AN EVALUATION OF THE FIRO-B SCALE WITH HOSPITALIZED PSYCHIATRIC PATIENTS

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THESIS

Presented to the Graduate Council of the
North Texas State College in Partial
Fulfillment of the Requirements

For the Degree of

MASTER OF SCIENCE

By

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Denton, Texas
January, 1961
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CHAPTER I

INTRODUCTION

One of the most promising developments in the field of Clinical Psychology is the emergence of new instruments designed to measure and/or predict human behavior. Research and therapy with hospitalized psychiatric patients must, because of the number involved, be generally aimed at (identifying and when possible isolating) those areas of personality which can be strengthened or re-inforced to the extent that the individuals involved can again function effectively in our society. Such research is normally concentrated on those patients sufficiently in contact with reality to benefit from some form of group or individual psychotherapy. The number of psychotics who can benefit from psychotherapy has been increased by the use of drugs but, even so, such therapy is definitely limited by the number of qualified therapists available. Therapy may take several hours a week over a long period of time and mental hospitals have hundreds or even thousands of patients for each trained therapist.

In order to make therapy as productive as possible it becomes necessary to select those psychotic patients who will benefit from the treatment.
Research involving psychotic patients, particularly those with schizophrenic disorders, reveals many factors in the individual's personal history which are considered very significant to the prediction of a favorable prognosis. Some of these critical factors, as presented by Coleman are: (1) early treatment—before eighteen months; (2) onset of illness acute—rather than gradual and insidious; (3) known precipitating conditions—environmental setbacks, etc.; (4) a mesomorphic body build; (5) a catatonic reaction pattern or one showing the presence of confusion or manic-depressive symptoms; (6) relative mature personality before illness, especially in terms of ability to initiate and maintain heterosexual relationships; (7) relief of symptoms after injection of sodium pentothal; (8) insight—the greater the patient's insight into his illness, the more favorable the prognosis; (9) a favorable and understanding environment to which the patient can be returned (1, p. 288).

In conjunction with the above factors which must of necessity be considered in choosing patients for the available forms of psychotherapy, many hospitals utilize some form of psychological evaluation consisting of a battery of tests designed to determine the individual's intelligence and his diagnostic classification. The administration of these psychological tests is an important prelude to diagnosis.
Coleman states:

It goes without saying that in contacts with a patient, it is vitally important that the psychologist or clinician maintain a sympathetic and understanding attitude, designed to gain the patient's confidence and cooperation. The nature of these contacts has a direct bearing upon the accuracy and value of the psychological evaluation (1, p. 524).

Many authors report research with hospitalized psychiatric patients not involved with either psychometrics or diagnostic classifications. Most of these studies have been considered successful, e.g. one study reported a test-retest situation with patients who were administered tests before and after psychotherapy. These tests revealed definite improvement in symptomatology of certain types of patients after psychotherapy (7, pp. 123-132). The instrument used in this study was the Impersonal Test Battery (3), consisting of: the Minnesota Multiphasic Personality Inventory; the Interpersonal Adjective Checklist; and a Ten-card form of the Thematic Apperception Test. Other investigators have been able to ascertain the group structure in acute psychiatric wards with the use of sociometric tests, and obtained favorable improvements in the ward atmosphere by utilizing the resulting data of such tests (2, pp. 91-111). These studies indicate that testing of hospitalized psychiatric patients can be of definite value, not only in the hospital setting, but perhaps also in the areas of preventative therapy.
Testing with psychiatric patients often takes considerable time. Consequently, many therapists and others in related fields feel there is little value in psychological evaluations, and assume that the patient's personality structure will be revealed in the course of psychotherapy (1, p. 528). Since not all patients can afford or obtain adequate psychotherapy, this view of the importance of psychological evaluations is perhaps limited to a select group of patients. Other therapists feel that the use of psychological tests with psychiatric patients paves the way for a more adequate program of rehabilitative planning for the individual.

Menninger observes:

... there have been devised psychological tests which are useful to psychiatrists just as a Wasserman test is useful to internists. These tests not only help to make a definite diagnosis in doubtful cases, but they can be applied to apparently normal patients, and in such patients often reveal the presence of schizophrenic tendencies which do not show in any clinical way (8, pp. 102-103).

Psychological testing and its results are commonly being accepted as an important aspect of the study of individuals in the growing field of work with emotionally unstable people. Such programs are not limited to adult populations. They are being utilized in all age groups throughout the world. This facet, combined with somatic therapy and a social history of the patient, composes the basic aspects of the team approach being utilized in the majority of our mental hospitals, i.e. the resources of the psychiatrists, the psychologists,
and the psychiatric social workers. Through these avenues many hospitals have shown an increase in the number of discharges from the hospital and a decrease in the number of re-admissions, which is a promising turn of events (5, pp. 413-419). This is not to say that the psychological testing is solely responsible for such heartening developments; however, such testing combined with the other areas of the team approach has proven very fruitful.

Concerning the present study, if in the test results of psychotic patients there is some distortion of reality concepts, as is generally expected, then their scores on any personality scale should vary considerably from norms established on the same test by "normal" subjects. Another factor which should influence test results, is the probable length of illness prior to the first hospitalization, particularly in schizophrenic patients. A somewhat guarded prognosis is generally predicted for those schizophrenic patients whose illness has been in effect for eighteen months or longer upon first admission to a hospital (6, pp. 434p441). If these patients do indeed have a poor prognosis, then it should follow that their scores on any form of personality test would vary considerably from the scores of "normals."

Perhaps differences in test scores between psychotic and normal subjects can more readily be accepted if a brief survey of the dynamics of a psychotic reaction is covered.
Common factors of a psychosis:

Concerning general behavior
1. The patient shows a severe degree of personality decompensation; reality contact markedly impaired; patient incapacitated in social functioning.

Nature of Symptoms
2. The patient has a wide range of psychosomatic symptoms and complaints with delusions, hallucinations, and other severely deviate behavior.

Orientation
3. The patient frequently loses orientation to environment.

Insight
4. The patient rarely has insight into the nature of his behavior.

Social aspects
5. The patient's behavior is frequently injurious or dangerous to patient or to society.

Treatment
6. The patient usually requires institutional care; shock and other somatic therapies in addition to psychotherapy frequently necessary (1, p. 253).

Considering these factors which present the general behavior pattern of the psychotic, it is understandable why there could be gross differences in the scores of this type person as compared to the scores of an average subject. Differences in scores between psychotic and normal subjects can generally be predicted on any type of personality inventory including the new tests which emerge periodically in the field of Clinical Psychology.
Statement of Problem

Operating on the premise that there are differences in personality traits or scores on any form of self-assessment scale between psychotic and "normal" subjects, two groups were administered the FIRO-B scale. A group of hospitalized psychiatric patients represented one group and the second group consisted of non-hospitalized "normal" controls. The following hypothesis has been set up for investigation:

1. There are significant differences in personality traits or scores between psychotic and "normal" subjects as measured by the new self-rating scale FIRO-B, and that these differences will be significantly raised or lowered on all traits measured by the FIRO-B Test.

2. The hypothesis is considered applicable to psychotic patients due to the very symptoms observable in schizophrenic illnesses, i.e. distortion of reality ties, confusion or lowering of self concepts, and inability to relate to the environment.

3. It is recognized that there are many limitations to the value of scores obtained on self-rating or personality scales of any type; however, these limitations are felt to be operating on both sides of the contiguity with regard to the questionable division between "normal" and psychotic subjects.

The personality inventory may be regarded as a form of interview, even though somewhat less personal than face to
face interviews. Personality questionnaires are in fact verbal stimuli; and, before the items are used to score individuals, they have been tested statically to show some discrimination between groups scoring high and low on some trait in question (10, Chapter VIII).

Description of Rating Scale

The measuring instrument used in this study is a new scale—the FIRO-B, *Fundamental Interpersonal Relations Orientation-Behavior*, a self-assessment inventory. This scale was developed, after six years of research, by William G. Schutz, while at Harvard University in the Department of Social Relations. It was published in its present form in 1958. (See Appendix)

The primary purposes for developing the FIRO-B Scale, as stated by Schutz, are:

1. To construct a measure of how an individual acts in interpersonal situations, and
2. To construct a measure that will lead to the prediction of interaction between people, based on data from the measuring instrument alone.

In this second regard FIRO-B is somewhat unique among personality tests. It is designed not only to measure individual characteristics, but to measure specifically characteristics that may be combined in particular ways to predict relations between people (9, p. 58).

It was the author's intention to assess what behavior the individual expresses toward others, and how he wants others to behave toward him. In order to assess this behavior, Schutz formulated the following Postulate of Interpersonal Needs:
(a) Every individual has three interpersonal needs:
(1) inclusion, (2) control, and (3) affection.
(b) Inclusion, control, and affection constitute a sufficient set of areas of interpersonal behavior for the prediction and explanation of interpersonal phenomena (9, p. 13).

These three interpersonal needs are defined by the author as:

The interpersonal need for inclusion is defined behaviorally as the need to establish and maintain a satisfactory relation with people with respect to interaction and association. "Satisfactory relation" includes (1) a psychologically comfortable relation with people somewhere on a dimension ranging from originating or initiating interaction with all people to not initiating interaction with anyone; (2) a psychologically comfortable relation with people with respect to eliciting behavior from them somewhere on a dimension ranging from always initiating interaction with the self to never initiating interaction with the self.

The interpersonal need for control is defined behaviorally as the need to establish and maintain a satisfactory relation with people with respect to control and power. "Satisfactory relation" includes (1) a psychologically comfortable relation with people somewhere on a dimension ranging from controlling all the behavior of other people to not controlling any behavior of others; and (2) a psychologically comfortable relation with people with respect to eliciting behavior from them somewhere on a dimension ranging from always being controlled by them to never being controlled by them.

The interpersonal need for affection is defined behaviorally as the need to establish and maintain a satisfactory relation with others with respect to love and affection. Affection always refers to a two-person (dyadic) relation. "Satisfactory relation" includes (1) a psychologically comfortable relation with others somewhere on a dimension ranging from initiating close, personal relation with everyone to originating close, personal relations with no one; (2) a psychologically comfortable relation with people with respect to eliciting behavior from them on a dimension ranging from
always originating close, personal relations toward the self to never originating close, personal relations toward the self (9, pp. 18-20).

Final development of the instrument set up six scales to measure the degree to which each of the following statements are true as reported by the respondent:

1. Expressed Inclusion \( (eI) \): I initiate interaction with people.

2. Wanted Inclusion \( (wI) \): I want to be included.

3. Expressed Control \( (eC) \): I try to control (influence) people.

4. Wanted Control \( (wC) \): I want people to control (influence) me.

5. Expressed Affection \( (eA) \): I act close and personal toward people.

6. Wanted Affection \( (wA) \): I want people to get close and personal with me.

There are nine questions which compose each of the six scales making a total of fifty-four questions on the inventory. The questions for each scale are distributed at random throughout the inventory so the respondent will not recognize the trait being measured. A scoring key was developed for each of the six scales.

Some examples of the test questions from each scale are:

\( (eI) \)  

I try to be with people

1. usually, 2. often, 3. sometimes, 4. occasionally, 5. rarely, 6. never, 
(Question no. 1)
(wI) — I like people to invite me to things
1. most, 2. many, 3. some, 4. a few,
5. one or two people people people
people, 6. nobody. (Question no. 28)

(eC) — I try to take charge of things when I am
with people 1. most, 2. many, 3. some,
4. a few, 5. one or two people people
people people, 6. nobody. (Question
no. 33)

(wC) — I am easily led by people 1. most, 2.
many, 3. some, 4. a few, 5. one or two
people people people people,
6. nobody. (Question no. 26)

(eA) — I try to get close and personal with people
1. usually, 2. often, 3. sometimes, 4.
occasionally, 5. rarely, 6. never.
(Question no. 12)

(wA) — I like people to act distant toward me
1. usually, 2. often, 3. sometimes, 4.
occasionally, 5. rarely, 6. never.
(Question no. 52)

The respondent's answers in the three interpersonal
need areas should give some indication as to his concept of
his own personality dynamics with regard to his relationship
to others or at least his concept of how he reacts in inter-
personal relationships.

Limitations of the Problem

The subjects used for this study were limited to hos-
pitalized psychiatric patients at the Terrell State Hospital,
Terrell, Texas. Because of certain administration policies
at the Terrell State Hospital, only thirty subjects were
made available for this study. Eight of the subjects tested
fell into diagnostic classifications which were not usable.
for the hypothesis proposed. Hence, there were only twenty-two subjects involved in the study: fifteen females and seven males. The mean age for the group was 28.4. Even though there was only a small sample left to test, the hypothesis set up for the investigation, the nature of the sample used and the newness of the instrument used (with regard to psychiatric subjects) were factors which led to the belief that the study was worthy of some merit.

The subjects were, or had been, overtly psychotic, and their symptoms were all diagnosed as schizophrenic in nature. Their illnesses were felt to be of a duration of eighteen months or longer.

Methodology and Gathering of Data

The tests were administered by the staff of the Psychology Department at the Terrell State Hospital. This procedure was followed for several reasons. The most pertinent reason being that no one other than a member of the professional staff at a state hospital is allowed to examine and/or test a patient in a state hospital. The psychology staff also felt the test results would be more valid if their members administered the tests because of the rapport already established with the subjects used. Two groups of patients in psychotherapy units were examined by their respective therapists and these groups represented twelve of the subjects used in this study. The remaining eighteen patients tested
were obtained from a patient council which represented the open wards at the hospital. This council met once a week and a member of the psychology staff also attended to help stimulate discussion about patients' needs, etc.

The psychology staff examined the instrument used and administered same, utilizing the directions suggested by the author of the scale. The subjects were encouraged to be as truthful as possible, and they were allowed as much time as was needed to complete the tests.

The degree of adjustment of scores obtained from the psychotic subjects in this study were compared to the scores obtained from the group of (50) controls which were essentially a non-screened group of people: Sunday School participants, nurses, friends, and others. Twenty-two were selected from the control group who most closely matched the psychotic population in the areas of age and sex. Intellectual level and other psychological data were not felt to be relevant to the specific study involved: namely, the evaluation of the usefulness of the FIRO-B Scale with hospitalized psychiatric patients as proposed in the particular hypothesis tested. The tests were administered to the control group after a brief explanation as to their function regarding the proposed study. The control group was further instructed to indicate only their sex and age on the test blanks and it was stressed that the results of individual scores would remain anonymous. Again, the general test instructions consisted of following
the author's suggestion that the subjects answer the statements from the standpoint of people in general and not with any family or work group in mind. The control group was also allowed as much time as necessary to complete the inventory and for the most part did not have any questions after the introductory explanation by the investigator. The control group was matched with the psychotic group by sex and age, i.e. fifteen females and seven males. The mean age for this group was 28.1, just slightly lower than the experimental group which was 28.4.

Thus, it was possible to investigate the hypothesis proposed by directly comparing the relationship between the scores obtained from the two groups, statistically evaluating the differences in the means with a t test for small non-related groups.

All of the subjects used in this study were participating in some interpersonal relationships with others away from the hospital wards—a factor which should render the results of this study more significant considering there was some form of re-socialization taking place among the patients tested.
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CHAPTER II

STATISTICAL ANALYSIS OF THE DATA

To evaluate the groups studied, the t test for small independent groups was used to note the relationship between the scores on each of the variables measured by the FIRO-B test. The results of this statistical comparison for the groups are presented in Table I.

As proposed in Chapter I, the theoretical proposition investigated was that there would be significant differences in personality traits or scores between psychotic and "normal" subjects as measured by the new self-rating scale FIRO-B, and that these differences will be significantly raised or lowered on all traits measured by the FIRO-B Test. Examination of Table I reveals that this hypothesis must be rejected for the six variables measured only one shows an indication in the predicted direction, that is the need of eI, and this variable is only significant at the 10 per cent level of confidence. The null hypothesis for this study must, therefore, be accepted.

The lack of over-all significant differences between the two groups studied tends to support the view that Personality Theory and Statistical Evaluation concerning human behavior are perhaps studying completely different
### TABLE I

TESTS OF SIGNIFICANCE OF THE DIFFERENCE BETWEEN THE MEANS OF HOSPITALIZED PSYCHIATRIC SUBJECTS AND NON-HOSPITALIZED CONTROL SUBJECTS

<table>
<thead>
<tr>
<th>Need Variable</th>
<th>$M_1$</th>
<th>$M_2$</th>
<th>$M_1 - M_2$</th>
<th>$t$</th>
<th>df</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>eI</td>
<td>5.81</td>
<td>4.28</td>
<td>1.53</td>
<td>1.35</td>
<td>42</td>
<td>.10</td>
</tr>
<tr>
<td>wI</td>
<td>4.90</td>
<td>3.66</td>
<td>1.24</td>
<td>.82</td>
<td>42</td>
<td>...</td>
</tr>
<tr>
<td>eC</td>
<td>4.32</td>
<td>2.82</td>
<td>1.50</td>
<td>1.06</td>
<td>42</td>
<td>...</td>
</tr>
<tr>
<td>wC</td>
<td>5.09</td>
<td>5.09</td>
<td>...</td>
<td>...</td>
<td>42</td>
<td>...</td>
</tr>
<tr>
<td>eA</td>
<td>3.81</td>
<td>3.71</td>
<td>.10</td>
<td>.09</td>
<td>42</td>
<td>...</td>
</tr>
<tr>
<td>wA</td>
<td>4.54</td>
<td>5.28</td>
<td>.74</td>
<td>1.00</td>
<td>42</td>
<td>...</td>
</tr>
</tbody>
</table>

*M$_1$ Hospitalized Subjects

**M$_2$ Non-hospitalized Subjects
aspects of personality. Considerable information has been written concerning this problem. Meehl suggests these opposing forces are perhaps both correct in their assumptions; i.e. the Clinical versus the Statistical Prediction, but their usefulness is confined to specific tasks. Meehl's position simply stated is as follows:

There is no convincing reason to assume that explicitly formalized mathematical rules and the clinician's creativity are equally suited for any given kind of task, or that their comparative effectiveness is the same for different tasks. Current clinical practice should be much more critically examined with this in mind than it has been (3, Preface).

The lack of statistical support for the clinical prediction made in this study supports Meehl's feelings regarding the different tasks these two fields are indulged in with regard to the study of human behavior.

While the experimental group in this study was definitely considered to require hospitalization from the clinical standpoint, the statistical results do not suggest any gross differentiation between this group's self-assessment scores and those of the control group.
CHAPTER II BIBLIOGRAPHY


CHAPTER III

SUMMARY AND CONCLUSIONS

A study of the scores obtained by two groups of subjects, one an experimental group of hospitalized psychiatric patients and the other a control group consisting of non-hospitalized "normals", failed to show any significant differences statistically on the variables measured by the new self-rating scale FIRO-B.

The hypothesis proposed that there would be significant differences between these two groups, primarily because the psychiatric patients were or had been overtly psychotic and their illnesses were of a duration of eighteen months or longer. The results further failed to show a prediction in the direction of the theoretical position taken and tended to support the thesis that clinical and statistical predictions on a given task are frequently not in agreement.

Some of the limitations to this study have already been pointed out; however, it is felt that other factors not previously considered may have had direct influence on the test results obtained from the hospitalized psychiatric patients. Of primary interest is the fact that twelve of these patients were responding to their psychotherapist's request in completing these tests. A test taking "set" or "attitude" may
have been operating, i. e. consciously responding to the test in a manner so as to paint a good or socially expected picture of their own self-assessment values. Also, many of these individuals may have gained considerable insight into what is expected in interpersonal relationships because of the very programs in which they were engaged while at the hospital.

It should be noted that the hospitalized subjects used in this study were in adequate control of their behavior, that is to say they were not presenting florid psychotic behavior. Psychotic patients out of contact are frequently not candidates for testing procedures and were not at the time available for theoretical testing programs at the state hospital involved.

From the standpoint of theoretical implications, the results of this study suggest that the benefits of the somatic, and of the psychic treatment program are clearly revealed in the test results obtained from the psychiatric group. This group displays the conscious understanding of what might be generally considered the "normal" adjustments necessary for satisfactory interpersonal relationships in our society. These patients may have demonstrated capacity to develop strong or obvious behavior reactions needed to relate to other individuals, or it may be that this group of patients has begun their development of a conscience which is felt by
Allport to be the "crucial agent in the growth of personality" (1, p. 68). In Murphy's views one might explain the test results of these psychotic patients from the position that they were demonstrating the potential to reach or develop "selfhood"; that capacity to bridge the gap between an individual's concept of himself and the norms or values of his society (4, p. 292). Still another position should be considered and that is specifically the peculiarity of a schizophrenic's world. To these people society is full of heartaches, disappointment, and danger which necessitate withdrawal from this threatening surrounding to the safety of his own "excellence" (2, p. 482). Maslow further states that the schizophrenic feels "Reality does not matter; only what I desire matters" (2, p. 482). In the consistent hospital program, perhaps the schizophrenic patient acquires some "appropriate" interpersonal relationships with some understanding of what is considered normal for most individuals. Again, the theoretical implications to explain the lack of differences between the two groups studied are countless; however, the differences between a schizophrenic's and a "normal" person's behavior does not require empirical measurement.

It is perhaps advisable to consider the question of the need for further research or the predictions for further study regarding hospitalized psychiatric patients, particularly
schizophrenic disorders of long standing. Of first issue is the necessity to exercise the caution to determine whether such studies are in fact genuine and/or feasible, or if maybe they represent pseudo-problems that will fail to contribute useful data for any area of psychology as is suggested by Meehl (3, p. 9). Certainly the need for additional research regarding hospitalized psychiatric patients which might shed more light leading to their rehabilitation is not questioned by those who have visited almost any state hospital, but the type and quality of this research, and perhaps the goals of such research, is of primary importance. Clinical psychology may be in need of more definite, empirical instruments in the study of personality characteristics to remove the subjectivity and criticism which now color this profession.
CHAPTER III BIBLIOGRAPHY


APPENDIX

Group ____________  Name ______________
Date ______________  I   C   A   c
Male ___ Female ____
Age ________________

Please place number of the answer that best applies to you in the space at the left of the statement. Please be as honest as you can.

___ 1. I try to be with people
    1. usually  2. often  3. sometimes  4. occasionally
    5. rarely   6. never

___ 2. I let other people decide what to do
    1. usually  2. often  3. sometimes  4. occasionally
    5. rarely   6. never

___ 3. I join social groups
    1. usually  2. often  3. sometimes  4. occasionally
    5. rarely   6. never

___ 4. I try to have close relationships with people
    1. usually  2. often  3. sometimes  4. occasionally
    5. rarely   6. never

___ 5. I tend to join social organizations when I have an opportunity
    1. usually  2. often  3. sometimes  4. occasionally
    5. rarely   6. never

___ 6. I let other people strongly influence my actions
    1. usually  2. often  3. sometimes  4. occasionally
    5. rarely   6. never

___ 7. I try to be included in informal social activities
    1. usually  2. often  3. sometimes  4. occasionally
    5. rarely   6. never

25
8. I try to have close, personal relationships with people
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

9. I try to include other people in my plans
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

10. I let other people control my actions
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

11. I try to have people around me
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

12. I try to get close and personal with people
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

13. When people are doing things together I tend to join them
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

14. I am easily led by people
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

15. I try to avoid being alone
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. never

16. I try to participate in group activities
1. usually 2. often 3. sometimes 4. occasionally
5. rarely 6. occasionally

17. I try to be friendly to people
1. most 2. many 3. some 4. a few 5. one or two people
6. nobody

18. I let other people decide what to do
1. most 2. many 3. some 4. a few 5. one or two people
6. nobody

PLEASE BE AS HONEST AS YOU CAN
19. My personal relations with people are cool and distant
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

20. I let other people take charge of things
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

21. I try to have close relationships with people
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

22. I let other people strongly influence my actions
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

23. I try to get close and personal with people
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

24. I let other people control my actions
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

25. I act cool and distant with people
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

26. I am easily led by people
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

27. I try to have close, personal relationships with people
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody

28. I like people to invite me to things
   1. most  2. many  3. some  4. a few  5. one or two
   people people people people people
   6. nobody
29. I like people to act close and personal with me
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

30. I try to influence strongly other people's actions
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

31. I like people to invite me to join their activities
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

32. I like people to act close toward me
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

33. I try to take charge of things when I am with people
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

34. I like people to include me in their activities
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

35. I like people to act cool and distant toward me
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

36. I try to have other people do things the way I want them done
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

37. I like people to ask me to participate in their discussions
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody

38. I like people to act friendly toward me
   1. most  2. many  3. some  4. a few  5. one or two people
   6. nobody
39. I like people to invite me to participate in their activities
   1. most  2. many  3. some  4. a few  5. one or two people  6. nobody

40. I like people to act distant toward me
   1. most  2. many  3. some  4. a few  5. one or two people  6. nobody

PLEASE REMEMBER TO BE AS HONEST AS YOU CAN

41. I try to be the dominant person when I am with people
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

42. I like people to invite me to things
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

43. I like people to act close toward me
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

44. I try to have other people do things I want done
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

45. I like people to invite me to join their activities
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

46. I like people to act cool and distant toward me
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

47. I try to influence strongly other people's actions
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

48. I like people to act close and personal with me
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never

49. I like people to act close and personal with me
   1. usually  2. often  3. sometimes  4. occasionally  5. rarely  6. never
50. I try to take charge of things when I'm with people
   1. usually  2. often  3. sometimes  4. occasionally
   5. rarely    6. never

51. I like people to invite me to participate in their activities
   1. usually  2. often  3. sometimes  4. occasionally
   5. rarely    6. never

52. I like people to act distant toward me
   1. usually  2. often  3. sometimes  4. occasionally
   5. rarely    6. never

53. I try to have other people do things the way I want them done
   1. usually  2. often  3. sometimes  4. occasionally
   5. rarely    6. never

54. I take charge of things when I'm with people
   1. usually  2. often  3. sometimes  4. occasionally
   5. rarely    6. never
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