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Linguistic Issues in Culturally Sensitive Assessment: A Rorschach Case Study

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Linguistic Issues in Culturally Sensitive Assessment:

A Rorschach Case Study

by

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DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2019.

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Department of Clinical Psychology
DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

**LINGUISTIC ISSUES IN CULTURALLY SENSITIVE ASSESSMENT:
A RORSCHACH CASE STUDY**

presented on September 23, 2019

by

Lauren Margaret Weisberg

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

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9/9/19

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Dedication

I want to dedicate this dissertation to a few different people and critters, but first and foremost, I would like to dedicate this dissertation to myself. This process has been grueling, uncomfortable, and has changed me in so many ways. I am proud of the growth I have accomplished, and of the knowledge and experience I now have and will continue to build. I have doubted myself so many times along the way, but here I am.

I am also dedicating this dissertation to the community of support I have learned to reach out to for help. This dissertation would not have been possible without the love, support, and connection I am so fortunate to have in my life.

To my parents, who have always believed that I was capable of anything I set my mind to: Your love and support has helped me through this process in more ways than you can ever possibly know. I can now finally say "I'm done," when you ask "How is your dissertation going?" for the 367th time.

To Dax, my first and heart horse: You have taught me about patience, compassion, kindness, and love. You have been my greatest form of self-care throughout my doctoral training, and as it turns out, also my greatest teacher. I love you, chicken nugget.

To my partner, Zach: You have been unrelentingly supportive through the final stretches of the dissertation process. You have given me the love and compassion that I often am not able to show myself in times of stress. You have shown me how to cut myself some slack, and I love you for that and so much more.

To George: I am forever thankful to you and Joy for helping me through the most stressful years of my life. Thank you. You will always have a place in my heart.

To Lauren, Kelsey, E.T., Kris, Julia, and Kara: Thank you for the laughter, the love, and the fun that has kept me sane. I know you're always there for me. And I love you.

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I also want to thank my committee members, Alan Lee, Psy.D., and Robert Hubbell, Psy.D. Your knowledge and expertise in the Rorschach have been invaluable, and I have been so grateful for your feedback. The Rorschach is a complex subject, and your guidance has been greatly appreciated!

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Abstract

The Rorschach Inkblot Test ("Rorschach") has historically been viewed as a culturally sensitive assessment instrument because it utilizes nonverbal stimulus cards (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011). As a result, it has been considered a more appropriate assessment tool for bilingual and multilingual patients than assessments which rely heavily on verbal language. However, there are no evidence-based practice recommendations for Rorschach assessment of bi- and multilingual patients, despite the incredible linguistic diversity in the United States and the widespread use of the Rorschach. This dissertation includes a case study of a multilingual French–Israeli immigrant who was admitted to an inpatient psychiatric unit after friends found her with a suicide note. She was subsequently given a psychological assessment battery, including the R-PAS, for diagnostic clarification. The case study was analyzed using a social justice interpretive framework. The case study highlights the issues that arise when administering the Rorschach to bi- and multilingual patients. The case study protocol was scored using the R-PAS. The R-PAS profile illustrates some of the linguistic issues that arise in assessing someone in a non-preferred language, such as word-finding difficulty and challenges differentiating which variables are due to psychopathology and which are due to linguistic issues. The study also provides an overview of the relevant Rorschach literature, including information on the Rorschach Inkblot Test itself (both the CS and the R-PAS), criticisms of the Rorschach, teaching the Rorschach, and a discussion of the case study's Rorschach assessment results.

Keywords: Performance-based Assessment, Rorschach, R-PAS, Multicultural, Language, Culturally Diverse, Case Study Method

Linguistic Issues in Culturally Sensitive Assessment: A Rorschach Case Study

Introduction

The case study selected is of "Yael," a young French-Israeli immigrant who had been living in the United States for several years, and whose first and primary language was Hebrew (second language being French, third language being English). The first time I saw Yael, she was walking slowly into her first treatment team meeting, eyes down with several tissues clenched into her right hand. She looked up briefly when she came into the team meeting, and seemed surprised by the number of people in the room. Nonetheless, she sat down facing an attending and resident psychiatrist, two medical students, a social worker, two social work students, a psychologist and psychology intern, two psychology practicum students, and a nurse. When the resident asked her if she knew why she had been admitted to inpatient psychiatry, she replied quietly with, "Because I want to die." Over the course of the brief interview, we learned that she had suffered several failed back surgeries, a painful and complicated divorce, and was feeling isolated from her Israeli community. Yael's English was accented, which made sense after she told us she was from Israel and had lived in France as a child. No one on the team spoke Hebrew. No one on the team spoke French. Her English was strong enough that a translator (this hospital utilized translator phones) would have hindered more than helped with communication. At times Yael became frustrated when struggling to find a word, or with linguistic nuances that confused the treatment team or took them a few moments to understand.

Yael had a history of several inpatient hospitalizations for suicidality. So she was not a stranger to inpatient psychiatry, though it was her first admission on this unit. After about a week into her admission, her treatment team was becoming increasingly frustrated because her mood had improved, but her suicidality had not. Though no one on the psychology team was able to

speak or assess in Hebrew, the treatment team requested a psychological assessment for Yael. The assessment was administered, scored, and interpreted over the several days following the request.

Included in Yael's assessment battery was the Rorschach Inkblot Test. The Rorschach is a performance-based assessment used to examine personality characteristics and emotional functioning in individual patients. The Rorschach provides insight into the patient's conscious and unconscious thought processes that manifest themselves in thoughts, behaviors, and ways of interacting with the world. The Rorschach can offer "in vivo" information about a patient's reality-testing, problem-solving, coping style, information processing, interpersonal functioning, and sense of self (Meyer et al., 2011). The Rorschach Performance Assessment System (R-PAS) is the most updated scoring system and is utilized to assess a broad range of clinical presentations in individuals of many backgrounds in the United States and around the world (Meyer et al., 2011). However, despite the strengths of the Rorschach, as well as its widespread use, there is little emphasis in the R-PAS on the administration, scoring, or interpretation of protocols for linguistically diverse patients in the United States. The present dissertation focused on the R-PAS because it is the most updated system available for Rorschach interpretation. The R-PAS manual briefly mentions culture in the administration section, but does not include any mention whatsoever of language and its impact on administration, scoring, and interpretation (Meyer et al., 2011). This dissertation used a single case study (Creswell, 2013), meant to highlight the ways language can affect administration, scoring, interpretation, and feedback with diverse patient populations in the United States.

Statement of the Problem

Due to the culturally diverse nature of the United States, many people's primary language

is one other than English. It is important to administer, score, and interpret the Rorschach using a language appropriate for the patient so that they fully understand the task. The R-PAS makes limited recommendations for adapting the Rorschach administration procedures for cultural sensitivity (these recommendations are described in the section on R-PAS administration (Meyer et al., 2011). There are no recommendations listed for linguistic considerations (Meyer et al., 2011). One of the issues with assessing in patients' preferred languages is that there are few psychologists who are competent providing these services in languages other than English. According to a 2015 survey performed by the American Psychological Association, approximately 10.8 percent of those surveyed reported that they are able to provide services in a language other than English. These included Spanish (5.5%), French (1.1%), and other languages (3.7%; American Psychological Association, 2016) which indicates that there may be a need for greater bi- and multilingual training at the doctoral level. This means that many of the patients who are either non-native English speakers, English language learners (ELLs), those who speak English as a second language (ESLs), those who use American Sign Language (ASL), or any other linguistically diverse patients are significantly more likely to be assessed by someone who does not speak their primary language than are patients who speak primarily English. Ultimately, there are no evidence-based practice standards for utilizing the Rorschach with linguistically diverse patients in the United States.

Objectives of the Study

An overview of the empirical Rorschach literature helps to illustrate areas where further research is necessary to help clinicians most ethically utilize the Rorschach with linguistically diverse patients. The purpose of the literature review was to review the recommendations for the ethical and effective administration, scoring, and interpretation of psychological assessment with

culturally diverse patients and to provide a context for better understanding the case study. Rorschach scores are completely dependent on language, including the language(s) of both the administrator and the patient, linguistic nuances, and hearing/speech impairment. A lack of recommendations for linguistically diverse Rorschach practice can lead to complications in administration, scoring, and interpretation. The purpose of the case study was to provide a clinical example illustrating these issues.

Significance of the Study and Potential Stakeholders

For the ethical administration, scoring, and interpretation of the Rorschach in the United States, it is necessary to delve further into the intricacies of how the task of the Rorschach interacts with a patient's language. Spoken language, our main way of communicating, can have an impact on the way a patient interacts with an assessment task. Establishing practice recommendations for Rorschach assessment related to language and comprehension may have implications for the way practitioners approach assessment with ELLs, ESLs, or patients who use ASL. The potential stakeholders, therefore, are both the psychologists utilizing the Rorschach with bi- and multilingual patients, as well as the patients being assessed.

<div align="center">

A Literature Review

</div>

The following section provides an overview of the relevant Rorschach literature, including: (a) information on cultural competence and sensitivity in assessment, (b) linguistic diversity in the United States, (c) use of language in psychological assessment, (d) the history and present use of the Rorschach Inkblot Test (including the Comprehensive System and the Rorschach-Performance Assessment System), (e) criticisms of the Rorschach, and (f) teaching the Rorschach.

Cultural Competence and Sensitivity in Assessment

Competence in the psychological assessment of culturally and racially diverse clients has become increasingly more prevalent in articles published on assessment. Culturally competent and sensitive psychology includes familiarity with the current research on multiculturalism and assessment and an appreciation for people's ethnic and/or racial identity, gender identity, sexual orientation, disability status, socioeconomic status, and how these identities intersect (cf. American Psychological Association, 2017; Magnusson & Marecek, 2012). Sanchez-Hucles and Jones (2005) discuss the importance of multicultural guidelines in developing cultural competence. These guidelines illustrate that all aspects of diversity, including race, racism, and discrimination, must be addressed. The authors emphasized that despite the push toward more culturally sensitive training, there still needs to be more training to help clinicians' ability to engage in dialogues about intersectional identities (cf. APA, 2017). The multicultural psychology literature emphasizes the importance of pursuing continuing education on diverse perspectives, and more generally, improving training on topics of diversity (Sanchez-Hucles & Jones, 2005). These multicultural guidelines for trainees are equally important in psychological assessment (Smith & Krishnamurthy, 2018). The Rorschach's applicability to a culturally and linguistically diverse population can only be better understood in the context of adequate cultural sensitivity and humility of those trained in assessment.

Most research on ethical assessment with culturally diverse patients is through a multicultural psychological lens. *Multicultural psychology* refers to a psychology that examines groups that are shaped in some way by the influences of group identity, oppression, and power. Multicultural psychology has specific underpinnings in feminist research, anthropology, and social psychology (Dana, 2000). The *culture* portion of multiculturalism generally refers to an

individual's different identities, including but not limited to racial identity, ethnic identity, socioeconomic status, gender identity, sexuality, religiousness, and/or spirituality. These identities are "intersectional," meaning that they interact with one another and cannot be understood accurately when they are taken out of context of the other identities (Magnusson & Marecek, 2012). Magnusson and Marecek describe intersectionality as social categories that do not simply "add on to one another," but instead "inextricably intertwine with one another from the very outset such that each takes its meaning partly from the other social categories" (p. 18). Tummala-Narra (2016) talks about how psychoanalytic assessment, including the Rorschach, often does not pay sufficient attention to cultural factors, particularly social identities. Traditional assessment focuses on the intrapsychic complexities of a patient without taking into consideration sociocultural context, which can have a substantial effect on psychological functioning. Examining these types of assessments through a multicultural and feminist lens can help ensure their applicability to a culturally and linguistically diverse patient population.

Linguistic Diversity in the United States

The population of the United States is incredibly diverse. There is ethnic/racial diversity, linguistic diversity, religious diversity, diversity in chronological age, socioeconomic diversity, gender diversity, diversity across sexual orientations, and diversity in mental and physical abilities. Sixty million people in the United States speak a language other than English in their home. Table 1 highlights the wide degree of linguistic diversity in the United States. According to the U.S. Census Bureau (2016), the top languages other than English spoken in the United States (spoken by more than 500,000 people) include Spanish, Chinese, Tagalog, Vietnamese, French, Korean, German, Arabic, Russian, French Creole, Italian, Portuguese, Hindi, and Polish (U.S. Census Bureau, 2016). The Comprehensive System (the Rorschach system preceding the

R-PAS) has been critiqued for lacking cultural sensitivity because its norms were developed in the context of White, European-American beliefs (Ephraim, 2000). However, multiple studies were conducted in the late 1990s and early 2000s to help develop international norms to address these criticisms of the CS (Mihura, Meyer, Dumitrascu, & Bombel, 2013). The R-PAS includes international reference sample data for a number of countries, which continued to address some of the limitations of the CS norms. The authors of the R-PAS created a system that is based on extensive and thorough Rorschach research; however, despite the clear effort to address cultural diversity in the R-PAS international data, there are still limited recommendations for the administration of the Rorschach with linguistically diverse patients (the R-PAS is addressed further in the following sections).

See Table 1 for data from the U.S. Census Bureau on languages spoken in the United States for any first language with over 500,000 people (Hebrew is also included because it is directly relevant to the case study). The table indicates that over 60 million people in the United States speak a language other than English in the home. With such a large number of people speaking a language other than English, it is critical that there are evidence-based recommendations for the psychological assessment of bi- and multilingual patients.

There are limited recommendations for accommodating linguistic diversity in the R-PAS assessment, though there is some research that provides guidelines with recommendations for language use in assessment with large population groups in the U.S. (i.e., Latinx, Black/African American, and Asian/Asian-American). These recommendations are generally not Rorschach specific, and if they are, they date back to the Comprehensive System and have not yet been updated to apply to the R-PAS.

Use of Language in Psychological Assessment

Language is an integral part of the field of psychology, and particularly psychological assessment. The most recent publication of the American Psychological Association's Multicultural Guidelines (2017) include a guideline that specifically addresses language. Guideline 3 states the following:

Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions. (APA, 2017, p. 4)

This guideline calls for both the sensitivity of the psychologist to the patient's preferred language and how that has influenced their experiences, as well as awareness of the psychologist regarding their own language background and how this intersects with the client's language and affects the patient-clinician interaction. Language sensitivity includes considering the ways in which an assessment may not be appropriate, even if it is an otherwise popular assessment tool, when there are both cultural and linguistic differences that require consideration. With regard to language, translation and back translation into English are required for the directions for test-taking and test items. But language translation does not address cultural meaningfulness of items. In all likelihood, "matching" the client and psychologist's languages is indicated if at all possible, but also through trained translators present in sessions, through telephone, as well as online (APA, 2017). Students who are not bilingual need training in the use of interpreters and interpreter-based applications. Monolingual English-only students need to be provided with training on communication from various cultural perspectives (e.g., code switching, high-context

versus low-context communication, linguistic and cultural equivalence; APA, 2017). Language responsiveness improves accessibility, equity, and utilization of healthcare for underserved populations (APA, 2017).

The Rorschach Inkblot Test

In a 2009 study, Musewicz, Marczyk, Knauss, and York (2009) examined current assessment practice, personality measurement, and Rorschach usage by psychologists. Their sample included psychologists holding memberships with either the Society for Personality Assessment (SPA) or the American Psychological Association (APA) and their response rate was 18% (215 respondents). They found that the most important factor in the test selection process was whether or not the test would help answer the referral question. Following this, psychologists also valued a personal sense of competence with the test, ethical guidelines, and the reliability and validity of the test. They found that 72% of respondents currently use the Rorschach (86% of SPA members, 60% of non-SPA members).

The Rorschach Inkblot Test was developed by Hermann Rorschach in the early 1900s. There have been several scoring systems used in the administration, scoring, and interpretation of the Rorschach since its creation. However, the overwhelming majority of practitioners currently utilize either the Rorschach Performance Assessment System (R-PAS) or the Comprehensive System (CS). Because the R-PAS is the most updated system, it was the system of focus in this case study. The Rorschach is comprised of 10 stimulus cards that depict inkblots ambiguous enough to allow for multiple responses to the same card. The administration of the test is completed in two phases: (a) the *response phase*, in which patients are asked only the question, "What might this be?" and are provided with minimal prompting, and (b) the *clarification phase*, when the examiner explores what about the inkblot made the patient think of

that response. Each response and clarification are recorded verbatim by the examiner, which is subsequently coded according to the R-PAS manual. These codes are then systematically interpreted utilizing the R-PAS manual (Meyer et al., 2011).

Clinical utility. The Rorschach can be useful in evaluating several components of a patient's psychological functioning. The Rorschach can help inform the clinician about a patient's ability to tolerate stress, their coping style, their ability to regulate emotion, their self-concept, and their ability to relate to others in an adaptive way. It can also help the clinician understand a patient's reality-testing and perceptual accuracy, which can be useful in evaluating the patient for psychosis. For patients that are overtly defended in a clinical interview or other self-reporting measures such as the Personality Assessment Inventory (PAI) or the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Rorschach can provide some insight into unexpressed suicidality, which can provide the clinician with evidence that warrants further exploration into possible suicidal ideation, intent, or plan.

One of the primary benefits of administering the Rorschach is that it is a covert measure of psychological functioning. It is especially useful with patients who are unwilling or unable to respond to overt measures of psychological functioning in a way that truly represents their psychological functioning, whether it be from a lack of self-awareness, from psychotic symptoms, a denial of psychopathology, or personality problems. It is important to remember that the Rorschach is meant to be integrated with other psychological assessment data to bolster the interpretations made from the test with converging data from additional assessments.

The Rorschach Comprehensive System (CS). The CS was developed by John Exner in 1974 and integrated the five major scoring systems that were in use at the time (Meyer & Eblin, 2012). Though the R-PAS was published in 2011, the CS is still used by some practitioners.

Exner (2001), the author of the CS, emphasized the importance of correct test administration and

for examiners to be well-versed in the language of the CS. Further detail on the CS is not

included because it is not the most updated Rorschach scoring system.

 Criticisms of the Rorschach

     In the late 1990s, several researchers began aggressively questioning the validity of the

Rorschach (Garb, 1999). One prominent article criticizing the Rorschach even suggested the

Rorschach be pulled from all clinical and forensic settings until further research was performed

determining the assessment's validity (Garb, 1999). In this article, the author argued that the

primary basis for the validity of the CS was on a methodologically flawed meta-analysis (Parker,

Hanson, & Hunsley. 1988), and additionally, that the majority of the Rorschach scores used by

clinicians did not have empirical validity. Garb's article called for a "moratorium" on all clinical

and forensic use of the Rorschach, while continuing to research the validity of the Rorschach.

     Though Garb (1999) was clearly opposed to the use of the Rorschach barring further

research, other researchers and practitioners responded with criticisms of Garb's negative

analysis of the Rorschach. Meyer and Archer (2001) acknowledged the "intense controversy"

that has characterized Rorschach assessment throughout its lifetime, though they also offered the

following support of the Rorschach:

> Overall, when all three tests [the Rorschach, MMPI, and WAIS] are placed on
>
> comparable methodological footing that excludes concurrent validity yielded by an
>
> alternative test of the same type, the Rorschach, MMPI, and WAIS obtain generally
>
> similar estimates of global validity […] Although effects of these magnitude are not
>
> dramatic, they are not unimportant either. For instance, these effects are about the same
>
> size as those found for the effectiveness of psychological, educational, and behavioral

treatments, or the extent to which therapists and clients agree on treatment-related

variables. (pp. 490-491)

Meyer and Archer) ultimately concluded that there is no reason for the Rorschach to be the target

of such intense scrutiny (based on previous research supporting its validity) because its validity

issues (outside of concurrent, convergent/divergent validity) were similar to that of other

assessment tools. The authors mentioned limitations of the Rorschach that should be addressed,

including the Rorschach's locus of effectiveness, normative reference groups, reliability and

adequacy of test administration, temporal stability, understudied variables, test-taking styles,

unpublished citations, noncumulative research, cross-cultural applications, incremental validity,

and documenting clinical utility. This paper mentioned criticisms of the Rorschach with ethnic

minority groups (at that time no normative reference data had been developed for widespread

use). However, there was no mention of language or language fluency and how this could

influence test administration, scoring, and interpretation.

The defenders and the critics of the Rorschach continued their battles into the 2010s.

Mihura et al. (2013) published a meta-analysis that examined all articles published (in English)

from 1974 to 2011. The authors found that the "Perceptual Thinking Index" and its two primary

components, "Critical Special Scores" and "Distorted Form" had the largest validity coefficients.

These indexes attempt to measure both thought disorganization and potential psychosis. They

found that the ability of these Rorschach variables to detect and differentiate patients with other

disorders was noteworthy. Other variables that are designed to assess psychological resources

and cognitive complexity were also supported by this meta-analysis (medium effect size

relationship with validity criteria). Other supported variables were "Form-Color Ratio," which

assesses emotional impulsivity or reactivity, and "Suicide Constellation," which assesses suicide

risk. "Sum of Shading," which assesses distressing or irritating internal stimuli, and "Inanimate Movement," which measures mental distraction or agitation (often as a reaction to stressors) were supported as valid measures. "Cooperative Movement," "Morbid," "Anatomy," and "X-ray" were also supported.

The least supported variables (i.e., no studies done, evidence of lack of validity, or low/inconsistent levels of validity) included both variables that receive minimal interpretative emphasis as well as variables that carry more interpretive weight. Among the less emphasized variables were "Animal Movement," "Nonhuman Movement," "Color Projection," "Human Movement," and "Formless" responses. Among the more heavily emphasized variables were "White Space," "Pure Color," "Egocentricity Index," "Processing Efficiency," and the "Coping Style" variables. Many of these variables were not included in Rorschach systems prior to the development of the CS.

The Rorschach critics responded to Mihura et al.'s (2013) comprehensive meta-analysis in 2013. Wood, Garb, Nezworski, Lilienfeld, and Duke (2015) concluded that the Mihura et al. (2013) meta-analysis was thorough and had only missed a handful of published studies that were not included. They re-analyzed the data, and found that Mihura et al.'s (2013) data analysis was accurate and did not appear to be over- or underestimating the validity of the CS. They criticized the meta-analysis for only including published studies and not all studies done on the CS, such as dissertations. They disagreed that the "Suicide Constellation," "Weighted Sum of Color," "Sum of Shading," "Anatomy," and "X-ray" scores were "strongly supported," but otherwise found the results of the meta-analysis to be valid. Perhaps the most significant result of Mihura et al.'s (2013) meta-analysis was that it resulted in Wood et al. (2015) retracting the "moratorium" on Rorschach in clinical and forensic settings.

The Rorschach proponents (Mihura, Meyer, Bombel, & Dumitrascu, 2015) responded to the criticisms of the Mihura et al. (2013) meta-analysis, arguing that some of their criticisms were unfounded. Mihura et al. (2015) felt that the criticism that the 2013 meta-analysis should have included dissertations was problematic, particularly since the Rorschach critics had argued against the inclusion of dissertations in the past because it lessens the quality of Rorschach research. Mihura et al. (2015) agreed with the critics about reducing redundancy in Rorschach variables, and that Rorschach research should continue so that it remains valid and becomes a stronger instrument.

One major criticism of the Rorschach was based on the less standard scoring systems that were used before the development of the empirically supported CS and subsequently the R-PAS. In the past, there appeared to be inconsistency in the interpretation of scores across clinicians, which may be a result of the differences in Rorschach. Another criticism is that the normative data, upon which the CS was based, sometimes leads to overpathologizing of patients, particularly because there is often a tendency to interpret data with a bias toward psychopathology rather than psychological health (Garb, 1999). The development of the R-PAS addressed most of these concerns, and provides updates based on current literature on the CS, which was developed over 40 years ago.

Teaching the Rorschach Inkblot Test. The greatest challenge in training future clinicians in Rorschach assessment is that the test is complex and takes a substantial amount of time to teach, which requires a greater time investment for programs to incorporate the Rorschach into their assessment coursework (Meyer & Eblin, 2012). One major criticism targets the great degree of variance in the way that the Rorschach is taught and trained across various training programs. The test requires a significant amount of training and experience to

administer, score, and interpret (Gurley, 2017). However, Childs and Eyde (2002) found that the

Rorschach was among the top assessments utilized in specific assessment training. In a 2016

survey of practicum sites affiliated with Antioch University New England, 61% (*n*=43) of

practicum sites were using performance-based personality tests, including the Rorschach. The

survey had a 44% (*N*=43) response rate, indicating that there was stability in the data (Roysircar,

Hawes, & Eagan, 2016). Though this is only one university's practicum data, practicum sites for

this program are based throughout New England and in some Mid-Atlantic States, indicating that

the Rorschach is a currently used training tool.

Development of the Rorschach Performance Assessment System (R-PAS)

The Rorschach Performance Assessment System (R-PAS) was published in 2012, and was

developed as an "evidence-focused, internationally-oriented approach to using the inkblot task

based on the latest available research" (Meyer et al., 2011, p. 2). The R-PAS authors began

developing the new scoring system after John Exner's death in 2006. With his death, the CS was

no longer updated to reflect changes in empirical research, nor were the norms updated to reflect

newer research. The R-PAS is the most updated Rorschach system, and continues to be updated

to reflect new empirical research.

The R-PAS is an evidence-focused approach that utilizes international data, and is the

most updated scoring system available for the Rorschach. The authors of the R-PAS specifically

outline the goals of the newer system in the R-PAS manual. They are outlined below:

1. Selecting and highlighting those variables with the strongest empirical,

    clinical, and response process/behavioral representational support, while

    eliminating those with insufficient support.

2. Comparing test takers' scores to a large international reference sample, using

a graphic array of percentiles and standard score equivalents.

3. Providing a simplified, uniform, and logical system of terminology, symbols, calculations, and data presentation, in order to reduce redundancy and increase parsimony.

4. Describing the empirical basis and psychological rationale for each score that is to be interpreted.

5. Providing a statistical procedure to adjust for the overall complexity of the record and a graphical illustration of its impact on each variable.

6. Optimizing the number of responses given to the task in order to ensure an interpretable and meaningful protocol, while drastically reducing both the number of times the task needs to be re-administered because of too few responses and the likelihood of inordinately long and taxing administrations because of too many responses.

7. Developing new and revised indices by applying contemporary statistical and computational approaches.

8. Offering access to a scoring program on a secure, encrypted web-platform from any device that can interface with the Internet (Meyer et al., 2011, pp. 2-3).

The administration phase. The R-PAS has two components of the administration, the initial Response Phase (RP) in which the examiner asks the patient, "What might this be?" and the Clarification Phase (CP; similar to the Inquiry Phase of the CS), in which the examiner asks questions about the initial responses to resolve any coding ambiguities. Both the responses and the clarifications are recorded verbatim. Unlike the CS, the examiner is required to state that two

or three responses are desired for each card, and to remove the card if more than four responses
are provided. A laptop or pen and paper are used to record patient responses. The R-PAS
instructions include a section marked "Cultural considerations regarding seating," which is
described as follows:

> Side-by-side seating is considered more intimate than corner-to-corner and opposite
> seating across a range of Western cultures. Comfort with side-by-side seating can vary by
> culture and examiners should be sensitive to the cultural conventions where they practice.
> In certain cultures, an examiner may need to address this practice more fully by
> acknowledging that the seating arrangement is not common while explaining the need to
> maintain standardized administration despite its awkwardness. (Meyer et al., 2011, p. 7)

Again, no new information is gathered during the Clarification Phase; this time is used to inquire
about responses so that they are coded most accurately. The R-PAS manual provides 25 pages of
detailed instructions about the RP and the CP, including information about prompting, seating,
and even whether to record responses on landscape or portrait-style paper. However, the R-PAS
manual includes no specifications about language-related issues during the administration phase.

 Language in the administration phase. The psychologist and the patient both bring their
own language backgrounds to the administration, and this dissertation study examined situations
in which patients who are bi- or multilingual are providing their responses and clarifications, and
are being asked questions, in English, which is their non-preferred language. The psychologist in
this situation is speaking English, which *is* their preferred language.

 The scoring phase. After the administration phase is complete, the responses and
clarifications are scored. Each response is coded for its orientation, location, space reversal or
space integration, content, object qualities, form quality, popular responses, determinants,

cognitive codes, thematic codes, and oral dependent language.

Language in the scoring phase. The scoring is the phase least dependent on language, because the protocol must be scored in adherence with the R-PAS manual. Though the responses and clarifications may have been influenced by the psychologist and patient's languages, at this point in the process, no modifications can be made to adjust for that influence.

The interpretation phase and the impact of language. The interpretation phase includes information from the Summary Scores and Profiles Pages, as well as integrating information from the clinical presentation. At this stage, the psychologist may include information about the patient's language in their interpretation.

Language challenges and the Rorschach. Language is perhaps the most important factor of culture that impacts the way a patient navigates the Rorschach because the scoring system relies entirely on a patient's verbal responses. Per Angel and Williams (2000), "translation from one complex symbolic system into another requires a deep understanding of each, and even then, the newcomer often remains an outsider" (p. 30). Language is a critical component of the meanings people attach to their experiences. Because some of the scoring of the Rorschach relies specifically on language, it is important to consider its effect on the administration, scoring, and interpretation of Rorschach with non-native English speakers, English language learners (ELL), patients who speak English as a second language (ESL), and hearing impaired or deaf patients. There are also challenges to administering, scoring, and interpreting the test in another language, such as how these results will be communicated to providers (who may speak a different language than the patient being tested), or writing a report in English when the testing was done in another language.

Ochoa, Riccio, Jimenez, Garcia de Alba, and Sines (2004) examined school

psychologists' assessment practice with English language learning students (ELLs). They found

that only 33% of school psychologists who assess ELLs speak more than one language, and that

78% of these psychologists had used an interpreter for psychological assessments (only 52% of

these had received training). Nonverbal and projective measures that do not require language,

such as the Bender-Gestalt Test, House-Tree-Person, and Kinetic Family Drawing, were favored

by psychologists for ELL students. However, these measures have psychometric limitations or

lack any psychometric foundation entirely, and are not as reliable or valid as tests that rely more

heavily on language, such as the Wechsler Intelligence Scale for Children. Of the psychologists

included in the above study, 78% used a measure of language proficiency. This data set was from

a school setting specifically. However, it is likely that psychologists practicing outside of the

school setting face similar challenges, such as speaking only one language, having limited

training with interpreters, test selection issues (Ochoa et al., 2004).

  Most culturally-based modifications take place in the scoring and interpretation phases of

the test, instead of in the test content itself or the administration phase, aside from the language

in which the test is administered (Franchi & Andronikof, 1999). Acevedo-Polakovich et al.

(2007) make four pre-test recommendations regarding language: (a) assessing the patient

language preference, (b) conducting the assessment in that language, (c) assessing the patient's

language proficiency, (d) and documenting the processes to be included in the report. It is also

important to take the patient's level of acculturation into consideration, the clinician actively

working to understand the culture of the patient, and their cultural values and assumptions (Dana,

2013). This case study continues to explore these recommendations considering recent research,

and whether these recommendations are being utilized in current practice.

Multicultural Research on the Rorschach

The argument that the Rorschach is a multicultural assessment is based on the idea that it does not assess the parts of personality that are culture-specific (e.g., communalism, interdependence), but rather targets the overall personality functioning that influences behavior (i.e., reality-testing, coping mechanisms). The Rorschach has been utilized in many different countries, including Israel, Spain, Greece, the Netherlands, Romania, Denmark, Italy, Argentina, Finland, Japan, Brazil and Portugal, most which have European influences (Meyer et al., 2011). Weiner (1996) contends that culture provides the context in which we understand personality, but that it is not what creates the "structure and dynamics" of who we are (Weiner, 1996, pp. 1-2). John Exner, who originally developed the CS, believed that the Rorschach is valid and interpretable across all cultures for these very reasons. Much of the assessment literature that focuses on specific populations in the United States was done utilizing the CS. However, the R-PAS has developed norms for specific racial and ethnic minority groups in different countries (see the R-PAS website) that can be helpful with interpretation of Rorschach data for clients with specific cultural backgrounds.

Meyer, Giromini, Viglione, Reese, and Mihura (2015) published a study exploring the association of gender, ethnicity, age, and education with Rorschach scores (using the R-PAS). They examined archival records from three large, independent samples of adults and of youth. The groups included the Adult Normative Sample, the Adult Clinical Sample, and the Outpatient Children and Adolescent Sample. They found that there were no significant associations with any Rorschach variable for gender in any group, nor were there significant associations or for age in the Adult Clinical Sample. However, in the Adult Normative Sample, the authors found that the V-Comp (Vigilance Composite) decreased with age and that T (texture) and PER

(personalization) increased with age. There were only two significant findings for ethnicity: (a)

PER (personalization) was higher in "Whites" than "Other Ethnicities" and, (b) Anatomy was

higher in "Other Ethnicities" than in "Whites." In the Adult Normative Sample. There were also

significant findings related to Education. In the Adult Normative Sample, Complexity, MC (the

Sum of Human Movement and Weighted Color), M (Human Movement), YTVC' (Sum of

Shading Variables), W% (Percent of Whole Responses), WSumC (Weighted Sum of Color),

SumH (Sum of Human Content), and V-Comp (Vigilance Composite) all increased with

increasing years of education. F% (Percent of Pure Form) and Dd% (Percent of Unusual Detail

responses) decreased with increasing years of education. In the Adult Clinical Sample,

Complexity, Sy (Synthesis), and MC increased with increasing years of education, whereas F%

decreased with increasing years of education (Meyer et al., 2015).

       Limitations of Rorschach research with ethnic and racial minorities. Overall, there

has been little research conducted that formally addresses the relationship between linguistic

diversity and performance-based tests. Earlier Rorschach researchers (pre-CS) were faced with

research encompassing the five major scoring systems in use (among others), which made it

difficult to compare research over time (Gurley, 2017). Both the CS and the R-PAS have

complicated scoring and interpretive systems, which make the Rorschach a difficult

psychological assessment to research without pre-determined hypotheses because there are

dozens of variables that can be tested (Nath, Lee, Belcher-Timme, & Chau, 2014).

       Deaf and hearing-impaired Rorschach assessment. Minimal research has been done

on the Rorschach and hearing impaired or deaf patients. Schwartz, Mebane, and Malony (1990)

compared Rorschach administration methods (using the CS) with patients whose preferred

language was American Sign Language (ASL). The authors compared written administration and

signed administration (using a counterbalanced test/retest design—each participant was given a Rorschach with written and signed administrations). The sample included 24 college-aged prelingually deaf adults. They found that there was underreporting of certain variables that were challenging to articulate in the written administration, and that these differences indicated that a signed administration was preferable to a written administration. The authors emphasized the importance of developing norms for deaf patients.

Research Questions

The following research questions guided the case study:

Question 1. Does applying standard Rorschach administration, scoring, and interpretation procedures to non-native English-speaking patient protocols contribute to overpathologized Rorschach interpretations?

Question 2. What are the language-related issues necessary to address in clinical practice for Rorschach assessment?

Conclusion

Ultimately, this case study is intended to highlight some of the practical issues clinicians encounter when administering a Rorschach to bi- or multilingual patients. The case study was not be a comprehensive illustration of these issues, but rather a start to shed light on how current practice methods are inadequate in producing a completely valid and interpretable protocol for bi- and multilingual patients. The following chapters detail the case study methodology, the "results" (including the Rorschach protocol, R-PAS coding, and components of the assessment report), and the discussion of these results.

Method

The goal of the case study was to illustrate challenges and problems that arise when the

Rorschach is given to ELL, ESL, and bilingual/multilingual patients by examining a Rorschach

"instrumental" case study. In an instrumental case study, the researcher selects a particular issue

and cultivates assertions about this issue based on a case study analysis (Creswell, 2013). For the

present examination, the case was intended to highlight linguistic issues for bilingual and

multilingual patients assessed with the R-PAS in the United States, and how these issues affect

the overall validity of the assessment (Creswell, 2013). Earlier in the first section, the initial story

of Yael's inpatient admission and emotional distress throughout her hospitalization was

presented. There has not yet been an examination of an R-PAS ELL or ESL case.

Social Justice Theoretical and Interpretive Framework

Social justice theory was utilized for the case study as the theoretical framework to guide

interpretation of results. This theory recognizes the potential bias of the researcher, the role of

the researcher, and the lens of the researcher as inherently subjective (Creswell, 2013).

In research done through a social justice theoretical lens, the problems, research questions, and

interpretation of results focus on societal-level power differentials such as hierarchy, hegemony,

racism, sexism, ableism, homophobia, transphobia, etc. Social justice research has foundations in

both feminist and multicultural research, which have criticized the current research base for

upholding the status quo that perpetuates those marginalized on the basis of race, ethnicity,

gender, language, sexual orientation, disability, immigration status, religion, and any other

marginalized social identity (Fassinger & Morrow, 2013).

In addition to acknowledging the researcher's bias, it is important that the researcher also

acknowledge that the research is a co-construction between researcher and participant, and that

the participant is actually the owner of the information gathered, not the researcher. Ultimately,

the goal of research is to create distinct steps forward to rectify the social justice issue

highlighted, as well as provide a call to action (Creswell, 2013). The case study seeks to

highlight the need for "best practice" recommendations for R-PAS assessment with bilingual and

multilingual patients, which constitute the "steps forward" to rectify the social justice issue

highlighted (i.e., inherent bias in English-based psychological assessment).

There are many possible outcomes to a social justice research project, including the

research project itself being a social change intervention or empowering the participants through

the research process (Fassinger & Morrow, 2013). In this case, the impact of the case study is to

consciousness-raise about a particular issue that is grounded in social inequality (i.e., bi- and

multilingual patients who do not speak English as their primary language are more likely to be

psychologically assessed in a non-preferred language than are native or primary English

speakers).

Procedure of Case Study

The case example is from a doctoral level-practicum placement on an inpatient

psychiatric unit at a large, northeastern medical center. The case has been de-identified.

Typically, the R-PAS protocol (including responses and clarifications) is not included in an

assessment report. However, this assessment data protocol is provided to develop the case study.

The background information on the case is an amalgamation of several patients (all of whom

were non-native English speakers) who were hospitalized on an inpatient unit and tested using

the Rorschach Inkblot Test. However, the assessment protocol is a real clinical protocol and is

unaltered to retain the integrity of the responses and scores.

The following questions were addressed for the case example:

1. What were the barriers to a culturally sensitive administration, scoring, and interpretation

    of the Rorschach based on Yael's language background?

     a.   How were these addressed?

     b.   What problems may have arisen as a result of these barriers?

2.   In a culturally-informed and culturally sensitive R-PAS, what language-related adaptations and accommodations could be made in the future?

     a.   Language proficiency (of psychologist and/or patient)

     b.   Use of a translator

     c.   Inclusion/exclusion of the Rorschach

     d.   Feedback to patient

     e.   Feedback to treatment team

     f.   Professional consultation

Acknowledging researcher bias and privilege. Acknowledging privilege, biases, and expectations, as required by feminist, social justice, and critical race research theory was important because it allowed for the identification and acknowledgement of biases to help mitigate their effect and thus allow the reader to contextualize the results of the study. Therefore, a self-analysis of researcher bias are included in Appendix A.

Conclusion

There is minimal research on the Rorschach with bilingual and multilingual patients in the United States. The case study methodology was selected because it illustrates some of the issues that arise in Rorschach assessment with bi- and multilingual patients, and also highlights the areas for potential future research.

Results

The purpose of this case example was to illustrate some of the language-related issues that arise when administering the Rorschach in clinical practice with linguistically diverse

patients. On the inpatient unit in which Yael was hospitalized, patients were consulted about

psychological testing. Yael was interested in testing and willing to complete an assessment

because she was hopeful that it would provide her treatment team with more information. She

felt that her team did not understand the nature of her physical and psychological pain, and was

frustrated by being unable to communicate how she was feeling to her team. Yael was engaged

with the assessment tasks presented to her, and though at times she became upset or frustrated,

she persevered. There were no behavioral issues that would have invalidated her assessment

results. The following information is the background portion of the assessment report (with some

information amalgamated from other cases for the purposes of anonymity). Following the

background information is the unaltered R-PAS protocol, the R-PAS scores, and the Summary

Scores and Profiles (Page 1), and an explanation of these scores and profiles.

<p align="center">**"Yael": An Integrated Case**</p>

Presenting Problem

Yael is a single, 34-year-old Israeli-American cisgender woman living in a medium-sized

northeastern city in the United States. She was admitted to inpatient psychiatry after two friends

brought her to the emergency room. Her friends had come over to surprise her with dinner, and

they found Yael writing a suicide note. Yael reported that she had been planning to drive off of a

cliff in a nearby state park, where another person had died around the same time the previous

year. Yael has an abundance of recent stressors, including a costly and complicated divorce,

chronic pain from three failed back surgeries, and isolation from her Israeli community. Four

days after admission, Yael appeared less tearful and agitated in treatment team meetings, but was

continuing to disclose a wish to die by suicide in individual sessions. Her treatment team

(including an attending psychiatrist, two resident psychiatrists, two medical students, a nurse, a

social worker, and social work students) had been unable to discharge her due to ongoing
concerns about suicide. Yael's team requested a psychological assessment to inform her
treatment and discharge plan, to help support her outpatient psychologist in addressing safety
concerns, and for diagnostic clarification.

      Social history and development. Yael's extended family resides in Israel, and both her
parents and younger two brothers currently live in Israel. Her parents moved their family from
France to Israel when she was 14 years old. Though Yael spoke both French and Hebrew in her
childhood home in rural France, once she moved to Israel she spoke primarily Hebrew both at
home and socially.

      Yael had visited the United States multiple times throughout her childhood, spending
summers at sleepaway camp in the mountains of the northeast. She described having learned
English primarily at these camps, but that she also took English classes while she was living in
France and in Israel. Yael participated in the mandatory military service in Israel (2 years), after
which she moved to the United States when she was 21 years old for college (after a year of
traveling). Following college, Yael completed a Master's of Business Administration program.
Yael met her ex-husband while in this program, and though he was also from Israel, he had
moved to the United States at a much younger age and they spoke primarily English together.
Yael felt that her ability to communicate her needs in her marriage was complicated by her
comfort with speaking English.

      Cultural background. Yael continues to identify as Jewish, but now only observes
Shabbat and major holidays whereas her family continues to observe Orthodox Judaism. She
stopped keeping Kosher when she moved to the United States, and has not told her parents or
brothers. Yael says that she misses France and her "simpler" life there; she and her family lived

in a more rural area of France, and she said that she had a "culture shock" when her family

moved just outside of Tel Aviv, Israel. Though Yael does not practice Judaism as rigorously as

when she lived in Israel, the isolation she feels from both her Israeli and Jewish communities

causes her anxiety. She stated that "no one is like, openly anti-Semitic," but they also "don't get

it" when it comes to her faith.

Family relationships. Yael reports that her relationship with both her parents is "pretty

good" and that she is close with her two younger brothers. She sees her family 3-4 times per

year, either when she returns to Israel, or when they visit her in the United States. Yael described

her relationship with her mother as a young child as "distant" because her mother struggled with

post-partum depression after the birth of each of her three children. She reports feeling more

emotionally supported by her father, but that his travel for work throughout her childhood was

hard for her. She said that the initial adjustment to moving to Israel was difficult, but that

ultimately it allowed for her family to grow closer because her father no longer needed to travel

for work.

Employment history. Yael has been working for a small non-profit company since she

earned her M.B.A. She describes the work as "easy," and that work has "never been too

stressful." She described feeling grateful about having a job that she likes, and that she feels

guilty because other people do not necessarily like their jobs. Prior to that, her parents wanted

her to focus on school and for her to have the opportunity to travel, and so they supported her

financially.

Mental Health History

Yael has had had two prior inpatient admissions (one at age 22 for suicidal statements,

the next at age 27 for a suicide attempt via car accident with no major injuries). Yael finalized

her divorce from her husband of six years approximately two months prior to her current admission, and was seeing an outpatient therapist throughout the duration of the divorce. She said that the therapist was helpful, but that when she started having more serious suicidal thoughts, she stopped attending sessions.

Family mental health history. Yael's mother struggled with post-partum depression after each of her three pregnancies. Yael's uncle on her father's side completed suicide before Yael was born, a part of her family history that she only recently discovered. Yael said that there may be other family mental health concerns, but that much of her extended family generations back were killed in the Holocaust, including her maternal grandparents.

Physical health history and medical issues. Yael utilized a cane to ambulate to each testing session. She has had several failed back surgeries, which have resulted in chronic pain and limited mobility. Prior to the back surgeries, Yael was active and exercised regularly. She has historically refused any opioid pain medication because she feels it makes her "foggy," but will take Naproxen, apply heat, and utilize Diclofenac gel throughout the day to help manage her discomfort. Yael's doctors have recommended an additional surgery to fix the issues from the initial surgeries, but she is anxious and skeptical of undergoing surgery again.

Substance use/misuse and other addictive behavior. Yael reported that she drinks 1-2 glasses of wine once a week on Shabbat, or for other religious occasions but rarely drinks otherwise. She denied use of any other substances.

Mental Status Exam and Behavioral Observations

Yael is a White, Jewish, 34-year-old cis-woman. She is of an average build, with dark hair and green eyes, and an otherwise unremarkable physical appearance. She presented to psychological testing dressed in hospital scrub pants and a sweatshirt, which is appropriate given

the inpatient setting. Yael was cooperative throughout testing and her speech was of normal rate and volume. She appeared able to understand the questions asked of her and was able to explain recent and past events in her personal history. Yael was oriented x3, alert, coherent, and attentive throughout testing. Yael appeared to have adequate judgment and impulse control, but limited insight into her psychological distress. Yael became tearful several times throughout testing, and this was congruent with a generally dysphoric mood. Yael was of low risk for harming others. She continued to express clear suicidal ideation, intent, and plan and should be considered high risk for dying by suicide.

        During the initial testing interview, Yael expressed frustrations multiple times at an inability to "find the right word." That being said, Yael was able to articulate details of her history clearly enough to report a solid psychosocial history, her mental and physical health history, and her current symptoms.

        Other psychological assessment. Yael was able to complete a full assessment battery for the purposes of diagnostic evaluation. These tests included the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV), the Thematic Apperception Test (TAT), the Rey-Osterreith Complex Figure, and Trailmaking Test A & B.

Rorschach Inkblot Test Response and Clarification Protocol

        The overall assessment administration took place over two sessions, and the Rorschach was given toward the beginning of the first session. During the Rorschach administration, Yael was tearful and had to pause several times throughout the administration to blow her nose, or to wipe away tears. She was shaking her leg throughout most of the administration, though it was unclear if this was due to habit or to testing-related anxiety. Yael remained on-task throughout

testing, and stated several times that she hoped it would help the treatment team make changes

that would be more helpful to her (she did not specify what these might be). Yael was able to

engage in casual conversation, and only encountered word-finding difficulties a handful of times.

From a linguistic perspective, she was also able to navigate the Rorschach well; however,

word-finding difficulties did arise in several different responses, which unfortunately were not

recorded in the protocol. The assessment protocol is included in Table 2.

R-PAS Scores

The scores included in this dissertation were scored by me in conjunction with her

clinical supervisor. Table 3 includes the R-PAS codes from the R-PAS protocol in the previous

section. Table 4 is a glossary of the codes in Table 5.

R-PAS Summary Scores and Profiles (Page 1)

The R-PAS Summary Scores and Profiles—Page 1 is the focus of this section because

Page 1 has a stronger evidence base (Meyer et al., 2011, p. 396). These scores are all listed in

Table 5. Yael's Summary Scores and Profiles were inconsistent and interpreting the protocol for

clinical purposes was complicated. The language issues were significant and therefore made it

difficult to differentiate true psychopathology from linguistic issues in scoring. The following

subsections include a breakdown of the Summary Scores and Profiles (Page 1) for the purposes

of exploring the variables where language issues may have had an impact on scoring.

Over half of the variables on the Summary Scores and Profile were within normal limits,

though there were some scores that were extremely atypical (i.e., more than two standard

deviations above the mean). The following sections describe the variable scores under each

Domain section of the R-PAS Summary Scores and Profiles—Page 1 Report.

Administration Behaviors and Observations Domain. In the *Administration Behaviors*

and Observations Domain, Pulls (Pu=0, SS=96), Card Turning (CT=1, SS=95) were both within

one standard deviation of the mean. Also, under this domain were Prompts (Pr=6, SS==134).

This may have in part been due to administrator error (over-prompting), difficulty understanding

or meeting the task requirements, or resistance to the task itself.

Engagement and Cognitive Processing Domain. All but one variable in the

Engagement and Cognitive Processing Domain were within normal limits, including Complexity

(Complexity=77, SS=104), F% (F%=31%, SS=91), Blend (Blend=3, SS=97), Synthesis (S=9,

SS=109), Human Movement and Weighted Color (MC=7.5, SS=103), Human Movement and

Weighted Color Minus Potentially Problematic Determinants (MC-PPD=0.5, SS=103), Human

Movement (M=5, SS=109), and Human Movement Proportion (M/MC=67%, SS=110). The

number of Responses (R=16, SS=60) was low and can contribute to protocol validity issues. In

the reference sample used to tabulate these results, the mean number of responses (R) was 24.2

and the modal number of responses was 20.0 (Meyer et al., 2011).

Perception and Thinking Problems Domain. The *Perception and Thinking Problems*

Domain had no variables within normal limits. Four of the eight scores in this domain were over

two standard deviations above the mean, including the Ego Impairment Index-3 (EII-3=4.3,

SS=143), the Thought and Perception Composite (TP-Comp=5.4, SS=142), Form Quality Minus

Percent (FQ-%=50%, SS=143), and Whole and Common Detail Form Quality Minus Percent

(WD-%=50%, SS=143). Three scores were nearly two standard deviations above the mean,

including Weighted Sum of the Six Cognitive Codes (WSumCog=25, SS=129) Form Quality

Ordinary Percent (FQo%=31%, SS=72), and Populars (P=2, SS=73). The remaining score on

this Domain, Severe Cognitive Codes (SevCog=1, SS=113), was close to one standard deviation

above the mean. The scores on this domain were primarily driven by Level 1 codes. This finding

is explored in greater depth in the following section.

      Stress and Distress Domain. The *Stress and Distress Domain* had only one score, Morbids (MOR=12, SS=146) that was outside the norm, though this score was three standard deviations above the mean. The Sum of Shading and Achromatic Color (YTVC'=4, SS=100), Inanimate Movement (m=2, SS=106), and Suicide Concern Composite (SC-Comp=5.0, SS=106) were within normal limits.

      Self and Other Representation Domain. The *Self and Other Representation* Domain had two scores over two standard deviations above the mean, including Poor Human Representation Proportion (PHR/GPHR=91%, SS=134) and Whole Human Content (H=11, SS=140). The Human Movement Form Quality Minus (M-=3, SS=129) and Aggressive Content (AGC=0, SS=74) were both approximately one standard deviation away from the mean. The Oral Dependent Language Percent (ODL%=12%, SS=105), Space Reversal (SR=0, SS=87), Mutuality of Autonomy Pathology Proportion (MAP/MAHP=75%, SS=118), Cooperative Movement (COP=1, SS=102), and Mutuality of Autonomy Health (MAH=1, SS=105) were within normal limits.

Language-Specific Scoring and Interpretation

      Overall, Yael's protocol had eight "Deviant Verbalization" codes (DV), all of which were Level 1 and none of which were Level 2. There were three "Deviant Response" codes (DR), two of which were Level 1 and one of which was Level 2. The remaining Cognitive Code was an INC1. These scores all contribute to the EII-3 Composite Score (the Ego Impairment Index-3), which was elevated almost three standard deviations (EII-3=143). The other components of the EII-3 include M-, GHR, PHR and the Critical Contents (both of which were also substantial, but less related to language issues). The EII-3 is a measure of thinking disturbance and severity of

psychopathology.

Conclusion

Yael's Rorschach presented several significant interpretation challenges due to multiple

profile scores being two to three standard deviations above the mean. The complexity of her

R-PAS profile scores were, at first glance, inconsistent with the suicidality and depression with

which she was struggling. However, upon closer inspection, Yael's scores were not necessarily

uninterpretable, but required more nuanced interpretation. The interpretation challenges of

Yael's Rorschach will be discussed in the following chapter.

<div align="center">

Discussion

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The aim of the case study was to highlight inherent issues in Rorschach assessment with

linguistically diverse clients and patients, particularly multilingual or people whose first

language is not English. Yael's case is not unique; there are many patients across the United

States who are bi- or multilingual who are assessed with psychological instruments designed for

English-speaking patients. The results illuminate how there are multifaceted issues in assessing

linguistically diverse patients without evidence-based recommendations for culturally and

linguistically-sensitive assessment. These will be described in the following sections.

Research Questions

The aim of the case study was to explore two research questions: (a) "Does applying

standard Rorschach administration, scoring, and interpretation procedures to non-native English

speaking patient protocols contribute to overpathologized Rorschach interpretations?" and (b),

"What are the language-related issues necessary to address in clinical practice for Rorschach

assessment?"

Major Findings

The scoring of Yael's Rorschach was challenging and time-intensive. The R-PAS coding rules for "Deviant Verbalizations" (DVs) and "Deviant Responses" (DRs) indicated that almost every one of Yael's responses included at least one DV or DR, and that many of these appeared to be a result of language issues (related to English being her second language). Yael's coding, therefore, was likely going to overpathologize her presentation and indicate that she was suffering from more severe psychopathology than was actually present. However, the degree to which her codes affected the Summary Scores and Profiles is impossible to determine. The variables in the *Perception and Thinking Problems Domain* were primarily driven by "Level 1" codes; despite the variables being extremely elevated, the "pathology" that drove these elevations were primarily minor errors in language or thinking. Knowing Yael's complicated language background is helpful in interpreting Yael's Rorschach because it contextualizes the minor errors. When ignored, it is possible that her scores may be interpreted as severe psychopathology, including virtually no ability to reality test, to organize thought, interpret reality, or function at all according to social norms and mores. In the context of her multilingual background, these scores more likely indicate either subtle disorganization due to depression, testing in a non-primary language, or both. Though Yael was on an inpatient unit, the level of pathology indicated by this index is above and beyond even extreme psychopathology sometimes present in inpatient psychiatric patients.

The most glaring barrier to a culturally sensitive administration was that there was no clinician available to administer the Rorschach in Hebrew, which was both Yael's first and preferred language. Though Yael was proficient in English and completed her M.B.A. program in the United States, there were clear language issues throughout her Rorschach protocol that are

characteristic of someone who does not speak English as their first language. Because of the limited resources and time allowed for both Yael's admission and psychological assessment, this issue went completely unaddressed throughout the assessment, as well as throughout her treatment while admitted. The language issue was clear to Yael, and at times she became mildly frustrated when encountering word-finding difficulties. Though this is sometimes a result of thought blocking or other disturbed mental processes, in Yael's case it appeared to be a result of a failure on the treatment team and the psychology team's part to accommodate her language needs. However, it is possible that these issues were, in fact, due to a problem with her mental processes, and those issues went unaddressed because they were attributed to a problem with language.

According to R-PAS guidelines, the linguistic issues in the protocol were coded as both deviant verbalizations and deviant responses. The decision of what is a linguistic issue versus a thought-quality issue then becomes a problem of interpretation. This can be problematic because there is no certain way of knowing if the verbal slip is due to a language issue, psychosis, depression, anxiety, or trauma, or a combination of these factors. Scoring the protocol in strict adherence to the R-PAS manual guidelines is necessary for a valid protocol, but may lead to overpathologizing of a patient's responses; however, there are no clear guidelines in the R-PAS manual regarding the interpretation of linguistically-diverse protocols. A high-quality R-PAS training program would train students in these issues, however, there is no standard empirically supported procedure for interpreting the protocols of bi- or multi-lingual patients in the United States.

One of the major criticisms on the Comprehensive System was that it was not sensitive to different cultures around the world, a problem solved by the R-PAS's international reference

norms. Unfortunately, there are no norms for immigrants in the United States who have experienced different degrees of acculturation, and may have cultural symbols that are missed by their native country, the U.S. norms, and/or the interpreter. It is virtually impossible to create norms that would encompass the linguistic diversity in the United States due to the great degree of variability in acculturation and language-learning in bi- and multilingual people. In the best case scenario, an assessor will compare subject scores from the general reference sample (American-English) with a specific cultural or linguistic group (i.e., Hebrew) to find possible outlier variables. However, this burden falls on the assessor, which adds additional time and energy required to complete the assessment.

The interpretation is also affected by these linguistic issues because it is based on issues in both administration and scoring. There is also the problem of whether the interpretation should err on the less pathologizing side (assuming the language issues influenced the scoring, leading to higher scores on the cognitive and language reasoning scores), or adhere more strictly to the information available. In Yael's case, the team of practicum students and supervising psychologist opted for a less-pathologizing interpretation given the variety of sociocultural factors that were influencing Yael's presentation. The scores indicated that she had significant enough thought disturbance to indicate an issue with psychotic thought processes; however, nothing in her history (including family history), or her clinical presentation indicated the presence of a psychotic disorder.

Due to these linguistic issues in Yael's assessment, it is possible that the Rorschach results interpreted were an inaccurate picture of her psychological health and pathology at the time of testing. Unfortunately, because there is virtually no research on this issue, it is impossible to know the ways in which her Rorschach scores were affected. In an ideal assessment for Yael,

there would have been a psychologist who could assess Yael in Hebrew. Alternatively, Yael could have been given a test of language proficiency; however, there is no research on the effectiveness of testing for language proficiency prior to utilizing the R-PAS, and how this affects performance on the assessment itself. There has also been no research on the use of a translator with the R-PAS. Use of a translator may lead to issues in translation, or the possibility that cognitive slippage is not recorded due to difficulty translating word errors or linguistic nuances from one language to another. If all of these issues are present and cannot be addressed, it may be necessary to exclude the Rorschach from the assessment battery. Though this is not recommended in culturally-sensitive assessment, neither is the administration of a test that may be inaccurate because of a patient's English proficiency. If the Rorschach had been excluded from the assessment battery, it would have been prudent to include the exclusion and the reasons for exclusion in the psychological assessment report.

The feedback to the patient is an important part of the assessment because it offers the opportunity for the patient to learn about what brought them to the hospital, and also to disconfirm any problematic or inaccurate information in the assessment report, based on the patient's level of insight and ability to reality-test. Ideally, the patient's feedback should be in their preferred language; however, in Yael's case that was not possible. The difficult feedback session highlighted the importance of communicating with Yael in her preferred language, and though she appeared to understand the results, conveying those results to her in English was a frustrating experience for her. Yael was also frustrated that a portion of the assessment was invalid, however, was open to hearing the overall feedback. Because the remainder of the testing was overall valid, Yael still received assessment results, even though she received no feedback on the Rorschach.

As with any assessment report, it is important to convey the findings and any mitigating factors to the treatment team, and in Yael's case that included how her multilingualism may have affected the accuracy of her testing results. Professional consultation with colleagues who regularly administer the Rorschach with linguistically diverse patients may also be beneficial. However, because R-PAS offers no guidelines for linguistically-diverse assessment, this consultation would be purely based on professional experience and case study examples (versus evidence-based research).

Social Justice Research

The needs and desires of the community on which I am focusing are the underlying thread through which social justice research is woven. In this case, the "need" is to have appropriate assessment measures for linguistically diverse people in the United States. In social justice research, the research team should be comprised of researchers who reflect the diversity of the community that is being studied. In the case of this dissertation, there is a single researcher by virtue of the dissertation task, making it virtually impossible to represent the community or even the case that was studied. However, there was diversity on the dissertation committee both in personal background and professional assessment experience that helped to ensure a more balanced perspective reflective of the linguistically diverse community. Generally, in this kind of research, the participants and researcher should have a collaborative relationship. Unfortunately in the present study, it was not possible to collaborate with the participant(s) because the research was conducted after patient discharge (Fassinger & Morrow, 2013).

Limitations of the Case Study

There were several limitations to this study. One of the inherent problems with case studies is that the researcher is selecting the case to be studied (Creswell, 2013). Even with

acknowledgement and exploration of biases, the researcher has control over case example selection and interpretation (Charmaz, 2016). Additionally, further research is necessary to provide empirical support for the best practice recommendations developed by the researcher because they are based on one case example.

Case study research allows for an in-depth analysis of a particular issue, in this instance the Rorschach and the patient's English language capacity. However, case studies cannot be generalized because the sample size is too small to represent population-level trends. Additionally, there is an alternative explanation of the findings. It is possible that Yael *did* have exceptionally rare psychopathology, and her Rorschach scores were an accurate representation of her psychological health. Results of Yael's Rorschach assessment, if evaluated from a research perspective, could be deemed as both Type I error (a "false positive," i.e. underpathologizing) as well as Type II error—a "false negative" (i.e., overpathologizing). Because of these possibilities, it is important to examine more Rorschach protocols of ELL and ESL speaking patients.

Another limitation is that, ideally, social justice research involves the community being studied (Fassinger & Morrow, 2013). In this dissertation, the participant(s) on which the case study was based were not involved in data collection, analysis, and reporting, which limits their ability to integrate this information into their own treatment and self-advocate based on this information.

Suggestions for Future Research

The purpose of the case study analysis was to highlight the need for "best practice" recommendations for R-PAS assessment with bilingual and multilingual patients. This is a part of the social justice theory included in the interpretation, and a call for future research on the inherent bias in English-based psychological assessment. A study examining both the

Rorschachs of ELL and ESL patients and comparing them to the protocols of patients who speak English as a first language would clarify whether or not the Rorschach overpathologizes ELL and/or ESL protocols. A larger sample would allow the results to be generalized to Rorschach administration, scoring, and interpretation of ELL and ESL protocols in clinical practice.

Testing English language proficiency. Future research avenues may include exploring the utility of a brief test of English language proficiency prior to assessment. An example of a language proficiency test is the Language Experience and Proficiency Questionnaire (LEAP-Q), which offers a descriptive account of patient's language histories (Marian, Blumenfeld, & Kaushanskaya, 2007). Though this is not a clear-cut way to evaluate language proficiency, it does offer more information about a patient's language history to help inform appropriate assessments. If a patient or client speaks minimal or no English, this test is unnecessary because referral of the client to a clinician that speaks their primary language is indicated.

Using an interpreter. There is virtually no research on the use of interpreters in Rorschach assessment. Though there may be research on the use of interpreters with other types of assessment, the Rorschach's assessment procedures make use of an interpreter particularly complicated (i.e., repeating back the responses during the clarification phase and writing down the responses and clarifications verbatim). The Rorschachs administered to populations speaking languages other than English are typically administered in the same language that the client speaks. There are several major issues with the use of an interpreter in Rorschach assessment. The first is that the administration needs to be translated in-vivo so that the clarification phase can take place. However, some of the response/clarification nuances may be lost with translation from the client's language to English, back to the client's language, and then back to English for the scoring and interpretation process. The problems with backtranslation have been documented

(The International Test Commission, 2016). The R-PAS manual emphasizes the importance of recording both the response and clarification portions of the administration phase verbatim, which presents a unique challenge when the words are translated from one language to another and then back again. Many hospitals and even mental health clinics have interpretation phone line services readily available to clinicians. These phone lines are not intended for use with psychological assessment, and they are not suitable for this purpose.

Conclusion

Though this case study certainly does not illustrate the full range of issues that arise when using the Rorschach to assess bi- and multilingual patients, according to social justice research theory, consciousness-raising can be an integral part of research (Fassinger & Morrow, 2013). This dissertation raises awareness about the need for recommendations and empirically supported practice standards for using the R-PAS with bi- and multilingual patients so that they are assessed in a preferred language. Further research and practice recommendations for the Rorschach assessment of bi- and multilingual patients in the United States will help shape training programs and hopefully hiring practices to better support patients who are a part of the 60 million people in the United States that speak a language other than English (U.S. Census Bureau, 2011).

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Tables and Figures

Table 1.

Detailed Languages Spoken at Home by English-Speaking Ability for the Population 5 Years and Over: 2011

Characteristics	Population 5 years and over (number)	Spoke a language other than English at home (percent)1	English-speaking ability (percent)2			
			Spoke English "very well"	Spoke English "well"	Spoke English "not well"	Spoke English "not at all"
Population 5 years and over…….	291,524,091	X	X	X	X	X
Spoke only English at home	230,947,071	X	X	X	X	X
Spoke a language other than English at home…	**60,577,020**	**100.0**	**58.2**	**19.4**	**15.4**	**7.0**
Spanish or Spanish Creole	37,579,787	62.0	56.3	17.8	16.9	9.0

Characteristics	Population 5 years and over (number)	Spoke a language other than English at home (percent)1	English-speaking ability (percent)2			
			Spoke English "very well"	Spoke English "well"	Spoke English "not well"	Spoke English "not at all"
French	1,301,443	2.1	79.6	13.9	5.9	0.6
French Creole	753,990	1.2	56.8	23.8	15.2	4.3
Italian	723,632	1.2	73.5	17.1	8.6	0.8
Portuguese	673,566	1.1	61.8	20.8	13.5	3.9
German	1,083,637	1.8	82.9	13.1	3.6	0.3
Russian	905,843	1.5	52.3	25.6	16.8	5.3
Polish	607,531	1.0	60.0	23.4	13.8	2.8
Hindi	648,983	1.1	77.0	16.3	5.3	1.4
Other Indic languages	815,345	1.3	60.6	21.5	9.9	3.4

Asian and Pacific Island languages:						
Chinese	2,882,497	4.8	44.3	26.1	19.9	9.7
Korean	1,141,277	1.9	44.5	27.0	24.4	4.0
Vietnamese	1,419,539	2.3	39.8	27.1	25.8	7.3
Other Asian languages	855,303	1.4	69.3	19.6	8.4	2.7
Tagalog	1,594,413	2.6	67.2	25.6	6.7	0.5
Other languages:						
African languages	884,660	1.5	68.1	21.1	8.6	2.1

Note. Source: (U.S. Census Bureau, 2011 American Community Survey; p. 3)

Table 2.

R-PAS Case Study Administration Phase Protocol

Card #	Response #	Response	Clarification
I	1	Someone needs help.	They're doing like this [*holds up hands*]. Cause he is between two things hard—one from the left and one thing from the side. They're going to injure…it's like he is going to fall. Everything collapose on him. He has strength because he is trying to push, but he doesn't have legs. [*Collapsed?*] This [*points to sides*]. [*Hard?*] Because something, they hold him from the leg, so you can do nothing.
I	2	I see the end of the world.	Yeah…because there's nothing left. Only one person. And this person is fighting with something really hard. He wants his freedom. Wants to be free. [*Nothing left?*] Do you see something left? There's nothing. All the white. They took him to another place in foggy sky.
II	3	I know that there is a tunnel.	Starts from here…then becomes larger. A little bit of option how to move. Then the tunnel starts to get smaller, smaller, smaller. And this is in the darkness. The tunnel is in the middle of the darkness. [*Pauses*] That's the end of the tunnel, but still there is something to fight with. There is something still there. There is nowhere to go and something with a wound, like hurting.
II	4	Someone wounded with blood	Because when the skin becomes red, that's why.

II	5	Two sisters—they hold hands together. You see? They are together.	They are very close, for me they have long hair, skirts. They are looking for something together. They're facing, looking like this.
III	6	I see two bad people. They are hurting someone in the surgery room. Those are the doctors, you know. They suggest pain [*points to red spot in middle of card]* and someone dying on the surgery table.	One from here and this is the back surgery. He's on the table, they're pushing his shoulder. Two men. I know this is surgery. And the person, she's like dead because she cannot respond, she's not responding. [*Doctor?*] Yeah…they're wearing masks. [*Pain?*] It started in the back, this is the chest, this is the clavicle. Its hurting so much, it's broken from the right. Because it's wounded, wound inside. Here [*points to card*] The color, it's darker. That means the wound is deeper, you know. The chest pain. The right is worse than the left. The doctors are doing something. They're pushing, they're communicating. But they're not paying attention to what's going on inside. Their faces are rude, they are mean, they are arrogant.
IV	7	That's a mess. See the body— that's how I feel. That's how my body now. It's like a tunnel of sadness. And there is nothing around. No help; no hope; no life. Everything about darkness. He's facing nobody, you see, just by himself. There's no one to help him. The doctors, they are not anymore here, then he gets angry. You see, his body became bigger, he gained weight. He is weak. He cannot stand on his leg.	Because it doesn't have something to stand on. Everything is going apart, there is brokenness. The arm, it can't be supported by the back. He cannot stand; he doesn't have a base to stand on.

V	8	That's the future. There is nothing left. It become weaker. There's no leg. Nothing left it's the future. Just bones, no skin. A lot of sadness. He is going to die.	Two person. They lie on here, they no care. They have faces, one face here. Now the doctor, they turned their back. Both, they don't care. The face, it's sad and crying. [*Nothing left?*] See how the body becomes? There's no skin. Nothing.
VI	9	There is nothing left, so they're eating his bones. That's the thoracic. This is after dying. There is animals eating the bone	The animals are going to eat all his bones. See? There is the spine. It looks chewed up. …I don't know why this time, I put vagina. But that's not what's bothering me.
VII	10	(^)Two people are facing. One of them, he's going to jump.	They're not facing now. They are connected by the hair, but this is girls—they wear skirts, feminine shape, hair. One of them, she wear glasses, one of them—she's crying, her face. One leg is already in the air, but both of them, they're going to jump.
VII	11	Something about sex. This is a vagina.	I don't know, because I see it everywhere. It's the shape, it's familiar.
VIII	12	Someone in the middle is going to die and there's tigers on both sides. They hold his hands you see. The tigers are jumping on his body and holding his hands and there is nothing left in thoracic. Part of the body—there's two parts, upper body and lower body—shows nothing. Nothing left, only meat. Even the meat, it isn't healthy.	They look like tigers. They hurt him in their leap. Then they show they're holding his hand, but here they are hurting him. They attack him. The spine, vertebrae, the middle. There is the cervical and the lumbar. This is empty—there is no muscle, there is no connection. Something is going wrong here. [*Isn't healthy?*] It's wounded. The color of the blood means it's unhealthy.
VIII	13	I see two sisters here on the top. But now they are not close—	I feel that they are sisters. When they're lonely, all that is left is

		there's something in the middle. There's space.	your sister. She will stay. The shape looks female.
IX	14	Here I see fire. The bodies burning, part of the body is carbonizing. There's nothing left because the fire is stronger, the body is wounded, there's nothing functional. There is no more sisters, you see? No more left. I can imagine this as the upper body, then this is the head. Everything is damaged with the head. Everything is foggy. There's a big fire, explosion. Something in the head that goes up. There is no defense, just explosion.	[*Fire?*] There's nothing left, no sisters, everything is done. The upper body is done. Even the spine is dying, something here, maybe blood, something like that. [*Explosion?*] This all over, it's between fire and darkness. This is life prisoners
X	15	(^) I see all the flowers, dead. There is no nature anymore.	[*Flowers?*] The color, the shape, when they die the shape changes.
X	16	I see two person here, they tried to survive the fire. I see…this is person without any defense. Without nothing. They will take her away.	Two people are here. Big people, they look like, you know people they go to planet [*astronauts*]. To reach the spine. There's nothing left. Each one holds something here, one here and one here. I don't know what they're going to do with the spine. Maybe they try to save something, but there's nothing left. No nature, no flower, there's nothing left. This is two people. Holding hands, or fighting I don't know This is someone who's dead. She's a female…the fire is all over burning. Flowers are burning. Everything—it's a mess. And they took an offering in the sky. Two dinosaurs are carrying the spirit of this person. But they took the spirit somewhere else.

Table 3.

R-PAS Case Study Coding

C	R	O	Loc	L#	SR	SI	Content	Sy	Vg	2	FQ	P	Det	Cog	Them	HR	ODL	R-Opt
I	1		W	1			H, NC	Sy			-		Mp	DV1	MOR	PH		Pr
	2		W	1		SI	H, NC				-		Ma.C'		AGM, MOR	PH		
II	3		D	5		SI	NC				u		V	DV1, DR1	MOR			
	4		D	3			Bl		Vg		u		C	DV1	MOR			
	5		D	6			H, Cg	Sy		2	o		Mp		COP, MAH	GH		
III	6		W	1			H, Bl, Cg	Sy		2	o	P	Ma.V		MAP, AGM, MOR	PH		Pr
IV	7		W	1			H				-		C'	DV1	MOR	PH	ODL	Pr
V	8		W	1			Hd, An	Sy		2	-		F	DV1, DR1	MOR	PH		Pr
VI	9		W	1			A, An, Sx	Sy			-		F	DR1	AGM, MOR, MAP			Pr
VII	10	v	W	1		SI	H	Sy		2	o		F	INC1		PH		
	11		D	4			Sx				-		F					
VIII	12		W	1			H,A, An	Sy		2	u	P	FMa	DV1	AGM, MOR, MAP	PH		
	13		D	4			H	Sy		2	-		F			PH		
IX	14		W	1			H, Bl, Ex, Fi				-		ma	DV1	AGM, MOR	PH		Pr
X	15	^	W	1			NC				o		CF		MOR			
	16		W	1		SI	H, A, An, Fi	Sy		2	-		Ma.ma	DV1, DR2	MOR	PH	ODL	

Table 4.

Coding Glossary of Cognitive Codes

Code Type Abbreviation	Code Type	Code Type Meaning	Possible Codes		
Cog	Cognitive Codes	Cognitive Codes are designed to capture disrupted or illogical thought processes	*Language and Reasoning Codes*	DV1	Deviant Verbalization Level 1
				DV2	Deviant Verbalization Level 2
				DR1	Deviant Response Level 1
				DR2	Deviant Response Level 2
				PEC	Peculiar Logic
				INC1	Incongruous Combination Level 1
			Perceptual Codes	INC2	Incongruous Combination Level 2
				FAB1	Fabulized Combination 1
				FAB2	Fabulized Combination 2
				CON	Contamination

Table 5.

R-PAS Summary Scores and Profiles—Page 1

Domain/Variables	Raw Scores	Raw %tile	SS
Administration Behaviors and Observations			
Pr**	6	99	**134**
Pu	0	40	96
CT (card turning)	1	38	95
Engagement and Cognitive Processing			
Complexity	77	60	104
R (Responses)*	16	<1	**60**
F% [Lambda=.045] (Simplicity)	31%	28	91
Blend	3	43	97
Sy	9	73	109
MC	7.5	57	103
MC-PPD	0.5	72	109
M	5	72	109
(CF+C)/SumC	NA		
Perception and Thinking Problems			
EII-3**	4.3	>99	**143**
TP-Comp**	5.4	99	**142**
WSumCog*	25	97	**129**
SevCog	1	80	113
FQ-%**	50%	>99	**143**
WD-%**	50%	>99	**143**
FQo%*	31%	3	**72**
P*	2	4	**73**
Stress and Distress			
YTVC'	4	49	100
m	2	66	106
Y	0	17	85
MOR**	12	>99	**146**
SC-Comp (Suicide Concern Comp.	5.0	65	106
Self and Other Representations			
ODL%	12%	63	105
SR (Space Reversal)	0	19	87
MAP/MAHP*	75%	88	**118**
PHR/GPHR**	91%	99	**134**
M-*	3	97	**129**
AGC*	0	4	**74**
H**	11	>99	**140**
COP	1	54	102
MAH	1	64	105

Appendix A

Self-reflection on personal privilege and biases

Exploring, understanding, and working against the biases of my societal position has

been an integral part of my doctoral training, both academically and clinically. However, because

several of my identities are privileged, I may have "blind spots,"—biases of which I have limited

awareness. One of the reasons I am writing these self-reflection notes is to work toward

minimizing these blind spots and mitigating their effects. My privilege in the following areas

makes me grateful, but it also leaves me at an emotional, socioeconomic, and educational

distance from many of the patients to whom the subject of this dissertation applies.

I am a White, Jewish, cis-woman and I speak English as my first and only language (I am

minimally proficient in Spanish, French, and Hebrew). I often say that my family was

socioeconomically upper middle-class; however, that was based on the extreme comparative

wealth of the community around which I was raised. In truth, compared to the rest of the United

States, and certainly the world, my family was wealthy, and I grew up in one of the most

expensive cultural hubs in the world, just north of New York City. Living in the United States,

my upbringing and my sociopolitical identities have afforded me great privilege and access to

education. Both of my parents have doctoral degrees, and my mother has a doctoral degree in

clinical psychology. I have never once questioned my place or whether I deserve to be working

toward a doctorate, which is quite rare for people seeking higher education. Some people don't

pursue a doctorate for financial reasons, for feelings of inadequacy, for a lack of role model, or

for sexism, racism, ableism, or any other "ism" that makes people feel that they don't belong. I

was fortunate to have none of those barriers (and was protected from some of the sexism that

prevents women from pursuing higher education by having a strong female role model in the

field, my mother, and psychology being a field that is now employing more women than men).

Ironically, my education and having the privilege to write this dissertation in itself indicates my own bias. Very few people have the socioeconomic stability or access to education to pursue a doctorate, and certainly no patient I saw on the inpatient unit where I saw "Yael" had a doctorate. The patients were, for the most part, disenfranchised, impoverished, and disproportionately from minority groups (compared to the general population of the area). I am not a representation of the patients that unit treated. I can sympathize with their experiences, listen to them, care about them deeply, but I will never truly understand what it is like to live through their sufferings.

I believe that anyone should be allowed to work toward any level of education, and that no one is less deserving because of their identity. Even though being Jewish means being a historically (and under the current administration, presently) targeted religious minority, psychology has always been tied to Judaism, from Freud to Frankl to Yallom and to the tradition of critical interpretation still carried on in biblical and Talmudic interpretation. Being Jewish in the United States puts me in the position of being a "model minority," and in psychology it puts me right at home among peers. Yet being Jewish and a religious minority means that I am more likely than some other religious group members in the United States (like Christians) to be the target of a hate crime, but because of the complicated history and often White-presenting nature of Jews, it means that my ability to truly empathize with other minority groups is incomplete. No one would know that I am Jewish if I choose to hide the Star of David on my necklace. A Latinx immigrant who speaks minimal English does not have that same privilege.

In my lifetime, I have been in situations in which I could not speak any English to communicate only a handful of times. Each time it happened, it was anxiety-provoking, and I

gave up trying to communicate relatively quickly. I opted for sitting silently because, in those few situations, that was an acceptable option and I knew it would be time-limited.

At least several patients on the inpatient unit at any given time spoke limited or no English. Can you imagine being taken to an emergency room, not really understanding what was going on, and then being brought to an inpatient unit where you are *locked in*, and then faced with a treatment team where no one spoke your language? The only way of communicating is a translator phone, whose use is at the discretion of your treatment team and not your own? I am horrified that this is the best option of treatment. However, it is difficult for me to truly understand not only the fear of being misunderstood, but the reality of not being heard at all.

The patients who spoke limited English did not fare much better. I was not helpful in these situations, unless I could meet one-on-one. It is time-consuming and mentally exhausting to parse out the meaning of what someone is trying to communicate to you in pieces, even if it is worth the effort to provide them with the services they deserve. My most salient experience with communicating in multiple languages is with my Israeli and Colombian families, both of whom speak Hebrew or Spanish as their first language, and then varying levels of English. All of these situations have been with family, where the stakes are low. If someone didn't understand me, I could find another family member who might be able to translate. It wasn't like I would continue being locked on an inpatient unit because my treatment team couldn't figure out if I was a safety risk because they couldn't understand me.

I understand the value and necessity of highlighting the issue of language in psychological assessment, especially in the United States where there are literally hundreds of languages in use. We have no national language, so it is our duty to provide services to patients as best as possible in an appropriate language. I am a stakeholder in the topic of this dissertation

as a practitioner trying to provide best-practice assessment, but not as someone receiving that assessment, and those are two inherently different positions. It is difficult to include the voice of someone on an inpatient unit, who speaks English as a second language and who is struggling with inpatient-level psychiatric issues. "Yael's" voice and perspective were not included because it would have been virtually impossible to track her down post-discharge (I am not understanding), but it would have made for more inclusive research, and it may be that future research *should* include these voices. My own academic bias, where the "researcher" is positioned as more knowledgeable than the subject they are researching and as an objective, scientific observer did not allow me to consider this as a possibility until writing these notes.