ISSN 0971 - 6610

Vol. 3-8, No. 2, Pgs. 73-152 SIS JOURNAL OF PROJECTIVE PSYCHOLOGY & MENTAL HEALTH 2001

SIS

JOURNAL OF PROJECTIVE PSYCHOLOGY & MENTAL HEALTH

The Official Publication of the Somatic Inkblot Society

Volume 3-8 Number 2
July, 2001

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. Editor- in -Chief SIS Journal, P.O.Box 1107, Sector-15 Post Office, Chandigarh 160015 (India). E-mail : sisdubey@hotmail.com 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 $40 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, Editor- in -Chief, (Address given above). Please add $5./Rs. 30/- if you are sending subscription through cheque.

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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

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Dr. B.L. Dubey, Editor-in-Chief
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 and 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 3-8, Number 2, July 2001

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Editorial

Projective Psychology in the New Millennium: Issues and Challenges.

I am pleased to have this opportunity to present my perspective on the issues and challenges projective psychology faces as we begin the new millennium. Projective psychology was conceived at the beginning of the past century, was developed and refined during the middle of the century, criticized in the latter part of the century, and is in a time of transition as we begin the new millennium. Based on the changes that have occurred in the area of projective psychology since the initial publication of the Rorschach in the 1920's, I see the following issues and challenges.

First, if projective techniques are to survive in the future, researchers will need to adequately demonstrate reliability and validity of the particular projective technique to satisfy our quantitatively oriented and skeptical colleagues. Specifically, Wood, Nezworski, and Stejskal (1996) and Lilienfeld, Wood, and Garb (2000) have recently attacked the bulwark of projective psychology, Exner's Comprehensive System for the Rorschach, by pointing out that, despite claims to the contrary, there is a lack of suitable validity, extant norms overpathologize normal subjects, and suitable norms for minority groups are not available. Thus, projective techniques that have acceptable levels of reliability, validity and standardization will survive and flourish, those, which do, not, will disappear from use. This point is clearly illustrated by observing the history of "drawing" projective techniques such as the Draw-A-Person-Test. Due to a lack of research support these techniques received substantial criticism, and is rarely reported in the literature.

Second, projective psychology needs to address cross-cultural differences as well as ethnic differences within cultures. As the world becomes smaller through advances in technology and transportation, and industries continue to become more "global," projective techniques must be able to adequately measure and explain potential cross-cultural and ethnic differences in scores or responses. Consequently, a specific score or response must be interpreted within the context of the culture or ethnic group, rather than an absolute standard. Hence, there is a need for projective techniques to develop norms for a variety of countries and ethnic groups within a particular country or culture.

Further, projective techniques must definitively confirm their utility or effectiveness in clinical and applied settings. Our colleagues in clinical or applied settings need to have confidence that projective techniques will measure or assess some relevant criteria for their particular need such as the presence or absence of psychosis, acting-out potential (workplace violence), etc. Therefore, projective techniques, which demonstrate sufficient utility or predictive validity, will increase in use in the future.

In addition, as we enter the new millennium it is now time for projective psychology to let go of the assumption that there is one "universal" projective technique that can measure all aspects and levels of personality or behavioral functioning. Thus, instead of rigidly

adhering to the use of one particular projective technique for all clients or persons in all settings, we must either administer a battery of projective tests or select a specific projective technique which is considered to be an effective instrument for assessing the referral question. In projective psychology “one size does not fit all.”

Finally, if projective techniques are to survive to the end this new millennium, those of us in projective psychology need to make our colleagues aware of the positive contributions that projective techniques can make to their particular area such as the assessment of treatment outcomes, predication of behaviors, industrial selection, as well as personality assessment. This can be accomplished thorough rigorous systematic research and publication.

In conclusion, despite the criticisms directed at projective techniques during the latter part of the last century, they continue to enjoy widespread popularity among clinicians (Lilienfeld et al., 2000). Therefore, those of us in projective psychology must strive to empirically demonstrate the psychometric “soundness” and clinical utility of projective techniques during the new millennium

References :

Lilienfeld, G. O., Wood, J. M., & Garb, H. N. (2000) The scientific status of projective techniques. Psychological Science in the Public Interest, 1, (2), 27-66.

Wood, J. M., Nezworski, M. T., and Stejskal, W. J. (1996). Thinking critically about the Comprehensive System for The Rorschach: A critical examination. Psychological Science, 7, 3-10.

Paul E. Panek, Ph.D.
Academic Dean & Professor of Psychology
The Ohio State University at Newark
University Drive
Newark, Ohio 43055
USA

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 75-94

Optimizing Spiritual Healing by Assessing Dream and SIS Imagery

Wilfred A. Cassell, Frank J. Ilardi, Alfred Collins, Mridula Mishra and Bankey L. Dubey

The paper demonstrates the application of Somatic Inkblot Series (SIS II Booklet). In the test Image 3A is in a monochromatic bluish gray color and the form is suggestive of a cross. For many devoted Christians this can stimulate spiritual imagery and affect in consciousness, activating healing. The image significantly contrasts with many traditional artistic representations of Christ 's crucifixion, which are highly structured and leave little to the imagination. With abstract symbols, such as this SIS inkblot, there is an enhanced potential for the external visual stimulus to tap into the Dreamer's deep inner well of divine spirituality. In employing this approach it must be remembered that different religions have their own unique symbols and rituals. SIS therapists must be open minded and unbiased in order to employ these for spiritual healing. It is not our role to change or convert any suffering individual's religious orientation. Rather, we need to foster healing by optimally activating the person's religious symbols in the therapy process. Those suffering should be encouraged to have reverence for spirituality arising spontaneously through dream imagery for themselves and their loved ones.

Mental health clinicians vary greatly in their use or dismissal of spirituality. Overly optimistic psychotherapists—often new to the profession—tend to envision treatment strategies based upon the philosophical assumption that good can ultimately triumph over evil. In formulating treatment plans, these inexperienced therapists are prone to naively assume that their therapeutic interventions have greater potency than they actually do. They may convince themselves that, given enough time, their efforts can provide relief - even in the most extreme forms of mental suffering.

At the opposite pole, there are those that tend to be more realistic about psychotherapeutic approaches, sometimes even to the point of pessimism. These include the growing number of biologically oriented psychiatrists that conceptualize mental illness physiologically. They tend to envision therapeutic strategies in which genetics and brain chemistry override psychological, socioeconomic and cultural factors. Many modern psychiatric residency programs primarily emphasize psychopharmacology. In such intellectually restricting academic settings it would be considered ridiculous, if not unethical, to incorporate spirituality in planning treatment. To challenge such bias requires an open mind, imagination and an element of courage.

To advance in this intellectual battle, investigators and clinicians now may include in their struggle SIS theory and methodology. A brief historical review will give perspective. During World War II the need to evaluate large numbers of recruits in the military gave

Wilfred A. Cassell, Frank J. Ilardi, Alfred Collins, SIS Center, 4501E, 104th Ave, Anbchorage, AK-99516(USA) E-mail: drcassell@corecom.net and Bankey L. Dubey and Mridula Mishra, SIS Center, Post Box:1107, sector-15 Post Office, Chandigarh-160015(India)E-mail: sisdubey@hotmail.com

impetus to psychologists developing instruments for personality assessment. As an outgrowth of this the Rorschach technique gained widespread popularity. In the postwar period its stature far exceeded its virtues. As an extreme example, in some American prisons Rorschach test results were strongly weighed in determining whether or not a particular inmate would be given the death penalty.

During this era there were also exaggerated expectations regarding the effectiveness of the "talk" therapies such as psychoanalysis. Psychoanalysts were prevalent in positions of educational influence and power, especially in American medical training programs. It was hoped that psychoanalysis could even effectively treat various so-called psychosomatic conditions. Eventually the unrealistic nature of such wishful thinking became apparent. For those who were trained in psychoanalytic therapy, it was highly demoralizing to realize the theory had been vastly overrated. Furthermore, with the exception of the Jungians, psychoanalysts tended to overlook the role of spirituality and religion in an individuals' mental functioning.

Gradually in medical schools the more scientifically oriented psychologists gained in influence. Concurrently, "objective" tests such as the MMPI became more widely accepted. Projective techniques were considered lacking in sufficient validity and reliability to be worthy of scientific inquiry. As a result, Rorschach analysis of direct and symbolic content, such as advocated by the psychoanalyst Roy Schafer, was no longer considered worthy of inclusion in training programs.

Along with these developments, therapists created other effective treatment approaches where an in-depth formulation was not of paramount importance to treatment outcome (e.g. cognitive therapy). In a more extreme extension of their roles, presently in the United States some psychologists are acquiring training in psychopharmacology and lobbying legislatures to obtain prescription privileges, This movement comes at a time when American insurance companies under managed care have dramatically restricted their coverage of diagnostic assessment. Along with the emergence of social workers as therapists, these events have tended to blur professional boundaries in the mental health field. Unfortunately, recent years have seen a growing pessimism in some circles about the cost-effectiveness of the various psychotherapies.

Against this background, therapies that emphasize spirituality have been developed by a relatively new discipline that calls themselves pastoral counselors. Historically the opportunity for their emergence was originally established by the poor results obtained by most existing therapies with addictions. For example, Alcoholics Anonymous, based upon the concept of a "Higher Power, has been more effective than non-spiritual approaches.

Of course the ancients were fully aware of the healing power of dreams and imagery. The legendary physician Asclepius championed their application, for example. His views were respected for centuries, until they were eventually suppressed by the emergence

of authoritarian religions. These have moved the focus of attention away from the appreciation of subjectively experienced spirituality and encourage the faithful to seek dependency on authoritarian leaders. These leaders feed their followers with promises of relief from pain and fulfillment of wishes. They also provide an opportunity to fulfill basic needs for socialization and group involvement in an increasingly alienated world. Of course, such simplistic sugar coated medicine has little value for mature individuals who are capable of thinking for themselves. For their mesmerized followers, such omnipotent and grandiose leaders undermine responsibility for exploring and integrating subjective images and feelings - the essence of one's humanity.

At this stage in the history of knowledge, there are an ever-growing number of scientific studies indicating that an individual's religious life is important to health, both physically and mentally. Even more exciting are new developments in investigation such as those of Gregg Jacobs at Harvard Medical School who has published several studies on the way the brain waves change in meditation. In terms of anatomical localization, investigators such as Andrew Newberg at the University of Pennsylvania have localized a small region near the back of the brain which becomes unusually quiet during meditation and prayer. Since this region has been considered to relate to spatial orientation, it could explain the borderless spiritual communion felt by mystics in many traditions. In this new millennium it is becoming more methodologically feasible to investigate the previously intangible spiritual dimension of life.

In the July 1997 issue of this journal, preliminary case history studies on the "Medical, Psychological and Spiritual" applications of the SIS were first published. With modesty and reverence for spirituality, we must attempt to overcome the many methodological limitations in this illusive area of inquiry. To avoid the scientific study of spirituality would be a comparable to burying one's intellect in the cement of rigid reductionism.

Phenomenological exploration of dreams and SIS triggered imagery may be partially conceptualized against this background. The nature of the "Dreamer" must be considered and distinguished from the person's conscious personality or ego. The natural source of imagery, affect and symbolism is spontaneous and largely beyond the sleeping individual's control. Frequently the sensory information in dreams refers to physiological body needs (e.g. dreaming of urination when there is accentuated sensory feedback from a full bladder). Other dreams may reflect primitive drives related to sex and aggression. In medical patients pain may be experienced in the diseased area. In traumatized individuals, dreams may reflect a direct or disguised reliving of the trauma. There are many other determinants of dreams besides spiritual influences. Attempting to identify spiritual content in these is as futile as a prospector's panning for gold in the Sahara Desert's sand.

Spiritual dreams are precious but comparatively rare. When they are experienced, they have great healing power and can motivate the individual to acquire a sense of reverence for the Dreamer's mystical healing power. Two examples follow: In the first instance, the

Dreamer introduces a scene of the after life, in which a diseased grandmother spiritually visits and reassures a grieving African American adolescent girl. In the second, the Dreamer extends hope of attaining an educational goal for a severely traumatized and lonely adolescent Alaskan Native girl

Case Histories :

Both patients were Christian adolescent girls who had been receiving psychiatric hospital treatment for severe Major Depression associated with for suicidal ideation. Following admission they had participated in psychotherapy together. They had bonded well emotionally and were quite supportive to each other. Evaluating their dreams and responses to the SIS Booklet Images in a two-person group setting created a more open atmosphere for demonstration purposes.

DR. CASSELL: We're going to hear BB's Dream. First Okay?

BB: Okay.

DR. CASSELL: How long ago did you have it?

BB: About like three — three days ago.

DR. CASSELL: Okay. Lets hear it, please.

BB: "I was in church.

DR. CASSELL: It's a great dream! (*It had recently been reported in a psychotherapy session.)*

BB: And — I was in church and my grandma had died, or whatever. And so there was a part at the end of the church where you get to go up and accept Jesus as Your Savior. And I went up there and I did. And then later on that night I went to sleep. And I was dreaming that I had died, or whatever, and — I had — went up to heaven and I was trying to get into the Gates, and my Grandma was on the other side, she was inside the Paradise, but I was on the other side trying to get in and she's just reaching out to me and I couldn't get in. That was my dream. *(The loss of a loved one often provides strong motivation for thinking about one's own mortality and religious beliefs).*

DR. CASSELL: And how did you feel in the dream?

BB: I felt hopeless kind of and

DR. CASSELL: What way hopeless? *(Seeking to elucidate the affective component of the dream, the least disguised part of any dream.)*

BB: That I wasn't going to get to heaven, or to see my grandmother again. But then part of me felt good because I knew she was okay.

DR. CASSELL: Yeah.

BB : It was wonderful to see her as okay.

DR CASSELL : In what way in real life has she suffered with her cancer? *(It had been previously learned that part of her depression was related to an unresolved grief reaction regarding her grandmother, noted previously on initial evaluation.)*

BB: She — it — it hurt her because she wanted to see me do better and stuff. And she ended up passing away before she could see me, like, coming to an adult and see me graduate and stuff like that.

DR. CASSELL: How did you feel? What was your sadness like when she died?

BB: I was sad, but then I didn't really cry because I knew she was going to heaven.

DR. CASSELL: Hm hm.

BB: And plus…

DR. CASSELL: That was a comforting thought. (*She received from her inner spirituality the message that her grandmother's spirit was on a higher plane, and that she no longer suffered from her terminal cancer. From the interviewer's perspective, the individual spirit goes on to a higher spiritual level of mystical existence after death of the physical body. While there is a loss of the physical body, the spirit continues on a different level and this can be reassuring to the grieving individual, who may have further communication via dreams, hallucinations, and SIS imagery.*)

BB: Yeah. And plus it'd be — when she died it would be a better place for her.

DR. CASSELL: Hm hm. So what do you think your dream means?

BB: I don't know.

DR. CASSELL: Please try.

BB: It probably means that I'm — my grandma is trying to tell me something, probably. *(The grandmother's spirit is fine and will be in contact.)*

DR. CASSELL: That she's okay and no longer suffering? And someday you'll be with her, after you've lived your life? Isn't that a comforting thought?

BB: Okay.

DR CASSELL : Thank you. And now we have Anna's dream — another dream that goes on a little longer. But it's a wonderful dream. *(As with BB, this dream was reported previously in therapy.)* When did you dream this dream?

ANNA: I think the day before last night.

DR. CASSELL: Okay. Can you tell us it, please? It's a wonderful dream.

ANNA: I had been shipped down into Montana, in Yellowstone, to go to long term with my little brother. And when I turned eighteen I signed my brother up for treatment.— and my mom and step-dad had died. And so my biological father had full custody of me.

And he ended up giving me full custody of my little brother. So I signed him up for treatment. And I worked and got enough money to move back to Fairbanks. And we stayed at my neighbor's house, right next door to my sister. And I had gotten my Masters Degree in Montana.

DR. CASSELL: Wonderful isn't it? How did you feel getting your Masters? *(Here the interviewer emphasized the fact that her academic future is positive. In this conceptual model the suggestion represents a type of self-enhancing support and motivation.)*

ANNA: I felt proud of myself.

DR. CASSELL: Yes.

ANNA: And — So I got a job in Fairbanks. And I was letting my little brother drive my car around while I was at work. With his — with his friends and stuff. As long as he didn't drink or smoke in it.

DR. CASSELL: She's a good big sister.*(An aside comment to BB calculated for Anna's benefit to further support the latter's self esteem.)*

ANNA: And I had told him before I made the decision of letting him drive my car that if I caught him high or drunk or drinking or smoking that he was — he wouldn't be able to go out for a week. *(Anna dreamer now acts in a maternal way towards her brother, identifying with her brother indirectly receiving soothing support from the dreamer.)*

And then a couple of years had past and we had moved back in with my sister and her boyfriend. And I shared a room with my little brother; of course, I wasn't there most of the time. *(An indirect acknowledgement of some incestuous sexual tension between her and brother, though denied. As will be shown later, the patient had been sexually victimized both by her father and her older brother. She thus needs to deny any overt sexuality more vigorously. Consistent with this theme in dream consciousness, next emerged symbolic sexuality in the dream by images of the brother impregnating another girl. This interpretation was not brought to the patient's attention because it was not felt to be a suitable therapeutic setting.)*

DR. CASSELL: How much younger is he?

ANNA: He's four years younger than me.

DR. CASSELL: Hm hm.

ANNA: So he was — he didn't really feel comfortable about being — staying in the same house as our older sister. So I bought a door lock and I gave him a key so that he could be in the room and lock the door. And I could still go in when I needed to. But my sister wouldn't be able to; cause the door would be locked.

And him and my best friend's little sister, Mary — or no, not Mary. Anyway. Him and (tying to recall her name)

DR. CASSELL: It doesn't matter.

ANNA: My best friend's little sister starting going out, and stuff. And my best friend and me were okay with it. You know. They got a little too close and — so we had to hide her sister at our house when she started showing her pregnancy. And Darleen., my best friend, she was getting kind of worried because she was seeing her sister less and less. And every time she saw her sister and — it would just be like her head, or something. And so she came over to my house, with her older brother, and she demanded to see her sister. And just at that moment my sister came screaming up from our room. She goes, Anna, Anna. It's happening, now. And we heard her scream.

DR. CASSELL: Go ahead.

ANNA: And she wanted to know what was going on with her sister. And so I told my little brother to take care of it. And my older sister told her boyfriend to take care of it so that Pete could be there. And — so — I don't know. She ended up giving birth to twins or something. And — so me and Mary, we're both aunts, again.

And — so I bought them an apartment and they had — Mikey had to get a job so that they could support the babies. And I would pop in like once a week or something and see if everything was okay. And I'd lend them money if they needed some, as long as they paid me back. That's it.

DR. CASSELL: Okay. And how did you feel in this dream?

ANNA: In the beginning I was actually kind of proud of — cause I got full custody of my little brother. And in the end I felt like — more like a grandma then an aunt. Cause I'm like the mom to my little brother. *(Consistent with our previous unstated interpretation. It must be realized that in any such interview much symbolic material can emerge that cannot be interpreted at that moment as it might be premature and thus not therapeutic.)*

DR. CASSELL: What do you think it means?

ANNA: That I can do whatever I want in life. Cause I've got my Masters Degree and full custody of my little brother.

DR. CASSELL: I have high hopes for you Anna. It's a wonderful dream and predicts your future possibilities. *(Again we use the dream as a vehicle for positive cognitive therapy. The fact that this dream was repeated verbatim twice supports the contention that this was a valid dream and not a confabulation. The excessive detail of this dream is consistent with the idea that this dream might also reflect a type of positive transference in which Anna presents a gift to her therapist. Again the time was not appropriate to make this interpretation in this artificial and tape recorded demonstration session.)* Okay. We're going to do something else now and — can you tell BB why you liked this when you first viewed the SIS images several months ago during your first hospitalization.

ANNA: I liked it cause — I don't know. I liked using my imagination with the pictures

that are in it.

DR. CASSELL: Okay.

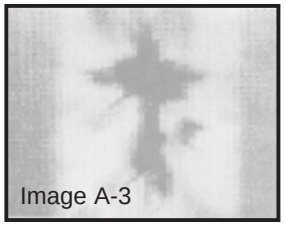
ANNA: And just opening up my mind. *(Anna had previously benefited from the therapeutic aspects of the SIS.)*

DR. CASSELL: Okay. Can you tell us the three that you liked most, and what they are?

ANNA: What they are to me?

DR. CASSELL: Yeah.

ANNA: I think my number one favorite would be 3A.


Image A-3

DR. CASSELL: And what do you see there?

ANNA: I see a cross, like — of both the heavenly world and the under world.

DR. CASSELL: And how do you feel looking at that?

ANNA: I don't know. I feel kind of happy cause in my mind it seems like both worlds are connected. And I hate seeing people using Hell against others. Like, if you're bad, you know you're going to go to Hell. But either way, I think, everybody goes to Heaven. Because everybody has a good inside of them. *(Her response initially reflects her positive experience with Christian symbolism. However her associations immediately lead her to the unhappy and spiritually disruptive memories of attending a fundamentalist church where the pastor's sermons threatened hell and brimstone).*

DR. CASSELL: Right. Okay. And the second one you like most?

ANNA: The second one I like most is — I don't know. I like 27A, also.


Image A-27

DR. CASSELL: Tell us about what you see in 27A, please.

ANNA: I see a lot of things.

DR. CASSELL: Hm hm.

ANNA: Like on the left side there's a guy with his head showing or something. And he looks like a lumberjack person.

DR. CASSELL: Hm hm.

ANNA: If you turn it upside down.

DR. CASSELL: Uh huh. What does that bring to mind?

ANNA: I think of my dad when I see that. Because he was always, like, working outside and stuff. And he was really strong. *(What is most remarkable here is the avoidance of the anatomical suggestion of a woman's breast. This avoidance is consistent with her lack of nurturing from her mother and their long-standing conflict. Since there is little structure on which for her to build an image of a man, this is clearly a projection of her idealized image and strong wish for a loving paternal figure in her life. At time she was desperate in attempting to persuade her mother to give permission to contact him. Her fantasy was that her father had changed since being incarcerated in prison for pedophilia. She raged at her mother when permission was denied.)*

DR. CASSELL: Tell us about your dad.

ANNA: My dad? Well, I kind of look down on him because he hurt my whole family.

DR. CASSELL: In what way?

ANNA: He molested my older sister, which triggered my older half brother's mind, you know. Oh, if I do this then I'll be just like him. And then I'll be carrying on the real family name. So he ended up molesting me.

ANNA: And — you know, but I kind of look up to him because he's the only real father that I know. And I was really close to him. So.

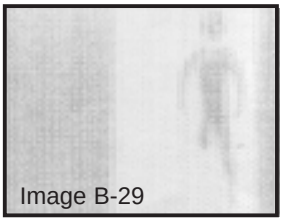
DR. CASSELL: Okay. And — and when did you last see him?

ANNA: I last saw him in '96.

DR. CASSELL: Okay. And where is he now?

ANNA: He's in a Texas State Penitentiary. *(Her response shows a dramatic ambivalence between good and bad in her internalized image of her father. In this demonstration interview there was no time to explore this ambivalence further. Subsequently it was examined further in psychotherapy.)*

DR. CASSELL: Now it's your turn BB to tell us the one that you like most? *(BB had never seen the SIS booklet before.)*


Image B-29

BB: 29B.

DR. CASSELL: And what do you see in 29B?

BB: I see a person, like, running into the light.

DR. CASSELL: And what does that bring to mind?
And how does it make you feel?

BB: It makes me — it kind of reminds me of myself, kind of.

DR. CASSELL: Hm hm. In what way is that?

BB: Cause most of the time I was, like, in the dark all the time.

DR. CASSELL: What way were you in the dark?

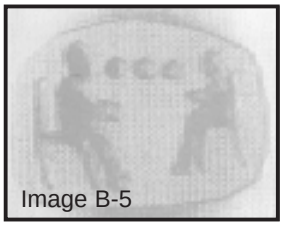
BB: Like I didn't really know, like, what life would bring whatever, or me. And. Like — I didn't — I just didn't really know myself.

DR. CASSELL: I see.

BB: And now it's like I'm getting to the point where I can talk — talk about things. And.

DR. CASSELL: In therapy it's helping?

BB: Yes. And now I'm, you know, going into the light about myself. I'm getting to recognize my feelings more. *(BB's initial phase of hospitalization has been quite positive. At this stage her depression was lifting and psychotherapy had provided release from some of the bad feeling projected onto her by her mother.)*.


Image B-5

DR. CASSELL: All the good things. Okay. What other one do you like?

BB: The next one — well, I like 5B.

DR. CASSELL: Tell us what you see in 5B?

BB : Well, this also one kind of reminds me of a situation that I was in with my mother. It looks like two people in a chair. And, like, the biggest one — it's like the bubbles are going to the — the girl, like she's talking at her.

DR. CASSELL: Hm hm.

BB: And not with her. And it reminds me of when my mother used to talk at me instead of with me. And it would just go out of — go in one ear and out the other. And.....

DR. CASSELL: How did you feel when it — she just talked at you and not with you?

BB: It made my self-esteem go very low, because — it was just like some of the things that she said would — wasn't very nice.

DR. CASSELL: Such as?

BB: Like — she said a lot of things to me. Like — to make me feel that my grandma's death was my fault.

DR. CASSELL: Could you explain that more? She put guilt on you?

BB: Yes.

DR. CASSELL: What did she say specifically?

BB: She said that I really wasn't trying to help my grandmother. When I would disobey her and not clean my room that was a stress on my grandmother.

DR. CASSELL: I see.

BB: And it added more to her cancer.

DR. CASSELL: Hm hm.

BB: And I disagreed with her because my grandma told me that her having cancer didn't have anything to do with me,

DR. CASSELL: That's right. *(Cognitive agreement and emotional support is given. It is apparent that the structure in this SIS inkblot brought out the issues with her mother that requires therapeutic resolution.)*

BB: She's had it before. And it just came back.

DR. CASSELL: That's right.

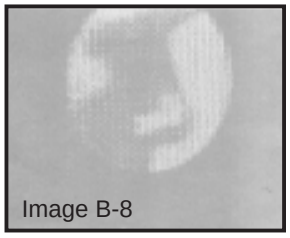
BB: But my grandma was — but my mom was still influencing me that it was my fault.

DR. CASSELL: But you know now, in your heart, it wasn't your fault?

BB: Hmmm, yeah.

DR. CASSELL: Next we will explore the meaning of the ones that bothered the most. Which one bothers you the most? Which one did you like the least?

ANNA: Probably 8B.


Image B-8

DR. CASSELL: Okay. And what do you see in 8B?

ANNA: I see a person with a hat on, and the light is behind. And they can't really see anything else but themselves.

DR. CASSELL: And what — what does that bring to mind?

ANNA: Depression and loneliness because there are no other people in the picture. And to me it looks like everybody is looking down on that one person.

DR. CASSELL: Have you felt that way at times?

ANNA: Yeah.

DR. CASSELL: Tell us about it.

ANNA: Well, I thought that everything was my fault, especially the time when my brother molested me. I thought that it was my fault for being — for looking like my sister. And.

DR. CASSELL: But you know different now? *(In order to retain a positive fantasy relationship with a family member who is abusive, ordinarily the child accepts the blame, resulting in cognitive confusion and self-hatred. Her previous therapy has been partially helpful in correcting this distortion.)*

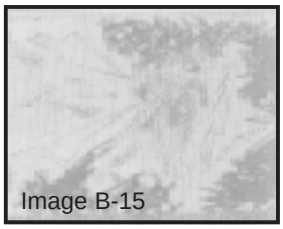
ANNA: Yeah.

DR. CASSELL: Okay. What was the second one that bothered you second most?

ANNA: I think it's — yeah, 15B.

DR. CASSELL: What do you see in 15B?

ANNA: I see, like, knives and stuff going at, like, some figure.


Image B-15

DR. CASSELL: Going at what kind of a figure?

ANNA: I don't know. It could be a person or an animal.

DR. CASSELL: And what does it bring to mind? And how do you feel looking at that?

ANNA: It brings war to mind. And I feel really disturbed cause I hate violence.

DR. CASSELL: To what extent have you witnessed violence?

ANNA: My next door neighbor he use to have a really, really bad problem with anger. And — and I was babysitting his two kids at the time and he told me to take them in the back. And I was like, okay. It's probably just another argument, cause they fought a lot. And, you know — but it didn't sound like just another argument. And so I tried to get the kids out of the house cause, I was hearing screaming and stuff and I saw that it was making them uncomfortable. And so I tried to get them out of the house. But he came and he saw me and he started yelling at me and saying that, you know, he — I couldn't take his kids.

DR. CASSELL: How did you feel at that point?

ANNA: I felt scared. Cause he had a knife in his hand. and he threw it at me one time.

DR. CASSELL: Wow.

ANNA: And it barely missed my head.

DR. CASSELL: Wow.

ANNA: And that — I was scared to leave cause I didn't know what he was going to do to the kids.

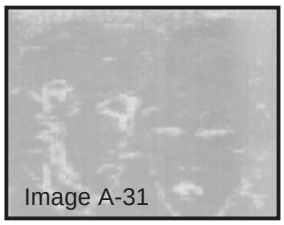
DR. CASSELL: Do you ever have dreams of that?

ANNA: *In her initial evaluation months earlier, this inkblot had triggered memories of childhood anxiety laden dreams depicting the original trauma.*

DR. CASSELL: Okay. What was the one that bothered you third most?

ANNA: Third most.

ANNA: 31A


Image A-31

DR. CASSELL: What do you see in 31A?

ANNA: I see two people, a man and a woman, and the woman looks scared or shocked.

DR. CASSELL: And what does it bring to mind?

ANNA: It brings to mind my mom and my dad. Because my mom would look like that whenever he was around. And if her and me went to the store, or something, she would look really scared.

DR. CASSELL: How would that affect your feelings?

ANNA: It would make me feel scared also. *(Just like the first viewing experience, this stimulated recall of past parental scenes of violence and their concomitant threatening dreams.)*

DR. CASSELL: Okay. Thank you.

What one bothered you the most, BB?


Image B-27

BB: 27B

DR. CASSELL: What do you see in 27B?

BB : It looks like two fetuses.

DR. CASSELL: Uh huh.

BB: It reminds me of my older sister, and me which is now dead. But like.....

DR. CASSELL: When did she die?

BB: She died in '83.

DR. CASSELL: At what age?

BB: Eighteen months. It was before I was born

DR. CASSELL: Oh, I see. Okay. Tell us how does that make you feel, then, looking at that image?

BB: It makes me feel sad because — my mom, when I was born, she told me that she always thought I was a re-incarnation of her — of my sister Samantha, because my mom says that my sister wasn't ready to die.

DR. CASSELL: So how did you feel when your mom said that?

BB : I felt mad. But.....

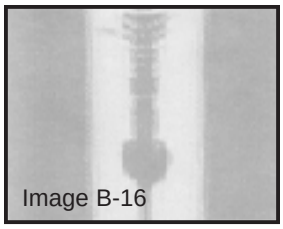
DR. CASSELL: Mad in what way?

BB: I was mad that my sister was gone. And then I was kind of like — I was just very — I don't know. *(This past history had been obtained when the patient was initially admitted to the hospital. Since then, little therapeutic attention had been given to this report. This oversight in the treatment plan was immediately remedied as a result of the new information concerning how threatening this was to BB. This illustrates the importance of rating responses on an anxiety-threat scale.)*

DR. CASSELL: Were you — you felt very sad? Okay. Please tell us what one bothered you second most BB.

BB: 16B

DR CASSELL: Tell us what you see


Image B-16

BB: It looks like an arrow going through someone's heart.

DR. CASSELL: (pointing to 16B in the booklet) this one?

BB: Yes.

DR. CASSELL: And how do you feel seeing that? And what does it bring to mind?

BB: It kind of reminds me of my feelings sometimes.

DR. CASSELL: Which feelings BB?

BB: Like my feelings about my grandmother, my brother, and myself.

DR. CASSELL: Could you be a little more specific, please? When do you feel that way about yourself, your grandma and brother?

BB: Well when my grandmother died it felt like — I felt very heartbroken. *This illustrates how the SIS symbolism can more readily capture the affective experience than words alone. Most languages lack sufficient words to describe the various types of human emotional suffering experiences after loss of a loved one.*

DR. CASSELL: It hurt? Did you have a heavy feeling in your heart?

BB: Yes.

DR. CASSELL: What was it like?

BB: It was very depressing. And it was like — it just hurt.

DR. CASSELL: Hm hm. And then it reminds you of — yourself and your brother and.....?

BB: Yeah, cause my brother he's motivation to me. He's a big motivator to me.

DR. CASSELL: And how — what's the age difference?

BB: We're six years apart.

DR. CASSELL: And he's younger?

BB: Yes. He's.....

DR. CASSELL: In what way is he a motivator for you, BB?

BB: Because no matter what I do, or how much I kick him out my room or — he still says he loves me. And no matter what people say, like his grand — his grandmother, not my grandmother, but his grandmother on his dad's side, is like — she tells him bad things about me, that I've done to him. That I actually didn't do. And he still loves me even though she's feeding him negative and false information. He still loves me. (*In this series of associations to the SIS inkblot new information again appears, namely that her half-brother's grandmother has been attempting to undermine her relationship with him.)*

DR. CASSELL: That's important, that love?

Okay. Did you want to say anything to Anna about her responses? What she saw and — what did you think about what she saw?

BB: I think that she has a creative mind. And...

DR. CASSELL: Yes.

BB: I think that she — some of the stuff that she seen, since she's, like, so young she shouldn't have seen.

DR. CASSELL: Hm hm. Left impressions — bad impressions that we have.

Okay. And what did you think, Anna, of what BB saw?

ANNA: I think she really dug deep. For 16B I would have just said a spinal cord. *(Here BB not only gives Anna positive emotional support but also does reality testing by correctly identifying the embedded anatomical structure in the inkblot.)*

DR. CASSELL: Hm hm.

ANNA: But now that I look at it really closely I can see the heart and the arrow.

DR. CASSELL: Hm hm. Her heartache came through, didn't it?

ANNA: Yeah. And I think it's really sad about everything that she went through. Because nobody deserves to go through any of that. And I feel kind of sad, in a way, cause I still have my grandparents.

DR. CASSELL: Yeah. Okay. We will stop now. When we meet for therapy again., we will discuss how the SIS may have helped in better understanding your dreams. Thank you girls!

Discussion :

The Dreamer can provide vital information from its God- given source for healing. For

those who pay attention, it can serve as a compassionate and infinitely wise inner "consultant". These spiritual dreams need to be documented for lifetime recall by the individual through written notes, voice recording or art work Most individuals - even those with limited intellectual ability – can decipher to a degree the direct and symbolic significance communications from this inner spiritual source. Frequently, however, psychological defenses resist the emergence of painful material. Consequently, sharing the dream with others, especially in group therapy situations, facilitates interpretation. Occasionally, exploring SIS triggered imagery can aide in this process.

BB's joyous dream represented a spiritual visitation from her diseased grandmother, with whom she had been living. It was tremendously reassuring for BB to realize that her beloved grandmother was no longer suffering from a cancer-ravaged body. The gradual death from cancer had provided terrible visual impressions with BB. The dream also pointed to the need for cognitive therapy to correct her low self-esteem, as symbolized in the dream by her not being able to enter "Heaven".

Like too many African-American children she had no father, and so had a greater than usual need for nurturing from her mother. Instead of receiving comfort and support in her grief, however, she was met with further rejection and irrational criticism. Certain of these communication problems were depicted in her projective responses to Image 5B. What was also significant was the imagery evoked by 27B. This pointed out the importance of therapeutically clarifying with BB in family therapy sessions the implications of her mother's reincarnation belief.

Anna's nighttime message from her Dreamer provided prophetic hope. It promised that if she persevered in her therapy eventually she would be able to obtain a university degree. She could then obtain suitable employment and accomplish her goal of providing for her beloved younger brother. Like BB's little brother, he gave her life meaning. Image 3A, with its Christian symbolism, provided a religious shield in spiritual consciousness against the surfacing of traumatic memories. Their ever-present tendency to painfully surface was reflected by her responses to images 8B, 15B, and 31A.

This particular demonstration involves the SIS II Booklet. In this Image 3A is in a monochromatic bluish gray color and the form is suggestive of a cross. For many devoted Christians this can stimulate spiritual imagery and affect in consciousness, activating healing. The image significantly contrasts with many traditional artistic representations of Christ 's crucifixion, which are highly structured and leave little to the imagination. With abstract symbols, such as this SIS inkblot, there is an enhanced potential for the external visual stimulus to tap into the Dreamer's deep inner well of divine spirituality.

In employing this approach it must be remembered that different religions have their own unique symbols and rituals. SIS therapists must be open minded and unbiased in order to employ these for spiritual healing. It is not our role to change or convert any suffering individual's religious orientation. Rather, we need to foster healing by optimally activating the person's religious symbols in the therapy process. Those suffering should

be encouraged to have reverence for spirituality arising spontaneously through dream imagery for themselves and their loved ones.

Tragically, in the modern world and throughout history groups have tried to destroy one another's religious structures. Anna's cultural background was partly Alaskan Native. Historically, American Christian missionaries moved into the north telling the Natives their religious symbols were Satanic. They had the power to take away their cultural rituals and dances. There are still elders in the villages that remember this era with great sadness. Now regions in the north have severe problems with alcoholism and their youth, especially the males, have the highest rate of suicide in the United States.

With the advent of nuclear, biological and chemical weapons, civilization is in a relatively precarious position if the biases of narrow-minded political leaders prevail. The members of the SIS Society through this journal can provide educational leadership. We need to train future leaders to respect the dreams of others and their religious symbolism.

Bibliography:

Abbasi, A. (1999) Review of Soul on the couch: spirituality, religion, and morality in contemporary psychoanalysis. Psychoanal. Books, 10: 150-154.

Balter, L. (1993) Review of *Psychoanalysis and Religion, Psychiatry and the Humanities, V. 11*, *Psychoanal. Q.*, 62: 481-486.

Bartemeier, L.H. (1965) *Psychoanalysis and religion. Bull. Menninger Clin.*, 29: 237-244.

Beit-Hallahmi, B. (1992) Review of *Psychoanalysis and Religion*, *Psychoanal. Books*, 3: 256-258

Benson, Peter L. and Williams, Dorothy L. (1987) Religion on Capitol Hill: Myths and realities. Oxford University Press

Benzein E.G., Saveman B.I. and Norberg A. (2000) The meaning of hope in healthy, non-religious Swedes. Western Journal of Nursing Research. 22(3): 303-19

Bilu, Yoram (2000) Oneirobiography and Oneirocommunity in saint worship in Israel: A two-tier model for dream-inspired religious revivals. Dreaming: Journal of the Association for the Study of Dreams 10(2), p. 85-102

Brenneis, C. B. (1994) Can *early* childhood trauma be reconstructed from *dreams*?. *Psychoanal. Psychol.*, 11: 429-448.

Brierley, M. (1953) Review of *Psychoanalysis and Religion. Int. J. Psychoanal.*, 34: 338-338.

Bulkeley, Kelly (1993) Gods and REMS: The implications of recent dream research for the psychology of religion. Pastoral Psychology; 41(6), p. 349-358

Bulkeley, Kelly (1994) The wilderness of dreams: Exploring the religious meanings of dreams in modern Western culture. SUNY series in dream studies.

Campbell, Joseph (1988) Myths, dreams, and religion. Spring Publications, Inc;

Chatters L.M. (2000) Religion and health: public health research and practice. [Review][185 refs] Annual Review of Public Health. 21: 335-67, new areas of investigation that could bridge the constructs of religion and health. [References: 185]

Dahlenburg, Robin Taylor (1993) The effect of group dreamwork on spiritual well being. Dissertation Abstracts International 54(4-A), p. 1238

Davis, Timothy L. and Hill, Clara E. (2001) Dream interpretation from a spiritual perspective. Innovations in clinical practice: A source book, Vol. 19. p. 79-94

Day, F. (1944) The future of *psychoanalysis and religion*. *Psychoanal. Q.*, 13: 84-92.

Deslauriers, Daniel (2000) Dreamwork in the light of emotional and spiritual intelligence. Advanced Development 9. p. 105-122

Doniger, Wendy and Bulkley, Kelly (1993) Why study dreams? A religious studies perspective. Dreaming: Journal of the Association for the Study of Dreams 3(1), p. 69-73

Ewing, Katherine P. (1990) The dream of spiritual initiation and the organization of self representations among Pakistani Sufis. American Ethnologist 17(1), p. 56-74

Fremantle, A. (1962) Review of *Psychoanalysis and Religion.*, *Psychoanal. Q.*, 31: 551-553.

Fromm, E. (1951) *Psychoanalysis and Religion.*, London: Gollancz

Graber D.R. and Johnson J.A. (2001) Spirituality and healthcare organizations. Journal of Healthcare Management. 46(1): 39-50; discussion 50-2

Gunter, P. Richard (1983) Religious dreaming: A viewpoint.; American Journal of Psychotherapy 37(3), p. 411-427

Hiltner, S. (1950) *Religion and psychoanalysis*, *Psychoanal. Rev.*, 37: 128-139.

Hintikka J., Koskela K., Kontula O. and Viinamaki H., (2000) Gender differences in associations between religious attendance and mental health in Finland. Journal of Nervous & Mental Disease. 188(11): 772-6

Hixson K.A., Gruchow H.W. and Morgan D.W. (1998) The relation between religiosity, selected health behaviors, and blood pressure among adult females. Preventive Medicine. 27(4): 545-52

Howe, Leroy T. (1986) Dream interpretation in spiritual guidance. Journal of Pastoral Care 40(3), p. 262-272

Kanzer, M. (1988) *Early* reviews of "Interpretation of *Dreams*"., *Psychoanal. Study Child*, 43: 33-50.

Kaplan, D. M. (1989) *The* place of *the dream in psychotherapy.*, *Bull. Menninger Clin.*, 53: 1-17. Koenig H.G., Pargament K.I., Nielsen J. (1998) Religious coping and health status

in medically ill hospitalized older adults. Journal of Nervous & Mental Disease. 186(9): 513-21

Larson, D.B., Sherrill K.A., Lyons J.S., Craigie F.C. Jr., Thielman S.B., Greenwold M.A. and Larson S.S., (1992) Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of American Journal of Psychiatry. 149(4): 557-9

Lindorff, David (1995); One thousand dreams: The spiritual awakening of Wolfgang Pauli. Journal of Analytical Psychology 40(4), p. 555-569

Mackenzie E.R., Rajagopal D.E., Meibohm M. and Lavizzo-Mourey R. (2000) Spiritual support and psychological well-being: older adults' perceptions of the religion and health connection. Alternative Therapies in Health & Medicine. 6(6): 37-45

Mancia, Mauro (1988) The dream as religion of the mind. International Journal of Psycho-Analysis 69(3), p. 419-426

Ostow, Mortimer (1986) Archetypes of apocalypse in dreams and fantasies, and in religious scripture. American Imago 43(4), p. 307-334

Pardini D.A., Plante T.G., Sherman A. and Stump J.E. (2000) Religious faith and spirituality in substance abuse recovery: Determining the mental health benefits. Journal of Substance Abuse Treatment. 19(4): 347-54

Rizzuoto, A. M. (1991) Review of *Psychoanalysis and Religion*., *Int. Rev. Psychoanal*., 18: 576-580

Robinson, L.H. (1985) The illusion of no future: *psychoanalysis and religion*, *J. Amer. Acad. Psychoanal*., 13: 211-228

Saul, L.J. (1940) Utilization *early* current *dreams* formulation psychoac. cases. *Psychoanal. Q*., 9: 453-469.

Savary, Louis M. (1990) Dreams for personal and spiritual growth. Dreamtime and dreamwork: Decoding the language of the night. p. 6-12

Schlossman, H.H. (1966) Circumcision as defense. A study in *psychoanalysis and religion*. *Psychoanal. Q*., 35: 340-356.

Shapiro D.H. Jr. (1990) A sense of control, health, and illness: exploring the mind-body relationship and the socio-cultural/spiritual context: reflections on Bali. International Journal of Psychosomatics. 37(1-4): 40-9

Smith, J. H. and Handelman, S. A. (eds.) (1990) *Psychoanalysis and Religion*, Baltimore, MD: Johns Hopkins University

Smith, J. and Handelman, S. (eds.) (1990) *Psychoanalysis and Religion, Psychiatry and the Humanities, V. 11*, Baltimore/London: Johns Hopkins Univ. P.

Spanjaard, J. (1969) *Manifest* dream *content*: significance in interpretation *of dreams*.., *Int. J. Psychoanal*., 50: 221-236.

Spezzano, C. and Gargiulo, G., (1997) *Soul on the couch: spirituality, religion, and morality in contemporary psychoanalysis*., Hillsdale, NJ:Analytic Press

Stewart, W. A. (1967) The *manifest content of* certain types *of* unusual *dreams*.., *Psychoanal. Q*., 36: 329-341.

Tatara, Mikihachiro (1994) Belief and religious sentiments in Japanese as revealed in their dreams. Hiroshima Forum for Psychology 16, p. 39-44

Tedeschi, Richard G., Park, Crystal L. and Calhoun, Lawrence G. (1998) *Posttraumatic Growth* Personality and Clinical Psychology Series. LEA Publishers

Vande Kemp and Hendrika, Sum (1994) Psycho-spiritual dreams in the nineteenth century: I. Dreams of death. Journal of Psychology & Theology 22(2), p. 97-108

Vande Kemp and Hendrika, Sum (1994) Psycho-spiritual dreams in the nineteenth century: II. Metaphysics and immortality; Journal of Psychology & Theology 22(2), p. 109-119

Wallace JM Jr., Forman TA. (1998) Religion's role in promoting health and reducing risk among American youth. Health Education & Behavior. 25(6): 721-41

Yazmajian, R.V. (1964) *First dreams* directly representing *the* analyst. *Psychoanal. Q*., 33: 536-551.

Zilboorg, G. (1962) *Psychoanalysis and Religion.*, New York: Farrar, Straus & Cudahy.

SIS Instruments can be Obtained from :

Somatic Inkblot Center
4501E, 104th Avenue,
Anchorage, Alaska - 99516 (U.S.A.)
Fax : (907) 563-3746
E-Mail : drcassell@corecom.net
Web Site at : http://www.somaticinkblots.com

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Tel./Fax. : 91-172-710986, Tel. : 91-172-710985
E-Mail: sisdubey@hotmail.com

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 95-106

Free Association to Rorschach Responses and Control of Internal States

Lisa C. Milne and Philip Greenway

The present study examines the nature of the free associations subjects give to their own Rorschach responses. It was hypothesized that subjects who produced more positive associations to their Rorschach responses would differ in personality functioning from those who gave more negative associations. Subjects were 77 (37 males and 40 females) normal adults from Victoria, Australia. Overall, the results indicated that subjects who gave more positive than negative associations, tended firstly to report greater satisfaction with and control over their thoughts and feelings than those who gave more negative than positive associations and those who gave equal number of each. Secondly, they scored tended to score higher on the defenses: Rationalization, Altruism, Humor, Idealization, and Acting Out. While subjects who gave more negative associations expressed less satisfaction with their control over thoughts and feelings and tended to use the defenses: Somatization, Passive-Aggression and Undoing more than subjects who gave more positive associations. The results provide preliminary support for the notion that associations to Rorschach responses can produce useful insights into a person's conscious and unconscious functioning.

Some specific parts of each of the Rorschach Inkblots predispose to produce particular types of responses, a phenomena referred to as 'card pull' (Weiner, 1998). The extent to which an individual deviates from the card pull becomes meaningful for Rorschach interpretation as it represents a shift from typical responses (Weiner, 1998). Card pull can incorporate both overt and covert characteristics. Overt characteristics are aspects, which the respondent consciously acknowledges and reports, e.g., the complexity; shape, color and shading of the blot, and any associations to its parts. Covert characteristics refer to aspects of the blots to which respondents do not directly refer, but are nonetheless influenced by, e.g., aggressive and sexual content of the blots (Weiner, 1998). These features are often censored by non-clinical subjects attempting to present themselves in a socially acceptable way (Bohm, 1958). Some cards are more likely to elicit whole responses (e.g., Card V) while others are more likely to elicit small detail responses (e.g., Card X). Some cards tend to produce more or less particular determinants than other cards, hence the presence or absence of a determinant on a card may be of significance. Most subjects, for example, give one texture (T) response, and their doing so suggests that they have a normal capacity to form attachments to others. Commonly, T responses are given to the fur-like features of Card VI, but a T response to Card IX (where a T is rarely identified) and its absence on Card VI takes on a special meaning (Weiner, 1998). Card pull represents a conscious tendency to react to specific cards or parts of them in a relatively conventional way, that is, they draw on a common pool of

Lisa C. Milne, Ph.D. Southern Health Care Network,Cranbourne, Victoria, Australia,and Philip Greenway,Ph.D. Monash University, Clayton, Victoria, Australia
Correspondence: Philip Greenway, Faculty of Education, Monash University, Clayton, Victoria, Australia 3168. Fax : 03 99052779, E-mail : Phillip.Greenway@Education.monash.edu.au

readily accessible images. Other responses likewise come about because individuals draw on their own more idiosyncratic or personal store of images. This network of associations forms the background to the Rorschach response process. Presumably, with every response comes a cluster of related images, which lies either close to the center of the individual's attention or more towards the periphery of consciousness.

The standard administration of the Rorschach does not elicit subjects' associations to their Rorschach responses, hence this information is lost. In comparing dream interpretation with Rorschach interpretation, with symbolism being central to both types of interpretation, Aronow and Rezikoff (1976) pointed out that the subject is asked to associate to the dream content, whereas he or she is generally not required to associate to Rorschach content.

Janis and Janis (1946) developed a supplementary test for the Rorschach, which asked subjects to free associate to their responses. They suggested that subjects project personal symbolism onto the blots, which free association might uncover. They argued further that it would furnish additional data on which to base inferences about personality strivings, attitudes, anxieties and conflicts (Janis & Janis, 1946). In their procedure, they first administered the test, following which they gave the supplementary test in a second session, in which each of a subject's responses were read, exactly as the subject had produced them. The subjects were then asked to say the first thing that came into their mind, as quickly as they could. They were encouraged to be completely free. They found that subjects produced characteristic types of associations. Some, for example, gave a fuller elaboration of the original Rorschach response, others tended to give associations that contained references to some event in their personal history, while others recalled dreams or used some other fantasy content

Responses to the inkblots are formulated by an individual, who has to some degree, been disturbed by the ambiguity of the blot. Hence, his or her verbal responses are an attempt to manage the disturbing material. We tested Janis and Janis' assumption that the words (nouns, verbs and adjectives), often emotionally loaded, which a subject uses, can provide insight into their personality functioning. We selected affectively positive and negatively toned words and phrases from the subjects' free associations to their own Rorschach responses. We then compared the frequencies of both positive and negative associations on a card-by-card basis. We used PCOISS, a questionnaire tapping conscious perceptions of an individual's control of their internal states and the Defense Style Questionnaire, DSQ, an instrument, which might reflect unconscious processes. We expected that if PCOISS scores varied with some associations, this might reflect conscious processing of associations and DSQ score variation might reflect less conscious processing.

Method :

Subjects :

Subjects were 77 (37 males and 40 females) normal adults from Victoria, Australia,

who volunteered to complete a battery of psychological tests. The mean and standard deviation for the age of the sample was 37.18 years and 11.41 years, respectively, with no significant gender differences on age.

Measures :

The instruments used were: Rorschach Inkblot Method administered following The Comprehensive System (Exner, 1993); the Defense Style Questionnaire (DSQ-40; Andrews, Pollock & Stewart, 1989); and the Perceived Control of Internal States Scale (PCOISS; Pallant, 1998)

The Defense Style Questionnaire is a 72-item 9-point likert-scale, questionnaire. The DSQ-40 measures 20 defenses, grouped according to three statistically obtained factors: Mature Defenses (10-items); Neurotic Defenses (16 items); and Immature Defenses (46 items). Mature Defenses include Sublimation, Humor, Anticipation, and Suppression. Neurotic Defenses include Undoing, Altruism, Idealization, and Reaction Formation. Neurotic Defenses include Projection, Passive-Aggression, Acting-Out, Isolation, Devaluation, Autistic Fantasy, Denial, Displacement, Dissociation, Splitting, Rationalization, and Somatization. The internal reliability estimate of the DSQ-40, N=425, Cronbach's a =.80, split-half reliability r = .71 (Watson & Sinha, 1998).

The Perceived Control of Internal States Scale is a 60 item, likert-scale ranging from 1 (strongly disagree) to 5 (strongly agree). The scale has nine subscales. Three deal with general beliefs about the degree to which internal states can be controlled or influenced. These three, each consisting of four items, were, first, Emogen focussing on beliefs about emotional states, second, Thgen, beliefs about thoughts, third, Phgen, beliefs about physical reactions. The possible scores for each of these subscales is Minimum=0, Maximum=20. Three further subscales concerned the amount of control that respondents felt they personally had over their internal states. These three, each consisting of 12 items each, were, first, Emoctrl, focussing on respondents' perceived control over their own emotional states, second, Thctrl, focussing on respondents' perceived control over their own thoughts, and third, Phctrl, focussing on respondents' perceived control over their own physical reactions. The possible range for each of these subscales was Minimum=0, Maximum=60. The last three subscales concerned how satisfied respondents were with their current level of control over their internal states. These last three, each consisting of four items each, were, first, Emosat, focussing on respondents' satisfaction with their control over their own emotions, second, Thsat, focussing on respondents' satisfaction with their control over their own thoughts, and Phsat, focussing on respondents' satisfaction with their control over their own physical reactions. The possible range for each of these subscales was Minimum=0, Maximum=20. The three subscales dealing with general beliefs were also summed to form Totgen. The three subscales dealing with perceived control over respondents' actual emotional states were summed to form Totctrl. The three subscales dealing with respondents' satisfaction over their internal states were summed to form Totsat. A total score for the scale is

calculated by adding the scores on each item, with total possible scores ranging from 18 to 90, with high scores indicative of greater perceived control of internal states. Mean scores on normal populations have ranged from 59.93 (SD=13.37) to 64.09 (SD=11.75) (Pallant, 1998). The scale has shown good reliability, with Cronbach's alpha co-efficients ranging from .86 to .92. The temporal stability to the scale was assessed in three studies, with test-retest correlations over 1 to 3 weeks, ranging from .81 to .91 (Pallant, 1998). The validity of the scale has been with predicted correlations being show with a number of scales (Pallant, 1998).

Procedure :

Subjects attended two sessions, during which a battery of inventories was administered, including: the Rorschach Inkblot Method; the Defense Style Questionnaire (DSQ-40; Andrews, Pollock & Stewart, 1989); and the Perceived Control of Internal States Scale (PCOISS; Pallant, 1998). There were no inducements to participate. The Rorschach was administered in the first session, in the second session, subjects were asked to free-associate to words (nouns, verbs and adjectives) extracted from their Rorschach responses.

The associations to each card, for each subject, were then classified into two groups. One group, Positive, included all positive descriptors, which was defined as any word that could be used to unambiguously to describe either self or other in positive terms e.g., happy, beautiful, strong, intelligent, generous, and kind etc. The other, Negative, included all negative descriptors that could used unambiguously to describe either self or other in negative terms e.g., ugly, mean, evil, sad, horrible, and dirty etc. The total number of associations for each card was also recorded.

The total of Positive and Negative associations were noted for each card. If for a particular card, a subject had more Negative than Positive associations the subject was placed in Group 1. If the subject had equal numbers of Positive and Negative responses, the subject was placed in Group 2. If the subject had more Positive than Negative responses, the subject was placed in Group 3. This was repeated for the associations to each card, so a card by card comparison could be made. In order to test the hypothesis that the type of associations to the Rorschach Card responses are related to the way one manages emotions both unconsciously (by using defenses) and consciously (the perception of control of internal states), ANOVAs were run comparing the groups on each of the DSQ and PCOISS scales and subscales.

Results and Discussion :

Descriptive statistics are shown in Tables 1a-5. Most people gave about one positive descriptor to each card, and slightly fewer negative descriptors. There was no significant difference across the 3 groups on total number of associations (including Positive, Negative, and other associations given) to each card, except on Cards V and VI. On Card V Group 1 subjects gave more associations than Group 2 subjects. On Card VI,

Group 3 subjects gave more associations than Group 2 subjects.

Table 1a
Descriptive Statistics for Number of Associations to Each Card

Associations	Group 1		Group 2		Group 3	
	M	SD	M	SD	M	SD
Card 1	25.86	13.17	25.03	12.04	30.62	13.65
Card 2	28.55	7.94	23.59	11.88	29.27	10.82
Card 3	24.88	10.22	25.50	10.58	28.15	11.67
Card 4	25.82	7.28	22.00	11.56	28.71	12.76
Card 5*	28.17	13.50	18.94	11.10	23.63	9.55
Card 6*	28.17	13.84	20.62	11.53	29.30	12.98
Card 7	25.43	13.26	22.29	11.85	28.74	12.29
Card 8	25.21	9.28	23.03	12.14	27.39	16.07
Card 9	28.16	10.47	23.69	13.37	25.70	11.59
Card 10	21.54	9.64	23.85	12.77	28.95	13.08

*for significant differences between groups refer to table 1b

Table 1b
ANOVA Results for Groups Significantly Related to Number of Associations Per Card

Variable	Df	MS	F	P	Bonferroni Post Hoc Test
Card 5	2, 70	423.16	3.47	.037	Gp 1> Gp2
Card 6	2, 70	604.40	3.97	.023	Gp2< Gp3

Table 2a
Descriptive Statistics for Positive Associations to Each Rorschach Card

Positive	Group 1		Group 2		Group 3	
Association	M	SD	M	SD	M	SD
Card 1	.32	.57	.34	.81	.23	.160
Card 2	.55	.93	.13	.52	2.73	1.93
Card 3	.44	.73	.25	.55	1.78	.89
Card 4	.88	1.62	.15	.36	3.14	2.13
Card 5	.33	.65	.14	.49	2.29	1.71
Card 6	.42	.69	.15	.59	2.55	2.26
Card 7	.29	.76	.08	.36	2.74	1.97
Card 8	.29	.61	.26	.92	2.30	1.40
Card 9	.69	1.14	.11	.52	2.20	2.19
Card 10	.38	.65	.23	.63	2.60	1.79

Tables 2a and 2b show the descriptive statistics for the number of positive associations to each card. On each card there were significant difference ($p<.001$) between the groups. For Card I, Group 1 and Group 2 had significantly higher mean numbers of

positive associations than Group 3, while for all other cards, Group 1 and Group 2 had significantly lower mean numbers of positive associations than Group 3.

Table 2b
ANOVA Results for Groups Significantly Related to Positive Associations Per Card

Variable	Df	MS	F	P	Bonferroni Post Hoc Test
Card 1	2,71	31.19	28.21	.00	Gp1 & Gp2 > Gp3
Card 2	2,71	48.77	34.53	.00	Gp1 & Gp2 < Gp3
Card 3	2,71	18.84	36.48	.00	Gp1 & Gp2 < Gp3
Card 4	2,71	59.34	29.97	.00	Gp1 & Gp2 < Gp3
Card 5	2,70	35.20	29.95	.00	Gp1 & Gp2 < Gp3
Card 6	2,70	39.46	23.34	.00	Gp1 & Gp2 < Gp3
Card 7	2,71	58.47	36.89	.00	Gp1 & Gp2 < Gp3
Card 8	2,71	32.54	29.39	.00	Gp1 & Gp2 < Gp3
Card 9	2,71	28.23	16.21	.00	Gp1 & Gp2 < Gp3
Card 10	2,71	39.35	33.60	.00	Gp1 & Gp2 < Gp3

Tables 3 and 3a show the descriptive statistics for the number of negative associations to each card. Again, there were significant differences on each of the cards. For all cards, as may be expected, Group 1 had significantly higher mean numbers of negative associations than Group 2 or Group 3.

Table 3a
Descriptive Statistics for Negative Associations to Each Rorschach Card

Negative	Group 1		Group 2		Group 3	
Associations	M	SD	M	SD	M	SD
Card 1	3.09	2.11	.34	.81	.33	.56
Card 2	2.36	1.69	.12	.52	.55	.74
Card 3	3.00	1.58	.25	.55	.26	.66
Card 4	2.88	2.03	.15	.36	.52	1.03
Card 5	1.58	1.00	.14	.49	.29	.75
Card 6	1.83	1.27	.15	.59	.35	.93
Card 7	2.57	.98	.08	.36	.26	.53
Card 8	2.50	1.70	.26	.92	.43	.79
Card 9	2.50	1.79	.11	.52	.20	.70
Card 10	1.85	.99	.23	.63	.25	.64

Table 3b

ANOVA Results for Groups Significantly Related to Negative Associations Per Card

Variable	Df	MS	F	P	Bonferroni Post Hoc Test
Card 1	2,71	57.81	33.51	.00	Gp1 > Gp2 & Gp3
Card 2	2,71	21.48	29.43	.00	Gp1 > Gp2 & Gp3
Card 3	2,71	29.69	48.86	.00	Gp1 > Gp2 & Gp3
Card 4	2,71	44.53	33.66	.00	Gp1 > Gp2 & Gp3
Card 5	2,70	9.65	20.41	.00	Gp1 > Gp2 & Gp3
Card 6	2,70	13.22	19.02	.00	Gp1 > Gp2 & Gp3
Card 7	2,71	58.47	36.89	.00	Gp1 > Gp2 & Gp3
Card 8	2,71	32.54	29.39	.00	Gp1 > Gp2 & Gp3
Card 9	2,71	34.62	35.79	.00	Gp1 > Gp2 & Gp3
Card 10	2,71	13.79	27.69	.00	Gp1 > Gp2 & Gp3

Tables 4 and 5 show the descriptive statistics for the DSQ and PCOISS, respectively.

Table 4

Descriptive Statistics for Defenses

Defense	Mean	SD	Defense	Mean	SD
Sublimation	9.51	3.06	Acting Out	8.60	3.51
Humor	11.98	4.06	Isolation	7.15	3.75
Anticipation	10.60	3.29	Devaluation	6.09	2.92
Suppression	10.35	3.16	Autistic Fantasy	6.53	3.43
Undoing	7.81	3.4	Denial	6.41	3.10
Altruism	10.18	3.38	Displacement	6.40	2.80
Idealization	7.01	3.83	Dissociation	7.25	3.09
Reaction Formation	9.89	3.58	Splitting	7.50	2.90
Projection	5.10	2.81	Rationalization	11.52	3.41
Passive Aggression	5.86	3.06	Somatization	6.60	3.37

ANOVAs were run for each Card, with Associations (Groups 1 - 3) as the IV and each of either the PCOIS scales or the DSQ scales as the DV. Table 6 shows the results of the significant ANOVAs. There were no significant ANOVAs for Cards IX and X.

Table 5

Descriptive Statistics for Perceived Control of Internal States of Control Scale

PCOISS Scale	Mean	SD
Thgen	15.68	2.47
Phgen	16.64	2.14
Thctrl	41.27	7.26
Phctrl	44.50	7.20
Emosat	13.43	3.68
Thsat	13.92	3.42
Phsat	13.21	3.45
Emoctrl	41.30	7.02
Emogen	15.51	3.18
Totgen	47.70	6.44

As the first card, Card I may give some indication as to how subjects manage a novel, unstructured situation. The popular response to the card is a winged creature, using W. The heavy shading in the card may disturb subjects. Group 3 subjects (who produced more positive than negative associations) showed significantly higher scores on Emosat, Thsat and Totsat than Group 2 subjects (subjects producing equal numbers of positive and negative associations). This suggests that subjects who produced more positive associations to Card I, were more likely to report feeling satisfied with their control over their own thoughts, as well as generally feeling satisfied with their level of control over thoughts, physical reactions and emotional responses, than those who produced equal numbers of positive and negative responses. Group 2 reported feeling less satisfied with their thought control. They were, perhaps, more likely to express both negative and positive feelings, thus opening themselves to disturbing feelings, leaving them somewhat dissatisfied with the way they handle feelings and thoughts.

Card II is the first card to introduce color. It is quite difficult to separate the bright red from the rest of the blot (Klopfer, et al., 1954) so if the subject wants or needs to avoid the affective experience of the red, it is likely to result in a disturbed response. Subjects in Groups 1 and 3 reported feeling more satisfied with their control over their emotions than those in Group 2. While Group 3 subjects reported more control over their own emotional states than Group 2 subjects. This may suggest that having positive or negative associations is not necessarily problematic, but that not consistently regulating feelings and thoughts creates a conscious dissatisfaction with one's perceived control over internal states. The other finding for Card II was that Group 1subjects were significantly more likely to use the defense somatization – where unpleasant emotions are converted into bodily experiences, than group 2 subjects. The bright red of Card II is frequently associated with blood (Weiner, 1998), so this finding seems to support the notion that Card II disturbances are a result of the color, presumably associated with blood by these subjects. Those that deal with the color disturbance, by giving responses to

Table 6

ANOVA results for Association types significantly related to DSQ-40 Defenses and PCOISS

Variable	Df	MS	F	P	Bonferroni Post Hoc Test
Card 1					
Emosat	2, 70	38.47	3.45	.038	Gp2=12.46; Gp3=14.81
Thsat	2, 69	43.93	5.43	.007	Gp2=12.39; Gp3=15.10
Totsat	2, 70	237.15	3.37	.040	Gp2=37.43; Gp3=43.71
Card 2					
Somatization	2, 69	31.46	3.79	.028	Gp1=8.09; Gp2=5.41
Emosat	2, 70	45.40	4.14	.020	Gp1=15.68; Gp2=12.68; Gp3=14.81 Gp2<, Gp1 & Gp3
Emoctrl	2, 70	152.77	3.25	.045	Gp2=39.95; Gp3=44.59
Card 3					
Sublimation	2, 69	33.48	3.95	.024	Gp1=8.00; Gp2=8.92; Gp3=10.68 Gp3> Gp1 & Gp2
Altruism	2, 68	42.61	4.28	.018	Gp2=8.74; Gp3=11.16
Rationalization	2, 70	35.44	3.25	.045	Gp1=8.56; Gp3=11.73
Thsat	2, 69	29.09	3.41	.039	Gp2=12.89; Gp3=14.69
Emoctrl	2, 70	191.67	4.19	.019	Gp2=39.53; Gp3=44.54
Totctrl	2, 70	1275.67	3.58	.033	Gp2=122.50; Gp3=135.04
Card 4					
Humor	2, 69	91.33	4.54	.014	Gp2=9.59; Gp3=13.32
Idealization	2, 68	55.88	5.15	.008	Gp1=6.41;Gp2=6.21; Gp3=9.17 Gp3>Gp1 & Gp2
Passive Aggression	2, 69	26.95	3.40	.039	Gp1=7.00; Gp2=4.68
Thsat	2, 69	31.28	3.70	.030	Gp1= Gp1=12.00; Gp3=14.65
Card 5					
Undoing	2, 68	30.04	3.67	.031	Gp1=9.25;Gp2=6.82; Gp3=6.75 Gp1>Gp2 & Gp3
Card 6					
Sublimation	2, 68	36.39	4.44	.016	Gp2=8.46; Gp3=10.53
Undoing	2, 68	47.18	6.16	.004	Gp1=8.91;Gp2=6.21; Gp3=8.32 Gp1<Gp2 & Gp3
Card 7					
Thsat	2, 69	32.68	3.88	.025	Gp2=12.58; Gp3=14.59
Card 8					
Sublimation	2, 69	30.27	3.53	.035	Gp1=11.00; Gp2=8.59
Humor	2, 69	86.80	4.28	.018	Gp2=9.62; Gp3=13.14
Acting Out	2, 69	65.26	6.10	.004	Gp2=6.79; Gp3=9.77
Somatization	2, 69	27.30	3.24	.046	Gp1=7.71; Gp2=5.38
Phsat	2, 70	61.26	5.02	.009	Gp1=11.50;Gp2=12.53; Gp3=14.91 Gp1<Gp2 & Gp3
Totsat	2, 69	296.92	4.33	.017	Gp1=36.93; Gp3=44.22

* Specifies the groups between which the significant difference was found

which they have negative associations, are more likely to bind their anxiety in bodily expression to avoid experiencing it directly.

The associations to Card III produced more differences than any other Cards' associations, and interestingly, for this card, it is the subjects who produced positive associations, that reported higher levels of the use of the defenses and higher levels of perceived control of emotional states. In this Card the red is more easily avoided (Klopfer, et al., 1954) and the popular response is a human figure (Weiner, 1998), and often two humans interacting. Group 3 subjects produced higher scores than: both Groups 1 and 2 on Sublimation; and than Group 2 on Altruism; and than Group 1 on Rationalization. These three defenses have in common that people in using them try to express themselves in a socially acceptable way, thus binding affect to apparently reasonable ideas. Sublimation serves to attenuate impulses into productive activity, Altruism handles anxiety by focussing on the needs of others, and Rationalization attempts to process unacceptable feelings by giving them logical explanations. Those who produce positive associations for this card may use these defenses when responding to Card III. Cooperative Movement (COP) is commonly found for this card and is associated with the popular response for the card. Group 3 subjects manage any anxiety, which they may feel to be evoked by this card by resorting to socially acceptable, or cooperative percepts. Given that the popular response may involve cooperation, some may do this consciously. This interpretation is reinforced by the fact that Group 3 subjects also reported more conscious control over their emotional states and more satisfaction with their control over their thoughts than Group 2 subjects.

Card IV is often disturbing to subjects because of its' resemblance to a giant or monster, it's heavy, dark shading, possible phallic significance, and the masculine associations that go with these characteristics (Weiner, 1998). The subjects who gave more positive than negative associations to this card used Humor as a defense more than Group 2 subjects, and they used Idealization more than Group 1 and 2 subjects. Humor, a mature defense, may enable the associations to the card to be positively toned, e.g., the overpowering masculine image may been seen as a 'cute monster', and then less aggressive associations to that response may follow. On the other hand, Idealization is a neurotic defense with primitive origins which comes about by a person's denying unwanted characteristics of an object and enhancing it by projecting onto it one's own libido (Lerner, 1991). Subjects using Idealization may produce positive associations to Card IV responses by idealizing the masculine and authoritative images suggested to them by the blot and effectively denying unwanted negative features such as the phallic image, the dark shading and the large size of the figure. Group 3 subjects reported feeling more satisfied with their thought control, perhaps indicating that they managed uncomfortable feelings unconsciously by the use of these defenses. Subjects who gave more negative associations for Card IV were more likely to use Passive-Aggression as defense more than other subjects. Passive Aggression is a defense that is used to gratify authority figures and avoid punishment, and but also includes frustrating the authority to obtain some sense of autonomy. This is a pertinent finding in light of the 'authoritative' nature of the card, and may indicate that passive-aggressive subjects do not like this card and tend to have negative associations to it.

Subjects producing negative associations to Card V used the defense Undoing more than Groups 2 and 3 subjects. Undoing is a defense that serves to maintain symmetry. Prior ideas are counterbalanced by their opposite (Kellerman & Bury, 1991). Card V is a relatively bland card, generally producing a winged- animal response and has been referred to as a recovery card as most subjects are able to compose themselves sufficiently to manage this card effectively (Klopfer at al, 1954). Perhaps negative associations here are indeed the result of the obsessive to 'undo' previous associations rather than what Card V itself elicits.

Card VI tends to draw sexual symbolism. Group 3 subjects, who gave positive associations, had higher scores on Sublimation more than Group 2 subjects. Possibly, the sexual content elicited this defense leading subjects to give positive associations. Group 1 subjects, who gave more negative associations to this card, tended to use Undoing more than subjects in Groups 2 and 3.

Associations to Card VII produced very little differences between the subjects, except that Group 3 subjects reported feeling more satisfied with their thought control.

Subjects cannot avoid color on Card VIII, consequently, this card may disturb people not comfortable with emotional expression. Group 1 subjects used Sublimation and Somatization more than group 2 subjects. Perhaps, discomfort with emotional expression, consistent with the use of Somatization, caused Group 1 subjects to use Sublimation to try transform their discomfort into a more acceptable form. Sublimation, although a mature defense, involves an individual's redirecting impulses into productive activity, rather than their 'sitting with' uncomfortable affect. The all-color blot may disallow the re-direction of emotional expression, eliciting instead some negative reaction, which then may have resulted in subjects giving negative associations. People who use Somatization tend not to experience difficult feelings, so they too may find the affective nature of this blot harder, and also experience a negative reaction to it. Group 1 subjects in general reported feeling less satisfied with their control over their own internal states than the other groups, which may indicate that, although they use Sublimation and Somatization, these defenses were not that effective causing them to experience some anxiety. Subjects' who gave more positive associations to this card, used the defenses Humor and Acting-Out more than Group 2 subjects. These two defenses operate by actively dealing with the anxiety provoked – one by dealing with the anxiety in a light-hearted manner and the other by substituting action for anxiety. These subjects may have been able to deal with the emotional impact of this card, and hence to experience the card more positively. These subjects also reported feeling more satisfied with their control over their internal states.

In general, subjects, who gave more positive than negative associations, tended to report greater satisfaction with and control over their internal states, that is, their thought and feelings than those who gave more negative than positive associations or those who gave an equal number of each. They also tended to score more highly on the defenses, Rationalization, Pseudo-altruism, Humor, Idealization and Acting-Out, more than subjects giving more negative than positive associations, or giving an equal number of both. Subjects, who gave more negative than positive associations, expressed less satisfaction with their control over thoughts and feelings and tended to use the defenses,

Somatization, Passive-Aggression, and Undoing than subjects giving more positive than negative associations. On the whole, those giving more positive than negative associations scored more highly on the more mature defenses and those giving more negative associations or an equal number of positive and negative associations scored more highly on immature defenses.

In summary, this study provides preliminary support for the notion that associations to Rorschach responses can produce useful insights into a persons conscious and unconscious functioning. Subjects may respond to card-pull by endeavoring to manage their anxiety in ways that address its specific characteristics and are consistent with their overall, defensive style. People, who have not developed consistent ways of dealing with anxiety may tend to manage anxiety less effectively, and as a result to report feeling less in control of their internal states. While these preliminary results are promising, there are several limitations of the present study. First, it was exploratory and requires further validation before any conclusions can be drawn. Second, present sample was drawn from the normal population, clinical and other defined samples and those drawn from subjects at different developmental stages may well differ substantially.

References :

Andrews, G., Pollock, C. and Stewart, G. (1989). The determination of defense style by questionnaire. Archives of General Psychiatry, 46, 455-460.

Aronow, E. and Reznikoff, M. (1976). Rorschach Content Interpretation. New York: Grune & Stratton.

Bohm, E. (1958). A textbook in Rorschach diagnosis. A.G. Beck and S.J. Beck (Trans.). New York: Grune & Stratton.

Exner, J.E. (1993). The Rorschach: A comprehensive system. Vol. 1. Basic Foundations (3rd Ed.). New York: Wiley.

Janis, M.G. and Janis, I.L. (1946). A supplementary test based on free associations to Rorschach responses. Rorschach Research Exchange, 10, 1-19.

Kellerman, H. and Bury, A. (1991). Handbook of Psychodiagnostic testing. Massachusetts: Allyn and Bacon.

Klopfer, B., Ainsworth, M., Klopfer,W. and Holt, R. (1954). Developments in the Rorschach Technique. Vol. 1. Yonkers-on-Hudson, N.Y.: World Book.

Lerner, P.M. (1991). Psychoanalytic Theory and the Rorschach. New Jersey: The Analytic Press.

Pallant, J. F. (1998). Development and evaluation of a multidimensionsal multidomain inventory to measure perceived control of internal states. Unpublished manuscript, Faculty of Education, Monash University, Melbourne.

Rapaport, D., Gill, M.M. and Schafer, R. (1968). Diagnostic Psychological Testing. Madison: International Universities Press.

Watson, D.C. and Sinha, B.K. (1998). Gender, age, and cultural differences in the Defense Style Questionnaire-40. Journal of Clinical Psychology, 54, 67-75.

Weiner, I.B. (1998). Principles of Rorschach Interpretation. New Jersey: Lawrence Erlbaum Associates.

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 107-115

A Normative Study with Portugues Children Aged Six to Ten Years Old

Danilo R. Silva, Rui Campos and Ana Monica Dias

Three hundred and forty four Portuguese children in the age range of 6 years to 10 years were administered Rorschach test following Exner's method. The findings suggest that Portuguese children, in average, locate their responses predominantly in *D,* a few numbers of *T* responses, a high Lambda and low form quality. The similarity and differences on Rorschach responses are discussed in the paper.

Given the limits of time each one disposes, we decided to cut as much as possible the introductory explanations and go ahead with the presentation of our data. Moreover these data will be presented with few comments for three main reasons: first, they are numerous; second, some of them raise questions that admit several answers; third, many of them demand, in our view, the necessary research to reach its real meaning or explanation. Of course, we are receptive to every question or comment concerning our presentation.

This study* had begun during the last years of the eighties and developed mainly along the nineties, particularly after 93. In order to observe some methodological lines suggested by Exner, such as each examiner not to depass a quarter of the administrations of the entire sample, it was necessary to prepare examiners for this task. Here is one of the reasons why our work has taken so much time. It was our aim to present normative data for age groups with at least 30 boys and 30 girls. Generally there is a larger number in each group, but, in the present sample, the group of 7-year-olds has only 29 girls and it seems that there was some mistake in inserting some child aged 6 year-old. This and other details will be corrected in due course.

The Sample :

Boys and girls from the region of Lisbon who in their large majority attended public primary schools and a few of them private schools form our sample. Table 1 presents the distribution of the number of subjects in each age group.

Table 1

Number of subjects in each age group

6-Year-olds	7-Year-olds	8-Year-olds	9-Year-olds	10-Year-olds
n=84	n=63	n=77	n=60	n=60

As far as economic and cultural levels are concerned, the profession of parents was the adopted criterion. It was not always possible to obtain for all the subjects information about profession and educational levels of their parents, especially in the case of the

Danilo R. Silva, Rui Campos and Ana Monica Dias, Faculdade de Psicologia e de Ciencias da Educacao, Universidade de Lisboa, Alameda da Universidade, 1649-013 Lisboa Portugal

* This study was sponsored by Fundacao Calouste Gulbenkian and Centro de Psicometria e Ciencias de Educacao of the Fundacao para a Ciencia e Tecnologia.

younger children. In any case, we believe that the data we present here to you are truly representative, in the sense that the absent data would not alter meaningfully the current distribution.

Three socio-economic levels were considered, as follows: low socio-economic level, middle socio-economic level and high socio-economic level, each one corresponding to a group of professions.

All children were volunteer and were tested with their parents' permission, during the school time. To prevent testing children with some physical or psychic handicap, teachers were asked to help the selection of volunteer children, as these should be middle or good learners (not very good), without behavioural or mental disturbances.

Generally, the examiner picked the child from the classroom whenever he or she was until the 4th degree; for children at 5th, they walked to the testing room on their own.

Testing session began with a brief interview aiming to gather some data concerning child's birth-day, his or her parents' job and educational level, number and gender of siblings, and having suffered some particular or serious disease. All this was done in a way that could favour a good relationship and prepare the child for the test. The administration of the Rorschach was preceded by the one of Coloured Progressive Matrices which had a double function: it was a way to bring the child into the test situation and to obtain information on his or her intellectual level. Several examiners with previous required knowledge and training collected protocols.

Preparing Data :

Both the authors who have primarily coded 60 protocols together in order to assure the desirable unanimity of criteria coded protocols. Unfortunately we have not yet a proof of inter-coders reliability. On the other hand, time has not permited us to come to the end of the scrutiny of all responses. So we are not going to present neither results on Localization nor Form Quality or Popular responses. All these elements were coded according Exner's Table A of his Workbook (Exner, 1965).A data base was then prepared by means of RIAP3 and the descriptive statistics were obtained with the SPSS. At this point I am in debt to my colleague and friend Abel Pires.

Results and their Analysis :

In order to prevent you from boredom in presenting such a large number of data, we decided to do it following the seven clusters of data proposed by Exner, begining with Information Processing and finishing with Interpersonal Perception. Even if we don't show you all the data, an important number of them will be shown.

Information Processing :

Analysis of the values presented in Table 2 give us some important keys concerning the way how Portuguese children tend to code or admit new stimuli that they must deal with. It permits us to underline the following comments concerning location, developmental quality and organization activity:

Location: in every age group mean D is higher than mean W, though in the case of seven-year-olds the difference between W and D is minimal. This is not the case with the American children who present in the entire correspondent age groups mean W higher than mean D.

Developmental quality: Data reveals a moderate DQ+, a high DQo and regular DQv and DQv/+. This means that these children tend to perceive objects in their simplest but specific form.

Organization activity Figures in the Zf row are common values but the ones corresponding to Zd are negative in all age groups and frequently high. This is certainly in relation with both items put forward before, namely the high means of D and DQo. Though it is not a rare occurence in children, percentages of hypoincorporaters are generally high as follows: 23% in 6-year-olds; 44% in 7-year-olds; 38% in 8-year-olds; 35% in 9-year-olds; 37% in 10-year olds.

Table 2

Mean Values of Some Variables Intervening in the Analysis of Information Processing

Variables	6-Year-olds (n=84)	7-Year-olds (n=63)	8-Year-olds (n=77)	9-Year-olds (n=60)	10-Year-olds (n=60)
Zf	9.51	12.97	11.10	10.87	11.33
Zd	-0.76	-3.13	-2.01	-1.77	-2.11
W	7.86	10.56	8.36	8.32	8.07
D	11.12	10.65	11.05	12.00	12.62
Dd	4.05	3.49	4.83	4.33	3.37
S	1.98	2.68	2.66	2.87	2.40
DQ+	3.34	4.43	4.49	4.08	5.22
DQo	16.51	17.89	17.16	17.87	18.20
DQv	2.93	2.00	2.12	2.18	0.53
DQv/+	0.24	0.38	0.48	0.52	0.10

Given the characteristics of information processing emphasized here, one can guess that mediation will reflect its features accordingly. In our view both organization activity and developmental quality may be in the origin of the low form quality and high Lambda present in the mediation activity. We might yet add the possibility that this same economic and simple information processing is responsible for the short number of W responses.

Mediation :

Table 3 presents means of the variables that form the cluster of mediation. As you can see, we have high Lambda in all age groups though a moderate reduction may be considered from seven-year-olds on.

In what respects Form Quality, XA% varies between 0.63 and 0.69 and you can see it distinctly looking at the X-% that is always high in reference to American norms. I'd like to call your attention for two aspects of these results. One is the fact that, in our population, Form Quality is a developmental variable that is, its value grow up along the years. Second some signs of this growing process can be seen in X+% or XA% values of 9 and 10-year-olds and more clearly in the F+% row, with values of 0.42 and 0.45 which get greater importance in our case of High Lambda values. If you consider that in the Portuguese adult population the means of X+% or XA%, as my friend Abel Pires has shown, are respectively 0.50 and 0.87 you will recognize easier the figures here presented.

Table 3

Mean Values of Some Variables Intervening in the Analysis of Mediation

Variables	6-Year-olds (n=84)	7-Year-olds (n=63)	8-Year-olds (n=77)	9-Year-olds (n=60)	10-Year-olds (n=60)
Lambda	4.08	4.04	2.97	2.89	2.95
P	2.77	3.70	3.91	4.05	3.55
X+%	0.37	0.38	0.33	0.38	0.42
XA%	0.63	0.66	0.66	0.69	0.68
F+%	0.39	0.40	0.35	0.42	0.45
X-%	0.33	0.32	0.33	0.29	0.32
S-%	0.12	0.15	0.16	0.16	0.19
Xu%	0.26	0.28	0.33	0.31	0.26

If our general hypothesis is correct these results distinctly reflect the effects of the input coding inserted in the information processing. These data may be very important and revealing for the planning of pre-primary and primary school education of our children.

Ideation :

Now let us have a look at variables of ideation and see if any peculiarity is noticeable. If you keep in mind the main features previously emphasized concerning information processing and mediation, namely the high L of this sample, the analysis of ideation data reveals that results are generally according with the expected ones. Differences between active and passive movement are slight but a is always higher than p with the exception of 9-year-olds group. The same occurs with Ma:Mp. With respect to M- it may be considered high but it must be said that among our children or even in adults an M- is not that uncommon. So, besides the generally low mean values of all ideation variables, nothing of special is openly noticeable from these data.

Table 4

Mean Values of Some Variables Intervening in the Analysis of Ideation

Variables	6-Year-olds (n=84)	7-Year-olds (n=63)	8-Year-olds (n=77)	9-Year-olds (n=60)	10-Year-olds (n=60)
M	1.18	1.70	1.77	2.10	2.47
a:p	2.08:1.43	2.57:1.54	3.05:2.25	2.35: 2.77	3.58: 2.85
Ma:Mp	.65:.52	1.08:.63	.95:.82	.93: 1.03	1.63:.88
Intellect	0.49	0.73	0.75	1.08	1.08
DV	1.23	1.95	2.09	1.35	0.83
INCOM	1.24	1.02	1.12	0.87	1.65
DR	0.15	0.16	0.06	0.08	0.03
FABCOM	0.30	0.21	0.32	0.27	0.63
ALOG	0.09	0.08	0.01	0.10	0.00
CONTAM	0.01	0.02	0.00	0.03	0.00
Sum6	3.18	3.68	3.79	2.83	3.45
WSum6	6.75	7.13	6.79	5.87	8.42
M-	0.29	0.42	0.44	0.52	0.97
M none	0.00	0.00	0.00	0.00	0.00

Controls and Stress Tolerance :

Results found in some variables of this cluster, present in Table 5, are very interesting because, as we see them, they characterize in some way our Portugality. You must always be aware of the high Lambda of this sample to duly evaluate these figures.

I begin the analysis of Table 5 calling your attention to the figures in SumC', V and Sum Shading rows, where we have inserted results from the American norms of equivalent age groups. As you can see these are values that, though the high Lambda, come close to the American ones and, in the case of V, they are always higher. In the case of C', the differences are slight and favorable to Portuguese sample in the case of 6 ans 10-year-olds. It is just in the case of the T variable that Portuguese results are systematically pretty low. This same profile is found in Abel Pires' adult normative data.

Coming back to our high Lambda you can confirm its reductive effects in the EA and es rows, where values are always low. They are very suggestive but we have not time to discuss them. In what concerns D score and Adjusted D, mean values fall in the expected range.

Table 5

Mean Values of Some Variables Intervening in the Analysis of Controls and Stress Tolerance

Variables	6-Year-olds (n=84)	7-Year-olds (n=63)	8-Year-olds (n=77)	9-Year-olds (n=60)	10-Year-olds (n=60)
FM	1.76	1.82	2.51	2.10	2.92
m	0.57	0.57	1.00	1.03	0.78
SumC'	1.17	1.17	1.19	1.73	1.15
	(0.58)	(1.25)	(1.30)	(1.16)	(0.79)
SumT	0.21	0.16	0.21	0.25	0.30
SumV	0.07	0.08	0.13	0.18	0.48
	(0.00)	(0.00)	(0.00)	(0.00)	(0.02)
SumY	0.15	0.16	0.30	0.63	0.25
Sum Sh	1.61	1.57	1.83	2.80	2.18
	(1.95)	(2.48)	(2.90)	(2.96)	(1.83)
EA	3.91	3.89	3.86	4.50	4.37
es	3.94	3.97	5.34	5.93	5.88
D Score	0.01	0.02	-0.48	-0.45	-0.40
AdjD	0.06	0.05	-0.32	-0.20	-0.30

Affect :

Table 6

Mean Values of Some Variables Intervening in the Analysis of Affect

Variables	6-Year-olds (n=84)	7-Year-olds (n=63)	8-Year-olds (n=77)	9-Year-olds (n=60)	10-Year-olds (n=60)
FC	1.06	1.14	1.10	1.48	1.37
CF	1.27	0.86	1.05	1.33	1.07
C	0.62	0.51	0.32	0.32	0.10
Cn	0.04	0.00	0.01	0.00	0.00
SumC	2.99	2.51	2.49	3.13	2.53
WSumC	2.73	2.19	2.09	2.55	1.90
Afr	0.58	0.52	0.51	0.51	0.55
Blends	1.12	1.29	1.44	2.05	2.03
Col-Sh Bls	0.17	0.29	0.21	0.48	0.43
CP	0.04	0.02	0.03	0.02	0.02

Let's move now to the analysis of Table nº 6. Values concerning Color responses are generally low but what may strike you is the fact that values in the CF row are generally lower than those in FC row, a datum that does not occur in the American norms. Nevertheless the ratio CF+C>FC is always positive but for the 10-year-olds group where there is 1 child with FC<CF+C. Finally, look at the progressive reduction of Pure C along

the age groups.

Values of Affective Ratio (Afr) suggest a moderate reactivity to emotional stimulation as it is moderate the whole expression of feelings and emotions. But I'd like to call your attention to the behaviour of this variable along the age groups. As you see, they come down from 6-year-olds group on and come up again at 10-year- olds. I see in this reduction a sign of the repression of emotional reactivity of the latency stage or, seen with other eyes, a sign of the important role of reason and new cognitive skills and competence along this same stage. This idea came to my mind after having found that, in contrast to the fact that colour increases the production of responses in adults, it has no such an effect in children, at least in 9-year-olds children (Silva, 2000).

The frequency of Blends is obviously scarce in accordamce with all other indicators.

Self-Perception :

Table 7 presents mean values of some variables related with Self-Perception. Such values are frequently distant from those presented by Exner and Weiner. If you look at values of the Index of Egocentricity you will remark that its figures are low because Pair responses are not frequent and particularlly Reflection responses are rare in all five age groups.

Table 7

Mean Values of Some Variables Intervening in the Analysis of Self-Perception

Variables	6-Year-olds (n=84)	7-Year-olds (n=63)	8-Year-olds (n=77)	9-Year-olds (n=60)	10-Year-olds (n=60)
3r+(2)/R	0.25	0.24	0.28	0.29	0.31
(2)	5.62	5.60	7.03	6.67	7.18
rF+Fr	0.01	0.05	0.00	0.13	0.07
FD	0.40	0.48	0.35	0.45	0.83
An	0.94	0.86	0.58	0.55	0.63
Xy	0.00	0.02	0.04	0.02	0.00
MOR	0.77	0.97	0.62	0.98	0.88

Another variable whose values deserve some attention is Form-Dimension. As a matter of fact, values here presented are not much lower than the American ones, overpassing them in groups of 7 and 10-year-olds. Given the fact that Portuguese values are almost all the time clearly lower than the American ones, with the decisive exception of Lambda, the fact that the variable FD gets such a level of expression must be emphasized. Yet it must be said that frequencies of such responses, in the several age groups, are as follows: 26%, 35%, 23%, 37% and 50%, from 6 to 10 years of age.

Finally, figures of the content Anatomy are always high. The same may be said about MOR though in this case they are generally lower than in the case of American children.

Interpersonal Perception :

Table 8 shows us some data that deserve our attention. First of all we wish to pick variables H and Hd to underline the fact that, in all age groups, mean values are similar, they are close to each other, what is not the case in the American sample where Hd is always much lower than H.Both cooperative and aggressive responses are short number and so it is the number of the children who give them.

Third points that must be emphasized are the figures of HVI and CDI. Hyper-vigilance index, against American normative data, where it is negative in all the equivalent five groups, is positive for some children in each group of Portuguese sample. Figures of the Coping Deficit Index are high in all our age groups in comparison with the American normative data. The true meaning of these and many other values need to be duly examined and studied before one can say anything consistent and valid about them.

Table 8

Mean Values of Some Variables Intervening in the Analysis of Interpersonal Perception

Variables	6-Year-olds (n=84)	7-Year-olds (n=63)	8-Year-olds (n=77)	9-Year-olds (n=60)	10-Year-olds (n=60)
PER	0.77	0.41	0.45	0.57	0.27
COP	0.21	0.24	0.30	0.32	0.53
AG	0.26	0.49	0.47	0.17	0.33
Isolate	0.15	0.15	0.17	0.15	0.13
Fd	0.20	0.22	0.09	0.07	0.08
H	1.55	1.56	1.84	1.63	2.13
Hd	1.61	1.30	1.39	1.32	1.75
(H)	0.99	1.40	1.36	1.15	1.17
(Hd)	0.37	0.71	0.42	0.70	0.65
A	9.42	10.59	10.65	10.02	10.83
Ad	2.05	2.24	2.39	3.18	3.32
(A)	0.25	0.40	0.27	0.35	0.35
(Ad)	0.01	0.05	0.06	0.12	0.05
HVI +	7%	13%	12%	12%	8%
CDI=4	36% (13%)	46% (11%)	44% (7%)	57% (6%)	35% (15%)

Conclusion :

In closing my presentation I wish to make two observations. My first observation is a tribute to Dr. John Exner for having had the courage, the will and the passion to develop all his work on the Rorschach, namely the methodology required to come to scientific

results. He has helped us to better know and understand the Rorschach and how it works, he gave us a renewed instrument or method that each of us must tune in his use and environment.

The second observation concerns the normative data I have presented to you with the numerous questions it poses to us. It is difficult to think that there are many things in common between peoples, at least at the level of Rorschach figures. On the other hand it seems that there are differences in the way how certain concepts both cognitive and affective concepts are expressed and/or experienced by these peoples. Questions are there: why do Portuguese children, in average, locate their responses predominantly in D? Why do they give such a few number of T answers or reflex answers? Why do they have such a high Lambda and such a low form quality? And overall what does this mean? As I see it, these and all the other questions demand an answer and the pursuit of this answer must be, to a large extent, the task of Portuguese psychologists themselves.

Reference:

Exner, J. E.Jr., (1995) A Rorschach Workbook for the Comprehensive System (4th Edition). Asheville, N.C., Rorschach Workshops.

Exner, J. E., Jr. (2000) 2000 Alumni Newsletter. November 20. Asheville, N.C. Rorschach Workshops.

Pires, A. A. (2000) National Norms for the Rorschach. Normative Study in Portugal. InR. Dana (Ed.) Handbook of Cross-Cultural and Multicultural Personality Assessment. New Jersey, Lawrence Erlbaum Associates, Publishers, pp. 367-392.

Silva, D.R. (2000) The effect of colour on productivity in Card X of the Rorschach. VIth European Congress of the European Rorschach Association for the Comprehensive System, Nanterre, Paris.

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 116-126

Personality Assessment, Projective Methods and a Triptych Perspective

Ann M. O'Roark.

The paper deals with various application potentials of projective devices. Since projective tests are versatile tools in both mental health and in development work, they can be used with clinical and non-clinical populations to establish a starting point for an intervention. Projective tests are likely to become more widely used when they are recognized as process facilitators for dialogue sessions, and when clients responses can be analyzed using checklists that include direct links to other types of assessment information.

Projective methodology involves working with images, devices or sets of procedures that are differentially provocative without being overly suggestive or directive. These techniques are designed to provide information about or insight into an individual's personality, motivations, attitudes, and values by allowing that person the opportunity to respond in an unrestricted manner to unstructured or ambiguous objects. The purpose of this paper is to describe three suggestions for expanding the ways we work with projectives:

1. to facilitate dialogue, especially with development clients and for establishing future goals;
2. to determine discussion priorities for both pathology and development interventions; and,
3. to introduce a draft of a checklist which emphasizes time references and records categories that provide links to several assessment instruments.

Personality Assessment and Projective Methods :

Personality assessment specialists who use projective approaches find that instrumentation options are increasingly varied and richly diverse. A few projective tools have been in use since the early 1900s. Others were developed in more recent decades. Some are visual representations prepared for display on heavy cue cards. Others require sketches or drawings to be made by the client or patient. In broadly inclusive discussions, the earliest and simplest forms of projectives, word associations and sentence completions, are grouped with considerations of the Vygotsky nonsense-word blocks with and the Bender-Gestalt geometric designs that have proven effective in testing of neurological functioning (Barclay, 1991).

Background on Projective Devices :

Formal assessments of individuals based on information gathered by a practitioner working with projective techniques began early in the 1900s. Informally, reports suggest that the ancient Sumarians used a version of word association to identify the particular *devil* that was bothering a person. They would pronounce a list of stimulus words and watch reactions. When agaitation occurred, the word was noted and the "devil" was diagnosed.

A variant of the Sumarian word association was used by the first psychologists, a

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

diverse group of turn of the last century contemporaries: Galton, Wundt, Kraepelin and Jung. Sir Frances Galton fathered behavior genetics in Great Britain. Wilhelm Wundt set up the first psychological laboratory to study conscious behavior in 1879 in Leipzig. L. Kraepelin of Munich Germany created the first classification system for mental illness. Carl Jung worked in Zurich Switzerland where he developed a theory of personality types and archetypes.

Other early projectives used in formal assessment and therapy include:

1921 Rorschach Inkblots published [1911 Hermann Rorschach's first work with inkblots]

1926 Florence L. Goodenough's *Measurement of Intelligence by Drawings.* Yonkers, NY: World Book Co.

1935 Henry Alexander Murray's Thematic Apperception Test [TAT] ;

1939 Rhode & Hildreth's sentence completions

1944 Molly Harrower's inkblots created to parallel Rorschach's

1945 Leopold Bellack and Sonja Sorrell Bellack's Children's Apperception Test (CAT);

1948 Rosenzweig's Picture Frustration Drawings

1948 John N. Buck's House-Tree-Person Drawing Test by

1949 Karen Machover*'s Personality Projections in the Drawings of Human Figures*

Projectives developed in more recent decades include:

1950 Rotter Sentence Completions

1951 Molly Harrower *Large Scale Rorschach*, and 1958. *Most Unpleasant Concept Test*

1962 *The Hand Test* by Edwin Wagner,

1963 The Goodenough-Harris Drawing Test by Florence L. Goodenough and Dale B. Harris

1969 *Luscher Colour Test,* M. Luscher.

1972 *The Holtzman Inkbot Technique,* Wayne Holtzman

1976 Roseline Davido's *The Hand that Disturbs* drawing test

2000 Antoinette Thomas' *Interpretations of Children's Drawings*, in-process publication.

Application of Projectives in Process Facilitation :

Among this second generation of projectives, the *Somatic Inkblot Series-I (SIS-I,1960*) *Somatic Inkblot Series-II (SIS-II booklet form 1980)* and *the SIS Living Images* (1985) stand out as prime examples of projective personality assessment instruments that lend themselves not only to formal diagnosis, but also for guided dialogue during therapy treatment sessions, or as a prelude to assisting a client who is working on growth and development objectives. The SIS and Living Images, products of the work of Wilfred Cassell, founder of the Somatic Inkblot Society, advance both the art and the science behind psychological applications of projective devices.

The Living Images, in my experience, readily lends itself for a neglected "process" role for the psychological projectives. Inviting discussion of ideas invoked by the colorful beauty of the Living Images visuals with the suggestion that the client "let these shapes lead our conversation – into the future, back to the past, or toward a current situation," led me to think of the stained glass artwork in a classic three-sectioned *triptych* and inspired the title for this paper.

Rakesh Kumar(2000) found that most researchers using the Cassell projectives prefer working with the expanded booklet form. My preference is to work with the video format, especially the *Living Images.* The video offers a flow of projectives, and allows for gentle surfacing of a client's innermost apperceptions, some of which relate to the past, some relate to the present while others are associated with future and yet unrealized aspirations. Responses that include comments about the past, the present or the future comprise what I consider to be the three panel *triptych* of projective information useful when determining and guiding intervention directions.

The work of the therapist or consultant/coach is to first "listen" to the client's responses to what is evoked by the images. Interpretative efficiency and validity are increased when the professional uses a screening model to sort mental products by categories that are salient in the broader community of experts. While observing and collecting responses, it is important to solicit and tabulate verbatim comments that indicate connections to past-present-or-future time frames. Once a prevailing time zone of reference is determined, work with the client can be focused to address and resolve issues in the triptych dimension that is key to healthful and productive behavior.

When responses associated with the past are prevalent and produce signs of discomfort or limitation, a consultant's objective is to help the client achieve a comfortable integration of early life experiences. When a client is concentrated on conditions existing in present realities, a coach's goal is for the client to achieve clarity and congruity in current emotions and behaviors. If responses relating to the future are confusing or worrisome, then an objective for the session is to stimulate the client's planning for the next phase of life and the establishment of realistic, meaningful and desirable goals.

An interesting cultural consideration arises when doing a triptych sorting of the client's time references. A major difference between Western (esp. British and USA) and Eastern (esp. Indian) conceptions of time is noted by Pittu Laungani (2000, in process..) He reports that in India the notion of time is more circular than linear, and that in Hindi the same word, kal, stands for both yesterday and tomorrow. The only way to know if a speaker is referring to the past or the future is to listen to the context of the person's statement. The Eastern tendency to hold a casual attitude about keeping appointments only disappears in the face of auspicious situations, such as weddings, funerals, taking an important journey. Conceptions of and attitudes toward "Time" arise as a universal social-cultural variable that will need to be accounted for when interpreting projective responses of individuals from backgrounds that are not the same as that of the counselor or consultant.

Projectives , Future Goals and the Creative Self :

Early depth psychologists, Freud and Jung both gave first attention to the influence of *past* experiences on current functioning. The power of the *future* was given priority by a third member of this influential set of colleagues, Alfred Adler. Adler separated from

the Vienna Psychoanalytic Society, resigning as it's president, to defend his position that what is inherent in human nature that shapes personality is a reaching out toward future goals. He maintained that the pull from this inherent *social interest* is stronger than the push of forces driven by early-life sexual emotions or primordial thought patterns.

Adler is credited with introducing the *creative self* that finds ways to fulfill one's own unique style of life. He essentially set the stage for recognizing the self as an important cause of behavior, and, thus, also set the stage for psychologists to work with the conscious intent of a client to plan and guide actions in full awareness of their meaning for self-realization and for reaching specific goals. Adler set a precedent for using projectives in assessment and intervention with non-clinical populations.

Adler was aware that *final goals* may reflect fictions, representing ideals which may be impossible to realize even for healthy achievers, but he argued that they also spur individuals and colleagues to concerted striving and, consequently, provide understandable explanations for behavior, choices, and activities. Adler asserted that people are motivated more by expectations of the future than the experiences of the past. Subsequently, work of the next generation of giants in our discipline, like Abraham Maslow, Carl Rogers, and Arthur Combs, elaborated on the importance of considering the *future* for individual healing and growth. Expectations, goals and dreaded possibilities became as critical in striving for mental health as resolving confusions and the injuries endured in the past.

The Present "Here & Now" time zone fills in the third panel of the triptych time frames. It was primarily the American behaviorists who demonstrated the effects of here-and-now management of contingencies, stimulus-response connections, and the behavior shaping effects of "rewards". Behavior therapists, sports psychologists and development coaches work with clients as they learn more effective ways to cope with present situations and to figure out how to arrange their current environments in order to receive healthy, enhancing rewards.

It is not in the scope of this paper to debate the relative importance of past, present or future motivations and explanations of human acts and thoughts. Sufficient here is to point out that there is evidence indicating strong influence on behavior by each of the three time frames. These studies support a pertinent role for a triptych perspective when working with projective tools.

Aligning the Triptych Agenda :

The next chart illustrates intervention differences determined by triptych time zone prevalence and type of client. It is usually necessary to address all three temporal categories before a reaching a satisfying conclusion of work with a client, nevertheless, in most situations the first focus will be on the zone that presents itself most often in the preliminary assessment, or during the first 15-20 minutes in a dialogue session.

Applying projectives as "process" devices, in contrast to "assessment" devices, can enrich work with two broadly inclusive types of patients and clients: Those with pathologies or situation reactions and Post Traumatic Life Experience (TLE) traumas; and, those interested in development of management or interpersonal style and potentials. In working with a pathology case and addressing the *past*, the professional's intent will be to make constructive *meaning* of troubling experiences and responses to

Table 1

Comparison of Types of Therapeutic Interventions According to Prevalent Time References by Pathology and Development Clients/Patients

Time Zones referenced in initial discussion and/or responses to projectives / Client Populations	**Past**	**Present**	**Future**	**MIX**
PATHOLOGY Treatment, re-educational	Integrate and make constructive meaning of troubling experience	Reinforce new behaviors that are healthful and productive	Clarify long range consequences of continuing to deny, avoid or ruminate	Special techniques such as : de-sensitization, re-framing, medications
DEVELOPMENT Growth, educational	Determine missing knowledge skills experiences	Gather data, analyze, draw conclusions plan adjustments	Prepare at least three long range future scenarios: best circumstances Worst circumstances; not much change	Career Planning Models; Decision Making Processes; Forecasting Skills

images. When working with a development client, the coach will attempt to identify missing knowledge, skills, and experiences that can be included in a personal development plan.

The first triptych oriented chart [Table 1] is illustrative, not inclusive, and calls attention to the fact that most interventions will reflect a mix of time zone elements.

In treatment sessions for dysfunctional conditions, sometimes labeled as re-education sessions, mixing attention to the present or to the future with resolving pains of the past typically calls for application of special techniques such as desensitization, introduction of medications and / or behavior modification. The professional worker is expected to respect the parameters of his/her education, training and licensure. Those specialized in *clinical* areas, who are trained in the techniques recognized as most effective for repairing and restoring health, will refer *development* work to those specialized as consultants and coaches, who are trained in techniques for discovering relevant talents and amendable ignorance or weakness while teaching others to use strategic thinking skills.

The development specialists will refer clients with severe mental or physical disturbances to clinical experts. Both types of professionals need to be competent in diagnosis so they can sort pathological or traumatized patients from the personal development and problem solving clients. All professionals work as *contemporary detectives,* searching for the clues that will allow the client to discover ways to engage in satisfying and productive living. The Cassell images are unique in form and modality, yet like other projectives they evoke salient information for personality assessment and mental health diagnosis. The projective methods facilitate oblique observations of patients and clients that provide information important in establishing mental status and functioning that can be classified according to diagnostic criteria set for identification of serious conditions and pernicious or unstable states of mind.

Assessment and intervention devices are among the most valuable tools for the mental health professional. A plethora of objective tests and questionnaires have proven easier to standardize and to transform into numerical data points that can be factor analyzed, co-varied, and eigen valued. But, because of a need to understand thinking processes and a need for content analysis to enrich statistical reports, dedicated and talented individuals specialized in projective methods. Therefore, we have come into an era where projective test authors and inventors are more consistently using similar lenses to discuss and interpret the mental associations derived from projective stimuli.

Although far from being standardized into one set of categories for analysis, even the most statistical of scoring methods (such as John Exner's formulas for thinking about a client's Rorschach responses) reveal important interpretive *common ground*: number of responses, initial response time, and how the client goes about thinking about the image. The widely respected proponent of analysis of the formal visual features of a client's percepts, Zygmunt A. Piotrowski, wrote that "One of Rorschach's greatest achievements is his development of a procedure[the inkblot] which allows a pertinent analysis of the thought process." (1979).

Analysis lenses in current use with eight popular assessment devices were used to create a synthesis list of tryptichcategories. As well as summarizing and guiding a practitioner's detective work, such variables compiled from respected contemporary instruments serve as a bridge between the several data sources. The checklist aims to collect parallel information in order to generate stronger validity for interpretations and intervention plans.

Analysis Lenses :

Although a triptych perspective is given to this observation checklist, most of the analysis topics named in Table 2 are drawn from categories used by authors of four projective and four objective instruments.

The projective devices are: The Hand Test [1972], The Somatic Inkblot Series [1953], the Thematic Apperception Test cards [1943], and the Rorschach inkblots[1921].

The objective questionnaires are: the California Psychological Inventory (CPI) [1933], the Myers Briggs Type Indicator (MBTI) [1942]; The Fundamental Interpersonal Relations Orientations – Behavior (FIRO-B) [1944], and the NEO – R/Five Factor Inventory (1989). The triptych perspective is intended to stimulate work by other practitioners who are also interested in advancing the beneficial uses of projective methods. These colleagues will need to contribute to the essential research and cross-referencing necessary when developing a formal checklist for professional use. There are many relevant instruments to review for inclusion in a comprehensive pool of categories.

Using Projectives with Clinical and Non-Clinical Populations :

The next chart maps instruments that are likely to be used with clinical and instruments frequently used with non-clinical client populations. This abbreviated overview is put in the context of a full range of assessment approaches: projective, objective, structured interviews or observations, and special techniques. Ideally, in a full scale work-up for either client group, projectives are rarely used alone. Moreover, early and recent assessment batteries that are set up for executive selection or promotion that I have worked include at least one projective, usually the TAT and sentence completions. Unfortunately, it is often inconvenient to have a practitioner present when a client is working on questionnaires, so the projectives are being dropped out of the battery. In such circumstances, including a projective in a subsequent dialogue session becomes especially valuable.

The dialogue process used when working with a development client is similar to "feedback" and coaching consultation sessions included in leadership development programs. The following three options for working with a video version of a projective device are variations of coaching techniques. In each, the professional and the client engage in a collaborative effort to interpret the implications of responses provided by the client to the projective. Constance Fischer of Duquesne U. and a member of the Board of the Society for Personality Assessment, has published a book describing and advocating this process for working with therapy and counseling clients.

Table 2

Sources and Topics for First Draft Triptych Observation Categories

PROJECTIVE		**OBJECTIVES**		
1972 Hand Test		1933 California Psychological Inventory (CPI)		
1953 Somatic Inkblot Series		1942 Myers Briggs Type Indicator (MBTI)		
1943 Thematic Apperception		1944 Fundamental Interpresonal Relation Orientations- Behavior		
1921 Rorschach Inkblots		1989 NEO-R Five Factor Inventory		
Observation Checklist	Session 1	Session 2	Session 3	Session 4
Triptych : Time Reference	Tally Checks 3	Tally Checks 3	Tally Checks 3	Tally Checks 3
Past				
Present				
Future				
Time				
Initial Response Time	Seconds			
Duration	Seconds			
Shock : no response	Seconds			
Stimulus				
Whole				
Detail				
Form				
Color				
Shade				
Projection				
Human				
Animal				
Nature				
Fantastic				
Movement				
Communication				
Aggression				
Exhibition				
Defensive				
Protective				
Goal Attainment				
Caring, Helpful				
Sex				
Nourishment, food				
Orderly				
Dominance				
Thinking Process				
Fast, Slow				
Inductive : Conservative Focus, Focus gambling (Brunner)				
Deductive : Successive scan, simultanious scan (Brunner)				
Flexible, Judgemental				

Table 3

Types of Assessment Instruments and Types of Client Populations

Data Collection Methods / Intervention Need	Projective	Objective	Structured Interview/ Observation	SPECIAL Techniques
PATHOLOGY Disease Disorder Dysfunction Traumatic Reaction	**Rorschach,** Sentence Completions, Neurological Test, Drawing Figures.	MMPI	WAIS [pix and blocks are semi-projective] Psychiatric Interview Biographical Info.	Hypnosis, Medications
DEVELOPMENT Hiring/Selection Promotion Management Training Leadership Development	TAT Hand Test Sentence Completions	CPI, MBTI, NEO Five Factor. Taylor-Johnson Temperatment, FIRO-B	Critical Incidents 360-degree surveys Biographical Info. Assessment Centers	Rogerian, Gestalt, Rational-emotional

1) The collaborative discussion begins after the client views the video making comments aloud about each image. The coach observes, taking notes and recording on a checklist the pertinent categories, their frequencies and any time references. Before the video is started the broad consultation goal is stated and the client is given information about the agenda for the session: the client will view the video and comment on each image; afterward, the practitioner and client will discuss the experience together. After responding to any questions from the client, there is an instruction to let the video images lead into thoughts about the past, the present or the future. The client is reminded to report aloud their first thoughts about the several images and to make special mention of reminders of events in the past, or present situations, or if the thoughts that arise are about things that might come to be in the future. When the video is finished, two-way discussion of the client's responses to the images begins. With a video as long as the Living Images and the client is scheduled for a one hour session, limit the viewing time to 15 or 20 minutes in order to have adequate discussion time in a one hour session.

2) A variation on this procedure begins in the same manner, and to provide the client with a hand control unit so that the video can be *paused* at any point. The "stop action" option allows an immediate and extended period for presentation of ideas and thoughts that seem important to the client. If the procedure is productive, and half of each session is reserved for collaborative discussion, two or three meetings can be scheduled in order to view the entire video. This type of session can bring out the creative self and activate the *active imagination* that Adler believed to strongly motivate people. The viewing may release untapped brainstorm-ideas and original thinking, especially for

persons working out complex solutions for a current problematic situation, or making innovative plans for the future.

3) A third way to manage the discussion session, one which is most like coaching sessions in the leadership training programs that I have worked with, is to have "stop action" controls available for both the client and the professional. This way the coach can see expressions on the client's face that indicate that something may be going on in the client's mind that is not being expressed.

Next Steps and Implications :

Links between Projective and Objective tools need to be strengthened. A practitioner-researcher who wants to improve upon the checklist presented here might include topics prominent in multi-rater - self-report questionnaires. Likely two synthesized checklists would need to be prepared. One for working with persons dealing with pathological conditions and another for working with individuals working on development goals.

At times language gets in the way of discussions between clients and professionals. Describing pathology treatments as re-education sessions and developmental consultations as education sessions eliminates some of the stigma that can become attached to words like pathology or clinical classifications.

Subtle language barriers that can arise when working with either client population become especially important if the professional's goal is to open up collaborative discussion. Carefully selected words will promote greater comfort for, and elicit more candid disclosure from the client. Alerts about such communications barriers would be included in explanations of how to go about using projectives to facilitate dialogues. It can be well worth the effort to allow projective devices to be the vehicle for working the miracle of dialogue. This concept is far from being a new discovery. In fact, theologian Reuel L.Howe (1963) devoted a whole book under that title to the beneficial consequence of these therapeutic discussions with a professional who has the well being of the client foremost in mind and heart.

Conclusion :

This paper calls attention to ways to expand the application potentials of projective devices. Since projectives are versatile tools in both mental health and in development work, they can be used with clinical and non-clinical populations to establish a starting point for an intervention. By tabulating the number of responses referencing the past, the present or the future, professionals can plan to begin collaborative work by addressing the time zone that generates the most frequent or pernicious source of limitation or confusion.

Projectives are likely to become more widely used when they are recognized as process facilitators for dialogue sessions, and when clients responses can be analyzed using checklists that include direct links to other types of assessment information. The purpose of this paper is to describe three suggestions for expanding the ways to work with projectives: 1. to facilitate dialogue; 2. to determine discussion priorities; and, 3. to collecting data for use with an interpretative checklist which links to several assessment instruments.

References :

Barclay, J.R. (1991) *Psychological Assessment.* Malabar, FL: Krieger Publishing Co.

Bellak, L. & Bristol, M. (1954). *The Thematic Apperception Test and the Children's Apperception Test in Clinical Use*. NY: Grune & Straton, Inc.

Bruner, J.S., Goodnow, J. J., and Austin, G.A. (1956). *A Study of Thinking.* NY: John Wiley and Sons.

Cassell, W. A. (1980). *Body Symbolism and the Somatic Inkblot Series.* Anchorage, AK: Aurora Publishing Co.

Harrower, M. & Bowers, D. (1987). *The Inside Story.* Hillsdale, NJ: Lawrence Erlbarum Associates, Inc.

Howell, R. L. (1963) The Miracle of Dialogue. Greenwich, Conn.: Seabury Press.

Kumar, R. (2000). Meta analysis of the Findings on SIS II*, SIS Journal*, 7,2, p.141-147.

O'Roark, A. & Exner, J. E. Jr. (1989). Eds. *History and Directory: The Society for Personality Assessment Fiftieth Anniversary.* Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Laungani, P. (2000, in process). *Cultural cognition and psychopathology.* New Zeland

Piotrowski, Z.A. (1957, 1979). *Perceptanalysis.* NY: MacMillen.

Wagner, E. and Young, G. R. (Eds.) (1999). *The Hand Test.* Malabar, FL: Krieger Publishing Co.

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 127-134

Personality Profile And HRD Intervention in a Telephone Cables Company

Bankey L. Dubey, Anil Agrawal and Ravinder S. Palia

Myers Briggs Type Indicators and Somatic Inkblot Series Tests were administered to 90 Executives of a private organization. Both the tests were administered in a group of 10 executives. Standard procedures of administration, scoring and interpretation were followed. The MBTI profile reveals that majority of the executives (60%) showed ESTJ profile followed by 13 % ISTJ . 86% belonged to Thinkers group and 12 % to Feelers group. Extroverted were 78% and the Introvert were 20%. There were 80% belonging to Sensing group and 18% to Intuitive group. Judgmental were 96% and the Perception group only 2%. A CEO belonging to INTJ category headed the Unit.

The Somatic Inkblot Series -Video profile reveals that they were supported by good ego strength, healthy interpersonal relationship, no erotic disturbances, controlled hostility and aggression, high team building concept, good human relationship, and keeping touch with reality. Two executives showed unhealthy profile suggesting disturbed sexual relations, poor ego strength and to an extent neurotic profiles.

The HRD intervention was planned in a meeting with top executives and the group was taken to a Forest Resort for two days. They got opportunity to express their feelings while having cocktail and dinner in a more soothing natural environment. They came out with lot of innovative ideas. The second day they were asked to work in groups of the area of their routine work/ specialization and instructed to prepare short-term realistic target to increase the productivity of the organization. They were to work on the assumption that every person can help tremendously from his capacity as individual contributors in the organization and can prove to be the champions.

Training programs on " Understanding Self and Others, Promoting Values and Team Building" with regular meeting of the entire work force was done. The organization showed significant improvement. The findings of the study are discussed in the paper.

The primary responsibility of every Manager is to utilize the existing resources under his control. Every Manager talks of empowerment of human resources and optimum utilization of material resources. Lot of industries are in crisis through out the world. Managers at the top are planning for the survival of their organizations. Re-structuring, right sizing and economic measure are the practice of most organizations. To imporve the functioning of the organisation and empowering human resoruces, the present study was planned on executives in a Telephone Cables Company to find out the personality profiles, their potentials and shortcomings and intervention through training programs and team building.

MBTI is widely used test for the assessment of personality. It measures four continuum viz. extrovert – introvert, sensing – intuition, thinking — feeling and judgment—

B.L. Dubey, Ph.D., Professor, UBS, Panjab University, Chandigarh -160 015 (India) (E-mail : sisdubey@hotmail.com), Anil Agrawal, MBA President & CEO, Telephone Cables Ltd., SCO 70, Sector 17-C, Chandigarh - 160 017 (E-mail : aagarwal@tclindia.com), Ravinder S. Palia, MSW, HRD Consultant, 17 Cattrick St., Mississauga, Ontario, L4T 1H6, Canada (E-mail : ravipalia@hotmail.com)

perception. Assessment of these preferences helps in utilizing the capacity of persons in fullest. It may also helps the person to understand his contributions to the organization, Leadership style he would exercise, preferred work environment, Potential pitfalls and suggestions for improvement. It will also help him to know what makes him irritated and how he irritates others. Such understanding may help in improving his own behavior and promoting interpersonal relationships.

Somatic Inkblot Series test is a projective instrument helping in assessing the basic personality of the individual. It assesses Interpersonal relationship, self and ego, team building, relationship with father and father figure, erotic thinking and some undesirable traits like hostility aggression, depression, suspicion and pathological anatomy. It brings out whatever is burried into deeper unconscious mind and helps in processing the material. It is an instrument, which can be used during therapy.

Material and Method:

The MBTI and Somatic Inkblot Series tests were administered to 90 personnel of Telephone Cables Limited, Chandigarh. The subjects belonged to varying age from 28 to 57 years. There were 86 males and 4 females. All were educated at least up to 12th grade. They were administered MBTI test and Somatic Inkblot Series-Video test in a group of 10 persons after giving standard instructions. They were also asked to read the instruction printed on the record sheet. Both MBTI and SIS were scored and the profile is discussed ahead.

Results:

MBTI Profile

Sixty percent people in the organization belonged to ESTJ profile. The characteristics of **ESTJ** organization are given below:

Table 1

Organizational Profile of the Company

ISTJ 12 (13%)	ISFJ 4 (4%)	INFJ 0	INTJ 3 (3%)
ISTP 0	ISFP 0	INFP 0	INTP 0
ESTP 0	ESFP 0	ENFP 1 (1%)	ENTP 1 (1%)
ESTJ 54 (60%)	ESTJ 3 (3%)	ENFJ 4 (4%)	ENTJ 8 (9%)

Introverted - 20%	ESTJ-60%	Extroverted -78%	ISTJ-13%	Thinkers-86%
Feelers-12%	Sensing-80%	Intuitive-18%	Judgment-96%	Perception-2%

Whatever its size, the ESTJ organizations grow very big. This kind of organization has an administrative or an operational flavor to it. It runs its show and does it well. It has rules. There are clear responsibilities and definite procedures, and they are consistent and logical. Details are attended to. The bottom line is what counts, and there is a

distrust of the abstract, the soft, or the unquantifiable. Time is money. There is a no-nonsense quality to the organization that is reassuring- but also limiting.

That same characteristic suggests that whatever dissenting voices there may be at best quibblers and at worst troublemakers. So ESTJ organizations do not get the benefit of alternative points of view very often.

The ESTI organization tends to be hierarchical. Status counts for a lot, and turf is important. Credentials are taken seriously, and the standards of the organization are likely to be both firm and orthodox. Standard operating procedures are used to hold variance to a minimum. There is an acceptable way to do everything, and that way is generally thought to be fairly obvious.

With its logical procedures, the ESTJ organization coordinates different efforts well. It sticks to schedules. It works out its plans carefully and doesn't spin off wild, risky ventures. Perceptions are tested before they are acted on-unless they fit with the collective wisdom and then they may be followed unthinkingly. The "right" kind of people feels they belong here and that their effort will be rewarded.

The ESTJ organization is solid, but the flip side is its rigidity. It is not very responsive to individual differences and may be impatient with prima donnas and superstars who are likely to be happier elsewhere. (Sad to say, even some very mild individualists find themselves called prima donnas.) In sending such folks packing or not hiring them in the first place, the organization loses out on a good deal of creativity.

Whatever its size, the ESTI organization acts like an institution that has been there for a while and means to stay. It is most at home in an environment that is not changing too fast, for it doesn't like to make fast turns or sudden reversals. It may have trouble spotting trends quickly, though it can get everyone focused on the trend when it finally does. It isn't likely to be very good at developing radically innovative new products or services, though it delivers whatever it does do efficiently and on time.

Denial can be a problem with this type of the organization—denial that any thing has really changed, then denial that the time —tested ways are inadequate. When denial breaks down, people become disoriented. This smoothly run organization can turn into chaos almost overnight.

The people who fit best in the ESTJ organization like things to be predictable. They are realistic people who aren't easily swept away by hunches or sudden insights. They mistrust feelings and often pass off a concern or an issue as "merely personal." They like interactions within the organization to be a little formal, and they have a soft spot for traditions. Deferring to superiors is not uncomfortable for them, and with the passing years, they grow into the tried and true workers who can be counted on to know the best way to deal with practical difficulties.

ESTJ organizations have a tendency to preserve and protect things-to insure that things

will happen as promised. That is their manner, but it can also be their business-that is, such organizations are often found in fields where the task is to establish something and then keep it there.

Any organization may go through a sort of ESTJ phase when it is coming out of a change or riding the calm waters between changes, for the ESTJ way is one of consolidating, system building, implementing, producing, anchoring, stabilizing, and regulating. As means to ends, these are essential qualities. Many other kinds of organizations fail because they lack them. But as ends in themselves, these qualities can spell trouble if the environment is changing quickly and constantly.

It is difficult to change the ESTI organization, partly because any habit is hard to break and ESTJ's thrive on habit, but also because the ESTJ organization takes its own collective wisdom so seriously. Innovative ideas usually come from individuals or small teams, and ESTJ organizations are likely to distrust individualism and little "maverick" groups. Furthermore, ESTJ organizations are highly prescriptive and full of expectations: People should do their duty, subordinate their personal needs to the general good, and act the right way. The ESTJ organization is a hard nut to crack.

In nut shell ESTJ people makes things moving, take realistic approach, embrace risk, remember factual information, persuade others to their point of view, have assertive style, seek action in immediate results. They may appear blunt and insensitive to others when acting quickly, rely too much on improvisation and miss the wider implications of their actions and get hooked by materialism.

ISTJ profile—the second prominent group in the company:

There are 13 % people belonging to ISTJ group. Such people are extremely dependable and have a complete realistic and practical respect for the facts. They absorb, remember, and use any number of facts and are careful about their accuracy. When they see that something needs to be done, they accept the responsibility, often beyond the call of duty. They like everything clearly stated. ISTJ are thorough, painstaking, systematic, hard working, and careful with particulars and procedures. Their perseverance tends to stabilize everything with which they are connected. They do not enter into things impulsively, but once committed, they are very hard to distract or discourage.

However, they may overlook the long-range implications in favor of day-to-day operations and may neglect interpersonal niceties. They become rigid in their ways and thought of as inflexible and may expect others to conform to standard operating procedures and thus not encourage innovation. They may also hesitate to try fresh alternatives to avoid ruts.

Many of the big manufacturing companies are ESTJ companies. So are the manufacturing or operations sectors in many large companies. IBM, as it has grown less introverted in recent years, is one. So are some of the United States phone companies, which have also learned that they have to pay attention to their markets. It's a similar story with

Kodak. In fact, many of the giant corporations used to be ISTJ, but then the new competition appeared, and everyone is hustling to become more extraverted.

However, the organizational profile is lacking executives having feeling and intuitive preferences. Low feeling preferences of people may indicate less concern of people for each other and busy with their own business. In lack of such profile ESTJ & ISTJ finds them, as there is no one to take care of them. Feelers work as healers during crisis.

INTJ— the profile of the Leader :

Though the company is lacking intuitive people however; an INTJ Executive leads the company. People with INTJ preferences are relentless innovators in thought as well as in action. They trust their intuitive insights into the true relationships and meanings of things, regardless of established authority or popularly accepted beliefs. Their faith in their inner vision can move mountains. Problems only stimulate them – the impossible takes a little longer, but not much. They are the most independent of all the types, sometimes to the point of being stubborn. They place a high value on competence – their own and others.

As a leader, they drive themselves and others to attain the organization's goals, act strongly and forcefully in the field of ideas, can be tough-minded with others. They conceptualize, design, and build new models and organize ideas into action plans. They have strong visions of what the organizations can be.

Sometimes problems may arise the INTJ's single-minded concentration on goals. They may see the end so clearly that they fail to look for other things, which might conflict with the goal. Therefore they need to actively seek the viewpoints of others. They also have difficulty letting go of impractical ideas.

SIS Profile :

The Somatic Inkblot profile suggests that except three persons others have shown more than 14 most typical responses (MT). MT responses are the indicators of conduct with reality, team building and working together. There are people who have more than 16 MT responses suggesting no conflict while working in a team. Such people either accept or make others to accept the ideas and keep the spirit of the team alive. Three persons those who had less than 13 MT responses showed neurotic profile. They had problems with their family members and even to their colleagues. They were administered psychotherapy. The three persons with inadequate personality profiles left the organisation in due course. The SIS profile is given below:

The Human responses are more than 20% suggesting their good interpersonal relationship. Animal responses were less than 20% suggesting their low frustration and aggression. They have shown good ego strength and self-awareness. Anatomical responses are indicative of body awareness though little higher responses may indicate tension because of existing business scenario and competing environment. Erotic

contents are within normal range. Pathological responses are almost nil except the presence of hostility and depression in a few cases. As a whole the SIS profile suggests high productivity of people, contact with reality, awareness of self, controlled erotic needs, controlled hostility and aggression and high on team building.

Table 2

SIS Response Pattern

Indices	Mean	Percentage
Total Response	65.57	---
Most Typical	15.24	---
Human	19.21	30.96
Animal	7.31	12.75
Anatomical	12.38	19.97
Sex	2.24	3.62
Movement	6.31	10.18
Pathological	0.19	0.21

The SIS test further helped in giving psychotherapy for their problems reflected through SIS images and narrated by executives. People appreciated the procedure and felt happy after therapeutic session.

The Type of HR Intervention Done:

1) Shop floor daily meeting.
2) Performance review.
3) Positive strokes for colleagues in a informal group.
4) Training on :
   a) Team Building,
   b) Strategic Leadership,
   c) Shared Vision,
   d) Stress Management,
   e) Communication,
5) Transparency in Performance Review.
6) Rationalization of Levels.
7) Small Group Activities.
8) Target setting by self,

The last intervention was by way of taking all Management Staff (90 people) to a Forest Resort amidst natural environment for two days. They got opportunity to share their experiences and express their ill feelings.

The program was desired to achieve following objectives :

a) Team building.
b) Open communication.
c) Improving interpersonal relationship.
d) Developing self-confidenc and
e) Target setting by self.

The group was divided into various teams and asked to choose their own leader. Various out door exercises were conducted. Later Heads of Department along with their work team were asked to prepare targets for the next 12 Months. This made them to feel important and gave confidence to the entire team that they can work on their own as well be interdependent on others. They appreciated such exercise and become closer than earlier.

Impact of HRD Intervention:

Phase I :

A climate survey was done in Jan 1999 and in July 2000. 11 variables were taken.

The comparative satisfaction score in percentages are given below :

Table 3

Impact of HRD Intervention

Variables	1999	2000
Aware of Organizational Goals & Objectives	23	66
Sense of belongingness	54	75
Remuneration	12	40
Organizational Culture	38	64
Communication System	54	74
Org. Role in Development of Individuals	26	63
Performance Monitoring System	25	54
Training & Development	25	83
Team Work	64	74
Self-Development	51	71
Growth Prospect	31	74

Table 4

In Terms of Production

1998-1999	0.97800 LCKM/Month
1999-2000	1.4700 LCKM/Month
2000-2001	2.4500 LCKM/Month

Phase II :

HRD Intervention:

The outcome of the first phase intervention encouraged and motivated us to arrange for the 2nd Phase for the year 2001-2002.This time the intervention was planned for the entire workforce of about 305 people of the company. They were taken to a forest resort for one day and made to under go various Team building exercises. The objectives of the program was as:

a) Performance review of previous targets

b) Setting up of new targets /goals

c) Redefining business scenario and

d) Total commitment

The main achievements during past 12 months, after first phase of the intervention in the organization, were highlighted and given below:

a) Capacity enhancement up to 40 lckm.

b) Modification of existing machines.

c) Designing new machines.

d) Bringing down the scrap level by 50%.

e) Cost of administration charges were brought down by 2%. etc.

Personality assessment of all the employees with the help of MBTI and Somatic Inkblot Video test (SIS) was done. Personal counseling was given individually to each employees and their strength and weakness were explained. Training program such as “Value Promotion”, “Business Ethics”, “Customer Satisfaction and Total Productive Maintenance” are being conducted regularly with the entire work force to promote team cohesiveness, re-alignment with business and empowerment to increase total effectiveness. Noticeable change in Team building and interpersonal relationship was perceived. The outcome of the second intervention will be reported towards the end of second phase.

Conclusions :

The business scenario and the impact of WTO on future business growth were explained to all personnel of the company. Different training programs one after another were organized to equip them with knowledge and skills. The regular meeting to highlight the progress of different teams in the company was done. Continuous improvement such as cost saving, increased production, scrap reduction, optimum utilization of resources and timely supply of materials were reported. On behavioral front Open communication and informal relationship have been noticed.

The impact of personal counseling worked in resolving their conflict, reducing job stress and promoting organizational culture. As a whole the impact of HR intervention were found to be very satisfying. The impact of this intervention will be reviewed once again after 12 months period and the findings will be reported later.

Reference :

Cassell, W.A. and Dubey, B.L. (1997) Somatic Inkblot Series-II/Video-Manual, SIS Center, Anchorage, Alaska (USA).

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 135-140

Mental Health During War : An Experience and Lesson from the Past

Amool R. Singh, K.R. Banerjee and Supraksh Chaudhury

The mounting tension among various countries is alarming and posing threat of nuclear war in future. The present study examines the trend of psychiatric disorders among military personnel during war who served in United Nations peacekeeping force in Congo. The incidence of psychiatric disorders was significantly more in young, inexperienced individuals with relatively short length of service, who had not seen or participated in war like conditions. The future perspective in context of the threat of nuclear war has also been discussed.

Since world war II, an increasing number of soldier have been deployed in UN peacekeeping forces. Very little is known about the psychological impact of such deployments. However, participation in combat has been found to have pathogenic effects (Ward, 1997). During battle, the stress of war may result in combat stress reaction also known as "battle shock", which is defined as a breakdown in a soldier's ability to function according to prescribed military duties (Solomon et al, 1988). Acute combat stress reaction encompasses a variety of combat induced polymorphous behavioral, cognitive and affective manifestations that result in impaired functioning or nonfunctioning. A number of studies over the last several year clearly indicates that war leaves long term psychological impact on the soldiers and other affected population. A definitive (PTSD). For the most part these studies including Bentosch et al (2000), Foy et al (1987), Green et al (1990), & Sharkansky et al (1990) have shown that combat experience and exposure to life threat, abusive violence or atrocities predict chronic symptoms of PTSD. The present study examines the trend of psychiatric disorders among military personnel participating in war with possible management plan for future in context to the threat of nuclear war, which is not a threat only for soldiers but also for the civilian population. Though the findings of the present study date back to the early 60's it does not seem to have lost it relevance even today. Time has changed mode and nature of war has changed but the stress faced by soldiers as well as the affected civilian population has not been reduced. Rather, it has increased due to the threat of nuclear war. Contemplating it disturbs serenity and complacency in a way that most of us would prefer to avoid. Most people recognize in some way at some level that the continuation of the nuclear race is a threat not only to the survival of civilization, but may be the survival of the human species (Grinspoon, 1982).

Material & Method :

The study included all the indoor psychiatric cases (exact number cannot be disclosed due to security reasons) admitted to O.N.U.S. Hospital, Leopoldville, Congo (now in

Amool R. Singh, Ph.D., Associate Professor and Head Dept. of Clinical Psychology, and Maj. Gen. K.R. Banerjee (Retd.) Director, Ranchi Institute of Neuropsychiatry and Allied Sciences, Kanke, Ranchi-834006 and Lt. Col. S. Chaudhury, MD, Ph.D, Associate Professor, Dept. of Psychiatry, AFMC, Pune-411040.

Zaire) during the period Oct 1960 to Aug 1961. Psychiatrists of United Nations Force including one of us (KRB) diagnosed all the cases. The psychiatrists treated the patients during the period of hospitalization. Methods of treatment followed were as under : (a) Rest and nutrition). (b) Pharmacotherapy (c) supportive psychotherapy (d) Physical therapy which included ECT, abreaction and so on. (e) Occupational therapy. The aim of the treatment was to return the patients to their units as expeditiously as possible. Those who did not recover within a month or so were repatriated to their home country.

Results & Discussion :

A large number of nations had sent varying number of personnel to United Nations Force operating from Congo. However, personnel from Afro-Asian countries exceeded those from Europe and America. There were civilian and men in uniform, as well as volunteers and conscripts. The strength of military personnel far exceeded that of civilians. Members of the fair sex were also represented among the civilians. The tenure of service ranged from six months to one year depending upon the nationality concerned.

Table 1
Demographic Characteristics of the Psychiatric Patients

Characteristic	Prevalence in Percentage	X^2	df	P
Age (in years)				
21-25	44.5			
26-30	23.5	46.78	4	<0.001
31-35	15.2			
36-40	7.5			
41 & above	9.1			
Service (in years)				
1-5	49.5			
6-10	32.7	78.09	4	<0.001
11-15	10.9			
16-20	2.6			
21 & above	4.2			
Rank				
Officer	5.04			
Sergeant	9.2	119.6	4	<0.001
Corporal	12.6			
Soldier	63.02			
Civilian	10.08			
Period of stay in Congo (in months)				
0-3	52.1			
4-6	34.4	83.32	3	<0.001
7-9	9.2			
10-12	4.2			

Details of the admitted psychiatric cases with regard to some selected variables are shown in Table 1. Chi-square values were calculated to determine the significance. From Table 1 it is clear that the maximum number of cases were significantly more in age group of 20-35 years. Downward trend started from 36 years onward. The table also illustrates that younger age group contributed to most of the casualties and it also shows that no age group was immune. Shorter the service more the problem is apparent from the table. However, people from all service groups were affected in various numbers. Further, the maximum incidence of psychiatric causalities is among the soldiers. Corporal, sergeant and officers in that order of frequency follow them. More than 85% of the total casualties occurred during first six months of service in the field and the incidence was significantly more among the people within three months of arrival to the war zone. There is a sudden drop in the number of cases in the last few months i.e. towards the fag end of their service tenure in Congo.

Table 2

Nations and Percentage of Cases with Different Psychiatric Disorders.

Nations	Anxiety disorders	Hysteria	Psychoses	Other disorders
Austria	-	100	-	-
Belgium	100	-	-	-
Canada	90.0	-	9.1	-
Columbia	100	-	-	-
Egypt	50	50	-	-
Ethiopia	-	-	-	100
Ghana	66.7	-	33.3	-
Guinea	100	-	-	-
India	50	25	12.5	12.5
Indonesia	100	-	-	-
Ireland	100	-	-	-
Itealy	100	-	-	-
Lebanon	100	-	-	-
Liberia	100	-	-	-
Malaya	33.3	33.3	16.6	16.6
Morocco	12.5	75	-	12.5
Nigeria	77.8	22.2	-	-
Pakistan	69.2	23.1	-	7.7
Spain	100		-	-
Sudan	-	-	100	-
Sweden	100	-	-	-
Tunisia	42.4	27.3	-	30.3
USA	100	-	-	-

Table 2 gives the incidence of psychiatric disorders in personnel from various countries. Maximum cases were from the categories of "Anxiety disorders" and "Hysteria". Here anxiety disorders included panic reaction and neurotic depression while commonest hysterical symptoms were fits, fugues, paresis and blindness. A small proportion of cases also suffered from psychosis e.g. manic-depressive psychoses, paranoid reaction and schizophrenia. Other diagnoses included cases with psychopathic personality, and some patients with mixed features of neurosis and malingering. After treatment 30.25% of cases returned to their units and the rest 69.74% cases were returned home for further treatment.

From the findings of the present study it is clear that the stress of war precipitated psychiatric disorders in some of the individuals. The incidence was significantly higher in young, inexperienced individuals with a relatively short length of service, who has neither participated in war nor experienced war like conditions, and had never been out of their home country before. Maximum incidence was noticed in the first three months of their arrival in Congo. During World War I and uptill the 1930s it was seen that the incidence of psychiatric and psychosomatic disorders increased during war and that hysterical reactions predominated over anxiety disorders. However, since Word War II and thereafter there has been a reversal of this trend. This is in agreement with out findings that anxiety states are more common than hysterical reactions. However, gross hysterical symptoms have been reported to be more common among Indian and African soldiers. This was also observed in Congo where most of the cases suffered from these two disorders. These however were not always seen in pure forms but usually coexisted in varying proportions.

Frontline treatment has been the prevailing doctrine for combat induced psychiatric disorders since the American Psychiatrist Solomon (1919) developed it. As per the principles of frontline treatment, afflicted soldier should be treated in close proximity to the combat zone as possible. Treatment should be started soon after the onset of symptoms and with the expectation of a quick return to combat. In the beginning treatment focuses on replenishing depleted physiological needs by satisfying the need for sleep, food and rest for a few days in a relative safe environment. During this period psychiatric intervention is carried out with drugs and allowing the solider opportunity to ventilate his recent traumatic experiences. Following this brief intervention, the soldier is expected to resume his military assignment. In case the solider does not recover after frontline treatment he is referred to hospital where he is treated with the help of pharmacotherapy and psychotherapy (individual & group). If required physical methods like ECT is also used.

Future Perspectives :

With technological advancement, the nature of war in the coming century will be entirely different. With the threat of nuclear weapons combat stress will not only be restricted to military personnel in the combat zone but on the whole population of the country involved

in war. The likelihood of acute anxiety reactions in an epidemic form cannot be ruled out. Some psychological problems, more somatic in nature because of environmental pollution due to excessive toxic gases and radiation liberated after nuclear explosion are likely to surface. The tragic experience of Hiroshima and Nagasaki are not yet faded away. Very little has been reported on the psychological reactions of children during war. Katz (1914) observed anxiety states and a minor epidemic of bed wetting in children under his care. Finally, posttraumatic stress disorders after war has also to be strictly managed on a long-term basis. Apart from nightmares, flashback, intrusive memories and amnesia for war experience, the patient with PTSD clinically also demonstrates alteration in memory. Bremner et al (1993) found deficits in short-term verbal memory among Vietnam veterans, which the result of a recent study by Bremner et al (1995) indicate may be related to alterations in the morphology of the hippocampus. Again hippocampus has also been hypothesized to play a role in binding together Individual components of memories that are stored in primary sensory neocortical areas (Zola-Morgan et al, 1990). Hence, vocational rehabilitation efforts should take into consideration potential deficits in memory function.

Speculating and analyzing these aforesaid points it becomes amply clear that the role of psychiatrists, clinical psychologists and other mental health professionals assume greater importance for providing quick services to the affected people. Medicines will be effective in some cases but at the same time individual and group counseling will be essential. The situation during war and thereafter will have to be tackled efficiently not only in hospitals but also in the community through group meetings to discuss the possible coping mechanisms relevant to the time and situation. We should have some well-prepared and structured educational material at our disposal, which may be used through various mass media available at the time of crisis. Senior hospital administrators and mental health planners should take immediate concrete steps to formulate some preventive, practical, feasible, cost-effective and structured package of management programs to cope with the stress and reaction of nuclear war.

Reference :

Artiss, K.L. (1963). Human behavior under stress from combat to social psychiatry. Mil. Med, 128 : 1011-1015.

Bentosch, E.G., Brailey, K., Vasterling, J.J., Uddo, M., Constans, J.I. & Suther, P.B. (2000). War zone stress, personal and environmental resources and PTSD symptoms in Gulf war veterans : A longitudinal perspective. J. Abnormal Psychol. 109 : 205-213.

Bremner, J.D., Steinberg, M., Southwick, S.M. et al (1993). Use of structured clinical interview for DSM IV dissociative disorders for systematic assessment of dissociative symptoms in posttraumatic stress disorder. Am. J Psychiatry, 150 : 1011-1014.

Bremner, J.D., Randall, P., Scott, T.M. (1995). MRI based measurement of hippocampal volume in patients with combat related PTSD. Am. J Psychiatry, 152 : 973-981.

Foy, D.W., Carroll, E.M. Donahue, C.P. Jr. (1987). Etiological factors in the development of PTSD in clincial samples of Vietnam combat veterans. J. Clin. Psychol. 43 : 17-27.

Green, B.L., Grace, M.C., Lindy, J.D., Gleser, G.C. and Leonard, A. (1990). Risk factors for PTSD and other diagnoses in a general sample of Vietnam veterans. Am. J. Psychiatry, 147 : 729-733.

Grinspoon, L. (1982). The threat of nuclear war. Am. J. Psychiatry, 139 : 10-11.

Sharkansky, E.J. King, D.W., King, L.A. Wolfe, J., Erickson, D.J. & Stokes, L.R. (2000). Coping with Gulf war combat stress : mediating and moderating effects. J. Abnormal Psychol. 109 : 188-197.

Solomon, T.W. (1919). The war neuroses and their lesson. New York State Journal of Medicine, 59, 993-994.

Solomon, Z., Kotler, M., Mikulineer, M (1988). Combat related PTSD among second generation holocaust survivors : Preliminary findings. Am. J. Psychiatry, 145 : 865-868.

Ward, W. (1997). Psychiatric morbidity in Australian veterans of the United Nations peace keeping force in Somalia. Australia & New Zealand Journal of Psychiatry, 31 : 184-193.

Zola-Morgan, S.M. & Squire, L.R. (1990). The primate hippocampal formaion : evidence for a time limited role in memory storage. Science, 250 : 288-290.

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 141-142

Diagnostic and Therapeutic Value of SIS-II Test

M.P.Singh and Nalini Mishra

The Somatic Inkblot Series-II was administered to a 20-year-old male student of graduate level who had a history of masturbation for last 3 years with a frequency of at least once a day. Because of this habit he developed guilt feeling and had a fear of failure. He got familiar with a female classmate but never had physical relation with her. He developed symptoms of withdrawal, avoiding meeting people, lack of interest in study, feeling of insecurity and odd thinking to commit suicide. He was given re-educative psychotherapy to channel his energy to academic activities. The result was very positive and the subject showed significant improvement. His suicidal ideation has gone and he has developed positive attitude towards life. The case in detail has been discussed in the paper.

The Somatic Inkblot Series (SIS) images have been found a successful therapeutic tool. Its efficacy has been described by different therapists. The SIS test was administered to a 20-year-old male student who had a history of masturbation. He developed symptoms of withdrawal, avoiding meeting people, lack of interest in study, feeling of insecurity and suicidal ideation. The SIS responses helped in understanding the unconscious process and planning for therapeutic intervention.

A few significant SIS responses are discussed for better understanding of the case:

5A: " Heart of a bird, a dangerous and a big animal behind it.." This response is indicating unfavorable conditions which are not allowing to meet his friend.

8A: "A man showing his private organ. " Erotic attraction is reflected through his image.

9A: " Two dancing puppets. " Instead of seeing human being he perceived dancing toys, indicating the person himself and his girl friend, made to live on desires of others. They are not able to enjoy like others.

14A: " A lady praying." Feeling of helplessness and remedial measures by depending on God has been reflected through this image.

18A: " Rat shaped stone or a bulb." Instead of seeing the common response heart he has perceived it as a stone, which might be reflecting his broken heart situation.

22A: " An extinguished lamp." Normally people see pelvic region and even male genitalia which he has avoided and has seen an extinguished lamp. This also indicates depressive content.

27A: " A Rat is trying to climb on the naked woman." Thought he has seen a naked

M.P.Singh, Ph.D. Lecturer in Psychology, Desh Bhagat College, Dhuri, Punjab (India) E-mail : drmps@usa.net and Nalini Mishra, Ph.D. Lecturer in Sociology, Maharani Banaras Mahila Mahavidyalaya, Ramnagar, Varanasi (India).

lady on this image, which might be very near to the common percept of female breast. The climbing of rat on the naked lady is not a healthy response. The small rat might be indication of sexual connotation of male sex organ representing subject's desire to be with his girl friend.

3B: " A crying squirrel." It again indicates the depressive content of the subject.

6B: " Meeting of two elephant." Erotic content is brought once again by perceiving two elephants who are in process of loving each other.

7B: On this image he has seen " An animal that is trying to come out." It indicates his desire to flee from the present unpleasant environment.

10B: "A man or man showing his private organ". Once again sexual preoccupation is brought back through this image. This may also indicate his frustrated sex desire.

12B: " A man is crying a lot, no one shows sympathy to him." This indicates his feeling of helplessness. He is not able to discuss his problem with others.

15B: " Weapons ready to kill somebody." His hostility and aggression towards someone has been brought out on this image.

20B: " A weeping African girl." The image has taken him back in time and reminds the side face of a girl who was acquainted with him while he was studying in a city away from his hometown. The girl wanted to make friendship with him and failure of which made her to cry.

22B: " A boy is sad due to pain in stomach. " This response again reflects his anxiety by seeing a sad boy having pain in stomach.

23B: " Fall of two trees." This response again reflects his depressive mood.

28B: " A lady waiting for her husband." This may indicate his desire as the girl friend that he left might be waiting for him. This may also indicate his own guilt feeling that he could not give company to his friend.

It can be concluded that SIS is a powerful instrument, which can peep into the inner deep and brings out traumatic memories. The process further helps as healing aid and relieved the symptoms of the subject.

References:

Cassell, W.A. and Dubey, B.L.(1997) Somatic Inkblot Series -II/ Video Manual. SIS Center, Anchorage (USA)

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 143-148

Alopecia Areata : Evaluation Using Psychological Tests and the Somatic Inkblot Test

S. Chaudhury, M.S.V.K. Raju, B. L. Dubey, T.R. John, S.K. Salujha and K. Srivastava

Fifty consecutive patients with Alopecia Areata (AA) and an equal number of age and sex matched control subjects without any physical or psychiatric disorders were evaluated with psychiatric interview and mental status examination, Sinha's Anxiety Scale, Carroll Rating scale for Depression, Toronto Alexithymia Scale, the Presumptive Stressful Life Events Scale and the SIS-II. Analysis revealed that patients with AA were significantly more anxious and depressed, obtained significantly higher Alexithymia scores and reported significantly more Stressful Life Events as compared to controls. The Somatic Inkblot Series-II test revealed psychological disturbances in 52% patients.

Alopecia Areata (AA) is a non-scarring hair loss in patches of typically well-demarcated smooth skin with breakages of the hair shaft resulting in characteristic "exclamation mark hairs". Hair loss often involves the scalp but can also affects the brows, lashes, beard, and body hair, and varies from a single patch to multiple patches or total hair loss. AA accounts for 2% of new dermatological outpatients in the United States, with an estimated 1% of the population having at least one episode by the age of 50 years. The incidence is equal in men and women and peaks during the third to fifth decade. The prognosis is variable : 20%-30% never recover from the first episode, and another 30% recover completely (Arnold, 2000).

Though first described 2000 years ago by Celsus (14-37 AD), its etiology is still not known with certainty. Although the autoimmune theory appears most promising at present, this does not negate the importance of emotional factors. Numerous anecdotal reports and systematic psychiatric studies have established that psychological stress is an important precipitating factor in some cases, but in many others it plays no part except when it arises secondary to cosmetic disfigurement and may then perpetuate it (Devar, 1983 ; Dawber et al, 1992). Many of these studies had important methodological shortcomings like use of non-standardized, subjective measures for the assessment of stress, anxiety and depression, lack of normal controls or control groups that were inadequately defined. In view of the methodological shortcomings of the earlier studies, the present investigation was undertaken.

Material and Method :

The study was undertaken at a large, multi-specialty, tertiary care hospital. Fifty

Lt. Col Suprakash Chaudhury, MD, Ph.D, Associate Professor, Col. MSVK Raju, MD, Professor & HOD, Lt. Col. Sudhir K. Salujha, MD, DPM, Associate Professor, Mrs Kalpana Srivastava, M Phil, Scientist 'D' (Clinical Psychologist), Dept. of Psychiatry, Armed Forces Medical College, Pune-411040 and Bankey L. Dubey, PhD, Director, SIS Center (India), Post Box 1107, Sector 15, P.O. Chandigarh-160015 and Maj T. Rajan John, MD, Psychiatrist, Command Hospital, Chandimandir-134 107

consecutive outpatients with AA formed the patient group. Patients were included in the study only after the diagnosis had been confirmed by the dermatologist. The control group consisted of age and sex matched subjects who were free of physical and psychiatric disorders. All subjects underwent a standard psychiatric interview and the following psychological tests :

1. Sinha's Anxiety Scale (SAS). The SAS is utilized to measure overall anxiety as well as anxiety such as social, psychological, economic and physical. The greater the score of the subject on the test, the higher is his level of anxiety. It is a clinically useful instrument for quick estimate of manifest anxiety (Sinha, 1968).

2. Carroll Rating Scale for Depression (CRSD). The CRSD is a 52 item self-rating version of the Hamilton Depression Rating Scale for the measurement of depression. Each item has a forced choice response alternative of yes or no. The scores are summed up to give a total score. The possible range of scores varies from 0 to 52. The CRSD has acceptable face validity and reliability. The concurrent validity of CRSD is also acceptable based on comparisons with the Hamilton Depression scale and Beck Depression Inventory.

3. Presumptive Stressful Life Events Scale (PSLE). PSLE scale is a 51-item scale suitable for measuring stressful life events for Indian population. It measures life events in lifetime and past one year. For the present study the past one-year events were measured.

4. Toronto Alexithymia scale (TAS). The TAS was developed using a construct oriented, factor analytic approach. The test consists of 26 items scored 1 to 5. Scores of all the items are summed to give the total score. Studies with both clinical and non clinical samples have shown that the internal consistency and factor structure of the TAS are stable and replicable. The test has been validated on normal and clinic population.

5. Somatic Inkblot Series (SIS) is a structured projective, diagnostic instrument and an adjunct to psychotherapy. It helps the therapist to peep into the inner world of the patient and allows hearing the inner cry of the individual. It brings out the unprocessed material from the unconscious. Somatic images provide a platform for catharsis and the patient feels released after viewing the images (Cassell & Dubey, 1995). The SIS-II a self-administered projective test was administered individually to each patient following standard procedure (Cassell and Dubey, 1997). Responses on the images were analyzed to find out pathological contents and psychological disturbances mainly in the area related to family, parents and occupation.

Results :

Demographic characteristics of the AA patients and normal control subjects are given in Table 1. There were no statistically significant differences among the AA patients and

control subjects with regard to age, sex, educational level, marital status, domicile and

Table 1

Demographic Characteristics of Alopecia Areata Patients and Control Subjects

Characteristic	Alopecia areata Patient (n=50)	Normal Controls (n=50)	P value
Age (in years)			
Mean	30.82	31.33	
SD	5.22	5.09	
Range	22-43	22-43	
Distribution			
20-29	23	22	
30-39	23	25	>0.80
40-49	4	3	
Sex			
Male	48	49	>0.95
Female	2	1	
Education			
0-5 class	3	1	
6-10 class	40	44	>0.30
11+	7	5	
Marital status			
Married	44	45	>0.70
Unmarried	6	5	
Domicile			
Rural	44	46	>0.70
Urban	6	4	
Family income (Rs./month)			
<4000	29	28	
4000-5000	16	18	>0.80
>5000	5	4	

family income. AA patients obtained significantly higher scores on SAS, CRSD, PSLE & TAS (Table 2). On clinical evaluation the prevalence of psychiatric disorders in AA patients (26%) was significantly more than that in controls (2%). Psychiatric disorders in AA patients consisted of adjustment disorder with depressed mood (n=7), dysthymia (n=2) and alcohol abuse / dependence (n=4). One control subject had alcohol abuse. Scores on SIS indices obtained by the AA patients and controls are shown in Table 3. In AA patients the Somatic Inkblot images revealed depressive content, hostility, feelings of insecurity, emotional blocking, lot of inner cry, conflicts in relation to opposite sex and unhealthy body imagery with preoccupation with his symptoms of hair loss.

Table 2

Scores of Alopecia Areata Patients (n=50) and Normal Control Subjects (n=50) on Sinha's Anxiety Scale (SAS), Carroll Rating Scale for Depression (CRSD), Toronto Alexitymia Scale (TAS) and Presumptive Stressful Life Event Scale (PSLE)

Tests	Scores of Aopecia Areata patients Mean (SD)	Scores of normal control Mean (SD)	P value
SAS	27.36 (16.14)	17.70 (16.18)	<0.05
CRSD	8.40 (4.87)	1.13 (0.46)	<0.05
TAS	65.56 (11.57)	52.31 (7.12)	<0.05
PSLE	3.94 (2.62)	2.06 (1.53)	<0.05

Table 3

Showing Comparison of SIS-II Indices of Alopecia Areata Patients (n=50) and Normal Control Subjects (n=50)

SIS-II indices	Alopecia areata Patient	Normal Controls	P value
Total responses	61.6	61.3	NS
Human responses	16.5	23.8	<0.05
Animal responses	10.9	7.2	<0.05
Anatomical responses	9.4	9.5	NS
Sex responses	2.7	6.0	<0.05
Movement responses	4.2	3.3	NS
Most Typical responses	9.0	11.5	<0.05
Typical responses	18.9	25.4	<0.05
Atypical responses	7.3	3.8	<0.05
Rejection responses	0.4	0.7	NS

NS = Not Significant

Discussion :

The finding of significantly higher levels of anxiety and depression in the AA patients as compared to normal controls is in agreement with few earlier studies (Mehlman and Griesman, 1968; Koo, 1994; Liakenpoulou et al, 1997). However, since the AA patients were symptomatic at the time of evaluation it is probable that the anxiety and depression

in the AA patients was secondary to their hair loss as a result of their dermatological condition. In agreement with the above it was found that the depressive symptoms preceded the onset of AA in only two of the patients with depressive disorders. The finding of higher number of stressful life events in AA patients as compared to normal control is in agreement with De Weert et al (1984), Mehlman & Grieserman (1968), Miller & Winkelman (1963) and Perini et al (1984).

The pathogenesis of AA is not completely understood, but probably involves genetic and immunological factors. About 30% of patients report a positive family history (Arnold, 2000), though in the present study a positive family history was given by only 6% of AA patients. Some preliminary evidence implies that AA is an autoimmune disorder with T suppressor cell dysfunction, and frequently positive response to immunosuppressant treatment such as corticosteroids or to induced delayed hypersensitivity reactions to a variety of sensitizers. Emotional reactions such as due to anxiety, depression or life events may adversely affect these mechanisms and play a role in the onset and exacerbation's of AA.

Similarly the presence of alexityhymic features prevents individuals from coping effectively with stress. The ineffective coping is due to the lack of affective awareness, which would permit identification of a particular event as stressful, and the tendency to use action as a primary generalized behavioral response. This ineffective coping would serve to prolong an individuals exposure to a stressor thereby adversely affecting the above mechanisms and play a role in the onset and exacerbation of AA.

Recent uncontrolled studies of lifetime co-morbid psychiatric disorders in adults with AA found that many had lifetime psychiatric diagnosis particularly major depression, generalized anxiety disorder and paranoid disorders (Koo 1999, Sharma et al, 1996). The finding of psychiatric disorders in 26% of patients in the present study is in agreement with the earlier studies. However, what was interesting to note was that after the findings of SIS were noted psychological disturbances were reported by 46% patient which is in agreement with an earlier work with the SIS (Sharma et al, 1997). This observation clearly underlines the diagnostic usefulness and clinical importance of the SIS.

Presently AA is treated by a combination of local and systematic medications. Apart from reassurance not much effort is made to alleviate the emotional distress of these patients suffering from a chronic and visibly disfiguring condition. Stress including life events including loss and reactive depression are commonly accepted as causative or precipitating factors for AA. It is obvious that reduction of emotional distress by appropriate psychiatric treatment will not only alleviate their psychological distress but may have an indirect beneficial effect on the dermatosis itself. While their treating physician can counsel most of the AA patients, psychiatric referral should be considered in severe or persistent cases. Psychotherapy is effective in some cases while others are helped by antidepressants. A recent double-blind placebo controlled trail of imipramine (75 mg/day) found that patients on imipramine had significantly more hair regrowth than controls, and this effect was independent of a reduction in anxiety or depression (Arnold, 2000).

Conclusion :

In conclusion we may state that AA patients have significantly higher levels of anxiety, depression and alexithymia as compared to normal controls. These emotional factors and stressful events are possible triggers in those with vulnerable personalities. The

SIS can be of immense help in identifying emotional distress in AA patients. The identification and treatment of emotional distress and psychiatric disorders in AA patients will not only improve their subjective well being but may aid in the treatment and even mitigate exacerbation's of this disorder. The role of liaison psychiatry in the management of AA merits further detailed evaluation.

References :

Arnold, L.M. (2000). Psychocutaneous disorders. In : Kaplan & Sadock's Comprehensive Textbook of Psychiatry. Sadock, B.J. & Sadock, V.A. Eds. 7th ed. Philadelphia : Lippincott, William & Wilkins. 1818-1227.

Cassell, W.A. and Dubey B.L. (1997). Somatic Inkblot Series-II Manual. Somatic Inkblot Center, Anchorage : USA.

Cassell, W.A. and Dubey, B.L. (1995). The use of the Rorschach and Somatic Inkblot Series in Releasing Somatised Grief. SIS J. Proj. Psy. Ment. Heatlh. 3 : 3-32.

Dawber, R.P.R. Ebling, F.T.J. and Wojnarowsha, F.T. (1992). Disorders of hair. In Textbook of Dermatology. Champion, R.H., Burton, J.L. Ebling, F.T.G. Eds. 5th ed. London : Blackwell Scientific Publication. 1533-1638.

Devar, J.V. (1983) Is Alopecia Areata Psychosomatic ? Indian J. Psychiat. 25 : 140-143.

DeWeert, J., Temmerman, L. and Kant, A (1984) Alopecia Areata : A Clinical Study. Dermatological 168 : 224-229.

Dubey, B.L. and Das, K.D. (1977) Personality Patterns of Alopecia Areat. Ind J. Clin Psychol. 4 : 45-50.

Koo, J.Y., Shellow, W.V., Hallman, C.P. and Edwards, J.E. (1994) Alopecia Areata and increased prevalence of psychiatric disorders. Int. J. Dermatol. 33: 849.

Liakenpoulou, M., Alifieraki, T., Katideriou, A, Kakourou, T., Tselalidou, E., Tsiantis, J. and Stradigos, J. (1997). Children with Alopecia Areata : Psychiatric Symptomatology and Life-Events. J. Am. Acd. Child Adolesc. Psychiat. 36 : 678.

Mehlman, R.D. and Griesermer, R.D, (1968) Alopecia Areata in the very young. Am. J. Psychiat. 125 : 605.

Miller, S.A. and Winkelman, R.K. (1963). Alopecia Areata : An evaluation of 736 patients. Arch. Dermatol. 88 : 290.

Perini, G. I. (1994) Imipramine in Alopecia Areata. A double-blind placebo controlled study. Psychother. Psychosom. 61 : 195.

Sharma, V.K., Dawn, G. and Kumar, B. (1996). Profile of Alopecia Areata in Northern India. Int. J. Dermatol. 35 : 22-27.

Sharma, V.K., Dubey, B.L., Muralidharan, S. and Kumar, B. (1997). Psychological profile of patients with Alopecia Areata SIS J. Proj. Psy. Ment. Health. 4: 161-166.

Sinha, D. (1968). Manual for Sinha W-A Self-Analysis Form (Anxiety scale) in Hindi. Varanasi: Rupa Psychological Corporation.

SIS J. Proj. Psy. & Ment . Health (2001) 8 : 149-152

Personality Assessment of Children with Psychosomatic Symptoms: Two Case Presentations

C. Coulacoglou, A. Tchinou and A. Michopoulou

The Fairy Tale Test (FTT), the Somatic Inkblot Series (SIS) and the family drawing tests were administered to a 11 years old girl and 10 years old boy, to evaluate their personality and its relation with their body. The FTT revealed high ratings on Self-Esteem (T= 14.6), Desire for Superiority (T= 75.4), Aggression as Dominance (T= 69), Aggression as Envy (T=72) and Need for Affection (T= 84). The SIS images revealed poor interpersonal relationship, disturbed body imagery and psychosomatic symptoms. Their only common symptom was low Self-Esteem. The cases are presented in the paper.

As strange as it sounds, psychosomatic symptoms may appear as early as a few months of age. The earliest disorders to be met appear in the areas of breathing, sleeping, feeding, elimination, and skin sensitivity. According to Anna Freud (1981) these disorders do not have a genuinely organic basis and their appearance can be interpreted in terms of the modes of interactions between the infant and the primary caregivers, most commonly, the mother, "her more or less skillful or insensitive, well – or ill- timed response to the infant's needs; or these disorders can be traced to the infant's high sensitivity to the mother's emotional states, her anxieties, her moods, her predilections and her avoidances" (p. 19).

During the early stages of development the mind easily accesses the body and vice-versa. This access forms the basis for the infantile psychosomatic reactions and "which remains the habitual manner of discharge of tension, until, with progressing mental development, new pathways will be opened up via thought, speech and purposeful action (p. 20). Since the Studies on Hysteria it has been considered a mystery why the patient selects specific body parts or organs to express his psychic conflicts and mental state. According to Anna Freud (1981) the answer to this question may be found in the concept of " somatic compliance" which renders certain body parts or physical functions (skin, intestinal tract, breathing, limbs, movement) more useful for this purpose than are others.

Case Study 1 :

11 –year old girl with stomach pains, a desire to vomit, and headaches.

The first case study is about an 11- year old girl that we shall call Anna. Anna lives with her parents and an older brother (18 years). They come from a low socio-cultural background. Mother describes the relationship between her daughter and herself as good. She said that Anna seeks the attention of the mother and wants to be told that she loves her. Father works all day and comes home late in the evening. The relationship with her older brother is not good. When Anna was born the boy was jealous of her and hit her. Gradually as he grew older he has accepted her, but now it is Anna who rejects

Carina Coulacoglou, Ph.D.,Psychologist, A. Tchinou and A. Michopoulou, University of La Verne, 40E, Esperou Str. Kifissia, Athens 14561, Greece E-mail : carina@hol.gr

him. She competes with him because he was a good student (now he is studying to go to College).

The main reason that they visited the Psychological Center was because of her difficulties in spelling (Her IQ is within the normal limits). She makes a lot of spelling mistakes when she writes. During the interview with her mother, the psychologist found out about Anna's bodily symptoms. She feels relieved when her mother takes care of her. These pains appear more frequently when she is at home than when she is at school. She is very anxious about her performance, especially during exams. Although she studies hard she does not perform well. She sleeps in the same room with her brother. When he comes late at night she waits up for him, as she does not want to sleep alone.

Anna was administered the Fairy Tale Test (FTT) (Coulacoglou in press), the SIS and the family drawing in order to evaluate her personality as a whole as well as her relation with her body. The FTT revealed high ratings on Self-Esteem (T= 14.6), Desire for Superiority (T= 75.4), Aggression as Dominance (T= 69), Aggression as Envy (T=72) and Need for Affection (T= 84). Some of her most characteristic responses are presented below:

"What does each dwarf think?"

Card 1: He thinks that he is very fat and stupid.

"What does each witch think?"

Card 3: She wants to be the most beautiful in the world and to destroy all the others.

"What can a wicked witch do?"

She wants to destroy the plants and animals that she dislikes (?) because they are prettier than her.

The qualitative analysis of responses revealed the appearance of the defense mechanisms of Undoing, Denial, Displacement, and Rationalization. All her defense mechanisms are motivated by her inability to acknowledge her aggressive tendencies (E.g. "This giant is very stupid, he would not hurt anyone" - Denial). A sense of optimism is reflected in some of her responses. For example:

"Who is the dwarf in the story of Snow White?"

Card 3: He is the most wise and always hoped that she will get well.

The SIS projective technique revealed anxiety and pressure, emotional distance from parents, aggressive attitude towards parents, disturbed body image and psychosomatic symptoms. Finally it revealed good ego strength, a sign of good prognosis. The following are some characteristic responses in the SIS:

Card I: Two clouds and underneath an armchair, with two pieces of wood and a dog in the middle.

Card VI: Two fish ready to catch some food and a fish skeleton next to them. Two eyes watching them.

Card IX: A water tap.

Card XIV: A sea animal that bites.

Discussion :

The two projective techniques revealed different aspects of this girl's personality. The FTT offers information on a large number of personality variables. In the present case it was found that underneath this girl's psychosomatic symptoms lies aggresion motivated mainly by envy and dominance, desire for superiority, need for affection and low self-esteem. It appears that low self- esteem which appears to be related to her brother's academic achievements, motivates her need for affection from others. This need for affection is confirmed through the interview with the mother. Her desire for superiority as well as her aggression probably stem from her low self- esteem. Her low self – esteem may be attributed to her learning difficulties and her inability to perform satisfactorily at school.

The Somatic Inkblot Series (SIS) an instrument that mainly contributes to the assessment of psychosomatic problems, revealed their existence in the subject's responses. In addition, responses reflected emotional distance from the parents. Both tests reveal ego strength and optimism which are signs of good prognosis in overcoming her emotional conflicts.

Case Study 2 :

10 year - old boy with Alopecia Areata :

George is a quite boy who speaks little and slowly. There is a sad expression on his face. George lives with his older brother and his older sister. He is the youngest in the family. Mother describes the relationship between George and his siblings. He is not aggressive but he defends himself when teased or hit. She said that his alopecia appeared 6 months ago. She said that George is perfectionist and is a very good student in his class. The incident that triggered the problem, according to the mother, was a theatrical performance at school in order to celebrate a Greek national holiday. George was asked to perform a difficult role by his teacher to which he could not respond. She pressed and scolded him all the time. Then she gave him another role but again pressed him to do his best. Finally she asked him to recite a short poem. After a few days his hair began to fall.

His responses on the FTT were generally short and their content was common. Quantitative analysis demonstrated low Self-Esteem (T= 14.6) and Depression (T= 78).The following are some characteristic responses.

"What does each dwarf think?"

Card 1: He thinks that he is short and old.

Card 2: He thinks that he has a beard and wears a hat. He wants to sit underneath the mushroom (?) he is tired.

In the qualitative interpretation of responses the only mechanism revealed was Repression: “This wolf wants to sleep. He feels nothing”

His responses on the Somatic Inkblot Series (SIS) revealed low Self- Esteem, tension and stress. Psychosomatic symptoms are reflected in the avoidance of body imagery. The following are some characteristic responses to the SIS :

Card IX: "Two trees". Normally people see "Kidney" on this image. Avoiding body imagery may indicate somatic pre-occupation.

Card XIII : "A scarebee". It may indicate his painful past and pensive mood.

Card XVII: "A bird". Normally people see spinal column on this image. He has avoided body imagery, once again indicating psycho-somatic problems.

Discussion :

The most characteristic feature, common to both protocols is limited fantasy reflected in the short and abrupt responses. In the FTT depression is revealed in his expressed feelings of sadness, loneliness and tiredness.

Conclusions :

The presentation of these two cases aimed to show the different personality structures of two children with psychosomatic symptoms, belonging to separate classifications, however, their only common symptom was low self – esteem. It would be interesting to study the personality structure of children with different types of somatic symptoms.

References :

Cassell, W.A. and Dubey, B.L. (1997) Somatic Inkblot Series-II/ Video Manual, SIS Center, Anchorage, Alaska, (USA).

Coulacoglou, C. (2001). Fairy Tale Test. Manual. Multi Health Systems, Inc. In press.

Freud, A. (1981). The Writings of Anna Freud. Vol. VIII 1970-1980. New York: International Universities Press, Inc.

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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 considred in lieu of Vol. 3-8 for future reference.

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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). E-Mail : drcassell@corecom.net
Web Site at http: //www.somaticinkblots.com

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,
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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@hotmail.com OR sisdubey@rediffmail.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

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