Hi folks -

These often lose formatting in the e-mail process. Hopes this clears it up.
The references are listed. Now Steve does have to give his results so we can
add them in.

Mel.

Rorschach Indicators of Trauma/Dissociation

Dissociation
(From Leavitt & Labott, 1997, Psychological Assessment. Volume 9 (3), 244-249)

1. References to percepts being seen thru veils, fog, mist so that objects
look blurry, unclear or unreal. Ex: People surrounded by clouds or walking
through the mist

2. Percepts defined as vague or far away from other percepts on the same
card. Must convey an exaggerated sense of depth perception or perspective
(looking up at a monster on Card IV doesnít make the cut). Ex: People at a
distance looking through something that is very deep and blurry.

3. Percepts described as shifting, moving or changing rapidly. EX: a
tornado blowing everything apart with debris flying everywhere. Some types
of ìtime-lapse photographyî percepts may also apply.

Of the above 3: 0 = minimal dissociative symptoms
1 = intermediate dissociative symptoms
2 or more = high level of dissociative symptoms likely

Scores greater than one should be followed up. It is not permissible to
diagnose dissociation on the basis of a Rorschach alone. These references
are meant to alert you to possible areas of concern.

Trauma and PTSD

(From International Handbook of Traumatic Stress, 1993, Chapter 16, Patti
Levin, The Trauma Center in Brookline, MA)

Note: These guidelines are derived from group data and may or may not be
seen in any given individual protocol. They are intended to give you a
jumping off point for conceptualizing your thinking.

1. Relatively high number of Y, V and m responses (Signals internal tension,
the most intensely painful affects and a sense of being out of control and/or
a helpless, powerless spectator).

2. Relatively high level of M- and M(none) responses (difficulty connecting
to people and attempts to detach from or disregard traumatic intrusions).

3. Relatively normal scores on Schizophrenia Index (SCHZI) with cognitive
slippage restricted to FABCOM2 (the 2 unimaginable events of the patient and
the trauma coming together at the same time).

4. Relatively little use of any kind of color (FC+CF+C+Cn)

5. When color is present, FC:CF+C that is extreme in either direction
(alternating flooding of affect or psychic numbing). Most commonly, CF+C
will be > FC.

6. Relatively low Afr. and an unusual amount of attention to small,
idiosyncratic detail (Dd). (Whatever the preferred premorbid coping style,
the organism is now trying to back away from pain and affect and trauma.
Denial and avoidance are used as a way of coping with uncontained or
unmanageable affect. Selective attending to the small details of a situation
is one way to do this.)

7. Positive findings on the Hypervigilance Index (HVI) and an elevation in
the use of clothing contents (Cg). (Represents the tendency to be
post-traumatically overly alert to signs of danger or threat in both daily

routines and relationships and a need to maintain a guarded, self-protective
position).

8. Percepts that directly reflect or refer to the patientsí own trauma.

9. X+% low and/or Xu%,X-% high,
WITH
Number of Populars Average
AND
D scores relatively low (Suggests that pt. is aware of conventional
reality but is unable to modulate feelings in a way that allows more adaptive
behavior vs. pt. has poor reality testing.)

10. Zf high (constant attempts at meaning-making), but Zd low (hasty or
impulsive decision-making in an attempt to close own painful stimuli quickly).

11. a:p ratio 3:1 in either direction (Reflects rigid, inflexible thinking,
i.e., getting ìstuckî in the trauma.)

12. Relatively high level of PSV responses (Again, an indication of ìstuck-ness).

13. On the Intellectualization Index, only AB (abstract content) may be
present at slightly higher levels (Patient tries to intellectualize away
psychic threats; to ìunderstand or ìmake meaningî out of what is inherent
illogical, i.e., a reason for the trauma, but is unsuccessful.

14. Contents of sex (Sx) and blood (Bl) are more likely seen than in
non-trauma profiles. (Suggests loss of emotional control or filtering.)

15. Elevations in space (S) response may signal a healthy underlying anger or
hostility.

16. Hd and (Hd) may be relatively high partially as a by-product of many Dd
responses. (This suggests both suspiciousness of others and attempts to
contain situations by attending only to parts of it.)

17. Increased incidence of MOR, Vista (V) and An responses likely correspond to the damaged self-image that is characteristic of PTSD.

COMPARISON OF DSM CATEGORIES AND RORSCHACH VARIABLES

DSM	RORSCHACH
Re-experiencing Symptoms	
Intrusions	M–; CF+C>FC; m&Y; HVI; PSV; Sx&Bl
Dreams	Indices not found
Dissociative symptoms: Flashbacks, etc.	C; concrete, trauma-related responses, m&Y; M–; M (no form); FABCOM2; X+% low; X–% high;AB
Triggers	m&Y; CF+C>FC; D low; maybe V
Avoidance	
Thoughts	Afr low; AB
Situations	Afr low; HVI; Zd; Hd>H
Amnesia	Indices not found
Diminished interest	Afr low; brief records
Detachment	M (no form); Afr; M–; HVI; no T; FD; Pure H<2
Restricted range of affect	Afr; FC+CF+C+Cn
Sense of doom	HVI; May have many MOR
Arousal Symptoms	
Difficulty with sleep	Indices not found
Irritability	m & Y; AdjD score
Difficulty concentrating	Maybe Pure C; Zd

Hypervigilance HVI

Startle Maybe Pure C

Physical hyper-reactivity Maybe Afr & CF+C>FC, MAYBE Pure
C; Maybe concrete, trauma-related
response