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Role assignment and role acquiescence in mental patient behaviour.

Morrie. Kleinplatz

University of Windsor

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ROLE ASSIGNMENT AND ROLE ACQUIESCENCE
IN MENTAL PATIENT BEHAVIOUR

by

Morrie Kleinplatz
B.A., McGill University, 1969.

A Thesis
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ABSTRACT

A study was done to examine differences in test behaviour between mental hospital patients who were rated as acquiescent to the sick role and those who were resistant to that role. Based on societal reaction theory, it was predicted that those patients conforming to the role of the mental patient would present themselves as relatively incapacitated compared to those who resisted the role, whenever the situation was relevant to the patient role. It was further predicted that such differences would diminish under circumstances extraneous to that role. Finally, it was predicted that long-term patients secure in their hospital roles, would behave consistently under both circumstances. Ten patients were assigned to each of 3 groups: 1) patients who had been hospitalized for less than 6 months and were rated as compliant were designated as the Compliant (C) group; 2) patients who had been hospitalized for less than 6 months and were rated as non-compliant comprised the Non-Compliant (NC) group; 3) patients who had been institutionalized for a total of one year or more comprised the Institutionalized (I) group. Each group was further subdivided, with half the Ss assigned to the role-salient (R-S) condition, and half to the non-salient (N-S) condition. Those in the R-S condition were tested by an
E posing as a staff psychometrician and were told that test results would be made available to hospital personnel; those in the N-S condition were tested by an E who presented himself as a student and were told that their test results would be used for research purposes only and would not be available to hospital personnel. All Ss were given an MMPI and an HVOT. Their raw scores on the F-scale, K-scale, F-K index, and an experimental (E) scale, neutral in social desirability, were recorded from the MMPI responses. Raw scores on the HVOT were collected. It was found that C group Ss scored in the predicted direction relative to the NC group on all the MMPI measures which contained social desirability factors, and that these differences disappeared on the E-scale. The HVOT scores, however, did not yield predicted differences between the C and NC groups. The predicted convergence of the C and NC groups under the N-S condition did not occur. As expected, the I group performed consistently across the R-S and N-S conditions.
ACKNOWLEDGEMENTS

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INTRODUCTION

THE MEDICAL MODEL OF MENTAL ILLNESS ........................................... 1.

SOCIOECONOMIC REACTION THEORY .................................................. 3.

SOCIOECONOMIC REACTION AND MENTAL ILLNESS ................................ 5.

Etiology and the Steps Towards Hospitalization .................................. 6.

The Transition to the Hospital ......................................................... 8.

The Effects of Hospitalization ......................................................... 10.

The Return of the Patient to Society ................................................ 13.

I. METHOD

Setting ......................................................................................... 18.

Subjects ......................................................................................... 19.

Instruments ..................................................................................... 22.

Procedure ......................................................................................... 24.

Predictions ......................................................................................... 27.

II. RESULTS

The F-Score ....................................................................................... 31.

The K-Score ....................................................................................... 35.

The F-K Score ................................................................................... 39.

The E-Score ....................................................................................... 39.

The HVOT Score ............................................................................... 43.

III. DISCUSSION

IV. CONCLUSIONS

BIBLIOGRAPHY

APPENDICES
Table 1. Criteria for Compliant and Non-Compliant Patients .................................................. 20.

Table 2. Experimental Paradigm ......................................................................................... 28.

Table 3. Means, standard deviations and analysis of variance for the distribution of F-scores obtained by compliant, non-compliant and institutionalized subjects under role-salient and non-salient conditions .................................................. 32.

Table 4. Comparisons of F-score distributions of compliant, non-compliant and institutionalized subjects when subjects in each category are pooled across conditions .................................................. 34.

Table 5. Means, standard deviations and analysis of variance for the distribution of K-scores obtained by compliant, non-compliant and institutionalized subjects under role-salient and non-salient conditions .................................................. 36.

Table 6. Comparisons of K-score distributions of compliant, non-compliant, and institutionalized subjects when subjects in each category are pooled across conditions .................................................. 38.

Table 7. Means, standard deviations and analysis of variance for the distribution of F-K scores obtained by compliant, non-compliant, and institutionalized subjects under role-salient and non-salient conditions .................................................. 40.

Table 8. Comparisons of F-K score distributions of compliant, non-compliant and institutionalized subjects when subjects in each category are pooled across conditions .................................................. 42.

Table 9. Means, standard deviations and analysis of variance for the distribution of E-scores obtained by compliant, non-compliant and institutionalized subjects under role-salient and non-salient conditions .................................................. 44.

Table 10. Means, standard deviations and analysis of variance for the distribution of HVOT scores obtained by compliant, non-compliant and institutionalized subjects under role-salient and non-salient conditions .................................................. 46.
Figure 1. F-scale Scores as a Function of Group Membership and Experimental Condition .... page 33.

Figure 2. K-scale Scores as a Function of Group Membership and Experimental Condition .... 37.

Figure 3. F-K Scores as a Function of Group Membership and Experimental Condition .... 41.

Figure 4. E-scale Scores as a Function of Group Membership and Experimental Condition .... 45.

Figure 5. HVOT Scores as a Function of Group Membership and Experimental Condition .... 47.
Appendix A. Numbers and Keyed Direction for the F-scale Items

Appendix B. Numbers and Keyed Direction for the K-scale Items

Appendix C. Numbers and Keyed Direction for the E-scale Items

Appendix D. Interpretation of F-scores Falling in Various Ranges

Appendix E. Interpretation of K-scores Falling in Various Ranges

Appendix F. Interpretation of HVOT Scores Falling in Various Ranges
The present study is an investigation of role assignment and role acquiescence in mental patient behaviour that is presumed to accompany hospitalization. The issue is related to a more general concern with the appropriateness of the medical model as a form of treatment of mental or emotional disturbance. The study attempts to test the effects of attitudes of acquiescence and resistance to the sick role upon the behaviour and adaptations in mental hospitals by psychiatric patients.

THE MEDICAL MODEL OF MENTAL ILLNESS

The traditional psychiatric approach to mental illness, as well as the current popular conceptions of mental disease, can be described within the framework of the medical or "disease" model. The model derives from the analogy between mental illness and non-psychiatric diseases. This analogy can be traced back to the historical period when insanity was removed from the sphere of demonology and placed in the sphere of medical disorders. Since that transition in perspective of mental illness, psychiatry has attempted to educate the public in terms of the disease model. Thus the often-heard expression, "Mental illness is like any other illness."

Central to the medical model of mental illness is the focus upon the internal functioning of the individual. Mental illness is seen as a pathological process which, like any other
disease, resides and develops within the individual, and is manifested by aberrations in behaviour. While early psychiatric ideology literally attributed the illness to lesions of the nervous system, contemporary doctrine distinguishes between "organic" and "functional" disorders. The latter term is employed when no physiological damage is evident, and admits to various etiological possibilities: social, cultural, developmental, and psychological factors, or combinations of these, have been used as explanations for the basis of functional disorders. Whatever the etiology, however, the medical model views the problem in terms of a disease residing and developing within the individual.

One of the implications of the medical model is seen in treatment philosophy. It is assumed that as in the case of other diseases, early detection and treatment are desirable, since otherwise the illness will become progressively more severe. An important corollary of this approach is that Type II errors in diagnosis (a diagnosis of "healthy" where illness in fact exists) are regarded as costly, since the untreated "illness" may deteriorate, while Type I errors (false diagnosis of "mental illness") resulting in hospitalization are regarded as neutral, or perhaps even benign, in their effect. Accordingly, a positive diagnosis is made unless there is overwhelming evidence pointing to a diagnosis as "healthy" (Scheff, 1966).

Finally, traditional psychiatric perspective places great emphasis on the assumption that successful treatment is
contingent upon the patient's acceptance of his illness, and where hospitalization occurs, of the role of the mentally ill patient (Petroni and Griffin, 1969).

SOCIETAL REACTION THEORY

In the past two decades many of the assumptions of the medical model have been questioned both from within psychiatry and from without. The strongest and most systematic attack, however, has come from the school of sociological thought known as "societal reaction" or "labelling" theory, which has been applied to such issues as crime, homosexuality, prostitution, alcoholism, etc., as well as to mental illness (Lemert, 1951; Goffman, 1961; Becker, 1963; Scheff, 1966; Lemert, 1967; Schur, 1969).

Central to the theory of societal reaction is the concept of deviance. Whereas earlier sociological models defined deviance as synonymous with rule-breaking, Becker (1963) pointed out the relative nature of the concept, and proposed instead that the deviant be operationally defined as "... one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label" (p. 9). By definition this category would include people who have broken no rule, but who have been reacted to as if they had, and would exclude those who have broken rules but have not been labelled. The importance

* Throughout the text, the terms "societal reaction theory" and "labelling theory" will be used interchangeably.
of this definition is its emphasis upon the interactional aspect of deviance, that is, the reaction of others to the manifested behaviour, and the reaction of the person to the reactions of others. This emphasis is found in Kitsuse's (1962) definition:

... deviance may be conceived as a process by which the members of a group, community, or society (1) interpret behaviour as deviant, (2) define persons who so behave as a certain kind of deviant, and (3) accord them the treatment considered appropriate to such deviants. (p. 41)

A further refinement of this position is found in the concepts of "primary deviation" and "secondary deviation". Lemert (1951) introduced these constructs to discriminate between that behaviour which leads to the label of "deviant" and that which follows as a result of the assignation of the label. In a later work (Lemert, 1967) he described these as follows:

... Primary deviation is assumed to arise in a wide variety of social, cultural, and psychological contexts, and at best has only marginal implication for the psychic structure of the individual; it does not lead to symbolic reorganization at the level of self-regarding attitudes and social roles. Secondary deviation is deviant behaviour or social roles based upon it, which becomes a means of defense, attack or adaptation to the overt and covert problems created by the societal reaction to primary deviation. (p. 17)

This distinction serves to further emphasize the relative importance of societal reaction and minimizes the importance of rule-breaking behaviour in itself.

Finally, the concept of "deviant careers" is used to describe the long-term effects of societal reaction upon the labelled deviant. The deviant career is seen as "... the development... of a pattern of deviant behaviour" (Becker, 1963,
p. 101) which is initiated when labelling occurs and is perpetuated by subsequent events. Goffman (1961) further distinguishes between the personal and public facets of the deviant's career. He terms the former the "moral" aspects of career, and defines them as "... the regular sequence of changes that career entails in the person's self and in his framework of imagery for judging himself and others." (p. 128)

Summarizing the theory of societal reactions, deviants are defined as those who have been labelled deviant by society. Labelling results in changes in the self-concept of the deviant, which leads to further acts of deviance, and ultimately to a deviant career.

SOCIETAL REACTION AND MENTAL ILLNESS

The earliest statement of the societal reaction approach to mental illness comes from Lemert (1951), who distinguished between "primary psychotic deviation" and "secondary psychotic deviation". He described the former as violations of societal roles, and the latter as the "symbolizing of symbolic responses", or the awareness of difference from other people. He suggested that the withholding of the label of "insanity" might allow the person to overcome his problems, while assignment of the label might lead to the stabilization of deviance through a vicious circle in which the internalization of the sick role leads to further inadequate behaviour, which in turn leads to failure and censure through societal reaction, and
finally to hospitalization. Hospitalization results in a drastic loss of status which is reflected in various restrictions to which the patient is subjected. Lemert concludes: "The full impact of this meaning unquestionably fixes and aggravates the symptoms of many patients." (p. 431)

Goffman (1961) expressed a similar point of view, but took hospitalization as his critical point of departure. In fact he defined the mental patient as one who is hospitalized. This is in accordance with Becker's (1953) formulation of deviance described above. Goffman described in detail the ways in which the process of hospitalization leads to negative changes in the self-image of the patient and to the stabilization of deviant behaviour.

The most systematic attempt to apply labelling theory to mental illness has been that of Scheff (1966), who elaborated nine propositions which form a model for describing the effects of societal reaction upon the mental patient. He defined mental illness as "residual deviation", or those forms of deviation which will not fit into any other category of deviant behaviour, and proposed that most residual deviance is transitory, but that labelling is the most important factor in the stabilization of residual deviance.

Etiology and the Steps Towards Hospitalization

Both the medical model and the labelling model agree that a variety of etiologies may account for the initial aber-
rations of behaviour seen in the prospective patient, but while the medical model sees an underlying pathology which leads to progressive deterioration, labelling theory holds that abnormal behaviour will usually dissipate if no label is applied. Scheff (1966) cites prevalence studies which show large numbers of undetected cases of residual deviance in the community as evidence that most cases of residually deviant behaviour are transitory.

Gove (1970) has criticized Scheff's conclusion, and posits instead a selection factor in the patients' behaviour. That is, those people who become hospital patients have less control over themselves and manifest symptoms which are more severe and more frequent than those who escape hospitalization.

On the other hand, Yarrow, Schwartz, Murphy and Deasy (1955), and Clausen and Yarrow (1955), in studies which traced the steps between the family's initial awareness of a problem and the final decision for hospitalization, concluded that members of the community will strongly resist defining behaviour as mentally ill despite an overwhelming amount of aberrant behaviour. Clausen and Yarrow conclude: "... In many instances... the way that patients came to be admitted to the hospital seemed almost fortuitous." (p. 26)
Thus Goffman (1961) proposes that many factors other than the severity of pathology may decide whether or not a person becomes labelled and hospitalized. He calls these "career contingencies", and includes socio-economic status, visibility of offense, proximity to a mental hospital, amount of treatment facilities available, and the type of treatment given in available hospitals. Other more haphazard contingencies include ulterior motives on the part of relatives or associates, and medically irrelevant circumstances in the community.

Mechanic (1968) further supports this argument:

... the basic decision about illness is usually made by community members and not professional personnel. Although the very 'sick' are usually found in mental hospitals, there are occasions when very 'sick' persons go unattended while moderately sick persons receive treatment. This selection is clearly based on social criteria, not on psychiatric ones.

The layman usually assumes that his conception of 'mental illness' is not the important definition since the psychiatrist is the expert and presumably makes the final decision. On the contrary, community persons are brought to the hospital on the basis of lay definitions, and once they arrive, their appearance alone is usually regarded as sufficient evidence of illness. (p. 198)

The Transition to the Hospital

A frequent model used by labelling theorists in describing the process of transition during hospitalization is
that of Garfinkel (1956). The hospitalization process is seen as a "degradation ceremony" in which the individual's old identity is reappraised in view of the behaviour which has led to hospitalization. The importance of this ceremony is that it proclaims this behaviour as typical of the person, and not as a unique occurrence; moreover, it redefines the individual as one who in retrospect can be seen as the type of person who would behave in such a manner. As such it is not only a proclamation of change in identity, but a declaration that this identity has been true all along, but masked until now. Erikson (1962) breaks this ceremony down into three components: 1) a confrontation between the deviant suspect and representatives of the community (e.g. a psychiatrist); 2) judgment about the nature of deviancy (e.g. diagnosis); and 3) the act of social placement (e.g. hospitalization).

Goffman (1961) suggests that the case history is an example of how a retroactive construction of the patient's life is made in order to justify hospitalization. The case history shows "... that all along he had been becoming sick, that he finally became very sick, and that if he had not been hospitalized much worse things would have happened to him..."(p. 145). This construction serves both to justify the hospital in retaining him and to relieve the guilt of those among his family or associates who have been responsible in bringing about hospitalization. Szasz (1960) adds that involuntary hospitalization can be inter-
interpreted as a moral rather than a medical verdict, thus adding to the sense of degradation.

Another issue confronted in the study of transition is that of the tendency of psychiatrists and courts to apply the label of "mental illness" when confronted with a candidate for hospitalization. Scheff (1966) demonstrated that despite excellent laws which state that prospective patients should only be hospitalized against their will if they are either unable to care for themselves or if they present a likely danger to society, candidates were routinely hospitalized by both physicians and the courts. This was so despite cursory examinations, and often despite the psychiatrist's failure to find more than the barest evidence of abnormality. In fact, even when the psychiatrist would recommend release, the courts would sometimes prescribe hospitalization. One explanation suggested by Scheff is that those holding the decision making power see much less danger in falsely prescribing institutionalization than in falsely allowing a mentally ill person to go free. (See the section on the medical model for a discussion of Type I and Type II errors.)

The Effects of Hospitalization

Scheff (1966) states: "Among residual deviates, labeling is the single most important cause of residual deviance." One of the ways in which deviant behaviour is stabilized, according to Scheff, is through the patient's adoption of social stereotypes of insanity. Scheff also suggests that patients are re-
warded for playing the stereotyped deviant role and punished for attempting to leave this role. This is in accordance with the medical model's insistence that patient acceptance of the sick role is essential for successful treatment. The patient is encouraged to adopt the hospital's definition of himself, and is praised for showing maturity and insight when he does so. Rejection of the hospital's point of view, however, is taken as further evidence of illness.

Lemert (1951) suggested that vague symptoms might well be crystallized in the hospital: "In fact, a very defensible hypothesis is that a paranoid reaction to the mental hospital situation is 'normal' for our society." (p. 431) Baint's (1957) "apostolic function" has been invoked (Scheff, 1966) as a description of the process by which the physician induces in the patient the expression of symptoms which he considers the patient to have.

Goffman (1961) presents a vivid account of the social life of the mental patient, with a particularly detailed and sensitive analysis of the ways in which non-verbal and physical features of the patient's environment aid in effecting a lowering of his self-image. Stainbrook (1970) has pointed out how such ecological features of the hospital as architecture may reflect to the patient a set of expectancies regarding his behaviour, and how these expectancies are transferred into realities. Burnham (1961) has argued that forcing the patient to accept the "sick" role instills a self-image of inferiority, failure, weakness, and worthlessness, and cites cases in which forced adoption of
this role led to drastic increases in "sick" behaviour. Elsewhere the consequences of hospitalization have been seen to include willful deviancy, passive dependency, and irresponsibility. The role-models presented by other patients and the pressure to conform to the norms of the patient group are proposed as salient factors in effecting such behaviour (Talbot, Miller, and White, 1951).

Roman and Trice (1968) suggest that the disease model applied to alcoholism virtually forces the alcoholic to perpetuate his behaviour once he has been labelled as such. Szasz (1961) has similarly depicted the plight of the mental patient as one in which he is forced into the adoption of the sick role as all other roles are denied to him. Waitzkin (1971) also sees the patient as under a great deal of pressure to accept the sick role and ascribes this to the latent functions such acceptance serves in stabilizing hospital functions. Erikson (1962) goes further in suggesting that deviance may be a means of preserving stability in the greater society by helping to define and clarify the boundaries of normality.

Roman (1971) summarizes the conflict between labelling theory and the medical model in his exploration of community psychiatry. He depicts the current movement towards community psychiatry as a compromise between the two theories, and as an attempt on the part of psychiatry to minimize the debilitating effects of hospitalization. However, Roman shows how the underlying conflicts manifest themselves in that diagnosis is still
made in medical terms, treatment is still the responsibility of medical staff, and the patient is still viewed as suffering from an emergent disease which must be treated by a medical agent. Moreover, the emphasis on early diagnosis and treatment is in direct conflict with the labelling theorists' argument that this procedure of public labelling is damaging.

The Return of the Patient to Society

Many of the propositions of the medical model as stated in the previous sections would imply that the patient is ill-equipped for his return to society. According to labelling theory, the patient has had a lowering of self-esteem, and has been given a new and degrading identity, along with an array of deviant responses acquired through immersion in the patient culture. Moreover, while the hospitalization process was a form of public degradation, no comparable ceremony of reinstatement is granted upon discharge (Erikson, 1962). Along these lines, Roman (1971) points out that the label "cured" is almost never used at discharge due to the vagueness of the concept of "mental health". Thus the patient must at least partially retain the sick role even after discharge, and hence the layman's conviction that "once a mental patient, always a mental patient" (Erikson, 1957). The cogency of the layman's bias against mental patients can be seen in Phillips' (1963) study, which found that people

* Perhaps this is also due to a fear of being disproved. Certainly a discharge diagnosis of "improved" or "in remission" can never be proved in error, whether or not further acts of deviance occur.
displayed progressively greater rejection as a response to the same written description of a man utilizing no help, the help of a clergyman, of a physician, of a psychiatrist, and of a mental hospital. A rather dramatic finding was that a description of a well-adjusted man followed by the statement that he had sought help in a mental hospital resulted in greater rejection than did descriptions of a phobic-compulsive, a depressed-neurotic, or a simple schizophrenic, when these were followed by the statement that no help had been sought.

Certainly the above studies suggest that the ex-mental patient is likely to suffer from feelings of isolation and rejection, leading to distrust and suspicion on the ex-patient's part, and perhaps to further deviance, rehospitalization, and a renewal of the cycle. Using an attitude scale measuring reactions to ex-mental patients, Whatley (1959) has found partial support for this model of post-hospital socialization. He discovered that while the ex-patient is generally accepted in impersonal situations, his social participation is limited, and acceptance tends to be withheld in more personal and ego-involving situations. Thus the ex-patient may be rejected when his need for belonging might be greatest.

Generally our understanding of the issues raised by societal reaction theory derives from three sources: a theoretical sociological framework, some observational data, and a minimum of research. Thus far, we are limited in the amount of empirical data available and work is needed to assess the value of employing
a labelling perspective. The results of such investigations should serve to answer some of the questions confronting workers in the field of mental health, and should raise other questions for further exploration. Specifically in this study we investigated the area of acceptance vs. rejection behaviour in relation to the sick role as these manifest themselves in mental patient behaviour.

According to labelling theory, acquiescence to the sick role should have specific effects. Theoretically, acceptance of the sick role should lead to stabilization of symptoms and an aggravation of existing problems. Support for this view comes from Erikson (1957), who depicted the hospitalized patient as a person in a dilemma: the psychiatric staff demands wholehearted commitment to treatment, while society suggests that healthy behaviour is the opposite of such commitments. Erikson uses anecdotal evidence to show how patients exaggerate their symptoms in order to prove their candidacy for the sick role. Initial willful exaggeration may turn to permanent immersion in the role.

Conversely, we might presume that patients who reject the "sick" role would be spared some of the damaging consequences of the role. In particular, these patients, in refusing to view themselves as ill, ought to be more resistant to the stabilization of deviant behaviour, and ought to function more "normally" than their compliant counterparts. Downing's (1958) observations bear
directly upon this issue. From a psychoanalytic point of view he describes the non-compliant, "disturbed" patient as a better candidate for discharge than the patient who passively accepts the patient role. Downing concludes that the latter type will become dependent upon the hospital, and will see discharge as a threatened removal from a safe environment. He describes this type of patient anecdotally:

A visitor watched a patient filling drug prescriptions in a hospital pharmacy. Later he happened to walk across the grounds with him, observing weird hallucinations, bizarre thought content and most peculiar mannerisms. At lunch, he spoke to the pharmacist, expressing concern over seeing such a psychotic person in a responsible job. The pharmacist laughed, "He thought you were a hospital inspector who might discharge him; he's been here a long time and only acts that way around strangers he's not sure of." (pp. 492-3)

Blumenthal, in an unpublished paper cited in Petroni and Griffin (1969), also found that non-compliant patients were discharged sooner than those who conformed to the compliant role. Petroni and Griffin also cite studies which report that non-compliant patients are viewed by staff as not actually sick. They conclude:

... The implication seems quite clear that acceptance of the patient role reinforces the staff's appraisal that one is sick. And acceptance of staff appraisals that one is sick reinforces commitment to the patient role. It seems that the two are mutually reinforcing, thus, are indicative of a "vicious circle." (pp. 242-3)

The present study was designed to test the following hypothesis:
Patients who meet the criteria defining the "compliant" patient will, on tests of psychological functioning, respond in such a manner as to present themselves as relatively disturbed and incompetent in comparison with those patients who meet the criteria defining the "non-compliant" patient.
CHAPTER I

METHOD

Setting

The study was done at a provincially supported psychiatric institution with a patient population of approximately 1000. Patients are housed in groups of approximately 25-30 and the units are usually locked day and night, with most patients receiving ground privileges. Such privileges are generally withheld from new admissions until a minimal level of "competence and responsibility" have been demonstrated; privileges are routinely withdrawn in response to aggressive, suicidal or bizarre behaviour.

Patients are admitted in one of three ways: 1) formally, or through a form signed by a physician which orders his institutionalization whether or not he agrees to it; 2) informally, when the patient voluntarily submits himself to treatment; and 3) through a court order for examination, in cases where a criminal offense has been committed and there is a suspicion that mental illness or deficiency can account for the crime.

The patients on most units are heterogeneous with respect to age, length of admission, sex, method of admission, and reasons for admission.
Subjects

Pre-Selection Procedure

1) Two types of Ss were pre-selected. The first type consisted of patients who had been hospitalized at one or more psychiatric facilities for a total time not exceeding six months. The second type consisted of patients who had been hospitalized at one or more psychiatric facilities for a total of one year or more. All Ss were at least 16 years of age. Ss who met these criteria were further pre-selected as to whether or not they were free from organic brain damage. Finally, a minimum degree of literacy and intelligence were required to perform the tests described below. Case histories and unit personnel were used as information sources for pre-selection.

2) All those patients falling into the first category (under six months) were referred to a staff psychologist for a 20-minute semi-structured interview, following which the interviewer rated the S along an 8-point Compliance-Non-Compliance scale, with a rating of 1 representing extreme non-compliance and a rating of 8 representing extreme compliance. Compliance and non-compliance were defined according to the criteria described in Table 1.
**Table 1. Criteria for Compliant and Non-Compliant Patients**

<table>
<thead>
<tr>
<th><strong>COMPLIANT</strong></th>
<th><strong>NON-COMPLIANT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accepts hospital's definition of himself as 'sick'</td>
<td>1. Resists defining himself as a 'sick' individual</td>
</tr>
<tr>
<td>2. Passively accepts need for hospitalization</td>
<td>2. Questions need for hospitalization</td>
</tr>
<tr>
<td>3. Explains precipitation of hospitalization in terms of pathology</td>
<td>3. Defines events leading to hospitalization as an unfortunate set of circumstances which did not really involve pathological behaviour, or claims that his aberrant behaviour was justified</td>
</tr>
<tr>
<td>4. Submits to treatment and accepts rationale for it</td>
<td>4. Questions the need and rationale for treatment</td>
</tr>
<tr>
<td>5. Explains violations of hospital rules as manifestations of his pathology ('I'm sick and can't help it.')</td>
<td>5. Explains violations of hospital rules as legitimate responses to unfair or inappropriate strictures ('&quot;I'm a grown man. I don't have to go to bed at 11:00.&quot;')</td>
</tr>
<tr>
<td>6. Deferential to authority</td>
<td>6. Rebels against perceived arbitrary expressions of authority</td>
</tr>
</tbody>
</table>

**In summary**

- Generally internalizes goals and doctrines of hospital
- Generally rejects goals and doctrines of hospital as they relate to him
Another staff member interviewed ten of the Ss a second time as a reliability check. Prior to the commencement of the experiment, the interviewers and the E arrived at a consensus as to the definitions of compliance and non-compliance through discussions, familiarization with Table 1, and role playing. Inter-rater reliability was found to be .68 (p < .05), based on a Pearson Product-Moment test of reliability. This was considered sufficiently high to warrant reliance on the ratings of the primary judge.

**Group A: Compliant (C) Group (n = 10)**

A median split procedure was used, so that of the 20 Ss of type I who were eventually tested, the ten who achieved the highest rating (i.e. the ten most compliant) were designated as the Compliant group.

**Group B: Non-Compliant (NC) Group (n = 10)**

The remaining 10 Ss, those receiving the lowest ratings, were assigned to the Non-Compliant group.

**Group C: Institutionalized (I) Group (n = 10)**

Ten Ss of the second type described above comprised the Institutionalized group.

Of the Ss who had been rated, 7 refused to do the tests, one was not sufficiently literate and was thus excluded, and 2 others were discarded when it was discovered that they had been admitted as court orders, since such patients were generally certain of release on a specified date. This aspect
removed the element of ambiguity necessary to the experiment.

Three of the institutionalized Ss refused to do the
tests. Another was discarded when it was found that he had
answered "true" to all the MMPI items. In the case of a
fifth S, testing was discontinued when his bizarre behaviour
indicated that he did not comprehend the instructions.

After the elimination of these Ss, 10 patients re-
mained in each category. The age range for the 30 patients in
the total sample was 16 to 91. The sample consisted of 18 men
and 12 women.

Instruments

1) Minnesota Multiphasic Personality Inventory
(MMPI) Form R.*

The MMPI is a personality test developed by J.C.
Hathaway and S.R. McKinley in 1963. The Form R version is an
individually administered test consisting of 566 True-False
items which have been found empirically to discriminate between
normals and various clinical populations along several dimen-
sions. Four validity scales and 10 clinical scales are in-
cluded in the standard interpretation of the test. The items
for these scales are found in the first 399 statements, and
this abbreviated version was employed. The test is published
by the University of Minnesota Press.

The following scores derived from this scale were
employed.

---

* MMPI information has been summarized from Dahlstrom, Welsh, and Dahlstrom (1970).
a) Raw score on the F-scale (64 items)

Items on this scale were chosen from among those which had been endorsed by less than 10% of the standardizing population. As a result, the contents of these items reflect unusual feelings and experiences. High scores on this scale are interpreted as either confusion or deliberate exaggeration of pathology. Patients acquiescing to the sick role would be likely to attain such scores. See Appendix D for a summary of the interpretations of various F-scores.

b) Raw score on the K-scale (30 items)

High scores on the K-scale indicate a rigid unwillingness to admit to personality weaknesses. Low scores are interpreted as a frank communication of difficulty or as a deliberate exaggeration designed to convey a picture of serious disturbance. Thus acquiescing patients would be expected to score low on the K-scale, while patients resisting a self-definition of "sick" should score high. Appendix F gives a more thorough breakdown of characteristics corresponding to various K-scores.

c) F Minus K (F-K) Index

The F-K index was developed by Gough (1947), and has been used as a measure of the degree to which a person is systematically distorting the extent of his emotional problems. The F-K score is obtained by subtracting the raw K-score from the raw F-score. Acquiescing patients should score higher than those resisting the sick role.
d) Raw score on the Experimental (E)-scale (56 items)

Jackson and Messick (1961) developed a scale consisting of 9 categories for rating each MMPI item along a social desirability-undesirability dimension. Sixty-two items (from 1-399 inclusive) falling within the middle category (i.e. items neutral in social desirability) were used to comprise the E-scale. Six of these items were dropped from the scale because they were also items on either the F or K-scale. Keying was randomly determined. The scale is arbitrarily referred to as the E-scale.

2) Raw score on the Hooper Visual Organization Test (HVOT) (30 items)

The HVOT, developed by H. Eliston Hooper in 1957, was designed for use as a diagnostic tool in the detection of organic brain damage. It consists of thirty cards with pictures of cut-up objects. The S is directed to look at each one and describe what it would be if the pieces were put together. A low score is interpreted as either an indication of organic involvement or a reflection of confusion. See Appendix F.

Procedure

Condition 1: Role-Salient (R-S) Condition

Half of the Ss in each group were assigned to the R-S condition on a random basis. Under this condition an appointment was set up with the E, who did not know whether the S had been assigned to the C or NC group. The E greeted the
S as follows:

"Hello, Mr. ______. I do psychological testing for the hospital and I have some tests I would like you to do. One of these tests is a kind of picture puzzle test, and the other is a true-false questionnaire. Before we begin, could you read this and sign at the bottom, please."

At this point, the S was presented with a consent form with the following statement:

"I, the undersigned, agree to undertake this psychological assessment, which will be made available to the treatment personnel on my unit."

The form was used simultaneously as a consent form and as a means of emphasizing that the tests would be seen by the unit personnel, perhaps to determine the course of their hospital stay. If the S questioned the need to sign, this was explained as the general legal procedure employed by the hospital, and assured that he was not compelled to sign or to undergo the tests if he would rather not do so. Assuming that the S agreed to take the tests, he was then presented with the test materials.

While the S was filling out the MMPI form, a simulated phone call took place as follows:

E: "Hello... Yes... I'm busy right now, but I may be able to see you in about one hour... try me again then... OK... Goodbye."
This conversation was staged to convey an air of businesslike authority. The E also wore a tie and jacket to emphasize his professional status.

**Condition 2: Non-Salient (N-S) Condition**

The remaining 5 Ss in each group were assigned to the N-S condition. An appointment was arranged, and the S was greeted by the E as follows:

"Hi, Mr. _____. Thanks for coming. Let me tell you a little about what I do. I'm a student and I am doing some research as part of my course work. Part of my research involves two tests which I am giving to some of the patients here. One is a kind of picture puzzle test, and the other is a true-false questionnaire. You could help me out by taking these tests. Read this, and if you would like to try the tests, sign over here and we can begin."

The S was presented with the following consent form:

"I, the undersigned, agree to participate as a subject in the research which has been described to me. I understand that my responses will be used for research purposes only and that they will be confidential."

While serving as a consent form, the statement underlined the confidentiality of the S's responses, with the implicit assurance that the tests would have no bearing on the course of his hospital stay. If the S expressed qualms about signing the form, he was assured that he was under no obligation to.
take part in the experiment, and that the form was a legal necessity assuring the confidentiality of his responses. If the S had no objections, testing commenced.

As in the R-S condition, a telephone call was staged while the S was responding to the MMPI. The substance of E's conversation follows:

"Hello... yes... oh, I'm in the middle of some tests; do you think I could use the room for another hour?... thanks, I shouldn't be longer than that... goodbye."

The tone used by the E was meant to convey an attitude of deference and lack of authority. His unofficial status was further emphasized by his dress, which consisted of dungarees and a sports shirt.

Table 2 summarizes the experimental paradigm for each measure.

**Predictions**

1) Compliant patients acquiescing to the stereotyped roles assigned to mental patients should tend to exaggerate this role behaviour when the situation is defined as one in which their status as patients is being evaluated. Non-compliant patients in the same situation should be strongly motivated to perform well and to minimize their mental patient role behaviour as evidence of their health. This behaviour should be reflected in their test scores as follows under the role-salient condition:
<table>
<thead>
<tr>
<th>Group</th>
<th>Condition</th>
<th>Test</th>
<th>Role-Sentent</th>
<th>Non-Sentent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>c = 5</td>
<td>b = 5</td>
<td>u = 5</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>c = 5</td>
<td>b = 5</td>
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<td></td>
</tr>
<tr>
<td>B</td>
<td>c = 5</td>
<td>b = 5</td>
<td>u = 5</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Experimental Paradigm
a) F-score: the C (Compliant) group should score higher than the NC (Non-Compliant) group, that is, the C group should show test scores that indicate greater willingness to ascribe pathology to themselves.

b) K-score: the NC scores should be higher than the C scores, that is, the NC Ss should demonstrate test scores that indicate greater resistance to accepting pathological attributes.

c) F-K index: the C group should attain higher scores than the NC group. This combines the F and K scales but does it in a way to heighten individual trends.

d) E-scale: with the removal of items which can be responded to in terms of social desirability, both groups should attain similar scores, since differences in willingness to accept pathological self-descriptions are not reflected in the E-scale.

e) HVOT: the NC group should perform more adequately than the C group, since the latter group should tend to use wrong responses as a means of conveying an exaggerated impression of pathology.

2) Assuming that under conditions which are not relevant to the patient role, the motivations for exaggerated self-representation are no longer present, we would expect that the differences observed between C and NC patients would lessen in the non-salient condition. That is, in responding to a student,
the Ss should no longer be concerned with the impressions they convey, since such impressions will have no effects relevant to the course of their hospital careers.

3) If institutionalized patients are presumed to be secure in their patient roles, consistent performances would be expected across the conditions, as no pressure to distort will be present. That is, the I group Ss, who have already established themselves within their roles, will have no need to convey a given impression to the E via the test, whether or not the E is a part of the hospital establishment.
CHAPTER II

RESULTS

An initial 3 x 2 analysis of variance (ANOVA) was employed to determine the effects of the three patient categories and two conditions upon the raw scores on each measure.

The F-Scale

Table 3 summarizes the F-scale results. As predicted, strong differences among the S groups were found, but these differences were maintained across conditions. That is, contrary to prediction, the scores remained similar within each group whether the E presented himself as a psychologist or as a student. While such consistency had been expected of the institutionalized patients, the student status of the E was expected to produce a reduction in the differences between the C and NC groups attained under the R-S condition. Figure 1 indicates that the greatest difference in scores under either condition was found between the C and NC groups, with the I group attaining intermediate scores.

On the basis of the small differences between the R-S and N-S scores, and the lack of interaction between the "group" and "condition" factors, a single factor analysis was performed with the R-S and N-S scores combined for each S category. Table 4 presents a summary of the results thus obtained. The overall differences between category means were highly significant (p < .01), with the largest difference ap-
## Analysis of Variance

<table>
<thead>
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<th>Source of Variation</th>
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<th>Error</th>
<th>Conditions x Groups</th>
<th>Groups</th>
<th>Conditions</th>
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**Non-Self-Imposed Test Condition**

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<td>Non-Compliant</td>
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<tr>
<td>Compliant</td>
<td>12.8</td>
<td>7.40</td>
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</table>

**Total N = 30**

*Note: For each of the six subgroups, data was collected under role-stimulated and non-stimulated conditions, and the non-stimulated subjects were exposed to processes opposite of compliant, non-compliant, and institutionized respondents for the distribution of means, standard deviations, and analyses of variance.*
Figure 1. F-scale Scores as a Function of Group Membership and Experimental Condition
<table>
<thead>
<tr>
<th>Group</th>
<th>Mean P-score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
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<td>Comppliant</td>
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<tr>
<td>Instructed</td>
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<tr>
<td>Non-Comppliant</td>
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</tr>
<tr>
<td>NC with I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C with I</td>
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<tr>
<td>C with NC</td>
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<td></td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(n = 10 for each group; total N = 30).

Table 4. Comparisons of P-score distributions of Comppliant, non-Comppliant, non-comppliant, and Instructed subjects when subjects in each category are pooled across conditions.
pearing between C and NC Ss, C Ss obtaining significantly higher scores than NC Ss.

While the difference between the C and NC groups was established, it was still possible that within each group there was no consistent relationship between the individual S's rating and his F-scale score within each category. Accordingly, a Pearson Product-Moment correlation was performed to determine the degree of relationship between individual ratings and F-scale scores. The result was an $r$ of .59, demonstrating a significant relationship ($t = 3.13, p < .01$) between compliance rating and F-score for the 20 Ss who were rated.

**The K-Scale**

A summary of the results obtained on the K-scale appears in Table 5. Again the predicted difference between the C and NC groups was found in the R-S condition, but again this difference persisted in the N-S condition. Figure 2 demonstrates graphically the relationships among the groups and between the conditions. Note that the NC and I groups are almost identical, with the C group obtaining considerably lower scores.

The negligible condition and interaction effects permit the pooling of the R-S and N-S Ss within each group. The results of the single factor analysis of the difference in mean scores between the three combined groups is presented in Table 6. After pooling, the results are much the same: the C group is significantly lower than both the NC and I groups, which are virtually identical.
<table>
<thead>
<tr>
<th>Source of Variation</th>
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<th>MS</th>
<th>df</th>
<th>MS</th>
<th>COMPLIANT</th>
<th>Non-compliant</th>
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ANALYSIS OF VARIANCE

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<th>15.6</th>
<th>4.95</th>
<th>15.6</th>
<th>4.88</th>
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<td>5.60</td>
<td>2.95</td>
<td>7.50</td>
<td>6.00</td>
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<tr>
<td>Non-Satisfied</td>
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<td>4.95</td>
<td>15.6</td>
<td>4.95</td>
<td>15.6</td>
<td>4.95</td>
<td>15.6</td>
<td>4.95</td>
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<tr>
<td>Mean</td>
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<td>10.4</td>
<td>4.96</td>
<td>10.4</td>
<td>4.96</td>
<td>10.4</td>
<td>4.96</td>
</tr>
</tbody>
</table>

Groups: Total N = 30

Under Role-Satisfied and Non-Satisfied conditions, non-compliant and non-compliant subjects scored relatively by condition and total condition. For the distribution of Table 5, means, standard deviations and errors of variance for the distribution of

---

Total N = 30
Figure 2. K-scale Scores as a Function of Group Membership and Experimental Condition
<table>
<thead>
<tr>
<th></th>
<th>15.6</th>
<th>15.3</th>
<th>9.7</th>
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</thead>
<tbody>
<tr>
<td>Instructed</td>
<td>Mean K-score</td>
<td>Non-compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td>Group</td>
<td>Total N = 30</td>
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</tr>
</tbody>
</table>

Table 6: Comparisons of K-score distributions of compliant, non-compliant, and instructed subjects when subjects in each category are pooled across conditions.
Correlating the K-scores of all the rated Ss with their ratings, an \( r \) of \(-.56\) is obtained. Thus there is a strong negative relationship between compliance rating and K-score: the more compliant the patient, the lower his K-score \((t = -2.86, p < .05)\).

**The F-K Score**

As may be expected in view of the results posed above, the F-K scores followed the patterns found on the F and K scales (See Table 7). The strong differences between the C and NC groups found on the separate scales were enhanced through the combination of the two scales into the F-K index. As before, the predicted differences due to the change in examiner status failed to appear (See Figure 3), permitting a single-factor analysis to be performed through the pooling of R-S and N-S Ss within each group. Table 8 summarizes the results: the C group attained significantly higher scores than both the NC and I groups; the I group scored slightly higher than the NC group.

A reliability coefficient of \(.69\) between compliance rating and F-K score was found. This was highly significant \((t = 3.98, p < .001)\).

**The E-Score**

As predicted, the E-scale scores did not differ significantly, with a range of only 4.8 points separating the
<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>DF</th>
<th>( \bar{x} ) Mean</th>
<th>( s ) Standard Deviation</th>
<th>( s^2 ) Variance</th>
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<tr>
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<td>Conditions x groups</td>
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</tr>
<tr>
<td><strong>Source of Variation</strong></td>
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</tr>
<tr>
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</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Non-Satellite</td>
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<td></td>
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<td>Rate-Satellite</td>
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<td>5.27</td>
<td>7.6</td>
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<tr>
<td>Total</td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

Note: For each of the 6 X-sub-groups under each condition, non-satellite and rate-satellite subjects were randomly assigned to the experimental subjects. The K scores obtained by each subject, non-competent and rate-satellite, were then analyzed for the determination of the K-means, standard deviations and variances. The data for the two experimental groups were then tabulated.
Figure 3. F-K Scores as a Function of Group Membership and Experimental Condition
<table>
<thead>
<tr>
<th>Group</th>
<th>Compliant</th>
<th>Non-Compliant</th>
<th>Institutionaled</th>
<th>Mean P-K Score</th>
</tr>
</thead>
<tbody>
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<td>6.3</td>
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<tr>
<td>Overall</td>
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</tr>
<tr>
<td>I with I</td>
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<tr>
<td>I with NC</td>
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<td>I with I</td>
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<tr>
<td>I with NC</td>
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<td>0.14</td>
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</tr>
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</table>

Note: (n = 10 for each group, total N = 30)
highest (R-S, I) and lowest (R-S, C) group means. The C and NC scores differed by only 2.4 points in the R-S condition, and by 1.5 points in the N-S condition. Table 9 summarizes the ANOVA for the E-scale, while Figure 4 demonstrates graphically the similarities in scores.

**The HVOT score**

Contrary to prediction, the HVOT scores did not differ between any of the groups. All six means fell within a 2-point range, and the mean C and NC scores fell within 0.2 and 1.2 points of each other in the R-S and N-S conditions respectively. Table 10 summarizes the results, while Figure 5 gives a graphic representation.

In summary, prediction 1 was largely borne out, as the C group presented themselves as more pathological than the NC group on each of the F, K, and F-K scales. The groups also performed according to prediction on the E-scale in that no difference appeared upon removal of the social desirability factor. However, the predicted differences between the groups did not appear on the HVOT.

The results did not follow the expected pattern for prediction 2, since the convergence of the C and NC scores did not occur under the non-salient condition.

While consistent performances by the I group did occur as predicted (prediction 3), the meaningfulness of this result is limited by the fact that prediction 2 was not fulfilled.
### ANOVA Table

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<th>Source of Variation</th>
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<th>Conditions x Groups</th>
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</tbody>
</table>

#### Table 9: Means, Standard Deviations, and Analysis of Variance for the Distribution of Scores Obtained by Compliant, Non-Compliant, and Instrumentalized Subjects under Role-Satellite and Non-Satellite Conditions (n = 5 for each of BLX subgroups)
Figure 4. E-scale Scores as a Function of Group Membership and Experimental Condition
<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Total</th>
<th>Error</th>
<th>Conditions X Groups</th>
<th>Groups</th>
<th>Conditions</th>
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**Analysis of Variance**

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*Note: Groups represent non-attendant and attendant conditions, non-compliant and institutionallized subjects. HVEOt scores obtained by comparing non-compliant and compliant groups for the distribution of subjects.*
Figure 5. HVOT scores as a Function of Group Membership and Experimental Condition
CHAPTER III

DISCUSSION

The results of the F, K, and F-K scores follow a similar pattern: regardless of examiner status, compliant short-term patients score in a manner that presents a more pathological picture than do non-compliant short-term patients, while long-term institutionalized patients generally attain scores intermediate between the C and NC groups, with a tendency towards the lesser degree of pathology presented by the NC group. However, one main factor under study - the condition of role salience - was found to have no discernible effect on performance. We are left with the question whether the group differences are due to differential attitudes towards the patient role which result in exaggerated self-portrayals, or whether these differences are due to differences in pathology. That is, is there a strong, positive relationship between degree of compliance and degree of illness?

A number of factors suggest the first interpretation. First, while F and K scores individually may reflect either deliberate misrepresentations or pathology, the combined F-K index generally represents a self-representation response set. Dahlstrom and Welsh (1972) describe normal scores as ranging between -2 and -19. Seven of the 10 NC Ss scored within this range, two others fell just above this with scores of 1 and 0.
respectively. In contrast, only one C S scored within the normal range (-4); one scored 0, and the rest had positive scores. These comparisons strongly suggest that the C group tended to exaggerate the degree of disturbance which they were experiencing.

A second source of support for the "exaggeration" hypothesis comes from the consistently high correlations between degree of compliance and each of the F, K, and F-K scores. Referring to Appendices D and E, it is apparent that only extreme scores are interpreted as representing pathology. Eleven of the 20 F scores (55%) and 14 of the 20 K scores (70%) fall within limits which are defined as non-indicative of pathology. Accordingly, it would be expected that the correlations between compliance ratings and F and K scores would break down in these middle ranges if pathology were the mediating factor, thus yielding low overall correlations. Moreover, the highest correlation of all is found between the F-K index and compliance ratings. It is more parsimonious to assume that this correlation resulted from the separate faking factors represented within each of the F-K scales than to assume that non-faking factors related to compliance combined fortuitously to produce the high correlation of F-K scores with the C-NC dimension.

The similar scores attained by all groups on the E scale indicate that when the element of social desirability has been removed, the groups no longer differ in response pattern.
The results of the HVOT contradict our original expectations. It was expected that on the HVOT the C group would score lower than the NC group, since a member of the former would use incorrect responses as a means of representing himself as ill, while his NC counterpart would not respond in such a manner. However, this seemingly contradictory evidence may be the result of a hidden and unwarranted assumption built into the prediction that HVOT scores would parallel those of the MMPI. The contents of F and K scale items clearly relate to self-representation, and as such they contain clear stimulus properties for the S relating the test situation to his role as a mental patient. The same is not true for the HVOT; here the stimulus properties of the items have no direct relationship to self-representation. Since the HVOT was always presented first, the inference linking "wrong response" with role behaviour may not have been forthcoming. Perhaps the HVOT would have been closer to the predicted pattern had the order of the test presentation been reversed, since exposure to MMPI items might have facilitated such an inference. In any case, it would seem that the HVOT is less amenable to self-representation than are the other measures.

Viewed according to the above interpretation, the homogeneity of HVOT scores might be seen as supporting the main hypothesis in much the same way as the pattern of E-scores. That is, without the element of social desirability to elicit differences
in the groups corresponding to their different roles, test behaviour tends to be the same. In addition, while non-organics would generally be expected to score similarly on a test for organicity, Appendix F suggests that if the C group were far more disturbed than the NC group, the former should have attained somewhat lower scores. The fact that this did not occur is another argument for the conclusion that exaggerated self-representation, rather than pathology, was the mediating factor in the MMPI-compliance correlations.

Finally, the scores attained by the I group lend support to the exaggeration interpretation. Their performance on the F, K, and F-K scales are consistent with the assumption that, in contrast to the C group Ss, the I group Ss were sufficiently secure in their roles to make systematic exaggeration unnecessary. Braginsky, Grosse, and Ring (1966), on the other hand, found that "old-timers" would deliberately fake illness when told that the test they were taking would determine whether or not they were to be discharged. That is, with their security undermined, they behaved similarly to the C group Ss in the present study.

If the hypothesized relationship between self-representation and role acquiescence were responsible for the differences between the C and NC groups, the question remains whether these differences would not have disappeared under the N-S condition when the E's student status removed the need for exaggerated self-representation? Again, the results may reflect
a methodological error rather than a theoretical one.

It was assumed that by identifying himself as a student, and by offering cues designed to assure the S that his responses would have no bearing on the course of his hospitalization, the E would create an atmosphere which would obviate the need for self-misrepresentation. In retrospect, this may have been a naive assumption. The similarities between the C and NC test situations may have outweighed the differences. The E was the same, and his personality and style may well have generated similar nonverbal cues in both situations. These cues may have been more important than the more obvious ones meant to elicit differences. The office used for testing was the same one for both conditions. The Ss in both groups were being tested within a few days of having been interviewed by the rater. The signing of a consent form, in particular, may have had implications which were far more meaningful than the contents of the forms. But perhaps the most important factor working to equate the two conditions was the fact that the patient within a given category (C or NC) had been immersed within a role throughout his hospitalization. It may have required far more psychological distance than that provided by the test situation to have allowed him to discard that role.

Some biases were introduced into the experiment and may have influenced the direction of the results. The E was
aware of the identity of the group members during testing. This may have led him to convey inadvertent cues to the being tested. It is also conceivable that the formulated judgments as to the degree of compliance for the C and NC groups, and such knowledge may have influenced his behavior in the test situation. Complete naivete on the part of the E as to the purpose of the experiment would have been preferable.

Another bias was introduced by the pre-selection procedure. Those patients who were judged as too confused or unintelligent to participate by ward staff were rejected beforehand. On the whole this tended to homogenize the groups and thus the results may have been a conservative estimate of the true effects. On the other hand, the effects may not generalize to the types of subjects who were considered unsuitable. Moreover, the pre-selection procedure may have unduly shifted the I means upwards relative to those of the C and NC groups, since it is probable that a disproportionately large number of potential I subjects were rejected beforehand as unsuitable.

Finally, no attempt was made to control for the effects of medication. This may have created a systematic bias in that the NC and I groups may have been subjected to heavier doses of medication than were the C group. Assuming this to be the case, however, the direction of the bias is unclear. Heavier medication may have minimized the number of bizarre or pathological kinds of responses given by the NC and I groups, thus producing relatively
normal profiles. But medication may also have led to a lowering of the experimental effect, in that the same docility could have led the rater to misclassify some of the Ss. Further research is required to determine whether the same results would still be obtained if medication were controlled for.
CHAPTER IV

CONCLUSIONS

The results of this study give qualified support to the labelling hypothesis. Although varying the experimental conditions in terms of role saliency did not lead to the predicted results, varying the groups did yield differences supportive of the hypothesis. Since an explanation of these differences in terms of differences in pathology seems inadequate, it is likely that these differences reflect differences in the attitudes chosen towards the patient role.

The above interpretation of the results would certainly suggest a re-examination of the traditional belief that rejection of the patient role and a refusal to acknowledge one's illness indicate lack of insight and resistance to treatment. On the contrary, a ready willingness to internalize the goals and perspectives of institutional authorities may well be an early warning sign of potential chronicity. It may then be advisable to stimulate an attitude of skepticism and a desire to partake in the decision-making process. Attitudes of extreme dependency and passivity have long been viewed as pathological or irresponsible (depending on one's point of view) outside of the mental hospital. Is it then logical to demand the same characteristics in the rehabilitation process?
Even if the results are viewed as reflections of differences in pathology between compliant and non-compliant groups, the above considerations still apply. If acquiescence implies pathology, compliance should be viewed as a detriment rather than an asset to rehabilitation.

A more radical interpretation of the present study is that hospitalization is often detrimental per se. If acquiescence to institutional norms has negative consequences, while resistance to those norms implies health, then perhaps the present means of dealing with mental illness are more damaging than beneficial.

However, the further claim that any form of labelling of "mental illness" is bound to be ultimately detrimental is beyond the scope of this paper, since the results are not generalizable beyond the type of mental hospital which was the setting for this study. The process of attitude change towards such situations as patient responsibility, long-term hospitalization, routine admission, and public re-education was already underway at that hospital, and awareness of the importance of such issues has created a search for new approaches to the problem of residual deviance. The community mental health program is one example of how a new model is being used as a basis for rehabilitation programs. It remains a question for future research whether some of these changes will result in a significant decrease in the negative effects
of labelling suggested by this study, and by societal reaction theory in general.

A number of questions have been raised by this study. In particular, research is needed to provide a more precise delineation of the parameters related to role behaviour in the mental hospital. While the size of the setting and time limitations made it difficult to maximize the discrepancy between the R-S and N-S conditions, it would be interesting to see whether future studies would yield the predicted effects by doing so. The number of ES should be increased to minimize the effects of the E's personality and the method of consent changed to one in which the two conditions differ more than they did in the present study. Ratings might be obtained indirectly through ward staff evaluations so as to remove the common interview experience prior to the test administration. Finally, the Ss in the N-S condition should be tested elsewhere than those in the R-S condition. If possible, the N-S group should be tested outside the hospital altogether, perhaps at an educational facility or in a private home. This procedure would presumably help to increase the psychological distance from hospital roles.

Exaggerated self-representation seemed to depend upon stimuli containing cues which elicit role behaviour. Thus the content of an MMPI item on the F-scale might clearly indicate to the patient that his response will convey an im-
pression of his state of mind to the examiner. On the other hand, the content of an HVOT item, such as a picture of a cut-up dog, has no such cue properties, and a higher level of inference is required by the patient to determine that his response will communicate something about his state of mind. This suggests that exaggerated role behaviour may be a function of environmental cues, and that these can be manipulated in such a way as to either minimize or maximize such behaviour.

Braginsky and Braginsky's (1967) study raises a related issue, that of the definition of goals. The authors of that study found that when they defined the situation as a test to determine whether the patient should be discharged, or left the goals of the test vague, long-term patients responded in such a manner as to present a picture of illness. However, these patients responded in a healthy manner when the purpose of the test was defined as determining the suitability of the patient for transfer to a more open and confortable ward.

Future research, then, should concern itself with assessing the types of environmental stimuli and the types of goals which will elicit relatively normal and pathological types of behaviour. These findings could be applied in the design of treatment programmes and hospital facilities so as to encourage the development of normal patterns of behaviour.
and to inhibit the perpetuation of pathological modes of responding.

Further study is needed to determine the generalizability of the present results, since the pre-selection procedure eliminated many of the subjects who were considered too confused or too handicapped intellectually to complete an MMPI. Sample bias could be reduced by the use of a less demanding measure of the dependent variable.

Finally, the effects of medication should be controlled, either by eliminating medication for the duration of the study, or by equalizing the groups for degree of sedation.
BIBLIOGRAPHY


Messick, S., and D.N. Jackson, Desirability Scale Values and Dispersions for MMPI Items. Psychological Reports, 8:415-17, 1961.


## APPENDIX A

**NUMBERS AND KEYED DIRECTION FOR THE P-SCALE ITEMS**

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## APPENDIX B

### NUMBERS AND KEYED DIRECTION

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**APPENDIX C**

NUMBERS AND KEYED DIRECTION FOR THE E-SCALE ITEMS

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## APPENDIX D

**INTERPRETATION OF P-SCORES FALLING IN VARIOUS RANGES**

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<td>0-2 (low)</td>
<td>Deliberate attempt to hide psychopathology... systematic refusal to endorse socially undesirable test items</td>
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<td>3-10 (middle)</td>
<td>Typical normal and clinical scores... endorsement of some items may accurately represent unusual interests or experiences</td>
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| 11-16 (moderately high) | 1) realistic reflection of extreme circumstances  
2) reading or comprehension difficulties  
3) severely neurotic or moderately psychotic reactions  
4) behavioral disturbance and lack of cooperation |
| 17-20 (very high) | 1) severely disorganized psychotics  
2) severely disturbed alcoholics  
3) severe behaviour problems  
4) reading and comprehension difficulties |
| 21-25 (markedly high) | details not provided |
| 26-38 (random)   | usually random responding unless rest of MMPI profile indicates otherwise |

*Summarized from Dahlstrom, Welsh and Dahlstrom (1972).*
APPENDIX E

INTERPRETATION OF K-SCORES FALLING IN VARIOUS RANGES*

Ranges

0-4 (markedly low)

Interpretation

1) deliberate attempt to create impression of severe disturbance
2) acute undifferentiated schizophrenic reaction
3) alcoholic on the verge of delirium tremens

5-9 (low)

Similar to markedly low range, but less naive in faking or less confused... also may reflect low status in everyday life

10-15 (middle)

Balance of self-disclosure and self-protection

16-20 (high average)

Generally indicates healthy self-control

21-25 (moderately high)

26-30 (markedly elevated)

Exaggerated attempt to maintain appearance of control and normality

*Summarized from Dahlstrom, Welsh, and Dahlstrom (1972)
## APPENDIX F

**INTERPRETATION OF HVOT SCORES FALLING IN VARIOUS RANGES**

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<td>10.0-19.5</td>
<td>generally indicates organic brain damage. May reflect extreme lack of attention or poor reality contact in schizophrenic disorder</td>
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<td>0.0-9.5</td>
<td>organic brain damage or severe and chronic schizophrenia</td>
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1947

Born in Munich, Germany to Mayer and Sarah Kleinplatz.

1953-1964

Educated at Young Israel School, Coronation School, Bedford School, Strathcona Academy, Outremont High School, and Montreal West High School in Montreal, Quebec.

1969

Graduated with a Bachelor of Arts degree (Major in Psychology), McGill University, Montreal, Quebec.

1969

Registered as a full-time graduate student at the University of Windsor, Windsor, Ontario.