ISSN 0971 - 6610

Vol. 7, No. 1, Pgs. 1-73 SIS JOURNAL OF PROJECTIVE PSYCHOLOGY & MENTAL HEALTH 2000

SIS

JOURNAL OF PROJECTIVE PSYCHOLOGY & MENTAL HEALTH

The Official Publication of the Somatic Inkblot Society

Volume 7 Number 1
January, 2000

SIS JOURNAL OF PROJECTIVE PSYCHOLOGY AND MENTAL HEALTH is published twice a year (January & July) by the **SOMATIC INKBLOT SOCIETY** and is devoted to the advancement of research in the areas of projective psychology, personality assessment, psychotherapy and mental health. The journal is broadly concerned with the development of inkblot tests and personality assessment in clinical, counselling, cross cultural, organizational and health psychology settings. It aims to reach clinical psychologists, psychotherapists, psychiatrists, social workers, medical professionals and professional managers interested in the understanding and modification of human behaviour.

The journal includes (a) research articles (b) book reviews (c) brief reports (d) news about conferences etc. and letters to the editor.

MANUSCRIPTS PREPARATION : Manuscripts should be typewritten (double spaced throughout) submitted in duplicate to B.L. Dubey, Ph.D. Chief Editor SIS Journal, P.O.Box 1107, Sector-15 Post Office, Chandigarh 160015 (India). Manuscript can also be submitted to Wilfred A. Cassell. M.D., Editor, 4501E, 104th Avenue, Anchorage, AK-99516 (USA). The Editors reserve the right to refuse manuscript submitted and to make minor additions/deletions. Authors should prepare their manuscripts according to the Journal of Personality Assessment.

SUBSCRIPTION : The journal is free to members of the Society, Annual membership fees are US $50 for foreign members and Rs. 250, for Indian members, Institutional subscriptions are US $100 for Foreign institutions and Rs. 500 for Indian institutions. Life membership is US $300 for foreign members and Rs. 1500 for Indian members. Non-members may subscribe for $30 or Rs. 150/- per issue. Cheques should be made payable to 'SOMATIC INKBLOT SOCIETY' Chandigarh and should reach Dr. B.L. Dubey, Chief Editor, (Address given above). Please add $5./Rs. 30 if you are sending subscription through cheque.

CHANGE OF ADDRESS : Society / journal members should inform Mrs Padma Dwivedi, Secretary, SIS Center, Post Box 1107, Sector-15 Post Office, Chandigarh-160015 (India), Tel/Fax 91-172-710986, E-Mail: sisdubey@ch1.dot.net.in OR sisdubey@hotmail.com and Foreign Members should inform Mrs. Mary Cassell, Executive Director, Somatic Inkblot Center, 4501E, 104th Avenue, Anchorage, AK-99516 (USA). Fax : (907) 563-3746.

E-Mail:drcassell@corecom.net of any change of mailing address.

Copyright @ 1994. SOMATIC INKBLOT SOCIETY, Anchorage U.S.A./India

STATEMENT SHOWING OWNERSHIP AND OTHER PARTICULARS ABOUT SIS JOURNAL OF PROJECTIVE PSYCHOLOGY AND MENTAL HEALTH

PLACE OF PUBLICATION		:	T-2/15, Sector-25 Chandigarh - 160014
PERIODICITY OF PUBLICATION		:	Half Yearly
EDITOR'S PRINTER'S PUBLISHER'S	Name	:	Dr. B.L. Dubey
NATIONALITY		:	Indian
ADDRESS		:	T-2/15, Sector 25, Chandigarh - 160015
OWNER		:	SOMATIC INKBLOT SOCIETY

I, Dr. B.L. Dubey, hereby declare that the particulars given above are true to the best of my knowledge and belief.

Sd/
Dr. B.L. Dubey, Chief Editor,
SIS Journal of Projective Psychology and Mental Health

Printed and Published by Dr. B.L. Dubey on behalf of Somatic Inkblot Society from T-2/15, Sector 25, Chandigarh - 160014 & Printed at Juneja Trading Agencies Pvt. Ltd. Printing Press, SCO 131-132, Sector 17-C, Chandigarh. Tel. : 702675, 704715.

Editor : Dr. B.L. Dubey

SIS Journal of Projective Psychology & Mental Health
Volume 7, Number 1, January 2000

		Page Nos.
1.	Editorial : **Sperbeck**	1-2
2.	Inkblot Responses as an Aide to Therapy Bankey L.Dubey and Wilfred A.Cassell	3-10
3.	Professional Activities, Cultural Background and Social Interaction in the Zulliger Collective Technique **Cicero Emidio Vaz**	11-26
4.	The Cross Cultural and Clinical Values of Fairy Tales and the Fairy Tale Test **Carina Coulacoglou Ph.D**	27-38
5.	Distortions of Body Image on SIS-II and D.A.P. Tests **S.K. Verma, Harprit Kaur and Rachna Bhargava**	39-43
6.	Treatment of Phobia & other Neurotic Disorders: the Role of Behavioural Medicine **K.S. Sengar and A. K. Srivastava**	44-48
7.	Psychological Factors in Drug Addicts and Normals: A Comparative Study **Gopa Mitra & Anjana Mukhopadhway**	49-70
8.	Some Popular Misconceptions about Inkblot Techniques **S.K. Verma**	71-73
9.	Membership Directory	74-

SIS J. Proj. Psy. & Ment.Health (2000) 1-2

Editorial

It is with great pride that I write this editorial introducing the January 2000 edition of the Journal of Projective Psychology and Mental Health. As a colleague and friend of Dr. Wilfred Cassell for nearly twenty years, I have seen his dedication to the progressive scientific development of the Somatic Inkblot Test. I have been pleased to consult on many cases over the years with Dr. Cassell and his patients and can attest to the clinical value of the SIS with respect to this instruments capacity to unearth deeply repressed and usually foundational emotional memories, making them available for therapeutic reconstruction and rehabilitation.

As socially responsible mental health practitioners, it is especially incumbent upon us all to monitor and help to remediate social and human injustice wherever and whenever we experience it's presence. As we enter the new millennium, we face a world where hate crimes, ethnic cleansing, and war-related human atrocities deface our planet. We live in a world dominated by information overload where children face a greater likelihood of developing a mental disorder than at any other time in history. It is therefore arguably more important now than at any other time in our history that we as mental health practitioners develop efficacious instruments for relieving human suffering.

This edition of the Journal of Projective Psychology and Mental Health takes on these weighty problems and gives us hope for scientifically addressing the problems experienced by sufferers of debilitating stress. We arc treated to a deeply sobering application of the SIS in the article by Cassell, and Dubey wherein the authors probe the fragile psyches of two very divergent cases of Posttraumatic Stress Disordered patients. In this article, the power of the SIS as a diagnostic tool for helping the clinician evaluate the (dis-) equilibrium between good and evil, id and superego, and the real versus ideal self, all have very important treatment planning implications for helping survivors of extremely distressing experiences.

As the reader will discern from the rich SIS data elicited from the case studies presented, the diagnostician will find an incredible wealth of information from which to launch cognitive restructuring therapy or even more foundational

psychotherapeutic interventions. Such powerful emotional experiences elicited from the SIS images, particularly in the video modality, has helped define the SIS as one of the prominent projective assessment methodology and therapy tools in the industry today.

It is with great enthusiasm and a heightened sense of optimism for our profession's future that I introduce you to this issue and its wealth of helpful techniques for relieving the suffering of our clients. It is my hope that after a careful review of this edition of the Journal of Projective Psychology & Mental Health, you will share my optimism.

David J. Sperbeck, Ph.D.
Fellow, American College of Forensic Psychology
Associate Clinical Professor
University of Washington School of Medicine,
Chairperson, State of Alaska Board of Psychology,
2530 Debarr Road, Anchorage, Alaska-99508(USA)

SIS J. Proj. Psy. & Ment.Health (2000) 3-10

Inkblot Responses as an Aide to Therapy

Bankey L.Dubey and Wilfred A.Cassell

Most clinicians consider the use of inkblot testing such as the Rorschach, primarily for its diagnostic applications. In recent years, the widespread use of numerical scoring systems such as those developed by Klopfer and Exner, have tended to bypass the therapeutic value of Herman's inkblots in stimulating imagery for free association and content analysis. This failure partially relates to the fact that most modern therapists are not adequately trained in this approach for recalling painful memories and PTSD dreams. In the past psychoanalysts such as Roy Schafer did preliminary explorations involving Rorschach content analysis as an aide in treatment, Another reason for the original ten plates becoming relatively unused as an aide to therapy concerns the fact that the color-form configurations lack sufficient structure to routinely stimulate clinically relevant interview themes.

As an attempt to create visual stimuli more consistently capable of stimulating imagery for diagnostic and therapeutic purposes, the Somatic Inkblot Series (SIS) was envisioned in 1959. Work was initiated designing a new series of ambiguous yet partially structured designs, whose use been reviewed in this journal and elsewhere. This presentation represents a longitudinal case history study of eight years comparing the diagnostic and therapeutic utility of inkblot images. [t may also refresh the memories of clinicians concealing how projective stimuli can facilitate not only diagnosis, but also provide a powerful yet underutilized tool in the various current day psychological treatments.

A male college student age nineteen was selected for the case history study. He was referred by a psychiatrist and was plagued by incapacitating examination anxiety, When interviewed, he had major problems with stammering. Part of his developmental history, involved his having been placed at age seven by his parents in a boarding school In another city. At that time he experienced considerable abandonment feelings and severe homesickness. In addition, it was noted that until age twelve he suffered from enuresis.

B.L.Dubey,Ph.D. Professor of Psychology, Director SIS Center, P.O.Box 1107, Sector-15 Post Office, Chandigarh-160015(India)Tel/Fax 91-172-710986, E-mail: sisdubey@ch1.dot.net.in OR sisdubey@hotmail.com

Wilfred A.Cassell,M.D.,A.P.C., FAPA, Director, SIS Center, 4501 E,104th Ave, Anchorage, AK-99516(USA), e-mail:drcassell@corecom.net

As part of assessment and treatment plan development, he was given the Rorschach, SIS-I and SIS-video Images These procedures were completed initially in March 1991, then repeated in October 1991, then the third time in April 1992 and fourthly in February 1999. Repeating the visualization processes facilitated evaluating the clinical progress, while at the same time providing an aide for stimulating imagery for therapeutic discussion.

The longitudinal treatment plan involved insight oriented psychotherapy discussing his abandonment issues, content analysis with him concerning the significance of his inkblot responses, cognitive therapy and hypnotic relaxation During the initial period of three months his psychiatrist provided him medication to assist in the control of his anxiety. Fortunately, he made impressive improvement from the biweekly psychological intervention.

After six sessions, since he was able to deal with his anxiety more effectively and consequently he was able to take and successfully pass examinations. The psychopharmacological approach was no longer necessary. However, therapeutic work on the stammering and interpersonal conflict issues continued at intervals over the observation period. These were on an "'if and when needed basis" for approximately seventy sessions over the eight years. As will be shown, eventually the latter sessions began to focus on stressful interpersonal issues not directly related to the original presenting problems.

Results of Inkblot Interviewing :

At the initial evaluation with the Rorschach, there were signs of both low productivity(R=12) and imaginative capacity suggestive of his anxiety problem. In spite of definite improvement in his clinical symptoms, the Rorschach responses did not reveal much change, nor did they in this instance, stimulate therapeutically relevant percepts. The total number of Human content responses remained only 2 in all test sessions. Most Klopfer'S scores were essentially no different with repeat testing. By contrast the Human content with the SIS-I was observed to increase over time This matched his reduced examination anxiety and improved social skills. Initially he gave five human responses on the twenty inkblots and this number doubled on the last testing session. The quality of contents during 3rd and 4th testing improved, which can be observed in the tables, presented in this report. This was associated with a greater ability to communicate and interact with people. A few clinically significant responses on Rorschach, SIS-Video and SIS-I are shown below for understanding the pulling power of the test.

Comparison of Rorschach Responses on 1st, 2nd 3rd and 4th

Testing :

First testing : When sick

Second testing : After 10 sessions of Hypnotherapy

Third testing : Six months after termination of Psychotherapy

Fourth testing : Four years after termination of Psychotherapy

Card No.	1st Testing	2nd Testing	3rd Testing	4th Testing
1	Bat	Bat	Bat	Bat
II	Faces of two persons clapping like	two persons clapping	Two kids clapping.	Two persons clapping like.
III	A person	Hand of an Animal	Frog-head	Two ladies dancing
IV	Skin of an Animal	Animal like bat	Bat Flying	Bat
V	Two deer's horn up	Bird like vulture flying	Bat Flying	Bat Flying
VI	Skin of a lion	Skin of a deer	Skin of an animal	Skin of an animal
VII	Squirrel standing on a Rock	Two children playing	Two kids standing on something.	Two children playing
VIII	Two animals climbing on a rock	Two animals like wolf going up	Two wolf going up	Two animals climbing
IX	Aerial view of a vally	Rejected	Wed's type	Two animals
X	Various animals Spider , Peacock Rats	Various animals Spider, Peacock Rats	Various animals Peacock, Spider, Rats	Various animals Spider, Peacock, Rats

Comparison of a Few Significant SIS-I Responses on 1st, 2nd 3rd and 4th Testing:

SIS-I Images	1st Testing	2nd Testing	3rd Testing	4th Testing
1	Two hens sitting	1. Two hens 2. head of a person	1. Two hens 2. head of a person	1. Two hens 2. head of a person
5.	1. Bat 2. Two children	As some one has been killed	Mother and two babies	Mother and two babies
6.	Two penguin playing	Two children playing	Two Children joining hands and playing	Two children playing
14.	Insect with mouth	Insect like Beatles	Clown	Clown
18.	Face of ghost	1. Bat 2. Eyes, mouth faces of some one	Man's face	Face of a person
20.	Rejected	Face of a person	Face of some thing	Face of a person

With the SIS-Video, there was a similar increase in his ability to recognize human content in the video presentations and their quality improved. For example, initially for Al) he responded 4'It looks like fungi or algae". Next he saw it as "A hand surrounded by fire", denoting the painful grief stemming from his unresolved abandonment issues. In the third session, he projected a response symbolizing his progress; 'A band getting out, surrounded by plants". Finally, he saw it as " A hand of a person clapping!" This reflected his appreciation for the therapeutic assistance given over the years.

Next consideration will be given to illustrating how the discussion of his SIS-Video responses facilitated treatment, Firstly, in regard to the early abandonment issues, exploration with him of the following responses warrant comment:

A3 Initially he saw this as '~A human cell or roots of a plant that has been uprooted". Here the significance of the projection of the responses "human cell" symbolizes his traumatic loss at age seven when psychologically uprooted as denoted in the "plant uprooted". After his therapist repeatedly processed the family significance of this 518 imagery to him, he gradually began to resolve his abandonment issues. He learned to accept dependency on people as a necessary part of mature life. In working through his transference to the therapist, he acquired insight into the fact that loss and grief need not always follow trusting in close human relationships.

It was highly significant that he rated this symbolic material denoting as the "least liked" or most threatening imagery evoked by the 62 SIS-Video presentations. This demonstrates the critical importance of the therapist knowing developmental history concerning early losses and not attempting to do "blind interpretations". Lastly, in the final retest situation eight years later, he imagined seeing "a lovely flower with colorful roots", With growth in his self-confidence and esteem he could readily identify with a "lovely flower", The color signified his enhanced emotional state.

Comparison of a Few Significant SIS-Video Responses on 1st, 2nd 3rd and 4th Testing:

SIS Image	1st Testing	2nd Testing	3rd Testing	4th Testing
A3	Plant uprooted	Roots of a plant	Roots of a plant with branches	Lovely flower with colored root
A13	Looking like fungi algae	Hand surrouned by fire	Hand surrounded by plant	Hand of person clapping
A14	Picture on a wall	Liver	Human Stomach	Energy being sent from a person
A18	Smoke ring	Lave /Smoke Volcano	Cloud from Volcano	Bright gases ejected by volcano
A21	Looking like a bat	Two small children with bat	Two children playing around their mother	Hand of a person who is clapping
A24	Rejected	Forest with tree	Pond in a Forest	Mother and baby
A31	Faces of man and women	Man and Women	Man and women's face	Two lovers kissing
B4	A girl seeing her face in a mirror	Two faces	Two male and famale faces	Girl and boy sitting in a park
B17	Looking like volcano crater	Heart beating	Bright flower with petals	Heart beating on valentine day
B18	Rocket going up in war	Penis	Penis of a person	Graphic artist working on Epic
B22	Aperson sleeping and thinking of some thing	Dead body, soual going up	Person lying down and thinking he is dead and soul is going up	Man sleeping and thinking of Shen Ming
B23	Depression created by a bomb	Spider with legs	Spider with legs	Bright color in a shop
B28	A girl embracing her mother	Women embacing her child.	A girl clinging her mother	Mother and daughter
B31	Couple with children	Man women with their children	Couple with their two Children boy and girl	Happy family

A14 Initially, he said that this represented "a picture on the wall" The next two responses correctly identified the anatomical structure embedded in the inkblot. This was consistent with his developing a more mature awareness and sensitivity to emotionally tinged body sensations, At the eighth year of therapy, he projected the response "Energy being sent from a person". This depicted his recognition that he could benefit from

establishing interdependency relationships with nurturing people. Since had a religious support system, the additional value of spiritual meditating as a higher source of human "energy" was also discussed.

A18 He responded to this in the SIS-Video presentations as follows: "Smoke ring", "Lava, smoke, volcano, cloud from volcano and finally bright gases and lava ejected by volcano". His free associations to these responses in therapy immediately led to his emotional pain, low self-esteem, hurt and anger when originally psychologically abandoned in childhood The fact that he visualized the "gases" in brighter colors he realized symbolized his more positive self-image and hope.

To complicate interpretation, his therapist realized that some of his angry symbolism was stemming from new conflict with his parents. They recently had proposed a bride for him whom he considered unacceptable. Shortly before the fourth interview he had established a love relationship with a woman of his choice, Consistent with this he imagined SIS-Video Image 31A to represent "Two lovers kissing". Similarly, he envisioned 17B as "A heart beating on Valentine's day". Previously he had given the following responses: "volcano crater", 'heart", and "Bright flower with pedals". Also related to his evolving amorous interests, he visualized 22B as "A man sleeping and thinking of a woman he loves". This illustrates how the SIS may be used to follow maturing as an individual attempts to move beyond childhood fixations through new life passages.

Discussion :

This longitudinal case history employing the Rorschach and two versions of the SIS perhaps may be best considered from an historical point of view. The use of inkblots in art and psychology predate Herman Rorschach by many years. What is of interest is the fact that even though there have been attempts to develop inkblots such as the work of Holtzman and others (references), somehow the great creativity inherent in Herman's blots have been forgotten by modem professionals who over utilize reductionism scoring in cult like training seminars. Most educated people associate the name Rorschach to the notion of inkblot testing when the subject is brought up. while scoring Systems have added immeasurably to diagnostic application, their very use has tended to obscure the clinical merit of using content analysis. Overlooking the rich

symbolism of inkblot responses, such as those illustrated in Body Symbolism (Cassell,1980), especially as they may readily lend themselves to the therapeutic approaches does the field of projective testing a great disservice. Although, many psychologists refer to the Rorschach data as resulting from "projective testing" this is a misnomer when standard scales are the sole source of data. What is even more of a tragedy for the field concerns the fact that there has been so little effort to improve in the design and presentation of the existing inkblots.

In this study it was shown how the rich imagery evoked by the SIS tended to make the Rorschach percepts pale in comparison. Ordinarily, ten relatively ambiguous blots can not compare in projective pulling power with the SIS stimuli designed with embedded clinically relevant material. For example, the SIS is much more able to stimulate human percepts. In this case illustration, the clinical improvement with treatment over time was associated with a doubling in the number of human responses observed with the SIS-I but not the Rorschach

Apart from having 62 more visual stimuli for presentation, the SIS in the video version has more pulling power as a result of technology. It reduces test anxiety by combining floral relaxation for inducing hypnotic viewing with the opportunity for the viewer to write responses. The subject is alone, and like in hypnotic writing, does not have to hear what is reported Moreover, it is unnecessary to immediately share potentially threatening imagery with a professional person at the time the projective images and their disturbing emotions enter consciousness. When the subjects rates responses for those that are "least liked" the interviewer has an opportunity to evaluate their anxiety treat A busy clinician may simply get free associations to the most anxiety laden SIS image, without taking interview time with the others. For the college student under study, most threatening imagery provided very important information confirming the therapist's suspicion that early abandonment was a major stress. Of course, during the initial assessment, the youth had not yet been provided with this insight It was only after his therapist made this inkblot interpretation that he was able to begin to resolve this childhood loss. Giving associations in therapy sessions to the response to M "A human cell or roots of a plant uprooted" quickly led to the imagery's affect linkage

and his long forgotten grief.

While longitudinal case histories such as this point the way for clinicians in the new millennium, it must be recognized that there are many obstacles to be overcome. This is particularly true in the United States where problems related to professionalism are formidable Psychoanalysts are rapidly becoming a vanishing breed. Even though they employ free association in interviews, most do not believe that they should include inkblot analysis in their treatment. Present

SIS J. Proj. Psy. & Ment.Health (2000) 11-26

Professional Activities, Cultural Background and Social Interaction in the Zulliger Collective Technique

Cicero Emidio Vaz

This paper reports a research carried out with the Zulliger Technique focused on professional activity, culture and personality issues. The author has approached the productiveness, performance capabilities , social interaction and rational control levels in a normative sample of adolescent and adult groups in Southern Brazil. The Zulliger Technique collective form, according to Klopfers's system , was given to a total of 740 men and 601 women. Data was studied according to their 15 professional categories as follows: nurse (60), physician (64), odontologist (21), pharmacist (10), professor (41), army activities (154), manager (17), aircraft pilot (48), bank teller (15), receptionist (11), office clerk (48), undertaker (33), workman (54) and household activities (15) , None of them had learning or behavioural problems . The Wilcoxon statistical form was used for k independent samples and Pearson correlation for comparing and correlating data. A review was made responses (R) such as production capacity and performance, rational control (F), objective perception (F+%) search for social contact (Fc, c, cF) and social interaction (M, FC, Fc). The results pointed out a higher score of R within those professional categories with higher education levels and economic power; no difference was found between M and FC scores within professional categories with higher and lower levels of education and economic power. However, different Fc+ cF + c scores according to education and economic levels were found within professional categories. Finally, the influence of cultural background in data from the Zulliger Technique collective form is discussed.

While analyzing things , the world and its environmental conditions as well as human artifacts in the light of cultural perception (Segall, 1979: Matsumoto, 1996;Vaz, 1998) we are led to admit that the relational and physical environment, the constant dealing with objects and situations that are typical to each activity as well as particular concerns involved in the person's professional occupation may act as "cultural background " factors that have an influence upon their general standard of behaviour as well as in the formation of their personality . Such background may become a discriminating factor in the performance of certain tasks and activities in general.

It is the goal of this research to study the Z-Test in relation to the subject's cultural background concerning the number of responses, performance capability, human integration and interpersonal relationship , drawing on 15 professional activity cathegories : Nurse , Physician, Odontologist, Pharmacist, Professor, Military Activities, Manager, Aircraft Pilot, Bank Teller, Receptionist, Office Clerk, Undertaker, Workmen and Household Activities.

Cicero Emidio Vaz, Ph.D., Av. Lajeado, 969 AP. 301, Port Alegre - RS - Brazil-90460-110.

This research was partly financed by the Research Support Foundation of Rio Grande do Sul (FAPERGS) and the National Council of Research and Technological Development (CNPq).

Human personality is not a plain organism susceptible only to strictly observable variables ; there are many other variables from the environment dynamically interacting within each individual's psychism which interfere with its development, that is the maturing of the perceptive-associative process, the emotional-affective system and also in human interaction and integration capability. Margarida Loosli-Usteri's comments are very wise:"(...) data from a Rorschach are always eminently individual, as individual as are human beings" and Teodora Alcock, referring to clinical psychologists, says " they tend to be concerned with the pathological side of things when(...) they turn a protocol's analysis into a real witch chase, neglecting some of the person's healthy elements, even if their Rorschach shows major personality difficulties" (Alcock, 1965, p. 132). The intense influence of the media on children, youngsters and adults on their changes of behaviour are a fact that makes it critical and highly debatable to psychological assess a person in the nowadays world without giving attention to their long term professional activity, their economical, educational and cultural background besides psychodynamical aspects. The thorough methodological quantitative approach followed by a researcher in projective techniques or a professional in applied psychology is necessary but not enough. Quantitative parameters built up through a test (standard stimulus for standard response) or a technique (made up by variables with a high level of internal consistency) to assess a person are objective elements to represent reality or realities inside that person. In official appraisals for legal proceedings, in law matters and forensic psychology, such elements become discussion topics both the parties. Nevertheless, " The professional must be well and clearly acquainted with Rorschach data and their relevance in the particular psychological context of the examinee (...)"(1998, 141). Data collected through techniques as the Rorschach and Zulliger require consideration to the geographical environment, educational and socio-economical conditions, mono/multiethnic interaction as will as the myths and social practice that make up the person's cultural context, besides relying on the methodological framework of such tools and basic assessment criteria that come along with it.

Method:

Zulliger's (Z-Test) technique in collective form was applied to each group of 30 to 35 subjects, making up a total of 1341 people leading a professional, family and social life that is considered fit. Subjects, male and female, aged 17 to 48 , come from several places in the state of Rio Grande do Sul and other states in southern Brazil and were set in a large group made up by 15 professional categories. The Zulliger technique was applied to 740 men and 601 women aged 17 to 48, with education levels ranging from Elementary school(complete or incomplete),High school (complete or incomplete), College (complete and incomplete). Subjects under research were distributed as follows: 740 men (55.2%) and 601 women (44.8%) divided into age groups 16 to 19 years (180

men and 266 women), 20 to 25 (355 men and 129 women), 26 to 35 years (166 Men and 129 women) years of age, 36 to 45 (30 men and 56 women, 46 to 65 (5 men and 14 women) and over 66 years of age with 4 men.

The research was started in 1995 as a project sponsored by the Research Support Foundation of Rio Grande do Sul (FAPERGS) and the National Council of Research and Technological Development (CNPq) and its goal was to study the ethnic-cultural interaction among groups of German, Italian Japanese and Polish descent in the state's interior as well mixed origin groups in the city of Porto Alegre, adding up to total of 673 people . Anther 668 collective Z-Test protocols from former job applications were picked in a fashion at the Psychotechnical Center of PUCRS and added to the data presented in this paper. General conditions, the procedure, the application system for both research and job recruiting purposes followed the same standards.

Results:

The 1341 protocols were divided into 30 categories according to professional occupations each one had been carrying out individually for over 5 years. Occupations that presented the highest number of subjects were students, people in military activity, physician, nurse, odontologist, workman, office clerk, undertaker, manager and household activities, as shown in Table 2. There are other one less in under such as social worker, engineer, typist ,entrepreneur, messenger and driver.

The verbalizations of the 1341 subjects make up a total of 9,206 responses, with an average of 6,86 per person, a standard deviation of 4.11 and variation of 16.91: the total amount of responses seen in global areas (G) is of 2.890, with an average of 2.15 and a percentage of 31.3 per person ; common detail responses (D) add up to 5.120 with an average of 3.81 and a percentage of 55.6 respectively; in the common detail category (Dd), however, 13% of the location areas show up. Poorest number of responses were 2 whereas the most productive people provided 19 responses. The universe is quite big , ANOVA variation analysis between formal educational levels and their influence on the cultural background and the comparison between some pairs of variables through the T-test, like man/ woman working/ not working and formal educational levels allow for the inference that there is a need on the researcher's part to take these variables into account concerning the criteria for common detail responses in the Z-Test collective form. Professional activities were the most remarkable discriminating factors for location areas in the three slides.

Dispersion is high and so is the standard deviation of the average responses between the groups. In the comparative of the research Variance analysis

(ANOVA, One Way) was used for three or more groups of sample and the T-Test when a comparison between two groups were made (independent samples) specifically man and woman. The reliability interval chosen for the results was of 95% and the statistic tool used was the SPSS - for Windows, v.7.5 (1996).

Number of Responses (R)

The fact that a large number of people were tested shall be considered. The universe is quit diversified and this contributes to the high dispersion seen in Table 1.

Table 1

General Table of Responses (R) in The Zulliger Technique Collective Form, According to Professional Occupation

Occupation	N	Mean	SD	VAR
Student	592	7.11	2.98	8.87
Nurse	60	6.28	2.48	6.17
Physician	64	5.59	2.34	5.48
Odontologist	21	5.71	2.34	5.48
Pharmacist	10	8.20	2.82	7.95
Office boy	6	5.66	3.07	9.46
Professor	41	8.12	2.91	8.51
Army activities	154	6.14	9.08	8.24
Manager	17	6.41	2.59	6.75
Aircraft pilot	141	7.31	2.74	7.54
Bank teller	15	7.06	2.63	6.92
Receptionist	11	6.63	3.32	11.0
Typist	6	6.50	1.16	4.70
Office clerk	48	6.29	2.47	6.12
Sales man	5	9.20	3.27	10.7
Sales promoter	5	5.00	1.58	2.50
Businessman	6	7.16	4.26	18.17
Commercial employee	2	10.0	4.24	18.0
Driver	2	5.50	.07	.500
Entrepreneur	5	7.20	3.08	9.50
Undertaker	33	8.33	2.80	7.85
Civil service	5	7.20	1.92	3.70
Social Worker	6	7.33	2.06	4.26
Workman	54	5.40	2.58	6.66
Engineer	7	7.71	2.43	5.90
Household activities	15	8.26	2.43	5.90
Laboratory technician	3	8.66	2.51	6.33
Physiotherapeutic	3	10.33	2.88	8.33
Lawyer	2	5.50	.70	.50
Agronomist	2	5.50	.70	.50

Such a fact is a fundamental reason for the extraction of 15 out these 30 categories

(Table 1) with a number equal or superior to 10 people, that is men and women who have their occupation (Table 2) student , nurse, physician odontologist , pharmacist professor, military activities, manager, aircraft pilot, bank teller, receptionist, office clerk, undertaker, workman and household activities.

The average Responses in the 15 professional occupation groups that make up a total 1261 out of 1341 people in the research universe varies around 5.4 for the workmen's group to 8.3 for the undertakers' group , followed by the pharmacists' and professors' groups with 8.2 and 8.1 respectively (Table 2). The average of the maximum and the minimum of the 95% reliability is 5.7 and 7.93 considering the 15 occupational activity groups; it is remarkable that the interval's minimum (5.7) refers to those groups of people with a higher formal education level and a distinguished cultural background . Hence, in a person's assessment , specially for psychotechnical and/or recruiting purposes it is advisable to refer not to the minimum 5.7 and maximum 7.93 of the 15 groups' interval, but rather the minimum and the maximum of the expected average in the group with which the examinee has the most affinity; for example , in a selection for a function as a desk clerk working with the public, it is more adequate to pick the 4.4 to 8.8 response expected average interval in the collective Z as refers to the occupation/ profession category receptionist (Vaz , 1998), according to Table 2.

Table 2
Mean of Responses (R) in Zulliger Technique Collective Form, According to Professional Occupation

Occupation	N	Mean OF R*	SD	95% Confidence Interval Mean	
				Lower	Upper
Student	592	7.1	2.9	6.8	7.3
Nurse	60	6.2	2.4	5.6	6.9
Physician	64	5.5	2.3	5.0	6.1
Odontologist	21	5.7	1.8	4.8	6.5
Pharmacist	10	8.2	2.8	6.1	10.2
Professor	41	8.1	2.9	7.2	9.0
Military activities	154	6.1	9.0	4.7	7.5
Manger	17	6.4	2.5	5.0	7.7
Aircraft pilot	141	7.3	2.7	6.8	7.7
Bank teller	15	7.0	2.6	5.6	8.5
Receptionist	11	6.6	3.3	4.4	8.8
Office clerk	48	6.2	2.4	5.5	7.0
Undertaker	33	8.3	2.8	7.3	9.3
Workman	54	5.4	2.5	4.7	6.1
Household activities	15	8.2	3.9	6.0	10.4

* ANOVA Sig ≤-0.5

Differences are statistically significant and call special attention to the one of

workmen whose formal education level (predominantly people with an elementary school degree only) stands out of the remaining groups . Groups with higher averages are those made up by undertakers, professors and others with a distinguished cultural level.

Differences found among professional groups indicate that professional activity - in the research all has five or over years working experience in the activity - is a discriminating factor regarding the number of responses.

Human Movement (M+, M-, M±)

Human movement has been regarded by Rorschach advocates as bearing the meaning of creativity and the human being's integration capability . Rorschach defined it as a representative of the person's life experiences . Cristiano de Souza (1971), defined it as the world of creativity and the human being's normal fantasies. Schaffer (1954), giving it a psychoanalytical name ,identifies it as the expression of the ego. Rappaport (1946) says it to be the personality's abundance of experiences and Schachtel (1962), regarding its importance in the assessment of human relationship conditions, refers human movement as the power of empathy.

In the Z-Test the sum of human movement (M+,M-, M±) be understood as an expression of the person's internal world , spontaneity and their power for adapting to the external environment; it is the expression of the personality's integrating funtions.

In this sample of adolescents and adults , the results point at an average percentage interval between 12 and 25% out of a total M(M+M-and M±) which corresponds to 1 to 2 M in an average protocol. It is normal, as can be seen in Table 3, that such index is a little lower in household activities (average .06) military activities (average .66) and workman (average, .81). Samples are diversified and show relevant differences. Discriminance, in the statistic point of view show in the workmen group as related to the other categories and there is correlation between these data and the cultural level.

is correlation between these data and the cultural level.

Table 3

Mean of Human movement (M) in Zulliger Technique Collective form, According to Professional Occupation

Occupation	N	Mean (U)*	Percentual Mean of M	SD %	95% Confidence Interval Mean	
					Lower	Upper
Student	592	1.17	17.1	16.0	15.8	18.3
Nurse	60	1.06	16.4	14.6	12.6	20.2
Pharmacist	64	1.03	19.1	18.4	14.5	23.7
Odontologist	21	1.09	18.3	17.6	10.3	26.3
Chemist	10	1.60	19.0	18.2	6.0	32.1
Professor	41	1.48	18.8	14.5	14.2	23.4
Military activities	154	.66	13.8	19.5	10.7	16.9
Manager	17	2.41	37.3	52.4	10.4	64.3
Aircraft pilot	141	1.25	18.0	16.4	15.3	20.8
Bank teller	15	1.20	17.3	12.7	10.2	24.4
Receptionist	11	1.09	16.5	9.6	10.0	23.0
Office clerk	48	1.06	19.1	15.6	14.6	23.6
Undertaker	33	1.45	17.4	16.9	11.4	23.5
Workman	54	.81	15.7	17.32	11.0	20.4
Household activities	15	.06	13.5	11.1	7.3	19.6

*ANOVA Sig < .05 From (u{M+,M-,M±uR) x 100

Shape and Color Determinant (FC)

Response featured by the shape and color determinant (FC) represent the person's capability of giving and taking affection properly, of investing affection in others and allowing for being the object of affections from other likewise. The better the quality of shape and color responses, the more mature are affective-emotional conditions . Often the presence of FC is not enough . " A red butterfly" in area Dl of slide 111, i.e., compared to " green algae" , area D2 of figure 11 classified as FC; both classifications indicate adequate condition for affective relationships, just that the second response(plant color) is more common in people with less affective and mature feelings than the first one .

Average FC frequency is not usually high; in general neither in the Rorschach nor in the Z-Test collective form. From what can be seen in Table 4 the average per protocol is around 1 to 2 FC, in general, in the fifteen groups. The use of the expected average interval at the level 95 of reliability , 3 to 11% over the total of responses per protocol, as a reference parameter for those who take numeric precision into account , seems more adequate. It may be found that professionals

in the field of health, like psychology, nursery and odontology tend to increase the index of shape and color response (Table 4).

Table 4

Mean of Form collor (FC) in Zulliger Technique Collective Form, According to Professional Occupation

Occupation	N (u)	Mean FC	Percentual Mean of Fc	SD %	95% Confidence Interval Mean	
					Lower	Upper
Student	592	.47	7.4	12.4	6.4	8.4
Nurse	60	.66	10.8	16.2	6.6	15.0
Physician	64	.28	4.3	8.8	2.1	6.5
Odontologist	21	.23	4.7	9.6	.35	9.1
Pharmacist	10	.60	6.0	6.6	1.3	10.8
Professor	41	.39	4.4	9.2	1.5	7.3
Military activities	154	.22	4.2	10.7	2.5	5.9
Manager	17	.05	.98	4.0	.03	3.0
Aircraft pilot	141	.39	5.5	10.7	3.7	7.3
Bank teller	15	.33	4.6	7.1	.65	8.5
Receptionist	11	.36	6.8	16.1	1.0	17.6
Office clerk	48	.47	7.0	11.6	3.6	10.3
Undertaker	33	.45	4.8	8.0	2.0	7.6
Workman	54	.18	3.1	8.4	.08	5.4
Household activities	15	.33	3.2	6.0	6.2	6.6

ANOVA Sig < .05

From (uFC+uR) X 100

Color Response without the Combinatory Shape (C)

Pure color (C) is the specific determinant in the Rorschach and the Z- Test through which the examinee projects his/ her emotional reactions that are free, intense and full with feelings, be they of appreciation , esteem, admiration, love and passion, or be they of depreciation, scorn, hatred, anger and aggressiveness.

Data form the protocols under study (Table 5) point out a very low C frequency which corresponds , to what is expected theoretically in researches with the Rorschach applied to people considered normal.

Table 5
Mean of Pure Collor (C) in Zulliger Technique Collective Form, According to Professional Occupation

Occupation	N	Mean (u)*	Percentual Mean of C	SD%	95% Confidence Interval Mean	
					Lower	Upper
Student	592	.03	.6	.3	.03	.9
Nurse	60	.01	.3	2.5	.31	1.0
Phsysican	64	.03	.5	3.4	.20	1.4
Odontologist	21	.00	0.0	0.0	0.0	0.0
Pharmacist	10	.00	0.0	0.0	0.0	0.0
Professor	41	.09	1.1	4.8	.03	2.7
Military activities	154	.04	.8	4.5	.11	1.5
Manager	17	.05	.8	3.4	.03	2.6
Aircraft pilot	141	.03	.4	2.8	2.6	.9
Bank teller	15	.00	0.0	0.0	0.0	0.0
Receptionist	11	.00	0.0	0.0	0.0	0.0
Office clerk	48	.04	1.3	6.7	.05	3.3
Undertaker	33	.00	.8	3.4	.09	2.4
Workman	54	.14	3.1	11.0	.01	6.1
Household activities	15	.00	.00	.00	0.0	0.0

ANOVA < .05 Form (uC+/uR) X100

The 95% reliability expected average percentage interval is of at least 0.23 and most 1.52. There are five professional occupation groups, at the least and at the most: odontologist , pharmacist, bank clerk , receptionist and household acivities; occupations having the highest expected index in the interval are workman , office clerk , professor, manager and military activity with 6. 1, 2.7, 2.6, 2.5, 2.4 respectively. It is remarkable that the workman's is the highest . Occupation may be a discrimination factor for that occupation group. If it is a workman who is being assessed and if the desired point of reference are the results of the research, the maximal expected interval to be used will be the one of the workman's group , that is not the 0.23 to 0.52 but rather the .01 to 6.1 one (Table 6).

Texture (Fc, cF, c)

Klopfer (1972) comments that the presence of Fc up to 1/3 of the total responses F in a Rorschach protocol indicates that the person is aware of their affective needs their attempt to control them through social contact.

From our point of view , texture is a tactile way of expressing the person's affective conditions, be it the search for affection from someone or something or the

investing of affection in other people , situations and objects. Those capable of adequate attitudes(with due limit perception) in the dynamizing of this search or investment, have an outcome in the Fc technique that is proportionally equal or higher than cF+c; on the other hand , those who fail to do it properly (without the due perception of limits) have an Fc lower than cF+c.

Texture is an indicator of shifting affection and emotions to activities and social contact; it is the inividual's capability for social interaction.

Data studied allow us to say that the expected texture percentage in a normal person would be as high as 17% for a receptionist, 15% for a nurse and 10.3% for an office clerk

Table 6

Mean of Texture Responses (FC+CF+C) in Zulliger Technique Collective Form, According to Professional Occupation

Occupation	N	Mean (u)*	Percentual Mean of FC, cF,c	SD%	95% Confidence Interval Mean	
					Lower	Upper
Student	592	.10	7.4	12.4	6.4	8.4
Nurse	60	.35	10.8	16.2	6.6	15.0
Phsysican	64	.78	4.3	8.8	2.1	6.5
Odontologist	21	.04	4.7	9.6	.35	9.1
Pharmacist	10	.00	6.0	6.6	1.3	10.8
Professor	41	0.9	4.4	9.2	1.5	7.3
Military activities	154	.11	4.2	10.7	2.5	5.9
Manager	17	.52	.98	4.0	.02	3.0
Aircraft pilot	141	.15	5.5	10.7	3.7	7.3
Bank teller	15	.06	4.62	7.1	.65	8.5
Receptionist	11	.00	6.8	16.1	4.0	17.6
Office clerk	48	.06	7.0	11.6	3.6	10.3
Undertaker	33	.12	4.8	8.0	2.0	7.6
Workman	54	.03	3.13	8.4	.83	5.4
Household activities	15	.13	3.2	6.0	.01	6.6

*ANOVA $\leq$ .05 Form (u[{Fc,cF,c}/R) x 100

Discussion :

The study of data from the Z-Test collective from call for the need of taking into consideration the kind of professional occupation inside the examinee's environmental and socio- cultural context while interpreting their number of responses, either in the case of an assessment with regards to psychotechnical

examinations or to a general assessment because the individual's personality is a whole context, like psychism.

Since they deal with the same instrumental elements for communication and peculiar ways of social and professional relationships , professional occupation activities , as long as they count on a long term experience (in the research a minimum 5 year activity was considered), make up a cultural environment worth taking into account while carrying out a psychological assessment via Zulliger Technique concerning performance and production capabilities , the personality's affective development as well as social interaction .

It is worth commenting on the need of dynamically integrating human movement responses with other variables. Two high quality human movement responses (M+) in a protocol with an F+ over 70 %, F% within the average (of the group) and with an elaborated DG indicate that the person has a creative and dynamic intelligence with a good planning capability. A high M index, more than three in a protocol, may mean a highly creative intelligence or a person prone to maniac defences or reactions. Such reactions become more critical as the high M index is combined with CF (poorly controlled emotional reactions) and FM (impulsive reactions) also with an increased index.

The absence of M. is frequent in the case of anxious, tense inhibited , depressive or less intelligent people. Still , the absence of M is frequent in cases of mental deficiency, plain schizophrenia with stereotyped thinking ; it is however necessary, to accept the hypothesis of mental deficiency, to check whether the number of responses is too low, to look at the F and the F+ percentage and check for the perseveration of the same content in the three sides ; as for the schizophrenia hypothesis if there is contamination (dissociation of ideas) , low F+% with a consequent increase in F-% and absence (discerditing of logical thinking)of chromatic responses (blockage or other problems of affective -emotional origin).

Responses with human content in action are the good quality movement kind (M+) and indicate good intellectual condition and creative imagination , whereas the M - kind ones are more often the case of inhibited and anxious people with a fearful and tense relationship. No cases were found in the research but, theoretically, men and women with difficulty of psychosexual nature, even intelligence and creativity, provide M- human movement responses rather than M+ due to shyness in integrating with people .

The verbalization of animal contents in action is childhood characteristic. The

stories (or tales) for children are always culturally featured by animal figures. Movies and TV programs for children are more and more full of animal characters or animals semicharcterized as humans . Alcock (1965) highlights the importance of FMs in a protocol of adults also , as a “release valve for libidinous impulses and as poor tolerance to frustration" (P.63) . Authors, in the majority think that FM shall be superior to the M index in normal personality cases. Klopfer(1954) considers FM as what is most primary and archaic in the personality's structure, featuring it as the representative of instincts and impulses. Schachtel (1969) classifies FM and M as expressions of past experiences, FM being the most instinctive and most primary , and , implying that M manifests as the meaning of as experiences lived in the past although functioning dynamically upon further maturing and adjusting to reality.

FC $\geq$ CF+C Index. When shape and color (FC) are proportionally higher than color and shape (CF) plus pure color (C) , we may say that the examinee is able to liberate his/ her feelings, affections and emotions in an adequate and mature way as well as to establish a good interpersonal relationship. It is timely to relate this proportion to human contents once the H+Hd index within the expected average indicates as adequate capability for social interaction whereas the presence of decharacterized human contents {(H) + (Hd)} mean a careful and fearful human relationship.

We may say, drawing on the data researched , that , as people grow old chronologically they tend to decrease color and shape responses (CF) in the Z-Test collective form. This leads us to statistically infer that they gradually learn to control their emotional reactions thus increasing their affective maturity. The FC $\geq$ CF+C predominates in the 15 groups of people considered normal concerning : occupation , professor , military activities , household activities and physician , specifically groups of people aged 26 to 35 and 36 to 45. Mattlar et al (1992) , having applied the Z-Test in people of British culture , states that the CF+C tend to come back in elderly years; people of that age have not been included in this research.

The proportion of FC $\geq$ CF+C is considered as an ideal parameter serving as an indicator of adequate affective and emotional relationship with other people . It is an index that occurs in mature people who work out their emotions and feelings in proper fashion. It is useful to check whether the FCs or not of the F/C or F-C kind , which then shall be interpreted as a sign of affective liability. In personnel recruiting it is always useful to take the job's characteristics and peculiar aspects

into account. There are activities in which it is necessary to have a more aggressive potential (not destructive), corresponding initiative, competition and dispute . Hence , besides the presence, in adequate percentage , of animal movement (FM) in well defined fashion (F+) and total responses with shape (F+,F-eF±) it is expected that there is CF as liberation of emotion with certain intensity so as to reinforce the instinctive of the search for the attaining of goals. In a personnel recruiting situation or similar, the inverse proportion (FC< CF+C) depending on how the F, F+ stand as well as the kinds of pure color may favour the person's protocol's evaluation. Named color and described color are elements that compromise the proportion above once they indicate emotional lack of control.

When FC index is less than the CF+C one the following interpretation is worthwile: the person, when affective and emotionally mobilized, finds it difficult to react in adequate fashion so as to adapt to the interpersonal relationship. Drawing on the Rorschach, it is known that this is higher in children (Beizman, 1968: Jacquemin ,1977) . It is an indicating index for " hasty emotional reaction, proper of the adolescent" , as referred to by (Exner e Weiner 1995, p . 294).

The CF determinant, as isolatedly regarded, indicates that the person reacts to emotional stimuli in a poorly controlled manner; his/her emotional system gets mobilized upon minimal intensity stimuli. People with tendencies to emotional excitability , aggressive escapes and attitudes lacking proper control tend to provide more CF responses than those considered "emothinally controlled". It may indicate irritability and internal uneasiness when associated to S, K or KF (increased situational anxiety) and expressions of criticism to the test or the examiner's person.

The presence of pure color is always a reason for attention to the examinee's capability of emotional control on the psychologist's part . It is necessary to properly integrate this variable to the general Z- Test data picture. Sometimes the presence of a pure C in a protocol with adequate indexes of F% ,F+%, M< G% and D% may be interpreted as a positive datum: a sign initiative and capability of firm emotional reaction necessary for decision taking.

Forced Color (F-C and C-F) and Arbitrary Color (F/C and C/F): responses of such nature in the Z- test collective hardly ever occur. When this happens, it is useful for the examiner to check it out , for it is commonly due to alterations in the " slide's" color. In the individual Z it is more frequent: it may mean affective

liability, careful and timid interpersonal relationship. There were of such kind of determinant.

Described color- Cdesc. None occurred in the research. This variable did not occur in the research. Cdesc is another type of reaction to color in which the examinee's thinking tends to disorganize, led by intellectual difficulty rather than personality disturbances. Having poor condition for organizing logical thinking and intelligence as a general factor , he/she starts to simpley describe blends of colors. People with limited intelligence describe colors without expressing feelings of hostility or other personality compromising manifestations: on the contrary, they ask directly or indirectly or verbalize feelings of impotence.

Symbolic color- Csimb. Some of this kind of determinant occured in the research carried out. Out of all shapeless chromatic responses, it is the one that least compromises the examinee's diagnosis. Upon the mobilization caused by the colors to their affective emotional system and the confusion thus experienced , he/ she uses the color as a symbol of abstract contents , in an attempt to escape, but in a non aggressive way. The presence of symbolic color is an indicating sign that the subject is trying to sublimate his/ her aggressive inpulses.

Pure color- C . In principle, pure color indicates the lack of emotional control , it is the aggressive escapes . In the Z- Test, this variable in personnel selection almost always suggests that these people are prone to reaction of enthusiasm, feeling burstouts, emotions and a behaviour showing unstability and unsteadiness; when C is high (more than 2 in a protocol with an average number of responses, according to its group of reference and combined with the FM index also expanded (More than expected) , the risks of control loss are higher due to primarity and childishness . However, when the C index is not high and general control (F%) is within normal, the capability of integration and empathy is of good quality (M) and there is no other compromise in Special Phenomena, the interpretation of C shall be lessened.

Named or number color- Cn . None occurred in the research . Named color appears in the protocols of people who , when facing colourful stimuli, become emotiuonally disturbed to an extent such that they cannot perceptualize any content; they can only number or name the colors.

It sometimes become hard for the examiner to identify a response featuring texture in the Z collective. The process of brightness, projection on screen , as well as the lack of verification (inquiry) on the examiner's part, are factors that

lead the examinee to not make clear whether it is by the shadow over that he/she is being led to provide such response or by any other factor as, for instance, the dark with plain blends or other factors . For this difficulty to lessen it is recommended that, during the application, at the time instruction giving for the mapping of the areas where each examinee saw the verbalize content, it is requested to comment in detail what was written in the first part of the testing .

The texture determinant (Fc, cF, c) that for years was considered an interpreting determinant in the Rorschach related to anxiety and anguish caused by the need of contact " from the grossest to the social one" according to Leme Lopes (1949), that is interpreted as a problem of sexual nature, is nowadays regarded as the presence in the examinee of needs for predominantly social contact. Texture , as a tactile kind of perception and as the human being's most primary case of affective contact is based on tactile sensations. Such sense provides the basis for tactile perception" due to its levels of development both intellectual and affective" (Schatel, 1954 , p13). This is why, during the application of the Rorschanch or the Z-Test , some people rub the area on the card at the same time as they verbalize what is being perceived there: it is like they were caressing the area where they verbalize the response. Tactile perception says Onativia (1972), polarizes several confluent nuclei of the experience between the body itself and the external world , between the intimate space and the social space. The "self" says the author " thus builds, from the very first time , through sensitivity and reactions with the mouth and later with the hands (...) an affective exchange between its internal sand external worlds" (Onativia, 1972, p. 17). Adrados (1969) interprets this as the sublimation of affective needs through social activities and contact.

References:

Adrados, I. (1967) . Teoria e pratica do test be Rorschach. Rio: Fundacao Getulio Vargas (FGV)

Adrados, I. (1976). Rorchach na adolescencia normal e patologica. Petropolis: Editora Vozes.

Alcock, T. (1956). La Pureba be Rorschach en la practica (1.ª edicao 1963). Mexico: Fondo be Cultura Economico.

Beizman, C. (1968) . El Rorschach experiment en el nine de tres a diez anos. Madrid: Aguilar, S.S. Ie Rorschach . Bull . Fr. du Gorupment Francais be Roschach , Junho, 11-17 .

Cristiano be Souza, C.(1971) O metodo be Rorschach(1. ª Edicao 1953).Sao Paulo : Vetor Editora Psico- Pedagogical Ltda.

Exner, J.E.& Wenier I.B.(1995). The Rorschach: A comprehensive system. assessment of children and adolescents (Vol. 3,2,ª. ed.) New York : John Willey & Sons, Inc .

Frank, G (1992). The response of African Americans to the Rorschach: a review of the research

Journal of Personality Assessment 59(2), 317-325.

Jacquemin, A.A.(1977). O teste be Rorschach em criancas brasileiras. Sao Paulo: Vetor Editora Psico- Pedagogica Ltda.

Klopfer, B.& Ainsworth, M.D.(1954). Deplopment in the Rorschach technique (Vol.I).New York: World Book Company, Yonkers-on- hudson.

Klopfer, B.& Kelly, D.(1972).Tecnica del psicodiagnostico be Rorchach (1.edicao 1946). Buenos Aires: Ed. Paidos.

Matsumoto, D. (1996). Culture and psychology. Boston: Brooks/ Cole Publishing Company.

Mattlar, C. E., Carlson, A., Forsander, C., Karppi S. L. & Heleniu, H.(1992). Rorschach and old age : personality chacteristic for group ofphsically fit 80 year old men. British Journal of Projective Psychology, 37(2),41-51.

Onativia, O.V.(1972). Rorschach tactil. Buenos Aires: Editorial paidos.

Rappaport D, Gill, M.& Shaffer, R. (1946). Diagnostic psychological testing (Vol.2). Chicago: Year Book Publishers.

Segall M. H. (1979) Cross Cultural Psychology: Human behavior in global perspective. Pacific Grove: Brooks/ Cole.

Schachtel, E. G. (1962). Metamorfosis. Mexico: Fondo be Cultura Economica>

Schafer R. (1954) Psychoanalytic interpretation in Rorschach testing. New Yourk : Grune & Straton.

Statistical Package for Social Sciences Inc .(1996) SPSS for Windows , v 7.5 . Michigan:Statistical Package for Social Sciences Inc

Vaz C.E. (1990) .Ansiedade, hostilidade e aculturacao: estudo comparativo entre indios Tukuna e brancos nao - Tukuna . Psico 19 (1), 9-22.

Vaz, C.E.(1993) Produtividade, cultura e etinia em adolescentes de origem protuguesa, afrobrasileira, alema , israelita e italiana . Psico 24(2), 41-52.

Tukuna e brancos nao - Tukuna. Psico, 19(1): 9-22.

Vaz, C .E.(1990).Z-Test -Tecnica de Zulliger Forma Coletiva. Sao Paulo Case do Psicologo.

At Somatic Inkblot Society, it gives us immense pleasure to acknowledge and place on record the fact that M/s. Jain Vinay Kumar & Co,. the Chartered Acccounts at New Dehli have been offering services to the Society since its inception in 1994. As a token of gratitude, we are pleased to honour Mr. Vinay Kumar Jain with Life Membership of the Society. May this association last for ever.

President

SIS J. Proj. Psy. & Ment.Health (2000) 27-38

The Cross Cultural and Clinical Values of Fairy Tales and the Fairy Tale Test

Carina Coulacoglou Ph.D

The fairy Tale Test can be effectively employed as a basic technique for clinical assessment of peronality. The test standardized on a large sample of non-referred children and found to be useful in assessing developmental changes, or situational effects in children. Most importantly, because of the universal values found in fairy tales, the FTT can prove to be a very useful technique in cross cultural personality research .

ORIGINS AND HISTORY OF FAIRY TALES

The origins of fairy tales has often been the main issue for debate among scholars in the field, such as folklorists and cultural anthropologists. Fairy tales appear to have been in existence for some thousands of years as oral folk tales. They were spread throughout the world by word of mouth to adult audiences. The motive for their narration appeared to have been nothing more than wonder and entertainment. Explanations concerning their appearance, range from ritual celebrations of the seasons and initiations rites to products of unsatisfied psychological needs or conflicts.

Tracking the historical development of fairy tales is a difficult task as their origins spread throughout the world and the temporal threshold between the oral folk-tale and its literary version is not always distinct. Heuscher (1974) notes: «Information concerning the early historical development of the folk tale will always remain vague and fragmentary...» (p. 37). Jane Yolen writes: «The oldest stories were transmitted and transmuted, the kaleidoscope patterns of motif changed by time and by the times, by the tellers and by the listeners by the country in which they arose and the countries to which they were carried. The old oral tales were changed the way culture itself changes, the way traditions change...» (p.23)

Oral folk tales became literary fairy tales when certain scholars decided to compile and write them down. Some well known fairy tale recorders and their collections are the Italians Straparola (The Pleasant Nights, 1550) and Basile (The Pentamerone, 1634- 1636), the French Charles Perrault (Mother Goose Tales, 1697), the German brothers Jacob and Wilhem Grimm (Nursery and Household Tales, 1812/1815), The Russian Aleksandr Afanasev (Russian Folk

Carina Coulacoglou, Ph.D. Psychologist, Unioversity of La Verma, 40 E, Esperou Str. Kifissa, Athens 14561 Greece Telefax : (301) 6252269 e-mail : carina@hot.gr

Tales, 1850), the Greek George Megas (Greek Folk Tales, 1967).

It was the brothers Grimm however, who are said to have altered parts of the original texts in order to make them more suitable for children. «Wilhem Grimm can be credited with sanitizing folk tales and thereby paving the way for the process that made them acceptable children's literature in all cultures» (Tatar, p. 24).

However, famous fairy tale collections have been found much earlier in history and possibly influenced the context of European fairy tales. Such a collection is Panchatantra which was put together in India before the 6th cent. AD and the Arabian Thousand and One Nights.

The subjective factor in the production of the literary fairy tale has been a cause for concern among scholars. The brothers Grimm in particular have been the main target of such criticisms. The extent of subjectivism in the Grimm's tales is controversial and cannot be exactly estimated, but nevertheless, their tales have gained in popularity over the years.

Adapting fairy tales is a composite task and should not be equated to simple translation of texts. Roth (1998) maintains that literal translations and the striving for formal and semantic equivalence should be avoided. «Even if the motifs and themes are international, the culture- specific may reside in their combination and in the elaboration of the details and traits or in the meaning they convey» (p.250).

The Arabian version of Snow White, recorded by Enno Littman (cited in L. Rohrich's Folktales and Reality) offers an example of such a cultural adaptation. Snow White becomes «Miss Snowey»; her father Hassan, is the chairman of the merchants' guild. The heroine is not led into the forest, but is pushed into a bottomless well and ends up at a robber's house instead of the dwarfs cottage. The evil stepmother gives Snow White poisoned coffee instead of the poisoned apple. The marriage to the prince is arranged through a contract signed by both parties. All of these details indicate that the Oriental folktale is realistic and that it has a more rational attitude than our own.

Values and characteristics of fairy tales

Fairy tales reflect in a poetic way the human situation: fear of abandonment, anxiety in the face of the unknown, child- parent relationship, the wish to achieve, feelings of antagonism, jealousy, hatred, vengeance, tenderness, ambivalence. In addition the reflect universal values such as friendship, humility, forgiveness, tolerance, sharing, justice, love and marriage.

The process of narrating fairy tales should not be underestimated as a further

element that enhances the appeal that fairy tales exert on both children and adults. In Greece, for example, the memory of favorite fairy tales is inextricably associated with a loving grandmother sitting by the fireplace during a cold winter evening. Fairy tales' universal language becomes an intimate exchange of human experiences as these are absorbed in the safe proximity of the «inexhaustible» grandmother. The powerful memories of tales as one gets old is characteristically presented in the following passage from «The Manuscripts of Loneliness» by I.M. Panayotopoulos:

«Right in the midst of summer, the ancient Zeus sulked and the sad rain gathered a herd of clouds and nailed them on us. Time to go home. The thirsty earth longed for the rain just like our hearts longed for the fairy tale. Behind the misty glass shivering dreams are passing. Sad Cinderella, missing her shoe removed the curtain: where is my treasure hiding? Little Red Riding Hood nests in the corner. All of a sudden the forest turned to winter. The wolf is spying through aging logs. We hear his howling in the stillness. Where is he coming from? The broken branches gasp under his foot. Well, dear Little Red Riding Hood it seems the weather has turned cold, snow is falling up on the mountains. Right here we shall light the ancient fire and wake up grandmother who sleeps for ageless times inside her shabby coffin and plead to her to start the tale once again. Around the fire we shall relive the great moment. The pale apple hangs from the beam along with the winter quince. Dear Little Red Riding Hood, the house is sweet on such a magic night».

Fairy tales are characterized by a number of features that make them suitable for children between five and eight years as they embody an accurate representation of the child's conception of the world (Favat, 1977). The child's belief in the omnipotence of thoughts exists in the fairy tales in the form of wishes. Animism and anthopomorphism are typical characteristics of preoperational thought and are often encountered in fairy tales whereby inanimate objects or animals adopt human qualities. Notions of retributive justice abound in fairy tales. Children of this age group prefer factual description of events to causal explanations. Causal relations in fairy tales are not explicitly expressed.

Identification with fairy tale characters

The process of identification with fairy tale characters is facilitated by the way these characters are presented: (a) the majority of characters in fairy tales are introduced to the listener/ reader in an «either -or» manner; they are either good or bad, young or old, beautiful or ugly, strong or weak (b) the names, when these appear, of the protagonists are usually descriptive: Snow White, Cinderella, Rapunzel, Rose Red, Tom O' Thumb, Dumbling. There are times that proper

names are given but in such case these names are common e.g. Hansel, Gretel, Jack, Elsa. Secondary characters are introduced according to their social role or status: mother, grandmother, king, princess, younger son. Zoe Valasi describes fairy tale characters in a poetic way: «Nameless heroes, clouds that resume their shape from our dreams, fleshless inhabitants of a world without dimensions, offsprings of our needs and aspirations, threads of the moon and the shadows. Symbols».

The great majority of fairy tale protagonists are children and on the whole females. The sex of the hero does not appear to affect identification as what matters most is what these characters symbolize. Little Red Riding Hood is the representation of naivete, disobedience and ambivalence. Snow White represents kindness, loyalty, naivete. Cinderella represents humility, dependence, passivity and submission. Gretel is a symbol of courage and determination. In addition to personality characteristics which are basically determined by specific actions, characters when not seen in isolation, but in connection with the plot are said to symbolize specific developmental conflicts, or anxieties. Thus, the story of Little Red Riding Hood deals with the issue of aggression and violence and in particular its most primitive form, oral aggression. Snow White and the Dwarfs deals with such issues as narcissism, oedipal feelings, antagonistic mother daughter relationship. Cinderella deals mainly with the issue of sibling rivalry.

Interpretations of fairy tales

Several attempts have been made been made to interpret the symbolisms of the fairy tales. Interpretations of fairy tales have been systematically criticized by folklorists (e.g. Dundes, 1989) as these interpretations are based on the literary form of the tales. For example, a folktale version of Little Red Riding Hood as presented by Paul Delarue (cited in Dunde's) appears to have preceded Perrault's and the text differs on a number of aspects: the red hood is missing, there is no mentioning of grandmother's physical health, gruesome details of how the wolf asks LRRH to taste her grandmother's flesh and blood are presented and finally LRRH manages to escape from the wolf by herself.

As most psychoanalytic interpretations focus on the literary versions of this tale and in particular to the significance of the red hood or cap and the role of the hunter, one wonders if and to what extent these are valid or accurate.

A. Psychoanalytic interpretations

It was Freud who observed that the symbols which occurred in dreams were to be found in a more developed way in folklore, myths and legends. According to psychoanalytic theories of symbolism, feelings and affects towards oneself and

important others in life can be found and released through symbolic representation.

Bettelheim's book «The Uses of Enchantment: the Meaning and Importance of Fairy Tales» (1976) became a landmark in the psychoanalytic theory of fairy tales. The book offers an elaborate account of the relation between children and fairy tales, placing special emphasis on the therapeutic value of tales. Bettelheim following the Freudian approach, produces extensive analyses of popular tales and attempts to demonstrate how each of these reflects conflicts or anxieties at specific stages of development. Additionally, through fairy tale characters children project «forbidden» thoughts and wishes. For example, the stepmother and the witch commonly symbolize the malevolent aspects of the mother, while the fairy or the Fates may represent the benevolent aspects of the mother. We may therefore observe the splitting of the mother figure into good and bad just as young children often perceive her.

More recently, Kaes et al. (1989) suggest that the fairy tale is closest to the dream in terms of its content, its processes and its subjective usage. The tale serves three functions: as a link, as a transformation and as an intermediary. More explicitly, it links primary with secondary processes; it transforms unconscious fantasies to structured narratives, whereby the form and symbolisms turn audible the voice of desire; and thirdly, it acts as an intermediary between the body and the social milieu. The authors have stressed the importance of fairy tales in groups, groups identified as siblings, family, members of a group, friends. Therefore these authors chose for analysis Grimm tales such as the Twelve Brothers, the Seven Ravens, the Six Swans, the Musiciens of Bremmen. They note that these tales may be interpreted according to different stages of development such as the pregenital, the oedipal, the genital.

B. Jungian interpretations

Jung once claimed that in fairy tales one can best study the comparative anatomy of the psyche. In myths and legends one gets the basic patterns of the psyche through an overlay of cultural material; in fairy tales there is much less specific conscious cultural materials. The fairy tale concretizes archetypes, the structural components of the collective unconscious. Some of the most well known archetypes are concerned with birth, rebirth, death, power, magic, unity, the hero, the child, God, the demon, the wise old man, the earth mother, the animal. A large majority of fairy tales begin with the so well known to most of us «Once upon a time..». This phrase signifies the timelessness and spacelessness of the events about to take place. In Jungian terms it signifies the nowhere of the collective unconscious (Von Franz, 1982). The king usually symbolizes the Self,

the regulating system of the psyche. A frequently appearing motif in fairy tales is about a king who has fallen ill or dies. This may be interpreted as the necessity for the king / Self to be renewed through death and rebirth. Other Self symbols may be the child, and various round objects such as the crystal ball or the ring.

The Ego is the conscious mind and the hero of a tale may serve as the restorer of the healthy, conscious situation. It can therefore be said that the hero is an archetype which represents a model of an ego functioning in accordance with the Self. The stepmother or the witch is a symbol of the unconscious in its destructive role- of its disturbing and devouring nature.

Other popular Jungian concepts and archetypes are often encountered in fairy tales such as the shadow, the animus or the anima. For example, in Little Red Riding Hood, the wolf represents the shadow, or the primitive, lower side of the human nature. «As a wolf, Little Red Riding Hood gets to know a side of herself that is «loose» that doesn't care about duties or what other think about her» (Kast, 1995 p. 14).

Clinical Applications of Fairy Tales

Because of the specific nature of fairy tales their use in therapeutic settings has been increasing during the last decade both in the realm of adult and child therapy. In India even at our times people who suffer mentally often visit the shaman, a priest or a wise man in order to relieve them from their troubles though the narration of fairy tales. Therapists following the psychoanalytic or the Jungian approach employ fairy tales in the treatment of patients in order to help them gain insight into their conflicts or anxieties. There are several ways of employing fairy tales in psychotherapy. Some of these are reading and reciting fairy tales, narration of fairy tales either by the therapist or the patient, continuing fairy tale beginnings, changing and modifying existing texts, inventing fairy tales, drawings, performing fairy tales (Franzke, 1989).

Following the Jungian approach Brun et al (1993), Kast (1995) and Dieckmann (1986) employ fairy tales in their analytic treatment of adult and occasionally children. Dieckmann (1986) refers to the association between dreams and fairy tale motifs and also to the favorite fairy tale. Through the presentation of case material he illustrates the basic parallels between personality structure, neurosis and favorite fairy tale. He maintains that in practice one can find many comparisons between the themes or symbols of the tales and the symptoms of neurosis.

Lafforgue (1990) proposes a way to employ fairy tales with autistic or psy-

chotic children in what he calls «atelier conte» (tale workshop). The two main features that render fairy tales therapeutic are their ability to simplify situations-unnecessary details are omitted from the plot and secondly, they are structured around oppositions: night- day, present- absent, inside-outside, human- animal, night- day, man- woman, good- bad, prohibition- transgression, combat- victory. We know that psychotic children have difficulty in differentiating between opposites and through the process of listening and later dramatizing the story the child begins to learn to discriminate between opposites.

The workshop takes place in a small theater in a day hospital. The narrator is sitting on a chair on a pedestal which is separated by a curtain from the auditorium where the children sit accompanied by their care-takers. The curtain opens when the process of narration begins and closes when the narration ends. This procedure is almost like a ritual and takes place every time in the tale workshop. The process of narration is almost a ritual, and requires the artistic talent of the narrator. The narrator should be able to use the right tone of voice when she imitates a character, gestures and facial expressions. The tales are chosen among a number of popular Grimm tales but the ones that Lafforgue suggests as most appropriate for psychotic children are the Three Little Pigs, Little Red Riding Hood, the Wolf and the Seven Kids. In these tales the child projects his oral predatory anxieties on the wolf who is present in all three tales.

After the narration is over children have the opportunity to dramatize the story or draw. Through role play children have the opportunity to work out their anxieties and feelings. In contrast to the normal child, the psychotic child does not have a sufficiently organized ego to protect himself from the aggressor. The psychotic child finds no difficulty to play the role of the grandmother who is being devoured by the wolf. When the child attempts to find a way to escape from the wolf, this may be considered as a positive change, a therapeutic outcome.

The workshop -the weekly narration of a specific tale, dramatization, drawing- takes place once a week for half an hour for a whole year. Interestingly enough children do not become tired of listening to the same tale again and again. According to Lafforgue this repetitive procedure is not boring as these children become absorbed in decoding the projected material.

Ekstein (1983) employs fairy tales in the psychoanalytic treatment of borderline and schizophrenic children and adolescents. He refers to the «interpretation within the metaphor» as a technique to establish communication between therapist and patient. The metaphor utilizes primary process material, but does not translate it into the language of the secondary process. He gives the example of

an adolescent girl who persistently asked him to describe her beauty as similar to Snow White, Cinderella or Tinker Bell. «In the treatment of these patients the therapist must become a visitor in their Wonderland, their realm of fantasy. It is as if he must acquire a temporary visa to a foreign country in which he momentarily suspends judgment and the language of his own world...» (p. 286).

Robinson (1986) sets out to illustrate the way fairy tales can be adapted to serve as a useful teaching tool in family therapy; fairy tales as well as dealing with conflicts in our inner world, represent from outer reality well known family constellations, dysfunctions and dynamics and life cycle events. Many fairy tales begin with the «childless couple», «death of a parent», «death of a child». In addition, they tell of siblings competing, parental preference for a child, children leaving home. Robinson gives the systemic interpretation of Snow White and the Dwarfs where emphasis is placed on the father's weak and insignificant role in the family's conflicts. She assumes that the death of his first wife casts shadows over relationships within the family.

Eric Berne (1972) employs fairy tales as part of his transactional analytic method of psychotherapy. He postulates that people have a «preconscious life plan» by which they structure and live their lives. Scripts are usually based on childlike illusions and may persist throughout a lifetime. The most important thing about a script is whether it is a winning or a losing one. Among the most important influences in script formation are the plots of myths an fairy tales. Children may adopt the plot of one particular tale and through identification with the protagonist or other secondary characters, they repeat the scenario time and time again. According to Berne, Little Riding Hoods for example, are commonly women who consistently seek to be rescued and are easily seduced. Cinderellas are usually women who tolerate humiliation or go out of their way to help others to the point of servility.

The Fairy Tale Test in the Personality Assessment of Children

The Fairy Tale Test -FTT (Coulacoglou & Kline, 1995) is a projective test for children aged 7 - 12 years. Its construction rests on the association between traditional fairy tales and unconscious processes. This association has been the focus of attention and continuous studies from different psychodynamic perspectives since the times of Freud. The test consists of 21 pictures of popular fairy tale characters, such as Little Red Riding Hood, the wolf, the dwarf, the witch, the giant as well as scenes from the stories of Little Red Riding Hood and Snow White and the Dwarfs. Although the figures in the cards are basically derived from Little Red Riding Hood and Snow White and the Dwarfs, the dwarf, the wolf, the witch and the giant are often related to other classic tales such as Cinderella, The Three Little Pigs, Snow White and Rose Red, Rapunzel

and others. The main reasons that the test's construction was based on these stories are:

(a) they are among the most popular and widely translated tales

(b) their themes and symbolisms have been systematically explored, from different perspectives such as the folkloristic and psychoanalytic perspectives (e.g. Dundes,1989; Roheim,1992; La Genardiere, 1996; Berne, 1972),

(c) their significance to children and their psychological development has been studied by several authors (e.g. Bettelheim, 1976; Mallet, 1984; Coulacoglou, 1986; Cashdan, 1999),

These pictures are presented to the child in sets of three at a time. More specifically there are three versions of all of the five different characters as well as three scenes from the stories of Little Red Riding Hood and Snow White and the Dwarfs. The differences in versions rest mainly on external characteristics such as expression, clothing, age. Following the presentation of each set of cards the child is asked to respond to a number of questions, for example, «What does each one think/ feel?», «Describe each scene». Responses to the questions are recorded by the examiner in the appropriate form. A major prerequisite for administering the test is that the child is familiar with fairy tales and in particular the stories of Little Red Riding Hood and Snow White and the Dwarfs. In order to ensure familiarity with these tales as well as the specific version of the story they know, the child is asked to narrate both stories. These narrations should also be recorded as they serve for background information in the interpretation of results.

Responses are rated for 25 personality parameters: Self Esteem, Ambivalence, Desire for Material Things, Sense of Property, Desire for Superiority, Aggression as Dominance, Aggression A (expansive aggression), Aggression B (includes Aggression as Jealousy, Aggression as Retaliation, Aggression as Defense), Oral Aggression, Fear of Aggression, Oral Needs, Anxiety, Depression, AFTC (Adaptation to Fairy Tale Content), Bizarres, Repetitions, Relationship with Mother, Morality, Sexual Preoccupation, Need for Affiliation, Need for Protection, Need for Affection, Desire to Help. The variables are rated on a 1-3 point scales (in terms of intensity whereby 1 signifies low and 3 high) or as positive (+) (Relationship with Mother and Self- Esteem). The total raw scores for all of the 25 variables are converted into T scores.

In addition to the quantitative analysis of results which consists of the ratings of the above mentioned variables, results may be interpreted qualitatively in a number

of ways through the study: of recurrent themes, significant conflicts, integration of the ego, thought process, nature of anxieties and defense mechanisms.

The FTT was standardized on 800 non- referred Greek children aged 7 to 12 years from the Athens area. The validity of the test was examined in the following ways:

(a) with the use of factor analysis of the 25 variables. Eight factors were extracted: Reality Testing, Mother Image, Assertiveness, Orality, Aggression, Possessiveness, Helpfulness and Depression.

(b) relation of high and low scorers on FTT factor scores with the CPQ (Children's Personality Questionnaire) and the Rutter Behavior Scales for Parents and Teachers.

(c) comparison of disturbed and non- disturbed children objectively defined by the Rutter Scales (emotional or conduct disorders)

(d) comparison of disturbed and non- disturbed children subjectively defined by the author of the FTT.

(e) comparison of scores on the FTT variables of the normal sample with the scores of two clinical samples: children with mild mental retardation and children with learning disabilities.

Two forms of reliability were examined: test- retest and interscorer reliability.

Advantages of the FTT

The FTT is a thematic projective test for children. It differs from other thematic projective techniques on several respects:

(a) Administration

The child is asked to respond to a number of questions that concern the pictures presented to her. The questions are direct and easy to understand. For example, «What does each think», «Which of the giants scare you most. Why?», «What can a wicked giant do?» e.t.c. Responding to specific questions makes the procedure of testing more entertaining and less stressful. In the majority of thematic tests the subject is asked to produce a story about a picture which may prove a quite stressful task for inhibited or mentally disadvantaged children. In the FTT the story already exists and the child's only requirement is to memorize parts of it.

(b) Scoring

The manual includes specific instructions and elaborative examples of the scoring for all the variables. Thus scoring assumes a more objective character and adds

to its satisfactory reliability.

© Interpretation

Because of the objectivity in scoring quantitative interpretation of results is fairly straightforward. In addition there are specific guidelines for qualitative analysis and in particular the analysis of defense mechanisms.

Finally regarding usage, the FTT can be effectively employed as a basic technique for clinical assessment, as an outcome measure to assess possible personality changes over time. Because of its standardization on a large sample of non-referred children, it may well be used in assessing developmental changes, or situational effects in children. Most importantly, because of the universal values found in fairy tales, the FTT can prove to be a very useful technique in cross cultural personality research.

References

Bettelheim, B. (1976). The Uses of Enchantment: the Meaning and Importance of Fairy Tales. New York: Vintage Books.

Brun, B., Pedersen, E. W., & Runberg, M. (1993). Symbols of the Soul: Therapy and Guidance Through Fairy Tales. London: Jessika Kingsley Publishers.

Cashdan, S. (1999). The Witch Must Die: how Fairy Tales Shape our Lives. New York: Basic Books.

Coulacoglou, C. (1986). Fairy Tales as a Means of Investigating Developmental Issues as Revealed in Children's Verbal Responses. MPhil thesis, UMI.

Coulacoglou, C. & Kline, P. (1995). The Fairy Tale Test: a novel approach inprojective assessment. British Journal of Projective Psychology, Vol. 40, no. 2.

Dieckmann, H. (1986). Twice Told Tales: the Psychological Use of Fairy Tales. Wilmette, Ill.: Chiron Publications.

Dundes, A. (1989). Little Red Riding Hood. A Case Book. Madison: The University of Wisconsin Press.

Ekstein, R. (1983). Children from Time and Space of Action and Impulse. Jason Aronson, Inc.

Favat, A. (1977). Child and Tale: the Origins of Interest. Urbana, Ill: The National Council of Teachers in English.

Heuscher, J. (1974). A Psychiatric Study of Myths and Fairy Tales: their Origin, Meaning and Usefulness. Springfield, Ill: Charles Thomas Publisher.

Kaes, R., et al. (1989). Contes et Divans. Paris: Dunod.

Kast, V. (1995). Folktales as Therapy. New York: Fromm International Publish ing Corporation.

Lafforgue, P. (1990). Une experience clinique autour de la psychose. In Art et Therapie, No. 36/37.

La Genardiere, Claude de (1996). Encore un Conte? Le Petit Chaperon Rouge a l' usage des Adultes. Paris: L' Harmattan.

Mallet, C. (1984). Fairy Tales and Children. New York: Schoken Books.

Robinson, J.G. (1986) Fairy tales and teaching family therapy. J. FamilyTherapy, 8, 383-393.

Roheim, G. (1992). Fire in the Dragon and Other Psychoanalytic Essays on Folklore. Princeton, NJ: Princeton University Press.

Rohrich, L. (1991). Folktales and Reality. Bloomington: Indiana University Press. Roth, Klaus (1998). Crossing boundaries: the translation and cultural adaptations of folk narratives. Fabula, Vol. 39, no. 3/4.

Tatar, M. (1987). The Hard Facts of the Grimm's Fairy Tales. Princeton, NJ: Princeton University Press.

Von Franz, M.L. (1982). Interpretation of Fairy Tales. Dallas, TX: Spring Publications

Yolen, J. (1981). Touch Magic: Fantasy, Faerie and Folklore in the Literature of Children. New York: Philomel.

SIS J. Proj. Psy. & Ment.Health (2000) 39-43

Distortions of Body Image on SIS-II and D.A.P. Tests

S.K. Verma, Harprit Kaur and Rachna Bhargava

Our own concept of our body becomes distorted by, interactions of different variables like aging process, physical disorders, psychological disorders and surgical interventions. It can be reflected through projective techniques like inkblot techniques and human figure drawings. We would like to share our experiences with Draw-a-Person Test and Somatic Inkblot Series - II with other mental health professionals through this Journal- SIS Journal of Projective Psychology and Mental Health. We invite reader's comments to improve our and other Indian readers's understanding of this complex process, which effects our behaviour to a large extent.

We all entertain some concept of our own body. These complex images about our own bodies are highly personal, subjective, and may be distorted at time. Schilder defined body image as the picture of our own body which we form in mind, in the way in which body appears to ourselves (Verma 1971). When we draw a figure we draw two- the figure and ourselves . They are reflections of our feelings, emotions, ideals, reality, aspirations, conflicts, behaviours, thoughts, etc. In an interesting upublished experiment, postgraduate psychology students were asked to rank themselves and their colleagues on certain subjective and objective traits (like beauty, intelligence, honesty , fairness of skin, height, thinness or fatness, ect.) and none of them were found to have very high correlation with the average rankings. This goes to show how complex these images are. These body images are reflections of our concepts as well as effect our behaviour , hence are important indicators of our personality. These are like to be effected by a number of variables like process, physical and psychological disoders as well as any possible or, real surgical interventions. Projective techniques like Draw-a-Person Test (DAPT) and ink blot like Somatic Inkblot Series (SIS) are more likely to elicit our conscious and unconscious body feelings fantasies and complexes (Machover 1949, 1951, 1960; Cassell 1980: etc).

In this paper, we would like to share some of our own experiences in the hope of stimulating further research in India and would welcome comments and suggestions from interested readers, in the form of a continuous dialogue on the subject.

Body - image and aging: Although Handler (1996) reports that DAP has few

S.K. Verma, Consultant- Clinical Psychologist, Harprit Kaur, ClinIcal Psychologist,
Rachna Bhargava, Play Therapist, Depratmet of Psychiatry, Government Medical College & Hospital, Sector 32, Chandigarh-160 047. India

age and intellignce limitations, in a study on 294 normal school going children using Draw -a- Person Test, Verma, Shah & Verma (1967) have reported that body image concept of these children undergoes many changes including less of omission of body parts, distortions, disproportionate body parts, transparent clothing, rejections, etc. as the age increases. Resistance to draw human figures was reported to be more in illiterate and older psychiatric patients -15 to 50 years of age (Verma1971). This was a cross-sectional study, but similar results can be expected from the longitudinal study also-as was the case with an unpublished study from P.G.I. Chandigarh (Mrs. Padama Dwivedi, personal communication). We are not aware of any such study in normal adults or elderly subjects, but in adult psychiatric patients the omissions, distortions, anatomy, rejections etc. were frequently seen (Verma 1971), as also in adult patients awaiting cardiac surgery (Verma, Wahi and Wig 1972) and in adult kidney transplant recipients (Chaturvedi et al 1981) though to a lesser degree. Needless to say that these subjects, being not normal, an additional factor of illness might be involved, in addition to aging. No such comparable work with normal children and elderly seem to have been done with Somatic Inkblot Series, though normative study with children, adolescents and adults have been reported with Rorschach Inkblot technique and case reports with children using SIS have also been reported at times (Handler 1996; Singh et al, 1999 etc.)

Body image distrurbance in patients population: Psychiatric patients, particularly schizophrenics are reported to refuse to draw human figures (more frequently than normal) or to reject one more cards or figures on Somatic inkblots series (Verma, 1971; Pershad et al 1997). They are also more prone to show anatomy, distorted body parts, picture criticisms (on SIS) or draw transparent bodies with internal anatomy showing and other distorted or disproportionate, incomplete and inaccurate body parts, omissions of body parts like mouth, nose, ear, eyes, hand or feet using a lot of shading, etc (on DAP). Proximity to possible death in patients awaiting cardiac surgery (Verma et al, 1972) might be the reason for a very high percentage of refusals, cartoon like figures by these patients suffering from serious, life threatening diseases. Pershad et al (1997) have reported such and other (low typical ropiness) body image disturbances of psychiatric patients on S I S. - II. Kapur and Kapur, (1967) have reported about one third of impotent patients drawing ugly, disproportionate human figures with asymmetric lines and good deal of shading.

Recently Verma and Kaur (1999) have proposed a model for quantification of abnormal somatic concern on SIS-II.

In our somewhat limited experience, sometimes very interesting results have been found in alcoholics and psychopaths-for examples one alcoholic patient drew the body like bottlle itself and a psychopath (claiming to eat stone everybody without any evidence, rather running away from any demonstration ever held) drew a female figure--described as a pregnant girl weeping--adding with a smile (as if laughing to himself)-that she is weeping because she is unmarried and pregnant. Handler (1996) has described many such disturbances (alongwith their sources of informtion) where quite interesting and revealing information is obtained merely by looking at the human figure drawings of adolescents, criminals, victims of crimes etc. However, one cannot expect such revealing drawings with every criminal, alcoholic or a psychopath. The simplicity of DAP test could be one of the reasons for its popularity everywhere (Sandbag 1961; Handler 1996) . Body symbolism has been dealt at great length by Cassell (1980) also.

Body Image Disturbance in Prisoners on Vipassana Meditation:

Chandirramani et al (1995) have recently reported some experiences with human figure drawings of prisoners in Tihar Jail, Delhi. In this before and after design, those prisoners who were on Vipassana meditation, showed significant decline in their body image disturbances, as well as increase in positive changes like more holistic, balanced picture of self (more complete and proportionate)- when compared to the control group of prisoners.Unfortunately SIS-II could not be used in this study, hence no comparisons can be made here.

A comparison of the two techniques:

S.I.S. technique is too recent - in comparison to DAP to make valid comparison in revealing body image disturbances in normal or patient population. However, it seems to reveal and add a new dimension in its area and could be useful in eliciting our conscious per - occupation with body feelings and fantasies - not as a substitute for DAP but as supplementary to the information received through DAP. The two techniques are different in the sense that in SIS one is asked to interpret as inkblot, without adding something to the standard vague stimulus, whereas in D.A.P. one is free to produce anything omitting , adding , distorting etc. as he pleases. One may refuse to draw- a human figure but still respond to most of SIS inkblots, as total rejection of SIS is very rare, if at all seen. Both techniques have their advantages and limitations and together they might be more useful and informative. One may prefer to draw, the other to interpret only. Both can be used on subjects together rather than one or the other and give more useful meaningful, insightful and valid results.

Popularity of both these projective techniques e.g. DAP with students (Verma et, al, 1967), psychiatric patients (Verma, 1971), impotence cases (Kapur & Kapur, 1967), patient awaiting surgery (Verma et. al, 1972) emotionally disturbed children (Solanki er al, 1975) prisoners (Chandiramani et al, 1995) , etc. and of S.I.S. with older subject (higher anatomical and sex responses - Singh et al, 1999), psychiatric patient (Verma et al , 1994; Kaur & Verma 1998; Pershad & Verma 1996; Pershad et al, 1997; etc), abnormal somatic concern (Verma & Kaur 1999), speech defects (Nehra et al, 1997), etc are well documented by psychologists and other mental health workers in India . This popularity is expected to grow further in future , particularly if both are used together as suggested above. Further work in this area is fully justified on the basis of such experiences.

References:

Cassely, W.A. (1980) Body symbolism and the somatic inkblot series Alkaska, USA: Arora Pvt. Co.

Chandiramani, K, Jean R., and Verma S.K. (1995) Human Figure Drawings of prisorners and Vipassana. SIS Jouranl of Projective Psychology and Mental Health . 2:153-158.

Chaturvedi, S. K.Pant, VLN, Varma V.K.Varma, S.K.Chug, K.S. and Yadav, R.V.S. (1981). Draw-a- Person Test in Kidney transplant recipients. Read at 12rth Annual Conference of Indian Association of Clinicial Psychologists Miraj.

Handler, L. (1996) The clinical use of drawings. In C.S.Newmark (ed.) Major Psychological assessment Instruments . Second Ed: Altyri Bacon. Chap . 6 Pp. 206-293.

Kaur , M. and Kapur, R.L. (1967) Study of impotence throgh projective tests. Indian Jornal of Psychiatry. 9:208-210.

Kapur , R.P.and Verma , S.K.(1998) A correlational study of selected Rovschach and SIS-II V-variables in psychiatric patients. SIS Journal of Projective Psychology and Mental Health . 5:115-118.

Machover,K(1949) Personality in the dawings of the human figures. Springfiend, II.: C.C.Thomas.

Machover, K.(1951) Drawing of the human figures : A method of personality investigation. In H. Anderson & G. Anderson (Eds.) An introduction of projective techniques . New York: Prentice- Hall.

Machover , K(1960) Sex differences in the developmental pattern of children as seen in human figure drawings . In a Rabin and M.Hawarth (Eds.) Projective techniques with children, New York : Grune & Strotton.

Pershad , D. Verma S.K. and Bhagat , K(1997) Body image disturbances in psychiatric cases. SIS Journal of Projective Psychology and Mental Health. 4:75-84.

Nehra , A., Raghunathan, M.Verma , S.K.and Mann, S.B.S. (1997) Recognition of Psycohological problem in patients suffering from speech defects with the help for SIS-II. SISJournal

of Projective Psychology and Mental Health. 4:145-151.

Singh M.P. and Dubey, B.L.(1999) Effect of age and sex on SIS-II responses. SIS Journal of Projective Psychology and Mental Health 6(2) 51-77.

Solanki , P.P.S and Sen Mazumder, D.P. (1975) A study of emotional indicators on Draw- A-Person Test with normal and emotionally disturbed female children of lower socio-economic group . Indian Joural of Clinical Psychology, 2: 13017,

Sundberg. N (1961)The clinical use of drawing in clinical services in the United States . American Psychologist, 16:79-83.

Verma,S.K.(1971) Disturbance of body image in Indian Psychiatric patients . Manas 18:111-116.

Verma, S.K. and Kaur , H. (1999) A proposed model for quantification of abnormal somatic concern. SIS Journal of Projective Psychology and Mental Health . 6(1) 65-68.

Verma , S.K.,Pershad, D.and Nehra, R. (1974) Cross-validation of SIS-II in Psychiatric population. SIS Journal of Projective Psychology and Mental Health, 1:15-18.

Verma, S.K. Shah , D.K. and Verma , H.C.(1967) Body image concept of growing children in India: A study of 294 children . Manas, 18:59-64.

Verma, S.K. Wahi, P.L. and Wig N.N.(1972). Disturbance of body image in patients awaiting cardiac surgery. Indian Journal of Applied Psychology, 9:44-46.

With Best Compliments from :

A GOLDEN HARVEST
50 YEARS OF RALLIS INDIA

RALLIS

A TATA Enterprise
AND FIFTY YEARS OF
COMMITMENT TO AGRICULTURE

SIS J. Proj. Psy. & Ment.Health (2000) 44-48

Treatment of Phobia & other Neurotic Disorders: the Role of Behavioural Medicine

K.S. Sengar and A. K. Srivastava

Anxiety is the phenomenon which improves the work performance of the individual but at the same time as it starts persisting for a long time it becomes pathological and starts producing several obstructions in the life of the individual. However it reduces the performance too. Since long back it has been described in the literature and termed as palpitating heart, D'Costa syndrome etc. The name of the pathological anxiety has been changed several times but sign & symptoms remain the same. Presently with the recent development of psychiatry it has been termed as obsession compulsion disorder, phobic disorder etc. Recent researches (Amine Hypothesis) give a new hope with the assumption of, that certain biochemical changes of the brain are the causative factor for such illnesses. In this context, poor recovery of the patient through medicines put a query on amine hypothesis and success rate of therapeutic means either alone or adjusted with chemotherapy indicates that causative factors whatsoever are, but the role of behavioural medicine in the treatment of different psychological disorders can not be ignored. The branch of Behavioural Medicine is proving its worth well and becoming an essential modality for the treatment of various psychological disorders, prevention of relapses and proper rehabilitation of the patient in society and work as well.

At all ages and all stages of life fear and tension present a problem for almost everyone, when your fears are appropriate to the circumstances, you can control them but sometimes fear becomes a terror what might happen, you avoid certain challenges, relationships. You may change your goal from promotion or pleasure or closeness to a simple and negative goal to limit to fear reaction. The inability to handle fear and tension which can narrow and confine your life even cripple you as a human being. The life of some people are ruled by fear and tension and they know it, some people are ruled by fear and tension and they don't know it. The fears and tension which are known to the individual and he knows that these fears and tension are illogical, irrational, cannot harm him anyway are known as Phobia, obsession-compulsion and anxiety disorder. These Phobias and other disorders may be in different areas but in Indian population often it is found as

Dr. K.S. Sengar, Consultant Clinical Psychologist, Mental Health Centre, 7/105 B, Swaroop Nagar, Kanpur.
Dr. A.K. Srivastava, Head, PG Deptt. of Psychology, D.A.V. College, Kanpur.

generalised phobia contaminating obsession and washing compulsion in male and Phobia from reptiles, insects (like lizards etc.) in female are more common.

Freud believed that Phobias were a shield serving as a protection against other, more disturbing unconscious fears. These fears stem from the unresolved oedipus complex. Should these fears threaten to become conscious, you develop Phobia to protect yourself from what really worries you. Thus you can reassure yourself that there is a Freud's famous case study (1909) of little Hanse a five year old boy who refused to go out into the street for fear that a horse might bite him. Freud discussed this case as Hanse unconscious fear that his father would punish him (Castration anxiety).

In Psychoanalytic treatment free association and dream interpretation were being used to work through the underlying oedipus complex as you resolve your conflicts. The Phobia itself disappears because the individual no longer needs it. While Freud and his followers believed that all people are basically helpless until they gain knowledge of the conflicts and fantasies that reside in the unconscious and the child-hood fear that generated them. But after the origin of behavioural model (Watson 1920) it was considered by behaviour therapist that fear is a learned reaction.

Apart from the above both considerations recently in the past few years a new approach of the treatment of Phobia and other neurotic disorders is also being strongly advocated by Psychiatrists and Biochemists. With the advent of organic aetiology it was thought that there is a certain imbalance in the brain amines (Neurotransmitters) which generate the problems. Current researches have largely laid stress on the role of basal ganglia (Rapaport and Weies 1988, Insel 1988). Recent clinical and laboratory studies have suggested that changes in brain serotonin (5HT) and dopamine functions may contribute to producing and maintaining of the anxiety symptom and the anxiety type behaviours (Murphy & Pigott 1986). Considering the above view of the organic aetiology the use of chemotherapy especially clomipramine, trazadone and amoxapine, flouxitine and also some other traditionally used and newer antidepressant and antianxiety drugs have taken place but the chemotherapy model (amines hypothesis) has not proved its worth as it was expected and it can be seen on the patients, those who are taking the mild to heavy doses of antidepressant and antianxiety drugs like Clomipramine, Imipramine, Amitrityline, doxipine amineptine, Trazadone, flouxetine and valium, librium and buspiron and also sometime lower doses of antipsychotic medicine since several years but patients are not showing the

response in a very good manner, So, it has developed some dilemma in amine hypothesis and it seems that the reason of the origin of the illness is not only the result of the imbalance in the brain chemistry, may be some-what different as it was assumed earlier.

Another idea which once again raises doubt about the amine hypothesis alone is that the population which has been taken for the laboratory investigation or clinical trials of the medicine were already suffering from the disorder. The anxiety is a disorder which produces the imbalance in the brain amines. This may be working as a complementary phenomenon to each other for developing and maintaining the disorder and imbalance of the brain amine. None of the studies is reported in the literature in which the patients of the Phobic and other neurotic disorders would have been investigated before the occurrence of the disorder. So it cannot be very fair to say very strongly whether the anxiety is responsible for producing the imbalance in the chemistry of the brain or amines are responsible for producing the disorder. It would have been better investigated if the normal population would have been taken for the study and the affected cases should have been investigated again later on after developing the disorder. So the concept of amines imbalance would have been clear. This article is just an approach to prove the worth of behaviour therapy in the treatment of Phobia and various other anxiety related disorders even in the era when almost the root causes of all Psychiatric illnesses are being searched in the disturbances in the neurochemistry.

It is said and well accepted by the various experts of the field that the neurochemistry plays a key role in origination of the problem, exaggeration and maintenance of the problem. It will be justified to say that if the problem is only maintained and originated by the said imbalance of the brain chemistry then it must be fully cured by those medicines which have been specially prepared for this purpose (management of brain chemistry) but the results of the chemotherapy alone practically do not support this concept. This lack of the proper response itself bother the clinician to think of several other alternate modalities of treatment. It has been seen well that the combined sessions of cognitive restructuring relaxation procedure, response prevention and exposure in vivo alongwith chemotherapy proved its efficacy well and 85% to 90% patients were returned to their normal life and also developed the ability to cope with stressers so they were also able to prevent the relapses. Though it was thought earlier that the Phobia and certain other anxiety related disorders are only learned (behavioural

model). It may also not be very wise to say, definitely there are certain biochemical factors whether they are cause of the illness or the one of the product of the illness playing an important role in the maintenance of the problem and cure as well.

As the role of tricyclic antidepressant and clomiramine in the treatment of Phobia and OCD has received considerable publicity in recent years, more and more Phobic and OCD clients have been experimented with these drugs. Monoamine inhibitors (MAO) have also been tried and found to have similar effects but are not widely used due to potentially serious side effects, the results of various researchers vary as to whether they add to the effect in vivo exposure. Data from most carefully conducted researches indicate negative answer but these drugs combined with education and systematic instruction turns to be an effective treatment. In the absence of therapist assisted exposure (Manish Kalin & Michelson ,1983) Phobic patients have often had bad experience with tricylic clomipramine because of the titration of the doses and some people extremely sensitive too and frightened by any side effects such as heart palpitation, hand tremors, dryness of mouth, constipation and blurredness of vision etc. There is a great drawback in the use of these drugs. The long terms disadvantages of the TCA, MAO and propanalol are the tendency for relapse once the drug is withdrawn. This again strengthens the logic that there is not only chemical imbalance of the brain that is responsible for producing the disease and their maintenance but more of that psychological factors are also playing key-role in the origination, development and maintenance of the illnesses (Phobic and other anxiety related disorder). This must be taken into account that poor response through the treatment by the drugs alone and the relapse of the problem after withdrawls of the medicine shows that the clients have learned, that there are no other ways of controlling their panic its attribute and their improvements with the drug. Furthermore there is about 20% initial refusal rate by clients who are afraid of ill effects of the drugs and or loss of control associated with the foreign substance in the body and there is an average 40% dropout rates due to various side effects.

In practice it has been seen often that patients are not being asked to get the therapeutic help from the person who is specialized in the domain. The reason may be the cost factor of the treatment, fear of losing patients, illiteracy, lack of awareness of the treatment of such modalities and inconvenience of regularly attending the clinic for certain durations. Patients consult once and purchase the

medicine for one week or fortnight and feel themselves free though the behavioural changes remain unnoticed by the clinician.

On account of all these considerations. It will not be wise to say that pharmaco therapy alone is potent and first line treatment of choice, unless there is an urgent need for rapid control of frequent panic. I do agree that the pharmacotherapy is a potent remedy to control the panic attack but it is unusual that this approach alone should be opted for the complete remission from the disease. At times the medication makes a dramatic difference but unfortunately the same factors that predict poor response to exposure (high depression and high frequency of panic) also predict poor results with drugs.

To conclude it can be said that even so many traditional and newer antidepressants and antianxiety drugs are being marketed today the behavioural method has got its worth too in the treatment of Phobic OCD and other anxiety related disorders and if it is being used as an adjunct to the pharmacoptherapy. It proves very effective for coping with the further stress and panic in future.

References:

Freud, Sigmund (1959) "Analysis of Phobia in a five year old boy" collected papers Vo. 3 P.P. 149-289, New York Basic Book 1959.

Insel T.R. (1989) Neuroethological Perspective Psychopharma Bull. 24, 365-369.

Murphy D.L. & Pigot T.A. (1986) A comparative examination of a roll for serotonin in obsessive-compulsive, panic disorder and anxiety. Journal of Clinic Psychiatry, 15 (Suppl.) 53-58.

Watson J.B. & Raymon R. (1920) Conditioned emotional response, Journal of experimental psychology -3, (1920).

SIS J. Proj. Psy. & Ment.Health (2000) 49-70

Psychological Factors in Drug Addicts and Normals: A Comparative Study

Gopa Mitra & Anjana Mukhopadhway

The study compared the three drug abuser groups namely, heroin (N=98), brown sugar (n=79) and tidigesic (N=70) and matched normals (N=48) in terms of level of depression, social anxiety and social motive components as well as the differences in pathological contents and indices of personality. The follow-up groups. i.e. rehabilitated (N=6) and the relapsed (N=35) were also assessed to search out support for the outcome. BDI, SIS I Social Evaluative Anxiety Scale (SAD & FNE) and AMS were used to explore the socio-psychological differences among the groups. Besides the investigation has also taken an account of the follow-up data compared the results with their aboriginal data of the same subjects. F-ratio used for the inference of the results obtained through questionnaires on t-applied to compare the percentage of the pathological contents and SIS indices. Mann –Whitney U-test explored the authenticity of acceptance and rejection of null hypotheses and subsequently the directional hypothesis. Level of depression and social anxiety (SAD & FINE) were reported to be significantly high among drug addict and follow-up relapsed group with low social approval motive when compared with the normals and follow-up rehabs groups. Pathological components, i.e. high PAS. D and Plow HAS were proved in the comparison, atypical, (Aty) anatomy. (Ant) Sex and human (H) SIS indices were reportedly discriminated the clinical groups. NB,SR,SA the low motive factors were reportedly discriminated the clinical groups. NB, SR,SA the low motive factors were reportedly improved in the SA the low motive factors were reportedly improved in the rehabilitated group.

The problem of drug abuse has become a menace in our society and elsewhere inspite of a general awareness of resulting physical and psychological damages. Seeding through the personal and family problems it leads to behavioural problems and social difficulties of an individual. However psychological damages caused by drug abuse have not been explored and identified substantially to the extent the physical damages have been attempted.

Drug abuse refers to the non-medical use of drugs to change the users mood, to alter his perception of himself and the world around him, to produce novel sensations and experience and to enhance his ability to function in certain settings, such as social or sexual ones (Fred, 1982). Habituation meant a desire for the drug and only personal impairment. Addiction meant compulsive use, a tendency to increase dosage, psychological and physical dependence and detrimental

---

Gopa Mitra. Ph.D. and Dr. Anjam Muykhopadya Ph.D., REeader in Psychology, MMV, B.H.U., Varansi

This paper is based on the awarded doctoral thesis carred out by the first author under the supervision and guidance of the second author.

effects to the individual and society. Loss of self-control, the preeminent criterion highlights that despite the best of intentions one engages in addictive behaviour. Involvement, the other common feature found, may include shared social rituals and self acceptance of a label such as 'addict'. Substances regarded as addictive, generally produce marked alterations in mood, psychomotor skills, social behaviour and cognitive processes.

Heavy drug abusers are agained found to be more maladjusted than moderate abusers. Other available evidence suggest that adolescent drug addicts are likely to have an underlying personality disorder.

Past three decades have registered various studies on drug addicts which have focused psychological problems as well as social problems. Attitudinal deviance, social values of drug addicts, psychopathological problems of LSD users, delinquency and criminality were the highlights of the decades of 70's (Rosenberg, 1971; Francis, et al., 1973; Weipert, et al., 1979; Shanmugam, 1979).

The next decade reported of centralized attempt to explore the personality components like sociopathy , sensation-seeking attitude, self-esteem, anxiety, depression, cognitive impairment etc., among drug addicts (Woody & Blaine) 1979; Griffin, et al., 1990; Basu, et al., 1995). The main social influences of drug abuse may be traced in the minority group status, parental loss, separation, disharmony, or illness, low income, restricted opportunities for acceptable socialization, defective socialising influences and drug availability (Blum, 1969; Carman, 1979; Lang, 1983)

Relapses are major problems in our society. Researches conducted so far have indicated that alongwith personality, other variables such as friends influence, social pressures, and stresses are also related to relapses (Najam & Parveen, 1992). The present study attempted to test the probable link of the relevant personality traits i.e., psychological problems, socio-cultural problems of the affected group and checked their social approval. A comparative control sample substantiated the role of contributory traits among drug addicts. Different social motivational aspects which may explore the extent of the possibilities of social adjustment and help regaining mental or psychological health have also been considered. How far social motives are functional in changing their approach towards life, have been checked. Alternations in pathological make up and its simultaneous social motivational impact have also been traced among follow-up

relapsed and rehabilitated cases.

Objectives :

Following objectives were framed in the present study :-

(I) To study the level of depression among narcotic drug addicts.

(II) To study the level of psychopathology among drug addicts through pathologic anatomy score (PAS), depression (D), hostility and aggression (HAS) and paranoia (P) and major SIS indices projected on to the body.

(III) To study the social anxiety components through social avoidance and distress (SAD) and fear of negative evauation (FNE) of drug addicts.

(IV) To study the strength of motive to seek social approval of drug addicts of different social aspects, such as, normative behaviour, social conformity, positive self presentation, defensiveness, dependency, social responsiveness, and social approval .

(V) To study and compare the responses of the drug addicts with the normals.

(VI) To study and compare the responses of the follow-up cases who have improved after treatment (rehabilitated) with higher social approval motive and who have failed to improve after treatment (relapsed) with lower social approval motive.

Hypothesis:

The following hypotheses were formulated to achieve the objectives framed:

Hypothesis 1: Heroin, Brown-sugar and Tidigesic the three drug addiction groups would score higher in the level of depression than their matched non-addiction group.

Psychological difficulties, particularly feelings of anxiety and depression are common problems found to be present in drug abusers (Robbins & Nugent III, 1975; Rounsaville, et al., 1986).

Hypothesis 2: Heroin, Brown-sugar and Tidigesic the three drug addiction groups would score higher on different pathological contents i.e.. pathological anatomy score, depression, hostility and aggression, and paranoia than their matched non addiction group.

Steer and Hassett (1982)in an earlier study paved the way and the hypothesis

hypothesis attempts to re-examine the findings that pointed out the most salient syndromes for the substance abuse patients as anxiety and paranoia. Enormous indications are available in the recent relevant investigations (Mukhopadhyay, et al., 1996; Mitra & Mukhopadhyay, 1996; Singh & Dubey, 1997).

Hypotheses 3: Heroin, Brown-sugar and Tidigesic the three drug addition groups would score high on different psychological indices i.e. At, H,A, Sex, Ant, Rej than matched non-addiction group.

Hypothesis 4: Heroin, Brown-sugar and Tidigesic the three drug addiction groups would score low on SIS indices i.e. T and Mt than their matched non-addiction group.

The hypotheses third and fourth are based on the following findings. Singh and Dubey (1997) found drug dependent group to be high on the following indices. i.e., A,H, Ant, Rej and low in Mt. Mitra and Mukhoadhyay (1996) found drug dependent groups i.e. Heroin, Brown-sugar and Tidigesic abusers score high in At, H, Sex, Ant and Rej than T and Mt scores. The two independent hypotheses framed with a view to search for the extent of normative level of drug addicts.

Hypothesis 5: Heroin, Brown-sugar and Tidigesic the three drug addiction groups would score high in Social Evaluative Anxiety i.e. social avoidance and distress and fear of negative evaluation than their matched non addiction group.

Social evaluative anxiety is the experience of distress, discomfort, fear, anxiety etc. in social situations (Watson & Friend, 1969). Family instability is assumed to be related to social avoidance. Available evidence suggest that drug addicts usually come from broken homes and to have parents who are alcoholic, anti-social or mentally ill (Chein, 1965; and Rosenberg, 1969). The character traits observed in the above findings lead to the assumption of high SAD FNE and is the justification of the hypothesis.

Hypothesis 6: Heroin, Brown-sugar and Tidigesic the three drug addiction groups would score lower on different social approval aspect namely, Normative behaviour , Social conformity Positive self presentation, Defensiveness, Dependency, Social responsiveness and Social approval.

Several studies have confirmed that addicts are sensation seekers (Basu, et al., 1995) and they have social conformity problems (Gersick, et al., 1981).

Schooler, et al (1972) approved of socially undesirable behaviour, distrust, non-conforming and significant self deception for the drug abusers. The above findings have substantiated to frame the present hypothesis.

Hypothesis 7: The initial score and follow-up scores of the relapsed drug addiction group would not differ in their extent of depression, pathological scores, social evaluative anxiety scores and social approval scores.

Many investigations conducted so far have indicated that alongwith personality, other variables such as, influence of peer group social pressures, stresses etc., are also related to relapses. Brown et al. (1971) reported influence of friends, relief from personal problems and easy availability as reasons for relapse in heroin addicts. Most lapses are related to negative emotional states, social pressure and interpersonal conflicts (Cummings, et al., 1980; Bradley, et al., 1989).

Hypothesis 8: Rehabilitated group would score lower in depression measure social evaluative anxiety and SIS factors than the relapsed drug addiction group. The hypothesis has been derived from the earlier assumption.

Hypothesis 9: Rehabilitated group would score higher in follow up response in social approval components than the relapsed drug addiction group.

SAMPLE :

The sample comprised of 247 registered male adult drug addicts (M.age-28.5 yrs) from Drug De-addiction Centre, Vinayaka, Bhelupur, Varanasi. The inclusion criteria for the study sample was minimum six months regular practice of narcotic drugs . The category of drug addicts considered for the present study are heroin , brown-sugar and tidigesic abusers. The admitted cases of the centre, after about one weeks treatment for deaddiction (or withdrawal symptoms) were exposed for clinical enquiry so that a convenient communication might be possible to have the reliable assessment of their personality.

The sample of follow-up cases were again screened to readminister the tests. The follow-up inclusion criteria was the second phase of contact after at least three months of their treatment and the first psychological enquiry . Two types of follow-up samples were considered for the study : first, relapsed (N=35) or 'failed to improve' after treatment and refered again to the centre, second, rehabilitated or 'improved' (N=6) who revisited the centre for the routine follow-up reporting.

A group of normal subjects (N=48) who never praciticed psychotropic drugs

and not chronic smokers or not habituated in excessive intake of tea or coffee, and maintained healthy, physical life, were selected by matching the variables i.e. age, sex, education, domicile (rural/urban) and marital status for comparative study.

TOOLS :

Following tools were selected to achieve the objectives :

1. Beck -Depression Inventory (BDI)
2. Somatic Ink- blot Series I (SIS)
3. Social Evaluative Anxiety Scale
4. Approval Motive Scale (AMS)

1. Beck - Depression Inventory (BDI):

The Hindi adaptation of Beck Depression Inventory (BDI) by Arora, et al., (1988) was chosen to assess depression . It is an unidimensional instrument. One rates himself on a series of four point ordinal scale i.e.. 0 to 3 for the alternatives, none to severe, respectively. Scores can be converted to a depression rating in one of four levels i.e., none (0), Mild (1), moderate (2), and severe (3) depression. The item scores are added to yield the total score.

2. Somatic Ink-blot Series I (SIS),(Cassell, 1980)

The test consists 20 inkblot images, printed on white card. The cards are printed in black, red and grey (screened black). Three are exclusively red and nine are achromatic. Images provide enough obvious anatomical structure to evoke spontaneous verbalization but not enough to limit the responses solely to the naming of body parts or colours. Responses are evaluated qualitatively. Four pathological contents have provision of rating in terms of severity. These are pathologic anatomy score (PAS), depression (D), hostility and aggression (HAS) and paranoia (P). The rating scale used are as follows, none (0), mild (1), moderate (2) and severe (3). SIS indices, namely, typical (T), atypical (At), most typical (Mt), human response (H), animal response (A), sex response (Sex), anatomy response (Ant) ,rejection (Rej) on the other hand are assessed qualitatively .

3. Social Evaluative Anxiety Scale, (Sheikh & Kaushik, 1990) :

The Hindi adaptation of Watson and Friend's scale is an objective questionnaire consisting of 56 items and measure social avoidance and distress (SAD) and fear of negative evaluation (FNE) . The SAD scale was designed to measure social avoidance and objective distress contain 28 'true' and 'false' items. The

FNE scale was designed to assess apprehension about other's evaluations , also contain 28 items . All positive items endorsed by the subjects as 'false' were given a score of one and the rest of the items were scored 'zero'.

4. Approval Motive Scale (AMS):

(Tripathi & Tripathi, 1980 a). This is also an objective questionnaire, containing 72 items out of which 37 were 'true' and remaining 35 items have 'false' option as indicative of approval orientation. The scale covered 7 areas of approval, namely, normative behaviour (NB), social conformity (SC) positive-self presentation (PSP), defensiveness (Def), dependency (Dep), social responsiveness (SR) and social approval(SA).

ADMINISTRATION :

Patients were selected for the sample only after their registration and diagnosis by the consultant In the process of administration of tests the information data-sheet was filled as a first step for each individual case . When the subjects sutisfied the screening criteria rapport was established with the subjects. This followed by the administration of the scales.

The same procedure followed for the relapsed sample who failed to improve and revisited the clinic after three months of their initial treatment. The follow-up cases who reported after three months and improved were also included in the sample as rehabilitated group and the tests readministered in the same order of presentation . The same procedure of administration was followed for the matched normal samples.

Results :

The data obtained from the investigation have been statistically treated and results have been narrated in the present chapter. Besides descriptive statistics parametric and non-parametric measures have been used for the inferential analysis of results. The samples used for the purpose of investigation were the drug addict in-patients. Present study has selected ANOVA to determine the significance of difference between means of the three clinical drug addicts and one non drug control group. Duncan's post hoc multiple range test (Edwards, 1968) have also checked the mean range and differences between means which proved the mean dominance for the classificatory groups as obtained in the variables. F-values computed in the present treatments have used the formula for harmonic mean (Winer, 1971) as the N obtained for the classificatory addict

groups were not equal.

The t-test measure has been selected to compare the mean scores of each clinical and control groups of the data obtained from projective SIS test. The contents of the scale measured in terms of four point rating scales have reported the significance of mean difference through, t-test. The SIS indices obtained in frequency and converted to percentage have also been checked their mean differences through t- tests.

Follow up data of relapsed and rehabilitated samples being substantially small, it was justified to use non parametric measures for the sake of comparison. Mann-Whitney U-test (Siegel, 1959) was found to be appropriate measure for the same. Being a most powerful alternative to the parametrict-test, this measure has checked whether the two groups i.e. relapsed and rehabilitated have been drawn from the same population as per the null hypothesis. In other words the directional or experimental hypotheses were to be checked rejecting the null hypothesis for each and every variable measured by objective or projective measures.

Table 1.1

Means, Standard Deviations and F ratios for drug addicts and normals on Beck- Depression Inventory (BDI)

Categories	N	M	SD	F
Heroin	98	32.77	7.93	
B.Sugar	79	32.30	9.44	
Tidigesic	70	32.29	10.52	185.80
Normal	48	12.48	8.12	**

** Significant at .01 lcvcl.

Table 1 clearly reflects a substantially higher mean scores of drug addicts in depressive component. F-ratio result signifies that the depression level measured of heroin, brown sugar, tidigesic and normal groups differ significantly (P<.01) when tested with one way analysis of variance. Duncan's post hoc multiple range test confirms the loswest mane depression score of normals and significantly higher mean csores of all the three drug addict groups. The first hypothesis thus stads in full support that drug users willl be higher in the extent of depression level.

Table 2.1

Means, Standard Deviations, and t-values of SIS pathological contents of drug addicts and normals.

Patrological contents		Heroin N=98	B.sugar N=79	Tidigesic N=70	Normal N=48	HvsN t	BSvsN t	TvsN t
PAS	M	9.91	12.25	9.42	3.35	7.05	9.45	5.89
	SD	8.67	7.87	8.23	2.22	**	**	**
D	M	8.02	8.65	10.14	2.94	6.27	6.07	6.99
	SD	7.39	7.90	8.23	2.20	**	**	**
HAS	M	5.16	5.48	4.50	6.17	1.77	1.10	2.83
	SD	4.54	4.73	4.37	2.40	NS	NS	**
P	M	2.56	2.63	2.71	1.69	3.63	2.44	4.25
	SD	1.87	4.03	1.75	1.09	**	*	**

* Significant at .05 level
** Significant at .01 level
NS Not significant

The foregoing table (Table 2.1) contains the means and SDs of the four pathological contents assessed in rating scales. A clear reflection of higher means except in HAS may be seen among the drug addict groups. The results reflected of high means by all the clinical groups, i.e. heroin, brown sugar and tidigesic obtained than normals in pathological anatomy score (PAS). Depression (D) and paranoid ideation (P). All the mean differences between the clinical groups and normals are proved to be significant (P<01). Hostility and aggression (HAS), the fourth factor however is not found to be in favour of the hypothesis framed. Tidigesic group on the contrary, is showing a significantly lower trend in hostility and aggression (HAS) score (Table 2.1). Hypothesis 2 for SIS pathological contents thus earns a substantial support.

Means may be noticed to be very high for At, H, Sex, Ant and Rej indices for the clinical groups than normals. A subsequent low mean scores may also be observed for T, Mt and A in terms of SIS indices. Out of the SIS indices atypical (At) and sex (Sex) responses are proved to be significantly high (p<.01) among all the clinical groups than their normal counterparts. Heroin addicts reported of significantly high (p<.05) human response and brown-sugar addicts reported of significantly high (p<.01) anatomical response (ant) than their comparable normal samples. Typical (T), most typical (Mt) and animal responses (A), the first two acclaimed normative responsive patterns and the third symbolized aggressive contents respectively are proved to be significantly low (P>.01) among clinical groups. Rejection (Rej) though not statistically significant a higher trend (P>.01) among clinical groups. Rejection (Rej) though not statistically signifi-

cant a higher trend among clinical groups may be seen. Hypothesis 3 and 4 are mostly accepted. Animal response (A) is the only pathological indice found to have reported contrary to the hypothesis.

Table3: Means, Standard Deviations and R ratios for drug addicts and normals on social anxiety components.

Society anxiety Components		Heroin N=98	B.sugar N=79	Tidigesic N=70	Normal N=48	F
SAD	M	16.01	16.67	16.71	8.73	97.81
	SD	4.72	5.01	5.59	3.82	**
FNE	M	20.14	19.27	17.29	9.77	180.57
	SD	3.43	4.17	5.30	5.99	**

** Significant at. 01 level

Table 3 Clearly indicate that heroin, brown-sugar and tidigesic addicts have higher mena scores in both the sub scales. The F-ratios reported for the clinical and normal groups are again reporting a significance of difference between the social anxiety pattern for the addicts and normals. Duncan's multiple comparison range test is providing results of reliable mean difference. The fifth hypothesis thus gains a complete corroboration with the results.

Table 4: Means, Standard Deviations and F ratios for drug addicts and normal on approval motive components (AMS).

Approval motive Components		Heroin N-98	B.sugar N=79	Tidigesic N=70	Normals N=48	F NB
M	5.80	5.86	5.81	5.75	.77	
	SD	1.58	1.60	1.68	1.48	NS
SC	M	4.66	4.77	5.00	4.81	2.41
	SD	1.34	1.49	1.60	1.55	NS
PSP	M	4.17	4.09	4.40	4.63	5.41
	SD	1.59	1.61	1.40	1.45	**
Def	M	5.03	5.00	4.96	5.75	25.06
	SD	1.17	1.07	1.19	1.48	**
Dep	M	3.93	4.32	4.19	4.25	.73
	SD	1.44	1.35	1.51	1.30	NS
SR	M	3.74	3.67	3.93	4.67	16.93
	SD	1.48	1.56	1.44	1.10	**
SA	M	11.55	11.11	11.56	13.44	30.85
	SD	2.36	2.41	2.39	0.80	**

** Significant at. .01 level, N S Not significant.

Out of the seven sub-scales positive self presentation (PSP), defensiveness

(Def), social responsiveness (SR) and social approval (SA) have proved their significance (P<.01) in the favourable direction as per the hypothesis (Table 4). Duncan's treatment approves that brown sugar group is significantly low (p>.04) in positive self presentation (PSP) than normals. Defensiveness (Def) social responsiveness (SR) and social approval (SA) the three components have proved of low scores compared to their normal counterparts in Duncan's post-hoc treatment. The order of means for social responsiveness (SR) and social approval (SA) are placed at the lowest in brown-sugar while lowest defensiveness score has been reported by tidigesic group.

Table 5: Means and Standard Deviations for relapsed and rehabilitated follow-up data for depressive component.

Depressive Component		Relapsed (initial data)			Relapsed (follow-up data)			Rehabilitated (follow-up data)		
		Heroin N=27	B.suger N=5	Tirdigesic N=3	Heroin N=27	B.suger N=5	Tidingesic N=3	Heroin N=1	B.suger N=2	Tidigestic N=3
BDI	M	34.93	34.40	22.00	38.00	44.00	17.00	6.00	8.50	7.00
	SD	9.26	7.83	19.52	8.35	7.11	12.00		2.12	2.65

Table 6: Mann-Whitney U-test values of depressive component of relapsed and rehabilitated follow-up data.

Relapsed (Folloe-up data) and Replased (initial data)				Rehabilitated (follow-up data and Relapsed (follow-up data)			
	Heroin N_1=27 N_2=27	B.suger N_1=5 N_2=5	Tirdigesic N_1=3 N_2=3		Heroin N_1=1 N_2=1	B.suger N_1=2 N_2=2	Tidigestic N_1=3 N_2=3
U	281.5	17	3	U	27	0	2
Z ≤	-1.44	--	--	z≥	1.670	--	--
p	0.75	.350	-350	p	.048	.047	.200

The mean scores reported have mean scores reported have clearly shown a higher trens in the relapsed follow-up data, except tidigesic group when compared with initial relapsed data. Acontray trend of distinct low despression level may be observed for the follow-up means of rehabilitated group than the mean scores obtained by both the relaspsed group. The objectained U-values and Z-values have been reported in Table 6. The nonparametric measure Mann-Whitney U-test have been reported in Table 6. The nonparametric measure Mann-Whitney U-test has been applied to test whether two groups are idependent in dependent in terms of relevant variables studied in the present

intigation or in other words drawn from the same population of depressive component for the cpmparison of the initial and follow-up data have focused that the probability levels do not justify rejection of null hypothesis thus the directional hypothesis (7) that their will not be any changes between initial and folow-up dataa of relapsed clinical group stands on full support. The second set of com parison of the follow-up data of relapsed and rehabilitied groups have proved that except tidigesic, heroin and brown sugar both the groups justify the rejection of the null hypothesis (p.048 and .047) and acceptance of the experiental hypothesis (8). In the present cases results revealed that depression level of the rehabilitated follow-up groups have gone down in comparision with relpased follow-up groups.

Table 7: Means and Standard Deviations for pathological contents of relapsed and rehabilitated follow-up drug addicts.

Pathological contents		Relapsed (Initial data)			Relapsed (Follow-up data)			Rehabilitated (Follow-up data)		
		Heroin N=27	B. Sugar N=5	Tidigesic N=3	Heroin N=27	B. Sugar N=5	Tidigesic N=3	Heroin N=27	B. Sugar N=5	Tidigesic N=3
PAS	M	10.59	9.60	10.67	12.26	12.80	9.000	0	0	0.33
	SD	12.34	3.71	9.87	9.05	4.15	7.81			0.58
D	M	8.78	10.00	7.33	13.00	14.40	7.33	1.00	2.00	2.33
	SD	9.51	9.22	5.51	7.54	7.16	4.04		1.41	2.08
HAS	M	4.67	4.60	7.66	5.89	5.80	8.00	2.00	5.00	8.33
	SD	5.41	2.61	4.73	4.93	2.17	3.46		2.83	2.08
P	M	1.85	1.60	4.33	1.63	1.00	2.67	0	1.00	1.00
	SD	2.20	1.67	0.58	1.42	0.71	1.54		0	1.00

The pathological contents of the SIS measurres have been reported with mean ratings and SDs of the initial and follow-up scores of relapsed group and followup scored of rehabilitated group. As per the hypothesis (8) rehabilitated groups hava scored low in pathological contentsa i.e. PAS, D and P. HAS however, is going against the hypothesis which is clearly reflected in the preceeding mean table (Table7). The means of all clinical groups viz. heroin, brown-sugar and tidigesic have reported increased scores in PAS, Dand HAS comnparatively to their initial data except p, while rehabilitated follow-up groups have reported a deceaing trend from relpased follow-up data.

Teble 8 : Mann Whitney Utset Values of SIS for pathological contents of relapsed and rehabilited follow-up data.

Pathological Contents		Relased (follow-up data) and Relapsed (initial data) Heroin N_1=27 N_2=27	B. Sugar N_1=5 N_2=5	Tidigesic N_1=3 N_2=3		Rehabitated (follow-up data) and Relased (follow up data) Heroin N_1=1 N_2=27	B. Sugar N_1=2 N_2=5	Tidigesic N_1=3 N_2=3
	U	293.5	18	3	U	20.5	o	o
PAS	Z	-1.23	---	---	Z	0.87	---	---
	P	.109	.579	.350	p	.192	.047	.050
	U	208	17	5	U	27	0	0
D	Z	-2.71	---	---	Z	1.67	---	---
	P	.003	.579	.650	p	.048	.047	.050
	U	278.5	11	4	U	23	4	4
HAS	Z	-1.49	-	-	Z	1.18	-	-
	p	.068	.421	.500	p	.119	.429	.500
	U	360.5	8	0	U	24.5	5	0
P	Z	-.07	--	--	Z	1.36	--	--
	p	.472	.210	.050	p	.087	.571	.050

Table 9 : Percentage mean, Standard Deviations for SIS indices of relapsed and rehabilited follow -up

SIS Indices		Relapsed (Initial data) Heroin N=27	B. Sugar N=5	Tidigesic N=3	Relapsed (Follow-up data) Heroin N=27	B. Sugar N=5	Tidigesic N=3	Rehabilitated (Follow-up data) Heroin N=27	B. Sugar N=5	Tidigesic N=3
T	M	14.93	18.00	13.67	14.93	15.60	21.00	12	23.00	26.33
	SD	4.23	5.10	6.43	4.10	6.54	4.36		4.24	4.04
At	M	18.11	20.20	18.67	19.30	19.60	14.00	15	8.00	8.67
	SD	5.71	6.53	5.51	4.37	2.88	1.73		1.41	4.04
MT	M	4.89	4.80	5.33	3.22	2.60	1.67	9	8.00	7.33
	SD	2.21	2.28	2.31	2.44	1.34	1.53		1.41	2.08
H	M	4.89	4.80	5.33	3.22	2.60	1.67	9	8.00	7.33
	SD	6.58	6.95	4.51	5.11	3.56	0.58		7.78	5.51
A	M	8.56	11.80	13.67	9.37	10.80	9.67	15	27.00	17.00
	SD	5.14	2.39	7.02	3.33	5.54	2.89		1.41	5.57
Sex	M	11.04	6.20	13.67	11.85	10.20	19.33	13	1.50	6.33
	SD	6.58	5.50	4.16	4.70	6.91	4.51		2.12	2.08
Ant	M	23.15	23,60	24.33	24.48	24.60	24.33	13	22.00	22.33
	SD	9.66	7.30	9.45	4.84	3.91	5.13		5.66	3.79
Rej	M	1.59	0	0	.93	.40	0	4	0	1.33
	SD	3.71			1.86	0.89				2.31

Table 9 : provides the percentage means and standard deviations for SIS indices of inital follow-up data of relapsed groups and also of rehabilitated followup

groups. Mean result shows heroin and brown-sugar addicts have mildly differed from their inital data to follow-up data when they relased after treatment. Heroin and brown-sugar groups have reported of higher percentage means after relapse while the tidigesic group has either reported of decreased percentage mean or maintained their previous level of pathological indices. Hand A decreased. Percentage means obtained in rehabilitated groups are reported to be high for the T, Mt, H, and A responses while compared to relapsed follow-up means T, Sex and Ant scores decreased, among rehabilitated group.

Table 10: Mann-Whitney U-test values of SIS indices of relapsed and rehabilitated follow-up data.

SIS Indices		Relased (follow-up data) and Relapsed (initial data)				Rehabitated (follow-up data) and Relased (follow up data)		
		Heroin N_1=27 N_2=27	B. Sugar N_1=5 N_2=5	Tidigesic N_1=3 N_2=3		Heroin N_1=1 N_2=27	B. Sugar N_1=2 N_2=5	Tidigesic N_1=3 N_2=3
	U	378.5	16	1	U	12.50	2	2
T	Z≥	.24	--	---	Z ≤	-.12	---	---
	p	.405	.579	.100	p	452	.190	.200
	U	303.5	13	1	U	21.50	0	0
At	Z ≤	-1.06	---	---	Z ≥	.99	---	---
	p	.145	.579	100	p	.161	.047	.050
	U	514	21	9	U	.50	0	0
MT	Z≥	2.89	---	---	Z ≤	-1.60	---	---
	p	.002	.579	.650	p	0.55	0.47	.050
	U	380	12	4	U	13.50	7	5
H	Z≥	.29	---	---	Z ≤	0	---	---
	p	.386	.500	.500	p	.500	.571	.650
	U	318	13	6	U	2.00	0	1
A	Z ≤	-.80	---	---	Z ≤	-1.42	---	
	p	.212	.579	.650	p	.078	.047	.100
	U	322.5	18	7	U	8.50	1	0
Sex	Z≥	.73	---	---	Z≥	.62	---	---
	p	2.32	.579	.650	p	.268	.095	.050
	U	382.5	15	5	U	26.0	3	4
Atn	Z≥	.31	---	---	Z≥	.62	---	---
	p	.378	.579	.650	P	.061	.286	.500
	U	399	5	0	U	1.0	0	3
Rej	Z≥	.60	---	---	Z ≤	-1.55	---	---
	p	.274	.075	---	p	.061	.047	.350

In support of the hypothesis the realsed follow-up scores of the SIS indices have not been changed significantly than their initial scores, except most typi-

cal response (Mt) of herion group which actually reported to be decreased after their relapse to addiction. Mt for the heroin group reject the null hypothesis in favour of the directionalhypothesis for the comparison of intial and follow-up data of relapsed group (table 10)

The comparison between follow-up relapsed group and rehabilitated group hights that serveal indices have supported the increase oof noprmative responses

Table 11: and Standard Deviations for social anxiety of relapsed and rehabilitated drug addicts.

		Relapsed(Initial data)			Relapsed(Initial data)			Rehabilitated(Initial data)		
Social anxiety		Heroin	B. Sugar	Tidigesic	Heroin	B. Sugar	Tidigesic	Heroin	B. Sugar	Tidigesic
Components		N=27	N=5	N=3	N=27	N=5	N=3	N=27	N=5	N=3
SAD	M	14.19	17.00	16.33	17.48	20.60	15.33	6	9.50	8.33
	SD	4.29	4.06	8.50	3.46	2.41	5.51		2.12	0.58
FNE	M	20.52	17.80	18.30	20.07	21.60	15.67	18	18.00	14.33
	SD	3.18	5.97	5.69	3.05	3.85	6.03		9.90	2.89

Table 12: Man-Whitney U-test values of social anxiety components of relapsed and rehabilitated data.

		Relased (follow-up data) and Relapsed (initial data)				Rehabitated (follow-up data) and Relased (follow up data)		
Social anxiety components		Heroin N_1=27 N_2=27	B. Sugar N_1=5 N_2=5	Tidigesic N_1=3 N_2=3		Heroin N_1=1 N_2=27	B. Sugar N_1=2 N_2=5	Tidigesic N_1=3 N_2=3
	U	192.5	20.	4	U	27	0	0
SAD	Z ≤	-2.98	---	---	Z ≥	1.67	---	---
	p	.001	.579	.048	.048	.047	.050	
	U	396	17	3	U	21	4	5
FNE	Z ≥	-.54	---	---	Z ≥	.93	---	---
	P	.295	.579	.350	p	.176	.429	.650

relapsed groups and follow-up data of rehabilitated groups. A decreasing trend in reha bilitated follow-up data than the follow-up data of relased group is fairly seen. Over all results reveal that all groups i.e. herown-sugar and tidigesic have proved to relapsed and rehabilitated for social avoidance and distress (SAD). However, they could not prove the experison hypothesis in fear of negative evaluation (FNE) Table 12). The comparison of intial and follow-up data of relapsed brown-suger and tidigesic groups accept the null hypotheses but heroin groups reject the null

hypothesis and reports of a higher social avoidance and distredd (SAD) in the relapsed groups. A similar level of FHNE for both the relapsed groups have been reported.

The approval motive components projected in table 13 clearly shows that the mean scores of rehabilitated groups have gone down for the dependency (Dep) component while the scale has registered an increase in normative behaviour (NB), defensiveness (Def), social responsiveness (SR) and social approval (SA) than the mean scores of replsed follow-up counterpart. Initial data and following up data on the contrary are not reporting of any betterment of approval motive but a detrimental score in several variables i.e. NB, SC, Def may be seen.

Table 13 : Mean and Standard Deviations for approval motive components of relapsed and rehabilitated drug addicts

Approval motive components		Relapsed (Initial data)			Relapsed (Follow-up data)			Rehabilitated (Follow-up data)		
		Heroin N=27	B. Sugar N=5	Tidigesic N=3	Heroin N=27	B. Sugar N=5	Tidigesic N=3	Heroin N=27	B. Sugar N=5	Tidigesic N=3
NB	M	5.70	6.20	6.33	4.78	4.40	4.33	7.00	6.00	7.67
	SD	1.41	1.30	2.08	1.05	1.14	1.53	---	0	.58
SC	M	4.89	4.80	4.33	3.93	3.20	4.67	4.00	4.50	4.67
	SD	1.50	1.92	.58	.78	.45	.58	---	.71	.58
PSP	M	4.19	4.60	4.00	4.22	3.80	4.33	4.00	5.00	4.67
	SD	1.11	1.00	1.53	1.13	1.22	1.53	---	0	.58
Def	M	5.07	5.00	6.67	4.85	4.00	5.67	6.00	6.00	5.00
	SD	1.11	1.00	1.53	1.13	1.22	1.53	---	1.41	1.73
Dep	M	3.89	4.20	3.30	4.37	3.60	4.00	4.00	3.50	3.33
SR	M	3.96	3.40	3.33	4.56	3.00	4.00	7.00	6.00	6.00
	SD	1.09	1.14	1.15	.93	1.22	1.00	---	1.41	0
SA	M	11.70	10.40	12.00	12.19	9.20	13.00	15.00	15.00	15.67
	SD	2.03	1.52	1.73	2.29	1.92	1.73	---	0	1.53

The scores on subscales of normative behaviour (NB), social conformity (SC) dependency (Dep) and social responsieness (SR) have obtained requisite index of U-values to reject the null hypothesis when initial and follow-up scores were compared of replased heroin addicts. The first two components reported of deterioration while the last two components reported of increased score after relapse. U-values computed for the tidigesic group stands in support of the null hypothesis in all approval motive components i.e., NB, SC, PSP, Def, Dep, SR and SA. Brown-sugar group again reports a significant deterioration in social

Table 14 Mannu-Whitney U-test values of approval motive components of reapsed and rehabilitated data

Approval Motivee components		Relapsed (follow up data) and Relapsed (initial data) Herion	B. Sugar	Tidigesic		Rehabilitated (follow-up data) and Relapsed (follow-up data) Herion	B. Sugar	Tidigesic
		N_1=27 N_2=27	N_1=5 N_2=5	N_1=3 N_2=3		N_1=1 N_2=27	N_1=2 N_2=5	N_1=3 N_2=3
	U	504.50	23	8	U	.50	2	0
NB	Z	2.42	---	---	Z	-1.61	---	---
	p	.008	.579	.650	p	.053	.190	.050
SC	Z	2.33	---	---	Z	0	---	---
	P	.009	.008	.650	p	.500	.571	.100
	U	361	5	4	U	16	8	4
Def	X	1.27	---	---	Z	-1.11	---	---
	p	.1020	.579	.650	p	.134	.190	.650
	U	260	6	6	U	16.50	4	3
Dep	Z	-1.81	---	---	Z	.37	---	---
	p	.035	.11	.650	p	.356	.429	.350
	U	263	17	4	U	.50	1	0
SR	Z	-1.76	---	---	Z	-1.61	---	---
	P	.0.39	.579	.500	p	.504	.095	.050
	U	307	19	2	U	3.00	0	1
SA	Z	.99	---	---	z	-1.29	---	---
	p	.1611	.579	.200	p	.099	.047	.100

conformity (SC) while all other motive components do not justify the rejection of null-hypothesis. Thus hypothesis 8 wins a support of no difference between the groups only in positive self presentation (PSP), defensiveness (Def) and also of social approval (SA) (Table14).

The comparison between two follow-up groups viz, replased and rehabilitated were assumed to score higher in terms of approval motive for the later group. Heroin and tidigesic groups U probability value justify to reject the null hypothesis in favour of experimental hypothesis 9 in approval motive components i.e. normative behaviour (NB) and social responsiveness (SR) and brown-sugar group proves the same for social approval (SA) component. Other approval motive components could not prove the experimental hypothesis for the groups when follow-up data of relapsed and rehabilitated groups compared.

Discussion

The results elaborated authenticate that narcotic addicts are substantially susceptible to depression. The outcome brings support to the previous investigations (Gilbert, etal. 1967; Robbins & Nugent III, 1975; Mukhopadhyay, et al., 1996). The depression level obtained by projective test results, namely, SIS again support the inference obtained through objective measures.

Other pathological scores like patholgical anatomy score and paranoid ideation which have proved to be significantly high among addicts are indicative of covert depression. It shows that drug addicts are anxious of their personal health, support for which may be traced with higher anatomy scores as recorded in SIS indices for the brown-sugar group. In an attempt to measure the relationship of projection and pathology, Murstein (1995) observed that clinical patients (psychiatric) respond to internal cues more than to external one's and healthy normals respond

to cues provided by the stimulus structure.

The responses of the drug addicts are so projected that the body appeared as diseased (PAS). The body awarness itself denotes depression (Pershad & Verma, 1995). Hostility and aggression score (HAS) has been proved to be low for the narcotic analgesic groups than their normal counterparts. Significantly lower level of hostility has been reported only for the tidigesic group. Aggression has been found to be a reaction commonly triggered by frustration. Thus lack of even a normal level of hotility and aggression may be interpreted as the euphoric feelings achieved through drug use which do not stimulate normal frustration level with common reaction pattrens.

The abuse potentiality of tidigesic is low. Prinicipal cause of pathology may be traced in their personality. Tidigesic group of the current sample have indicated the presence of psychopathological components in their personality in terms of pathological anatomy score, depression and paranoid ideation.

The drug addicts reported more of eye responses than persecutory complaints in the present investigation thus indicating their self awareness which are subsequently being supported with high fear of negative evaluation. High paranoid response have been reported among drug addicts in earlier studies as well (Kleckner, 1968; Steer & Hassett, 1982).

Social avoidance and distress (SAD) one of the social anxiety components explored in the present study has approved of a higher trend with higher depression among drug addicts. The other component viz, fear of negative evaluation (FNE) has also established its prominence among drug addicts. Approval motive measures revealed that addiction groups obtained significantly low scores in defensiveness (Def), social responsiveness (SR) and social approval (SA) alongwith high social anxiety. Brown-sugar group has reported of significantly low PSP in the current observation while the lower trend has been maintained for the other two groups as well as could not reach the level of significance. Social avoidance and social phobia as per the recent trend, possibly originates with shyness.

Positive self presentation refers to the content of self disclosure to other people for the sake of acquiring social approval. Conforming behaviour is a less stable form of normative behaviour. Social conformity refers to a person's changing his or her behaviour to fit with the expectations or demands of others. In the present investigation the results for the social conformity and normative behaviour both do not establish any mean difference between addicts and non-addicts. Thus the dimensions are not having their reliable prominence for approval motive among addicts. The mode of drug intake probably substitute the motive.

Significantly lower typical (T) and most typical (Mt) and higher atypical responses (At) have been reported in the present study for the drug addicts. They have also reported of higher sex responses. A higher number of sex responses and lower number of most typical (Mt) responses reported by schizophrenic when compared to normal were interpreted by Dubey, et al., (1994) as of their poor organizational capacity and disorganized thinking of schizophrenics. Similar interpretations may be implied among the addicts as well. Mitra and Mukhopadhyay (1996) found high percentage of anatomy (Ant) responses among drug addicts suggesting that they are body conscious. Somatic awareness transietly increase in state of hunger, physical exertion, emotional

arousal and sexual excitement. Subsequently the mental representation in the body fade into the background of consciousness (Cassell, 1980). Present study supports similar trend i.e. significantly high mean scores of sex responses in drug addicts compared to normals. Relationships have been found to exist between an individual's physical disturbances and projected anatomical responses and a higher number of rejections are the sign of depression (Cassell, 1980). Rejection (Rej) of images were found to be more in neurotics (Dubey, 1982) and also in schizophrenics (Dwivedi, et al., 1995) than normals. A similar trend may be seen as the mean scores are higher for the drug addicts though t scores are not significant. This is also indicative of high depression level of drug addicts than normals.

Human response (H) is the symbol of identification. High human response (H) reported by the drug addicts in the present investigation denote an attempt of following normals life style among them. Animal response (A) symbolizes hostility, frustration, immaturity and primitive behaviour as well as low socialization (Dubey, 1982). Drug addicts, however, have shown a significantly lower score in the component.

Relapsed or recurrence of symptoms are the central problem to any type of habitual addication. Gossopy (1989) attempted to explore the process of recurrence in different forms of addicative behaviour shortly after leaving treatment.

Present study rechecked the inferences drawn with the follow-up scores ascertained for all the clinical groups. The groups were divided into rehabilitated or 'imporved' and relapsed or 'failed to imporve' category after treatment.

Relapsed drug affected groups when compared in terms of their pre and post treatment measurements proved that they either maintained their pathological components of personality or degratded further. Depression level of the heroin, brown-sugar and tidigestic groups were reported to be stable for the initial and relapsed follow-up scores. High social anxiety with stable fear of negative evaluation and higher social avoidance and distress specially among heroinabbicts alongwith stable high depression level of the relapsed follow-up group brings support to the findings of Brown, et. al (1996). In an earlier, Brown et al. (1971) reported of relief from personal problems as reson for relapse in heroin addicts. Rehabilitated heroin, broen-sugar and tidigesic group's depression level decreased after treatment.

Present study rechecked the inferences drawn with the follow-up scores ascertained for all the clinical groups. The groups were divided into rehabilitated or 'improved' and relapsed or 'failed to improve' category after treatment.

Relapsed drug affected groups when compared in terms of their pre and post treatment measurements proved that they either maintained their pathological components of personality or degraded further. Depression level of the heroin, brown-sugar and tidigesic groups were reported to be stable for the initial and relapsed follow-up scores. High social anxiety with stable fear of negative evaluation and a higher social avoidance and distress specially among heroin addicts alongwith stable high depression level of the relapsed follow-up group brings support to the findings of Brown, et al. (1996). In an earlier study, Brown, et al. (1971) reported of relief from personal problems as reason for relapse in heroin addicts. Rehabilitated heroin, brown-sugar and

tidigesic group's depression level decreased after treatment.

Social anxiety subscale SAD approves that the follow-up data of the heroin addicts significatnly increased that their initial data. Brown sugar and tidigesic groups also either maintained their social anxiety level or reported a minute change both for SAD and FNE in their follow-up scores. Research reviews have indicated that the common cause of relapse to addiction are the influence of addicted friends, social pressures and stresses (Brown, et al., 1971; Gossop, et al., 1989). The inferential U values justify the rejection of null hypotheses for four out of seven dimensions for the heroin addicts and brown sugar addicts stands in support only for social conformity (SC). Findings approve of further downfall of relapsed follow-up scores in NB, SC and Dep yet the only significant improvement reported for approval motive is the area of social responsiveness (SR). Social responsiveness refers to individual's tendency to respond to social stimuli in high frequency and magnitude. In social situations he tends to react and sometimes over-react to social stimuli. The pressure of SR component among relapsed groups indicate that there are hopes for their recovery if such motives are utilized for counselling.

Follow-up rehabilitated groups have focused the change in favour of improvement when compared with relapsed with relapsed follow-up groups in SIS contents. As the addicts succeeded to abstain from drugs and started leading a normal healthy life the pathological contents of PAS, D and P have decreased substantially. High pathological contents among clinical patients have been repeatedly reported when assessed with normals (Rahtee, et al., 1995; Dubey, et al., 1995). The lowering of PAS obtained by rehabilitated groups than relapsed follow-up groups indicate that the pathological component is reduced with improvement in life style. A supplicated component of low HAS and low HAS and low P are also present in the rehabilitated follow-up sample. U values highlight that depression (D) content of all the groups approved the justification of rejection of null hypothesis which have shown its evidence when the extent of depressive symptoms measured through objective test. The positive factors of SIS indices, namely, typical (T) and most typical (Mt) have been obtained high while the U values reached the significance level for MT only. Atypical (At) scores have found to be significantly low in brown-sugar and tidigesic groups and reject the null hypotheses but heroin group accept the null hypothesis of rehabilitated follow-up groups. The trends touched the level of normality for the rehabilitated group as reported in number of observations (Dubey, et al., 1995: Verma, et al., 1995).

Animal response (A) reortedly increased in all the rehabilitated groups (Singh, et al., 1997). More animal response is indicative of low socialization (Dubey, et al., 1994). It appears that even after treatment and decrease in social anxiety the addicts are still facing fear of negative evaluation which justifies the high animal responses (A) signifying low socialization. Both anatomical (Ant) and Sex responses (Sex) have significantly decreased indicating moderation in personality pathology except that of heroin addicts. All the addict groups after rehabilitation have reportedly found with low anatomy scores (Ant). Anatomy scores denote body awareness which are reported to be high when the body goes through a phase of arousal thus the lower scores in anatomy scale signify that the arousal phase is over and the individual has gained control over somatic consciousness.

Human response is indicative of intellect, identification with humans and interest in other persons as per the interpretations suggested in Rorschach response. A higher trend of responses have been recorded on Human response (H) among the rehabilitated group than their relapsed counterpart, thus summarily SIS indices are producing evidence of social support of improvement with declining trend in patholgical life style after rehabilitation.

Rehabilitated groups scored lower in fear of negative evaluation when the comparison traced between rehabilitated groups and relapsed groups. With decreasing trend of fear of negative evaluation in increasing trend of social approval (SA) have also been reported for all the three groups considered in the present study.

Findings obtained through approval motive scores also highlight the enhancement of positive factors i.e. normative behaviour (NB) social responsiveness (SR) and social approval (SA) among rehabilitated groups. Social conformity (SC), positive self presentation (PSP) and defensiveness (Def), all have shown the higher trend in rehabilitates than the relapsed follow-up group. These positive change towards normal healthy life may possibly be detected as the cue factors for rehabilitation.

The influence of positive self presentation help one to control the social anxiety. Social anxiety arises in real or imagined social situations when people are movtivated to impress others.

Conclusion :

From the above results conclusion is derived that the narcotic addicts suffer from high depression than normal population. The social anxiety develops as a consequence of addiction when the proper monitoring of life style is not done and the flexibility in trait pattern is over looked in the course of treatment. The pathological contents and indices ascertained also indicate their intense inner feelings for the deviation from normal healthy management of life. Extreme body awareness alongwith depression and paranoia with lack of hostility and aggression have indicated the trend of personality of the narcotic addicts. Pathological patterns have also been traced with high atypical response, sex and anatomical response as indicators for the addicts, all of which were found to be decreased when the addicts reportedly improved after treatment and not returned to their drug intake habituation.

Approval motive dimensions have focused four principal components viz. positive self presentation (PSP) defensiveness (Def), social responsiveness (SR) and social approval (SA) are reported to be significantly low among addicts. Rehabilitated follow-up groups in reverse highlighted three components i.e. normative behaviour (NB) social responsiveness (SR) and social approval (SA) to be significantly high after the reported improvement.

The drug addicts have the potential to return to their normal healthy life style if every possible more and mental support is given to them. The obtained social cue components may be utilized in the process of counselling to monitor their pathological components of personality to help them to gain the required mental strength to avoid drug dependence.

References :

Arora, M.; Kumari, A., and Enright, R., (1988). Adolescents' stress in India : Age and sex differences.. Psycholgical Reports, 62,30.

Basu, D.; Verma, V.K; Malhotra, S., and Malhotra, A. (1995). The sensation seeker who is also alienated : Towards a new hypothesis for genesis of opiate addiction. Indian Journal of Psychiatry, 37, 17-22.

Blum, R. (1969). Students and Drugs. San Francisco : Jossey Bass.

Bradley, B.P. : Philips, G. and Green, L. (1989). Circumstances surrounding the initial lapse to opiate use following detoxication. British Journal of Psychiatry, 154, 354-359.

Brown, B.S.; Gauvey, S.K.; Meyer, M.B., and Stark, S.D. (1971). In their own words, addicts reasons for initiating and withdrawing from heroin. The International Journal of Addiction, 6, 635-645.

Brown, G.W.; Harris, T.O., and Eales, M.J. (1996). Social factors and comorbidity of depressive and anxiet disorders. British Journal of Psychiatry, 168, 50-57.

Carman, R.S. (1979). Motivations for drug use and problematic outcomes among rural junior high school students. Addictive Behaviours, 4, 91-93.

Cassell, W.A. (

SIS J. Proj. Psy. & Ment.Health (2000) 70-73

Some Popular Misconceptions about Inkblot Techniques

S.K. Verma

In clinical practice, one comes across many fears, misgiving, apprehensions and misconceptions about projective techniques, particularly about the inkblot techniques. These misconceptions in general population need to be effectively removed or controlled at least if it is not possible to remove them completely. This needs to be done at an early date and sooner the better for all concerned-before it takes roots and starts biasing or poisoning the young scientists mind against them and their usefulness or uselenssness as the case might be. Unrealistic expectations may be as bad as misconceptions.

Firstly, it is sometimes stated that "these are unstandardized techniques and not tests". Here one can find two misconceptions rather than one-inkblot techniques are as standardized as any other psycholgical instrument or test, the stimulus is fixed and so are the instructions and administration. Very little variation, if any is allowed by trained and qualified tester. However, untrained tester or unqualified testers may show varioations at time. We cannot take for granted their ownclaims of being "trained" or "self trained". These claims need to be checked first. Like any other highly complex tasks, inkbots also require sufficient training and practice under qualified, well experienced persons in the use of these techniques-without which it would not be surprising to find variations in results obtained and often being misinterpreted to indicate limitations of the instrument as such. After all any well standardized test can be misused, in an unstandartised way, by self-proclaimed "qualified" testers. The standard instruments get thus blamed for any unreliablity of the results. It goes without saying that actual blame lies elsewhere.

Differentiation between a "technique" and a "test" is very difficult, if not impossible. Both terms are sometimes used interchangeably to denote all projective tests or techniques used in clinical practice. The difference lies in the use of language.

One might say that Rorschach test (or SIS Test) uses inkblot technique or method in the same way the MMPI uses questionnaire method or, Hamilton Rating Scale for Depression sues rating method, without downgrading them in any way. Besides, as difference is no difference. In other words, it should not make a difference whether we call a projective test as a projective technique and vice versa. Bothare standardized way of comparing the behaviour of two moreand vice versa. Both are standardized way of comparing the behaviour of two more person/ groups at any given time or of the same person/group at

S.K.Verma Ph.D. Consultant Clinical Psychology, Govt. Medical College & Hospital, Chandigarh 160 047 (India).

different period of time – when used by qualified person, in a well standardized way and in standardized situation, time and place.

Secondly, it is sometimes said that "all inkblot technique are useless" for various reasons. Many of these stated reasons may be considered as separate independent misconceptions. Different inkblot techniques may suffer from different limitations, for example, equivalent form are available for SIS-II but not for Roschach test. SIS has card booklet form and video version but this is not true for other inkblot techniques. Reliability and indexes/ratios can be and are different, so that any generalization about all inkblot techniques would be itself an invalid statement. Not only that, but any single statement about reliability and validity for any single inkblot techniques would be incorrect and incomplete, as there are scores of variables, indexes, ratios present in each technique.

In fact, one score of any one technique ma be more stable and consistent (therefore has high reliability), while another variable of the same technique may be more useful –as suggestive of a particular mental disorder e.g. confabulation or, contamination as suggestive of psychosis. Higher number of some responses and low p% suggestive of paranoid tendency. So usefulness of some indicator may be more or less depending upon the specific scoring criteria, use, condition of the mental disorder at a particular time (severe or, during treatment / no treatment phase), etc. hasty generalization are unjustified.

In an oft-quoted experiment, uselessness of Rorschach was attributed to the acceptance of the same general, personality description by a group of students as of their own personality assessment based on Rosarch test. Much faith in such experiments can not be placed, as other projective techniques, by the same group of subjects, under similar circumstances.

Thirdly, "only psycho-diagnosticians use inkblot techniques and not clinical psychologists whose main job is to tread the patients with mental disorders". Emphasis on treatment not necessarily mean looking down upon the projective techniques. Besides people now also of projective psychotherapy, where inkblot techniques are also used for both psycho-diagnostic and correction at the earliest stage i.e. early identification and treatment, for better outcome.

Fourthly, "Only clinical psychologists should use inkblot techniques and no psychiatrist should enter in this area". Here, one forgets that many psychiatrists including H. Roschach and W. Cassell have been pioneers in this very area and denying psychiatrists the use of inkblot techniques is absurd, to say the least. Little knowledge is a dangerous thing. Surprisingly, many psychologists are still unaware of this historical root of the use of

inkblot techniques for psycho diagnostic (Rorschach and psychotherapeutic purpose (Cassell). Nobody is born as a psychiatrist or a psychologies. It is the training that makes it so and anybody with good training in inkblot technique (and of mental disorders) should be able to do full justice to it and therefore cannot be denied its use.

Fifthly, "Inkblot technique is an outdated thing, a thing of the past the past that need to be discarded and is no longer used by clinical psychologists now-a-days". This is another of the common misconceptions. In fact, the inkblot after its waxing and waning periods, is again on the rise, not only in clinical practice but also in research. A new society called "Somatic Inkblot Society" has been formed with its membership spread across the world and a research journal "SIS Journal of projective psychology and mental health" has recently joined hands with other such journals. The scope is increasing.

Misconceptions in this area are many, that need correction. Let us hope that they soon are taken care of by the increasing use of inkblot techniques and adequate training for their proper use, keeping in mind their limitations.

Reference:

Verma, S.K. (1993) Psycholo-diagnistics: An evaluation. Psychological Studies. 38: 101-113.

Verma, S.K. (1995) Reliability and validity of inkblot series tests. SIS Journal of Projective Psychology and Mental Health 2:67-71.

Verma, S.K. Pershad, D.Kaur, R. and Nehra R (1995) Diagnostic Significance of SIS-II. SIS Journal of Projective Psychology and Mental Health. 2: 72-76.

Verma, S.K. (1996) Newer trends in inkblot techniques. SIS Journal of Projective Psychology and Mental Health. 3: 1-2.

Verma, S.K. (1977) A secret message and a challenge. SIS Journal of projective Psychology and Mental Health. 4: 1-2.

Somatic Inkblot Society

(MEMBERSHIP DIRECTORY - 2001)

Anil Agrawal, MBA
President & CEO
Telephone Cables Limited
SCO 68-70, Sector 17-C,
Chandigarh-160017 (India) (LM 99)
Tel. : 91-0172-704368, 702720
E-Mail : aagarwal@tclindia.com

S. Alam, Ph.D.
Lecturer, Dept. of Psychology, Women's College, Aligarh Muslim University,
Aligarh-202002 (India) (LM 97)

Ms. Zahirunnisa Ali
Specialist in Physical Therapy,
Plot No. 65, Ayppa Nagar,
P.O. Katol Road, Nagpur (India)
Tel. : 91-712-539418 (LM 95)

Deepak Anand, MBA,
University Business School,
Punjab University, Chandigarh (India)

Raman Bansal,
39-C, Sector 14, PU. Campus,
Chandigarh. (India)
Tel. : 778214 (LM 2000)

Phillip. W. Baker, Ed.D.
4325, Laurel, Suit 215,
Anchorage, AK 99508 (USA)
Res. : 2305 Susitna Dr. Anchorage,
AK 99517 (USA) Tel.: (907) 562-2392(W)
(907) 243-8042 (H) (M 95)
E-Mail : wcbaker@alaska.net

Mrs. Shubhra Banerjee, Ph.D.
"Shubhalaya", 7, Mahaveer Colony,
Kamachha, Varanasi - 221 010,
(India) (LM 97) Tel. : 91-542-312049 (H)

R.S. Basi, Ph.D.,
11651, Hill Side Drive, Ancharage, AK99516
Tel. : (907) 345-6655 (H) LM99

Ms. Jayanti Basu, Ph.D.
Consultant Psychologist, AE 692, Salt Lake,
Sector 1, Calcutta - 700 064, (India)
Tel. : 91-33-341421, 3379772 (H) (LM 95)
E-Mail : btapas@cal2.vsnl.net.in

Saugata Basu, M.Sc, M.Phil.
Clinical Psychologist.
Surendranath Cooperative,
201, Manikatala Main Road, Flat No.12,
Calcutta - 700 054, (India)
Tel. : 91-33-3379772 (H) (LM 97)
E-Mail : saubasu@cal3.vsnl.net.in

J.S. Bedi, Chairman
Gian Jyoti Inst. of Mgt. & Technology
Phase-II, Mohali-Chandigarh (LM 99)
Tel. : 91-172-671100, 661327 (H)

Mahesh Bhargava, Ph.D.
Director, National Psychological Corporation, 4/230, Kacherighat,
Agra - 282 004 (India) (LM 95)
Tel. : 91-562-350 113 (H)

Ishlesh Bhaskar, MBA
34 Green Enclave, Borewal,
Ludhiana-142027(M 99) (India)
Tel: 91-161-462772

D.K. Bhatt, BE
Director Mktg., IFFCO,
54, Nehru Place, New Delhi-110019
Tel. : 91-124-6341210 (H), 91-11-6463622

Shantanu Chatterjee, MBA,
University Business School,
Punjab University, Chandigarh (India)

Ram Chander, MBA,
University Business School,
Punjab University, Chandigarh (India)

Carina Coulacoglou, Ph.D.
Psychologist, University of La Verne,
40E, Esperou Str. Kifissia, Athens 14561
Greece (M99) Telefax : (301) 6252269
E-mail : carina@hol.gr

Mrs. Mary Cassell,
Executive Director, 4501E, 104th Avenue,
Anchorage, Alaska - 99516 (USA).
Fax : 907-563-3746 (W) (FM92)
E-Mail : marycassell@hotmail.com

Wilfred A. Cassell, MD, FAPA, APC,
Director, SIS Center, President, Somatic Inkblot Society, 4501E, 104th Avenue,
Anchorage, Alaska - 99516 (USA).
Fax : 907-563-3746 (W) (FM92)
E-Mail : drcassell@corecom.net

Sweta Chhabra, MBA
112, Sec 27-A, Chandigarh (India)
Tel: 91-172-656893 (M 99)

Tena Chhabra, MBA
UBS, Punjab University,
Chandigarh (India) (M 99)

Lt. Col. S. Chaudhury, MD, Ph.D.
Deptt. of Psychiatry,
Armed Force Medical College,
Pune-411040
E-Mail : suprakashchaudhury@hotmail.com

Sebestian Chembakam, Ph.D.
Consultant Clinical Psychologist,
Kalavathu Road, Palarivattom,
Cochin-682025 (India)
Tel. : 91-484-336162 (LM 96)

Alfred Collins, Ph.D.
Consultant Clinical Psychologist
615 East, 82nd Ave, Suite 102,
Anchorage, Alaska - 99518 (USA)
Tel. : (907)-344-3338 (W)
Telefax : (907)-346-4084 (H) (LM 95)
E-Mail : acollins@alaska.net

Laurence Steve. Corp.
3000 Doris St. Ancharage, AK 99517 (M99)
Telefax : (907) 276-7182
email: scorp@sinbad.net

Commandant, Command Hospital (WC)
Chandimandir - 134107, Haryana
India (LM 97)

Neeraj Shayam Deo, DMSP
C/o Dr. S. R. Deo, Gandhi Chowk,
Jalna - 421203 (India) (M 98)
Tel. : 91-252- 225445 (W), 33831 (H)

Dr. Sonali De Ph.D.
B-1015, Karuna Moyee Housing Estate,
Salt Lake, Calcutta - 700091 (India)
Tel. : 3590561 (H) (LM 2000)
E-Mail : sonali.de@cucc.ernet.in

Ankur Dhamija
488, Model Town,
Karnal, Haryana (India) (M 2000)

Vishal Dingra
1013 PAU. Campus,
Ludhiana-141004 (India) (M 2000)

Mrs. Pratibha Dhondia, M.A.
2366, Sector 35-C, Chandigarh - 160 034.
Tel. : 91-172-664562 (H) (LM 97)

N. L. Dosajh, Ph.D.
1121, Sector 15-B, Chandigarh - 160 015.
Tel. : 91-172-772651 (H) (LM 95)

Director, Agra Mansik Arogyashala,
Agra - 282002 (India) (M 98-99)

Anand Dubey, B.E., MBA (Final Year),
Joint Editor, Post Box 244045,
Anchorage, Alaska - 99524 (USA). (LM 97)
E-Mail : adubey@hotmail.com

Asheem Dubey
Joint Editor, 4220 Edinburg Drive,
Anchorage, Alaska - 99515 (USA). (LM 97)
E-Mail : batli@usa.net

Bankey L. Dubey, Ph.D.
Director SIS Center India, Vice President
Somatic Inkblot Society, Post Box : 1107,
Sector 15 Post Office, Chandigarh - 160 015
(India)
Tel. : 91-172-710985, Tel./Fax : 91-172-710986
(FM 92) E-mail : sisdubey@hotmail.com

Rajan Dutta, M.P.M.I.R.
Chief HR & TQM, Escotel Pvt. Ltd.
H. No. 1348, Sector 17-C,
Gurgaon-122001 (India)
Tel. : 91-124-343828 (H) (LM 95)
E-Mail : rdutta@escotel.net

Mrs. Padma Dwivedi, M.A.
Secretary Somatic Inkblot Society,
Social Worker, Dept. of Cardiology,
Post Graduate Medical Institute,
Chandigarh - 160 012, (India) (FM 92)
Tel. : 91-172-710985, 710986
E-mail : sisdubey@hotmail.com

Ferro Roberto, Ph.D.
Consultant Clinical Psychologist,
Via Bernardino Bellincione -14,
20134 MILANO (ITALY), (M 95)
Tel. : 39-2-2154874 (H)
E-Mail : csguazzin@fsm.it

K. L. Garg, MD
Consultant Neuro-Psychiatrist
SCO-6, 1st Floor, Sector 17-E,
Chandigarh - 160 017 (India) (LM 95)
Tel. : 91-172-702281 (W) 564800 (H)

Varun Garg, MBA
151,Veer Nagar, Bhatinda (Pb)
(India) (M99)

Nitin Girdhar,
1559, Sector 14, Sonepat (India)
Tel. : 01264-51202 (LM 2000)

Anil Kumar Goel,
M/s High Tech. Storing Industries,
Gali No.9, 12th Cots Road.
Tibba Danu sher
Hisar -125001 (India) (M 2000)

Ambreen Kaur Grewal,
471, Sarabha Nagar, Ludhiana (India)
Tel. : 0161-452206 (LM 2000)

Ravikant Gunthey, Ph.D.
A-111, Shastri Nagar,
Jodhpur-342003 (India) (LM 96)
Tel. : 91-291-33943 (H) 622755 (W)

Neha Gupta,
E3, Sector 14, P.U. Campus,
Sector 14, Chandigarh (India)
Tel. : 5422190 H (LM 2000)

S.C. Gupta, Ph.D.
1/5, Balda Road Colony,
Nishat Ganj, Lucknow-226007 (India)
(LM 1996) Tel. : 91-522-386033
E-Mail : sureshcgupta@hotmail.com

Ms. Sarita Gupta, M.A.
Research Scholar, University Business School, Panjab University, Chandigarh (India) (M 96)

Vishal Gupta, MBA
UBS, Panjab University,
Chandigarh-160014 (India) (M 99)

Bhavana Jain,
255, Sector 17, Panchkula - 134109 (India)
Tel. : 561290 H (LM 2000)

Anuradha Jatana, M.A.
118, Sector 8, Panchkula-134109
Haryana (India) (LM 2000)
Tel. : 91-172-567181
E-Mail : ritzu999@yahoo.com

Mukesh K. Jha, M.A.
Dept. of Yoga Psychology,
Bihar Yoga Bharati,
Ganga Darshan, Munger - 811201,
Bihar (India) (LM 97)
Tel. : 91-6344-22430 (W) (M 97)

M. R. Jhanwar, DPM
Consultant Neuro Psychiatrist,
Deva Institute of Mental Health,
B-27/70, Barhal Kothi, Durga Kund,
Varanasi - 221 005. (India) (LM 94)
Tel. : 91-542-310670 (W)

Ruchika Jindal,
Ashok Rice Mill, Industrial Area,
Sirsa - 125055 (India)
Tel. : 01666-22834 (LM 2000)

Lt. Col. T. Rajan John, MD.
Dept. of Psychiatry,
Command Hospital (WC)
Chandimandir, Panchkula-134107 (LM 97) India)
Tel. : 91-172-866574 (W)

R. K. Joshi, DM & SP
Consultant Clinical Psychologist,
B-27/70, Barhal Kothi, Durga Kund,
Varanasi - 221 005, (India)
Tel. : 91-542-310670 (W) (LM 94)

Vishal Kataria, MBA,
University Business School,
Punjab University, Chandigarh (India)

Maj. Sanjay Kaul, MBA
477 Sector 7, Panchkula (India)
Tel. : 561960 (H) (LM 2000)

Ms. Harpreet Kaur, M.Phil
Clinical Psychologist,
Dept. of Psychiatry
Govt. Medical College & Hospital,
Sector 32, Chandigarh (India) (LM 98)

Rajinder P. Kaur, Ph.D.
Social Scientist, Dept. of Psychiatry,
PGIMER, Chandigarh - 160012
(India) (LM 98)

Gulrej Khan,
2510, Sector 19-C, Chandigarh (India)
Tel. : 774087 H (LM 2000)

Darshan K. Khera, DPM
760, Phase-IV, Mohali (Near Chandigarh)
(India) (LM 96)
Tel. : 91-172-261415 (H), 708961 (W)

Anatoly Khromov
N6, Micr, VI apt. 163, Kurgan,
Russia - 640023
Tel. : 007-352-2-485740 (H)
E-Mail : anatolykh@hotmail.com

Mrs. Rohini Khullar
22 A, Ring Road, Lajpat Nagar-IV,
New Delhi - 110 024 (India) (LM 95)
Tel. : 91-11-6434121, 6225695 (H)
E-Mail : rohini3@vsnl.com

Mr. Navin Kumar
S/o Mr. Mahesh Prasad Sah, Vill.-Paria,
P.O. Bariarpur, Distt. Munger - 811211
Bihar (INDIA) (M 98)

Rakesh Kumar, Ph.D.
Sr. Clinical Psychologist,
Agra Mansik Arogyashala,
Agra-282002 (India) (LM 98)
Tel. : 91-562-322650 Fax : 322648

Vikas Kumar,
Deptt. of Yoga Psychology,
Bihar Yoga Bharti,
Munger-811201 Bihar (India) LM 2000)

A. S. Kundu, Ph.D.
Indian Council of Medical Research,
Ansari Nagar, New Delhi - 110 029
Tel. : 91-11-653980 (W) (FM 94)

Yuvraj Singh Lehl,
106, Sector 8-A, Chandigarh (India)
Tel. : 547686 (LM 2000)

Principle, K.S. Saket, Post Graduate College,
Ayodhyaya, Faizabad-224001 (India) (M 2000)

Princial, Rajaury Library, P.N. College,
Khurda - 752057 (Orissa), (India) (M 2000)
Principal SBAS, Khalsa College,
Sandaur, Distt. Sangrur (Punjab)
(India) (LM 2000)

Librarian, Bhavnagar
University Library, University Campus,
Gijubhai Badheka Marg,
Bhavanagar - 364002 (India) (M 98)

Principal Desh Bhagat College,
Dhuri, Distt. Sangrur (India)
Tel. : (01675) 20583 (LM 2000)

Dr. K.R. Banerjee, Director
Ranchi Institute of Neuro Psychiatry and Allied Sciences, Kanke, Ranchi-834006 (India) (M99)
Librarian, Haryana Institute of
Public Administration
76, Sector 18, Gurgaon (M 98)

Librarian, H.P. University,
Shimla (India) (M 98)

Indian Council of Social Science Research (ICSSR), INU Institutional Area,
Aruna Asaf Ali Road, Post Box No. 10528,
New Delhi -110067 (India)

Librarian, Tilak Dhari College,
Jaunpur, UP (India) (M 99)

Librarian, University Business School,
Panjab University, Chandigarh-160014
India (M 98)

Librarian, Bhaikaka Library, S.P. University
Distt. Kheda-388120, Gujarat, (India) (M 99)
Librarian, Gyan Bharati,Bangalore University,
Bangalore-560056 (India)(M 99)

Librarian, Technical Library & Documentation
IFFCO, Aonla Unit, PO. IFFCO Township,
Bareilly-243403 (India) (M 97)

L.B. Publishers & Distributors Pvt. Ltd.,
Subscription Department, 91 MG Road,
Bangalore-560001 (2000)
Tel. : 91-80-5587621, 5587302
E-Mail : lbpdshp@bgl.vsnl.net.in

Magzine World,
Station Road, Anand-388001

Rajneesh Tiwari, Engineer HRD.
Power Grid Corp. of India Ltd.
Hemkunt Chambers
89, Nehru Place New, Delhi-110019

Rekha Mittal, Scientist- E1
Indian National Scientific
Documentation Centre,
14, Satsang Vihar Marg,
New Delhi-110067

B.N. Puhan, Ph.D.
Department of Psychology
Utkal University
Bhubaneswar-751004 Orissa.

Principal, LAD College
Seminary Hills, Nagpur-440006 (M98)

Rama Tejpal, Documentation Officer
Indian Council of Social Science Research
Aruna Asaf Ali Marg, P.O. BO Box 10528
New Delhi-110067

Assistant Librarian
English Section
National Library
Belvedore Road, Calcutta (India)

National Library of Medicine
Serral Records S229401
Building 38, Room B1W10
8600, Rockville Pike, Bethesda MD
MD - 20894 USA (M 98)

Psyc INFO
American Psychological Association,
P.O.Box 91600,
Washington, DC 20090-1600(USA)
Tel:(202) 336-5682 Fax (202) 336-5630
e-Mail:psycinfo@apa.org

The Head, PG Dept. of Psychology,
LN. Mithila University, Kameshwar Nagar,
Durbhanga-846004 Bihar (India) (M 97-2001)

Jagdip Singh Lotay, MBA
K 155, AWHO, Complex, Sector 4,
Mansadevi, Distt. Panchkula,
Haryana (India) (M 99)

Nisha Mehta,
6338 B, Rajeev Vihar, AWHO Society,
Manimajra Complex, Chandigarh-160001 (India)
Tel. : 98140-15235

Prabhdeep Metha, MBA,
University Business School,Punjab University,
Chandigarh (India)

Seema Malhotra, Ph.D.
Asst. Prof. in Clinical Psychology,
Dept. of Psychiatry, Kasturba Medical
College, Manipal-576 119 Karnataka
(India) (LM 95)

L. Sam Manickam, Ph.D.
Director, Center for Applied Psy. Studies
(CAPS) Baith Shalom, Thirupuram,
Thiruvananthapuram - 695133 (India) (LM 97)
Tel. : 91-471-260148 (H), 443587 (W)

B. P. Mishra, Ph.D.
Dept. of Psychiatry, Dayanand Medical
College & Hospital, Ludhiana - 141001
(India) Res. : 481, College Road, Oppo,
Kitty Bakery, Civil Lines, Ludhiana - 141001
Tel. : 91-161-471634 (LM 95)

Miss. Mridula Mishra, Ph.D.
Treasurer, Somatic Inkblot Society,
Lecturer, Bihar Yoga Bharti,
Munger-811201, Bihar (India) (FM 94)
Tel. : 91-542 - 312703 (H)
E-Mail : sisdubey@hotmail.com

Mrs. Nalini Mishra, Ph.D.
Lecturer in Sociology,
C/O Advocate Anuj Bhanot
Chakia, Varanasi - 232103 (India)
Tel. : 91-5413-22267, (FM 94)
E-Mail : sisdubey@hotmail.com

Mrs. Nishi Misra, DM & SP
Scientist 'C' 201, Nag Chaudhuri Hostel,
DRDO Residential Complex, Lucknow Raod,
Timarpur, Delhi-110054 (India) (LM 1995)

P. K. Mishra, Ph.D.
Reader, Center for Advance Studies
in Psychology, Utkal University,
Bhubaneswar-751004 (India) (LM 1997)
Tel. : 91-674-583286 (H) 581739 (W)

P. N. Mishra, Ph.D.
Executive Director, Center for
Entrepreneur Development M.P.
60, Jail Road, Jehangirabad,
Bhopal - 462008 (India) (LM 94)
Tel/Fax : 91-755-574772 (W)

Sunil Mittal, M.D.
Consultant Psychiatrist, Delhi Psychiatry
Center, 35 Defence Enclave, Vikas Nagar,
Delhi - 110 092, (India) (LM 95)
Tel. : 91-11-2214726 (W) 2222767 (H)

Mrs. Reetinder Mohan, Ph.D.
269, Sec. 16-A, Chandigarh - 160016
(India) (LM 97)
Tel. : 91-172-770269, 781026

Ms. Anjana Mukhopadhyay, Ph.D.
Dept. of Psychology, Women's College,
Banaras Hindu University,
Varanasi - 221 005 (India)
Tel. : 91-542-310206 (H) (LM 94)

Bernard I, Murstein, Ph.D.
Dept. of Psychology, Connecticut College,
Box - 5581, New London, CT-06320-4196
(USA). (LM 94) Tel. (203) 442-1816 (H)
Fax : 203-439-2700 (W)

Atul Naku, MBA,
University Business School,
Punjab University, Chandigarh (India)

Ashima Nehra, Ph.D.
5175/1, Modern Housing Complex
Manimajra, Chandigarh-160001 (India)
Tel. : 91-172-553055 (H) (LM 96)

Paola Nicolini, MA
Via Enrico Fermi 14,
Lomagna (LC) 23871, Italy (M 99)
e-mail : paola.nicolini@libero.it
Telefax : 039-9220137 (W)

K. N. Ojha, Assitt. Director,
N.I.M.H. Regional Trg. Center,
Kasturba Niketan, Lajpat Nagar - II,
New Delhi - 110 024, (India) (LM 95)
Tel. : 91-11-6831012 (W) 6840233 (H)

Ann M. O'Roark, Ph.D.
866, Amelia Coart, NE
St. Petersburg, Fl 33702-2784
(USA) (M 98) Tel/Fax : (813) 527-9863
E-Mail : AnnMORoark@aol.com

Rakesh Pandey, Ph.D., Lecturer,
Deptt. of Psychology, DDU.
Gorakhpur University, Gorakhpur-273009
(India) (LM 2000) Tel. : 91-551-337361
E-Mail : rpan_in@yahoo.com

Col. Vijay Pandey, MD,
Psychiatrist, Dept. of Psychiatry,
Command Hospital (EC), Alipore
Calcutta-700027. (India) (M 95)
Tel. : 91-33-4792184

Ravi Palia, MSW
Vice President, HRD
1918, Phase 10, Mohali- Chandigarh (India)
Tel. : 91-172-702720 (W) 676094 (H) (LM 99)
E-Mail : ravipalia@hotmail.com

Lt. Col. S. S. Panglia, MD
Consultant Physician,
1446, Phase-10, SAS Nagar, Mohali
Distt. Ropar (India) Tel. : 91-172-675536(LM 94)

Paul E. Panek, Ph.D.
Associate Dean, OSU Newark Campus,
1179, Uni. Drive, Newark, Ohio-43055,
USA. (M 98) Tel. : (614) 366-9315
E-Mail : panek.1@osu.edu

Suresh Parekh, Prof. Deptt. of Psychology
MMG Mahila College, Opp. Moti Bagh,
Junagarh-362001, Gujrat (India) (LM 2000)

Rekha Prabhakar, MA
160, Sector 16, Panchkula (India) (M 99)

Marisa Porreca, Ph.D.
Professor of Psychology
Via Valsesia 8, 20152, Milano (Italy)
(LM 99) Tel. : 024531624

Sheetala Prasad, Ph.D. Lecturer in Psy.,
Ewing Christian College, Allahabad-211008
Tel. : 91-532-613363 (H) (M 95)

S. Ramachandra, Ph.D.
Addl. Prof. (NIMHANS),292, 2nd Main, 3rd Phase, J.P. Nagar,Bangalore - 560 078. (India) (LM 94)
Tel. : 91-80-6584267 (H)
E-Mail : ramas@nimhans.kar.nic.in

Dalbir Kaur Randhawa, DM&SP,
1106, Sec. 33-C, Chandigarh(India)
Tel :91-172-615774(L.M.97)

Rakesh .K. Ranjan
Rd No. 8-B, Ashok Nagar
Patana-800020 (M99)

Ritesh Ranjan,
N-84/5, Telco Colony,
Jamashedpur - 831004 (India)
Tel. : 0657-281215 (LM 2000)

C.S. Rao, Ph.D,
Chief Manager (HRD), IFFCO,
54, Nehru Place, New Delhi-110019 (LM 2001)
Tel. : 91-11-6432844 (W), 91-124-6341034 (H)
E-Mail : csrao@iffco.nic.in

S.P. Rathee, Ph.D
Dept. of Psychiatry, Command Hospital (WC), Chandi Mandir Cantt -134 107.
Haryana (India)
Tel. : 91-172-866574 (W) (LM 94)

Kapil Rohatgi, MBA
1282-Chowk Shah Mubrik, Bazar Sita Ram ,
Delhi -110006 (India)
Tel: 91-11-3238355(M99)

Gilbert J. Roth, D. Min.
62, Timmerman Drive, Richland,
WA-99352 (USA). (M 94)
Tel./Fax : (509) 628-2132 (H)
E-Mail : gil@owt.com

Sunil Sachdeva
1479, Sector 42-B,
Chandigarh (India) (M 2000)

M. Sahay, Ph.D.
Clinical Psychologist, 95, Doctors Apartments, 4, Vasundhara Enclave,
Delhi - 110096 (India) (FM 94)
Tel. : 91-11-2621789 (H)
E-Mail : dr_m_sahay@hotmail.com

D. Saldanha, DM
Consultant Psychiatrist, Military Hospital Merrut (India) (LM 94)
E-Mail : danval4@hotmail.com

Mrs. Amandeep K. Sandhu, MPMIR
Tej Form, Manimajra, Chandigarh-160101
Tel. : 91-172-740991 (H) 782135 (LM98)

Vivek Shanker, MBA,
20, 4th Cross, 4th Main Road,
N.S. Palya, BTM II Stage, Banglore-560076 (India) (LM 2000)

George Savage, M.Sc.
Consultant Clinical Psychologist,
'Deogratias' 37 Victoria Road,
Retreat 7945, South Africa (LM 95)
Fax : (27) 21-454-161, 461-7564
Tel. : (27) 21-712-1281 (H)
E-Mail : gsav@worldonline.co.za

Shanti P.R., MBA,
University Business School,
Panjab University, Chandigarh (LM 2000)

Harish K. Sharma, M.Phil.
Lecturer in Psychology,
SBS (M) College, Kotkapura,
Punjab (India) (LM 97)

Hemant K. Sharma, Ph. D.
Hemant Mansion, Near Haveli Barkat Sahib,
Nai Sarak, Jodhpur -342001 (India)
Tel. : 91-291-54088 (H). 22755 (LM 96)

Narendra K. Sharma, Ph.D.
Dean Academic Affairs, Prof. of Psychology,
4055. Type-IV, P.O.-IIT, Kanpur-208016 (India) (LM 98) Fax : 91-512-590260
E-Mail : doac@iitk.ernet.in

Neelakshi Sharma, MBA
HL-167, Phase-1,
Mohali-Chandigarh-160055
Tel. : 91-172-224921 (M 99)

Preeti Sharma, MBA
1257, Sector 21-B,
Chandigarh-160022 (India) (M 99)
Tel.: 91-172-700691

Abhayman Sidhu, MBA
120, Sector 9-B,
Chandigarh-160009 (India)
Tel. : 91-172-742105, 743917
e-mail : shenmings@yahoo.com

Agyajit Singh, Ph.D.
136, Civil Lines, Patiala. (India) (LM 97)
Tel. : 91-175-72797

Amool Ranjan Singh, Ph.D.
Clinical Psychologist, Mental Hospital,
Kanke, Ranchi, Bihar (India) (LM 95)

Anup K. Singh
C/o Mrs. Kanta Balangir, At Sagur Para,
P.O. Belangir, Distt. Belangir - 767001 (Orissa) (India) (M 98)

D. P. Singh, MPMIR,
President,
Montari Industries Ltd., 78 Nehru Place, New Delhi - 110 019. (INDIA)
Tel. : 91-11-6436175 (H) (LM 95)

Harmanjit Singh, MBA
2369 Phase 10 , SAS Nagar-160062(M99)

Lt. Col. Gurpinder Singh, MBA
1098, Sector 8-C, Chandigarh (India)
Tel. : 547825 (W) (LM 2000)

Maninder Singh, MBA,
University Business School,
Punjab University, Chandigarh (India)

Narinder Pal Singh, MBA
C-7, HMT Colony,
Pinjore - 134101 (India)
Tel. : 01733-64083 H (LM 2000)

Randeep Singh, MBA,
University Business School,
Punjab University, Chandigarh

M.P.Singh, MBA
House No. 14935,Near NFL Mandir,
Bhatinda (India) (M99)

M. P. Singh, M. Phil
Lecturer in Psychology,
1329, Sec. 70, Guru Teg Bahadur
Complex, Mohali (Near Chandigarh)
(INDIA) Tel. : 91-1675-20583 (W)
Tel. : 91-172-223658 (H) (LM 95)
E-Mail : drmps@usa.net

Navneet Singh, M. P. M. & I.R.
Vice President, S-20/6, DLF, Phase-3,
Gurgaon-122002 (India) (LM 95)
Tel. : 91-124-6387544 (H), 9810058444
E-Mail : navnit.singh@hsbcam.com

Col. Rajinder Singh. MD
Consultant Psychiatrist, 1734, Sec. 33-D,
Chandigarh - 160 047 (India)
Tel. : 91-172-600694 (H) (LM 96)

Col. Rajinder Singh
Management Consultant,
1526, Sector 34-D, Chandigarh, (India)
Tel. : 91-172-601398 (H) (LM 98)

Ripudaman Singh,MBA
1594 Phase 10, Mohali-160062 (India)
Tel: 91-172-220932 (M 99)

Col. Surinder Singh, MBA
5807, Modern Housing Complex,
Manimajra, Chandigarh -160001 (India)
Tel. : 91-172-735231 (H) (M 99)

Virender Singh, MPM & IR
Vill. & P.O. Bir Banga,
Distt. Kaithal, Haryana (India) (LM 98)

Ankur Sood, MBA
676, Civil Lines, Monga (Punjab) (India)
Tel. : 01636-24773 H (LM 2000)

Kalpana Srivastava, M.Phil.
Scientist 'D' Deptt. of Psychiatry,
Armed Force Medical College, Pune-411040
(India) (LM 2000)

Gyanesh Kumar Tiwari, MA
C/o Dr. A Jaiswal, B-34,
Sheel Nagar Colony, Mahmoorgang,
Varanasi-221010 (India) (M 99)

Seema Tripathi, M.A.,
Lecturer in Psychology, DDU, Gorakhpur
University, Gorakhpur-273009 (LM 2001)
Tel. : 91-551-273526 (H)

Ailo Uhinki, Ps.D., Ed.I.,
Psykologitoimisto, Synteesi,
Linnankatu-37a A 9,
Fin-20100 Turku, Finland (LM 98)
Tel. : +358-(0)2-232 2001
Fax : +358 - (0)2-232 5007
E-Mail : a.uhinki@synteesi.inet.fi

Acharya Vinay Vinekar,
Institute of Universal consciousnes,
21, Milton Street, Cooke Town,
Bangalore - 560005 (India) (LM 2000)
Tel. 91-80-5472603 (W), 5548348 (H)

De-Cicero Emidio Vaz. Ph.D.
Av. Lajeado. 969 AP. 301, Porto Alegre,
R.S. Brazil, Brazil - 90460-110 (M 96)
Tel. : 501-3344235 (W)
E-Mail : vaz@pucrs.br

Kiran Bala Verma, Ph.D.
Head Dept. of Psychology,
Harishchandra PG College,
Varanasi - 221001 (India) (M 98)
Tel. : (0542) 332042 (W) 32031 (H)

S. K. Verma, Ph.D.
5522, Modern Housing Complex
Manimajra, Chandigarh - 160 001 (India)
Tel. : 91-172-730993 (H) (FM 95)

Sanjay Vohra, MA.
Psy-Com Services, B-4,
80/2, Safadurjung Enclave,
New Delhi-110029 (India) (LM 95)
Tel. : 91-11-6106433 Fax : 91-11-6175191

V.N. Yadav, Ph.D.
Head Dept. of Psychology
98, Housing Board Colony,
Bhiwani-127021 (India) Haryana (LM 99)
N. Kumar Yaduvanshi, DPM.
CMO, TPT Bn. ITBP, Airport
Chandigarh - 160003 (India) (LM 98)
Tel. : 91-172-640182

S. Yuvraj, Ph.D.
Asstt. Prof. in Psychology
12, NITIE Qrts., NITIE, Vihar Lake
Bombay-400087 (India) (LM 99)
Tel. : 91-22-857337 Fax : 857325
E-Mail : Prog@nitie.ernet.in

Consultants

J. C. Bubber, MBA
General Manager (HRD),P.A.C.L.
SCO 125-127, Sector 17-B, Chandigarh
Tel. : 91-172-713823 (W), 742428 (H)

Ron Ginsberg
353 Carlton Drive, Chapel Hill
NC 27516 (USA)
Tel. : 919-967-9558 (H)

Vinay K. Jain, CA,
Jain Vinay Kumar & Co.
1280,Vakilpura, Delhi-110006 (India)
Tel. : 91-11-3256269 (M 99)

K. V. Kaliappan, Ph.D.
Professor, Dept. of Psychology,
University of Madras, Madras - 600005
(India) Tel. : 91-44-6260571 (H)

Barry A. Ritzler, Ph.D.
Dept. of Psychology, Long Island
University, University Plaza, Brooklyn
NY 11201 (USA)Tel. : (718) 488-1068 (W),
(201) 327-1292 (H)

David Sperbeck, Ph.D.
2530, De Barr Road,
Anchorage Alaska - 99508. (USA)

M. K. Tewari, MS. M.Ch.
Consultant Neuro-Surgeon,
Dept. of Neurosurgery,
Post Graduate Medical Institute,
Chandigarh - 160 012 (India)
Tel. : 91-172-745845 (H)

M.S. Thimmappa, Ph.D
Prof. Deptt. of Psychology, Bangalore University,
Bangalore-560056 (India) Tel. : 91-80-6692075
(H)

Yasho V. Verma, Ph.D.
Vice President-HR & MS, LG Electronics India
(P)Ltd., Plot No. 51, Udyog Vihar, Surajpur-Kasna
Road, Greater Noida-201306 U.P., (India)
Tel. : 91-11-914569635, 4560900-940
Fax : 91-11-914560926, 4560921
E-Mail : yvverma@lgeil.com

ANNOUNCEMENT

To make parity with the earlier issues of the SIS Journal of Projective Psychology & Mental Health, which has already reached to various National & International Universities/Libraries, Vol. 3-7 is merged with Vol. 8. Now hereafter, Vol. 8 may be considered in lieu of Vol. 3-8 for future reference.

Editor

SOMATIC INKBLOT SOCIETY is an International organization helping thru **SOMATIC INKBLOT SERIES TEST (SIS). The SIS** is a structured, projective, diagnostic test and an adjunct to psychotherapy. It helps in hearing the inner cry of suffering individuals.

SOMATIC INKBLOT SOCIETY is publishing its Journal **SIS JOURNAL OF PROJECTIVE PSYCHOLOGY AND MENTAL HEALTH** a half yearly publication in January and July. It has 2 Awards of $250 employing the use of Inkblot Tests SIS & Rorschach.

For details please contact :

Wilfred A. Cassell, M.D., FAPA, APC, FSIS, Director, Somatic Inkblot Center, President, Somatic Inkblot Society and Editor, SIS Journal of Projective Psychology & Mental Health, 4501E, 104th Avenue, Anchorage, AK-99516 (USA). Fax : (907) 563-3746 E-Mail : drcassell@corecom.net
Web Site at http: //www.owt.com/sis/

OR

B.L. Dubey, Ph.D., DPM, FSIS,
Chief Editor, SIS Jr. of Proj. Psy. & Mental Health,
Director, Somatic Inkblot Center India,
Post Box 1107, Sector 15 Post Office, Chandigarh-160015 (India)
Tele/Fax : 91 - 172 - 710986, Tel. : 91 - 172-710985,
E-Mail: sisdubey@ch1.dot.net.in OR sisdubey@hotmail.com

THE SOMATIC INKBLOT SOCIETY

I wish to be a Member _____ a Life Member _____ of the Somatic Inkblot Society. Please submit this request to the Membership Committee.

NAME _____ Birth date _____

(Print or type) First Middle Last

_____ Zip _____

Business/Office Address : _____

_____

_____Tel. : (W)_____

_____(H)_____

EDUCATION

Degree Year Institution Major Field of Study

_____

_____

_____

EMPLOYMENT : Current position, employer, dates (Graduate Students indicate area of study and degree toward which you are working).

_____

_____

MEMBERSHIP : _____

_____

TRAINING AND EXPERIENCE IN PERSONALITY ASSESSMENT :

_____

_____

SPONSOR (S)

Name Address Telephone

1. _____

2. _____

SIS subscription payable every year in January through Cashier Cheque/Draft

I certify that the information provided above is accurate and correct. An APPLICATION FEE Cheque is enclosed for Foreign Members ($40) & Life Membership ($300). For Members in India Rs. 250/- & Life Membership Rs. 1500/-

Total Cheque $/Rs._____Drawn at_____

Signature of applicant : _____ Date :_____

PLEASE RETURN with your cheque to :

B.L. Dubey, Ph.D., Vice-President, Post Box No. 1107, Sector 15 Post Office, Chandigarh – 160 015 (India). Tele/Fax : 91-172-710986, Tel. : 91-172-710985, E-mail : sisdubey@ch1.vsnl.net.in OR sisdubey@hotmail.com

Make cheques payable to Somatic Inkblot Society, Chandigarh (India)

N.B. : Please add Rs. 50/- as one time registration fee; and $5 / Rs. 30 if you are sending subscription through out station cheque.

Abstracted in "APA's Psychological Abstract"
Regd. No. 71632/99, RNI Delhi

SIS JOURNAL OF PROJECTIVE PSYCHOLOGY & MENTAL HEALTH

(OFFICIAL JOURNAL OF SOMATIC INKBLOT SOCIETY)

CHIEF EDITOR : B.L. Dubey, Ph.D., Director SIS Center India, Post Box 1107, Sector 15 Post Office, Chandigarh-160 015 [Res. : T2/15, Sector 25, Chandigarh-160014 (India)] Tel/fax : 91-172-710986, Tel.: 91-172-710985, E-Mail: sisdubey@ch1.dot.net.in OR sisdubey@hotmail.com

EDITORS : Wilfred A. Cassell, MD, Director, SIS Center, 4501E, 104th Avenue, Anchorage, AK 99516 (USA) Fax: (907) 563-3746 E-Mail: drcassell@corecom.net

: N.L. Dosajh, Ph.D., 1121, Sector 15-B, Chandigarh (INDIA)

: C. B. Dwivedi, Ph.D., Prof. Dept. of Psychology, Banaras Hindu University, Varanasi-221005 (INDIA) Tel. : 91-542-317430

: Gilbert J. Roth, D. Min., 62 Timmerman Drive, Richland, WA-99352 (USA). Tel./Fax : (509) 628-2132 (H) E-Mail : gil@owt.com

: S. K. Verma, Consultant in Clinical Psychology, Govt. Medical College and Hospital, Sector 32, Chandigarh.

JOINT EDITORS : Padma Dwivedi, M.A., Social Worker, Dept. of Cardiology, P.G.I.M.E.R., Chandigarh-160 012

: A. Dubey, MBA, SIS Center, 4501E, 104th Ave, Anchorage, AK 99516 (USA) E-Mail: adubey@hotmail.com

ASST. EDITORS : M.P. Singh, Ph.D, Lecturer, 1329, Sector 70, Mohali-Chandigarh Tel. : 91-172-223658 (H) E-mail : drmps@usa.net

: Mridula Mishra, Ph.D., Lecturer, Bihar Yoga Bharati, Munger-811201 (India) Tel. : 91-6344-22430

EDITORIAL CONSULTANTS

R. N. Agnihotri, M.Sc., India
Anil Agrawal, MBA,India
Phillip W. Baker, Ed.D., U.S.A
K.R. Banerjee, FAPA., India
Mahesh Bhargava, Ph.D., India
D.K. Bhatt, B.E., India
J.C. Bubber, MBA, India
S. Chaudhury, M.D., Ph.D., India
Alfred Collins, Ph.D., U.S.A.
Anna L. Comunian, Ph.D., Italy
Carina Coulacoglou, Ph.D., Greece
D.S. Gujral, MBA, India
K.V. Kaliappan, Ph.D., India
Anatoly B. Khromov, Russia
Raj Kumar, I.A.S., India
Nalini Mishra, Ph.D., India
Vipul Mittra, IAS, India
Anjana Mukhopadhyay, Ph.D. India
Les Nyman, MD. U.S.A.
Ravi Palia, MSW, India
Paul E. Panek, Ph.D., U.S.A.
Marisa Porecca, Ph.D., Italy
S. Ramachandra, Ph.D., India
C.S. Rao, Ph.D., India
S.P.Rathee, Ph.D, India
Barry A. Ritzler, Ph.D., U.S.A.
Ferro Roberto, Ph.D., Italy
Ann C. O'Roark, Ph.D., U.S.A.
M. Sahay, Ph.D., India
Abhayman Sidhu, MBA, India
B. P. Singla, LL.B., India
Amool R. Singh, Ph.D., India
David Sperbeck, Ph.D., USA
M.K. Tewari, MS, M.Ch., India
M.S. Thimmappa, Ph.D., India
Ailo Uhinki Ps.D., Finland
De-Cicero E. Vaz, Ph.D., Brazil
Yasho V. Verma, Ph.D., India

Executive Director :

Mrs. Mary Cassell, SIS Center, 4501E, 104th Avenue, Anchorage, AK-99516, (USA) Fax: (907) 563-3746 E-Mail : drcassell@corecom.net; web site at : http://www.owt.com/sis/