PHYSICALISM AND PSYCHODIAGNOSIS*

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This paper sets itself the task of confronting the promise as well as the plight of psychodiagnostics. Many graduate training programs and clinical agencies, extended portions of the research literature on tests, and a good many individual psychologists hold testing in limited esteem. All too rarely do the teaching and practice of psychodiagnosis measure up to standards of excellence in which one can take pride. This state of neglect has been used argumentatively by the critics of testing. They say, "You see, even the practitioners themselves are indifferent to their tests, and given the slightest chance, they escape from this dubious occupation to more attractive fields of endeavor, such as psychotherapy or research."

However, this argument is too facile. It assumes that professional ambivalence is an inevitable response and a sure proof that the testing discipline is useless and hopeless. On closer scrutiny it appears that testers are neither reluctant followers of their occupation, nor are critics disapproving of it, only because the tests are imperfect, but are critical for a variety of reasons which are less obvious and which ought, therefore, to be explicated. The doldrums of testing are in a good many instances largely a matter of conflicting values and of disappointed faith. That is, rather personal factors are responsible for a good deal of poor testing and apathetic training, and for some of the criticism of tests, even though this criticism may be offered in an orderly and detached manner. Nevertheless, these remarks are not intended to circumvent questions concerning the validity of test inferences. Rather, and perhaps ironically, the purpose is to elucidate some factors which have gotten in the way of more *relevant* criticism and of more energetic efforts to enhance the profession.

The discussion will begin with a brief mention of several factors which produce ambivalence toward testing and will then consider one of these factors in some detail. Most, if not all, manifestations of professional compromise have their source in the am-

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biguities of the tester's role and in the conflicting values which are tied up with the several components of this role.*

To begin with, testing is not a static category. It does not mean the same thing to everyone or in every circumstance. Accordingly, it seems wise to distinguish, for instance, between the projective hypothesis, which constitutes the rationale of psychodiagnosis, and the multifarious settings and enterprises in which diagnostic tests are used. Depending on whether one thinks of testing primarily as a professional service, as a research tool, as a vehicle for acute clinical insight, or as a teaching device, one associates quite different connotations and values with the term, and, as will be indicated, encounters different value conflicts. For instance, testing as a clinical service requires that the practitioner be well-informed about a variety of nosologic, therapeutic, and prognostic issues, that he be steeped in clinical experience and linguistic as well as practical usage. He should know something about people and their lives, about varieties of cultural organization and experience, about the fountains of mythology, history, art, folklore and mass culture.

One does not master these domains systematically but gains knowledge gradually and interminably. A tester utilizing diagnostic instruments in such a setting and bringing his personal maturity to bear upon them, is likely to develop a rather different regard for tests, for himself, and for the relationship between them, than a worker who episodically borrows a diagnostic device for a circumscribed research purpose. These two exemplary workers maintain rather different viewpoints concerning the usefulness of a given diagnostic test. In a research program, pragmatic decisions are reached with fair dispatch through the application of widely accepted and public criteria, whereas the clinical practitioner is less hasty in arriving at convictions concerning the usefulness of a specific test dimension and frequently applies rather private measuring sticks to the refinement and legitimation of his diagnostic practices. If only in regard to patience and the validative criterion, the two outlooks are rather different.

It is not impossible for *one* scientist-practitioner to use tests for rather divergent purposes at various times and ordinarily without incurring great inner discord. Nevertheless, the foregoing distinction indicates that clinical practitioner and research scien-

*These values are treated in greater detail elsewhere (Rosenwald, 1963).

tist maintain dissimilar expectations and confidence in their tools, epistemological biases, cultivation of skills, and professional values. While some testers stress the rigorous and impersonal approach of the technician wielding micro-tools with precision, others emphasize the intuitive interpretation of test findings with heavy utilization of their own life experiences and empathic grasp of the tested person's individuality and uniqueness. Clinicians in academic settings employ test material as a concrete exemplification of abstract generalizations about personality. This orientation de-emphasizes practical decision-making, clinical exigencies and checking up on predictions in favor of sometimes far-reaching speculations and training in characterology. These diverse employments of and attitudes toward the same instruments, often by one and the same worker, probably aggravate the difficulties common to *all* testing. Even the concrete practices may differ somewhat depending on whether the tester happens to be wearing the practitioner's, the teacher's, or the researcher's hat at the moment.

For instance, as a pedagogue and demonstrator he may indulge himself in relatively more venturesome character constructions and concern himself with relatively unpragmatic rubrics of diagnostic assessment. As a researcher, on the other hand, he will tend to forego even the most tempting procedural deviations from standard practice, and focus on particular variables selected beforehand as relevant to the investigation in progress. As an artist and craftman, he will perhaps bring his own personal sensitivities and insights more freely into the assessment process and into the task of characterization itself. As a member of the mental health team he may become involved with the patient in a more personal and empathic manner than is usually allowed for in the limited, transient contact of the tester who functions merely as a technician or experimenter. More of his personal aspirations, central sublimations and anxieties may be called into play. None of these value-clusters are mutually exclusive or irreconcilable, but it is important to note that identities of individual testers synthesize their allegiances to one or several of these role models. Consequently, they will not only differ from each other as regards the minutiae of practice and formulation, but they will also experience greater or lesser role- and value-conflicts depending on the intricacy and success of their personal syntheses.

It is a commonplace that each professional role of which testing partakes is heir to specific as well as overlapping personal gratifications and obstacles. Nevertheless, some writers have discussed testing as though it were an immutable term. To repeat, the definitions of testing are many, and their combinations almost beyond survey. It, therefore, seems profitable to elucidate the ambivalence which may be engendered by each of the several roles which the tester may choose. For instance, where testing is viewed as a routine technical service requested by a hospital psychiatrist and delivered by the psychologist in the form of a standardized laboratory report, the diagnostician's defenses and attitudes toward personal passivity and inconspicuousness will be activated. The tester will be aware that he is only remotely helpful to the patient and is in tenuous contact with his colleagues in other professions. This aura causes various degrees of suffering or satisfaction to different testers. Where the tester has full freedom, material and spiritual support, and access to interesting patients, but where clinical dispositions and management take little account of his findings, the tester's contentment depends on the gratification he provides for himself. A meticulous or somewhat doubt-ridden tester will find this situation agreeable, because no decisions are expected of him. So will a diagnostician who enjoys the exercise of writing reports for no one in particular.

Another example of role-related conflict, perhaps minimized when diagnostic devices are used as part of research with anonymous subjects, is the opportunity and necessity of getting to know the intimate and secret inner life of another person. This function depends on more or less well-regulated voyeuristic impulses in the tester and will therefore evoke reactions of enthusiasm, boredom, perfectionism, or aversion in various testers, depending on psychosexual fixations, preferred defenses and a host of character variables specific to the tester.

As for the tester qua artist, he, too, is susceptible to culturally supported stereotypes and prejudices. The self-consciousness and social role of the artist will become part of his self-image.

Perhaps the most conspicuous cause of the tester's professional uncertainty has been his simultaneous loyalty to the artistry of his craft and his participation in the scientific values of the larger community of psychologists. On the whole, scientific values have guided the appraisal of diagnostic techniques without much ques-

tion. To treat the diagnostician's claims (for example, "I can tell neurotics from psychotics in a manner agreeable to the rest of the mental health team") as just another empirical hypothesis (such as, "Compulsives are more authoritarian than hysterics") is, however, not the only form of evaluation under the sun. Besides the testing of scientific hypotheses, man's attainments may be evaluated in other ways. The criteria of survival on the market, comparison with ethical ideals, standards of personal satisfaction and of public relations and welfare come to mind.

Whereas no paradigm seems more relevant to a test of the projective hypothesis than the scientific one, the professional identity of the psychodiagnostician comprises more than a belief in the projective hypothesis; a professional practice is not an empirical proposition and ought therefore to be legitimized in some other way. This has been generally overlooked by the most vociferous advocates of the homely cookbook approach. (Cf. Meehl, 1956.) The next task is, therefore, to consider the application of physicalism, that is, the language of physical science, to psychodiagnostic tasks and to show that while it may be possible, in cookbook terms, to scramble the diagnostic task, the result will not necessarily be edible.

Psychodiagnostics, as we know it today, is far removed from the first efforts made by psychologists and physiologists to explore the parameters of fundamental human functions. Originally, interest was focused, not so much on the unique individual, as on the species exemplified by the individual. Problems of sensory receptivity, neural conduction and interference, mental organization, memory and attention were studied by psychologists long before workers in applied psychology adopted their tools, gadgets and conceptualizations for the prediction of academic performance or the formulation of psychiatric diagnosis. One gains the feeling that in large measure the old tools dictated not only the concepts of intelligence and of traits, but in some instances, the psychologist's total view of man. After all, how complexly could a psychologist conceive of cognitive behavior if he felt that reaction time and other such psychophysical dimensions were the most important components of intelligence? Today's conceptions are more advanced, but public judgment of current clinical practice often appears to have remained unchanged. It is a critical spirit which is ideo-historically conditioned and culturally em-

bedded. Its appropriateness for modern clinical psychology should, therefore, not be taken for granted.

The early psychometric tools were recognizably the physiologist's and the physicist's. The logical conceptions of traits were strictly physicalistic. The significance of physicalism for psychodiagnostics is, therefore, the main focus of this paper. The aspects to be considered are three: disjunctivism, quantification, and oligotomy.*

Disjunctivism

To begin with, the simple, as against sophisticated, physicalistic language is bound by two traditional laws of thought: the law of the excluded middle and the law of contradiction. The first of these proclaims that every particle or object encountered either has a given property or does not have the given property. The second states that no object can at once have and not have a particular property.

It is not necessary to enter a metaphysical discussion concerning the applicability of these laws to the study of man. It seems more to the point that conditions are known in dynamic psychology which are not easily subsumed under these guiding rules, and that these conditions puzzle the physicalist. A symptom or a dream or a Rorschach response may contain aspects of an impulse and of a defense against the impulse. A TAT figure may derive its complexion from several sources in the personality of the patient. The study of the unconscious has inured us to dynamic condensations, topographic layerings, symbolizations and compromise formations. Common as such observations may be to the clinician, his physicalist-minded colleague feels tempted to attribute them to the clinician's own muddleheaded thinking.

The application of disjunctivism, that is, of the laws of the excluded middle and of contradiction, to diagnostic classification entails the following policy. Once it is agreed that traits such as obstinacy or suspiciousness are relevant to personality assessment, no patient may be classified as simultaneously obstinate and pliant or simultaneously suspicious and trusting, but every patient must be *either* obstinate *or* pliant, suspicious *or* trusting, and generous *or* envious. That is, of any trait pair (or dimension) at least one value, but never more than one, must be assignable. Such a view of man and of assessing him entangles us in great

*Descriptive economy.

difficulties because it ignores clinical understanding and diagnostic experience. However, even though this physicalistic model prejudices the question of test validity, it has a simple classic beauty and will, therefore, be enticing to many psychologists.

The realities of testing-practice indicate that one can say of any trait that it is present to a certain degree, that it is absent, or that there is no evidence concerning it. Whatever one's attitude toward the abstract proposition that every person is either honest or not, it must not be confused with the practical demand on the tester that he commit himself to the presence or absence of the trait of honesty in the case of any given patient. Neither in conceptualizing nor in measuring personality can it be assumed that every person will have either a given trait or its opposite, or that a person cannot exhibit both traits simultaneously.

The methodology of Q-sorting is the chief exhibit of disjunctivistic thinking in diagnostics. It is a procedure which remains necessarily oblivious to the restraints discussed. This makes it more manageable for the statistician, but hardly qualifies it as a scientifically standardized replica of the diagnostician's daily practice.

For instance, Meehl has implied that given any of his 300 or so Q-items, and given any patient, one ought to be able to rate the patient on the item (Meehl, 1956, 1959, 1960). This is a disjunctivistic view. It does not represent the type of description which readers of test reports are eager to receive. An illustration is in order here. In analyzing test batteries, the tester may one day hit upon a case which leads him to state: "This subject strikes me as an honest person," or "This patient thinks women want to devour him," or "This girl has a Cinderella complex." These characterizations are unusual but they have clinical meaning, and they can be verified independently. Yet the tester who has in one case drawn such a sketch would shudder at the suggestion that henceforth he state for every patient he encounters to what extent he or she has a Cinderella complex, or is honest or deluded in a specific way.

Meehl's own argument applies here: We frequently diagnose traits and dispositions which have low base rates in the population. The caution which follows from this is that we commit ourselves to the presence or absence of a trait only where there is evidence relevant to it. Of all the traits ever characteristic of people at

large, only a small fraction is characteristic (that is, discernibly present or absent) of one particular person, and of these some may not be indicated in the test protocol. For instance, if we attempt to Q-sort a patient on 1,000 items, 950 of these might be objectively irrelevant or inapplicable to his personality, and of the 50 which apply, only 25 might be indicated in the tests. Nor should it be assumed that all of the 1,000 traits have the same chance of being applicable to any given patient.

Beyond the well-known fact that many of these traits are correlated with each other in the population at large, there is an issue of contingent relevancy to be taken into account. Depending on the personality structure we are dealing with, certain traits will not only be predictably present or absent, but the measurement of some will be predictably irrelevant. For instance, in the case of certain deteriorated schizophrenics it is not meaningful to inquire into the trait of honesty vs. treachery. Honesty is a disposition which presupposes cognitive differentiation of people both from the self and from each other, anticipation of outcomes, memory of promises and commitments, the judgment and concept of moral obligation—all of which such a patient does not have. He is, therefore, neither honest nor dishonest; this dimension is not applicable to him.

While this is an extreme example of irrelevance, other less dramatic cases could be cited. The judgment of relevance itself requires clinical sensitivity. Some schizophrenics *will* be capable of honesty; others will show pseudo-honesty, or rigid delusional self-righteousness. Experience with testing reveals that patients frequently demonstrate those traits most clearly which are located at the nodal point where important psychic forces intersect. Similarly, it is found that in a great many Rorschach protocols there is no salient expression of, say, the patient's body image, because the neurosis has not drawn that portion of the ego deeply into the pathology. In that case, it will probably also be clinically unremarkable. In schizophrenic malignancy, body image distortion is frequently observed both clinically and in tests. In short, when the level of developmental and/or pathological integration or disintegration is not considered, the clinician is likely to pose inappropriate problems, and the validater is likely to beg the question of test validity.

Although there are very few dimensions of such universal ap-

plicability in the field of personality testing that one could ask a tester to commit himself on them in every patient, there are even fewer dimensions of which the assessment is never of consequence. In sum, strict adherence to the law of the excluded middle sometimes forces the diagnostician, whether in clinical or validational work, to render irrelevant or Procrustean judgments.

As regards the law of contradiction, that no patient can simultaneously exhibit a trait and its opposite, this is basic in Q-sort methodology and merits the following objection. In the study of both well-functioning and disturbed personality, it is a common assumption that traits which are logical contraries can well coexist in one person and in one piece of behavior. For instance, a student who asks for extraordinary concessions from a teacher may voice his demands in diffidently mumbled tones. This condensation is not semantic but motivational, and is difficult to disentangle and classify as to purpose and intention. In fact, in certain clinical disorders the simultaneous striving for expression of two apparently opposed tendencies may constitute a conspicuous and defining characteristic. Mutually exclusive motivations and perceptions are conceptualized under the rubric of ambivalence. Not only is the diagnostician not taken aback by such occurrences, but he sets himself the subtle task of specifying the structural and functional properties of such a trait-pair, or trait-complex. He determines which member is the more prominent, how aware the patient is of the less prominent one, and the like. A procedure for validating tests which does not take such complexities into account will be inadequate.

Even if it were possible to eliminate the drawbacks built into the Q-sort method, tests, as they are commonly used, would not always yield perfect descriptions or predictions. One ought, however, not to be too quick to reject the instruments for that reason. How we evaluate the usefulness of projective tests in predicting obstinacy or suspiciousness cannot be made to depend on experimental designs in which each of 100 patients is assessed with respect to these traits. Neither people nor tests are constructed so as to satisfy this requirement. Some other procedure is needed to provide an estimate of diagnostic fallibility. It seems a research task of great importance to determine what position in the personality constellation is assumed by those character features which emerge clearly in the tests as against those which appear

vaguely or not at all. There is a widespread, but uncertain, belief that the more central the character trait is in the psychic economy of the patient, the more conspicuous its manifestations will be in the test protocol. Yet many experienced testers find that some traits which are very clear in the *clinical* picture may be only peripherally evident in the tests. Nothing is known about such discrepancies except that they can be used polemically to discredit the tester.

Quantification

The wish to quantify psychological traits is the second physicalistic trend to be discussed. It has been widely debated in the literature and will be dealt with only briefly here. Quantification as a heuristic value for psychology probably has its origin in the so-called exact sciences which the physicalistic-minded psychologist takes as his model. Some psychologists feel that their field of interest must be subjected to strict metric mathematization in order to take its place among the sciences. Others defer the decision, saying that much of psychology is still too young to be amenable to quantification and that it may never become amenable.

The appurtenances of testing look appealingly scientific and quantifiable. The diagnostician couches some of his communications in numbers, and letter symbols. He performs a few impressive calculations. He appraises the significance of percentages and ratios. He is busy with much counting and tallying, and he does not go out of his way to minimize the public appeal of these measurements. Especially if he feels embarrassed about his intuitive inferences, he will gain respite in the IQ, the F+%, or in the M: ΣC ratio. Those experimenters who are forever casting about for a clinical procedure that is amenable to laboratory techniques and to quantitative statement will consider this an invitation, and some diagnosticians will help to bowdlerize diagnostic tests; for if such an experiment yields positive results, the diagnostician can point to these documentations of his daily clinical activity, no matter how grossly unrepresentative the experimental procedures are of what he actually does in interpreting clinical tests.

It is a recurrent temptation for the ambivalent tester to hand over the more easily communicated of his work habits to the experimenter who will, with good hope, render them legitimate with a pithy *t*-test. Psychodiagnostic methods look superficially

more objective, rigorous and explicit than they are. Many diagnosticians vindictively underscore these scientific aspects to make their work more acceptable to their experimental challengers and to their own scientific consciences. Ironically enough, they often vitiate the essence and body of test interpretation in this sacrifice to Science.

Be that as it may, one should recognize two cautions which this issue entails for diagnostics. The first caution applies to the belief that behavior, as in test responses, can be quantified in more than an *ad hoc* manner while the psychological dimensions which determine the behavior are neither exhaustively charted nor even crudely conceptualized or interrelated as yet. After all, test observations are supposed to provide information concerning an inner state of the individual, which in turn is a determinant of the behavior we wish to describe or predict. The opportunities for obtaining meaningful correlations between test responses and a characterological dimension are therefore no greater than the opportunities for a meaningful quantification of the character dimension itself.

> When the physicist measures, he knows the dimensions of observables as expressed in terms of the CGS (centimeter, gram, second) system, and when he establishes a constant he knows that its dimension is such as to make his equation not only quantitatively but also dimensionally true. In $s = (g/2)\ t^2$ the dimension of s is C, of t is S, and of g is C/S^2; thus substituting these dimensions, we get $C = (C/S^2)\ S^2$, indicating that the equation is dimensionally true. The classic scale of *hardness* is a means of quantification too. But instead of a dimensional measure, it provides only an *ad hoc* quantification. Most—if not all—measurements (e.g., IQ's) of present-day psychology are *ad hoc* quantifications. (Rapaport, 1959.)

That is, theoretical analysis is sidestepped in much psychological experimentation with gross criteria not because it is unnecessary, but because it is too difficult as yet. To take a historical example, our understanding of intelligence, its origin, its functions, its vulnerabilities, has been strengthened since we de-emphasized the prediction of gross academic achievement measures (for example, graduating from high school) from gross test measures (for instance, total IQ) and began, however tentatively, (a) to conceptualize and interrelate components of intelligence and (b) to seek their representation in subscores of the over-all IQ.

So far we do not know how to achieve a dimensional quantification of psychoanalytic variables; and yet we cannot sit with folded hands,

since additional observations are needed for the systematization of the theory and for dimensional quantification. Thus in gathering new observations we must be satisfied with *ad hoc* quantifications, but we must not lose sight of the goal of dimensional quantification. To achieve that, we will have to learn to consider the locus of our variables in the motivational and structural hierarchy and to play variables against each other so as to arrive at equations which represent actual balance of forces, or balances between structures and forces, etc. (Rapaport, 1959.)

The need for this sort of analysis should become especially clear when we consider that our most commonly used tests were not generated from a well-understood model of the mind, but rather in relative independence of what they were later expected to measure. Therefore, to go from the Rorschach to the therapy situation one needs to understand not only the Rorschach and the therapy, but also the mechanisms and structures—the dimensions of which Rapaport speaks—which are thought to mediate the prediction and understanding to be derived from the tests. (In this we see the most prominent heuristic dissonance between the cookbook approach and that based on clinical judgment, since the former seems to circumvent the analysis of mediating mechanisms.)

The second caution against quantification arises from its relative inflexibility. In the contemporary literature on test validation, one finds rather forcible efforts to squeeze the essence of personality description into ratings by means of brief, non-interrelated Q-sort or check list items. While the shortcomings of blind matching are obvious, it does preserve the advantage of verisimilitude. In testing practice one does not string up a series of Q-items. The most cogent reason for not doing so is that personality structure is conceived otherwise in dynamic psychology.

For instance, "While the patient is haughty and overtly oppositional toward authority figures who make demands on him, he tends to be acquiescent and even servile when dictated what he is to do 'for his own sake.'" This is a useful piece of description but one which is not easily fragmented into two or three brief components. Its significance lies in the contrast between the patient's behavior toward demanding and solicitous authorities. Similarly, there is a singular meaning in a tester's admission at the end of the report that a patient may at times be despondent even though his main argument has been to dismiss depression as a primary symptom.

A test report is configural in the same sense that a character structure is. One intends to translate the interrelationships, dependencies, contradictions, exceptions, saliences, omissions, equivalences and deceptions of the various psychic and behavioral elements into their semantic and grammatic representations.

"The patient's aggressiveness is first of all the wrath of a person who finds himself abandoned. This oral hunger becomes supplanted, however, by an aggression of somewhat different origin, when he finds that his pleas have little effect on the external world. Then aggressiveness serves to mitigate his solitude and his sense of futility and provides him with a sense of his own personal integrity and of his capacity for emotional experience —a capacity of which he secretly despairs." These sentences by their contiguity indicate not only the subtle change in the meaning of aggression, but also that an observer might easily overlook the one because of undue attention to the other. Thus the need for expediently quantified procedures should not take precedence over the need to preserve the most useful products contained in our diagnostic work.

Oligotomy

The last physicalistic policy to be discussed is oligotomy, meaning division into few categories. The physical scientist attempts to pinpoint the facts and processes of interest to him with the greatest descriptive and terminological economy. The less irrelevant information intrudes into his descriptive scheme, the more manageable it becomes and the more efficiently he will predict the movement of his particles.* Oligotomy, as a methodological value,

*Oligotomy should not be confused with theoretical parsimony. The scientist's effort to reduce the descriptive complexity of natural phenomena does not necessarily stem from a conviction that the world is simple. Rather, this simplification is the joint product of practical, logical and experimental considerations. The artificial isolation of variables is quite proper for scientific theorization and experimentation. In the course of time, the scientist proceeds from the simple to the more complex and requires fewer and fewer higher-order statements to encompass the large catalogue of data-language facts. Parsimony is, in other words, an economy in the conceptual and explanatory sense, while oligotomy refers to descriptive economy. S-R learning theory, for instance, seeks to specify a relatively small number of descriptive variables which will sufficiently localize and define the animal particles which it studies and whose behavior it attempts to predict. Most clinicians feel that the particles which they study require a more variegated, that is, more polytomous, definition. That is to say, the tester who is firmly committed to *parsimonious* explanations of the phenomena of character development, structure and dynamics, may yet feel forced to retain a highly *polytomous* (or multiple) array of descriptive dimensions.

is implemented by the physicalistic-minded psychologist in two ways. The descriptive universe is attenuated first by *omission,* and second by *reduction.*

Attenuation through omission is a disjunctivistic compromise and has already been discussed. The Q-sorter feels forced to omit certain items from the pool, because, no matter how poignantly they may capture the character of one or another patient, it is too exacting a task to apply them to everyone he encounters. Other items are retained because they are easily applied to most, though by no means to all, patients. Such a compromise Q-pool yields an unsatisfactory evaluation of the spontaneous diagnostic inferences made in the course of daily clinical work. It is undoubtedly common for a diagnostician assessing a particular patient to address himself to a trait which has rarely seemed to matter before and which he may discuss only rarely in relation to other patients. That is to say, unusual traits and, more important, constellations of traits may force themselves on the perceptive tester's attention even though no one asked him to look out for them. The methodological question of how one can experimentally standardize the practising diagnostician's unlimited descriptive domain without losing the benefits arising from such freedom is as yet unanswered.

Oligotomy is also implemented by descriptive reduction. Although the physical scientist seeks to limit his descriptive vocabulary as much as possible, effective clinical work is not possible if one adheres to this value. Let us assume that a patient's Rorschach psychogram indicates an unusual emphasis on S, M and C′ responses. An untrained tester might interpret mechanically that M points to ideational activity and internal intellectual control, S toward a stubbornly assertive, oppositional or oblique responsiveness, and C′ toward moody, depressed or anxious emotionality. These three separate diagnostic statements are too discontinuous, however. With further deliberation and closer empathy, the tester could add, "The patient is probably sulky." This quality of sulkiness expresses simultaneously ruminative (M), dejected (C′) and accusatory (S) response components. This condensation of meanings is more lifelike and requires greater creative synthesis on the tester's part. While the physicalist would characteristically prefer the discrete components, thereby avoiding the new superfluous category, the clinician must not shy away from the novel

integration. His test report becomes in fact more valuable as he begins to dispense with dry technical terminology and substitutes more vital categories for it.

In this preference one may observe the collision between a cognitive bias of the physicalist and a practical ambition of the psychodiagnostician. Such collisions cause confusion and ambivalence. And yet the task of the tester who wants to capture the individuality of the patient is best served if he enlarges his vocabulary of traits. For all practical purposes, it is the labels we attach to people which express their uniqueness, and this uniqueness is abrogated by reducing such traits as sulkiness to the Rorschach experience balance and approach type. The opportunities for uniqueness are derived from the very obvious fact that there are more traits we can attach to people than there are dimensions we can isolate on the tests themselves. There are only a handful of Rorschach dimensions compared to the nearly limitless domain of traits which we utilize in describing our friends, our neighbors and our patients.

The discussion of the previous pages has been directed at the conflicting values of the psychodiagnostician. As a psychological scientist, he is committed to the values which his science has inherited from the physical sciences. As a clinician committed to dynamic psychological thinking, he finds himself pulled away from physicalism. The psychoanalytic orientation does not only embody an essential vision of human nature—that is, not only a theory of personality growth and functioning, but also certain methodological and epistemological directives which can come into serious conflict with physicalism. It is unfortunate that many individuals who were initially committed to both the science and the profession of the psychologist have found the conflict between these identities unbearable and have either disaffiliated themselves from one or become unsure of both.

Summary

This paper has singled out physicalism, one of several sources of professional ambivalence. Other sources have been mentioned as well. Not all of these conflicting values have comparable origins. Some stem from the vicissitudes of individual character development, others rise out of the history of ideas, and others still are carried forward by the flux of fashion. It is in the nature of pro-

fessional identity to satisfy many personal as well as social needs and to agree upon them in an implicit contract between the worker and his society.

Values of many different sorts promote the utilization of diagnostic tests in clinical, scientific and academic contexts. Other values appear to conflict and present synthetic challenges. For this reason, no *one* circumscribed model of legitimation can be sufficient. For instance, a new testing technique may satisfy physicalistic criteria, but will perhaps fail to attract the most talented and dedicated diagnosticians. As a result, it will disappoint the consumer and fall into neglect and obsolescence. Cookbook recipes may find favor with a short-order cook bent on producing standardized, if unexciting, diagnostic fare, but they will be spurned by the self-reliant chef and the discriminating palate.

The reformatory movements we have seen so far have only brought about professional unrest and mediocre practice. The doubts which trammel the testing profession today cannot be dismissed with one stroke. The most pressing business at this time is to scrutinize more carefully what values animate us as psychologists before we chase headlong after alien and factitious ideals.

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