The present investigation aims at finding out the various factors which can foretell the prospect of recovery from depressive illness. The factors studied include some facts of personal and family history, symptoms of depressive illness, level of neuroticism, ego strength and some measures from Rorschach Ink Blot Test.

The patients included in the study are the out-patients attending the clinic of a private psychiatrist. Only cases attending one psychiatrist's clinic were taken because study requires control of drug to be administered. And psychiatrists differ in their selection of drug for depressive illness. The psychiatrist administered same drug to all the depressives in the same dose. All the consecutive patients suffering from depressive illness were included in the study. But patients who were schizo-affective and in whom features of anxiety were more marked than those of depression were excluded. Patients with depressive symptoms associated with organic syndrome were also not included. Similarly, patients who were getting some anti-depressant during last three months were also excluded. The patients whose illness was so severe that immediate E.C.T. was imperative were not included in the study.

All the cases studied received same drug treatment.

**DRUGS ADMINISTERED**

- Imipramine ----- 25 mg. ... twice daily for two days.
- Then --------- 50 mg. ... twice daily.

The diagnosis of the depression was made by the referring psychiatrist. Only agreed cases of depression were taken and no attempt was made to have any sub-classification of depression.
In the final data, patients were followed-up for six weeks. But initially, to decide about the length of the period of follow-up, fifteen cases were followed-up for a period of 12 weeks. Their score on Beck's (1961) Inventory were noted down at the intervals of three weeks, 6 weeks, 9 weeks and 12 weeks. The graph plotted by taking period of follow-up on X-axis and Score on Beck's Inventory on Y-axis indicates that maximum of improvement occurred during the first six weeks. So, rest of the patients were followed-up for the period of six weeks only.

After the establishment of the diagnosis, the case was referred for the study. Within the next two days, adapted version of Beck's Inventory for measuring depth of depression (Ajmany and Nandi 1973) was administered and Case Record Schedule was filled up during an interview. Within the following two days, came the second interview session in which Barron's Ego-Strength-Scale, KNPI and Rorschach Ink Blot Test were administered. The follow-up data was taken at the interval of 3 weeks and 6 weeks after the start of the treatment. In the follow-up session, Adapted Version of Beck's Inventory for measuring depression, as mentioned above, was administered. Change in score on the Inventory was taken as Criteria of Improvement.

During the last decade, there have appeared several scales for measuring depression (Beck et. al. 1961, Hamilton 1960, BECK ET. AL'S"AN INVENTORY FOR MEASURING DEPRESSION" (1965). Prabhu (1967), while reviewing objectivity in psychiatric research observed: "In
mentioning the various scales meant for assessing depression, two scales deserve special mention, though they belong to the category of scales left out of the present review, namely, the self-evaluation scales. The scale by Beck et. al. (1961) and Wechsler (1963) have a sound basis in them and deserve careful attention of workers working with depressive patients.

Hamilton (1961) Rating Scale and Beck et. al. (1961) scale are used frequently by different researchers. Main value of Beck's Inventory lies in its being a form of 'Inventory. As pointed out by Metcalf and Goldman (1965), "clinical assessment by an experienced psychiatrist even when it is quantified on the basis of rating scale has the disadvantage of being dependent on the skill of the rater and his clinical bias." So, Beck's Inventory for measuring depression was selected for the use for this study and it was adapted for use with Bengali-speaking population (Ajsany and Nandi 1973).

The inventory consists of 21 categories of symptoms. Each category describes a specific behavioural manifestation of depression and consists of 4-5 self-evaluation statements. The statements are ranked to reflect the range of severity of symptom from neutral to maximal severity. Numerical value from 0-3 are assigned to each statement to indicate the degree of severity. In many categories, two alternative statements are presented at a given level and are assigned the same weight. The equivalent statements are labelled 'a' and 'b' (for example - 2a and 2b) to indicate that they are at the same level. The symptom categories are as follows:-
a) Mood; b) Pessimism; c) Sense of failure; d) Lack of satisfaction; e) Guilt Feeling; f) Sense of punishment; g) Self-hate; h) Self-accusation; i) Self-punitive wishes; j) Crying Spells; k) Irritability; l) Social Withdrawal; m) Indecisiveness; n) Body-image; o) Work-inhibition; p) Sleep-disturbance; q) Fatiguability; r) Loss of Appetite; s) Weight Loss; t) Somatic Preoccupation; u) Loss of libido.

In India, data regarding weight loss is rarely possible to obtain. Accordingly, this category is not included in the adapted version of the scale. Items of rest of the categories were translated in Bengali taking care to ensure that it is as near to the colloquial use as possible. The process of administration was also somewhat modified. It was administered in the form of very-much-structured interview. The patients were told that they must answer to the questions put to them in affirmative or negative on the basis of their present condition. Perhaps one example will make the difference clear. For Category 'a', they were asked in Bengali English equivalent of 'Do you feel sad?' If the answer given was in the affirmative, they were next asked: "Do you feel so sad that you cannot get out of it" or, "it is painful to you"; or, "Do you feel so sad that you cannot stand it". Scoring was done according to answer received. This procedure makes the task of the patient lighter. Attempt was also made to find out the validity and reliability of this modified form of the scale.

For this purpose, the modified version of the scale was administered against Psychiatrist's rating. Altogether 100 cases suffering from various psychiatric problems were taken. So far
as Reliability is concerned, product-moment-correlation between odd and even categories, after application of Spearman Brown Correction, was found to be 0.81. Kruskal-Wallis Test was applied to see whether ranks of total scores increased significantly with increase in score on a particular category; and it was found that in all twenty categories, the relationship with total score was significant beyond 0.001 level.

So far as the validity is concerned, the bi-serial correlation between the inventory score and clinical judgement of depth of depression was found to be 0.87. Mann-Whitney's U-Test (Sidney-Siegel 1956) was used to see whether the difference in rank (obtained on the basis of scores on inventory) of the two adjacent groups (obtained on the basis of clinical rating of cases where clinical rating agreed) differed significantly or not. Here, the value was always found to be significant beyond 0.008 level.

Barron's Ego-Strength Scale was developed in 1953. Barron (1953a) was trying to find out the test correlates of psychotherapy for which he administered various scales like MMPI, Rorschach and Intelligence tests to the patients undergoing psychotherapy and rated their improvement. He found that some items of MMPI correlated highly with the rated improvement. On the basis of this work, he derived the 68-item Ego-Strength-Scale from MMPI and maintained (Barron 1953b). "Consideration of the scale content and its correlates suggest that a somewhat broader psychological interpretation be placed upon it, making it useful as an assessment device in any situation where some estimate of adaptability and personal re-
sourcefulness is wanted”. It appears to measure the various aspects of effective personal functioning which are usually subsumed under the term Ego-strength. Various studies (Taft 1957, Gottesman 1959, Temkin 1957, Korman 1960, Kleinmuntz 1960 and R. Sinnet 1962) seem to indicate the validity of the scale. But the scale in its original form cannot be administered to the Indian population. Hasan (1970) adapted the scale for Hindi-speaking population. An Adaptation for Bengali-speaking population was requisite for the present study. So, this was duly done.

The scale has been derived from MMPI. It consists of 68 items. These 68 items of the scale were grouped by Barron according to the psychological homogeneities of the item-content in the following manner:

**Physical Functioning and Physiological Stability** :-
Herein are grouped all the items related to the physical health of the patient. It consists of 11 items. Original MMPI nos. of corresponding items are :-

153; 51; 174; 189; 187; 34; 2; 14; 341; 36; 43.

**Psychasthenia and Seclusiveness** : subsumes ten items of MMPI with corresponding MMPI numbers as :-

384; 489; 236; 317; 100; 234; 270; 359; 344; 241.

**Attitude towards religion** : groups six items with numbers under MMPI as :-

95; 488; 483; 58; 420; 209.

**Moral Posture** : has eleven items whose MMPI numbers are :-

410; 181; 94; 253; 109; 430; 208; 548; 231; 378; 355.

**Senses of Reality** : has grouped eight items. Their MMPI numbers are :-
Personal Adequacy and Ability to Cope: Eleven items come under this group with corresponding MMPI numbers as:

33, 349; 251; 48; 22; 192; 62; 541.

Phobias and Infantile Anxiety: Five items covered under this group are having MMPI numbers as:

367; 525; 510; 494; 559.

Miscellaneous: This group has five items whose MMPI numbers are:

221; 513; 561; 458; 421.

Each item of the Scale is followed by Yes and No and the subject has to only underline this Yes or No according to the factual consideration whether the statement under consideration is true in his/her life or not.

For Adaptation, test items were translated into Bengali, required modifications were made (e.g., item nos. 99 and 483 were found unsuitable for Indian population and these were changed). This Bengali Version was passed on to five experts to obtain their opinion and necessary modifications were made. The Scale was printed in book-let form along with the translated version of Ego-Strength Scale of Cattell's 16 PF Form A and B. This booklet was administered to college-students (Age-range: 18-30 years) in group form and data was scored. On the basis of the total score, the individuals were divided into two groups (above and median group and below and median group). Phi-correlation was calculated among the score on each item and total score of the two groups. Separate calculations were made for Male (N = 200) and Female (N = 150). Items having significant correla-
tion in both the groups were selected and taken into the final form of Adapted Scale. MMPI numbers of the selected items are:

- 2; 14; 36; 43; 48; 51; 58; 62; 82; 94; 100; 153; 189; 192; 217; 236; 241; 244; 251; 253; 270; 341; 344; 359; 367; 389; 483; 488; 489; 494; 510; 525; 544; 555.

Final Adapted Version, therefore, has 34 items. The odd-even reliability of the Scale was found to be 0.60. Various other correlations calculated are:

<table>
<thead>
<tr>
<th>Correlation with</th>
<th>34-item Barron (Adapted Version)</th>
<th>68-item Barron</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form A of 16 PF</td>
<td>0.45</td>
<td>0.39</td>
</tr>
<tr>
<td>Form B of 16 PF</td>
<td>0.48</td>
<td>0.457</td>
</tr>
<tr>
<td>Form A &amp; B of 16 PF</td>
<td>0.52</td>
<td>0.398</td>
</tr>
<tr>
<td>Odd-Even Reliability</td>
<td>0.60</td>
<td>0.58</td>
</tr>
</tbody>
</table>

Correlation between 34-item Barron and 68-item Barron's was found to be 0.84 and between Form A and B of 16 PF 0.39.

So, Adapted Version of Barron's Ego-Strength Scale has approximately the same odd-even reliability (rather somewhat higher). And, it has higher correlation with other tests of Ego-Strength Scale. This Adapted Version of the Barron Ego-Strength Scale was used in the Study.

Projective Tests: "It is in Clinical Psychology, of course, that..."
study and diagnosis and appraisal of the progress of Psychotherapy" (Abt & Bellak 1959, p. 68).

Symonds (The dynamics of human adjustment 1946) maintained that the term projective technique was first used by Frank - where he maintains that the term projective is derived from the mechanism projection but is a somewhat liberal and inexact use of the term. In projective technique, there is an implication that as a person expresses himself in any kind of constructive or interpretative story, he projects in the story his own impulses, feelings and thought.

Symond also has linked the term projective with psycho-analytical mechanism of projection.

But Shneidman (1965) maintained that the obvious similarity in sound between the two words has been a possible source of high level theoretical confusion in entire history of projective technique.

The issue has been recognised by several writers and was stated in the opening sentence of Bell's early book - Projective Technique (1948) in which he points out the two dominant and confusing possible meanings of projection: Firstly, projection has the specific psycho-analytical meaning as defensive process under the sway of pleasure principle whereby the ego thrusts forth on the external world unconscious wishes and ideas which if allowed to penetrate into consciousness would be painful to ego. Secondly, in commonsense usage, and dictionary sense of the word, projection means to cast forward, to project an almost physical extension of psychological attribute.

But according to Abt and Bellak (1959), even Freud recog-
nised both the aspects of the meaning of the word projection.

Freud (1894) maintained that the psyche develops the neurosis of anxiety when it feels itself unequal to the task of mastering (sexual) excitation arising endogenously - that is to say - it acts as if it has projected this excitation into the outer world.

Freud (1896) elaborated further that the term "projection is a process of ascribing one's own desires, feelings and sentiments to other people or to the outside world as a defensive process that permits one to be unaware of these undesirable phenomena in oneself."

This is the first usage of the world projection meaning a type of defense mechanism. But Abt and Bellak (1959) reported that it was found by experiments that if post-hypnotic suggestion is given to the subject that he should feel extremely elated, this elation too was projected into the stories of Thematic Apperception Test Pictures. This phenomenon cannot be explained with the help of concept of projection as defensive mechanism, because there was no particular need for the ego to guard against the effects of joy. This is required if joy is inappropriate, as in case of death of a person toward whom ambivalence is felt. Such was not the case in the experiments involved. So, the concept of projection seems to require some elaboration. And a careful reading of Freud showed that he had anticipated the difficulty. He has said in Totem and Taboo - But projection is not specially created for the purpose of defence; it also comes into being where there is no conflict; projection of inner perceptions to the outside is a primitive mechanism which for instance also
influences our sense perception so that it normally has greatest share in shaping our outside world.

According to Murphy (1947), the term Projective Method has come into general use in recent years to denote the device that enables the subject to project himself into a planned situation. Here, unlike educational tests, quantity of production is not taken into account but interpretation is based on what he tells about himself through his manner of confronting the task. All the psychological methods involve some projection in the sense that a person reveals himself in whatever he does. One may put little or much of one's self into the production. Since there is a continuum, the definition is for convenience only. Under the projective technique, are included all those methods in which individual has full opportunity to live empathetically, that is, in terms of identification with the material presented to him.

Guilford (1959) emphasised the unstructured aspect of the stimulus material. According to him, projective techniques are distinguished from other methods of assessment by the use of unstructured task and ambiguous materials. The examinee is given a minimum of instructions, within the limits of the testing-situation and the kind of the material, he is free to go in his own directions and to give his own unique response. It is hoped thus to obtain information concerning his personality by the fact that he projects.

Bellak (1950) accordingly suggests abandoning the broad use of the term projection in favour of the more inclusive term apperceptive distortion. Included within the general category
of apperceptive distortion is a variety of mechanisms that Beljajak labels Projection, Inverted Projection, Simple Projection, Sensitization and Externalization. He recommended reserving the term Projection for processes involving the largest degree of distortion where the individual actually misperceives others through assigning to them self characteristics that are so unacceptable to him that he could only recognize them through prolonged therapy. While Simple Projection is used to refer to normal processes whereby the individual misperceives the outer world as a result of inner states. Inverted Projection is a defensive mechanism of reaction formation when it is applied to unacceptable impulse prior to its being projected onto the outer world. A typical instance of Inverted Projection is the case of the paranoid where it is hypothesized that his initial formulation of 'I love you' becomes reversed into 'I hate him, before the process of projection converts it into 'He hates me. The term Sensitization is used to refer to the well-known tendency of an individual to pay particular attention to those real stimuli in the external world that are relevant to and fit with his own inner states. Externalization is the process whereby the individual consciously attributes to the outer world characteristic of himself, as in the case where the individual tells a story in response to a projective technique with full awareness that the characteristics in the story represent himself and figures from his life.

But these suggested modifications in sum have had limited impact. Anna Freud identified Projection as one of the nine mechanisms of defense outlined in his father's writings. The
essence of this conservative view is captured very well by Murray (1951) who suggests that an orthodox definition of projection implies:

a) An actual misperception in which the individual believes something that is manifestly false concerning another;

b) This misperception involves attributing to the other person a tendency directed towards either the perceiver or towards a third person;

c) The tendency is an important part of perceiver's own personality;

d) The tendency is unacceptable to the perceiver and he is unaware of its existence in his own make-up;

e) The function of the process is to maintain self-esteem or to escape from anxiety.

According to Lindzey (1961), the term Projection has been used in two important senses. The first of these, which might be termed as Classical Projection, refers to an unconscious and pathological process whereby the individual defends against unacceptable impulse or qualities in himself by inaccurately ascribing them to individuals or objects in the outer world. The second usage, which might be called Generalised Projection, refers to a normal process whereby the individual's inner states or qualities influence his perception and interpretation of the outer world. Although it is customary to assume that Freud used the term to refer to Classical Projection, there is evidence in his writings that he used the term in both the senses. Projective Technique have been variously classified. Frank (1939) classified the projective techniques on the basis of type of res-
The projective test may be classified under two heads — Formal techniques Vs. Content techniques on the basis of the way their results are interpreted (Lindzey 1959). In formal techniques, in interpreting, the focus of the examiner is upon the way in which the task is performed — speed, quality of response, relative frequency of certain type of words etc. Rorschach Technique is usually considered to be primarily a formal test although there is a shift in recent years in more extensive use of content in analysis.

The instrument is classified as content technique if the interpretation is focussed upon what the individual says or does and its meaning, e.g. Thematic Apperception Test.

Lindzey (1961) has given a classification which is based on the nature of the elicitation of the response under the following heads — Constitutive, Interpretative, Cathartic and Constructive.

The test is considered Constitutive if S is required to provide a structure or form for relatively unstructured or ambiguous stimuli, e.g. finger prints, rorschach cards.

The test is considered to be Interpretative if subject is asked to indicate what the meaning of stimulus is to him, e.g. if he is asked to give meaning to pictures.

The Cathartic test involves some deliberate attempt to induce the S to express or release emotion in the process of reacting to stimuli e.g. psychodrama.

If subject is required to build or organize stimulus material such as blocks or toys, in such a manner as to reveal some of the organizing conceptions of life, the test is labelled Constructive.
upon the differences in type of response. According to him there are five general types of responses:

Constructive Technique, Completion Task, Choice or ordering Technique, Expression Technique, Associative Technique.

Every test can not be fitted neatly into one of these categories. In reality, there is customary overlap and ambiguity. But, with a little effort it is possible to classify virtually every projective technique as involving predominantly one of these type of response.

Constructive Technique: In these projective instruments subject has to create or construct a product which is typically an art form such as a story or picture. A minimum of restriction is placed upon the subject's response. In some cases such as the blank card of the thematic apperception test even the original stimulus is not under control of the examiner. Interpretation is mainly dependent upon the outcome or product constructed by the subject and not upon his behaviour or style in the process of creating or responding. Unlike associative technique these instruments require the subject to engage in complex, cognitive activity that goes far beyond mere association. Example of tests belonging to this group are Thematic Apperception Test.

Completion Technique: Here subject is provided with some type of incomplete product and subject has to complete it in any manner he wishes. Completed product is usually expected to meet certain external standards of good form or rationality - say in case of incomplete story or sentence, subject has to complete it and there are no doubt rules about what constitutes a sentence.
or a story. For example, Rosenzweig's Picture Frustration Study.
Choice or ordering Techniques: In these devices, subjects' task is relatively simple. Subject merely has to choose from a number of alternatives the item or arrangement that fits some criterion such as correctness, relevance, attractiveness or repugnance. In some cases such as the multiple choice Rorschach and TAT, these devices mirror other techniques except that the subject is asked not to produce an association or a construction but he is asked to select from a number of hypothetical responses the one that seems most appropriate to him. Other tests of this group are "The Szondi Test", S. Thomkins and D. Horn's "The Picture Arrangement Test" etc.
Expressive Technique: These techniques are used both as diagnostic and therapeutic devices. Here subject not only reveals himself but also expresses himself in such a manner as to influence his personal economy or adjustment. Like constructive technique subject has to incorporate stimuli into some kind of novel production. But unlike the constructive techniques, in these techniques there is more emphasis upon the manner or style in which the product is created. The tests belonging to this group are Play techniques, Drawing and Painting techniques, Psychodrama and Role Playing.
Association Technique: In these techniques subject responds to some stimulus presented by the examiner with the first word, image or percept that occurs to him. These devices minimize ideation and emphasize immediacy. The subject is not to reflect or reason but only responds with whatever concept or word, however unreasonable, first rises to consciousness.
Once Freud had devised the method of free association, this appeared to be an important means of gaining insight into the unconscious region of mind. So a number of important techniques embodying this response set have been developed, the most popular of which are the Word Association Test, and the Rorschach Test.

Rorschach Inkblot Test was first published in 1921 (Rorschach 1921). After its introduction in America by Beck (1930) and establishment of Rorschach society by Klopfer in 1932, it became the most popular projective technique in both clinical work and personality research.

The test consists of 10 symmetrical ink blots designs, printed on white paper 8 by 10 inches in size (S. J. Bock 1951). All the figures are centered on the paper which is mounted on stiff card board. They are always presented in exactly same order. Five of the cards are grey in varying amount of saturation. These are figure I, IV, V, VI, VII. In figure II and III bright red patches are present, but no other colour. Three are constituted of colour blots only—figure VIII, IX, X (some minor details in X are greyish).

The cards are presented to the subject one at a time and in prescribed sequence. The instructions are very simple, the subject is asked "What does it look like, what could this be?" Several clinicians and investigators who have used the test extensively have somewhat modified the original instructions, though not in their essentials. In the present study, Klopfer and Kelley (1942)'s instructions were followed, which read as follows:
"People see all sorts of things in these inkblots; now tell me what you see, what it might be for you, what it makes you think of".

In administration and scoring, B. Klopfer, Ainsworth M., Administration Klopfer W. and R. Holt (1964)'s method was strictly followed. According to them, examination consists of four phases:

Performance proper: This part aims at obtaining response of the subject to the stimulus material in a permissive and unstructured situation. Here role of examiner is chiefly that of a recorder. The examiner makes note of various aspects of subject's behaviour; namely verbatim record of (as far as possible) the response, time elasped between presentation of each card and first response to it, position in which the card is kept etc.

Inquiry: This phase aims at obtaining the information required for scoring the record. It starts after all ten cards have been presented for response. The only questions that should be asked are those needed to clarify the scoring. Here, it is necessary to refrain from suggestions that might prejudice the subject.

Rest of the two phases - Analogy period and Testing the limit are more important when one is interested in having a comprehensive picture of each subject's personality. They help in arriving at better interpretations from the scores. But aim of the present study is to develop a scale for predicting the outcome of the course of illness in depressives in which raw scores (M, W, C, FM) etc. are used in calculation and not the interpretations based on them. So, these two phases are omitted.
in the administration.

The scoring of Rorschach is highly complex and individualized. There are many scoring systems; at the same time there are certain similarities among all the scoring systems (Rorschach 1921, Beck 1944, 1945, 1952, Klopfer and Kelly 1942, Klopfer, Ainsworth, Klopfer and Holt 1954).

In scoring, Klopfer, Ainsworth, Klopfer and Holt (1954)'s method was followed. Scoring of location, determinants, content and original vs. popular was made according to their instructions. And percentage of these categories was used directly in calculations.

For testing the reliability and validity of the test, various studies have been carried out (Holtman 1950, Krugman 1942, Vernon 1935, Serbin 1939, Robin and Sanderson 1947, Wallen 1948, Hutt, Gibby, Milton and Pottharst 1950, Gibby 1951 etc.). But their findings are conflicting. Thus, while, for the clinicians, Projective Techniques are the Psychologists' X-Ray apparatus for penetrating beneath the facades and barriers to the deeper needs and dynamic forces of personality, others reject the Projective Techniques as being little more than a vehicle for Clinicians' imagination (Eysenck 1960a).

Such an extreme condemnation of Projective Testing is exceptional. The Techniques have not only survived the repeated attacks but are also being used more and more, not only by clinical psychologists but also by experimental and developmental psychologists, anthropologists (Lindzey 1961). According to Vernon (1964), an enormous amount has been written on the Rorschach alone there were 2685 publications up to 1955 (Klopfer et al.)
So far as Reliability is concerned, by parallel set method, it was found that the test devised by Harrower and Steiner (1945) elicit much the same type of responses as do the Rorschach test. Behn Rorschach (Zulliger 1956) a parallel series was used for retesting two groups after a period of 20-21 days. The average correlation of Scoring categories was 0.56-0.65. With another group of 100 normal subjects and 96 abnormal persons, the average Co-efficients for the scores of two sets were respectively 0.41 and 0.52 (Eichler R.M. 1951). But range of co-efficients was very wide 0.0-0.86.

It is in reality very difficult to construct a parallel set; because unless the ink-blots are very identical, their stimulus value will not be equal.

Use of Split-half-method is not possible, because odd-even cards are not of equal stimulus value. Still, work has been performed along these lines (Hertz M. R. 1951, Detel and Gengerelli 1955) which has yielded co-efficient ranging from 0.60 to 0.95.

Test-Retest-Method also should be used with caution. If the interval in the test and retest is short, there may be carry-over resulting from recall of previous responses. If this interval is long, change in behaviour might have taken place as a result of maturation, therapy or environmental factors, which decreases the co-efficient unnecessarily. So, studies with this method have shown various degrees of co-efficient (Eichler R.M. 1951, Ford M. 1946, Holzberg J.D. and M. Wexler 1950).
Various Validity studies have also been performed. To test the Validity of the Test, Rorschach Diagnosis is compared with Diagnosis by Therapist. Benjamin and Ebaugh (1938) compared the diagnosis of 50 patients representing a variety of disorders with the diagnosis based on Rorschach Test. These patients were examined psychiatrically by one of the authors, the other author administered the Rorschach test personally to 34 of the cases. The remainder of the Rorschach examinations were interpreted blindly - that is, they were administered by an examiner other than the interpreter. Four of the cases were eliminated from calculations because examiner was somewhat acquainted with them. Complete agreement in diagnosis occurred in 39 of the remaining 46 cases. Five others had only minor disagreement.

A similar study was reported by Siegel (1948). There was 61.5% agreement between Rorschach and psychiatric diagnosis. After a year, at the time of reevaluation, the percentage of agreement became 88.8. And all the shift in diagnosis responsible for increase in agreement were made by psychiatrists.

A classic experiment relevant for both Reliability and Validity was reported by Hertz and Rubenstein (1939). Hertz administered the Rorschach to one case and interpreted it without any knowledge of the clinical findings. The author collected clinical material in a series of 14 interviews. The verbatim rorschach record was sent out for 'Blind' interpretation to two trained Rorschach Workers (Bock and Klopfer). A comparison of three interpretations obtained showed a high degree of agreement with clinical description (validity). Main weakness of the study is number of cases.
Even Krugman (1942)'s investigation dealt with both Reliability and Validity. The Rorschach personality descriptions of 25 problem children were matched in groups of five with the abstracts of the clinical charts of those cases by five judges. Average co-efficient of 0.85 showed a highly significant relationship between Rorschach and clinical descriptions.

Molecular approach attempts to investigate the Validity of Single Rorschach Variables or combinations of them against certain aspect of the subject's behaviour. The variables most frequently investigated have been Colour, Movement, Form response etc. (Ruesch J. and Finesinger J.E., 1941, Gustav 1946, Wishner 1948). Here, on the whole, the results have been inconclusive.

Another attempt to validate Rorschach consists in studying the effect of Special experimental conditions on the Rorschach responses. Various such attempts have been made (Sarbin 1939, Levine, Grassi and Gerson, 1943, Kelley and Levine, 1940 and Williams, 1947).

The results are somewhat encouraging and, from the standpoint of methodology, these studies have demonstrated that Rorschach Variables can be well selected and defined for experimental validation. But for further proof, more studies with larger number of cases are needed.

So far as the present status of the test is concerned, we can say that if success is measured by popularity, Rorschach is the most successful of all the technique. So far as its reliability and validity are concerned, there are clear evidences of Construct Validity, global matching and some positive correlations with clinical criteria. All these indicate that we can say...
with Lindzey (1961) - That they are neither infallible nor devoid of utility. There are many studies, some of them replicated, indicating that the Rorschach effectively serves psychodiagnostic or personality description needs. There are many other studies that indicate that, in particular settings, the test has failed to function properly. But as pointed out by Klopfer et al. (1954, p.410), evidence of invalidity of one hypothesis or set of hypotheses cannot be generalized to the test material as the basis of a method of investigating nor to the other interpretative hypotheses advanced by the same or other individuals.

So, in the present type of the study, what is required is; if some scoring categories (W, F, D, Fc etc.) are found to be significantly related with prognosis, their interpretative hypothesis should be used with caution after reviewing their status in the present literature.

Kundu's Neurotic Personality Inventory (KNPI) is the scale for measuring Neuroticism which was developed by Kundu (1962, 1963a, 1963b, 1964, 1966).

Neuroticism is a trait which forms continuum from the normal to the neurotic end. Points near the normal end of the continuum represent well-adjusted emotionally stable, non-neurotic personalities and points near the other end of the continuum represent poorly adjusted, emotionally unstable neurotic personalities. Variations in neuroticism are matter of degree and KNPI purports to measure this degree of neuroticism present in an individual.

There are other tests available for measuring neuroticism.
like Bernreuter (1935) and EPI (Eysenck and Eysenck 1964). But these tests cannot be used with Indian population without proper adaptation. Adaptation requires change of some questions which are not suitable for Indian culture. Thus, proper adaptation is time-consuming. There is no need for spending that much time and energy when KNPI, a test developed in this country, is available. The test has been found to be quite reliable and valid (Kundu 1964, A. Khanna and Kundu 1968).

In its final form (Kundu 1966), the test consists of 66 items or statements which are printed in a booklet-form. On one side of the booklet are given instructions with examples as to how to answer each of the questions. The other sides contain the questions proper. There is a separate answer sheet having same serial numbers as the statements. There are five choices for answering each statement. The subject has to read each statement very carefully and minutely and has to determine one choice that suits his case and thereafter he has to write 1, 2, 3, 4 or 5 against each statement number. Here:

1) means "almost always", "yes" etc.
2) means "almost never", "no" etc.
3) means "frequently", "usually" etc.
4) means "rarely", "sometimes" etc.
5) means "occasionally", "an average amount" etc.

Kundu (1966) has reported reliability coefficient of the scale as follows:

<table>
<thead>
<tr>
<th>Group</th>
<th>1st Half Vs. 2nd Half</th>
<th>Odd Vs. Even</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0.85</td>
<td>0.89</td>
</tr>
<tr>
<td>Female</td>
<td>0.80</td>
<td>0.88</td>
</tr>
<tr>
<td>Neurotic</td>
<td>0.72</td>
<td>0.80</td>
</tr>
</tbody>
</table>
Validity co-efficient has been reported as 0.86 for Male-population and 0.87 for Female-population (Kundu 1964). A. Khanna and Kundu (1968) have reported the comparison of Bernreuter personality Inventory and KNPI. It was found that KNPI is positively related to B₁ - N (Neurotic) B₃ - I (Introversion-Extroversion) F₁ - C (Self Confidence Scale) and negatively related to B₄ - D (Dominance-Submission Scale).

Now a Bengali version of the test is available (Kundu 1976). But at the time the work was undertaken, this version was not available. So, with the permission of Dr. Kundu, the Scale was suitably modified. It was translated into Bengali, making its language as simple and as near the colloquial use as possible. Original Scale and the Bengali version was passed on to ten experts (Bengali-speaking psychiatrists or clinical psychologists) for comments and requisite changes in language were incorporated.

This adapted version of the scale was used in the present study. Data was collected in the form of structured interviews where the subject was properly instructed, each statement was read out to the subject and her/his response such as "frequently", "rarely" etc. was converted into 1), 2), or 3) etc., according to the instructions in the test-manual and this response was noted down in the case - record-sheet against the statement numbers for which the response was given.

The reliability and validity of the scale were calculated from the data on depressive cases. Split-half reliability (Odd-Even) after application of Spearman Brown's formula is found to be 0.91, while Score on 1st-Half Vs. 2nd-Half have a correlation 0.87 (after application of Spearman Brown's formula). This co-
relation is a bit higher than those reported by Kundu (1976, 1964).

To have a measure of validity, data was collected for same aged individuals attending an eye-clinic. The test was administered to them. Mean score of this Normal Group is 137.5, S.D. being 24.96 (N = 50), while mean score of depressive cases is 197.36, S.D. being 34.78. The difference in means is highly significant.

So, this modified version is found to be quite reliable and valid. And it was used in the present study.

**CASE-RECORD-SCHEDULE**

For collection of the relevant facts of personal and family history and symptoms of depressive illness, a Case-Record-Schedule was constructed. To construct the Case-Record-Schedule, a thorough survey of the available literature was made. And a list of various factors relevant for diagnostic categories (Neurotic Vs. Endogenous) and factors relevant for prognosis was also made. List of these factors was incorporated in the Case-Record-Schedule.

Data for completing the Case-Record-Schedule was collected by Semi-Structured Interview with the subject as well as the family members of the subject. While conducting the interview, an eye was kept on the schedule so that all the facts are noted down. The first interview for completing case-record-schedule and administering Beck’s Inventory for measuring depth of depression came within two days of referral. The second session for administering Barron’s Ego-strength Scale, KNPI and Rorschach was conducted within another two days. The follow-up data was taken at intervals of 3 weeks and 6 weeks after the start of the treatment.