not require significant changes, although research on CS must be continued, following Exner's approach.

In 2011 Meyer et al., on the basis of both the international norms as well as a systematic review and meta-analyses of the CS variables (Mihura, Meyer, Dumitrascu, & Bombel, 2013), developed a new system called the Rorschach Performance Assessment System (R-PAS). R-PAS introduced notable, somewhat shocking, changes in administration, coding, and interpretation that divided the scientific community. Mattlar (2011) affirmed that the development of the R-PAS has not been productive, rather it has "confused and bewildered many in the psychological community" (p. 1). He added that "the goal of the scientific community should be to continue Dr. Exner's deliberate and methodical evolutionary process for a still better Comprehensive System" (p. 1).

The Current Study

In our opinion, healthy (not only nonpatient) RCS reference data are needed. Psychological pain should not be evaluated according to statistical criteria only: Psychological pain is always psychological pain and clinicians need valid assessment tools with which to identify it.

Normative samples are not necessarily healthy samples; if they are collected with methodological accuracy they include healthy and less healthy or not healthy people, although in each nonpatient sample, individuals suffering from manifest psychic pathology are excluded. Globally, RCS nonpatient studies have not taken into account the level of psychopathology in their samples, and so we cannot know its impact on the reference data or on differences among the samples. In addition, there is a dire paucity of clinical reference data other than Exner's (2001). In this scenario, to initiate changes in the Rorschach interpretation guidelines seems to be premature.

The aim of the current study was to collect an RCS adult nonpatient sample from Italy using more stringent exclusion criteria, controlling for psychopathology, taking into account the methodological suggestions of Ritzler and Sciara (2008), as far as our financial and time resources allowed.

We hypothesized that:

1. Adult nonpatient samples are not truly psychologically healthy in that a large number of psychopathological symptoms are experienced by participants, particularly anxiety and depression, although they have never been in psychological treatment.
2. There are significant differences between healthy and nonhealthy groups on Rorschach variables, particularly on CS psychopathological indexes.
3. CS Rorschach psychopathological indexes are significantly correlated in the expected direction with scores on psychopathological scales.

Method

Participants

Demographic Information

The sample consisted of 212 adults ranging in age from 19 to 71 years ($M = 36.59$, $SD = 13.34$), recruited by 85 examiners. They came from northern Italy, 61.8% from large urban areas, 26.4% from small urban

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

areas, and 11.8% from villages. There were 99 (46.7%) women and 113 (53.3%) men. All the participants were born in Italy from Italian parents and Italian was their first or sole language. They were well educated, with 37.7% reporting 16 or more years of education, 45.8%, reporting 13–15 years of education, 2.8% reporting 12 years of education, and 13.7% reporting fewer than 12 years of education. Married individuals constituted 34.4% of the sample and 50% were single. Divorced individuals made up 3.8% of the sample, 1.9% were separated, and 1.9% were widowed. Eight percent of the sample reported that they were living with their partner. Students comprised 24.6% of the sample, 2.4% were housekeepers, 67.8% were regular workers, and 5.2% were pensioners.

Psychiatric Characteristics

Individuals who reported any past or current psychological, psychiatric, or neurological treatment and use of psychotropic medication or abuse of alcohol or illegal drugs were excluded from the study. The Italian version of the SCL-90-R (Sarno, Preti, Prunas, & Madeddu, 2011) and the Beck Depression Inventory II (BDI-II; Ghisi, Flebus, Montano, Sanavio, & Sica, 1996) were administered to evaluate self-reported psychiatric symptoms. Thirty-three individuals (15.6%) had scores in the clinical range on BDI-II ($M = 5.97, SD = 5.43$), and 98 (46.2%) had at least one scale elevation in the clinical range on SCL-90-R. Detailed results of the SCL-90-R scores are reported in Table 1. Women had higher mean scores on the BDI-II ($M = 7.04, SD = 5.57$) than men did ($M = 5.04, SD = 4.98$). Men had

Table 1. SCL-90-R scores

	<i>M</i>	<i>SD</i>	<i>T</i> > 55
Somatization	47.13	6.88	10.8%
Obsessive-compulsive	47.75	7.38	14.6%
Interpersonal sensitivity	47.18	7.14	9.9%
Depression	46.35	6.90	9%
Anxiety	48.54	7.39	18.4%
Hostility	47.67	7.88	15.6%
Phobic anxiety	52.49	4.53	27.8%
Paranoid ideation	46.37	7.35	12.7%
Psychoticism	46.91	6.44	9%
Global Severity Index	46.99	6.99	9%

Note. SCL-90-R = Symptom Checklist-90-Revised.

A. M. Rosso et al.

higher scores on the Anxiety scale of the SCL-90-R ($M = 49.75$, $SD = 8.29$) than women did ($M = 46.80$, $SD = 7.33$). No significant correlation was found between age, education, and scores on psychopathological scales.

Participant Recruitment

Each examiner recruited from one to four participants using a solicitation letter (available on request) written by the first author. The letter, which also served as an informed consent form, discounted any possibility of feedback concerning results and identified the project as one involving the collection of adult nonpatient reference data. The letter clearly made known all the exclusion criteria. In accord with the statement in the letter, participants who signed the informed consent form were subsequently called by other examiners, who were not acquainted with them, to make an appointment. No compensation was provided.

Examiners

Examiners were recruited through the academic course in Projective Methods at the University of Genoa. Examiners were graduate students who had attended two academic courses on Rorschach testing for a total of 125 hr. A total of 50 hr were dedicated exclusively to administration and inquiry issues. As practicum, each student administered at least two protocols. First they received individual feedback about each administration and later they participated in group discussion about the administration practicum. Each examiner had previously completed a clinical practicum, ranging from 250 to 500 hr.

After passing the examination, 85 out of 112 students were admitted to collaborate in the research. Only those students who had an evaluation higher than 27/30 (those students who showed a good enough ability to engage in an appropriate relationship with the subjects examined and to administer the Rorschach appropriately) were admitted to collect records for this study. They received study credit for their contribution. During the project's 3 years, 85 examiners collected 232 protocols. Each examiner administered one to four protocols.

CS Administration

Test administration occurred at a time and place convenient for the participant. Examiners expressed gratitude for agreement to participate in

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

the study, briefly described the project, assured the participant of confidentiality, ascertained the exclusion criteria again, and collected demographic data (age, education, marital status, and occupation).

First the Rorschach test was administered, followed by the Italian version (Ghisi, Flebus, Montano, Sanavio, & Sica, 2006) of the BDI-II (Beck, Steer, & Brown, 1996) and the Italian version (Sarno et al., 2011) of the SCL-90-R (Derogatis, 1994) in counterbalanced order.

Administration, inquiry, and scoring followed Exner's (2001, 2003) guidelines. These included side-by-side seating and use of standard location sheets to record location during inquiry.

Examiners used the standard instructions (Exner, 2001) to obtain $R > 13$ and/or to constrain high R . It was not necessary to repeat the text, because no participant gave less than 14 responses during the initial response phase. There was no attempt to constrain lengthy responses other than the standard guidelines, and the longest record in the sample contained 63 answers.

Monitoring of Test Administration Quality

The first author checked all the protocols collected. She removed 20 protocols because of inadequate inquiry (keywords not inquired, incorrectly inquired, or unnecessary inquiry questions).

Scoring Procedures and Interrater Reliability

The protocols were coded by the three authors. The first author received formal training in Rorschach testing by Dr. Bruno Zanchi in 1991, the second and third authors were licensed psychologists trained by the first author. They completed their Rorschach training 4 years before the beginning of the present study. Each of them had already adequately coded at least 100 protocols before the current project.

The first author coded all the protocols. Each of the other two authors recoded 106 protocols. The final decision on disagreements was made by the first author. Then, 40 protocols were randomly selected to calculate interrater reliability. The percentage of agreement and iota values (Janson & Olsson, 2004) were calculated and the results are reported in Table 2.

Table 2. Rorschach interrater agreement on coding segments

Variable	% Agreement	Iota
<i>Whole responses</i>	.98	.89
<i>Location and space</i>	.99	.97
<i>DQ (+, o, v, v/+)</i>	.91	.82
<i>Determinants</i>	.98	.89
<i>Form quality</i>	.86	.78
<i>Pairs</i>	.99	.98
<i>Contents</i>	.99	.91
<i>P</i>	.98	.96
<i>Z Score</i>	.90	.88
<i>Special scores</i>	.99	.86

Data Analysis

Descriptive statistics were calculated for Rorschach continuous variables and frequencies were computed for nominal variables. We compared our sample with an Italian nonpatient sample (Lis, Parolin, Salcuni, & Zennaro, 2007), with the international norms (Meyer et al., 2007), and with Exner’s new norms (Exner, 2007) using Cohen’s *d* as the effect size index, which indicates how far apart two means are in pooled standard deviation units.

Two groups, a healthy group (HG; $n = 112$) and a nonhealthy group (NHG; $n = 82$), were formed depending on the participants’ scores on the BDI-II and SCL-90-R, blinded to Rorschach scores. According to the Italian versions of the tests, we considered a positive risk if the subjects had a BDI-II score of >12 and/or a GSI score or at least two primary dimension scores of ≥ 55 on the SCL-90-R.

We excluded men who had a PST raw score of ≥ 3 on the SCL-90-R, women who had a PST raw score of ≥ 4 on the SCL-90-R, and individuals who scored 1.00 on the PSDI, according to Derogatis (1994), who found that these scores suggest an attempt to communicate freedom from psychological distress. Using these criteria we excluded 18 individuals (two women and 16 men). In our sample we did not find any individual with scores on the SCL-90-R indicative of attempting to “fake bad.”

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

We then compared the demographic variables and Rorschach variables in the two groups using the chi-square test for nominal variables and the Mann–Whitney U test for continuous variables.

Subsequently, HG was compared with the Italian nonpatient sample (Lis et al., 2007), with international norms (Meyer et al., 2007), and with Exner's new norms (Exner, 2007) computing Cohen's d .

We calculated the correlations between scores on psychopathological scales and PTI using Spearman's ρ . Finally, using the Mann–Whitney U , we investigated the differences in scores on psychopathological scales comparing positive and negative DEPI protocols, positive and negative CDI protocols, and positive and negative HVI protocols.

Results

Descriptive statistics and frequencies for the whole sample ($n = 212$) are reported in Tables 3 and 4. Our sample comprised more well-educated participants than did the other Italian sample (Lis et al., 2007) and more males. Compared with Exner's new sample (Exner, 2007), in our sample there were more single subjects and fewer married or divorced individuals.

In comparison with the other Italian sample (Lis et al., 2007), our sample showed a high effect size ($d > 0.8$) for *SumY* ($d = -0.96$), *DV* ($d = -0.84$), and *INCOM* ($d = -0.81$). Our sample had a lower number of protocols with positive CDI (20 vs. 43%) and positive DEPI (22 vs. 40%). Compared with the international norms, our sample did not show a high effect size for any variable. For international norms, a mean of 31% positive DEPI and a mean of 36% positive CDI protocols were reported, higher values than those found in our sample.

We observed a high effect size for the following Rorschach variables: *DQ+* ($d = -1.21$); *DQv* ($d = 0.88$); *FQxo* ($d = -1.05$); *FQx-* ($d = 0.97$); *MQ-* ($d = 0.86$); *active movement* ($d = -0.82$); *Blends* ($d = -0.88$); *Blends/R* ($d = -0.80$); *XA%* ($d = -1.29$); *WDA%* ($d = -1.50$); *X+%* ($d = -1.36$); *X-%* ($d = 1.29$); *COP* ($d = -0.85$); *PTI* ($d = 1.19$), and *CDI total* ($d = 0.82$).

Compared with our sample, Exner's sample yielded more introversive and extratensive subjects and a lower number of ambitent and avoidant

Table 3. Descriptive statistics for 212 adult nonpatients from Italy

Variable	<i>M</i>	<i>SD</i>	Min	Max	<i>f</i>	<i>Mdn</i>	Mode	SK	KU	Cohen's <i>d</i> Lis et al. (2007)	Cohen's <i>d</i> Intern. norms (2007)	Cohen's <i>d</i> Exner's (2007)
<i>Age</i>	36.59	13.33	19	71	212	33	22	0.58	-0.84	-0.26	0.01	0.13
<i>YrsEd</i>	14.24	3.07	5	23	212	14.5	13	-0.45	0.64	N/A	N/A	0.12
<i>R</i>	22.77	7.97	14	63	212	21	18	1.87	5.09	0.33	0.06	-0.10
<i>W</i>	9.40	4.14	2	23	212	9	7	.89	1.01	0.22	0.07	0.08
<i>D</i>	11.06	6.61	1	38	212	10	7	1.15	1.89	0.31	0.19	-0.34
<i>Dd</i>	2.36	2.66	0	21	168	2	1	2.81	12.95	-0.08	-0.32	0.37
<i>S</i>	2.53	2.08	0	14	184	2	2	1.63	4.90	-0.03	0.02	0.08
<i>DQ+</i>	4.70	2.79	0	13	206	4	4	0.56	-0.08	-0.36	-0.49	-1.21
<i>DQo</i>	16.70	7.69	4	53	212	14.50	13	1.56	3.63	0.49	0.28	0.52
<i>DQv</i>	1	1.14	0	7	128	1	0	1.73	4.49	0.14	-0.07	0.88
<i>DQv/+</i>	0.37	0.71	0	4	60	0	0	2.55	7.89	0.01	0.12	0.16
<i>FQx+</i>	0.10	0.37	0	3	17	0	0	4.54	24.52	-0.05	-0.21	-0.47
<i>FQxo</i>	11.72	4.03	3	24	212	11	10	0.65	0.25	0.44	0.16	-1.05
<i>FQxu</i>	5.93	3.60	0	22	208	5	5	1.21	2.23	0.08	-0.07	0.37
<i>FQx-</i>	4.68	3.21	0	23	205	4	3	1.62	5.41	0.14	0.08	0.97
<i>FQxnone</i>	0.25	0.53	0	3	45	0	0	2.44	6.98	0.02	-0.13	0.24
<i>MQ+</i>	0.08	0.31	0	2	15	0	0	4.07	17.50	0.03	-0.11	-0.47
<i>MQo</i>	2.42	1.61	0	7	196	2	1	0.69	0	0.41	0.10	-0.74
<i>MQu</i>	0.55	0.93	0	8	79	0	0	3.22	19.08	-0.21	-0.15	0.14
<i>MQ-</i>	0.72	0.95	0	5	99	0	0	1.47	2.36	0.19	0.09	0.86
<i>MQnone</i>	0.01	0.10	0	1	2	0	0	10.22	103.4	-0.08	-0.13	0.00
<i>SQuat-</i>	1.06	1.25	0	8	125	1	0	1.91	5.84	0.23	0.16	0.54

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 3. (Continued)

Variable	M	SD	Min	Max	f	Mdn	Mode	SK	KU	Cohen's d Lis et al. (2007)	Cohen's d Intern. norms (2007)	Cohen's d Exner's (2007)
M	3.75	2.39	0	11	206	3	2	0.78	0.12	0.25	0.01	-0.50
FM	2.88	1.84	0	11	196	3	2	0.93	1.74	0.04	-0.25	-0.62
m	1.09	1.25	0	5	122	1	0	1.21	1.08	-0.22	-0.29	-0.36
FM+m	3.96	2.23	0	11	207	4	4	0.72	0.37	-0.10	-0.36	-0.66
FC	2.28	1.89	0	11	177	2	1	1.22	2.57	0.16	0.20	-0.39
CF	1.96	1.64	0	8	175	2	1	1.13	1.45	0.25	0.19	-0.51
C	0.23	0.50	0	3	40	0	0	2.45	6.57	-0.04	-0.21	0.13
Cn	0	0	0	0	0	0	0			-0.25	-0.29	0.00
Sum Col	4.48	2.78	0	17	206	4	3	1.20	2.55	0.25	0.20	-0.60
WSumC	3.45	2.17	0	12	206	3	2.50	1	1.27	0.25	0.15	-0.55
SumC'	1.78	1.79	0	10	151	1	0	1.26	2.01	-0.32	0.02	0.14
SumT	0.72	1.08	0	6	94	0	0	2.21	6.31	-0.07	0.07	-0.42
SumV	0.44	0.83	0	5	61	0	0	2.41	6.99	-0.08	-0.09	0.12
SumY	0.65	0.89	0	4	93	0	0	1.52	2.21	-0.96	-0.55	-0.27
SumSh	3.57	2.85	0	14	196	3	2	1.23	1.57	-0.65	-0.24	-0.15
Fy+rF	0.41	0.94	0	5	47	0	0	2.79	7.66	0.02	0.00	0.31
FD	0.95	1.05	0	5	122	1	0	1.14	1.40	0.32	-0.06	-0.42
F	9.69	5.54	1	36	212	8	7	1.49	3.36	0.49	0.15	0.48
(2)	7.05	3.82	0	20	209	6	5	0.83	0.75	0.28	-0.09	-0.57
F+(2)/R	0.37	0.18	0	1.21	211	0.36	0.50	1.18	3.01	0.11	-0.06	-0.30
Lambda	0.84	0.59	0.08	4	212	0.75	1	1.98	5.43	0.32	-0.01	0.70
EA	7.23	3.44	1	21	212	6.50	6.50	0.94	1.12	0.32	0.10	-0.71

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Table 3. (Continued)

Variable	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	<i>f</i>	<i>Mdn</i>	<i>Mode</i>	<i>SK</i>	<i>KU</i>	Cohen's <i>d</i> Lis et al. (2007)	Cohen's <i>d</i> Intern. norms (2007)	Cohen's <i>d</i> Exner's (2007)
<i>es</i>	7.52	4.00	1	24	212	7	5	1.36	2.62	-0.50	-0.35	-0.51
<i>D Score</i>	-0.04	1.15	-4	4	212	0	0	-0.01	2.4	0.76	0.49	0.08
<i>AdjD</i>	0.13	1.06	-4	4	212	0	0	0.36	2.83	0.57	0.14	-0.07
<i>a</i>	4.42	2.69	0	16	205	4	4	0.98	1.67	-0.04	-0.17	-0.82
<i>p</i>	3.34	2.17	0	12	201	3	3	0.92	1.16	0.21	-0.16	-0.17
<i>Ma</i>	2.01	1.82	0	10	175	2	1	1.40	2.35	0.03	-0.04	-0.55
<i>Mp</i>	1.84	1.47	0	8	176	2	1	0.96	1.19	0.43	0.11	-0.07
<i>Intellect</i>	2.41	2.20	0	11	178	2	1	1.54	2.70	0.01	0.03	0.11
<i>Zf</i>	11.38	4.24	3	28	212	11	9	1	1.38	-0.10	-0.24	-0.49
<i>Zd</i>	-0.84	4.49	-17	12.50	212	-0.50	0.50	-0.09	0.71	-0.15	-0.04	-0.29
<i>Blends</i>	3.32	2.59	0	13	194	3	2	1.10	1.09	-0.25	-0.25	-0.88
<i>Blends/R</i>	0.16	0.13	0	0.64	194	0.13	0	1.19	1.29	-0.29	-0.15	-0.80
<i>Col-Sh</i>	0.61	0.97	0	6	81	0	0	2.13	6.26	-0.13	0.01	-0.06
<i>Afr</i>	0.60	0.22	0.23	1.43	212	0.56	0.50	1.03	1.25	0.49	0.33	-0.06
<i>Populars</i>	5.26	1.92	1	11	212	5	4	0.44	0.13	0.11	-0.05	-0.67
<i>XA%</i>	0.79	0.10	0.53	1	212	0.79	0.76	-0.14	-0.46	0.00	0.00	-1.29
<i>WDA%</i>	0.82	0.10	0.53	1	212	0.82	0.89	-0.33	-0.30	0.09	0.00	-1.50
<i>X+%</i>	0.53	0.13	0.28	0.86	212	0.53	0.50	0.18	-0.37	0.07	0.08	-1.36
<i>X-%</i>	0.20	0.10	0	0.47	206	0.20	0.06	0.15	-0.54	0.00	0.10	1.29
<i>Xu%</i>	0.26	0.11	0	0.86	209	0.25	0.32	0.79	3.47	-0.08	-0.09	0.67
<i>Isolate/R</i>	0.17	0.12	0	0.64	192	0.15	0	1.00	1.46	-0.22	-0.23	-0.22
<i>H</i>	2.29	1.73	0	9	190	2	2	1.19	1.49	0.18	-0.08	-0.52

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 3. (Continued)

Variable	<i>M</i>	<i>SD</i>	Min	Max	<i>f</i>	<i>Mdn</i>	Mode	SK	KU	Cohen's <i>d</i> Lis et al. (2007)	Cohen's <i>d</i> Intern. norms (2007)	Cohen's <i>d</i> Exner's (2007)
(H)	1.25	1.27	0	6	141	1	0	1.15	1.15	0.02	0.02	-0.09
Hd	1.33	1.44	0	8	139	1	0	1.39	2.37	0.15	-0.12	0.15
(Hd)	0.95	1	0	4	126	1	0	0.95	0.48	0.26	0.32	0.35
Hx	0.12	0.35	0	2	23	0	0	3.03	9.06	-0.49	-0.44	-0.06
H+(H)+Hd+(Hd)	5.90	3	0	17	210	5	5	0.84	0.85	0.28	0.03	-0.14
A	7.39	3.27	0	20	210	7	5	0.68	0.85	0.12	-0.10	-0.31
(A)	0.56	0.83	0	5	86	0	0	1.92	4.96	0.23	0.18	0.20
Ad	1.94	1.82	0	12	165	2	2	1.67	4.76	0.02	-0.25	-0.58
(Ad)	0.22	0.45	0	2	44	0	0	1.81	2.40	0.19	0.13	0.24
An	1.13	1.41	0	9	124	1	0	2.10	6.84	0.04	-0.02	0.24
Art	1.30	1.29	0	6	144	1	1	1.03	0.69	0.31	0.06	0.08
Ay	0.83	1.05	0	5	107	1	0	1.42	2.12	0.62	0.32	0.39
Bl	0.12	0.36	0	2	22	0	0	2.23	10.52	-0.22	-0.29	-0.24
Bt	1.28	1.32	0	8	141	1	0	1.32	2.76	0.05	-0.09	-0.62
Cg	2.25	1.81	0	8	178	2	1	0.88	0.42	0.25	0.20	0.06
Cl	0.16	0.59	0	6	23	0	0	6.46	53.38	0.02	-0.04	0.00
Ex	0.21	0.50	0	3	36	0	0	2.64	7.40	0.15	0.04	0.00
Fi	0.32	0.66	0	3	48	0	0	2.25	4.81	-0.32	-0.25	-0.58
Food	0.42	0.81	0	5	60	0	0	2.47	7.39	0.23	0.12	0.29
Ge	0.34	0.73	0	4	50	0	0	2.49	6.43	0.32	0.12	0.44
Hh	1.06	1.10	0	7	136	1	0	1.50	4.22	0.29	0.21	-0.17
Is	0.66	0.93	0	4	88	0	0	1.30	0.83	-0.16	-0.20	-0.26

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Table 3. (Continued)

Variable	M	SD	Min	Max	f	Mdn	Mode	SK	KU	Cohen's d Lis et al. (2007)	Cohen's d Intern. norms (2007)	Cohen's d Exner's (2007)
Na	0.59	0.74	0	3	98	0	0	1.18	1.07	-0.26	-0.17	0.17
Sc	1.30	1.35	0	6	137	1	0	1.10	0.92	0.42	0.14	-0.24
Sx	0.25	0.67	0	5	34	0	0	3.74	17.55	-0.07	-0.27	0.11
Xy	0.22	0.54	0	4	38	0	0	3.12	13.26	0.10	0.06	0.50
Idio	0.71	0.95	0	4	96	0	0	1.41	1.63	-0.84	-0.17	0.57
DV	0.28	0.69	0	4	41	0	0	3.05	10.57	-0.81	-0.44	-0.09
INCOM	0.33	0.67	0	3	50	0	0	2.16	4.32	-0.06	-0.49	-0.41
DR	0.09	0.40	0	4	15	0	0	6.05	46.79	-0.65	-0.59	-0.75
FABCOM	0.28	0.56	0	3	50	0	0	2.20	5.33	0.05	-0.26	-0.22
DV2	0.03	0.20	0	2	6	0	0	6.85	51.56	-0.09	0.12	0.43
INC2	0.17	0.45	0	3	31	0	0	3.01	10.67	0.12	0.18	0.44
DR2	0	0	0	0	0	0	0			-0.53	-0.39	-0.33
FAB2	0.23	0.55	0	4	39	0	0	3.23	14.05	0.46	0.35	0.75
ALOG	0.09	0.30	0	2	16	0	0	3.40	11.54	-0.34	-0.18	0.24
CONTAM	0	0	0	0	0	0	0			-0.40	-0.27	0
Sum6SpSc	1.51	1.67	0	9	141	1	0	1.61	3.34	-0.66	-0.61	-0.54
Lv2 Sp Sc	0.43	0.79	0	4	62	0	0	2.21	5.46	0.10	0.26	0.72
WSum6	5.14	6.22	0	37	141	4	0	2.02	5.60	-0.33	-0.36	-0.34
AB	0.17	0.83	0	9	18	0	0	7.56	68.81	-0.40	-0.18	-0.07
AG	0.53	0.99	0	9	73	0	0	3.80	25.14	0.16	-0.01	-0.35
COP	0.97	1.10	0	5	117	1	0	0.99	0.38	0.03	-0.09	-0.85

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 3. (Continued)

Variable	<i>M</i>	<i>SD</i>	Min	Max	<i>f</i>	<i>Mdn</i>	Mode	SK	KU	Cohen's <i>d</i> Lis et al. (2007)	Cohen's <i>d</i> Intern. norms (2007)	Cohen's <i>d</i> Exner's (2007)
<i>CP</i>	0.01	0.12	0	1	3	0	0	8.29	67.29	-0.08	-0.07	0.00
<i>GHR</i>	3.72	2.10	0	13	208	3	3	0.96	1.59	-0.24	0.01	-0.64
<i>PHR</i>	2.68	2.10	0	11	188	2	1	1.04	1.12	0.38	-0.08	0.31
<i>MOR</i>	0.76	1.03	0	5	103	0	0	1.67	2.78	-0.37	-0.41	-0.17
<i>PER</i>	0.54	0.92	0	5	75	0	0	2.30	6.30	-0.29	-0.21	-0.41
<i>PSV</i>	0.10	0.31	0	2	20	0	0	3.15	9.65	-0.22	-0.30	-0.05
<i>PTI total</i>	0.61	0.94	0	3	76	0	0	1.33	0.53	0.03	0.02	1.19
<i>DEPI total</i>	3.68	1.22	1	7	212	4	4	0.05	-0.18	-0.39	-0.56	0.66
<i>CDI total</i>	2.49	1.22	0	5	199	3	3	-0.14	-0.43	-0.57	-0.33	0.82
<i>S-CON total</i>	4.33	1.59	1	8	212	4	4	0.22	-0.38	-0.47	-0.21	0.55

Note. SK = skewness; KU = kurtosis; bold values indicate large effect size (Cohen's *d* ≥ .8).

Table 4. Frequencies for 212 adult nonpatients from Italy

Marital status			Lis et al. (2007)	International norms	Exner (2007)
	N	%	N = 249	N = 4,704	N = 450
Single	106	50%	44%	–	32%
Lives w/S.O.	17	8%	4%	–	4%
Married	73	34.4%	40%	–	47%
Separated	8	3.8%	3%	–	3%
Divorced	4	1.9%	6%	–	12%
Widowed	4	1.9%	2%	–	2%
Age					
18–25	61	28.8%	8%	–	26%
26–35	59	27.8%	50%	–	35%
36–45	34	16%	23%	–	19%
46–55	33	15.6%	12%	–	10%
56–65	21	9.9%	6%	–	6%
Over 65	4	1.9%	1%	–	4%
Sex					
Male	113	53.3%	34.5%	–	49%
Female	99	46.7%	65.5%	–	51%
Education					
Under 12	29	13.7%	8%	–	2%
12 Years	6	2.8%	30%	–	26%
13–15 Years	97	45.8%	47%	–	48%
16+Years	80	37.7%	15%	–	24%
Styles					
Introversive	46	22%	22%	26%	38%
Pervasive introversive	27	13%	9%	16%	6%
Ambitent	75	35%	38%	31%	18%
Extratensive	42	20%	18%	16%	31%
Pervasive extratensive	18	9%	10%	9%	4%
Avoidant	47	22%	22%	28%	13%
D-Scores					
D Score>0	42	20%	6%	12%	14%
D Score=0	120	57%	38%	46%	68%
D Score<0	51	24%	55%	41%	17%
D Score<-1	18	8%	32%	23%	6%
AdjD Score>0	46	22%	10%	19%	27%
AdjD Score=0	129	61%	51%	52%	63%
AdjD Score<0	35	16%	40%	30%	10%
AdjD Score<-1	10	5%	15%	13%	3%

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 4. (Continued)

Marital status			Lis et al. (2007) N = 249	International norms N = 4,704	Exner (2007) N = 450
Zd					
Zd>+3.0 (Overincorp)	34	16%	22%	19%	20%
Zd<-3.0 (Underincorp)	60	28%	25%	29%	14%
Form Quality					
XA %>.89	29	14%	28%	19%	45%
XA %<.70	41	19%	26%	18%	1%
WDA %<.85	121	57%	54%	49%	16%
WDA %<.75	49	23%	26%	20%	2%
X+ %<.55	108	51%	57%	55%	12%
Xu %>.20	144	68%	65%	68%	45%
X- %>.20	100	47%	45%	41%	10%
X- %>.30	38	18%	22%	14%	1%
FC:CF+C Ratio					
FC>(CF+C)+2	33	16%	15%	13%	15%
FC>(CF+C)+1	53	25%	26%	22%	26%
(CF+C)>FC+1	47	22%	24%	24%	26%
(CF+C)>FC+2	26	12%	12%	15%	14%
Constellations					
S-Constellation positive	6	3%	6%	4%	2%
HVI positive	24	11%	7%	12%	4%
OBS positive	0	0%	0%	0%	1%
PTI=5	0	0%	0%	0%	0%
PTI=4	0	0%	1%	2%	0%
PTI=3	14	7%	4%	6%	0%
DEPI=7	1	0%	3%	2%	0%
DEPI=6	16	8%	12%	10%	4%
DEPI=5	30	14%	25%	19%	10%
CDI=5	9	4%	14%	11%	2%
CDI=4	34	16%	29%	25%	7%
Miscellaneous variables					
R<17	42	20%	37%	25%	6%
R>27	47	22%	15%	20%	14%
DQt>2	21	10%	22%	16%	2%
S>2	90	42%	44%	40%	38%
SumT=0	115	54%	50%	57%	19%
SumT>1	34	16%	20%	15%	17%

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Table 4. (Continued)

Marital status			Lis et al. (2007)	International norms	Exner (2007)
			N = 249	N = 4,704	N = 450
<i>3r+(2)/R<.33</i>	87	41%	45%	39%	20%
<i>3r+(2)/R>.44</i>	59	28%	26%	30%	30%
<i>Fr+rF>0</i>	47	22%	25%	25%	12%
<i>Pure C>0</i>	41	19%	17%	25%	14%
<i>PureC>1</i>	6	3%	5%	7%	2%
<i>Afr.<.40</i>	36	17%	29%	27%	9%
<i>Afr.<.50</i>	71	33%	53%	47%	24%
<i>(FM+m) < Sum Sh</i>	78	37%	60%	35%	18%
<i>(2AB+Art+Ay)>5</i>	18	8%	13%	11%	8%
<i>Populars<4</i>	33	16%	20%	16%	4%
<i>Populars>7</i>	27	13%	9%	12%	18%
<i>COP=0</i>	93	44%	44%	42%	11%
<i>COP>2</i>	22	10%	8%	13%	36%
<i>AG=0</i>	139	66%	71%	64%	44%
<i>AG>2</i>	10	5%	2%	4%	7%
<i>MOR>2</i>	15	7%	14%	16%	7%
<i>Level 2 Sp.Sc. >0</i>	66	31%	23%	17%	13%
<i>GHR>PHR</i>	128	60%	70%	57%	85%
<i>Pure H<2</i>	75	35%	47%	35%	17%
<i>Pure H=0</i>	22	10%	12%	11%	4%
<i>p>a+1</i>	39	18%	15%	21%	10%
<i>Mp>Ma</i>	81	38%	14%	32%	23%

people. Furthermore, in our sample we found a higher number of positive HVI (11 vs. 4%), positive CDI (20 vs. 9%), positive DEPI (22 vs. 14%), and PTI = 3 (7 vs. 0%) protocols.

The HG in our study comprised more well-educated (*Yrs Ed.*: $M = 14.64$, $SD = 3.09$) subjects than NHG did (*Yrs Ed.*: $M = 13.06$ $SD = 3.07$). The comparison of the Rorschach variables between the two groups showed significant differences for: $DQ+$ ($p = .27$); $FQx-$ ($p = .001$); $S-$ ($p = .006$); $SumV$ ($p < .001$); $SumSh$ ($p = .047$); *Intellectualization Index* ($p = .044$); $XA\%$ ($p < .001$); $WDA\%$ ($p = .022$); $X+\%$ ($p = .003$); $X-\%$ ($p < .001$); $FAB2$ ($p = .002$); $Sum6SpSc$ ($p < .001$); $Lvl2SpSc$ ($p = .004$); $WSum6$ ($p < .001$); PTI ($p < .001$); $DEPI$ total ($p = 0.29$); $S-CON$ total ($p = .021$).

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Furthermore, HG showed a higher number of protocols with $XA \% > .89$ ($p = .035$) and a lower number of protocols with $XA \% < .70$ ($p = .003$); $WDA\% < .75$ ($p = .003$); $X-\% > .20$ ($p = .029$); $X-\% > .30$ ($p = .001$); $DQv > 2$ ($p = .034$); $(FM + m) < SumSh$ ($p = .025$); $Level\ 2\ Sp.\ Sc. > 0$ ($p = .008$).

In the HG group, there was a significantly lower number of HVI-positive protocols (6 vs. 20%, Fisher's exact test, $p = .006$); a lower number of DEPI = 6 protocols (3 vs. 11%, Fisher's exact test, $p = .031$), a lower number of DEPI = 5 protocols (6 vs. 27%, Fisher's exact test, $p < .001$), and a lower number of CDI = 4 protocols (10 vs. 23%, Fisher's exact test, $p = .015$). Comparing HG with the Lis et al. sample, we found a high effect size for *SumY* responses ($d = -1.03$), *D* score ($d = .80$), *Idiographic contents* ($d = -.099$), *DV* ($d = -0.91$), and *Sum6SpSc* ($d = -0.87$). The comparison between HG and international norms showed a high effect size only for *Sum6SpSc* ($d = -0.83$).

When comparing our HG with Exner's sample, many differences remained for continuous variables, especially for variables related to form quality. We found a high effect size for: *DQ+* ($d = -1.42$); *FQx+* ($d = -0.82$); *FQxo* ($d = -0.87$); *MQo* ($d = -0.82$); *active movements* ($d = -0.95$); *Blends* ($d = -0.94$); *XA%* ($d = -0.87$); *WDA%* ($d = -1.07$); *X+%* ($d = -1.00$); *X-%* ($d = 0.88$); *Sum6SpSc* ($d = -0.83$); and *COP* ($d = -0.85$).

There were more ambivalent subjects in our HG than in Exner's sample (36 vs. 18%), although the percentage of avoidant individuals was lower in the HG compared with the NHG (20 vs. 30%) in our sample and there was a slightly increased number of both introversive and extratensive individuals (from 20 to 22% and from 19 to 21%, respectively). No significant differences emerged between our HG and Exner's sample regarding constellations. Detailed results, including effect sizes, are reported in Tables 5 and 6.

PTI showed positive significant correlations with BDI-II ($p < .001$) and the following SCL-90-R scales: Obsessive-Compulsive ($p = .008$), Depression ($p = .001$), Anxiety ($p = .007$), Hostility ($p = .004$), Paranoid ideation ($p = .002$), and the Global Severity Index ($p = .001$). The results are presented in Table 7.

Subjects who were scored positive on the DEPI, when compared with DEPI-negative individuals had higher scores on the BDI-II ($p = .042$) and on the following SCL-90-R scales: Obsessive-Compulsive ($p = .042$), Depression ($p = .010$), Anxiety ($p = .014$), Hostility ($p = .038$), Paranoid ideation ($p = .014$), Psychoticism ($p = .002$), and the Global Severity Index ($p = .002$).

Table 5. Comparison between HG (healthy group) and NHG (nonhealthy group)^a

	HG N = 112		NHG N = 82		Z	p	Cohen's <i>d</i>		Cohen's <i>d</i> Intern. norms (2007)	Cohen's <i>d</i> Exner (2007)
	M	SD	M	SD			Lis et al. (2007)	Intern. norms (2007)		
<i>Age</i>	35.79	12.33	38.24	14.97	-0.782	n.s.	-0.34	-0.05	0.07	
<i>Yrs Ed</i>	14.64	3.09	13.06	3.07	-2.427	.015	N/A	N/A	0.25	
<i>R</i>	21.92	6.77	24.11	9.29	-1.572	n.s.	0.23	-0.05	-0.23	
<i>W</i>	9.26	3.69	9.74	4.54	-0.286	n.s.	0.19	0.04	0.04	
<i>D</i>	10.71	6.54	11.65	7	-0.788	n.s.	0.25	0.13	-0.35	
<i>Dd</i>	2.40	2.01	2.72	3.29	-1.272	n.s.	-0.08	-0.35	0.39	
<i>S</i>	2.27	1.66	2.85	2.45	-1.414	n.s.	-0.17	-0.12	-0.06	
<i>DQ+</i>	4.35	2.66	5.24	2.91	-2.211	.027	-0.49	-0.61	-1.42	
<i>DQo</i>	16.42	7.08	17.26	8.76	-0.237	n.s.	0.47	0.25	0.36	
<i>DQv</i>	0.83	0.89	1.17	1.38	-1.268	n.s.	0.00	-0.22	0.57	
<i>DQv/+</i>	0.32	0.59	0.44	0.85	-0.477	n.s.	-0.06	0.05	0.08	
<i>FQ+</i>	0.06	0.24	0.16	0.51	-1.235	n.s.	-0.17	-0.33	-0.82	
<i>FQso</i>	11.98	3.94	11.52	4.28	-0.925	n.s.	0.51	0.23	-0.87	
<i>FQvu</i>	5.68	3.30	6.26	4.02	-0.910	n.s.	0.02	-0.14	0.27	
<i>FQ-</i>	3.95	2.34	5.70	3.86	-3.295	.001	-0.09	-0.17	0.56	
<i>FQnone</i>	0.25	0.59	0.27	0.47	-0.983	n.s.	0.02	-0.12	0.20	
<i>MQ+</i>	0.05	0.23	0.12	0.40	-1.201	n.s.	-0.08	-0.21	-0.78	
<i>MQo</i>	2.38	1.52	2.59	1.78	-0.552	n.s.	0.39	0.08	-0.82	
<i>MQu</i>	0.47	0.75	0.72	1.16	-1.570	n.s.	-0.32	-0.25	0.04	
<i>MQ-</i>	0.63	0.84	0.84	1.09	-1.040	n.s.	0.10	0.00	0.57	
<i>MQnone</i>	0	0	0.02	0.16	-1.657	n.s.	-0.29	-0.30	-0.25	

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 5. (Continued)

	HG N = 112		NHG N = 82		<i>Z</i>	<i>p</i>	Cohen's <i>d</i>		Cohen's <i>d</i>	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			Lis et al. (2007)	Intern. norms (2007)		
<i>SQual</i>	0.80	0.91	1.38	1.51	-2.743	.006	0.02	-0.07	0.24	0.24
<i>M</i>	3.54	2.17	4.22	2.70	-1.480	n.s.	0.16	-0.08	-0.59	-0.59
<i>FM</i>	2.90	1.80	2.93	1.92	-0.043	n.s.	0.04	-0.25	-0.62	-0.62
<i>m</i>	1.09	1.31	1.02	1.07	-0.277	n.s.	-0.21	-0.29	-0.36	-0.36
<i>FM+m</i>	3.99	2.19	3.95	2.23	-0.010	n.s.	-0.09	-0.36	-0.69	-0.69
<i>FC</i>	2.31	1.82	2.33	2.02	-0.317	n.s.	0.17	0.21	-0.37	-0.37
<i>CF</i>	2.03	1.52	1.89	1.74	-1.047	n.s.	0.30	0.25	-0.49	-0.49
<i>C</i>	0.21	0.49	0.24	0.51	-0.702	n.s.	-0.07	-0.25	0.09	0.09
<i>Cn</i>	0	0	0	0	-0.856	n.s.	-0.25	-0.29	0.00	0.00
<i>Sum Col</i>	4.56	2.42	4.46	3.17	-0.997	n.s.	0.29	0.24	-0.57	-0.57
<i>WSumC</i>	3.51	1.89	3.42	2.50	-1.068	n.s.	0.29	0.18	-0.53	-0.53
<i>SumC'</i>	1.58	1.65	2.02	1.74	-1.923	.054	-0.44	-0.10	-0.01	-0.01
<i>SumT</i>	0.79	1.06	0.72	1.18	-0.879	n.s.	0.00	0.14	-0.25	-0.25
<i>SumV</i>	0.26	0.63	0.63	0.99	-3.549	<.001	-0.33	-0.34	-0.13	-0.13
<i>SumY</i>	0.59	0.81	0.72	0.97	-0.657	n.s.	-1.03	-0.61	-0.38	-0.38
<i>SumSh</i>	3.25	2.66	4.02	2.90	-1.957	.050	-0.76	-0.34	-0.27	-0.27
<i>F++F</i>	0.31	0.72	0.56	1.17	-1.104	n.s.	-0.12	-0.14	0.14	0.14
<i>FD</i>	0.96	0.91	0.94	1.14	-0.736	n.s.	0.35	-0.06	-0.46	-0.46
<i>F</i>	9.23	5.52	10.22	6.10	-0.838	n.s.	0.42	0.06	0.32	0.32
(2)	6.91	3.44	7.48	4.37	-0.657	n.s.	0.25	-0.13	-0.59	-0.59
<i>3++(2)/R</i>	0.36	0.16	0.39	0.17	-1.607	n.s.	0.06	-0.13	-0.31	-0.31

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Table 5. (Continued)

	HG N = 112		NHG N = 82		<i>Z</i>	<i>p</i>	Cohen's <i>d</i>		Cohen's <i>d</i> Exner (2007)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			Lis et al. (2007)	Intern. norms (2007)	
<i>Lambda</i>	0.82	0.56	0.84	0.61	-1.161	n.s.	0.27	-0.05	0.52
<i>EA</i>	7.07	2.99	7.68	3.97	-0.649	n.s.	0.30	0.07	-0.77
<i>es</i>	7.20	3.72	7.99	4.16	-1.566	n.s.	-0.59	-0.43	-0.61
<i>D Score</i>	0.18	1.16	-0.06	1.18	-0.534	n.s.	0.91	0.65	0.14
<i>AdjD</i>	0.17	1.05	0.10	1.15	-0.576	n.s.	0.61	0.17	0.00
<i>a</i>	4.30	2.89	4.62	2.98	-0.270	n.s.	-0.09	-0.20	-0.85
<i>p</i>	3.22	2.07	3.65	2.27	-1.273	n.s.	0.16	-0.22	-0.23
<i>Ma</i>	1.87	1.47	2.21	2.05	-0.481	n.s.	-0.06	-0.13	-0.68
<i>Mp</i>	1.68	1.33	2.10	1.55	-1.879	n.s.	0.33	0.01	-0.19
<i>Intellct</i>	2.11	1.84	2.84	2.46	-2.015	.044	-0.11	-0.11	-0.03
<i>Zf</i>	11.13	3.84	11.87	4.55	-0.890	n.s.	-0.16	-0.31	-0.58
<i>Zd</i>	-0.76	4.44	-1.08	4.88	-0.538	n.s.	-0.13	-0.02	-0.25
<i>Blends</i>	3.22	2.46	3.46	2.63	-0.666	n.s.	-0.29	-0.29	-0.93
<i>Blends/R</i>	.16	.13	.15	.11	-0.097	n.s.	-0.29	-0.15	-0.70
<i>ColSh</i>	0.54	0.88	0.68	1.05	-0.779	n.s.	-0.21	-0.07	-0.14
<i>Afr</i>	0.59	0.23	0.61	0.23	-0.760	n.s.	0.43	0.28	-0.10
<i>Populars</i>	5.37	1.86	5.26	2.02	-0.526	n.s.	0.17	0.01	-0.54
<i>XA %</i>	0.81	0.09	0.76	0.10	-3.522	<.001	0.17	0.20	-0.87
<i>WDA %</i>	0.83	0.09	0.80	0.10	-2.292	.022	0.18	0.10	-1.07
<i>X+ %</i>	0.56	0.13	0.50	0.12	-2.990	.003	0.30	0.31	-1.00
<i>X- %</i>	0.18	0.09	0.23	0.11	-3.519	<.001	-0.17	-0.10	0.88

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 5. (Continued)

	HG N = 112		NHG N = 82		<i>Z</i>	<i>p</i>	Cohen's <i>d</i>		Cohen's <i>d</i>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			Lis et al. (2007)	Intern. norms (2007)	Exner (2007)	Cohen's <i>d</i>
<i>Xu %</i>	0.25	0.11	0.26	0.12	-0.525	n.s.	-0.17	-0.18	0.50	
<i>Isolate/R</i>	0.16	0.13	0.18	0.15	-1.119	n.s.	-0.29	-0.30	-0.27	
<i>H</i>	2.19	1.54	2.50	2.03	-0.388	n.s.	0.13	-0.14	-0.61	
<i>(H)</i>	1.21	1.30	1.35	1.27	-0.924	n.s.	-0.01	-0.01	-0.12	
<i>Hd</i>	1.15	1.26	1.49	1.63	-1.183	n.s.	0.03	-0.25	0.01	
<i>(Hd)</i>	1.04	0.97	0.89	1.01	-1.284	n.s.	0.36	0.42	0.46	
<i>Hx</i>	0.13	0.38	0.12	0.33	-0.273	n.s.	-0.47	-0.41	-0.05	
<i>H+(H)+Hd+(Hd)</i>	5.63	2.61	6.32	3.43	-1.057	n.s.	0.21	-0.08	-0.25	
<i>A</i>	7.24	3.10	7.68	3.56	-0.988	n.s.	0.08	-0.15	-0.33	
<i>(A)</i>	0.59	0.80	0.52	0.91	-0.947	n.s.	0.28	0.22	0.23	
<i>Ad</i>	1.89	1.76	2.04	1.97	-0.365	n.s.	-0.01	-0.28	-0.59	
<i>(Ad)</i>	0.18	0.41	0.23	0.42	-1.037	n.s.	0.10	0.05	0.13	
<i>An</i>	0.96	1.15	1.35	1.75	-1.212	n.s.	-0.09	-0.16	0.07	
<i>Avt</i>	1.15	1.09	1.52	1.42	-1.530	n.s.	0.21	-0.06	-0.03	
<i>Ay</i>	0.77	1.01	0.95	1.06	-1.419	n.s.	0.56	0.27	0.25	
<i>Bl</i>	0.10	0.35	0.13	0.38	-0.932	n.s.	-0.26	-0.33	-0.33	
<i>Bt</i>	1.24	1.32	1.37	1.33	-0.699	n.s.	0.02	-0.12	-0.69	
<i>Cg</i>	2.13	1.78	2.45	1.85	-0.797	n.s.	0.18	0.14	-0.02	
<i>Cl</i>	0.21	0.75	0.11	0.35	-1.322	n.s.	0.10	0.05	0.09	
<i>Ex</i>	0.20	0.46	0.20	0.55	-0.577	n.s.	0.14	0.02	-0.02	
<i>Fi</i>	0.29	0.64	0.33	0.69	-0.309	n.s.	-0.36	-0.29	-0.70	

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Table 5. (Continued)

	HG N = 112		NHG N = 82		<i>Z</i>	<i>p</i>	Cohen's <i>d</i>		Cohen's <i>d</i>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			Lis et al. (2007)	Intern. norms (2007)	Exner (2007)	
<i>Food</i>	0.42	0.85	0.48	0.80	-0.608	n.s.	0.23	0.12	0.23	
<i>Ge</i>	0.29	0.64	0.45	0.88	-0.913	n.s.	0.25	0.05	0.28	
<i>Hh</i>	1.04	1.07	1.13	1.18	-0.485	n.s.	0.28	0.19	-0.19	
<i>Ls</i>	0.65	0.93	0.63	0.92	-0.236	n.s.	-0.17	-0.21	-0.28	
<i>Na</i>	0.51	0.70	0.68	0.77	-1.681	n.s.	-0.35	-0.27	0.08	
<i>Sc</i>	1.12	1.21	1.54	1.49	-1.871	n.s.	0.29	0.01	-0.40	
<i>Sx</i>	0.21	0.56	0.30	0.83	-0.746	n.s.	-0.14	-0.35	0.04	
<i>Xy</i>	0.23	0.57	0.23	0.50	-0.155	n.s.	0.12	0.07	0.35	
<i>Idio</i>	0.64	0.85	0.78	1.05	-0.562	n.s.	-0.99	-0.24	0.40	
<i>DV</i>	0.21	0.62	0.37	0.79	-1.611	n.s.	-0.91	-0.55	-0.20	
<i>INCOM</i>	0.25	0.56	0.41	0.75	-1.504	n.s.	-0.20	-0.63	-0.62	
<i>DR</i>	0.07	2.29	0.13	0.54	-0.629	n.s.	-0.27	-0.26	-0.47	
<i>FABCOM</i>	0.24	0.49	0.38	0.68	-1.333	n.s.	-0.02	-0.34	-0.33	
<i>DV2</i>	0.03	0.21	0.04	0.19	-0.797	n.s.	-0.09	0.11	0.21	
<i>INC2</i>	0.13	0.37	0.23	0.55	-1.172	n.s.	0.03	0.09	0.23	
<i>DR2</i>	0	0	0	0	0	n.s.	-0.53	-0.39	-0.33	
<i>FAB2</i>	0.14	0.48	0.35	0.62	-3.122	.002	0.25	0.15	0.25	
<i>ALOG</i>	0.08	0.30	0.10	0.30	-0.630	n.s.	-0.36	-0.21	0.16	
<i>CONTAM</i>	0	0	0	0	0	n.s.	-0.40	-0.27	0	
<i>Sum6SpSc</i>	1.16	1.44	2.02	1.92	-3.487	<.001	-0.87	-0.83	-0.83	
<i>Lvl2 Sp Sc</i>	0.30	0.67	0.62	0.92	-2.842	.004	-0.07	0.08	0.28	

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 5. (Continued)

	HG N = 112		NHG N = 82		<i>Z</i>	<i>p</i>	Cohen's <i>d</i> Lis et al. (2007)	Cohen's <i>d</i> Intern. norms (2007)	Cohen's <i>d</i> Exner (2007)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>					
<i>WSum6</i>	3.91	5.43	7.05	7.07	-3.597	<.001	-0.53	-0.56	-0.57
<i>AB</i>	0.17	0.99	0.17	0.49	-1.890	n.s.	-0.37	-0.17	-0.05
<i>AG</i>	0.59	1.16	0.49	0.76	-0.064	n.s.	0.21	0.05	-0.28
<i>COP</i>	1.02	0.99	0.96	1.24	-1.108	n.s.	0.08	-0.05	-0.92
<i>CP</i>	0.01	0.09	0.02	0.16	-0.860	n.s.	-0.09	-0.08	0.00
<i>GHR</i>	3.75	1.96	3.38	2.24	-0.083	n.s.	-0.24	0.02	-0.65
<i>PHR</i>	2.43	1.90	3.02	2.36	-1.653	n.s.	0.24	-0.19	0.17
<i>MOR</i>	0.71	1.02	0.88	1.08	-1.284	n.s.	-0.42	-0.45	-0.22
<i>PER</i>	0.54	1	0.57	0.86	-1.001	n.s.	-0.28	-0.20	-0.43
<i>PSV</i>	0.11	0.34	0.09	0.28	-0.322	n.s.	-0.18	-0.27	-0.03
<i>PTI total</i>	0.40	0.78	0.89	1.07	-3.540	<.001	-0.21	-0.22	0.48
<i>DEPI total</i>	3.48	1.04	3.93	1.25	-2.234	.025	-0.59	0.41	0.56
<i>CDI total</i>	2.36	1.14	2.72	1.27	-1.900	.057	-0.70	-0.45	0.76
<i>S-CON total</i>	4.12	1.55	4.57	1.52	-2.374	.018	-0.61	-0.35	0.50

Note. ^aCohen's *d* refers to the comparisons between HG and the other samples; bold values indicate large effect size (Cohen's *d* ≥ .8).

Table 6. Comparisons between HG (healthy group) with NHG (nonhealthy group)

Variables	HG = 112	NHG = 82	p	Lis et al. (2007)		International norms		Exner (2007)
				N = 249	N = 4,704	N = 4,704	N = 450	
Styles								
Introversive	25%	19%	n.s.	22%	26%	38%		
Pervasive Introversive	15%	11%	n.s.	9%	16%	6%		
Ambitent	37%	32%	n.s.	38%	31%	18%		
Extratensive	22%	16%	n.s.	18%	16%	31%		
Pervasive Extratensive	10%	7%	n.s.	10%	9%	4%		
Avoidant	15%	30%	.021	22%	28%	13%		
D-Scores								
D Score>0	22%	19%	n.s.	6%	12%	14%		
D Score=0	55%	56%	n.s.	38%	46%	68%		
D Score<0	22%	26%	n.s.	55%	41%	17%		
D Score<-1	8%	10%	n.s.	32%	23%	6%		
AdjD Score>0	25%	22%	n.s.	10%	19%	27%		
AdjD Score=0	60%	56%	n.s.	51%	52%	63%		
AdjD Score<0	15%	20%	n.s.	40%	30%	10%		
AdjD Score<-1	4%	6%	n.s.	15%	13%	3%		
Zd								
Zd>+3.0 (Overincorp)	15%	18%	n.s.	22%	19%	20%		
Zd<-3.0 (Underincorp)	29%	32%	n.s.	25%	29%	14%		
Form Quality								
XA%>.89	18%	7%	.035	28%	19%	45%		
XA%<.70	11%	29%	.003	26%	18%	1%		

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 6. (Continued)

Variables	HG = 112	NHG = 82	p	International norms		Exner (2007) N = 450
				Lis et al. (2007) N = 249	N = 4,704	
WDA%<.85	53%	62%	n.s.	54%	49%	16%
WDA%<.75	16%	34%	.003	26%	20%	2%
X+%<.55	45%	60%	n.s.	57%	55%	12%
Xu%>.20	64%	72%	n.s.	65%	68%	45%
X-%>.20	41%	58%	.029	45%	41%	10%
X-%>.30	10%	28%	.001	22%	14%	1%
FC:CF+C Ratio						
FC>(CF+C)+2	14%	17%	n.s.	15%	13%	15%
FC>(CF+C)+1	25%	26%	n.s.	26%	22%	26%
(CF+C)>FC+1	20%	23%	n.s.	24%	24%	26%
(CF+C)>FC+2	13%	12%	n.s.	12%	15%	14%
Constellations						
S-Constellation Posit.	3%	1%	n.s.	6%	4%	2%
HVI Positive	6%	20%	.006	7%	12%	4%
OBS Positive	0%	0%	n.s.	0%	0%	1%
PTI=5	0%	0%	n.s.	0%	0%	0%
PTI=4	0%	0%	n.s.	1%	2%	0%
PTI=3	4%	11%	n.s.	4%	6%	0%
DEPI=7	0%	0%	n.s.	3%	2%	0%
DEPI=6	3%	11%	.031	12%	10%	4%
DEPI=5	6%	27%	<.001	25%	19%	10%
CDI=5	2%	7%	n.s.	14%	11%	2%

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Table 6. (Continued)

Variables	HG = 112	NHG = 82	<i>p</i>	Lis et al. (2007)		International norms		Exner (2007)
				N = 249	N = 4,704	N = 4,704	N = 450	
CDI=4	10%	23%	.015	29%	25%	25%	7%	
Miscellaneous variables								
<i>R<17</i>	20%	18%	n.s.	37%	25%	25%	6%	
<i>R>27</i>	22%	24%	n.s.	15%	20%	20%	14%	
<i>DQ>2</i>	6%	16%	.034	22%	16%	16%	2%	
<i>S>2</i>	40%	45%	n.s.	44%	40%	40%	38%	
<i>SumT=0</i>	50%	56%	n.s.	50%	57%	57%	19%	
<i>SumT>1</i>	19%	16%	n.s.	20%	15%	15%	17%	
<i>3+(2)/R<.33</i>	45%	33%	n.s.	45%	39%	39%	20%	
<i>3+(2)/R>.44</i>	27%	31%	n.s.	26%	30%	30%	30%	
<i>F++F<0</i>	20%	26%	n.s.	25%	25%	25%	12%	
<i>Pure C>0</i>	18%	21%	n.s.	17%	25%	25%	14%	
<i>Pure C>1</i>	2%	4%	s.s.	5%	7%	7%	2%	
<i>Afr.<.40</i>	20%	16%	n.s.	29%	27%	27%	9%	
<i>Afr.<.50</i>	40%	27%	n.s.	53%	47%	47%	24%	
<i>(FM+m) < Sum Sh</i>	30%	46%	.025	60%	35%	35%	18%	
<i>(2AB+Ar+Ay)>5</i>	5%	12%	n.s.	13%	11%	11%	8%	
<i>Populans<4</i>	13%	17%	n.s.	20%	16%	16%	4%	
<i>Populans>7</i>	14%	12%	n.s.	9%	12%	12%	18%	
<i>COP=0</i>	37%	49%	n.s.	44%	42%	42%	11%	
<i>COP>2</i>	7%	15%	n.s.	8%	13%	13%	36%	
<i>AG=0</i>	66%	63%	n.s.	71%	64%	64%	44%	

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Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 6. (Continued)

Variables	HG = 112	NHG = 82	<i>p</i>	Lis et al. (2007)		International norms		Exner (2007)
				N = 249	N = 4,704	N = 4,704	N = 450	
<i>AG>2</i>	5%	4%	n.s.	2%	4%	4%	7%	7%
<i>MOR>2</i>	6%	9%	n.s.	14%	16%	16%	7%	7%
<i>Level 2 Sp.Sc. >0</i>	24%	43%	.008	23%	17%	17%	13%	13%
<i>GHR>PHR</i>	65%	55%	n.s.	70%	57%	57%	85%	85%
<i>Pure H<2</i>	33%	39%	n.s.	47%	35%	35%	17%	17%
<i>Pure H=0</i>	11%	9%	n.s.	12%	11%	11%	4%	4%
<i>f>a+1</i>	18%	21%	n.s.	15%	21%	21%	10%	10%
<i>Mp>Ma</i>	38%	42%	n.s.	14%	32%	32%	23%	23%

Note. Statistically significant values at least at .05 level are indicated in bold.

Table 7. Spearman correlations

	PTI
BDI-II	.261
	.000
SCL-90-R Somatization	.121
	.092
SCL-90-R Obsessive-Compulsive	.191
	.008
SCL-90-R Interpersonal sensitivity	.095
	.186
SCL-90-R Depression	.232
	.001
SCL-90-R Anxiety	.186
	.007
SCL-90-R Hostility	.203
	.004
SCL-90-R Phobic anxiety	.090
	.213
SCL-90-R Paranoid ideation	.225
	.002
SCL-90-R Psychoticism	.125
	.083
SCL-90-R Global Severity Index	.235
	.001

Note. *PTI* = Perceptual-Thinking Index. *BDI-II* = Beck Depression Inventory II. *SCL-90-R* = Symptom Checklist-90-Revised. Statistically significant values at least at .01 level are indicated in bold.

Participants who score positive on the CDI, when compared with CDI-negative subjects had higher scores on the BDI-II ($p = .051$) and Phobic Anxiety ($p = .029$).

Individuals who scored positive on the HVI, when compared with HVI-negative subjects, had higher scores on the following SCL-90-R scales: Somatization ($p = .011$), Obsessive-Compulsive ($p = .003$), Depression ($p = -.010$), Hostility ($p = .044$), Paranoid ideation ($p = .040$), and the Global Severity Index ($p = .002$). Results are presented in Table 8.

Moreover, significant associations emerged between positive DEPI scores and BDI >12 (Fisher's exact test $p = .004$), Obsessive-Compulsive >55 (Fisher's exact test $p = .009$), Depression >55 (Fisher's exact test

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Table 8. Comparison between positive and negative scores on Rorschach psychopathological indexes, BDI-II, and SCL-90-R scores

	DEPI≥5			DEPI<5			CDI≥4			CDI<4			Positive HVI			Negative HV		
	N = 47			N = 165			N = 41			N = 171			N = 24			N = 188		
	M	SD	Z	M	SD	Z	M	SD	Z	M	SD	Z	M	SD	Z	M	SD	Z
BDI-II	8.28	7.39	5.32	4.41	-2.030	.042	7.90	6.46	5.51	4.95	-1.952	.051	8.13	6.33	5.70	5.16	-1.834	n.s.
SCL-90-R Somatization	47.87	7.35	46.91	6.75	-0.852	n.s.	48.34	6.87	48.84	6.88	-1.414	n.s.	50.63	7.92	46.68	6.63	-2.540	.011
SCL-90-R Obsessive-Compulsive	50.17	9.23	47.07	6.64	-2.031	.042	48.56	7.41	47.56	7.38	-0.945	n.s.	51.88	7.99	47.23	7.15	-3.000	.003
SCL-90-R Interper. sensitivity	48.70	8.74	46.75	6.58	-1.075	n.s.	48.68	7.53	46.82	7.02	-1.737	n.s.	50.25	9.6	46.79	6.70	-1.814	n.s.
SCL-90-R Depression	48.85	8.23	45.64	6.32	-2.561	.010	47.59	7.27	46.06	6.8	-1.515	n.s.	50.63	9.79	45.81	6.27	2.589	.010
SCL-90-R Anxiety	51.11	8.53	47.81	6.89	-2.459	.014	48.90	7.09	48.46	6.8	-0.516	n.s.	51.25	8.31	48.20	7.22	-1.822	n.s.
SCL-90-R Hostility	49.89	8.60	47.04	7.58	-2.077	.038	47.66	7.34	47.67	8.03	-0.371	n.s.	50.13	7.44	47.36	7.90	-2.01	.044
SCL-90-R Phobic anxiety	53.38	5.05	52.23	4.36	-1.674	n.s.	53.76	4.28	52.18	4.55	-2.189	.029	53.33	4.62	52.38	4.52	-0.901	n.s.
SCL-90-R Paranoid ideation	48.77	8.13	45.68	6.99	-2.466	.014	46.9	6.84	46.24	7.49	-0.770	0	49.92	9.35	45.91	6.96	-2.050	.040
SCL-90-R Psychoticism	49.77	7.82	46.09	5.76	-3.064	.022	47.59	6.01	46.74	6.55	-1.037	n.s.	49.75	9.19	46.54	5.94	-1.763	.780
SCL-90-R Global Severity Index	49.64	8.04	46.24	6.49	-3.062	.002	48.17	6.85	46.70	7.02	-1.610	n.s.	51.5	8.82	46.41	6.53	-3.034	.002

A. M. Rosso et al.

$p = .002$), Anxiety >55 (Fisher's exact test $p < .011$), Hostility >55 (Fisher's exact test $p = .020$), Psychoticism >55 (Fisher's exact test $p = .041$), and Global Severity Index >55 (Fisher's exact test $p = .041$).

Positive HVI resulted significantly associated with BDI-II >12 (Fisher's exact test $p = .018$), Somatization >55 (Fisher's exact test $p = .030$), and Global Severity Index >55 (Fisher's exact test $p = .011$). A positive significant association also emerged between positive CDI and BDI-II > 12 (Fisher's exact test $p = .010$).

Discussion

This study was designed to investigate the impact of psychopathology on RCS data for samples of adult nonpatients. As is well known, nonpatient studies included in the JPA Special Supplement published in 2007 showed data that revealed an elevated number of positive DEPI and positive CDI protocols. As we previously stated, these findings were not surprising and are in fact in line with epidemiological data about psychological disorders.

We conducted our study because, in our opinion, RCS reference data on psychologically healthy individuals are necessary. We used very strict exclusion criteria, enrolling in the study only people who were studying or working, who never used psychotropic medications, who never received neurological, psychological, or psychiatric treatment, and who never abused alcohol or illegal drugs.

Several differences were found when comparing our sample and the previous Italian sample (Lis et al., 2007): The most relevant dissimilarities (Cohen's $d >.80$) were related to *SumY*, *SumSh*, *Idiographic Contents*, and *DV*. Smaller, yet statistically significant, differences ($.50 < \text{Cohen's } d < .80$) were found for *es*, *D* scores, *Ay*, *DR*, *DR2*, *SumSpSc*, and *CDI total*. Our sample comprised fewer distressed subjects, with a higher level of coping abilities and a smaller number of cognitive slippages. These differences can be due to the fact that our exclusion criteria were more stringent than those adopted by our Italian colleagues. Discrepancies regarding *Ay* and *Idiographic Contents* could be related to differences in coding because our research group and Lis's research group are based at different sites.

Interestingly, we did not find any major difference between our results and the international norms (Meyer et al., 2007). Minor differences were observed for *Sum Y*, *DR*, *Sum6SpSc*, and *DEPI total*. The results show that

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

our sample comprised healthier subjects, presumably because of the more stringent exclusion criteria applied. Furthermore, we found a lower percentage of positive DEPI and CDI protocols in our sample, compared with the sample of Lis et al. and the international norms.

However, many differences were found in the comparison of our sample with Exner's new sample (Exner, 2007). The most important discrepancies regarded synthesizing ability, reality testing, tendency to perceive positive and collaborative interpersonal relations, coping deficit, distorted perception, and disturbed thinking. Other minor differences were found regarding movement and color responses, *EA*, *Lambda*, *GHR*, *H contents*, *DEPI total*, and *S-CON*. Compared with Exner's study, our sample appeared less psychologically healthy. Considerable differences were also seen regarding coping style. Similar to Lis's sample and to international norms, we found more ambivalent and avoidant subjects in our sample.

Despite the stringent exclusion criteria used, when we analyzed the BDI-II and SCL-90-R scores we found that many individuals reported psychological symptoms in the clinical range. A total of 33 subjects (16%) had scores in the clinical range on BDI-II and 60 subjects (28%) had critical scores on SCL-90-R on at least on two psychopathological scales. Generalized anxiety and phobic anxiety were the symptoms more often reported on SCL-90-R. In our sample, 18% had *T* scores >55 on the Anxiety scale and 28% had *T* scores >55 on Phobic Anxiety. Nevertheless, 33 subjects (16%) had a *T* score >55 on the Hostility scale. Thus, only 112 subjects (53%) in our sample reported not to be suffering from psychological symptoms. When compared with the group of nonpatients who reported psychological symptoms, the HG showed significant differences on the following Rorschach variables: *DQ+*, *FQx-*, *XA* %, *WDA* %, *X+* %, *X-* %, *S-*, *SumC'*, *SumY*, *SumSh*, *Intellectualization Index*, *FAB2*, *Sum6SpSc*, *Level2SpSc*, *WSum6*, *PTI total*, *DEPI total*, and *S-CON total*.

Our results showed that even in a nonclinical sample, the RCS is able to discriminate between diverse levels of psychological pain. Moreover, the variables that discriminate between the two groups are mainly related to painful affects, reality testing, logic, and coherence of thinking. Interestingly, positive DEPI decreased from 38% in the NHG to 9% in the HG, while positive CDI dropped from 30% in the NHG to 12% in the HG. The HG, compared with Lis's sample and international norms, comprised healthier subjects regarding reality testing, painful affects, controls, logic and coherence of thinking, vulnerability to affective disorders and coping abilities, although effect size was only moderate for many variables.

There were, however, significant differences between our HG and Exner's sample, although generally effect size decreased, particularly for form quality and PTI (e.g., effect size regarding $X - \%$ decreased from $d = 1.29$ to $d = 0.88$, and for PTI Cohen's d decreased from 1.19 to 0.48). Concerning color responses, we still found a moderate effect size with a lower number of color responses in our HG. In the HG, we found a slightly increased number of introversive and extratensive subjects and a decreased number of avoidant people; 36% of the individuals were ambitent. Regarding constellations, however, our HG was very similar to Exner's new sample and differed greatly from Lis's sample and from international norms. Only 9 and 12% of healthy subjects had positive DEPI and positive CDI, respectively. Presumably, these findings were partly due to the lower shading responses in our sample, which in turn affected D scores, contributing to a lower DEPI and a lower CDI.

Finally, PTI correlated moderately with scores on BDI-II and many SCL-90-R scales, especially with Depression, Paranoid ideation, and Global Severity Index. Positive DEPI protocols were significantly different from negative DEPI protocols on BDI-II scores and on various SCL-90-R scales, above all Depression, Psychoticism, and Global Severity Index. The only difference seen between positive CDI protocols and negative CDI protocols concerned Phobic Anxiety scores. Positive HVI protocols were different from negative HVI protocols particularly for scores on the Global Severity Index. The RCS psychopathological indexes were significantly associated with higher scores on psychopathological scales.

In conclusion, our findings confirmed to some extent our hypotheses suggesting the need to collect healthy samples in addition to normative and nonpatient samples. Many differences among the adult nonpatient samples could be due, at least partially, to different levels of psychopathology in the samples. The results of our study suggest that in nonpatient samples the variables related to cognitive mediation, ideation, and painful affects could be more frequently associated with higher scores on psychopathological scales. However, at least one question needs to be further addressed. It remains unclear whether, and to what extent, the difference between Exner's sample and the other samples could be due to different levels of psychopathology in the samples and/or to methodological issues.

On the one hand, the results of the current study supports the hypothesis that it is important to have RCS reference data from homogeneous samples regarding psychological health. On the other hand, in this study we could only partly follow the methodological suggestions indicated by

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Ritzler and Sciara (2008), which presents some notable methodological limitations whose impact on the findings is unclear.

As Ritzler and Sciara suggested, we sampled from large and small urban areas, as well as from villages, but our sample is limited to a northern Italian region. We paid attention to warm-up and administration procedures, and each protocol was checked by the first author to evaluate the adequacy of the administration with thorough monitoring of the inquiry phase. Nevertheless, a major methodological weakness was related to examiners. For economic reasons, we have to use graduate students to administer protocols. We carried out their training carefully and used strict evaluation criteria to admit them to participate in the administration, after they had successfully completed their training; however, they were not experienced clinical psychologists.

Each examiner collected very few protocols; this is advantageous in that we avoided bias related to few examiners, but also disadvantageous in that we could not analyze examiner differences. The other major limitation related to subject recruitment procedures. Although each examiner was not acquainted with the participant they administered the test to, all the participants were recruited by graduate students among their acquaintances, and thus inevitably our sample was composed of people who were familiar to students of psychology. Ritzler and Sciara (2008) stated that these selection procedures increase the possibility that the participants are more like the examiners concerning either demographic characteristics or psychological traits.

On the basis of our results, we can infer that form quality, *Sum C*, *Sum V*, *Sum Sh*, *FAB2*, *Sum6SpSc*, *Level2 SpSc*, *WSum6*, *PTI total*, *DEPI total*, *S-CON total* and positivity of the constellations were associated with different levels of psychopathology; however, we do not know whether the differences observed between our sample and Exner's new sample were related to methodological limitations of the current study.

The high number of color and movement responses reported by Exner (although Cohen's *d* yielded moderate values for *M* and *WSumC*) had an obvious impact on coping styles. Our sample, as well as nearly all the other adult nonpatient samples, had a larger number of ambivalent and avoidant subjects than Exner's sample did. This finding may be either the result of a lower level of engagement in the task or an insufficient inquiry about the keywords owing to the lack of experience of the examiners. We are confident in excluding the second possibility, because the first author carefully checked each protocol regarding how the inquiry was carried out; however, we cannot exclude the fact that the limited

clinical experience of our examiners could have contributed to a moderate level of engagement in the task. Of course, it could also depend on the moderate motivation to participate in the research; nonetheless, we found no significant difference in R ($d = -0.23$) between our sample and Exner's sample and only a moderate effect size for Λ ($d = 0.53$). Interestingly, concerning coping style, we observed the same distribution found by Sultan et al. (2004), although they remunerated clinical psychologists to administer the Rorschach. In conclusion, we think that future research should investigate the construct validity of ambivalent style. Moreover, our findings showed that differences in form quality among the different samples were partially related to different levels of psychopathology, but they also showed that the difference between our HG and Exner's new sample remained unexplained. We wonder whether it could be determined to some extent by the subjectivity required when coders do not find the content given by the respondent in the form quality tables. Perhaps the Rorschach scientific community needs more extensive form quality tables, enriched with objects that are currently not included.

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A. M. Rosso et al.

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Summary

This study was designed to investigate the impact of psychopathology on Rorschach Comprehensive System data for samples of adult nonpatients.

As is well known, nonpatient studies included in the *JPA Special Supplement* published in 2007 showed data that revealed an elevated number of positive DEPI and positive CDI protocols. These findings were not surprising as they were in line with epidemiological data about psychological disorders.

In the authors' opinion, psychologically healthy individuals are necessary for Rorschach Comprehensive System reference data, in addition to normative and nonpatients samples.

In the present study, we used very strict exclusion criteria, enrolling in the study only people who were studying or working, who never used psychotropic

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

medications, who never received neurological, psychological, or psychiatric treatment, and who never abused alcohol or illegal drugs.

Despite the stringent exclusion criteria used, many individuals reported psychological symptoms in the clinical range on Beck Depression Inventory II and the Symptom Checklist-90-Revised (SCL-90-R).

A total of 33 subjects (16%) reported scores in the clinical range on BDI-II and 60 subjects (28%) had critical scores on SCL-90-R for at least on two psychopathological scales. Thus, only 112 subjects (53%) in our sample reported not to be suffering from psychological symptoms. When compared with the group of nonpatients who reported psychological symptoms, the healthy group (HG) showed significant differences on the following Rorschach variables: *DQ+*, *FQx-*, *XA %*, *WDA %*, *X+ %*, *X- %*, *S-*, *SumC'*, *SumY*, *SumSh*, *Intellectualization Index*, *FAB2*, *Sum6SpSc*, *Level2SpSc*, *WSum6*, *PTI total*, *DEPI total*, and *S-CON total*.

The results showed that, even in a nonclinical sample, the Rorschach Comprehensive System is able to discriminate between diverse levels of psychological pain. Moreover, the variables that discriminate between the two groups are mainly related to painful affects, reality testing, logic, and coherence of thinking.

Interestingly, positive DEPI decreased from 38% in the nonhealthy group (NHG) to 9% in the HG, while positive CDI dropped from 30% in the NHG to 12% in the HG.

In the comparison between our HG and Exner's sample (2007), main differences were seen for form quality and coping styles. The HG reported lower *XA %* and had more ambivalent style. Regarding constellations, however, the HG was very similar to Exner's new sample and differed greatly from the sample of Lis, Parolin, Salcuni, and Zennaro (2007) and from international norms.

Future research should further investigate the construct validity of ambivalent style and the culturally specific influence on form quality. Moreover, the Rorschach scientific community needs to have more extensive form quality tables, enriched with objects that are currently not included.

Riassunto

Questo studio è stato condotto allo scopo di studiare l'impatto della psicopatologia sui dati del Sistema Comprensivo relativi a campioni di non pazienti.

Come è ben noto, gli studi su campioni di non pazienti inclusi nel Supplemento del JPA pubblicato nel 2007 hanno evidenziato un numero elevato di protocolli con DEPI e CDI positivi. Questi risultati non sono stati sorprendenti essendo in linea con i dati epidemiologici riguardo i disturbi psicologici.

Gli autori del presente studio ritengono che sia necessario raccogliere dati di riferimento in popolazioni psicologicamente sane, in aggiunta ai campioni normativi e ai campioni di non pazienti.

In questo studio sono stati utilizzati criteri di esclusione molto rigorosi, ammettendo allo studio solo studenti e persone occupate, che non hanno mai fatto

A. M. Rosso et al.

uso di psicofarmaci, che non hanno mai ricevuto cure neurologiche, psicologiche o psichiatriche e che non hanno mai abusato di alcool o di droghe illegali.

Nonostante i rigidi criteri di esclusione utilizzati, molte persone hanno riferito sintomi psicologici nel range clinico al Beck Depression Inventory II e al SCL-90-R.

33 soggetti (16%) hanno riportato punteggi nel range clinico al BDI-II e 60 soggetti (28%) hanno riportato punteggi critici al SCL-90-R almeno in due scale psicopatologiche. Quindi solo 112 soggetti (53%) hanno riferito di non soffrire di sintomi psicologici. Confrontati con il gruppo di non pazienti che ha riferito sintomi psicologici, il gruppo sano (Health Group, HG) ha riportato differenze significative per le seguenti variabili Rorschach: *DQ+*, *FQx-*, *XA %*, *WDA %*, *X+ %*, *X- %*, *S-*, *SumC*, *SumY*, *SumSh*, *Intellectualization Index*, *FAB2*, *Sum6SpSc*, *Level2SpSc*, *WSum6*, *PTI total*, *DEPI total*, *S-CON total*.

I risultati hanno mostrato che, persino in un campione non clinico, il Sistema Comprensivo è in grado di discriminare diversi livelli di sofferenza psicologica. Inoltre, le variabili che discriminano i due gruppi sono prevalentemente relative all'esperienza affettiva dolorosa, all'esame di realtà, alla logica e alla coerenza del pensiero.

È stato interessante osservare che la positività del DEPI è diminuita dal 38% nel gruppo non sano (No Healthy Group, NHG) al 9% nell'HG, mentre la positività del CDI è diminuita dal 30% nel NHG al 12% nell'HG.

Dal confronto tra l'HG e il campione di non pazienti di Exner (2007) sono emerse differenze significative riguardo alla qualità formale e agli stili di coping. L'HG ha riportato un minore *XA%* ed è risultato più ambivalente. Riguardo alle costellazioni, invece, l'HG è risultato molto simile al nuovo campione di Exner e molto differente sia dal campione italiano di Lis et al. (2007) sia dalle norme internazionali.

La ricerca futura dovrebbe studiare ulteriormente la validità di costruito dello stile ambivalente e le influenze culturali sulla qualità formale. Inoltre, la comunità scientifica Rorschach necessita di ampliare le tavole di lavoro relative alla qualità formale, arricchendole con le risposte che finora non vi sono incluse.

Résumé

Cette étude a été conçue pour étudier l'impact de la psychopathologie sur les données du Système Intégré (RCS) pour les échantillons de nonpatients adultes.

Comme il est bien connu, les études de nonpatients inclus dans le supplément spécial JPA publiée en 2007 a montré que les données ont révélé un nombre élevé de DEPI positif et protocoles avec CDI positif. Ces résultats ne sont pas surprenants car ils étaient en ligne avec les données épidémiologiques sur les troubles psychologiques.

De l'avis des auteurs, des données de référence du RCS des sujets sains psychologiquement sont nécessaires, en plus des données normatives et des échantillons de nonpatients.

Critères d'exclusion très strictes ont été utilisés, en admettant à l'étude seulement des sujets qui étudiaient ou travaillaient, qui n'utilisent jamais de médicaments psychotropes, qui n'ont jamais reçu des traitements neurologiques, psychologiques ou psychiatriques, qui n'ont jamais abusé de l'alcool ou des drogues illégales.

Are Individuals in Rorschach Nonpatient Samples Truly Psychologically Healthy?

Malgré les strictes critères d'exclusion utilisés, nombreuses personnes ont signalé des symptômes psychologiques de la gamme clinique au Beck Depression Inventory II et à la SCL-90-R.

33 sujets (16%) ont rapporté des scores compris entre la gamme clinique au BDI-II et 60 sujets (28%) avaient des scores critiques à la SCL-90-R au moins dans deux échelles psychopathologiques. Ainsi, seulement 112 sujets (53%) du notre échantillon ont déclaré de ne pas souffrir de symptômes psychologiques. Par rapport au groupe de nonpatients qui ont rapporté des symptômes psychologiques, le groupe en santé (Healthy Group, HG) a rapporté des différences significatives sur les suivants variables Rorschach: *DQ+*, *FQx-*, *XA%*, *WDA%*, *X+%*, *X-%*, *S-*, *SumC'*, *SumY*, *SumSh*, *Index de intellectualisation*, *FAB2*, *Sum6SpSc*, *Level2SpSc*, *WSum6*, *PTI total*, *DEPI total*, *S-Con total*.

Les résultats ont montré que, même dans un échantillon non clinique, le RCS est capable de discriminer différents niveaux de souffrance psychologique. En outre, les variables qui discriminent les deux groupes sont principalement liés aux affects douloureux, à l'épreuve de réalité, à la logique et à la cohérence de la pensée.

Il est intéressant de noter que le DEPI positif a diminué du 38% dans le NHG (Non Healthy Group) au 9% dans le HG, pendant que le CDI positif a diminué du 30% dans le NHG au 12% dans le HG.

A' partir de la comparaison entre l'HG et l'échantillon de Exner (2007), les principales différences sont apparues quant à la qualité formelle et au styles d'adaptation. Le HG a rapporté un *XA%* inférieur et se trouve être plus ambiequal. En ce qui concerne les constellations, au contraire, l'HG était très similaire au nouvel échantillon de Exner et très différente de l'échantillon de Lis et des normes internationales.

Les recherches futures devraient étudier davantage la validité de construit du type de résonance intime ambiequal et la spécifique influence culturelle sur la qualité formelle. En outre, la communauté scientifique du Rorschach a besoin d'avoir plus vastes tableaux de la qualité formelle, enrichis avec des objets qui jusqu'aujourd'hui ne sont pas inclus.

Resumen

Este estudio fue diseñado para investigar el impacto de la psicopatología en los datos del Sistema Comprehensivo Rorschach para muestras de adultos no pacientes.

Como es bien sabido, los estudios de no pacientes incluidos en el Suplemento Especial JPA publicado en 2007 mostraron datos que revelaban un elevado número de DEPI positivo y protocolos con CDI positivos. Estos hallazgos no sorprendieron ya que estuvieron en línea con los datos epidemiológicos sobre los trastornos psicológicos.

En opinión de los autores, se requirieron datos de referencia del Sistema Comprehensivo Rorschach de individuos psicológicamente sanos, como refuerzo de las muestras de los no pacientes de referencia.

A. M. Rosso et al.

Se utilizaron muy estrictos criterios de exclusión, admitiendo en el estudio sólo las personas que estaban estudiando o trabajando, que nunca utilizan medicamentos psicotrópicos, que nunca recibieron tratamiento neurológico, psicológico o psiquiátrico y que nunca abusaron del alcohol o drogas ilegales.

A pesar de los estrictos criterios de exclusión utilizados, muchas personas reportan síntomas psicológicos en el rango clínico en el Beck Depression Inventory II y en el SCL-90-R.

33 sujetos (16%) informaron puntuaciones en el rango clínico en el BDI-II y 60 sujetos (28%) tuvieron resultados críticos en el SCL-90-R, al menos en dos escalas psicopatológicas. Así, sólo 112 sujetos (53%) de nuestra muestra informaron que no sufren de síntomas psicológicos.

Cuando se compara con el grupo de no pacientes que refieren síntomas psicológicos, el Grupo Sano (Healthy Group, HG) informó diferencias significativas en las siguientes variables Rorschach: *DQ+*, *FQx-*, *XA %*, *WDA %*, *X+ %*, *X- %*, *S-*, *SumC'*, *SumY*, *SumSh*, *Índice de intelectualización*, *FAB2*, *Sum6SpSc*, *Level2SpSc*, *WSum6*, *PTI total*, *DEPI total*, *S-Con total*.

Los resultados mostraron que, incluso en una muestra no clínica, el Sistema Comprehensivo Rorschach es capaz de discriminar diferentes niveles de sufrimiento psicológico. Por otra parte, las variables que discriminan a los dos grupos se relacionan principalmente con los afectos dolorosos, la prueba de realidad, la lógica y la coherencia del pensamiento.

Curiosamente, el DEPI positivo se redujo del 38% en NHG al 9% en el HG, mientras el CDI positivo disminuyó del 30% en NHG al 12% en el HG.

De la comparación entre HG y la muestra de Exner (2007), las diferencias principales surgieron acerca de la calidad formal y de las estrategias de coping. El HG informó menor *XA%* y resultó más ambientante. En relación a las constelaciones, en cambio, el HG era muy similar a la nueva muestra de Exner y en gran medida diferente de la muestra de Lis y de las normas internacionales.

La investigación futura debe investigar más a fondo la validez de constructo del estilo ambientante y la influencia cultural específica en la calidad formal. Además, la comunidad científica Rorschach necesita tener tablas más extensas de calidad formal, enriquecidas con objetos que hasta ahora no están incluidos.

要約

本研究は成人の患者ではないロールシャッハ包括システムのデータにおける精神病理の衝撃を調査するためにデザインされた。よく知られていることであるが、Journal of Personality Assessment の 2007 年の臨時増刊号に収蔵された非患者群の研究は DEPI と CDI が該当するプロトコルの数が多いデータを示していた。この発見は心理学的な障害の疫学的なデータに沿ってみれば驚くべきことではなかった。

著者らの考えでは、ロールシャッハ包括システムは基準データとして、規範的な非患者のデータに加えて、心理学的に健康な個人を必要としている。現在、在学しているか就労しており、精神に作用する薬物を使用することがなく、神経学的、心理学的あるいは精神医学的治療を受けたことがなく、アルコールや違法薬物の乱用したことがない人のみがこの研究に参加できるという、非常に厳しい除外基準が取り入れられた。この厳しい除外基準にもか

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かわらず、多くの個人が Beck の BDI-II と SCL-90-R において臨床群の範疇に入る心理学的症状を示していた。

全部で 33 名の対象者 (16%) が BDI-II で臨床群の範囲のスコアを報告しており、60 名の対象者 (28%) が SCL-90-R の少なくとも 2 つの精神病理的尺度において重篤なスコアを示していた。こうして、われわれの標本において、112 名の対象者 (56%) のみが心理学的な症状に苦しんでいないと報告された。心理学的な症状により紹介された非患者群と比較した場合に、この健康群 (HG) は以下のロールシャッフ変数において有意差が見出された: DQ+, FGx-, XA%, WDA%, X+%, X-%, S-, SumC', SumSh, Intellectualization Index, FAB2, Sum6SpSc, Level2SpSc, WSum6, PTI total, DEPI total, S-Con total。この結果は、非臨床群のサンプルであっても、ロールシャッフ包括システムは心理学的な苦痛の異なったレベルを識別することができるということである。さらに言えば、この 2 つの群を識別する変数は、主に苦痛な感情や、現実検討、論理と思考の一貫性に関するものであった。興味深いことに、DEPI 該当は非患者群の 38% から健康群の 9% に、CDI 該当は非患者群の 30% から健康群の 12% に減少した。Exner (2007) のサンプルと比較すると、主な違いは形態水準と対処スタイルであった。健康群は XA% が低く、不定型がより多いと報告された。心理学的な布置に関しては、そうではなく、健康群は Exner の新しいサンプルにとてもよく類似しており、Lis のサンプルや国際的な基準ととても異なっていた。不定型の構成概念妥当性や形態水準の文化に特有の影響についてはさらなる研究がおこなわれるべきであろう。さらに、ロールシャッフの科学的なコミュニティは、今現在は含まれていない対象がより多く含まれる、より幅広い形態水準表を持つことが必要である。