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Contents

		Page Nos.
1.	Editorial : **Bernard I. Murstein**	1-2
2.	Somatic Inkblot SeriesVideo: Case Report and Discussion, **Wilfred A. Cassell and Donald Fields**	3-15
3.	Effect of Sodium Pentothal on SIS-Video-A Inkblot Images, **D. Saldanha and B.L. Dubey**	16-21
4.	Bereavement and Hypnosis: A Case Study, **George Savage**	22-31
5.	The Relationship of Stimulus, Projection, and Pathology in Projective Techniques and the "Levels Effect", **Bernard I. Murstein**	32-40
6.	Body Imagery in SIS Test, **S. Ramachandra and S.K. Chaturvedi**	41-47
7.	Diagnostic Efficacy of Somatic Inkblot Series-II among Psychiatric Patents of Armed Forces: A Preliminary Study, **S.P. Rathee, V. Pande and A. Singh**	48-52
8.	Reliability and Validity of Somatic Inkblot Series Tests, **S.K. Verma**	53-56
9	Diagnostic Significance of SIS –II, **S.K. Verma, D. Pershad, R. Kaur, and R. Nehra**	57-60
10	Diagnostic Utility of Somatic Inkblot Series, **B.L. Dubey, Wilfred A. Cassell, D. Pershad and Padma Dwivedi**	61-67
11.	Hospitalized Suicidal Patients and the Somatic Video Procedure: A Descriptive Study, **Elizabeth N. Bellamy**	68-73

SIS J. Proj. Psy. & Mental Helth (1995) 3: 1-2

Editorial

I am pleased and honored to have been not only to contribute an article for this issue, but to write the editorial as well. I would like to use the opportunity to briefly explain the philosophy behind my article.

Projective techniques were born as a revolt against the paper and pencil tests of the half of the twentieth century, which were extremely susceptible to “social desirability” effects, or the tendency of test-takers to present them in the most positive light. The efficacy of these paper and pencil test at that time was largely dependent on the test takers willingness to reveal their inner selves, assuming that they actually knew themselves very well, which was rarely the case.

Projective techniques were envisioned by their creators as depth instruments which could penetrate the individuals’ defenses and would thereby provide royal road to the unconscious. With the aid of hindsight, we can see that this claim was widely over stand. The mixed evidence in support of these and other claims by friends and foes of projective techniques was reviewed over a third of a century ago (Murstein, 1961).

Two main criticisms by the critics were, first that the techniques did not correlate highly with overt behavior and second, that they did not correlate highly with other paper and pencil tests, and were therefore, invalid. The critics failed to grasp that these techniques were exactly that-techniques, not tests in the psychometric sense. As techniques they were highly dependent on the skill of the examiner. Just as a Stradivarius violin in the hands of a chimpanzee would nor result in beautiful music, an unskilled, or insufficiently trained examiner should not be expected to utilize projective techniques to their full potential. Thus, projective techniques are neither valid nor invalid. They represent only potential and opportunity. The fact that we are dealing with techniques, however, does not mean that more empirical research is not needed.

The finding in my article in the current issue that “Projection” and “pathology” as measured in a number of projective techniques corralled highly in two independent studies indicates that there is some thing radically wrong with our assessment remaining in projective techniques. Any upgrading in training ought to start with an appreciation of the stimulus properties of projective techniques. Some norms and empirical research on the stimulus properties of a number of projective techniques already exist, and when clinicians analyze responses, these norms can aid greatly in differentiating the presence of pathology from normal test-takers respect for the stimulus properties of projective techniques. These data have already taught us, for example, that complete ambiguity on the TAT does not illicit maximum projection, because in the absence of a stimulus, the test-taker becomes cautious. In fact, medium-ambiguous cards reveal the most meaningful responses.

We need more research on the structure and use of projective techniques and on the assumptions underlying them, as well as more recent norms, particularly on how pathology-free individuals respond to the various techniques. We need to teach students how to detect signs of mental health, rather than regarding mental health as simply the absence of pathology. Only when we have accomplished these tasks can we validate the claim that projective techniques can indeed give us insight into personality beyond that provided by paper and pencil tests.

Reference:

Murstein, B.I. (1961) Assumptions, Adaptation-level, and Projective Techniques. Perceptual and Motor Skills, Monograph Supplement 2-V 12, 107-125.

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SIS J. Proj. Psy. & Mental Helth (1995) 3: 3-15

Somatic Inkblot Series-Video: Case Report and Discussion

Wilfred A. Cassell and Donald Fields

SIS Video has been found to be a powerful test in understanding the inner world of the suffering individual. It brings out unprocessed material from the unconscious, which needs processing. A case report of 30 years woman suffering from episodes of anger with history of physical and family sexual abuse has been presented to see how SIS could take the patient back in time and help in processing unconscious material. Discussion among Drs. Wilfred Casssell, Donald Fields, William Earl, Evelyn Wiszinkas, and Kathleen Addison in a conference on Jan 31, 1994 at Kodiak Alaska is given to highlight the clinical relevance of the test.

The Somatic Inkblot Series (SIS) was originally conceived in 1959. After years of research and filed-testing, the SIS Video (SIS II) is now available. It provides a diagnostic and therapeutic video viewing experience, consisting of five segments:

1 A series of beautiful flowers to reduce test anxiety.

2 An instructional section in which a “subject” illustrates how to give free associations to a video inkblot.

3 An induction period in which semi-hypnotic relaxation suggestions are given.

4 A test section in which 62 specifically designed images having color, structured form and, at times, movement are presented.

5 A recovery portion in which a series of non-threatening nature scenes, combined with upbeat music, bring the viewer back to the time and space reality of test situation.

The viewer then writes responses on an answer sheet with outlines of the 62 images. Most of what included in the ambiguous structure relates to specific life situations and posttraumatic dream content that has been found to have clinical significance. Viewing the SIS has both diagnostic and therapeutic applications that are far reaching.

The SIS Video is highly innovative. It takes the viewer away from present reality. If there is unresolved painful material in the past memory storage-through the magic of television, the projected responses will tend to be shaped by this material. This can emerge even through the viewer may have long forgotten the buried traumatic images and their associated affect. It facilitates the expression of feelings and earlier forgotten life events underlying may forms of mental illness and conversion pain. When the viewer relates those images, which are the most threatening, the examiner gets a quick psychological overview of the subject. The technique enables the professional to more readily empathize.

The administration of the SIS is designed to maximize the pulling power of inkblot projection. The subject is given an answer booklet. The first section includes a health

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questionnaire. The process of filling out the health questionnaire creates an immediate perceptual set to project images related to medical and psychiatric problems, for themselves or for loved ones. The space/time dimensions of the viewing situation are subtly altered by the video presentation of mesmerizing flowered. These are electronically transformed so the viewer experiences a magical feeling of traveling through a mental garden of beautiful followers. This dares the subject away from the present reality, back in time to episodes of previous illness or trauma. Following this sequence, a photograph of a beautiful mountain followed by an artist's rendition of the same scene, heights the hypnotic effect.

Next, an example of a person responding to a typical inkblot is cited to show the viewer how to fill out the answer booklet. After this presentation, audio suggestions to relax set the stage for slipping further back in time and re-experiencing images of illness or post traumatic dreams. During the initial viewing the subject is entirely alone just as in dreaming. This eliminated the inhibiting effect of another's presence.

By writing responses, rather than verbalizing them, just like in hypnotic writing the subject may more readily access and release painful material. In addition to the cathartic, therapeutic responses, the person may gain some insight and sense of mastery of the traumatic material by the act of drawing and labeling the images. Also, when the procedure is assigned repetitively over time, the experience of the healing followers, in association with the threatening, anxiety-laden images, may serve to desensitize the viewer.

In many instances, there is a sufficient richness of material elicited by interviewing the subject concerning the "threatening" images that little more needs to be delved into. In this sense, for the busy clinician or interviewer, the procedure readily serves as what has been referred to as a "quick and dirty" test Occasionally an insightful subject may, after having completed the procedure, or having experienced previously repressed post traumatic dreams, open the interview with a statement about how helpful it was. This person may simply wish to elaborate on memories of past upsetting experiences such as an emotionally unresolved abortion, a miscarriage, past psychological, physical or sexual abuse, or the witnessing of an accident, etc.

Given the power of the technique, it is rarely necessary to review associations to the entire 62 images. However, the psychologist, who becomes sophisticated concerning content analysis and symbolic interpretation, may glean much additional information from an overall scrutiny of the responses.

Applications of this procedure have proven to be far-reaching and international. The use of graphic images, rather than words allows the SIIS Video to cross both cultural and language image boundaries. The number of uses in medical diagnosis psychological assessment and psychotherapy is rapidly growing. It is anticipated that in the 21st century, all students of the healing arts and psychology, during their training will have the opportunity to be introduced to this technique. Currently, a complete data bank is being developed where individuals from various SIS Centers around the world

may submit data and assess information via modem or facsimile communication. This could truly be a comprehensive artificial intelligence system to be employed for good in a world beset by evil.

A spontaneous case conference was held in Kodiak Alaska (USA) on Januarys 31, 1994. A transcript from a tape recording of that conference follows.

Dr. Cassell: This is spontaneous case conference in Kodiak, Alaska, doing some associations with a patient who has been in therapy for a while with the somatic video procedure. We hope this information is useful for various clinicians especially those interested in doing meaningful therapy.

Don Fields: This is a case, which is really striking for me. It shows how powerful the Somatic Inkblot Series can be. One of the things I am struck by is its ability to bypass a lot of consciousness, a lot of repression, a lot defenses and really pinpointing and targeting the personal images of pain and loss, or trauma, as well as targeting an individual kind of images of what we consider healing-individual images of what they aspire for, ideals which, when you contrast them also give you some sense of the depth of trauma of loss, sometimes even more so than looking just at the images that have a high negative affect content.

I am going to talk about a young Asian woman, 30 years old. She came to therapy presenting with a long history of depression, just about as long as she can remember, increasing episodes of anger, a conscious and admitted history of physical abuse (familial), some sexual abuse (also familial), and the loss of a parent at an early age.

I had her do the SIS. When we started to do the debriefing after the administration there was a situation in her life that struck home with one of the images so we started debriefing with an image that actually was not selected as one that she liked least or one that she liked best. This is the image. It is A30.

What had happened was after the administration of the Somatic Inkblot Series she had a fight with her spouse and felt unable to really respond to it though, somehow that struck a card and she came in and wanted to see the image. Instead on starting in on the one she liked least, we went directly to this one. The responses that she has initially put down were simply “ the skull of a person who cannot speak”. So we went ahead and debriefed this image and the affects that went with it were sadness, powerlessness, the eyes are wide, part of the skull is aware, so there is some sense of awareness. It is not death but inability to express, inability to speak.

The somatic responses that went with the image had to do with tightness around the throat and jaws-a kind of swallowing feeling. That certainly goes with in expression of feelings. As we began to move from the associated somatic feelings and affects, she began retrace the last physical abuse situation she had experienced.

Her paternal grandmother from the United State shows up and evidently a couple of the older sibling knew about this, to take her and another sibling with her back to the United States. They were not allowed to take any of their belonging with them-only the

clothes on their back. As she was taken out to the car, she wants back into the house to retrieve some toys. (It was around Christmas time). She was left in the car for over 24 hours, feeling fear, helpless, and intimidated.

The interesting thing was that as we debrief this that trauma situation was the latest in a long line. Months later, as we were processing through a wad of information, we came back on this time and time again. That is one of the things I would like to emphasize that is really useful with this. The images that are so personal for a person tend to be thematic on all levels. They are happening within a person's interactions now, they have happened in their recent past, they tend to be associated with early experience and trauma. Maybe I can illustrate that by mentioning how the skull of a person who cannot speak related to a recent trauma as well as early.

This woman's mother died when she was only 4 year old and she was not living in the United State at the time. The father was very strong and intimidating even then. She was very close to the mother, the youngest child. Within a few months after the death of the mother, suddenly one night the paternal grandmother from the United State shows up ad evidently a couple of the other siblings knew about this, but showed up to take her and another sidling with her back to the States. They were not allowed up to take any belongings with them, only the clothes on their back. As she was taken out the car she went back into the house to try to get some belonging, some teddy bear like things. It was right after Christmas and she wanted to take some Christmas gifts as well. When they saw what she was doing, the grandmother took the things out of the car and put them back into the house. She was told to be quite. The scene that followed was her getting up on the back seat and crying and yelling. The grandmother pulled her down onto the seat and put her hand across her mouth for quite some time and did not let her speak, did not let her say anything.

That is a very poignant kind of situation. What is even more poignant is this was little girl who didn't speak English and was then brought under those circumstances to the United State. She was told that all she could speak was English and was not allowed to speak her native language so she should not articulate anything. It was years before she could be familiar enough with the English language that she could really articulate and by then a lot of this was really repressed.

So, there we have an example of an image that came up from a response in day-to-day life that was directly linked to recent trauma or the end series of a long series of traumatic abuse experiences where she was intimidated into silence, too. This is a big thigh in this person's life-the inability to speak and the need to find a voice to be able to express oneself (Image A23).

Evelyn: Don could you explain again how she focused on this here in her session. Did it come back to her? Has she been thinking about it" How did she come to on that image? After she took test one day, did she thing about that image and come back after she had the argument" Did she dream about it? Is than an image that kept coming back to her after the argument?

Don Fields: She took the test was set up to see me the next week and we were going to begin debriefing. Typically, I would have started with either the one she liked least. We were trying to hit on both of those the someday. What had happened was his arguments had struck a nerve with this image and the image stayed with her. I am not sure if it was several days or if it was just one day before she came in, I'm not sure about that. But, she came in and this was not one that had been identified as least liking or liking at al, but it just stuck with her, so we started with it. It was real helpful because it certainly has been part of a central image in her treatment over and over again.

All of the images that you find, in particular the healing ones or the ones that have both a sense of trauma as well as the direction of healing or recovery are real important and you can begin to integrate them when you see and very quickly a person you can say this image or that image and they immediately drop into an awareness, and over a period of time begin to experience the image in a different way as recovery takes place.

The next image we are going to look at is the one she liked lest so, this would have been the first negative one we would have debriefed. Her initial response when she completed the Somatic Inkblot Series was "a large insect. The bottom part is the mouth". She then has an arrow pointing and wrote out "the mouth". This was the one that she liked the least, or that evoked the strongest negative emotional response. It gave her kind of a crawly, yucky feeling, kind of disgusting and crazy. As we debriefed it she said it had to do with the shape-thin at the bottom and larger at the top-kind of like a tool. As we continued on with the debriefing it became "more like being in a corner and an insect is one my leg crawling", and then she associated panic responses with it.

From there the association went to "like when people tickle me I want to control " What she related was at this point in her life when people try to tickle her she-has a very strong aversive response and almost automatically begins to fight and punch and bite-a real primitive, protective response.

What we eventually came back to and what this brought back to subconscious awareness was several episodes of an older brother who would tickle her until she cried and also use this as a prelude to fondling her. He would tickle her and then tell her to relax and she would have this panic feeling and wanting to fight. Part of the ongoing way we used this image was she was able to label this particular older sibling as a creep and someone who bugged her. So we went from a very powerful, intimidating, controlling kind of image to one that became a little more neutralized and one that became an image that she could use as part of her healing.

Dr. Cassell: Don, does it have any relevance that there is, in fact, a high degree of somatic content in this image? Many people see this as a spinal cord and also, it appears from working with different patients that, in fact, it has some phallic connotations.

Don Fields: Yes, I think that the phallic association, "the tool", is really the somatic response that she was giving. I think that it was too threatening for her to say that directly, so she began to describe it in some round about ways, in ways that were more consistent with what she could handle.

Dr. Cassell: Could you answer that again please?

Don Fields: The question had to do with the imbedded somatic imagery and this image has to do with both the spinal column and phallic symbol. I think that the phallic symbol is finial what this person was responding to, but her responses, her descriptions were in more of a round about way with some distance in ways which her consciousness could handle, rather than directly saying “this is a phallic symbol, this is someone trying to violate me. “So, her descriptions were more consistent with what she could deal with. But it definitely came back to a sexual abuse episode and episodes. Part of what we want to mention with that is that it was not necessary for her to make the direct identification of this as a sexual organ in order to get to the episodes of sexual abuse. It was enough to evoke some subliminal or unconscious kinds of responses, which consciously expressed in a way that she could handle, that weren’t going to be overwhelming for her. To me this means she has some degree of ego strength.

I would like to more on to some positive images, in particular, two that we also used. The first is (A7). But before I go through the personalized associations and images that go with these positive ones, again, I’II just remind you of this person’s background of severe loss and trauma at an early age, several incidents of sexual and physical abuse, the trauma of being thrown into a different culture and not allowed to speak her native and childhood language.

The first positive image she identified was A7. Her initial response was “ A flowing and loose person”, She described movement in the lines. There is movement in the color and that is probably what she saw with movement in the lines. The associations had to do with being carefree, smooth movements, young children figures, kind of elementary age. How kids move in a very spontaneous and carefree, kind of way. She identified the upper image as an apple. The general theme was colorful and somewhat that represents freedom. The affects are hopeful and this person actually said directly. “This is who I want to be-happy with myself”. The boundaries are distinct and very defended but positive. The ideal of control is flexible. That person would know when it is okay to be silly, this is one of the things she identified-a part of how she wants to be the child within.

As we debriefed this image, she was able to identify literally to events what were separate tag took place when she felt like this. One was just before her mother died and the second was when she was in the seventh grade when she was on a camping trip with the aunt who she had some nurturing kinds of associations with. After identifying these two real discrete times of actually feeling this way, she became very tearful and said it had been a long time since she felt this way. This became part of her personal image goal of who she wants to be spontaneous, flowing, a goose sense of personal boundaries but flexible control having to do with flexibility, knowing when it is okay to be silly, knowing when it is okay to be serious. As you can imagine, this was a person who was always series.

Evelyn: As you are describing some movement for that individual or some insight, do you feel that the series facilitates that and makes it happen more quickly than it would perhaps with ordinary psychotherapy? Would it take longer using the usual, traditional approaches that it does with this particular process?

Don Fields: That is a good question. I think the answer has to do with the idea that people bring themselves and their images to therapy. Some people are able to articulate them directly, some people are able to articulate them in secondary kinds of way that, as therapists, we can pick up on a thread and begin to help them flesh in, if you will. May people, like this person, bring in an inability to identify the images and it is very difficult to identify their personal images and ideas both or trauma and possible healing, but, one of the things we need to recognize is when we do that we are using our own projections, perhaps too much for these people, and they may not connected with them. I think with the Somatic Inkblot Series or other projective techniques then what we have is a direct access to their personalized images that they don't have awareness either. Definitely, it makes the course of treatment move along quicker, because then what we are working with are their own images of trauma and healing, which are the images that need to be used for long-term integration.

Evelyn: I also wonder if, by having the series and talking about them in a close time frame, if it allows images that, like you said, are there for the individual, but are possible fragmented, to be juxtaposed so that connections can be made for the individual. For instance, an instance, as you said, what could have been playfulness that turned into something that was frightening and traumatic for her, that memory (in discussing it close in time to this one) become juxtaposed with a wish that also was there of being able to experience playfulness in a safe way. She talks about a wish here. Both are there, but not close for her. Here, they are close. She can put them together and will in time if she hasn't done it in treatment yet; they are there available for her.

Don Fields: Certainly, you don't debrief these all at one in session. In fact, you won't completely debrief an image. You do an initial debriefing of an image, but then it's meaning is uncovered over a period of time. You're right-the juxtaposition between the positive and the negative associations being you have some sense of interplay and meaning to a person of time as you work with them.

Evelyn: Even the week that may separate these is closer than years.

Don Fields: The second positive image identified was A18, the one coming up now. The initial response was "a butterfly and a heart ready to burst". The butterfly is right up here at the very top-this little tiny butterfly. The interesting thing is the person said was that this was not a light-hearted image, like the first in, not like the flowing, loose feeling. The butterfly is ready to let go of the past and fly away, on the verge of leaving the nest. Although, there are some good feelings because the butterfly is ready. The heart is ready to burst and that bring both a sense of pain but a sense of growth with it. In the middle of this image is a flower and there is also an ugly square. That is actually in the

area that is sometimes taken as veginal somatic responses. Amid all this, the heart is light and the butterfly is there and the heart is soothing. There is room for the heart to move around which, for this person, has some association of expressing oneself, or freedom to express.

Evelyn: Are the things you are describing projection she made at the beginning or are some of them made as she went along in treatment? It almost sound as if it is progressing to treatment.

Done Fields: The ones I am mentioning are the initial responses that were put down in the Booklet. For this one, was “a butterfly and a heart ready to burst”. The butterfly with an arrow was identified at the top of the image. That was the only thing identified initially. What I am filling in here is from specific debriefing of this image. Although, burring treatment, the way this image was used, again, like the other, it began to evolve and become a regular part of recovery.

Eveleyn: The things which you are reading now are her responses given fairly soon after and not later on in treatment.

Don Fields: Yes, within a couple of weeks after the administration and during a specific debriefing session.

There is also a sense of an immature heart that goes back to the idea of growth and a black color feeling so there is some sense of deterioration and shrinking. I believe what she saw was a smaller heart in the dark space had a sense of sadness and a sense of not being able to move. What she begins to associate that with, again, had to do with expression and the difficult to “say good things to myself”. At the end of this debriefing session I asked this person to say the phrase” my heart needs room to grow” and she couldn’t and she just cried. It took her about a month before she could say: my heart needs room to grow” and then that phrase “my heart needs room to grow” became part of her recovery image that has to do with the heart growing and moving on and the butterfly able to move.

Don Fields: The power of the Somatic Inkblot Series it not only in using it for the bpurpose of assessment. kind of assessment. The power of it is using it in interaction in a dynamic in treatment. That is the real power of it. If I just want some assessment I can ask one of our psychologists to do the Rorschach and they can do write up on that and that, while it has its uses, is not useful in the treatment, for me.

Don Fields: The last image is A5. The initial response was “a heart, a smile and a fat person” in that order. In the subsequent images and associations as we debriefed this she liked the flow, the looseness, the image with tiny shoes, the heart on top. She associated the heart on top like thoughts people think and what she was talking about was positive thoughts. The affects or the feelings she associated with this were “warm”, “good”, “feels nice”, not stressful”. Some of the associations she had with it had to do with non-judgmental, free, and always welcome-a-sense of a feeling that “there is always a place for me”.

One of the things I do when I debrief a person is we go through the initial responses, the feeling that are associated, any somatic type of responses that are associated and then the kind of themes that are associated. From there I usually ask the person “have you ever felt this way “or” when was the last time you felt this way or had this kind of scene?”, was able to identify feelings this way briefly, that is felt that the person was non-judgmental and listened well to her when she was 12 years old. This was with the aunt I had mentioned previously, that she had some kind of nurturing associations with, nurturing images with.

One of the jumps this person made as we debriefed the images was the idea of wanting to be able to own “as part me, this image”, that is the sense that she had not accessed this part of her, that she began to realize was there and was hers, even in her experience of it was very brief, and she began to talk about realizing that she needed to have access to it because she had perceived herself as dependent on other people in an external kind of a way for self worth, for a sense of being validated. She also associated comforting, expressive body movement, a kind of welcoming and holding. One of the affects also later mentioned was a kind of delight, so there is a real kind of lightheartedness, and again that looseness, that flexibility, a sense of self worth, but a sense of more directly for her, with this image that ‘this is a part of me that I need to recapture”, which began to again be apart of how she saw herself in recovery.

This person, just a few weeks ago, about a year after we initially began using the Somatic Inkblot Series, asked for copies of the positive images. I photocopied them and blown them up for her.

Dr. Cassell: I do have the color prints made from computer imaging of the Video.It is very expensive but these are available.

Don Fields: What precipitated.. I think this person asking for the images, was the possibility that she was going to be moving away suddenly, with some events in her life, and then (in the last two weeks) has found out that she will be moving off Island in about a month or so.

Dr. Cassell: So, when she is away she can look at an image of that and recall some of the good feelings and healthy associations as a measure of working through further treatment and maintaining her gains.

Don Fields: What we want is for her recovery to continue on every time she does see that positive images. This is a person who has really struggled to be able to learn to express herself and be assertive and has really come quite a way. Any reinforcement we can do of those positive images of where she wants to be in her life, I think, are important. The ones that she asked for, particularly theise positive ones, are very important. The ones that she asked for, particularly these positive ones, are very healing and not just healing in general, but they have very specific and personal kinds of associations for her that, I think, will continue forever.

Kathleen Addison: So the result of the work you have done with her is not only that through the Somatic Inkblot Series she has able to identify and integrate some parts of

herself and work with those, but also she has been able to address the presenting issues that brought her to therapy in the first place, right? I think there was some abuse by her husband and so forth that you had maintained at the beginning. Those things also we were able to dealt as a result of the therapy.

Don Fields: Right, but there was no abuse from the husband. I was referring to the most recent abuse that was actually by the father. Some for the feelings were stimulated when she would be in an argument with her spouse.

Dr. Cassell: So she would misinterpret a normal " marital argument" and then read through the images of abuse form her father and see her husband as abusive. I think that's what we're getting at.

Don Fields: Right, and herself as powerless and unable to deal with the situation in any kind effective way, which would really give rise to these intermittent episodes of anger, agitation, and bordering on rage.

Dr. Cassell: One aspect of the therapeutic application is to teach the patient about projection. Not only does the person project out of the blots, they see how they project out of a loved one or spouse images of the past. That has a lot of therapeutic value in terms of insight.

Don Fields: Right and of having both closeness and distance in different kinds of way to their experiences and images so they can come closer and recapture some sense of what has gone on with them, but see some distance differences and separateness in their present life. With a lot of people this tends to be very confused in the way they experience the image from their past experiences with their present life situations becomes very confused and this helps separate out a lot of that with helping them be a lot clearer.

Dr Cassell: And it helps them separate within themselves parts of themselves that may have identified with abusing parents. They can see the good, loving or with the abusing, harsh, judgmental, part. So it it's not just projecting onto a person like a spouse, it's dealing with their own inner objects, sort of speak, and it helps clarify this and works through this.

Don Fields: This was a person who, when they started treatment, was able to say, " I am depressed. I cry a lot I have times of anger, but I don't know why". They were able to say "I have had some bad experiences in my past" but really without a cleat association of feelings or an appreciation of what these experiences actually mean to them and their present life. So they were really recapturing their own personal emotional history making some sense of it and separating from it and moving on.

One of the interesting things is, we have through a few of the images that we debriefed in more detail, but quite a few of the other responses from the Somatic Inkblot Series are kind of a gold mine. You could actually spend an awful lot time going on and debriefing over a little different content of emotional tones and associations, but I think we have really hit the main ones. I guess if you have opportunity with the person you could keep doing that. When you don't have the opportunity and you need to move on

some, mainly delaying with the main three images, both positively and negatively associated is adequate for what you are trying to use it for.

Dr. Cassell: Even though there are 62 images, which makes of a great deal on clinical information, working either in a diagnostic or therapeutic way, the three they like most and the three they like least, that really is helpful. The reason we start with the three they like most because we want to set up an interview where they are clam and relaxed. It is easy to talk about these low-anxiety images and should they decompensate when taking later about the ones they dislike, you can always bring them back. If you are dealing with a borderline patient this is sort of like a harbor of safety that they can turn to.

Dr Cassell: I wonder if there are any other questions that you might have about this. I have one question that I would like to ask. In the beginning of the video we talked about the risk and benefits. We have heard a lot of the benefits. I wonder, Don, if you could comment on any of the risks or negative aspects using the SIS with this patient. For example, were there any follow-up posttraumatic that you have had with this procedure, because, with anything so powerful we have to look at the bad as well as the good the risks as well as the benefits.

Don Fields: With this person, specifically, the risk that came up had to do, I think, was bringing to the foreground, the emotional playing field that she was dealing and needs to have a period of time in her life where that was assimilated and digested and kind of incorporated. There are a lot of ups and downs as that takes place in a person's life and this begins to speed that process up. Certainly, there is some risk associated with it and for her, for a while there was more conflict with her spouse, more conflict in her interpersonal relationship.

Dr. Cassell: So, the husband may say I have encouraged my wife to see your clinic for help and now I can't live with her what' going on? You have to let them know there can be some storm before the clam and its' going to be though for a while. You have rules in therapy-don't make any sudden decisions about your marriage or your work, or whatever. Were there any other negative aspects?

Don Fields: Not with this patients, but one we do have to be careful with is the possibility for some very intense kinds of responses when we are debriefing some of the negative images and negatives associations.. There is the possibility of emotional flooding and some regressive responses.

I think the main things that we can do in treatment to deal with that are to have an awareness of the possibility of it happening the building in the use of the positive images first very strongly with people that you have some sense that might happen with, working with them also to build some ability for relaxation and stress management, not being afraid to let them pace what you are doing with them when you are debriefing negative images and stopping when you need on just stopping and coming back later on, or not coming back if they don't want to (if the images is too overwhelming, not coming back to it a visual way, but you can come back to it by thinking about it usually

in a way that is safer, but without presenting visually the image to them if that image is too overwhelming if it accesses to deeply a particular trauma in ways that make them feel unsafe or that they are loosing some sense of control or self control. The main thing is having an awareness of that potential and addressing it and having some sense of what you are going to do with this person and how you can approach it with them.

William: Do you have theoretical insights that complement this particulate approach that Dr. Cassell is using?

Don Fields: I do, and on a whole lot of different levels. On one levels, if you want to say the union level, a kind of a sense that we all share image in life-some of those we recognize and some we don't recognize. The way we can begin to use (in a positive way) some recognition, whether fully conscious or not, can be very important in every person's life, particular in treatment. One of the ways I can also see some application for this is as a bride, also for specific targeting with some desensitization technique. EMDR, eye movement, digitization and reprocessing in the last couple or years is a fair new desensitization method and in my experience with it, it can be very effectfive for very specific trauma images and associational links. It is not always easy to find the specific image or to specify the target with a lot of people. A lot of people have real difficulty with that and one of the things I think the Somatic Inkblot Series can do is very quickly bring into a very sharp focus, images for targets for desensitization. For instance, if you hit on some that you fear is going to have some emotional flooding or very strong regressive kind of response, a possible therapeutic innovation would be desensitization effort in response to those image which brings them down into an affect kind of internist that is workable for the person and they are able to pick it up and begin to incorporate it in a usable way on their lives, whereas before they had been too overwhelming.

Dr. Cassell: Is there any reference to dreams you would like to discuss?

Don Fields: There were two in particular which were stimulated after some further debriefing. There is an image, which the patient interpreted looks like, to this person, a gun going off (B21). This dream was about threat and violence.

Dr. Cassell: How did you relate this to her therapy?

Don Fields: This seemed to relate mainly to boundaries and boundary intrusion and a sense of a lack of nurturing. I do believe it is real helpful to use the dreams that people bring particularly after they have been stimulated by the Somatic Inkblot Series. I tend to help move people through those images in ways of recognizing it as parts of themselves rather than just externalize. That seems to be more helpful. This person certainly did that and was able to move towards to seeing her images as parts of herself rather than just externalize, even the ones of anger and of aggression, recognizing the parts of her that have that kinds of potential, even through they seared her very much.

Dr. Cassell: Another variation of the technique is to have them drawn their images and the dreams related to those images. Somehow, this gives them some sense of mastery. For example, your patient, if she actually drew the one she enjoyed, most, that would

probably have more meaning than giving her photographs of the material because it would be more personal.

William : Have you done anything about cataloging the change in dream content that these images may or may not impose? Meaning right after having seen this do some of their dreams change? Does some of this material get processed in a way that is nearly conscious of that you can recapture?

Dr. Cassell: Earlier, I mentioned a case of a woman who had seen the video at bedtime and had dream in which for the first time she saw her little brother. Over a time of therapy she was able not just to see his face but to see his whole body and process some of that trauma. That is an example of how over time the images proceed as the individual is able to take and tolerate the horrible affect associated with it. Again, it provides another measure for the therapist to appraise the extent that the therapy has been successful in expressing and resolving painful injury.

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Effect of Sodium Pentothal on SIS-Video-A Inkblot Images

D. Saldanha and B.L. Dubey

The psychiatric patient in the service is guarded in their responses to projective psychological tests. There is a need to evolve a method by which their defensive mechanisms are broken to facilitate better response pattern on psychological tests. 30 psychiatric patients were given Cassell's SIS video 'A' series tests before and after sodium pentathal. Their responses measured on emotional reaction, rejection of the image, Typical, Atypical, Anatomical, non-anatomical and female genital responses improved significantly. Emotional reaction improved from 40 percent of positivity to 90 percent. Rejection rate reduced from 62.63 percent to 18.13 percent. Typical responses increased from 28.90 percent to 35.63 percent. Atypical responses from 32.37 percent to 33.97 percent , Anatomical responses from 31.93 percent to 34.51 percent, non anatomical responses from 30.44 percent to 35.19 percent and female genital responses 32.12 percent to 33.21 percent. The usefulness of sodium pentothal in psychological tests is highlighted.

It is the genius of Hermann Rorschach's projective tests that lead Dr. Cassell to develop Somatic Inkblots to measure the "inner cry" of the individual that is hidden not only from others but often from ones own conscious awarness as well. Somatic Inkblot Series is a strctured projective diagnostic instrument and an adjunct to psychotherapy (Cassell 1980). It is based on spontaneous individualized responses to semi-ambiguous inkblot figures, which elicit intra- psychic associations specific to the personality of the person presented with them. It is a diagnostic instrument by the interaction of structure and stimuli, which evokes symbolism and meaning unique to the individual that can be differentiated from typical, and atypical peer norms and current diagnostic criteria. It is an adjunct to therapy because responses can be explored to create a more effective treatment plan. It helps in abreacting emotional conflicts elicited by the images (Cassell 1990). The tests are simple to administer and easy to interpret. The test can be easily administered to a large number of patient's in a single sitting. It is seen that the patients with a service background are guarded in their verbal expression on their responses are muted. Whenever tests are administered to them they do not come out freely with their feelings or thoughts. Hence it is necessary to break these defenses before they are subjected to the tests. William Sargeant used hypnotic drugs to abreact war neurosis during second world war (Sargant and Slater, 1940). A number of works reported on the use of LSD as an aid to psychotherapy (Sanderson and whitely, 1957; Adamson 1956). There can be little doubt that the drug facilitates the recapture of past experiences that have been long forgotten. Intense abreaction sometimes occurs and proportion of patients emerge from the experiences with memories that appear to have made a profound emotional impact. Sodium Pentothal had been used to break the defensive mechanisms in neurotic disorders by way of abreaction. It causes mild alteration in consciousness for a very brief period. It is a common knowledge that a person when

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inebriated is uninhibited in his recounting of life experiences. It is in this background that the present study was carried out to see whether there is any difference in various categories of responses given by an individual when SIS-II test is administered alone vis a vis when subjected to effect of sodium pentothal.

Material and Method:

The department of psychiatry in a zonal peripheral hospital conducted the study. This study was carried out from June 1992 to Nov. 1992.

Material:

(i) Dr. Cassell's Somatic Inkblot video (Series A) was used. This has 31 images with colored inkblots, which are less threatening and semi ambiguous in nature. The images take the individual back to his past and helps in processing the unprocessed material. It brings out the inner cry of the body. The test is projected on a TV Screen.

(ii) 3.4 percent solution of sodium pentathal was used to break the defense. 5 percent causes venous thrombosis and 2 percent causes hemolytic hence care was taken to keep the concentration at 3.4 percent level. Plasma half-life is 3 minutes Elimination half time nine hours. With a single intervenes dose unconsciousness sets in after 10 to 20 seconds (arm to brain). Consciousness returns within 5 to 10 minutes depending on the amount of drug injected (Byan and Willman, 1985).

Method:

Patients admitted were diagnosed as per ICD-9 Criteria. They were free from organic illness. Following points were ensured in the conduct of the study.

(i) Individual had good eyesight.

(ii) Familiarization of the test images on video was done prior to administration.

(iii) Images were shown in equal intervals of 3 days (before drug administration, on the day of drug administration and after 3 days of drug administration).

(iv) Hemoglobin levels were built up to normal levels to prevent any side effects of sodium pentathlon

(v) Pentothal dosage was kept at half of normal values/Kg. wt. to prevent undue sedation.

(vi) Thirty minutes integral was given after the individual was fully awake from drug administration to the test administration.

Administration of the test:

All the subject were given SIS-II Video series 'A' and the responses were noted. 3 days later they were given sodium pentothal. The dose calculated was uniform to all the patients i.e. exactly twice the body weight, (If the subject is 50 Kg. Wt. Dose calculated

was 100 mg so that the drug used is just sufficient of break the psychological defense. 30 minutes after they have fully recovered from the effects of sodium penothal, the test was administered. 3 days later they were again given the test and their responses were noted. The results thus obtained were tabulated, computed and analyzed. Following parameters were tested.

(a) Emotional reaction.

(b) Rejection of the images.

(c) Typical and Atypical responses.

(d) Anatomic and non-anatomic responses.

(e) Female genital and reproductive organ responses.

Results and Discussion:

The test sample consisted of a diversity of patient's population. They included neurotics (n=13), psychotics (n=7) substance abusers (5) and those with minor adjustment problems designated as NAD case (n=5). Their mean age ranged from 28.23 to 32.71 SD difference of 3.42 to 7.30 (Table 1). Emotional reaction of the individual is shown in Table 2).

Table 2
Profile of Age (Range 23-43 Yrs.)

		M	SD
Neurosis	(N=13)	28.23	5.61
Psychosis	(N=7)	32.71	7.30
Dependence	(N=5)	32.0	5.83
NAD Cases	(N=5)	28.8	3.42
Total	(N=30)	29	5.99

Table 2
Emotional Reaction

Positive and Negative Indicators	<P	>P	3 > p
Positive	40%	86.66%	90%
Negative	60%	13.33%	10%

To measure the emotional reaction four grades were used from 0 to3. Grade zero indicated negative motional reaction. Positive emotional reaction was indicated by 1 to 3 grades. These are shown in graphs (A to C). Rejection of the inkblot images by the subjects is shown in Table 3 and by various groups in the graphs. The table and graph

indicates the extent of reduction in the rejection of the images there by showing the usefulness of Sodium pentathlon. Typical and Atypical responses which are given by the subject to a particular test in conformity with the inkblot explained in the manual by Cassell. Majority of the inkblot pertain to the body Parts. It is but natural that anatomical responses should be more than non-anatomical responses. This is a fact and is shown in Table 4-7. Some of the inkblots depict female genitalia and female reproductive organs. The number of responses given by the subjects after pentothal indicate that subjects are uninhibited towards opposite sex as all the test subjects were male. This is shown in Table 6. The variability of the tests indicated in the different parameters are shown by co-efficient of variation (CV). Table I9 shown the summary of all the parameters tested.

Table 3
Rejection of the images

Test days	n	M	SD	CV
1. >P	114	28.9	13.23	45.77
2. >P	35	9.75	7.78	79.79 2.13 times
3.3 >P	33	8.25	8.07	97.81

<P Before Pentothal
>P After Pentothal
3>P 3 days after pentothal

Table 4
Typical Responses

Test Day	n	M	SD	CV
1. <P	490	16.33	3.22	19.71
2. >P	601	20.03	4.40	21.96
3. 3>P	604	20.13	5.35	26.57

Table 5
Atypical Responses

Test Day	n	M	SD	CV
1. <P	324	10.8	3.70	34.25%
2.>P	340	11.33	4.43	39.09% 1.14 times
3. 3>p	337	11.23	4.34	38.64

Table 6
Anatomical Responses

Test Day	n	M	SD	CV
1. >P	453	15.1	3.60	23.84%
2. >P	492	16.40	4.41	26.89% 1.12 times
3. 3>P	498	16.47	4.50	27.32

<P Before Pentothal
>P After Pentothal
3>P 3 days after pentothal

Table 7
Non -Anatomic Responses

Test Day	n	M	SD	CV
1. >P	334	11.13	4.41	39.62%
2. >P	377	12.57	5.45	43.35% 1.09 times
3.3. >P	386	13.53	5.49	40.57%

Table 8
Female Genital & Reproductive Organ Responses

Test Day	n	M	SD	CV
1. >P	88	2.92	1.42	48.63%
2. >P	95	3.16	1.98	62.65% 1.28 times
3. 3>P	91	3.09	1.52	69.19%

Table 9

Parameters		P	>P	3>P
1.	Emotional reaction Positive	40%	85.66%	90%
2.	Negative	60%	13.33%	10%
3.	Rejection	62.63%	19.24	18.13%
4.	Typical responses	28.90%	35.90%	35.63%
5.	Atypical responses	32.37%	33.97%	33.66%
6.	Anatomic responses	31.39%	34.39%	34.51%
7.	Non-anatomic responses	30.44%	34.37%	35.19%
8.	Female genital and Reproductive organ responses.	32.12	34.67%	33.21%

No study has yet documented the effectiveness of pentothal in psychological tests. The therapeutic effectiveness however is well documented (Mayer Gross et. Al.1969). The fact that pentothal did effect the performance in various parameters brings home the reality that psychological tests when given without breaking the individuals defensive mechanism do not measure the realistic profile of their psyche. It is important to bear in mind given a situation like the services most of our patients are muted in their responses to psychological tests or retarded in giving adequate responses. Sodium pentathlon is the test and safe drug, which can be given under controlled conditions.

Beneficial effect of the drug can be easily seen in almost all the parameters measured (Table 9). The rejection rate which is high (62.63) percent initially comes down to 18.13 percent after the use of pentothal. The rising trend in the response pattern in the typical, atypical, anatomical, non-anatomical and females genital responses indicate the usefulness of the mild neurotic disorders became a symptomatic when anxiety level was induced considerably due to the therapeutic effects of the drug and the test itself.

In most psychiatric settings the test in psychological test battery are individually chosen in terms of how well they contribute to a psychodynamic formulation of the personality function. Behavior is often motivated by forces that vary as to their accessibility to awareness and behavior expression (Kaplan, 1998). Sodium pentothal given under controlled condition as in the present study does help in breaking the defense mechanism and accessibility to the person's unconscious mind leading to awareness for a better expression as reflected in the various parameters studied.

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Bereavement and Hypnosis: A Case Study

George Savage

The treatment of complicated bereavement poses specific management problems. This paper describes a patient who was treated with hypnosis for pathological bereavement following the number of her husband. Hypnosis proved successful after months of conventional therapy did not bring out any symptom relief.

Grief is a pervasive highly individualized dynamic process (Cowles and Rogers, 1991). There is general agreement in the literature that mourning can be conceptualized as a movement through predefined, predictable phases. These phases need not be sequential and not all persons experience the same degree or intensity of emotions. Different names are given but essentially the phases consist of denial, a feeling of numbness, depression and re cover (Conroy, 1997; Clayton, 1990; Parking 1981).

The patient may experience a wide range of symptoms. There are feelings of guilt and hopelessness, decedent anger, fear, feelings of resentment towards intact families and a variety of somatic symptoms. Changes in the financial status, possible changes in residence and different roles are added stressors (Shelton and Sanders, 1973; Sauna 1983; Conroy, 1997; Clayton 1990; Eisenbruch, 1991). The most commonly reported symptom is depression. A distinction can be made between persons suffering depression as part of an affective illness and depression following a loss through death. The affective disorder patients report more depressive symptoms that do the bereaved patients (Clayton, Hispanic, Murphy and Woodruff, 1974).

The survivor may in addition complain of anxiety, a same of unrelated, isolation and inner emptiness (Willis, 1998; Provost, 1989; Hovey and Berkram, 1990). Largely neglected in the literature is the physiological response to grief. Reports of infections and neoclassic shortly after bereavement seem to suggest a relationship between grief as a stress mechanism depressing the immune responses via the pituitary-adrenal axis(Vachon, 1976; Fedrick, 1977). Grief is therefore a multidimensional reaction to a loss through death (Vargas, Loya and Hodde-Vargas, 1989).

The Treatment of Grief:

The aim of any treatment intervention is to help the individual to come to terms with the loss. The person must further “work” through and come to terms with feelings of guilt and decedent directed anger. Treatment within a group setting provides the emotional and social support necessary when strong emotions are expressed (Flatt, 1988; Kawaz, Roesch and Friesen, 1990; De Boer and van der Wal, 1991). Art and music therapy is used successfully for self-expressions when treating children. In a group setting the children can express their emotions without fear of disapproval. The children experience their sadness and express it through art and music (Davis, 1989; Mc Intyre, 1990).

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Ritual is a useful psychotherapeutic technique to help individuals to over from a maladaptive to a more adaptive style of grieving (Reeves and Boersma, 1990; Irions 1991). The giving of support during the mourning process is helpful. The nature, type and timing of the support are controversial issue (Murphy, Aaron and Laugher, 1989; Zimpfer 1991). Logo therapy, psycho educational programs, constructs therapy, play therapy, behavior therapy, cognitive and reactive therapies are all successfully used in the treatment of grief. Psychotherapy is used to focus intensively on a single issue causing distress to an therapy is used to focus intensively on a single issue causing distress to an otherwise emotionally healthy and adjusted individual (Gillett,, 1986; Boschemeyer, 1989; Lucas 1990; Rynearson, 1990; Christ et al, 1991; Viney 1991; Smith, 1991). The treatment of complicated bereavement however is problematic, as it does not response to conventional treatment for depression.

Complicated Bereavement:

The criteria of the Diagnostic and Statistical Manual, Third edition-Revised (DSM III-R). (1987) for the diagnosis of a major depressive illness. This is inadequate and too restrictive. It does not account for the classification of the full, range of emotional experience of an individual's reaction to a major transitional life event (Marwit, 1991). Low social-economic status, little or no warning of death, sport terminal illness, multiple life crises and severe distress following the death intensity and duration of the grief reaction are additional important factors for a poor outcome (parks, 1975; Cancelmo, Milan and Vasques, 1990; Rynearson, 1990). The prolonged absence of conscious grieving is a further indication of complicated bereavement (Raphael and Mlddleton 1990). Most person who has been bereaved may experience some difficulty in relinquishing the lost object. Pathology is measured by the intensity of the conflict related to this process (Vargas, Loya and Hoodde-Vargas, 1989). Complicated bereavement is associated with an anxious subtype of depression and occurs in conjunction with severe, prolonged separation anxiety (Kim and Jacob, 1991). It is important to recognize pathological grief because it will not respond to the usual treatment measure for depression.

Case History:

A patient whose eleven-month history of depression followed the murder of her husband on his way back from work is described. A characteristic of her symptom pattern was depression, an unwillingness to talk in the group therapy sessions and an overwhelming anxiety to the extent that she would run out of the group therapy session. She experienced persistent and disturbing nightmares but refused to discuss the content of the dreams. Four months of conventional treatment in a specialized unit did not reduce the intensity of frequency of the symptoms or suicidal ideation. In the fourth month of her admission hypnotherapy was done with dramatic results.

Mrs. H. a 31-year-old widow was referred for admission to specialized unit for the treatment of depression following the murder of her husband during November 1990. She gave a four-month history of depression, loss of appetite, episodes of weeping and disturbing nightmares. She was socially withdrawn and became anxious whenever she left the house. Four months of outpatient treatment before admission did not result in any symptom relief. There was psychomotor retardation, frequent crying and suicidal ideation for three months preceding admission. One week after her husband's funeral she tried to run in front of a car in a suicide attempt but was prevented from doing so by bystanders. One week before admission she took an overdose of tablets.

Mrs. H. had a sense of husband's presence, and experienced auditory hallucinations. She would hear her husband calling her name. Her husband's clothes were still in his cupboard and at 1700 hours in the evening she went to window to wait for him to return home from work. She was intensely angry with the unknown murderers but refused to elaborate. She said their seven-year marriage was a happy one. Two children were born to the couple.

Progress Notes:

Week 1

Patient refused to talk in group therapy sessions, was tearful and uncooperative. At on time she mentioned that whenever she loved some one she loses them but refused to elaborate.

Weeks 2-5

Patient remained tearful and uncooperative, refused to talk in group therapy sessions. She remained actively suicidal and was not allowed to go home for weekend leave. Nightmares disturbed her sleep but the patient refused to discuss the contents of these disturbing dreams. During the fourth week She attempted to abscond from the unit and was brought back to the ward by the nursing staff. In week five she again attempted to abscond.

Week 6

After six weeks hospitalization there was no reduction of symptoms. The patient was actively suicidal and refused to participate in the group therapy discussions. It was clear from the few she did say that Mrs. H. was intensely angry with the unknown perpetrators of her husband's murder. Mrs. H . was placed in a grief group together with three fellow patients who had suffered loses through death. The group was run by the author with the social worker of the unit as co-therapist. The object of the group was to provide an opportunity for mutual sharing, support and expression of anger while working towards acceptance of the loss.

Week 9

After seven group therapy sessions Mrs. H. was still unable to express any anger. She did speak briefly about her difficulty at looking at her husband's clothes. After the seventh group therapy session she took an overdose of tablets. By session ten, no reduction in the intensity of her symptom s was apparent. She was uncooperative and made another bid to abscond from the unit. The patient complained of feeling confused, helpless and had a fear of losing control. Two of the dour group patients were ready for discharge and the group was disbanded. At that point on her therapy the author went on a three-week vacation.

Weeks 11-15

During this period Mrs. H. remained suicidal and very uncooperative. She refused to talk about her or the disturbing dreams. She was frequently tearful and expressed feeling of hopelessness. She was certified in terms of section 9 of the Mental Health Act (No. 18 of 1973, Amended Act No. 3 of 1984). Certification was necessary as Mrs. H was actively suicidal, demanded her discharge, was verbally aggressive, very tearful and attempted to abscond.

Week 16

The author returned from leave. There was no reduction in the frequency and intensity of Mrs. H's symptoms. A reappraisal of the situation was made.

(i) The disturbing nightmares suggested repressed material that the patient found was overwhelming.

The intensity and persistence of anger was a further indication of repressed material the patient had difficulty with.

The fear of losing control prevented her from adequately dealing with her emotions.

Intervention Through Somatic Inkblot Series:

A decision was made to do hypnotherapy. Using the Somatic Inkblot Series II (SIS-II) designed by Dr. Wilfred Cassell (1980) did the initial assessment. The blot consists of 62 semi ambiguous visual stimuli in booklet form, based on specific anatomical structures. The SIS-II can be used in a variety of ways but was designed for self-administration after supervised instruction. One advantage of self-administration is that it saves therapy time, reduces possibility of inhibiting responses due to presence of the therapist and serves to reduce test anxiety. The booklet can be taken home by the patient and completed in privacy in a relaxed atmosphere. Mental health professionals with training In the use of projective techniques such as human figure drawing, thematic apperception test, word association or sentence completion test will have no difficulty adapting the SIS-II to their work. The patient is requested to identify three "most liked" responses. This serves to reduce anxiety. The three "least liked"

responses are examined next in the detailed inquiry. The entire series of 62 images are then scrutinized for psychopathological material or themes. The test has been found successful as therapeutic and diagnostic measure (Cassel, 1994; Dubey et. al 1993, 1994: Verma, et. al 1994).

The night after the administration of the SIS-II Mrs. H. had one of her nightmares. When she woke, she broke the frame containing the photograph of her husband and threw the furniture around in her room.

Mrs. H. identified images A23, 20 and 5 as the “most liked” and images B13 and 22 as the “least liked”. The detailed inquiry was done in hypnosis.

Session 1:

The patient was introduced to the experience of hypnosis in the first session. Induction was by systematic relaxation and deepening by counting backwards from 10 to 1wit suggestion that relaxation will increase with each successive number. Mrs. H. proved to be an excellent subject and induction and deepening was readily achieved. No post hypnotic suggestion was given and no exploration was done as the patient was promised that the first session would only be used for relaxation and to allow her to experience what hypnotic induction felt like. She could decide to continue after the first session. The patient agreed to continue with the sessions.

Session 2:

The second session was held on the following day as the patient became distressed and tearful during the night. Induction was by systematic relaxation and deepening by counting backwards from 10 to1. The patient was then “awakened by reversing the induction procedure with the post hypnotic suggestion that she would still feel completely relaxed and calm. She was asked to focus on the first of the “least liked” images 4Bm and to concentrate on it. A second induction was come with deepening. She was instructed to visualize the images and to say whatever it made her feel. The following is a translation and summary of her responses.

Murderers,

They killed my husband.

I hate them; they made me feel like this.

I want to get a gun and shoot them. I am entitled to feel like this.

She refused to say more even when encouraged to do so. The same procedure was followed with second “least liked” image, 13B. The following is a summary and translation of her responses.

It is a graveyard.

It lets me think of my husband’s grave.

It is not right that he should be here.

He did not die as he should have, he was murdered and that is not right.

It brings many questions to my mind.

Why him, where was God, why did he allow it, it's not human.

If he did not love me he would not have died.

We married because we lived each other.

It is only people whom I love that die.

Mrs. H. then went on to give a detailed account of three major losses she had experienced that made her feel guilty. At the age of 14, a car killed her pet dog when it followed her to the shop. Family and friends could not understand her grief and told her it was only a dog. Mrs. H. felt responsible for the dog's death. "If it had not followed me to the shop, it would not have died".

The second loss was her boyfriend who died in a car accident on his way home after visiting her. She again felt responsible by saying that if he had not been in love with her and visited her he would not have died. She did not view the body and has still not visited his grave. She was 16 years old at that time. The third loss was a girl friend who died of cancer when Mrs. H. was 18 years old. "If she was not my friend she would not have died". She did attend the funeral but did not view the body. Mrs. H. was given the opportunity to "speak" to her husband and tell him how she felt and how desperately she wanted to have helped him if she could. Mrs. H. was taught a self-hypnotic technique (visualization in a safe place) at the end of the session. The session lasted about one and a half hours.

Session 3:

One week after the second session the third session was given . the same induction procedure was followed. Patient was noticeably anxious at the start of the session and 10 minutes were necessary to help her to relax. The following is a translation and summary of her responses to the third "least liked" image-B22.

It is a picture of a person lying on the ground ….it makes me think of something I don't want to think about.

I feel the pain … I want to forget about it.

I don't want to talk about it.

It reminds me of what happened to my husband.

It reminds me of my nightmares…what happened to my husband … I don't want to talk about my nightmares.

At this point Mrs. H. cried uncontrollably for about 15 to 29 minutes. At the end of that period she repeated that she did not want to se that scene again. Mrs. H. was formally given the opportunity to say “goodbye” to him.

Four days after the third session she again had a nightmare, but fell asleep again after doing self-hypnosis.

Behavior in the ward after hypnosis:

There was an immediate change in the patient’s behavior after the third session. Her mood had lifted; she was cooperative and became a full participating member of the group. Following the third session, the patient reported that she had accepted her husband’s death and was able to give support to fellow patients in the group. Two weeks after the third hypnosis session she was discharged from the unit. She was almost completely symptom free and not suicidal. At her one week follow up appointment she was still symptom free and reported feeling sad about her husband’s death. She had not looked at his clothes but said she knew she had to do it.

Discussion:

The dramatic response after only three hypno-therapy sessions is consistent with reports in the literature (Fromm and Eises, 1982; Handelsman, 1984: Manthrope, 1990). It must be clearly stated that in complicated bereavement it is not the depression but the repressed material that is treated. There are definite contradictions for the use of hypnosis for the treatment of depression and this is not recommended as a treatment for this condition.

Mrs. H’s symptoms can be understood in psychodynamic terms as her struggle to relinquish or to preserve the lost object. The reality of her actual loss is greatly increased by an unconscious fantasy of having lost her internal good objects as well. Her internal world was predominated by bad objects and was in danger disintegration (Klien, 1975; Segal, 1978). The patient is unable to grieve normally because of an obstacle in normal grieving. She is unable to move in therapy because of her guilt and self blame. She believed her husband died because she loved him. An unconscious sense of guilt or a need for punishment operated to prevent relief from her suffering. Once she is freed from her self-punishment and guilt, through the use of hypnosis, she was able to take control of her life (Brabant, 1990; Epston, 1991).

The use of hypnotherapy and the SIS-II enabled the therapist and the patient to identify repressed material that caused her distress. This case demonstrates the usefulness of the SIS-II and that rapid symptomatic relief in complicated bereavement can be achieved through hypnosis.

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The Relationship of Stimulus, Projection, and Pathology in Projective Techniques and the "Levels Effect"

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The importance of the stimulus prosperities of projective techniques and their influence in creating a "leave effect," was examined as well as the relationship between projection and pathology in prior studies published and unpublished. It was concluded that there is some support or a levels effect, and that projection pathology are correlated. Accordingly, highly verbal test-asker run a considerable risk of appearing pathological regardless of their actual diagnosis because of the negative orientation of most assessment systems.

When projective techniques first appeared they were viewed as providing an opportunity to go beyond the constraints of paper and pencil tests of personality, which were viewed as tapping mainly the overtly conscious level of personality. Projective techniques were viewed as reaching much deeper levels of personality that the individual would or could not otherwise reveal. Projective techniques were, in short, alleged to provide a royal road to the unconscious (Frank, 1939).

In the Thematic Apperception Test (TAT) manual Murray states "If the pictures are presented a test of imagination, the subject …. can be so involved in the task that he forgets his sensitive self an the necessity of defending it against the probing of the examiner, and before he knows it he has said things about an invented character in response to a direct question. As a rule the subject leaves the test happily unaware that he has presented the psychologist with what amounts to an X-ray picture of his inner self (Murray, 1943, p.1)"

With the passage of time and increasing sophistication on the part of researchers, it was realized that projective techniques differed in their degree of stimulus structure, and that different test might penetrate different layers of personality. The more ambiguous the stimulus structure, the deeper the layer of personality attained. Despite much speculation, the first study to empirically measure the "levels hypothesis' was that of Stone and Dellis (1960). They hypothesized that "there is an inverse relationship between the stimulus structure inherent in the test and the level of personality or impulse control system being 'tapped' by the test" (p.336). The greater the degree of pathology presents in an individual the more likely the individual will manifest a loss of impulse control to relatively structured stimuli.

These authors tested thesis with 20 hospitalized patients diagnosed as either pseudo-neurotic of pseudo-character logical schizophrenic. The test used from most structured to least structured were: Wechsler-Bellvue Intelligence Test (WAIS), Former Structured Sentence Completion Test, TAT, Rorschach, and Draw-A-Person (DAP).

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As a measure of loss of impulse control they, used the Menninger Health-Sickness Rating Scale (1952), which gives a global measure of an individual's mental health and capacity to function as an independent person. Using three judges, the reliability of this scale as applied to each test ranged from a correlation of .69 for the WAIS to .85 for the Rorschach, all correlations being significant beyond the .01 point.

They found that the degree of pathology followed the order predicted: From highest to least pathology, the order was DAP, Rorschach, TAT, Former Structured Sentence Completion Test, and the WAIS, although only two adjacent test (Rorschach, TAT) showed significant differences. Despite this support, the study was flawed in a number of ways.

Foremost among the omissions was the absence of a control group of normal. Such a group might have shown a greater levels effect because, being relatively free of pathology, they would be more attuned to the stimulus pathology of the cards. By contrast the patient, as a function of their pathology, might have been more disposed to pay attention to their own internal cues. This may have been the reason for the failure to find attention pronounced differences between the tests on pathology.

The Morbidity of Projection:

Another explanation of the levels effect is that it is not about levels at all, but about the negativity of projection. According to this way of thinking, most assessment scoring systems are geared to recognizing pathology much more than health; hence, the more opportunity to project, the great ambiguity should elicit both more projection and more pathology than tests with more structure and less ambiguity. It follows from this line of reasoning also that projection and pathology should be positively correlated.

Murstein and Wolf experiment:

Murstein and Wolf (1970) tested these speculations using a group of 20 college students and navy personnel who reported no history of pathology (whom we shall refer to as the group), and a group of 20 psychiatric patients drawn from a state hospital and navy base. They administered to these participants a battery of projective tests which, from more to least structured, consisted of the Bender-Gestalt (B-G) the Incomplete Sentences Blank (ISB) TAT, Rorschach, and DAP. The Menninger scale was again used to measure pathology, and a five point scale was created to measure projection, the former having an inter judge reliability of 68, and the latter one of. 81.

Results:

As expected, normal exhibited much less pathology than patients, and they manifested less projecting as well. The levels effect was supported for normal, but not for patients, who showed a tendency towards consistent pathology regardless of the stimulus properties of the tests. Last as predicted, projection was found to be highly correlated with pathology across every test for both normal and patients.

Discussion:

The result supported the conclusion that psychiatric patients followed internal cues and paid minimal attention to the stimulus properties of the tests in their manifestation of anthology. Normal, on the other hand displayed decreasing amounts of pathology as the stimulus properties became increasingly evident, responding thus, to external cues. The theoretical set of curves, which describe this condition, is shone in figure 1.

A the normal group approached the most structured test such as the ISB and B-G, the correlation between projection and pathology increased, which was not true of the patients. The consistently significant correlation between projection and pathology across all test and both group as shown in Table1 offers strong support to the premise that scoring systems are weighted towards the pathology.

Table-1

Correlations Between Pathology and Projection for Normal and Psychiatric Groups for Different Techniques in Murstein & Wolf Study

	Population		Tests		
	B-G	ISB	TAT	Research	D P
Normal	.79***	.70***	.48*	.63***	51***
Psychiatric	.39*	.58**	.58**	.50**	.55**

p<.05 **p <<.01 *** p.001

Note : Reproduced from Mustering & Wolf, 1971, p. 40 by permission of the American Psychological Association.

Although Bellak (1956) has written about regression in the service of the ego in which an individual taking a projective technique can give him/herself up to playful fantasy and tell a story, which shows no pathology, no evidence for that occurred with our group of normal participants.

Mathes Experiment:

Mathes (1971) attempted to replicate the work of Mursterin and Wolf with some modifications. She reasoned that stimulus structure could be more perfectly controlled if instead of using different tests in which one compared inkblots, pictures, and incomplete sentences, she employed only one test, the TAT, and used cards varying in ambiguity. In the pervious research, for example, the responses, which were scored for pathology, included sentences (ISB), stories (TAT), perceptions of inkblot (Rorschach), and drawing (DAP). Despite the fact that the variation of structure would be compared to studying differences on pathology between tests greatly varying stimulus structure, she hoped to duplicate the levels findings or Murstein and Wolf.

Tests and Population:

She selected the TAT and employed 9 cards covering three levels of ambiguity (low, medium, and high) as determined in earlier research by Murstein (1964) using H, the measure of uncertainty. The Menninger Health Scale was used to measure pathology, and the Neuroticism Scale from the Eysenck Personality Inventory (EPI) was also administered in order to obtain an independent measure of pathology. Her participants were 20 male psychiatric patients from a state hospital and 20 presumably normal navy men awaiting assignment to submarine duty.

Results:

The attempt to use the Menninger Scale to measure pathology had to be scrapped because her clinical rater were not able to achieve even moderate interpreter agreement in scoring. A three point rating of pathology was substituted, and acceptable coefficients of agreement at the P<.01 or beyond were achieved: For normal, pathology r(19) =.66, projection (5 point scale as in Murstein and Wolf, 1970) r(19) = .61. For patients pathology r(19) = .69, projection r(19) = .71.

The levels effect was not found either patients or normal in that pathology did not decrease as a function of decreasing ambiguity. Moreover, the patients and normal groups did not differ significantly in the manifestation of pathology. However, a significant ambiguity effect was found, with the medium ambiguous card exceeding both high and low levels of ambiguity in the amount of pathology elicited.

Normal projected more than patients, but what was more interesting was that once again projection and pathology were found to be significantly correlated both for normal r (19) = .54, p<. 01, one-tailed, and patients r (19) -.51p<. 01 one-tailed. Also noteworthy were the findings shown in table 2 that for normals the correlation between projection and pathology steadily increased as the cards became less ambiguous, whereas exactly the opposite occurred with the patients.

Table 2

Correlations Between Pathology and Projection for Normal and Psychiatric Population for Different Levels of Ambiguity on the TAT (Mathes Study)

	Psychiatric Patients	Normal Subjects	Total Group
TAT	N=20	N=20	N=20
Low	.35	.76***	.45***
Medium	.55*	.57**	.58***
Highh	.61**	.38*	.48***
Combined	.51*	.54**	.50**

*p<.05, **p<.01 ***p<.001

A correlation of r (39) =. 39 p<. 50 were found the EPI neuroticism score and projection for the total group, and a correlation of .03 between neuroticism and pathology.

Discussion of Mathes Experiment:

The failure to support the levels effect for the normal group seems at first glance rather puzzling. However, it should be noted that differences in ambiguity within an overall moderately structured tests such as the TAT represent rather fine distinctions compared it the differences in ambiguity between tests. Further, the nature of the task for the test-taker is different on the TAT than for the other projective techniques. An analysis of the challenges for each level of ambiguity on the TAT will clarify this statement.

For the low-ambiguity cards all participants could control the expression of pathology by adherence to the stimulus properties of the cards and by minimizing projection. Faced with the medium-ambiguity cards, the task became more challenging, because it was not so easy to determine exactly what these properties were and, consequently, whether one was projecting or merely following the lead provided by the stimulus qualities of the cards. With the high-ambiguity cards, in order to look “healthy”, participant would have to project a lot but not necessarily show any pathology. In the context where participants may already have seen more structured cards, on what ever they rated. There is little in the way of stimulus to hide behind. Hence a cautious note is sounded, and story is more likely to be heavily censored by the subject that for the less ambiguous cards. Similar findings were recorded for other studies reviewed in Murstein and wolf (1970).

It might be asked why the participants in Murstein and Wolf’s study did not become defensive with unstructured tests such as the Rorschach and the DAP? In the case of the Rorschach they probably did not need to do so, because they know that the Rorschach consisted of bilateral inkblots and the threat was less than that for responding to somewhat structured pictures as in the TAT. Regarding the DAP, the subjects were quite aware that when presented with a blank sheet and asked to draw a person, they would be held responsible for what they drew. However, there was no help for it. Short of refusing to participate in the test they had to draw a person. If they drew a person who reflected the way they felt, i.e. a “defensive person”, they would be projecting in spite of themselves.

The finding that the correlations between projection and pathology increased with decreasing ambiguity for normal suggests that, as stimuli became clearer, normal individuals to some extent were able to control both projection and pathology so that there was a consistency between the two. This was not the case for patients. They were probably responding to internal cues more than to external ones such as TAT cards; consequently, ambiguous cards did not arouse more threat or need to control than structured cards, and in fact, they showed their highest correlation between projection and pathology to the highly ambiguous cards.

The significant correlation between the neuroticism score and projection indicates that neurotics may be slightly less cautious about what they say in their stories than normals.

However, the correlation of .03 between neuroticism and pathology suggests that the pathology scores may reflect something other than personality disturbance. We shall consider these implicates in our General Discussion.

General Discussion:
Projection and Pathology:

The most outstanding finding among the studies reviewed was the substantial correlation found between projection and pathology across a wide variety of tests, including every test sampled. This finding is all the more noteworthy considering that two different measures of pathology were used, and that neither had outstanding reliability. Because a lack of reliability limits validity, we can only conclude that these already substantial correlations would have been even more imposing with highly reliable scoring systems.

Not withstanding Bellak's claim about the possibility of individuals relating imaginative, healthy stories through "regression in the service of the ego," both normal and psychiatric patients showed high correlations between projection and pathology. It its possible the clinicians saw pathology where there was none, or that there was inadequate sensitivity to noting signs of heart as compared to the training in deciphering signs of pathology. Therefore, garrulous but otherwise hearthy test-takers are in jeopardy, because the more they talk or see on a projective technique, the more likely they are to be judged pathological.

Any attempt at improving assessment with projective techniques might profit by starting with a basic formula enunciated earlier (Murstein, 1961).

Projection = Stimulus(a), Background (b), Personality (c),where stimulus refers to the measured stimulus properties of the cards, background refers to the context in which the test is taken, personality represents the contribution of the personality of the test-taker, and the superscripts the superscripts refer to the weighting of the variables. Thus, until we can ascertain how much of a response is determined by the stimulus properties of the test, and the circumstances under which the test is taken (e.g. applying for a job, patients in hospital, student whose achievement motive has been elevated), we cannot determine what the individual is projecting.

Earlier, I undertook a study in which some of the stimulus, background and personality factor were controlled and /or measured. (Murstien, 1965b). The stimulus was measured by scaling the TAT for hostility, background by the use of 2 instructional sets: "Look your best" and "impersonal," and the personality variable by selecting, through screening, college student who were either extremely hostile or friendly (group judgments), and who thought of themselves as either very hostile or very friendly. The hypotheses that possession of either high hostility or friendliness of itself would not differentiate the groups on projection of hostility, but that hostile persons with hostile self-concepts

would project more hostility, than hostile persons with friendly self-concepts were confirmed. The stimulus was by far the most important determinant of response, and low-and medium-hostile cards were better than highly hostile ones in discriminating groups.

These data do not support Murray's assertion that test-takers are unaware of what they project. They do, however, support the conclusion that objective passion of a characteristic without knowledge of the self-concept is of little value in predicating the expression of that characteristic on the TAT. It is noteworthy that I found similar results with the Rorschach a decade earlier (Murstein, 1956).

For the purpose of supplying further information on the stimulus properties of the TAT cards, I scaled them for achievement (Murstein, 1965c), hostility (Mursetein, David, Fisher & Further, 1961), ambiguity (Mursetein, 1958, 1960, 1964, 1965a, 1966), and normative responses (Murstein, 1972), among other measures. The use of these data might have done much to aid in differentiating projection from stories which, although full of negative affects, merely reflected the stimulus properties of the cards rather than any true pathology in the test-taker.

In the absence of any concrete data, I can only rely on my impression that most clinicians have not related on norms in analyzing TAT responses either through lack of awareness of the research literature or lack of motivation. Perhaps also the preference for paper and pencil test with computerized interpretations for readily scores responses have contributed to the reduced popularity of the TAT and projective techniques in general.

The result is that test-takers, regardless of the projective technique they take, stands in some jeopardy of being judged more pathological than they actually are because of the negative slant of most scoring systems. Learning to diagnose signs of healthy personality seems to be a worthwhile task for future assessment system constructors.

Levels Effect:

Regarding the levels effects, the Mathes study does not seem a crucial blow against it, because, as noted, variations within a moderately structured test may be too slight compared to variations in stimulus structure between tests. Based on the Stone and Dells and Murstein and Wolf studies there does seem to be a levels effect. The implications are that the moderately to moderately high structured test such as the TAT and ISB seemed to bring out the maximum differentiation between normal and pathological groups (See figure 1). Interestingly enough, the medium ambiguous TAT cards were also the most useful in differentiating individual with a high need for achievement. Elsewhere (Murstein, 1963), I have developed a theoretical scheme for reducing differences between high and low achievement motive individuals which is highly similar to the differences between normal and patients depicted in Figure 1. According to this schema, high and low achievement toward highly ambiguous for

achievement because of their sensitivity to this area even with little help from the card. Once a medium degree of achievement ambiguity is present, they respond extremely strongly to what to them seems like a strong cue. To the low achievement motive person this depiction is far less clear. When the cards strongly focused on achievement are shown, however the low achievement motive person cannot help but grasp the stimulus properties, and differences between the stories regarding achievement are minimal as compared to high achievement persons.

Conclusions:

This brief review indicates that scoring systems which do not take cognizance of the stimulus properties of projective tests result in an over-estimation of the pathology present in an individual. The levels effect has some promise as a means of establishing the relationship of pathology and stimulus structure, but further research is needed to clarify the issue.

Finally, the notion that test-takers must reveal themselves when confronted with a projective technique has found little support. Healthy subjects seemed able to regulate their production of both projection and pathology in response to cues provided by the stimulus structure of the technique in question. There is, true, no simple road to the unconscious. Nothing less than total consideration of the stimulus, background, and personality of the test-taker is necessary to prepare for such a demanding journey.

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Body Imagery in SIS Test

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SIS-II was administered to a 28 years, graduate, female patient. She had H/O various kinds of traumatic experiences during her childhood. Responses on SIS-II were able to bring out her inner cry.

To begin with, life in infancy is said to be one of a generalized oceanic feeling state, wherein there is no knowledge of definite human form. Gradually, this vagueness is replaced by a clear identification of various bodily parts. Also, there is the growth of the ego, and the process of individuation steadily moving towards stable and enduring characteristics. Even, concepts such as introjections and projection have a physical basis and they are viewed to have basically originated out of the gustatory experiences, for whatever testes good the infant swallows (introjection), and whatever is distasteful is thrown out (projection)(Blum 1969). Cassell (1980) who developed the Somatic inkblot Series tests rightly points out Freud's observation that "the conscious ego is first and foremost a body ego". Also, for Freud, the body and mind formed a single continuum.

The importance of body language and body image during the course of the therapeutic interview:

These aspects can be broadly viewed from at least 3 angles:

1. Interviewing at the outset, as it includes aspects like questions, enquires, elaboration, etc., occur at the conscious level, in other words language happens to be the primary vehicle of communication.
2. Non-verbal communication or expressive language like how the things are said, body postures, movements, facial expressions, gestures, eye-contact and so on form the not so conscious expressions. Expressions such as these are not learnt or taught. Henley (1977) rightly noted that "We respond to gestures with an extreme alertness and, one might almost say, in accordance with an elaborate and secret code that is written nowhere, known by none and understood by all." This phenomenon holds no better when it is said, "one should learn to read the body as one would read a book". What are implicit in the above lines is that the body mirrors one's thoughts, fears, anxieties, and other mood states, and that a therapist should be quick to grasp the meaning of these bodily expressions. In this context Freud aptly observed that the unconscious is more closed to the body than the conscious.

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3. This interplay of the unconscious with the body as the medium and its role in the perception of oneself and others is what Cassell (1990) describes succinctly in what he calls the “inner cry”. The “inner cry” is always trying to surface in the form of perceptual, cognitive, or emotional spheres. An understanding of this “inner-cry” is made possible and more meaningful in the Somatic Inkblot Series Test. He and several other researchers have found it to be a new diagnostic aid especially for body-percept assessment in conditions such as conversion reactions, somatic delusions, and sexual dysfunctions.

Following is the case report of a patient showing responses on the SIS test and their interpretation: The patients Ms. H. aged 28 years belonged to an economically poor joint family. She graduated in arts subjects. Her family life during childhood was witnessed by “Utter neglect and unconcern to others’ problems which resulted in misunderstanding, backbiting, and physical trauma”. Rheumatoid arthritis along with periodic depression are present in grandfather, maternal aunt and mother.

She has also been a victim of a number of physical ailments, underwent surgery on her right hand for burns, suffered from typhoid when she was 22 years old. Subsequently she had eczema on her feet, and urinary infection for the past 2 years. On and off she also reports of dizziness, nausea and itching all over the body, dental problems, and eczema,

She underwent variety of treatment starting from allopathic, homeopathy, acupuncture, ayurvedic and zen medication.

During the interview sessions, she appeared quite cooperative and communicative.

Bhata’s battery of intelligence test indicated an IQ of 116. Rorschach and TAT test reveled the presence of depression, insecurity feelings, interpersonal disturbances, and features of anxiety. However, these findings were obvious to some extent during the interview sessions as well. But, it was not possible to link these surface manifestations with the underlying psychopathology.

At this point SIS test was considered to see if it could throw more light in this direction.

SIS intervention:

The patient was allowed to take the SIS booklet home as she felt she could go through the test leisurely. She completed the test by next day. She responded to each image. A few responses are given below along with its interpretation:

A2: She saw “Lord Ganesha”. Probably an interest in religious aggressive tendency.

A4: “Left hand figure looks like a lady, whose existence hangs on small strings without support from any man”. This reflects her feelings of insecurity and loneliness due to interpersonal conflicts.

A5: She saw “Mickey mouse-makes you feel like laughing”. This is a healthy response with a positive emotional content.

A6: She viewed “a teddy bear sad-child-like being sandwiched between parents”. This is indicative of her childhood feelings of sadness and depression. In fact her inner cry of physical abuse and traumatic experiences have come out through such responses.

A7: She perceived “Lady looks like dancing and an object has slipped out of her hand”. This shows that she is unable to control or manage the situation; something has gone out of her control. This also suggests her feelings of helplessness.

A8: She saw “Shadow like Lunar eclipse which swallows the very existence of man”. This reflects almost an insurmountable obstacle, which makes life impossible with panic.

A9: She responded “two women communicating with each other. Two dots in the middle show they are thinking alike”. This refers to a yearning that she wants to confide herself with someone for support.

A12: She saw “ear” and “word”. Here the phenomenon of figure and ground is apparent which is usually present in individuals with above average intelligence both responses are normal.

A13: “Hand of a common man asking of the rights of birth right” was her response on this image. It shows the ill treatment she has undergone by others, and an assertion as a resection.

A14: “A child or bird-something from above is trying to suppress or eliminate it”. Vivid ruminations about hostile forces during childhood are projected through this response.

A15: “Mass suicide of birds in Japan” is indicating of her suicidal pre-occupation.

A16: “Two birds having a chat” is normal healthy response.

A17: “Two birds in opposite directions-must be having great suspicion” suggest her suspicious attitude.

A18: she perceived Middle figure looks like a fox or jackal which has survived all the hurdles”. It is the clever ones who usually survive? Suggests the presence of ego-strength.

A21: “Natraja posture” was her response on this image. A sense of religious preoccupation and interest is shown through this image.

A22: and A23: She viewed “Scary creature like scorpion”. This might have phallic connotation and some traumatic experience, which needs further exploration.,

A24: It looks like a “scary owl and does not give a nice feelings” regression of famine functions which are viewed as unpleasant.

A25: “looks clumsy like muddy water. It should become clean in the end and I want to regain that purity”. This is an atypical response but with a strong mechanism of symbolization. (Has the water becomes muddy?) To this, she relates by saying “I want to regain that purity”. (Has she become impure) and I should become clean in the end (How is this process of purification carried out?) These show intense preoccupations in sex area because the common perception in this image is female sex organ. Females having traumatic sex experience avoid perceiving female sex organ on this image.

A27: looks like “The mother’s breast to feed the baby. But where is the baby? On the left side, there is explosion – fire, earth is divided”. A natural role played by a mother is confronted with an utter catastrophe. It further suggests her conflicting relationship with mother.

A29: “Everything in the picture is dark and cloudy. Figure of a gun is prominent in the middle – a war atmosphere’ Quite an unstructured card, but a very vivid and volatile depiction of gloom and aggression.

A30: She saw “Scary skull. We all turn into that one-day. If we accept that, our miseries will be over”. This is the turning inward of aggression.

A31: “Man and woman, or the son has done some mistake”. It may indicate her feelings of guilt.

B1: She saw “ Ship in the ocean. Man and woman are inside it. They may be safe on the ship, but not in their minds”. This reveals highly disturbed frame of mind irrespective of the place.

B3: is viewed as “darkness all around – light is in the middle. Even if there is pollution all over, still you can be clam within”, shows her ego-strength, can fall back on herself for supports as a last resort.

B5: “ Man and woman. They don’t speak, but their mental wavelength matches. Everyone should be like that”. It may indicate her ego-strength, and at the same time a wish to lessen conflicts.

B8: “face of the man in the circle who is sad and is not lovable. He is paying for his sins. I hate to have such a husband”. Guilt feelings with a repressive content are staging a comeback through this image. Low self and conflicting opposite sex relations might be other interpretation of this image.

B9: “Dying heart, blood circulation is low”, Shows frustration and depression driving one to the point of total helplessness. It also suggests her inner cry.

B20: “Squirrel, scorpion and a plant. Small tree below wants to grow. Right figure (snake) wants to sallow it”. It could suggest her conflict relating to sex and interpersonal relationship. The hostile environment threatens even the least hope of survival.

B13: was viewed as ‘Inside of a temple. Gold plated food is visible. Below is snake’ an interest in religion/god along with sexual connotation is depicted through the image.

B14: “It is dark all over. Even if there is darkness all over, try to find a ray of light”. An effort to sustain ego-strength is clear.

B17: “Darkness in middle. Brightness all over will be there some day”. Wishful optimism and hope in future is depicted again.

B18: “Dead lizard or a snake”. Atypical responses concern with sexual conflict. This image brings out phallic content, which is suppressed here.

B19: seen as “Scary octopus. There are signs of love still. You can over each and every hurdle. In spite of so many problems, there is an indication of ego-strength. This also indicates good prognosis.

B20: was viewed as “Skull or moon, which is clouded or baby in the womb, a depressing picture” indicating depressive content, and also aversion towards maternal role.

B22: She saw “When a man dies, body stays on earth. Soul goes up to mingle in atmosphere-floats in different state-outlet” shows wishful preoccupation with ideas of death, and death as a release from problems as well.

B23: “A creature with several legs is resisting some force on the left and also a stick on the right. If you have life you should live that”. A conflict / tussle between survival on the one hand and external hostile forces on the other.

25B: “Pot full of water, mangoes leaves at the time of marriage or festival” Once again sex content is suppressed. Usually people see female sex organ here.

26 B “Motionless or dead snake” is an Atypical response with an aversion/fear towards sex. Similar response on B18 further confirms her conflict in sex area.

B27: is seen as “Twins – one is dead, the other is surprised. Can’t react because of shock. They are in mother’s womb”. Aversion / fear about conception or maternal roles. This also suggest a regressive tendency.

B28: She saw “Sad figure of an old man who is dejected, or ghost like figure”. Not seeing mother – with a child a typical response suggests his disturbed relationship with her mother.

B29: "That is the spirit – athletic in Olympic – impression of light, one should move towards light" indicating wishful thinking, optimism and good ego-strength.

B30: "Heart, two humans facing each other in the mother's womb". Here the emphasis shifts abruptly from the heart to the mother's womb, where two humans are facing each other. This shows a letting down in the sphere of affection/love and consequently towards regression.

B31: "Family – husband, wife, kids. Husband and wife are so engrossed that they are not ready to listen to the kids. Left one is trying to draw the attention, and the right one is sad after being neglected. If you can not look after your children don't have them". Interpersonal conflicts, depression, and a feeling of neglect expressed vehemently. Disturbed family relationship is clearly brought out though this image.

Various responses that are mentioned could be brought under the following areas:

Intellectually superior level as indicated by – unusual symbolic and reversal of figure **and ground perception responses –** A9, 12, B3, 14, 17, 19, 29.

Values, self-concept, and Perception of others – A8, 13, 14, 17, 18, 25, 27, 30, B1, 8, 9, 10, 14, 23, 31.

Affective Tone: Anxiety, fears and sadness. A4, 5, 7, 8, 15, 27, 29, 15, 20, 28.

Ego – Strength: A12, B17, 18, 3, 29.

Advantages of SIS Test in Clinical Setup:

Qualitative analysis of the test helps in understanding other areas as well. For example in arriving at an approximate level of intelligence (unusual and symbolic responses indicate higher levels of intelligence), and also the phenomenon or figure and ground (Ramachandra, 1984), (2) Value systems could be understood as revealed in the form of comments/ remarks made as a part of the responses themselves (3) "just enough obvious anatomical structure to evoke spontaneous verbalization, but not enough to limit the responses solely to the naming of body parts or colors" (Cassell 1980) helps in eliciting psychopathology and psychodynamics with greater ease than other projective tests: (4) the test also helps in understanding various affective tones ranging from mid to grossly disturbed ones: (5) the test has the combined advantage of both Rorschach and TAT put together which is a unique future of the test, and the quality and extent of information elicited is a unique feature of the test, and the quality and extent of information elicited often exceeds than that provided by either Rorschach or TAT alone; (6) the analysis and interpretation of the test lends itself with comparative ease than several other projective tests (Dubey, 1993) (7) free verbalization or writing about images can elicit a lot psychopathology and psychodynamics.

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Diagnostic Efficacy of Somatic Inkblot Series-II among Psychiatric Patents of Armed Forces: A Preliminary Study

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The Somatic Inkblot Series-II (SIS-II) is a structure projective diagnostic instrument and an adjunct to psychotherapy. It was administered to 150 Army subject (50 each - Psychosis, Neurosis and Normal) individually, following standard procedures (Cassell, 1990). The protocols were scored on a few SIS variables. The result showed that psychotic patients tend to produce higher number of Responses (R), low Typical responses and low number of Rejection of Images (Rej.) Normal subjects projected more Typical responses with less Rejection of images (Rej.) The clinical groups had more of Pathological responses (Pathological Anatomy, Depression and Paranoia as compared to normal subjects.

The Somatic Inkblot Series is the latest development in the field of inkblot techniques. It is a structured projective diagnostic instrument and an adjunct to psychotherapy (Cassell, 1990). It helps in hearing the inner cry of a suffering individual. It continued Research's concept that ambiguous and semi-ambiguous stimuli evoke spontaneous responses associated with body imagery (Cassell 1990 and 1994).

The Somatic Inkblot Series have been found very sensitive instrument for assessing emotion problems (Cassell, 1997). Various studies have been conducted in India on psychiatric and non-psychiatric population revealed that schizophrenics tend to produce low number of responses (R), human and anatomical responses, where as normal subjects gave more of most typical and typical responses, (Dubey and Cassell, 1993; Dubey et al, 1994 and Verma et al,1994). In a study conducted on Coronay cases of Armed Forces, it was found that heart patients denied somatic imageries (Goel et al,1990). In addition to somatic repression, the somatic heightening was also seen in some cases as they gave low number of responses on some images and higher responses on other images as compared to their normal counter parts (Saldanha, et al,1993 and Rathee et al,1994). As such no much difference was observed among the schizophrenic and neurotic patients on their number of responses, movement responses, human and sex responses, but schizophrenic and neurotic patients tend to produce less typical and movement responses as compared to normal subject. However, rejection of images was seen in a few cases in both the groups (Dubey et al, 1994).

Usually the purpose of psychological test is to assess the personality and to arrive at a psychiatric diagnosis. The purpose of SIS is much more. It helps the clinician to understand the psychopathology of the patient and hearing the severity of the problems as experienced and verbalized symbolically by the patients. Such technique may be more useful among psychiatric patients of army, where people are found to be more

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guarded and hesitant to reveal their problems. Considering the importance of Somatic Inkblot Series and its relevance in different setups, the present study was undertaken to find out the diagnostic efficacy of Somatic Inkblot Series among psychiatric patients of armed forces.

Objectives of the study:

1. To study the Response Pattern of Psychotic and Neurotic Patients as compared to Normal subjects on SIS-II
2. To develop the diagnostic indicators of SIS-II for psychiatric patients of armed forces.

Material and Mesthod:

Sample:

The present study consists of 150 Army subjects (50 each of Psychosis, Neurosis and Normal) in the age range of 20 to 55 yrs. (mean age 31.8 Yrs.) Most of them had their education up to high school. The psychiatrists diagnosed the psychiatric cases. Persons working in army, have no history of any psychiatric symptoms formed the sample of Normal group.

Tool and Procedure:

The Somatic Inkblot Series-II consists of 62 images, 31 each in series A and B was administered to each subject individually following standard procedures (Cassell, 1990).. As such there is no times limit for this test, but generally people take 45 minutes to complete it.

The protocols were scored for 10 SIS variables viz total number of responses (R), Typical, Atypical, and other responses, (uncovered in former two categories,) Rejection of images (Rej.), Sex and four pathological categories (Pathological Anatomical scale (PAS); Hostility Aggression scale (HAS); Depression (D) and Paranoia (P) Scale)

Results and Discussion:

That data thus obtained was statistically analyzed. Mean and Standards Deviation were calculated. In order to find out the significant level, mean difference, t-ratios and Chi Square were also calculated.

Table 1 shoes that psychotic patients tended to give more number of responses (R) as competed to normal and neurotic patients. The difference was found significant between neurotics and normal subjects. The typical responses wee higher in normal group; where as neurotic patients gave more of atypical responses. There was also significant difference between psychotics and neurotics and neurotics and normal subject as far as their “other” responses were concerned. The rejection pattern of images (Rej), was also found to be significant between psychotics and neurotics; and neurotics and

normal subjects, however psychotics and neurotics could not differ on rejection of images.

The present study supports the findings of earlier studies (Dubey and Cassell, 1993) and Verma et al, 1994) for the typical responses but contradicts with total responses and rejection of images, among clinical and normal groups. The significant difference in the present study may be attributed to army culture. The similar difference between civil and military subjects have been observed on other projective tests like Rorschach (Dubey, 1979, 1981 and 1982).

The analysis of pathological response categories did not suggest much difference in the groups. The Pathological Anatomy scale (PAS) and Hostility & Aggression scale (HAS) could not have much bearing in differentiating the three groups. However, Depression scale was found to be an important indicator in differentiating psychotics and neurotics from normal. No difference between neurotic and psychotic was found on depression scores. The normal subjects in this study gave less number of depressive responses.

Table 1

Significance of Response Pattern on Somatic Inkblot Series-II Among 3 Groups.

SIS Variable	A Pasychotics (N0=50)	B Neurotics (N0=50)	C Normals (N0=50)	Groups	Level of Sig. t-value	
Responses	M 57.44	50,46	52.4	A&B	: 2.3	.05
	SD 12.77	17.40	12.88	B&C	: .63,	NS
				C&A	: 1,98	.05
Typical	M 22.52	19.82	27.4	A&B	:1.07	NS
				B&C	: 4.59	.01
	SD 7.36	8.45	8.11	C&A	: 3.16	.01
Atypical	M 17.44	20.78	8.8	A&B	: 1.70	NS
				B&C	: 1.70	NS
	SD 12.38	14.02	7.02	C&A	: 4.03	.01
Other	M 16.26	9.14	17.5	A&B	: 3.17	.01
				B&C	: 4.42	.01
	SD 12.86	9.27	9.65	C&A	: .54	NS
Rejection	M 9.6	36.6	12.2	A&B	: 7.5	.01
				B&C	: 6.81	.01
	SD 9.7	23.59	9.21	C&A	: 1.38	NS

Table 2
Significance of Pathological Responses Among three Groups

SIS-II Rating Scales	Psychotic (N=50)	Neurotics (N=50)	Normal (N=50)	Level of Sig. X2
PAS	n = 35	34	35	.93
	M = 2.54	2.0	2.32	NS
	SD = 2.7	1.30	2.1	
HAS	n = 15	16	22	2.5
	M = 1.78	1.42	1.72	NS
	SD = 2.4	2.4	1.5	
D	n= 31	30	20	5.9
	M = 2.92	2.26	1.9	.05
	SD = 3.25	.6	1.92	
P	n = 21	9	4	16.45
	M = 2.8	0.62	0.54	.01
	SD = 4.62	1.0	.28	
Sex	n = 17	13	32	18.31
	M 2.5	.9	2.14	.01
	SD = 2.0	.04	7.5	

The Paranoia score was high in psychotic groups. Normal subjects as usual scored lowest on paranoia scale. The difference between psychotic and normal and psychotics and neurotics was found to be significant. The paranoia scale also turned to be a power full diagnostic indicator in three groups. Though the sex contents was found to be high in normal subjects and significantly low in both clinical groups, suggests that the clinical cases did not perceive the usual sex contents projected through SIS images. Perception of sex responses on certain images are very normal because the images project the sexual contents (A8, 22, 25, 27 and B18 and 25). If a person denies sexual imagery on these images, cloud lead to conflicting relationship tend to perceive sex organs on these images. Psychotics either suppress / deny sexual imagery or show preoccupation with it leading to more sex responses. Preoccupation with sexual imagery has been reported in many studies particularly on army cases because of their separation from spouse (Dubey, 1981, 1982).

Conclusion:

The present study indicates different response pattern of three groups on SIS-II. The quality of responses viz Typical, Atypical and other, are important diagnostic indicators. Neurotic patients tend to give more of atypical responses with more rejection of images.

Psychotic patients gave more of pathological anatomy, depression and paranoia scores. The normal subjects as usual tens to produce more typical responses, sexual responses with less number of pathological scores. The SIS can serve as a better diagnostic instrument in army subjects.

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Reliability and Validity of Somatic Inkblot Series Tests

S.K. Verma

SIS test have been the latest in the inkblot type of projective test used with patients with psychological disorder. In fact there are three types of inkblots with 5 forms available, cards, booklets and Videotape versions, to be used un a variety of ways. Test-retest, parallel form, Split half and inter-scorer reliabilities have been used with normal adults, adolescents, cardiac cases, vertigo, schizophrenic, neurotic, and transsexual patients. The results have been encouraging with normative, diagnostic and therapeutic studies reporting its utility as a quantitative as well qualitative measure. It seems to have a bright future.

Introduction:

Developed by an American Psychiatrist, Wilfred A. Cassell, Somatic Inkblot Series is the latest ones among the Inkblot Series of projective tests. (Cassell 1980, 1984, 1985, 1992) They have all the characteristics of a standardized projective test. The stimulus is ambiguous, situation more or less semi-structured and the aim is disguised. The tests are all standardized ones. There are five versions of it available in the market. The first one was brought out in 1960 the card version or SIS-I. There are 20 Inkblots images, black, red and gray. The test takes about 30 minutes for administration. The second one is a booklet version SIS-II, containing 62 images brought out in 1980. The third test is the Video version of SIS-II uses color, movement and sound and brought out in 1984. The fourth is the "SIS living images" brought out in 1992, exclusively made for females, consisting of 40 images videotape using color movement and sound. It is specially for eliciting sexual trauma. The fifth is the Video version of SIS-I card form brought out in 1992.

SIS tests can be administered in a variety of ways. For example – they can be self administered or they may be after supervised instructions (video). There may be a continuous administration or, an intermittent administration in a more relaxed manner at home. Another variation is self-administration before going for sleep, followed by in depth interview in the morning including the dream (s) analysis, if any. Also, there might be group administration.

Obviously, the evaluation of the tests had to be different for each type of test and for each type of administration. Also, when used in a different culture, some rechecking about reliability and validity is desirable. Over the years there have been a number of studies relating to the two of these most important aspects of tests standardization viz reliability and validity of SIS test. The results are briefly described below, with emphasis on studies done in India and/or on Indian patients, subjects. (These studies are given in the references).

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Reliability:

Although there are five forms available, essentially the two video versions of SIS-I and SIS-II can be called as parallel forms of the same tests in card form (SIS-I) and the booklet form (SIS-II). Additions of movement, music, and flowers in between the images are for further strengthening their stimulus values, inviting greater participation of the subject and ultimately to facilitate greater projection and revelation of their inner "cries"(Dubey and Cassell 1993).

Similar is the case with series A and Series B of SIS-II. They might also be called as parallel forms. Recent studies have shown that in fact, the two series give more or less the same mean scores on most parameters tested (Dubey and Cassell 1993).

Split-half reliabilities have been reported to be high and satisfactory for the SIS-II, on as many as 220 subjects, 100 of them normal and 120 psychiatric patients. Inter-scorer reliabilities were also found to be very high kind in fact no differences were found in different scoring categories, indicating thereby a high degree of objectivity (Pershad and Dubey 1994).

Due to late arrival of SIS tests in the world arena, it is not surprising that little work about its reliability is reported in India. If found suitable through various studies on their validity with different types of patient populations, it is to be hoped that more and more work will be reported on this essential aspect. More work is required for SIS-I and SIS-Living images.

Validity:

It is not sufficient for a test to have high reliability or consistency. It is also equally essential; if not more important, to show whether it is useful in differentiating patients from the normal and among different types of illnesses themselves. Its diagnostic and therapeutic efficacy has to be demonstrated before it can form part of the armamentarium of a clinical psychologist or, a psychiatrist while treating different types of psychological disorders.

A number of studies have been conducted in India, which point out to its utility as a valid instrument, some of which have been published also (Dubey and Cassell 1993; Sahay and Srivastava 1994; Dubey et al 1994; Dwivedi et al 1994; Rathee et al 1994; Verma et al 1994).

As compared to adults, adolescents have been reported to give greater number of human and anatomical responses but lower number of sex, movement and typical responses. Adolescents have also rejected greater number of images (Dwivedi et al 1994; Dubey et al 1994).

These studies have been reported on normal adults, adolescents, neurotics, psychotics, schizophrenics, vertigo patients, coronary cases, transsexuals, and others. Some of

these studies are normative studies; some case studies while others indicate therapeutic efficacies of SIS tests. Thus both quantitative and qualitative studies have been carried out in India.

As expected, psychotic patients mainly schizophrenics gave the greatest number of a typical responses. Paranoia ration Scores were also higher in them but surprisingly anatomical, hostility and depression scores did not differentiate the different diagnostic groups. (Dubey et. al. 1994; Dubey and Cassell 1993; Verma et. al. 1994).

As compared to American neurotics, Indian neurotics rejected greater number of SIS images and gave relatively fewer movement, anatomy and typical responses (Dubey et. al. 1994; Dubey and Cassell 1993).

Qualitatively, SIS tests have been shown to give useful leads to be followed up in therapeutic situations like with transsexuals (Sahay & Srivastava 1994), coronary cases (Rathi et.al 1994), adolescents (Dwivedi et. al 1994), vertigo cases (Dharamvir et. al. 1994) etc. The Somatic Inkblot Series is being used in various clinics and in different parts of India, where initial results have been reported to be encouraging (Personal Communications).

Conclusions:

Though a late arrival on the scene in India, Somatic Inkblot Series have shown some promise when used quantitatively as well as qualitatively, the reliability and validity of the scale scores has so for been quite encouraging and satisfactory. It is hoped that in future greater amount of work would be reported from different parts of the country, particularly after the formation of the Somatic Inkblot Society and SIS journal, whose inaugural issue was launched this year. It seems to have a great future as projective tools.

Suggestions:

1) There is a felt need to develop a list of most typical responses for Indian subjects for the different forms of SIS.

2) Physiological data on patients – particularly psychosomatic patients may also be generated and correlated with different responses to these projective images.

3) Providing the controls to the patients for the amount of exposure of and change of various SIS images as also over the type of music and free expression of movements like singing, dancing, jumping, crying, laughing, etc. may also be tried in future and not limiting to a few responses only per images.

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Diagnostic Significance of SIS –II

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As part of an ongoing study, the authors attempted to see if neurotics and psychotics can be dedifferentiated on selected SIS-II variables. Total Number of Responses, Movement responses, Typical and Pathological responses were low but Rejections and Atypical responses were more in the psychotic group as compared to the neurotic group. These results justify further studies on the subject.

Introduction:

Using Somatic Inkblot Series-II (Cassell 1980), Verma et.al (1994) had reported its usefulness in differentiating normal from the psychiatric population. Continuing the same theme, an attempt was considered necessary to see if neurotics and psychotics can also be differentiated from each other, before further continuing with this ongoing study – with the selected SIS variables. The present study is such an attempt.

Objective:

1. To find out whether SIS-II can differentiate between psychotic and neurotic disorders on selected variables.
2. If yes, on what parameters the two groups can be differentiated and on what they cannot be.

Material and Method:

Sample:

25 Psychotic and 23 neurotic patients diagnosed a per ICD – 10 criteria by the Psychiatrist, from the Psychiatry O.P.D. of Nehru Hospital, attached to Postgraduate Institute of Medical Education and Research Chandigarh – 160 012(India). The patients were group matched on selected important variables viz. Age, Sex and Education. All patients were volunteers who agreed to cooperate on request for the research purposes.

Tool:

Somatic Inkblot Series-II developed by Cassell (1980) was used. It consists 62 images specially designed to elicit body theme and “Cry for help”. The test was given under supervised self-administration. Subjects wrote down their responses for each of the images. Standard instructions for administration and scoring were followed.

Results and Discussion:

Sample Characteristics are shown in Table 1.

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Table 1
Sample Characteristics

Background Variables		Psychotics n=25)	Neurotics (=23)
Age in Years			
	Mean	33.60	29.30
	S.D.	12.66	9.57
Sex			
	Male	16	15
	Female	9	8
Education			
	Up to Primary	1	1
	Middle	3	3
	10-12 Class	9	10
	Graduate	10	6
	Postgraduate	2	3

The groups were found to be roughly matched, so no need was felt to use statistical methods to find out significance of difference e.g. the difference in the means was even less than half of the standard deviation.

Comparative Data:

The two groups are compared on SIS-II variables, as shown in Table 2. As compared to the neurotics, the psychotics showed lower number of responses, lower typical and pathological responses but higher rejection of images and atypical responses. Other categories of responses like Movement, Human, Animal Anatomical, Sex and Most typical responses did not show significant differences.

When both groups were compared with the normal as reported by Dubey et. al (1993). They showed low number of total responses, movement, sex responses and most typical responses but higher human responses, rejection of images and atypical responses.

Table 2
Comparison

Categories		Norms N=100) Dubey et.al 1993	Present Study (1994) Neurotic n=23)	Psychotic (n=25)
Total Responses	Mean	74.08	61.00	56.88
	S.D.	12.40	88.69	5.90
Movement	Mean	9.60	2.22	1.76
	S.D.	5.33	1.81	2.07
Human	Mean	14.66	18.33	17.32
	S.D.	5.46	5.44	5.46
Animal	Mean	8.65	9.30	7.88
	S.D.	4.69	6.54	4.05
Anatomical	Mean	9.18	9.43	8.16
	S.D.	4.24	6.73	8.09
Sex	Mean	4.12	1.48	1.12
	S.D.	2.58	2.25	2.05
Rejection	Mean	0.82	3.52	5.16
	S.D.	2.0	3.72	5.91
Most Typical	Mean	13.68	10.48	9.64
	(Max.17) S.D.	1.98	3.45	2.55
Atypical	0-2	93%	0%	0%
	3+	7%	100%	100%
Typical	Mean	-	24.04%	19.04
	S.D.	7.17	5.70	-
Pathology	Mean	-	1.61	-
	S.D.	-	1.73	1.46
Others	Mean	-	119.26	23.68
	S.D.	-	9.31	7.80

Since the study is ongoing, further differentiation would be made when a larger number of patients in each category are obtained. However, the available data justifies further continuation of work. The study is continuing and more data on different diagnostic groups would be reported in due course of time.

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Diagnostic Utility of Somatic Inkblot Series

B.L. Dubey, Wilfred A. Cassell, D. Pershad and Padma Dwivedi

Protocols of 500 subjects including 300 normal and 200 psychiatric patients (Neurosis and schizophrenia) were analyzed to find out whether the pattern of responses in two forms (SIS-II and SIS-Video) are different, (2) to demonstrate whether series A and series B of SIS-Video can be used independently to curtail the testing time and (3) to find out whether some of the objective scoring criteria be formulated to differentiate the patients of major psychiatric diagnostic categories. Results suggest that the SIS-II and SIS-Video can be divided into two short test consisting of series A and series B separately. The normal and the clinical groups differed on various scoring categories adopted here. SIS can help during selection as screening instruments. These scoring categories, however, are less informative as far as general psychology of individual patient is concerned. The profile of anticipated and given responses for the image are more important for thorough understanding of the patient.

Introduction:

The Somatic Inkblot Series (SIS) is the latest test in the armamentarium of personality assessment after the Rorschach test and Holtzman Inkblot Test. Somatic Inkblot Series has long history. Initially it was developed in 1960 as Somatic Inkblot Series I - 20 cards set. Encouraged with the clinical utility of this test and the experience gained, a self-administered technique Somatic Inkblot Series-II was developed in 1980. This consists of 62 images printed on 8 pages booklet. The subject can read the instructions written on the last page and can write the responses in the space provided for each inkblot images. Cassell took the advantage of new video technology and developed the third test of the series Somatic Inkblot Series-Video (1984) based on the 62 image of SIS-II. The SIS Living Images was developed in 1992 with 40 images exclusive for female subjects. The fifth test in the series in the video of SIS-I: 20-card set (Cassell, 1992)

The SIS-Video it is a color and sound videotape version of SIS-II images for supervised administration. The videotape begins with picture of followers and soft background music followed by stimulus images one by one. Each images stays on screen for nearly 30 second. The images are colored and impression of movement is also visualized. Many of the images have become sharper on screen compared to images in SIS-II. Background music continues up to the presentation of sample image and thereafter it stops. Floral presentation, however, precedes each image. Floral presentation with soft background music induces relaxation in the subjects. The rejection rate of images has dropped considerably and interest of the subject is maintained through out. Group administration if needed can be done with video/booklet forms.

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Usually the purpose of psychological tests is to assess the personality and to arrive at a psychiatric diagnosis. The purpose of SIS is much more. It helps to understand the psychopathology of the patient and to understand the severity of the problems as experienced and verbalized symbolically by the patient. In the interpretation of the problems the somatic inkblot series uses language of dreams, visual imagery and symbolic thought, which are most basic forms of thinking and expression. Since projective test are not based on verbal communication they more effectively penetrate the 'outer shell' of defenses and surface behavior. Because they do not require reading or manual performance such as in personality and intelligence testing, they more directly access mental processes.

Objectives:

The present study was started with the following objectives:

1. The find out whether the pattern of responses in two forms (SIS-II and SIS-Video) are different.
2. To demonstrate whether series A and series B of SIS-II or SIS-Video can be used independently to curtail the testing time.
3. To find out diagnostic indicators in neurotics and schizophrenics on the basis of worked out protocols.

Material and Methods:

Protocols of 500 subjects (300 Normal, 100 Neurotics and 100 Schizophrenics) were analyzed. SIS-II and SIS-Video was used as supervised self-administered test. All the subjects were largely in the age range of 18 to 45 years. Nearly 80 percent of them were male.

Results:

The SIS-Video stimulates the subjects more than SIS-II leading to more number of total responses (R=74.08). The percentage of responses under the category of Movement, Human, Animal, Anatomical and Most-Typical responses had been different in the two sets. Moment responses were more in SIS-Video images where as images are static in SIS-II. The table does not indicate much difference in the scoring categories except for the percentages of responses in Movement, Human and Anatomical categories as shown in Table 1.

Table 1

Comparison of Responses on SIS-II and SIS-Video in Healthy Normal

	Frequency per Protocol	
Categories	**SIS-II* (n=100)**	**SIS-II Video (n=100)**
Total Number of Responses	69.50	74.08
Movement Responses	5.00 (7.19)	9.60 (12.96)
Human Responses	17.40 (25.02)	14.66 (19.79)
Animal Responses	9.20 (13.2)	8.65 (11.68)
Anatomical Responses	12.20 (17.55)	9.18 (12.39)
Most Typical Responses	12.00 (17.26)	13.68 (18.47)

* Reproduced from Dubey and Cassell (1993) Mean Percentage is given in parenthesis.

Table 2

Comparison of Responses on Series A and Series B of SIS-Video

Categories	**Series A**	**Series B**	**r**
Total Number of Responses	40.10	33.92	.86
Human Responses	18.60	21.46	.56
Animal Responses	12.64	10.11	.60
Anatomical Responses	12.42	12.17	.59
Sex Responses	6.08	5.07	.45
Movement Responses	14.01	11.82	.59
Most Typical Responses	17.46	19.28	.39
Rejection of Images	0.57	1.71	.74

(R is shown in Mean and other Categories in Mean percentage)

Table 2 suggests that the responses in series A and B are almost proportionate. The correlations for the different scoring categories are significantly high except for Most Typical responses where the range of score is less hence correlation was low but still significant beyond .01 level.

Table 3
Diagnostic Indicators of SIS-II/Video

Indies	**Normal N=300**	**Neurotic n=100**	**Schizophrenia n=100**
Responses ®	61-75 >62	53-65 <59	50-65 <62
Most Typical Response (Out of 18)	>31	<11	<8
Typical Responses	>50%	35-50%	<30%
Atypical Responses	<12%	15-20%	>20%
Human Content Animal Content	20-25% <11%	>25% >12%	>25 with poor form >16%
Anatomical Content	<15%	>15%	>18%
Sex Content	About 6%	About 4%	About 6%
Movement	<13	<8	<10
Rejection of Images	<11 Image	>5	>4
Pathological Response (PAS, HAS, D, P)	Almost Absent	More of HAS & Depression	More of P (Paranoid & PAS)
Hardcore Indices	: Mt, Rejection, Pathological, Atypical		
Soft Indices	: H, A, AT, Sex		

Analysis Based of Data Published in SIS J. Proj. Psy & Men Health(1994) and Brit. Jr. Proj. Psy. (1993) on over 500 cases.

Table 3 suggests that 62 images of SIS-Video are able to discriminate normal subject from neurotics and schizophrenics. Certain indices are able to differentiate within the clinical groups-neurotics and schizophrenia. As evident the total number of responses is more in normal than in the other two groups. Normal subjects give more of Most-Typical responses and schizophrenics the least. Neurotics are in between. Similar trend is found in Typical responses also. Atypical responses are more in schizophre-

nia, and least in normal subjects. Neurotics are again in between. Human responses have not been able to differentiate the groups expect that the quality of human responses are poor in schizophrenia. Animal and Anatomical responses are more in schizophrenia than in the normal group. Movement responses are unable to discriminate the groups. Rejection of responses is much higher in clinical groups and lowest in the normal group. Pathological responses are almost absent in the normal group. Neurotics give more of Hostility Aggression score and Depression Score where as the Schizophrenics give more of paranoid and Pathological Anatomy Score. On the basis of the results, Most Typical responses, Rejection, Pathological Scores and Atypical indices are found to be hardcore indicators and H, A, At and Sex as soft core indices. The findings are shone in Table 3.

Keep the above indices in view the SIS was tried during the selection of employees as a screening test. The findings are very encouraging. The subjects, who did not reject any images, gave more than 13 MT responses, more than 20 percent of Human responses, less than 15 percent of Animal and Anatomical responses and no pathological responses were recommended for inclusion. However, non-was rejected on the basis of psychological tests. Selection was finalized on the basis of overall performance in the interview. Indices found successful are shown in Table 4.

Table 4
Successful SIS Indices

Indices	
Rejection	Less Than 1 Percent
Most Typical Responses	More than 13 (Out of 18)
Human Responses	More Than 20 Percent
Animal Responses	Less Than 15 Percent
Anatomical Responses	Less Than 15 Percent
Pathological Responses	Almost Absent

To give a better understanding to one having less exposure to SIS procedure, images, assessing different areas are shone in Table 5.

Table 5
SIS Images Assessing Different Area

Area	Images
Impersonal Relationship	A9, 21, 24, 28, 31, B4, 5, 28, 31
Ego/Self Image	A5, 6, 7, B 22,27, 28, 29
Healthy Body imagery	A10, 12, 13, 14,15, 16, 17, 18, 19, 20, 22, 23, B 9, 11, 16, 17, 20, 30
Erotic Imagery	A 4, 8, 22, 25, 27, B 18, 25
Hostility / Aggression	B15, 21
Insecurity	A13, 24, 26, B19
Thinking in Group conformity	A7, 7, 9, 13, 20, 23, 27, 30, 31, B 4,5,9,22,27,28,29,30,31

Discussion:

The results given in Table 1 and the experience obtained after administering SIS-II and SIS-Video suggests that SIS video helps in facilitating the patients to verbalize more. Many patients/subjects dream after viewing video and this further helps in processing their unprocessed face-lifting unconscious material. Such material helps during therapy. These objectives have been achieved without disturbing the purpose of the images. A busy clinician generally hard pressed for time for supervising complete administration of the test taking around one hour to administer form A and B. The series A and B as observed in Table 2, give almost similar results with significantly high correlations for various scoring categories such as total number of Responses, Human, Animal Anatomy, Sex, Movement, Rejection and Most Typical Responses. Thus the clinical utility of the test is not disturbed even if the length of the test is reduced fifty percent though complete administration helps in better understanding of the case.

Normal and Psychiatric cases differed almost on all the categories significantly as observed in table 3 and 4. These scoring categories nevertheless, are the means of demonstration in researches rather than helping much in understanding the psycho-pathology of the patient. For the purpose each protocol is to be evaluated for the responses a subject has given for the images carrying specific stimulus value.

Table 4 suggests how SIS helps as a quick screening test during selection through the final selection is based on the basis of over all performance in the interview.

Table 5 suggest various areas being assessed by Somatic Inkblot Series-II and the corresponding Video

Conclusion:

It can be concludes that the SIS-II and SIS-Video both elicit almost similar responses but the interest of the patient is maintained more in SIS-Video. SIS Video can be divided into two short tests consisting of series A and B separately. It was found that the normal and the clinical groups differed on different scoring categories adopted here. These scoring categories however, are less informative as far as general psychopathology of the individual patient is concerned. The profile of the individual/patients anticipated and given responses the images are more important for thorough understanding of the patients.

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SIS J. Proj. Psy. & Mental Helth (1995) 3: 68-73

Hospitalized Suicidal Patients and the Somatic Video Procedure: A Descriptive Study

Elizabeth N. Bellamy

A descriptive study was undertaken to examine correlation between suicidal ideation and certain results of the Somatic Inkblot Series Test (SIS). Comparisons of test results of five case studies of threatened suicide and/or attempted suicide were done showing increased deviant response in the two cases in which suicide was threatened and also acted upon. Data from the study suggest that significant correlation exists between suicidal ideation and deviant responses to the SIS Test. However, due to the small sample no definite conclusion can be drawn.

Each year approximately 30,000 completed suicides are reported in the United States (Robinson, 1989; Wrobleski, 1989). However, this figure does not include completed suicides that appear to be accidental, such as single-victim accidents due to motor vehicles, hunting, industrial mishaps or poisonings. The actual number may be higher due to under-reporting (Hafen and Frandsen, 1986).

Men kill themselves four times more often than women. Women attempt suicide three times more often than men (Wrobleski, 1989). Teenage suicide has become a critical national problem. The extent of that problem is mind-boggling: a teenager attempts suicide every ninety seconds, and another succeeds every ninety minutes. But the problem is difficult to estimate because many suicides are confused as accidents, and other deaths are not reported as suicides in order to save the family from embarrassment. Recent estimates, however, are distributing: some feel that as many as 7,000 teenagers each year commit suicide, while an additional 400,000 try unsuccessfully to end their own lives (Grollman, 1988 ; Hafen and Frandsen, 1986 ; Robinson, 1989).

An expert in the field, Los Angeles psychologist Dr. Michael Peck, estimates that a million children each year think at one time or another suicide – something he calls “an epidemic of suicidal communication among young people” (Hafen and Frandsen, 1986).

Approximately 0.3 percent to I percent of all emergency room visits involves a suicide attempt. The ratio suicide attempts on compete suicides is estimated to be about one in forty. Failure to recognize the risk may help the patient to succeed on the next attempt.

Suicide as a deliberate act of self-destruction is a specifically human behavioral phenomenon; its occurrence can be traced through recorded history (Grollman1988; Wrobleski, 1989). Although causal explanations have been sought in terms of climate and creed, religious persuasion and cultural belief, personality structures and social custom, we are still far from a clear understanding of the reasons, which drive some

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people to such a decision. Reliable figures are not available, but it has been estimated that at least 11,000 persons through out the world commit suicide every day (Grolman, 1988; Hafen and Frandsen, 1989; Robinson, 1989; Worbleski, 1989).

Suicide is one of the ten leading causes of death in the United States and is the second most frequent cause of death among teenagers, and young abuts (Crow, and Crow, 1967). The age at which young people commit or attempt to commit suicide is declining each year. Suicide affects all segments of society the young and old, the poor and rich, males and females, and people of all races and ethnic groups (Wrobleski, 1989.) Suicide statistics are conflicting; they attempt to present a scientific evaluation of a highly emotional and individual act. For many years more men than women committed suicide. The ratio was four men to one woman. For women, the reverse is true for attempted suicides. But over the past twenty years, the incidence of suicide among women has risen more than for men, especially among peoples from forty five to forty-nine years of age (Hyde and Forsyth, 1978). Present day mobility and lack of roots, weekend family structures, and increased pressures to succeed have all been suggested as playing a part in the trend toward higher suicide rates.

Suicides have generally been greater among whites than blacks; however, black suicide is on the risk, especially among the young. The suicide rate for black males in their early twenties has shown an alarming increase (Hafen and Frandsen, 1988).

Objectives:

1. Does the SIS Test reliably select-out those patients who have gone on to make serious suicidal attempts?
2. Is the SIS Test a reliable predictor of suicidal ideation within the groups sampled?
3. What are the clinical implications of the study?

Material and Method:

This study included five cases of male and female subjects between the ages of 17 and 44 years, who expressed suicidal ideation, two of them had history of serious attempts to end their lives. The scope of this study focused on patients in an inpatient setting who had been hospitalized for suicidal indention. SIS-Video was administered as per procedure (Cassell, 1984, 1990).

Results:

Five ease studies with the help of SIS-Video are given below. In each case a brief history, psychiatric diagnosis and the finding of SIS Video indicating aggression and violence are given.

Case 1:

DSM-III R309.00: Adjustment Disorder with Depressed Mood.

Forty year-old fireman who experienced intermittent pain in his neck, back and chest from Thoracic Outlet Tunnel Syndrome. He had undergone an unsuccessful surgical procedure to relieve nerve pressure and had become clinically depressed facing further surgery. He was evaluated in a psychiatric hospital when his depression deepened to the point of his development of significant suicidal ideation. Using interviews it was determined that the suicidal ideation had disappeared before he took the SIS Test.

	Heart	**Weapons**	**Violence**	**Blood**
Typical	8	2	0	0
Given Response	4	2	0	0

His responses verify lack of suicidal ideation at the time of testing

Case 2:

DSM-III 296.34: Major depression, with psychotic features.

Twenty-year old married woman who was hospitalized when she experienced significant suicidal ideation after visiting her mother and stepfather. When admitted, she was 10 months postpartum after the birth of her first baby. She had a life long history of abuse involving her brother, her biotical father and her stepfather, with possible sexual abuse of which she had no memory. Frequently, she ruminated in her mind about the terrible verbal abuse she had experienced in visiting her family. She contemplated cutting her wrists at times and at other, either taking an overdose of pills or shooting herself.

	Heart	**Weapons**	**Violence**	**Blood**
Typical	8	22	0	0
Given Responses	6	3=3AT	0	1

Her responses to the heart images were typical. Of interest is her response to weapons. She saw A29 as a gun. A 29 is the one image in the series that is “projective” in which the person projects their own image on to the scene. In viewing B 21, which is typically seen as a gun, she was unable to give a response. She did not give any violent responses. Her one-blood response was seen as her mother’s face with blood on it. Her responses to the SIS Test shown moderate suicidal indications.

Case 3:

DSM-IIIR 295.9x: Schizophrenic Disorder, Chronic Undifferentiated Type 309.89Post Traumatic Stress Disorder.

Forty-one year old single female veteran of Vietnam. She had been admitted to a psychiatric hospital with suicidal ideation. In the past, she had made suicide attempts with overdoses and cutting her wrists. She showed major psychotic defects in cognition. She experienced both auditory and visual hallucinations. She was extremely paranoid. In a delusional fashion she believed that people on television were talking about her and at times she saw herself on the television screen. She first became mentally ill while in the military at the end of the Vietnam War. During the period of her initial breakdown, like many Vietnam veterans, she was greatly stressed by public reactions to the war.

	Heart	**Weapons**	**Violence**	**Blood**
Typical	8	2	0	0
Given Response	7	1	6	1

Her heart responses are typical as is her weapons responses. These may be the results of the Post-Traumatic Stress Disorder stemming from her experiences in Vietnam. Of interest is her one blood response. She saw B14 as a vase with blood in it. Her responses to the SIS Test images show moderate to high suicidal ideation.

Case 4:

DSM-III-R 296.3x: Major Depression, Recurrent: 303.90 Alcohol Dependence, possible 300.14 Multiple Personality Director.

Forty-four year old married women with training in medical technology was initially evaluated in a psychiatric hospital after having been treated with blood transfusion in an intensive care unit of a medical ward. At the time, she was anemic from lacerated veins in her ankles. She had indicated her injury in a serious suicide attempt. She made the attempt within twenty-four hours following her therapist's advice to leave her husband. In her lifetime, she had made a dozen suicide gestures. In the preceding eight years, four true death attempts.

	Heart	**Weapons**	**Violence**	**Blood**
Typical	8	2	0	0
Given Response	7=3AT	2=2AT	3	3

Her heart responses were typical except for A17, "Heart torn in half," B14, "x-ray of a diseases heart," and B19, "Medusa world separating hearts." For the two weapons images, she saw B15 as "Shrouds of broken glass puncturing woman in shower," and

B21, "Handgun firing" The three violent images were B4, "Shark caught in a dam by its tail" B 21, "A dark threat to little children": B 20, "Brain destroyed by hemorrhage". The three blood images she saw were A29, "Blood spilled on the floor, A31 "Two people with red brains. "and B 2 "A bloody goat head." Of interest is her responses to B 24, " God cradling spirit child," and B 22, "Spirit oozing from physical body. Her responses to the SIS Test reveal severe suicidal ideation.

CASE 5:

SDM-III-R 296.3X: Major Depression, single episode, severe, without psychotic features.

Seventeen-year-old single female who was admitted to a hospital because of major depression and suicidal ideation. She was transferred to a psychiatric facility where she attempted to cut her wrist with a coke can. She was then transferred to an adolescent facility where she was evaluated using the SIS Test.

	HEART	**weapons**	**Violence**	**Blood**
Typical	8	2	0	0
Given Responses	5=3 AT	3=3 AT	4	4

On her five heart responses, there were atypical; A 16, "Two song birds with bills together, blood pouring down and a heart in-between, "B17, "A bright red heart that burst, "and B19 "A big fuzzy spider with its heart broken searching for a new heart. "Her responses to the weapon images were also atypical. A29, "A shadow of someone with a gun and blood in the background," B15 "Some one cutting themselves with a knives and sharp point," B21, "A gun that just shot someone." The violent images she saw were A2 "An old women walking with skeletons behind her, B2, "Two people hanging upside down. They look torn apart," B4 "My self image. I known somewhere I'm bright. I can't face that I'm depressed and want to be dead," B20, "A brain that looks as if it's getting ready to blackout, "and B 31, "A family that used to be happy but now are down like they are at a funeral. The blood images she saw were A16, "Two song birds with bill together, blood pouring down and a heart in between" A 29, " shadow of someone with a gun and blood in the background," B3, " A blotch with blood and a first," and B 22, "A person lying down dead loosing blood fast." Her response to the SIS Test shows severe suicidal ideation.

The purpose of this descriptive study was to explore the relationship between serious suicidal ideation and verbalization/imagery of aggressive contents: heart, weapons, violence and blood on the SIS Test. This study attempted to sow that the more serious the suicidal ideation, the more atypical heart, weapons, violence and blood responses would be on the SIS. The summary chart of the cases on SIS is shown ahead.

	Heart	Weapons	Violence	Blood
Typical	8	2	0	0
Case #1	4	2	0	0
Case #2	6	3=3AT	0	0
Case #3	7	1	6	1
Case #4	7=3 AT	2=2 AT	3	3
Case #5	5=3 AT	3=3 AT	4	4

In looking at the earlier summary chart, it is clear that the cases progress from moderate to sever with case # 4 and # 5 showing the most deviant responses, thus expressing more suicidal ideation. Results suggest that significant relationship exists between ideation and deviant responses on the SIS Test.

Conclusion:

Suicide is one of the most serious and social dilemmas facing society today. It is clear that a more accurate predictive tool is needed to isolate those cases in which suicidal ideation is extreme enough to cause a person to kill one self. Research into the SIS Test and suicidal ideation may point the way to such a predictive tool.

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