CHAPTER 1
Schizophrenia and affective disorders (mood disorders) are found in all societies and geographical areas, incidence and lifetime prevalence are roughly equal worldwide. Schizophrenia begins early in life, causes significant and long-lasting impairments, makes heavy demands for hospital care, rehabilitation and support services and therefore, the cost of treatment is higher than that of mood disorders. The incidence of schizophrenia approximates 28.7 percent of total psychiatric population and of affective disorders is still higher in India. These two disorders comprise more than 50 percent of total psychiatric disorder consequencing a heavy financial burden on mental health budget of our country. Despite methodological advancement in diagnosis, treatment, and rehabilitation programme, these disorders blow their triumphant over human misery. Schizophrenia is a paradigmatic illness of psychiatry containing a clinical syndrome of variable and profoundly disruptive psychopathology that involves thought, perception, emotion, movement and behaviour. The expression of these symptoms varies across patients and over time, but the cumulative effect of the illness is always severe and usually long lasting. Schizophrenia can broadly be defined as diseased
process or condition characterized by a range of symptoms involving disturbances in content of thought, form of thought, perception, affect, sense of self motivation, behaviour and interpersonal functioning. The characteristic symptoms for diagnosis of Schizophrenia are catalogued in D.S.M. IV (2000) as follows:

**Criteria for Schizophrenia**

A. Characteristic Symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated);

1) delusions
2) hallucinations
3) disorganized speech (e.g. frequent derailment or incoherence)
4) grossly disorganized speech or catatonic behaviour
5) negative symptoms, i.e. affective flattening, alogia, or avolition

Note: Only one criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.
B. Social / occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations or self-care are markedly below the level achieved prior to the onset (or when the onset is in the childhood or adolescence, failure to achieve expected level of interpersonal, academic or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet criterion A (i.e. active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in criterion A present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder with Psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently
with the active - phase symptoms; or (2) if mood episodes have occurred during active - phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance / general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Mood disorders are characterized by pervasive dysregulation of mood and psychomotor activity and by related bio-rhythmic and cognitive disturbances. It is basically disorder of emotion accompanied by secondary disorder of cognition, perception and behaviour. The disorder is classified into two types - unipolar and bipolar mood disorder. Unipolar mood disorder is defined as occurrence of either depression or mania with intermittent interval of normalcy but bipolar disorder is
characterized by occurrence of both depression and mania in a cyclical order with intermittent interval of normalcy in life-cycle. Moods convey sustained emotions; their enduring nature is experienced long enough to be felt inwardly. The criteria for diagnosis of mood disorder: major depressive episode and manic episode, are listed below (DSM IV):

Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly everyday, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful) Note: in children or adolescents, can be irritable mood

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every
day (as indicated either by subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly everyday. Note: in children, consider failure to make expected weight gains

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
B. The symptoms do not meet criteria for a mixed episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

E. The symptoms are not better accounted for by bereavement, i.e. after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.

Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted
(four if the mood is only irritable) and have been present to a significant degree:

1. inflated self-esteem or grandiosity

2. decreased need for sleep (e.g. feels rested after only 3 hours of sleep)

3. more talkative than usual or pressure to keep talking

4. flight of ideas or subjective experience that thoughts are racing

5. distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)

6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investment)

C. The symptoms do not meet criteria for a mixed episode.
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationship with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hyperthyroidism)

Note: Manic-like episodes that are clearly caused by somatic anti-depressant treatment (e.g. medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.

In brief, behaviour, psychological functioning (perception, emotion and cognition) and interpersonal relations are impaired both in schizophrenia and mood disorders (affective disorders) but dimension and magnitude of impairment in these behavioural and psychological functioning are variant in varied nosological classificatory type of disorders. According to psychoanalytic theory, Ego is the governing authority of connotion, perception, volition, emotion and cognition, and disturbance in ego-functioning for its poor development is the attributable dynamic factor of genesis of the disorders.
Ego Functions in Normals and Psychiatric Population

Libido (psychical life energy) and mortido (psychical death / aggression energy) are differentially invested in variant topographical states of mind. Ego regulates balanced investment of these psychical energy, libido and mortido, in conscious states that frequently deals with reality. It, thus, serves as regulatory mechanism controlling behaviour and psychological functioning. In face of moderate stress, frustration and internal conflicts, ego operates in partially conscious and partially unconscious province of mind and directs libido in variant appropriate measures of ego defenses to maintain mental balance, but in severe life stress it appears to operate more often in unconscious and to regulate ego defences influencing psychological functioning. In brief, ego operates variantly in conscious and unconscious and utilizes differentially the psychological energy; libido and mortido for regulating psychological functioning. In normals, ego generally operates in conscious state where as in psychic illness it more often operates in unconscious governing the psychological functioning.

The most comprehensive function of the ego can best be described as follows:

“Here are the principal characteristics of the ego. In consequence of the pre-established connection between sense
and perception and muscular action, the ego has voluntary movement at its command. It has the task of self-preservation. As regards external events, it performs that task by becoming aware of stimuli, by storing up experiences about them (in the memory), by avoiding excessively strong stimuli (through flight), by dealing with moderate stimuli (through adaptation) and finally by learning to bring about expedient changes in external world to its own advantage (through activity). As regards internal events in relation to Id, it performs that task by gaining control over the demands of the instincts, by deciding whether they are to be allowed satisfaction, by postponing that satisfaction to times and circumstances favourable in the external world or by suppressing their excitations entirely. It is guided in its activity by consideration of the tension produced by stimuli whether these tensions are present in it or introduced into it” (Freud, 1938).

In essence, the ego controls motility, perception, contact with reality, and through the mechanisms of defense available to it, it delays, postpones and modulates the drives for their expression. It is an agency or organization of functions that have in common the task of mediating between the instincts and the outside world. The abstracted descriptions reflect the activities that are generally regarded as basic and fundamentals of operation of ego.
1. It has potential capacity to control and regulate instinctual drive in form of delaying or postponing drive discharge, to test reality, to promote socialization acquiring language and secondary order of thinking, to think in a logical and abstract manner allowing the representation of drives in fantasy or in other measures of defensive functioning.

2. It regulates judgement which involves the ability to anticipate the consequences of one’s action. As with the control and regulation of instinctual drives, judgement develops in parallel with the growth of secondary process of thinking.

3. It mediates between internal world and external world. Reality testing is a fundamental function of the ego that differentiates psychotics from non-psychotics. To next, it has the ability to utilize one’s resources for developing effective responses to changing circumstances on the basis of previous experiences with reality.

4. It has the ability of developing mutual satisfying object / parental relationship and of internalizing positive and negative aspect of others and to maintain an internal sense of others, even in their absence.

5. It has the capacity of organizing, coordinating and generalizing or simplifying large amount of data.
6. It regulates defense mechanisms to maintain mental balance in face of severe trauma, life stress and inner mental conflicts.

In normals, by means of psychological efficacies, ego directs libido for resolution of inner conflicts, and it accommodates with reality effectively by means of cogent utilization of psychological apparatus, perception, emotion and cognition, and thus, it is left with only a much reduced fraction of libido for defences or experience contents of unconscious. But in psychotic process, ego fails to evaluate reality properly resulting distortion, and therefore utilizes suppression and regression mechanism along with libido to the oral stage. Ego-regression disintegrates the boundary between self and non-self resulting development of hallucinations and delusions. Ego functioning becomes very poor in schizophrenia and pervading impairment spreads to behaviour, perception, emotion and cognitive domain. But in mood disorder, ego impairment invades pronouncedly to emotion and secondarily to perception and cognition; especially in depression ego submerges in superego, loosing its controlling ability over psychological apparatus. In turn, this condition results in depression accompanied by self-criticism, self-blame, guilt, suicidal ideation and retardation of activity. The ego gradually retreats and reappears to have control over psychic apparatus but fruitlessly utilizes compensatory defense (manic symptoms against depression) i.e. delusion of grandeur against underlying
deep sense of psychological deficiencies. Ego frequently operates, in psychotic condition, in unconscious province for having control over psychic apparatus. Congruent with intrapsychic analytic model, the contents and drives of unconscious are forbidden to move directly to consciousness that is the core concept of psychosis.

To unearth the unconscious contents and drives and to bring them to conscious province, projective technique is evidenced to be instrumental. In backdrop of this theoretical model, projective techniques were developed to scan ego strength, to bring back unconscious contents, and to rescue and resurrect libidinal drive in direction of reintegrating with consciousness, and to free one from tyrannical sufferings of psychosis.

Projective techniques (Murray, 1928) are born, nurtured and developed in climate of psychoanalysis. The school of psychoanalysis assumes symptoms of mental disorders as symbolical representation of unconscious contents whose accumulated energy is directed towards soma when their flow is denied by ego to consciousness. Symptoms of mental disorders are, therefore, conceptualized as allegorical portrait of unconscious drives, forces, experiences, conflicts, e.g. impotency as symbolical manifestation of incestuous conflict, delusions as unconscious homosexual drive, hallucination as symbiotic ties of self with external environment etc. Projective
techniques are means to uncover unconscious contents reflected in responses to unstructured / semi-structured stimuli. Discovery of unconscious contents helps the clinician for integrating them to consciousness, resulting in insight development into disorder, restructuralization of cognition and affect in client. The technique, thus, is an aid for understanding dynamics of the disorder and for reducing sufferings in clients (therapeutic value). It is equally used for diagnostic purpose when client presents a cluster of mixed symptoms evidenced in variant disorders. Projective tests are now a day widely used for diagnostic clarity, psychodynamic formulation and psychotherapeutic effectiveness.

Despite several criticisms raised against projective tests from biological sciences, school of experimental psychology and social schools of thought, the status of projective technique for purpose of diagnostic formulation, psychodynamic and therapeutic utility can not altogether be denied.

Lindzey (1961) synthesizing the major elements described in the literature has offered a definition of projective technique. A projective technique is an instrument that is considered especially sensitive to covert or unconscious aspects of behaviour, it permits or encourages a wide variety of subject responses, is highly multidimensional, and it evokes unusually rich or profuse response data with a minimum of subject awareness concerning the purpose of the test. Further, it is very
often true that the stimulus material presented by the projective test is ambiguous, interpreters depend upon holistic analysis, the test evokes fantasy responses, and there are no correct or incorrect responses to the test.

CLASSIFICATIONS OF PROJECTIVE TECHNIQUES

Projective techniques have been classified by different psychologists into different categories. Frank (1939) classified on the basis of the nature of responses evoked by the materials of projective techniques.

Constitutive

This category includes all those test situation in which the examinee constitutes or frames structures upon materials which are yet unstructured. Rorschach, Finger painting are its best examples.

Constructive

The constructive category though apparently similar to the constitutive category, includes all those situations where the examinee is required to construct a specified task. He is required to impose a degree of structure upon the situation in the direction specified by the examiner. The examinee may be asked to draw a figure of human male or female according to his own wish.
Interpretative

This category includes all those test situation where the examinee is required to add a comprehensive meaning to the situation. Thematic Apperception Test and Word Association Test are included under this category.

Refractive

Included in this category are all those techniques through which the examinee is given an opportunity to express his personality in the form of painting, drawing, handwriting and so on.

Cathartic

This category includes those situations whereby the examinee is given opportunity through some manipulative tasks for the release of his conflicts and wish. Play techniques are its best example.

An examination of Frank's (1939) categorization system of responses of projective technique, reveals that constitutive, constructive, interpretative, refractive and cathartic typology emphasizes the underlying mechanism of flow of unconscious emotional, motivational contents to consciousness that directly influence the perception, cognition and behaviour. Frank's classification is based basically on evoked responses by projective material but he appears to be silent of creative
persuit of the client that is generally manifested in client’s performance.

Lindzey (1961) therefore categorized projective technique into five types which are briefly abstracted below:

**Association Techniques**

Here the subject is asked to tell what is suggested by a verbal, visual, or auditory stimulus (e.g. Word Association, Rorschach).

**Construction Techniques**

These Techniques involve the creating of an imaginal production for which the test materials provide a framework (e.g. T.A.T., Make – A – Picture Story).

**Completion Techniques**

They require the subject to complete a statement or story; they are a more structured construction procedure (e.g. Rosenzweig Picture – Frustration Study, Sentence Completion Test).

**Choice or Ordering Techniques**

Here subjects are asked to arrange materials in story telling sequences, in order of choice etc. often with no verbal elaboration (e.g. Tomkins – Horn Picture Arrangement Test, Szondi Test).
Expressive Techniques

These techniques do not depend on test stimuli, rather the subject is asked to perform an artistic or creative act (e.g. Draw - A - Person, Finger Painting, Play, Psychodrama)

Lindzey’s classification system is based on the types of task involved. The tasks are not stimuli-dependent rather they are stimuli-independent and are creative / artistic. It is, therefore, presumed that unconscious drive, affect and frustrated malignant contents (basic matrix of symptom formation) are sublimated in a creative / artistic mode when the client is provided an opportunity. In other words, his mortido is transformed into libido (life-force) and is directed towards creative performance.

Best (1978) synthesized both the classificatory systems and proposed a four way classification as summarized below:

Association:

Under this category are included all those techniques where the examinee is presented with stimulus materials like Picture, inkblot and words, (e.g. Rorschach Test, Holtzman Inkblot Test, Word Association Test).

Completion:

In this category some incomplete sentences are presented to the examinee who completes them in the way he likes. The Sentence Completion Test belongs to this category.
**Role - Playing:**

This technique requires the examinee to act out a specific role in a group of two or more individuals for a certain period of time.

**Creative or Constructive:**

This technique includes all those test situations where the examinee is required to do some tasks like playing with dolls or toys, paint or finger print and draw a figure.

Projective techniques in brief are variant modes of extracting unconscious contents that can best be utilized for understanding psychodynamics, enriching cognitions and integrating affective, cognitive and connotive components.

**INKBLOT TECHNIQUES**

Inkblot is a blotted pattern of spilled ink. It is prepared by throwing the ink on a piece of paper and folding it in the middle. When the paper is opened, an unstructured picture will be seen which is called inkblot. On these techniques, it is presumed that an individual projects his conscious / and unconscious contents - drives, conflicts, inner feelings, attributes, likes and dislikes on the external environment and thus reveals his personality. From among the various projective techniques inkblot techniques are the most favored and widely used to study an individual's projections. The tests give access
to the deeper levels of personality. Inkblot techniques are especially helpful in evaluating patients with limited language and verbal skills, such as children, foreign-born or new immigrants, native people, the learning disabled or the mentally retarded.

The available inkblot tests are:

a) Rorschach Inkblot Test  
b) Holtzman Inkblot Test  
c) Shukla’s Coloured Inkblot Technique  
d) Somatic Inkblot Series – I  
e) Somatic Inkblot Series – II  
f) Somatic Inkblot Series – I Video  
g) Somatic Inkblot Series – II Video  
h) Somatic Inkblot Series – Living Images.

History of Inkblot Techniques

The utilization of amorphous or ambiguous stimuli for reaching decisions probably had a long pre-historic development. Kerner (1857) noticed the way in which the accidental inkblots assumed various forms. Tracing the history of inkblot technique is not easy. It is traceable only through Rorschach’s own writing and through the writings of Emil Oberholzer, Walter Morgenthaler and George Roemer. Zubin, Eron and Schumer (1965) indicated that the concept of formless
stimuli used in inkblot techniques to stimulate imagination can be traced back to Leonardo Da Vinci and Botticelli in the 15th century.

Exner (1969) wrote that it was important to note that in Europe during the latter half of the nineteenth century, and the early part of the twentieth century, there was much public interest in inkblots, not as a test but more as a game. It was very common for inkblots to be used in a popular parlor game called "Blotto", where the challenge was to associate an image to a design. The design might well have been created right there, or taken from the many inkblots and similar designs appearing in contemporary books and magazines. Krugman (1942) cites the evidence that as early as 1895, Binet and Henri suggested that inkblots could be used for studying various personality traits, especially visual imagination. Dearborn, while working at Harvard University, published an article in 1897 discussed the potentials of employing inkblot techniques in experimental psychology. As Tulchin mentions, in 1848 Dearborn published the results of applying an inkblot technique to a group of sixteen subjects, wherein he used twelve sets of inkblots, each having ten blots similar in nature. Tulchin also cites the pre-Rorschach work of Sharp, Kirkpatrick, Whipple, Pyle, Bartlette and Parsons, all of whom published material between 1900 and 1917 concerning inkblot methodology in the United States and England (Exner, 1974).
Zubin and Eron (1966) described three periods in the history of inkblot use in projective testing. Artists who painted "indeterminate forms to simulate creative imagination" comprised the pre-experimental period in the nineteenth century. Binet introduced the "Psychological experimental period" in 1895 with his assessment techniques, which measured imagination as an index of cognitive ability. Binet believed that a large number and variety of inkblot responses were positively correlated to "lively visual imagination" (Binet and Henry, 1895). Other inkblot researchers hypothesized that conscious awareness was slowed by ambiguous stimuli, thus making the perceptual process accessible for research purposes (Dearborn, 1897; Whipple, 1910).

The third historical period began in 1911 with Hermann Rorschach's innovative research on "the interpretation of accidental forms". His interest in art forms and perception surfaced when he was a school boy. He was affectionately nicknamed "Klex" or "inkblots" by his peers (Cassell, 1980). Roemer (1967) wrote that Rorschach's first purpose for developing an inkblot test was to investigate the subject's reflex hallucination through viewing inkblots. Cassell (1965) initially used inkblot to study the subject's body perception and somatic symptoms. Cassell (1980) extended the use of this technique to where the clinician could better hear the suffering individual's "inner cry".
**Inkblot Techniques in India:**

Rorschach test was introduced in India probably in the pre-independence period, and the earliest published work appeared in 1947 (Prasad and Asthana, 1947). Some earlier reviewers of the test (Bhargava and Saxena, 1995) have opined that Dosajh (1956) and Jain (1956) being the pioneers in using the tool for research in India. The study of Prasad and Asthana (1947) was an experimental one from a 'general psychology perspective' wherein they looked into the signs of meaning on Rorschach test.

setting had been using the test. Asthana (1965, 1966) published Rorschach study on child development in India. Dixit (1964) conducted developmental study of the Rorschach response pattern of children between 5 plus and 10 plus.

In nineteen seventies, a lot of work was done on the test. Some of the important studies on the test published during sixties and seventies are as follows:

Ardhapurkar et al. (1965, 1967) studied Rorschach on Ischaemic heart disease and bronchial asthma. Arundale and Chandra (1967) studied the attitudes using projective tests and especially the Rorschach test. Akhtar et al. (1975) published a Rorschach study of obsessional neurosis.


26


During the eighties and nineties projective psychology in India spread practically in all departments of psychology leading to many research studies. Dr. B. L. Dubey brought Somatic Inkblot Series (SIS) test to India in 1988. The SIS is based on the assumption of the Rorschach test and is a further extension of Rorschach. Dr. Wilfred Cassell is credited to be the leader and pioneer in the inkblot video technology. Lot of work is being carried out on this test in different countries (Mishra, 1996; Rathee et al., 1998; Mitra, 1998; Bellamy, 1995; and Brady, 1995), normative data and clinical indices (Cassell and Dubey, 1996, 1997, 1998; Dwivedi et al., 1994, 1995;

THEORETICAL BACKGROUND

a) Rorschach inkblot test

Projective testing, indeed the modern clinical psychology starts with the Rorschach inkblot test, which remains the most studied, used, and argued-over technique of clinical assessment. Hermann Rorschach, a Swiss psychiatrist, who began his experimentation with inkblots as a means of stimulating and testing imagination. He was the first investigator to perceive the possibilities of inkblots in experimental psychology although his work was most extensive having continued from 1911 to 1921. He is credited with being the first to develop a technique for use in personality diagnosis. Rorschach (1921) stated that he developed inkblot test for an exclusively theoretical purpose to study perception and its three processes – sensation, memory and association. He added that the test’s diagnostic power was an empirical finding, which has not been anticipated, and he warned that it was impossible to furnish instruction on how to reach a diagnosis from the test data alone to provide simple diagnostic tables. These words of caution and restrain did not
stop him and a host of others from trying to shape the Rorschach inkblot test into an objective diagnostic procedure that would be at least as good as the X-ray or the electroencephalogram.

Hermann Rorschach did not postulate any specific theoretical background with regard to the inkblot technique for personality assessment in general (Exner, 1969). His observations pertaining to the responses to the vague inkblots by the patients and non-patients individuals led him to a variety of conclusions concerning the perceptual determinants of responses. These determinants were colour, form, movement etc. He did not formulate any specific theory concerning his test. All the results he gathered were predominantly empirical. The conclusions drawn by him on the basis of percepts were regarded more as observations rather than theoretical deduction.

**Diagnostic Indicators on Rorschach (Pershad & Parekh, 2001)**

**Schizophrenia**

1. Total number of responses (R) is variable, it could be low or it could be high.
2. Organization Capacity (Z) is low.
3. ‘W’ is fewer than normal.
4. ‘M’ could be high in paranoid schizophrenia, in others, more M – or even absence of M.
5. C and CF could be high, it could be absent if it is not a reactive schizophrenia.

6. F+% is less than 70%.

7. P is less than 5.

8. F – to F+ approach, i.e. ‘inversion’ is present.

9. Position response (Po) may be present.

10. Pathognomic signs likely to be present.

11. H responses low or absent except in paranoid schizophrenia.

**Depression**

1. Total number of responses (R) is low.

2. Reaction time and response time are increased.

3. W responses are less.

4. Major detail (D) responses are more.

5. Rejection of card is present.

6. M responses are absent.

7. Shading responses are present.

8. F+% is high, it could be even upto 100%.

9. Colour or shading shock is present.

10. P responses are more than 5.

11. A responses are more.

12. Width of content category is narrow.
Mania

1. Total number of responses is high.
2. Reaction time is short.
3. C and CF are high.
4. H responses are more.
5. Minor detail responses (Dd) are present.
6. F+% is low.
7. Range of content category is wider.
8. Forgetting of responses during enquiry, many responses are rejected and new responses are added.
9. Affective ratio is high.
10. Experience balance is tilted toward C than M.

b) Somatic Inkblot Series - I

The SIS provides clinicians and researchers with a new diagnostic aid for body percept assessment. It can be used to assess the depth and significance of somatic symptoms, conversion reactions, somatic delusions, and sexual dysfunction. A psychoanalysis of mutilated or distorted anatomy responses can assess the possibility or level of castration anxiety (Cassell, 1980). Responses depicting themes of body assault may further clarify the extent of aggressive impulses (Cassell, 1977).
The SIS is a semi-structured projective diagnostic instrument and is an adjunct to psychotherapy and counselling. It is structured by a sequential presentation of intentionally designed and field-tested inkblot-like images. These images demonstrate typical and atypical response potentials. The SIS procedure is projective because it is based on spontaneous, individually generated responses to semi-ambiguous figures, which elicit intrapsychic associations specific to the person presented with them.

The SIS is a diagnostic procedure as a consequence of the interaction of structure and stimuli. These stimuli evoke symbolism and meanings unique to the responding individual. These can be differentiated from typical and atypical peer norms, and can be analyzed according to internationally recognized diagnostic criteria. The procedure is an adjunct to therapy because responses can be further explored to create a more effective treatment plan. During the administration of the SIS procedure, the patient may abreact emotional conflict raised to consciousness by the images, which can be a therapeutic experience in itself.

The SIS can help therapists more sensitively 'hear' a suffering individual's cry for help, the "inner cry" that is not only hidden from others, but often hidden from one's own conscious awareness as well.
Somatic imagery theory proposes that everyone has a unique and highly personalized system of attitudes, both conscious and unconscious, that is projected on to the body concept as a special entity. These interact with feedback sources and internal sensations. Relatively discrete mental representations exist for particular somatic regions, which constantly compete for full registration in consciousness. Somatic awareness transiently increases in states of hunger, physical exertion, emotional arousal and sexual excitement. Subsequently, the mental representations in the body fade into the background of consciousness.

Alterations in body perception also occur in physical illness. In the diseased body, pathophysiologic processes give rise to percepts from the diseased area, which directly or indirectly, enter into awareness. The patient's sensitivity to these depends partially on the pre-existing body concept. Sensations that arise from regions of high priority in the body gestalt are more likely to register than those from more perceptually silent areas. If the sensations are subjectively considered aberrant, the individual must then evaluate the significance of the sensations. At this stage the patient makes a kind of lay "diagnosis".

The cognitive appraisal of the altered body state is influenced by factors such as age, sex, socio-economic status
and past medical and family history of disease experience. There may be a strong motive, conscious or unconscious, to adopt a sick role to obtain disability compensation. There may also be a stress-induced wish to regress to an infantile, dependent position, and be taken care of by paternal figures such as a spouse, grown children, physicians, nurses or nursing home staff.

Interaction between these multiple determinants will influence whether or not an individual decides to consult a physician to report subjective experiences. "Symptoms" reported in the early stages of an initial visit represent verbal communication, which contains special reference to specific organ images within the body. The information content reflects altered anatomical awareness associated with the patient's belief that the given region has impaired function. The physician formulates a series of diagnostic hypotheses based on "presenting symptoms", on the nature of the underlying disease processes. Then he conducts a formal medical interview, with questions designed to uncover the pathological significance of somatic symptom clues. In most instances, an insightful physician will be in a relatively strong position to establish a working diagnosis upon completion of the history.

In this situation, there is no strong need for additional aids in diagnostic interviewing, such as projective techniques.
There are, however, some cases when the diagnosis is not clear. Patients may present symptoms, which do not fit into recognizable disease patterns, or there may be major obstacles in communication with the individual. Some patients minimize or deny physical illness while others exaggerate them.

Clinical experience, upon which the SIS procedure builds, indicates that persons suffering from physical illness, psychosomatic illness or conversion reaction will perceive abnormal anatomical structure in the semi-ambiguous SIS images. There may be sensitization with anatomy (increase in number of anatomical responses) or repression with avoidance of somatic content.

By assessing an individual’s responses and his/her associations with them, much can be learned about the person’s innermost thoughts and feelings, what he sees in ambiguous or semi-ambiguous images reveals his self-perception. When someone projects onto an inkblot the response “sick stomach”, it may indicate a concern or focus on that organ in one-self or another person. It also might indicate some association or deeper symbolization involving the stomach. An organic or functional disorder in that organ system is consistent with Rorschach’s view that certain anatomy responses may be a projection of kinesthetic sensation in the musculature (Rorschach, 1951). Freud, and later Alexander and French
described how gastrointestinal dysfunction or distress can be a manifestation of underlying psychological conflict, which is below conscious awareness.

For physicians, therapists and researchers, the body, its organ systems and its perceived functions are "doorways to the mind". By assessing how people perceive or misperceive body and organ function, much can be learned about their innermost thoughts and feelings. What they see in ambiguous or semi-ambiguous inkblots shows how they see themselves, the quality of their life and life style, their adjustment to conflict, their coping skills and their view of the reality of life.

An examination of Psychoanalytic School of thought explaining symptom formation and status of projective technique lead to reason-laden thinking for investigating schizophrenia and affective disorders by means of Rorschach inkblot test and SIS-I to tap specific indices for psychodiagnosis.

In the back drop of the literature linked to clinical diagnosis, psychodynamic analysis of symptom formation, there is a good reason to speculate that Rorschach's inkblot test and SIS - I can more predictably tap specific diagnostic indices in the defined disorders. Tapping and identification of specific diagnostic indices would seem to be beneficial for both clients
and clinicians. The assessed clients would benefit by having their typical symptoms seen within more valid and dynamic perspective and receiving therapies that are both more valid and innately linked to effective and stable therapeutic outcome. Psychologists can cease their role only as diagnosticians and serve their clients more productively as diagnosticians and therapists. Limits upon diagnosis and therapy continue to exist; identification of indices and formulation of psychodynamics for finalization of therapy to be given to client for relieving him from sufferings, offers a new view of these limits and help both clients and clinicians alike in attaining those limits.