PREMORBID LEVEL OF FUNCTIONING AND PERSPECTIVE TAKING DURING SELF-NARRATIVES

THESIS

Presented to the Graduate Council of the University of North Texas in Partial Fulfillment of the Requirements For the Degree of

MASTER OF SCIENCE

By

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Denton, Texas
May, 1991
Isler, William C. Premorbid Level of Functioning and Perspective Taking During Self-Narratives. Master of Science (Clinical Psychology), December, 1990, 57 pp., 6 tables, references, 38 titles.

Two interviews were conducted with 20 participants from a Mental Health and Mental Retardation (MHMR) crisis house. Subjects were classified as good or poor premorbid level of functioning using a case history form and information from their social history charts. The study employed a self-narrative method to direct self-disclosure. In the first interview, participants were asked to describe themselves. In the second interview they were asked to identify what they would change about their histories and to describe how this would make a difference in how their lives turned out. Support was not found for the hypothesis that those with the higher premorbid functioning would be better able to shift perspectives and use more positive self constructs. Methodological, theoretical and future research areas are discussed.
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"A man may not now choose his past but he may select his future" (Kelly, 1955, p. 833). One of the underlying assumptions of Kelly's (1955) Personal Construct Theory is that of constructive alternativism. The emphasis is placed on an inner reality and the individual's interpretation of his world is neither right nor wrong. There are always alternative ways of construing any event and there are always different perspectives.

In describing the different ways in which personality theories may be framed, Rychlack (1981, p. 21) defines perspective "as the stance a theorist takes in capturing that which he or she intends to explain." He then goes on to describe two basic types of perspectives which he calls extraspective and introspective. When using the extraspective perspective, the theorist attempts to frame things in the third person as if he or she were an outside observer. The introspective perspective is used when the theorist frames things in the first person. This is a personal outlook on the world and is taking the point of view of the item or person under observation.

Piaget was also well aware of perspective taking and its impact on the development of children. Piaget's (1926) term "egocentrism" has often been used in the context of
discussing perspective. Ford (1979) states that egocentrism "... refers to an individual's failure to perceive a situation or an event in more than one way" (pp. 1170-1171). Piaget (1926) used his concept of egocentrism as a means of bringing together social and individual aspects of thinking (Light, 1983). In social situations, egocentrism is displayed when a child focused on his or her own viewpoint while neglecting others. Intellectually, egocentrism is shown when a child focuses on one aspect of a situation or object and neglects other aspects. As a result, egocentrism is a hindrance to both the child's social and intellectual development.

In normal development it is believed that the child's initial egocentrism will gradually give way to a more perspective style of thought which will allow functioning at new levels of cooperation and competence (Looft, 1972). A number of investigations cited by Chandler (1973) have provided support for the view that persistent egocentric thought is associated with social deviancy (Anthony, 1959; Chandler, 1972; Feffer, 1970; Gough, 1948; Martin, 1968; Sarbin, 1954; Thompson, 1968). Chandler (1973) found that chronically delinquent subjects exhibited a deficiency in the ability to adopt the roles or perspectives of others. He also found that training in role-taking skills was effective in reducing egocentrism, and that this training was able to reduce the amount of reported delinquent behavior among the subjects.
Shantz (1975), in his review of social cognitive development, has divided perspective taking into three categories: (a) visual-spatial, or what the other sees; (b) affective, or what the other feels; and (c) social cognitive, or what the other is thinking. Each of these categories demonstrates an aspect of appreciation for other's perspectives, as well as the ability to generate alternative perspectives in a given situation (Ford, 1979).

Perspectivism has been associated with better psychological adjustment (Landfield, 1980a; Leitner, 1981b). Landfield (1980) has elaborated on the concepts of Kelly's (1955) personal construct theory and has related three personality styles: perspectivism, literalism and chaotic fragmentalism. Literalism is "a way of thinking feeling, or doing which implies the restricted and absolute interpretation of an event or a relationship" (Landfield, 1980a, p. 315). Leitner (1981a, 1981b) has shown that literalism is associated with psychopathology and is related to personality variables characteristic of rigid, anxious defensiveness. Leitner (1979) found that subjects diagnosed with neuroses or personality disorders scored as literal on a repertory grid measure.

Landfield (1980a) describes chaotic fragmentalism as "an unorganized complexity of thinking, feeling, or doing which implies an unrestricted, loose, undirected, and shifting interpretation of an event or a relationship" (p. 316).
Leitner (1981a,b) has shown chaotic fragmentalism to be associated with severe psychopathology and linked to personality variables associated with confusion, disorganization, and a disintegration in the person's defensive structure. Leitner (1979) found that subjects diagnosed as schizophrenic scored as fragmented on a repertory grid measure.

Landfield (1980a) believes that perspectivism suggests, "... some capacity to step back from a problem and to conceptualize it more thoughtfully, complexly, and integratively" (p. 289). "The person who functions with perspective can distance himself from the immediacy of an event by utilizing higher order or more general comprehensions within his system of personal meanings" (Landfield, 1980a, p. 290).

Leitner (1981a) believes that the relationship between these three personality types can be described in a curvilinear fashion ranging from the rigid, enmeshed (literalist) to the very unorganized and loose (fragmented), with the perspectivist in the optimal position between the two.

Rowe (1985) views depression as a prison in which the person has become trapped. Depressed persons are seen as unable to free themselves from their construction of the world. Fransella (1985) views a person with a problem as, "someone who, for the moment, cannot find any alternative way
of dealing with it..." (p. 287) and the therapist must help the client get 'unstuck'. The client appears unable to take a different perspective and has become trapped in a prison of self-construction. For these types of people, change can be a very difficult thing to accomplish.

In the past one of the variables that clinicians and researches have paid attention to is this idea of 'stuckness'. A favorable prognosis has often been associated with good premorbid adjustment. If, in the past, the person has been able to function adequately then there is a better chance that with time he or she may be able to return to this premorbid level of functioning. Measures such as the Phillips Scale (Phillips, 1953) have been used as a measure of distinguishing schizophrenics and their chances of recovery. In dealing with schizophrenics, Strauss and Carpenter (1974) found that employment history, social relations, and previous duration of hospitalization were among the best predictors of outcome. Kay and Lindenmayer (1975) listed significant predictors of outcome as premorbid adjustment, course of illness, and presenting clinical profile.

Kelly (1955) recommended the Self-Characterization as a way of gaining a clinical understanding of clients. In this method, they imagine themselves as their own best friend, "one who knows them intimately and sympathetically" (Kelly, 1955, p. 323). The instructions used in a Self-Characterization are:
I want you to write a character sketch of Harry Brown just as if he were the principle character in a play. Write it as it might be written by a friend who knew him very intimately and very sympathetically, perhaps better than anyone could every really know him. Be sure to write it in the third person. For example, start out by saying, 'Harry Brown' is.... (p. 323)

Writing in the role of another person in this manner seems to encourage a greater amount of perspective taking (Landfield & Epting, 1987).

The fixed role therapy technique of George Kelly, (1955) utilizes the clients' descriptions of another person to allow them to shift perspectives in construing themselves. The clients are able to play the role of this other person and think of themselves as having the other person's characteristics and identity. The fixed role technique presents the client with a way of having new experiences and provides the opportunity to engage in new sets of behaviors in various situations (Landfield & Epting, 1987).

Watzlawick (1974) believes there are two different types of change possible: first and second order change. First order change is defined as "one that occurs within a given system which itself remains unchanged" (p. 10). Watzlawick gives an example of a person having a nightmare and having many different types of behaviors at his disposal such as running or fighting, none of which will terminate the nightmare. A
second order change is "one whose occurrence changes the system itself" (p.10). If the person were to awake they would now have changed to an altogether different state.

One technique which Watzlawick (1974) believes helps to bring about change is that of reframing. Reframing is defined as:

a means to change conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes its entire meaning. (p. 95)

In other words the therapist gives the client the opportunity to view his or her situation or statement from a different perspective without changing the concrete facts.

In talking about the elicitation of constructs, Landfield and Epting (1987) speak of the "magic wand" technique (p. 87). In this technique, the person imagines that he has the power to transform himself. "How the person does or does not do this is a key to vital concerns and anxieties" (p. 87).

Many deterministic theories view the persons basic character as being set by a particular age, with events that happen in infancy directing the rest of life. Other theories view the person as constantly moving and always subject to change. Lietner (1982) describes psychoanalysis, client centered therapy and cognitive behavior therapy among others
as therapies whose techniques seem to shift the client in the direction of perspectivism. In psychoanalysis the therapist may use interpretations or confrontations as a means of pointing out an aspect of the client which may help him or her out of a literalist view and into a more perspectivist view. In client centered therapy, when the therapist is unconditionally expressing positive regard the client’s literalisms may become challenged and a more perspectivist position adopted. Finally in the use of cognitive behavioral therapy Beck (1976) describes the modification of the "cognitive triad". Beck believes that the person should test his or her assumptions. As the client gains knowledge from experimenting it is hoped that a more perspectivist attitude will arise. Although there are many different therapeutic techniques and schools of thought within psychology, effective psychotherapy should include the process of moving a client in the direction of perspectivism (Leitner, 1982).

Kelly (1955) used an "as if" technique in which the therapist approaches the constructs as if they were true. This keeps the process of therapy from getting bogged down in literalisms and allows both the therapist and client to explore different meanings and perspectives within these constructs.

Mair (1989) speaks of Kelly in his initial writings (Kelly, 1955) and even more so in his latter essays (Kelly, 1969) as a "story telling psychologist" (p. 3). Mair states that,
The make-believe of fictional modes encourages the imagination to soar to possibilities that may yet allow the building of new worlds within which the fact-making activities of the developer can follow on from the fiction-creating capacities of the explorer. (p. 11)

In other words if a person tells a story from a different perspective, new possibilities may become apparent. The present study asks the question: "Can a person, if given the opportunity, tell two stories about his or her life that are qualitatively different?"

**Purpose**

Perspective taking is the ability to shift viewpoints or to see a situation in different ways. Many times people are unable to do this. They appear to be "stuck" in their own perspective and unable to shift. It is often these people clinicians term chronic who are unable to see different perspectives, to see their situations from different viewpoints, or to change their way of thinking, acting or perceiving. Reframing is one technique that is often used in an attempt to allow clients the opportunity to view statements or situations from a different perspective. When the person hears a viewpoint that may not have been apparent before, it may become valid and useful alternative. Clients who are able to shift perspectives more easily without prompting would seem more likely to be able to function at a higher level and thus their premorbid level of functioning would be expected to be
better. This study will attempt to show that the ability to take a different perspective is associated with the level of premorbid functioning.

In summary, the primary purpose of the study is to examine the hypothesis that altering the perspective from which a person describes life experiences will facilitate a change in the constructs he or she employs. Specifically, it is predicted that asking subjects to describe their life experiences and then describe them again as if things had been different in their life will allow them to try on new and more positive constructs, and that those with the poorer premorbid history will be less able to accomplish this task.

Method

Subjects

Twenty residents of a crisis house operated by Mental Health and Mental Retardation (MHMR) volunteered to participate. There were a total of 11 males and nine females included in this study. Of the 11 males, five were classified as good premorbid and six were poor premorbid. Of the nine females, five were good premorbid history and four were poor premorbid. The ages ranged from 21 to 70 years. The age range for the good premorbid was 26 to 70 with a mean of 43.8 years, while the poor premorbid group was 21 to 46 with a mean of 33 years.

Typically this MHMR facility houses between 4 and 8 clients for a variety of reasons. Often people are admitted who are
in a situational crisis (e.g., wife leaving husband) and at other times MHMR clients are admitted in an attempt to forgo another hospitalization (e.g., chronic schizophrenics). The interviewer was notified by MHMR staff at each new admission. Each successive admission was asked to participate over a four month period although the interviewer was unable to contact several clients before they had left the facility. Several people were not comfortable with participating after all the conditions of the study had been explained to them but most clients were willing to be involved. The interviewer was blind to premorbid level of functioning and information dealing with admission.

Measures

List of construct labels. This list was compiled by the examiner derived from the verbal exchange between the participant and examiner which included 2 consecutive 10 minute interviews. The list represented the verbal construct labels (descriptive adjectives and nouns) used by the participant.

Ratings of constructs. Constructs were rated as positive, negative or ambiguous by two graduate students. An inter-rater agreement level of 86% was reached. The rating of the construct labels involved the use of modifications made by Doster & Brooks (1974) on Powell's (1968) system to score verbal content. Positive statements were categorized as those that appeared to reveal socially desirable qualities.
(e.g., "I'm a nice person. I've always loved my family."). Negative statements were defined as those which appeared to reveal socially undesirable qualities (e.g., "I've never liked anyone. I'm a drunk. I'm a slob."). Ambiguous labels were those for which the raters were unable to make a distinction. The participant's scores for each rating of positive, negative or ambiguous construct labels was expressed as a frequency (percentage) and rate (number per minute) of the total verbal responses in that category.

Training procedure for the rating of construct labels. A training procedure was conducted in which a sample interview was discussed and the construct labels were rated. Discussion of their ratings were encouraged to enable the judges to attain the greatest interrater reliability possible.

Number of interviewer encouragements. The interviewer offered encouragements (see Appendix A and B) when a pause of 8-10 seconds had elapsed. When an encouragement was needed the examiner looked up at the participant and stated one of the three encouragements listed. The encouragement list remained with the interviewer as a reference in order to maintain consistency. There was a limit of three encouragements given to each individual participant after which no further encouragements were given. If the participant was unable to continue that part of the interview was concluded.
Duration of speech. A measure of the total time the client talked was taken for each of the two separate interviews.

Level of premorbid functioning. The instrument used (see Appendix C) is a modification made by Nicholson (1985) of a scale originally devised by Kanton, Wallner, and Winder (1953) to differentiate process from reactive disorders. It consists of 24 items constructed in a bipolar manner (e.g., early psychological trauma vs. good psychological history) which described various life circumstances and psychological symptoms. The items on this scale cover the entire spectrum of life. Each item was rated (see Appendix D) on a five-point scale (-2, -1, 0, +1, +2). A lower score indicate those people with a long history of poor adjustment, and a higher score reflects a more normal development. Kantor's scale has been shown to correlate significantly with other measures of premorbid adjustment ($r = .70$ with Phillip's Prognostic Rating Scale and $r = .77$ with Elgins Prognostic Scale).

Training procedure for raters of case history form. The case history form (see appendix A) was rated by the interviewer and one MHMR mental health technician. The raters were not blind to diagnoses. The case histories of several nonparticipants were reviewed in practice sessions using a score key (see Appendix B) until the raters reached an agreement rating of 75%. Discussion of their ratings was encouraged in order to enable the judges to attain the
greatest interrater reliability. When information on a particular scaled item was unavailable or unspecific the raters used their best judgement in responding.

Procedure

The instructions used in this study are an adaptation of those previously used by Doster and Brooks (1974). The total interview time of 20 minutes consisted of two consecutive 10 minute interviews. To control for interviewing bias, the experimenter made a special effort to avoid verbal and nonverbal cues and to be as consistent as possible across interviews (e.g., facial gestures, eye contact, nods of the head). When the subject began talking the interviewer focused his attention on writing what was said on the data record sheet. Requests or questions about the type of information desired by the examiner were responded to with, "Whatever you think will help me know you better."

All interviews took place within 72 hours of admission, and between the hours of 2 p.m. and 9 p.m. The interviews were conducted in one of three settings which included a room that was 20 x 20 in which the interviewer placed partitions to create an area 10 x 20, the front porch of the facility, and the bedrooms. Two identical chairs were placed at a right angle to each other with approximately three feet between them. The interviewer held a clip board in his lap in order to write down the construct labels. The interviewer directed his attention to the task of writing unless the participant
either paused for more than 8-10 seconds (at which time an encouragement was given), or asked a question (at which time an appropriate rephrase or the response, "Whatever you think will help me to know you better" was given). Questions asked by the participant which were not appropriate to the interviewing procedure were responded to by saying, "Let's discuss that when we have finished here."

An introduction was given in order to familiarize the clients with the study and to assure them that it was in no way connected with MHMR and would not affect their treatment (see Appendix E). If the client agreed to participate the introduction to the consent form was read to them (see Appendix F). The participant was then asked to read and sign the remaining portion of the consent form. Explanations were given when necessary.

Following the introduction and the signing of the consent forms the examiner proceeded with the first interview by saying: "I think we should start with your just talking about what you think would be important for somebody to know about your life if they really want to know you". While the participant talked, the examiner wrote down the construct labels used. Encouragements were given after 8-10 seconds of silence in order to facilitate the flow of information. After completing the first interview the examiner stated: "Looking back over your life, what would you change in order to cause things to have turned out differently for you? What might be
one significant event or happening that you might want to change about your life)? At this point if the participant was unable to think of an event to change, the interviewer referred to something significant that the participant mentioned in the first 10 minute interview. The examiner then continued with the instructions. "Go back through and talk about how this change might have had an effect on your life. Tell me about your life and the effects or changes that this event might have on you. Talk about what you think would be important for somebody to know about your life if they really wanted to know you and talk about how things might be different because of this change". Construct labels from this second task were also written down.

After completion of the interviews, construct labels were rated at positive, negative, or ambiguous in the manner described above. Then the charts of each of the participants were examined by two other raters who filled out a case history form in order to attain a measure of premorbid functioning. The participants were divided into two groups based on their premorbid functioning (good premorbid and poor premorbid).

Results

There were two separate raters for both the interviews and the case history forms. The two raters for the case history form, the interviewer and an employee of MHMR, coded each subject on the 25 items of the Nicholson (1985) premorbid
history format. A concordance of 81% for the same score was achieved. The scores were summed for both raters, the totals were then ranked and a median split performed to divide the subjects into two groups. The poor premorbid history group scores ranged from -26 to +11, with a mean of 0.8. The range for the good premorbid history ranged from +18 to +41, with a mean of 25.9. Thus the range of scores on the case history form across both groups was from -26 to +41. There was an interval of 7 points between the highest score of the low group and the lowest score of the high group.

The two raters for the interviews coded each self reference construct as either positive, negative, or ambiguous. A concordance of 86% for the same rating by each judge was achieved. Discrepantly coded constructs were resolved by the experimenter. The number of negative, positive, or ambiguous constructs were then totaled for each interview and a self constructive ratio for each interview was calculated (number of negative minus number of positive divided by total).

The demographic data seemed to indicate that the two groups based on good and poor premorbid history were not significantly different on variables such as marital status, education, and sex. The two groups were fairly homogeneous with regard to race. Seventeen of the participants were Caucasian, one Afro-American, one African, and one Iranian.

Five of the participants were married, while 15 were not. In the good premorbid group, three were married while seven
were not. In the poor premorbid group, two were married while eight were not.

Table 1
Marital Status of Groups

<table>
<thead>
<tr>
<th>Married</th>
<th>Single</th>
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</thead>
<tbody>
<tr>
<td>Good Premorbid</td>
<td>3</td>
</tr>
<tr>
<td>Poor Premorbid</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
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</table>

Of the 11 males in the study, five were classified as good premorbid and six were poor premorbid. Five of the nine females were good premorbid and four were poor premorbid.

Table 2
Male - Female Distribution in Groups

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Premorbid</td>
<td>5</td>
</tr>
<tr>
<td>Poor Premorbid</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>

There was a significant demographic difference for age ($t = 2.14, df = 18, p < .05$) between good and poor premorbid groups. The age range for the poor premorbid group was 21 to
46 with a mean of 33 years, while the age range for the good premorbid was 26 to 70 with a mean of 43.8 years. However, an outlier at the upper age limit may have skewed the data. In order to examine this fact another t-test was done without the outlier \( t = 1.83, \text{df} = 17 \ p > .05 \). It was found that in fact this had caused the two groups to appear more different on this variable than was actually the case.

There was no systematic manipulation of where the interviews were conducted. It did appear that the interviews conducted within the bedrooms were much shorter and thus led to lower verbal productivity. The shorter interviews may have been a confounding variable. Although it did seem that the three different locations for the interviews were evenly distributed among both the good and poor premorbid groups.

In order to check for any possible differences arising from the use of encouragements, a 2 x 2 analysis of variance with repeated measures was performed. As Table 1 illustrates, there was no significant main effect either for groups or condition. Nor was there an interaction effect. In sum encouragements were not needed for one group more than for the other.
Table 3

Analysis of Variance for Encouragement by Premorbid Level

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (good vs poor)</td>
<td>1</td>
<td>.90</td>
<td>.82</td>
</tr>
<tr>
<td>Residual (between)</td>
<td>18</td>
<td>1.09</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>1</td>
<td>.40</td>
<td>1.11</td>
</tr>
<tr>
<td>Group by Condition</td>
<td>1</td>
<td>.10</td>
<td>.28</td>
</tr>
<tr>
<td>Residual Within</td>
<td>18</td>
<td>.36</td>
<td></td>
</tr>
</tbody>
</table>

A 2 x 2 analysis of variance (premorbid history by interview) with repeated measures on the second variable was conducted with the self constructive ratio as the dependent measure. The initial hypothesis tested was that asking subjects to describe themselves using a narrative technique and then to reframe their lives as if things had been different would allow them to use more positive constructs and that those with the poorer premorbid history would be less able to do so. As Table 2 shows, there was no significant effect from the first to the second interview. No significant differences were found between the interviews with regard to the proportion of positive self constructs. Thus, the results do not provide support for this hypothesis.
Table 4

Analysis of Variance for Self Constructive Ratio

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (good vs poor)</td>
<td>1</td>
<td>.16</td>
<td>.54</td>
</tr>
<tr>
<td>Residual (between)</td>
<td>18</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>1</td>
<td>.01</td>
<td>.06</td>
</tr>
<tr>
<td>Group by Condition</td>
<td>1</td>
<td>.09</td>
<td>.46</td>
</tr>
<tr>
<td>Residual Within</td>
<td>18</td>
<td>.20</td>
<td></td>
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</tbody>
</table>

A 2 x 2 analysis of variance (premorbid history by interview) with repeated measures on the second variable was conducted with the rate of positive constructs (number of positive in minutes) as the dependent measure. As Table 3 illustrates the two groups, good and poor premorbids were found to be significantly different in their rate of positive construct presentation although there was no interaction effects. This finding was in an unexpected direction with the poor premorbids having the higher rate of positive constructs in both interviews.
Table 5

Analysis of Variance for Rate of Positive Self Constructs

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (good vs poor)</td>
<td>1</td>
<td>9.15</td>
<td>7.14</td>
</tr>
<tr>
<td>Residual (between)</td>
<td>18</td>
<td>1.28</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>1</td>
<td>.12</td>
<td>.05</td>
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<tr>
<td>Group by Condition</td>
<td>1</td>
<td>.22</td>
<td>.09</td>
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<tr>
<td>Residual Within</td>
<td>18</td>
<td>2.46</td>
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## Table 6

### Means and Standard Deviations for Measures

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<th>Interview 1</th>
<th>Interview 2</th>
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<td></td>
<td>M</td>
<td>SD</td>
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<tr>
<td>Good Premorbid</td>
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<td>Rate of Ambiguous</td>
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Additional Findings

An additional finding of replicated results was that the rate of ambiguous constructs was significantly higher for the poor premorbid group in the second interview ($t = 1.73$, $df = 18$, $p < .05$).

Discussion

The present study investigated the hypothesis that a person with poorer premorbid history would be less able to shift perspective and use more positive self constructs than a person with a better premorbid history. The results did not provide support for this hypothesis.

Change in positive self constructs was used unsuccessfully as a dependent measure to indicate a positive shift in perspective taking. Other instruments may be more sensitive to such a shift. It appears that the present study may not have used adequate measures in attempting to capture this predicted shift and that the small number of subjects which participated in this study may have led to a high degree of variability.

This case history form may not represent current demographic patterns. Another scale which includes more recent empirical findings or revision of this scale may have provided a clearer measure of premorbid functioning. Although the case history form has been used successfully in other situations to predict process versus reactive disorders (Nicholson, 1985), it may have provided an inadequate
discrimination in this study. Many of the participants seemed to display a somewhat chronic pattern as evidenced by the interview content. The majority had had at least one hospitalization. Inaccurate scores could have resulted from the use of the participants' MHMR chart, which in some cases may have been deficient. This lack of information may have caused some participants to score higher on the premorbid scale than would have truly been the case had the social charts been complete.

It is also possible that the hypothesis that those with poorer premorbid history would be less able to shift to a more positive perspective is incorrect. Those who are in a more situational crisis and have not experienced long-term stress may be less able to shift perspectives. The stress they are experiencing could be causing them to focus more on the negative. The unstructured interview may have increased this stress. The more chronic participants may become more tolerant of their situations and lifestyles, not be as focused on the negative, and thus more able to shift perspective or use positive self constructs.

Another possible explanation for the lack of significant findings is that many of the more chronic participants were better able to utilize impression management skills. The participants with the poorer premorbid history have probably had more opportunity to practice their skills in social service and hospital interviews. They may have felt they
could impress the interviewer or gain something by presenting themselves in a more favorable light. This may be one explanation for the poor premorbid group having a higher rate of positive constructs.

The intervention did seem to stimulate thought in some of the participants. Several made comments to the interviewer days later, such as, "I've been thinking about that question you asked me the other day," or "That sure was a hard question you asked me". Others seemed to have taken offense to the question and made later comments such as, "I wish you had not asked me that question because I can't stop thinking about it". The questions, "What would you change about your life to cause things to be different for you"? and "How would this have changed things for you"? seemed to generate some thought in several of the participants. The present study may have measured the clients capacity to acquire the ability to shift perspective and not how they used it. a therapist may often guide a client until they are able to acquire such a tool to use in their life. Since the measures were taken so close together it may be beneficial to consider the broader process rather than its immediate impact. These questions may have served as a catalyst for a shift in perspective that was difficult to capture, or which occurred in a time interval which extended beyond the second interview.

One additional finding was that the rate of ambiguous constructs was significantly higher for the poor premorbid
history in the second interview. Angelillo, Cimbolic, Doster, and Chapman (1985) found that depressed and psychiatric controls utilized more ambiguous constructs than did normal subjects. It appears that when the subjects in the poor premorbid group were faced with a question about how they would change, they shifted into using more ambiguous constructs, instead of using more positive or more negative constructs. The use of ambiguous constructs may serve as a defense for these subjects. Ambiguity may help to insulate or protect the individual from invalidation. When a person uses constructs that are definitively positive or negative, there is more opportunity for invalidation and discouragement. While the use of ambiguous constructs may help defend against invalidation, it could also increase the possibility of receiving ambiguous feedback. Angelillo (1985) terms this a "vicious circle" which may leave the person feeling helpless, reflecting his or her poor abilities at gaining social validation or feedback in his or her life.

In summary, the results of this study did not provide support for the hypothesis that those with a poorer premorbid history will be less able to shift in the use of more positive self constructs. Different types of methodology and measurement for this hypothesis may be indicated. Continued investigation into the effects of perspective taking may benefit from the use of more powerful measures of shifts in perspective taking and its relation to levels of functioning.
APPENDIX A

Guidelines For Interviewer Encouragements Used In
Interview One
Appendix A

Guidelines For Interviewer Encouragements Used In Interview

One

After a pause of at least 8-10 seconds the interviewer made one of the following statements.

(a.) I'm sure there is more about your life you might want someone to know.

(b.) Please think of something more you can tell me about your life.

(c.) Try to help me understand more about yourself.
Appendix B

Guidelines For Interviewer Encouragements Used In Interview

One

(a.) I'm sure there is more about your life and how this change could have effected you that you might want to tell someone.

(b.) Please think of something more you can tell me about your life and how this change might have effected you.

(c.) Try to help me understand more about yourself and how this change might make things different for you.
APPENDIX C

Case History Form
Appendix C

CASE HISTORY FORM

(Mark 0 if the category doesn't apply or if a clear decision can't be made)

Birth to the fifth year

1. Early psychological trauma Good psychological history
   -2 -1 0 +1 +2

   (Considerations: child abuse; death of parent, sibling or significant other; incest; deprivation of physical necessities; neglect)

2. Physical illness Good physical health severe or long
   -2 -1 0 +1 +2

   (Considerations: birth trauma; physically handicapped; major disease-cancer, leukemia, etc.; major injuries-spinal injury, burns, etc.; patient had a "sickly childhood"—a series of repeated illnesses, perhaps none of which was individually traumatic.)

3. Odd member of family Normal member of family
   -2 -1 0 +1 +2

   (Considerations: physically isolated from rest of family; self-reported feelings of peculiarity or oddness; adoption; achieves higher or lower than other members; different race, religion, etc. than others; described as "odd-looking.")

4. Difficulties at school Well adjusted at school
   -2 -1 0 +1 +2

   (Considerations: held back a grade; failed a grade; "slow learner"; special education classes; repeated discipline problems; school phobic; described as a "loner.")
5. Family troubles paralleled with sudden changes in behavior  
Domestic troubles unaccompanied by behavior disruptions. Patient "had what it took" to withstand family troubles  

-2 -1 0 +1 +2  

(Considerations: patient's symptoms were responsive to family distress; patient did not have what it took to maintain psychological stability in relation to family problems; e.g., divorce, alcoholic parent.)  

6. Introverted behavior trends and interests  
Extroverted behavior trends and interests  

-2 -1 0 +1 +2  

(Considerations: lots of friends/made friends easily; extracurricular activities; personal hobbies; sports activities; use of leisure time; did patient have a "best friend" or chum.)  

7. History or breakdown of social, physical, mental functioning  
History of adequate social, physical, mental functioning  

-2 -1 0 +1 +2  

(Considerations: a key element here is the repetitive nature of the patient's difficulties: serious illness, car accidents, drug use, psychiatric hospitalizations; the person has "really been through a lot.")  

8. Pathological siblings  
Normal siblings  

-2 -1 0 +1 +2  

(Considerations: siblings showed maladjustment in social, physical or emotional functioning; trouble with law; drugs; psychiatric hospitalization.)  

9. Over protective or rejecting mother  
Normally protective, accepting mother  

-2 -1 0 +1 +2  

(Considerations: Mother's "vibes"; patient has lived with mother beyond normal time limit; family won't allow patient to make independent decisions.)
10. Rejecting father Accepting father

\[
\begin{array}{cccccc}
-2 & -1 & 0 & +1 & +2 \\
\end{array}
\]

(Considerations: Patient's self-report; father abandoned family; father rarely at home; workaholic father; step-father)

Adolescence to adulthood

11. Lack of heterosexuality Heterosexual behavior

\[
\begin{array}{cccccc}
-2 & -1 & 0 & +1 & +2 \\
\end{array}
\]

(Considerations: all female or male companion; dating history; flirting; went to parties.)

12. Insidious, gradual onset of mental/emotional problems without pertinent stress Sudden onset of emotional problems; stress present and pertinent. Later onset

\[
\begin{array}{cccccc}
-2 & -1 & 0 & +1 & +2 \\
\end{array}
\]

(Considerations: person who just "breaks" suddenly due to a clear and evident stressor; person who has had long standing problems without evident stress.)

13. Physical aggression against people Verbal aggression against people

\[
\begin{array}{cccccc}
-2 & -1 & 0 & +1 & +2 \\
\end{array}
\]

(Considerations: repeated incidents or patterns of unprovoked, undue physical aggression; a tendency to "fight it out" rather than expressing anger or disagreement verbally.)

14. Poor response to treatment Good response to treatment

\[
\begin{array}{cccccc}
-2 & -1 & 0 & +1 & +2 \\
\end{array}
\]

(Considerations: lengthy stay in hospital; prescribed treatment is not reducing symptoms or patient is uncooperative with treatment.)
15. Lengthy stay in hospital | Short stay in hospital
| -2 | -1 | 0 | +1 | +2 |

(Considerations: lengthy stay in hospital >3 months, short stay <3 months.)

**Adulthood**

16. Massive paranoia | Minor paranoid trends
| -2 | -1 | 0 | +1 | +2 |

(Considerations: difference between being suspicious and a very imposed delusional system; a diagnosis of paranoid schizophrenia.)

17. Little capacity for alcohol | Much capacity for alcohol
| -2 | -1 | 0 | +1 | +2 |

(Considerations: has alcohol been a source of conflict or problems in the patient's life, e.g., job loss, marital discord et.; diagnosis of alcohol abuse either now or in the past; social vs. excessive drinking; DWI convictions; alcoholic pattern.)

18. No manic-depressive components | Presence of manic-depressive component
| -2 | -1 | 0 | +1 | +2 |

(Considerations: present or past diagnosis of manic-depressive illness; high and low mood swings not related to situational circumstances.)

19. Failure under adversity | Success despite adversity
| -2 | -1 | 0 | +1 | +2 |

(Considerations: job stress/ performance; number of jobs; loss of job; how patient has recovered from traumatic experiences, divorce, death of loved one)

20. Discrepancy between ability and achievement | Harmony between ability and achievement
| -2 | -1 | 0 | +1 | +2 |
(Considerations: job satisfaction; the discrepancy can be manifested by either too high or too low achievement levels.)

21. Awareness of change

|      | -2 | -1 | 0   | +1  | +2  |

No sensation of change in self

(Considerations: self-report)

22. Somatic delusions

|      | -2 | -1 | 0   | +1  | +2  |

(Considerations: self-report; mental status exam.)

23. Clash between culture and environment

|      | -2 | -1 | 0   | +1  | +2  |

Harmony between culture and environment

(Considerations: person of whatever race has difficulty integrating into society as a whole; patient is an immigrant; born or raised in one socio-economic level and currently living in another; contrast does not always mean conflict, e.g., contrast and harmony versus contrast and conflict.)

24. Loss of decency

|      | -2 | -1 | 0   | +1  | +2  |

Retention of decency

(Considerations: public nudity; public masturbation, etc.)
APPENDIX D

Scoring Key for Items on the Case History Form
Appendix D

Scoring Key for Items on the Case History Form

1. Early psychological trauma

-Death of parent: Patient was 0-1 year old = +1*
  1-5 year old = -2
-Death of sibling: Patient was 0-2 year old = +1*
  2-5 year old = -1
-Child abuse = -2
-Sexual molestation/incest = -2
-Divorce: Patient was 0-1 years old = +1*
  >1 year old = at least = -1
  (if an adverse reaction is specified score -2)

Good psychological history
-No mention or comment of trauma = +1
-Specific mention of a good early psychological history = +2

2. Physical illness

-Birth trauma = -1 if survived intact
-Minor physical handicap = -1 (crossed eye, missing finger etc.)
-More than one serious illness = -1

Good physical health
-One serious illness surrounded by good health= +1
-Minor problems or absence of physical problems= +2
-No mention of physical problems = +2

3. Odd member of family

-Different race = -2
-Different religion =0
-Unwanted child = -2
-Odd looking = -1

Normal member of family
-Positive comment = +2
-Good circumstances and no comment = +1

4. Difficulties at school

-Held back or failed: Patient in grades 1 or 2 = 0, 3 or = -1, 5 and over = -2

*Unless a negative comment is made about the patient's reaction in which case score negative.
-Slow learner (with no other comment) = -1
-In special education = -2
-School phobic = -2
- Discipline problems = -2
- Dropout = at least -1 even if at 8th and 9th

Well adjusted at school
- C or better grades combined with extra-curricular involvement or good peer relations = +2
- No comment or mention of problems = +1

5. Family troubles with sudden behavior change
- If a clear connection between the two is made = -1 or -2
  Patient withstood family problems
- Family clearly has problems but patient is without major symptoms = +1 or +2
- No mention of family problems = 0
- No mention of correlation between family problems and symptoms = 0

6. Introverted behavior
- Major seclusion (more than shyness or lack of socialability) = -2

Extraverted behavior
- Numerous extra-curricular activities = +2
- Big man on campus, homecoming queen = +2
- No mention or comment = 0

7. History of breakdown (social, physical, mental)
- Psychiatric hospitalization = -2
- One serious illness = 0, 2=3 illness = -1, >3=-2

History of adequate functioning
- Favorable comment = +2
- No mention or comment = +1

8. Pathological siblings
- Mention of drugs or legal problems (even for one sibling) = -1 at least
- Psychiatric hospitalization = -2

Normal siblings
- No comment = +1
- Positive comment = +2

9. Overprotection or rejecting mother
- Specific negative comments = -2

Normally protective, accepting mother
- No comment (but text suggests normal relationship) = +1
- Positive comment = +2
10. Rejective father
- Father abandons home = -2
- Rarely at home, workaholic = -1
- Step-father = depends upon comment

Accepting father
- No comment = +1
- Positive comment = +2

11. Lack of heterosexuality
- Excessive shyness with opposite sex = -1
- Reported homosexuality = -2

Heterosexual behavior
- Normal relations with opposite sex or no comment = +1
- Lots of dating, at ease with opposite sex = +2

12. Gradual onset of mental problems without stress
- Lifelong problems in adjustment without clear stressor = -1 or -2
- Problems without any particular cause or stressor = -1 or -2

Sudden onset
- Serious decompensation with clear stressors = +2
- If no inference can be made = 0

13. Physical aggression against people
- Isolated incidents = -1, One incident = +1
- Chronic pattern of aggression = -2

Verbal aggression against people
- No comment +1
- Positive comment = +2

14. Poor response to treatment
- Unreduced symptoms = -2
- Negative attitude problems = -1
- Patient fails to follow discharge treatment plans = -1
- Repeated hospitalizations with brief intervals = -1
- Repeated hospitalizations with long intervals = 0

Good response to treatment
- Short stay and reduced symptoms = +2, reduced symptoms = +1
15. Lengthy stay in hospital (if patient has been hospitalized more than once, go by their longest stay)
-91 days-6 months (179 days) = -1
->6 months (180 days) = -2

Short stay in hospital
-7 weeks-90 days = +1
-1-6 weeks = +2

16. Massive paranoia (include grandiosity as a symptom)
- Diagnosis of paranoid schizophrenia or any other paranoid disorder = -2

Minor paranoid trends
- No comment = 0
- Patient is reported to be suspicious of others but not truly paranoid = -1

17. Little capacity for alcohol (include drugs)
- Marital discord at least in part due to substance abuse = -1
- Major problems due to substance abuse (DWI, job loss, divorce) = -2

Much capacity for alcohol
- Social drinker = +1
- Specific comment that the patient drinks without negative effects = +2
- No comment = 0

18. No mania-depressive comments
- No comment or mention = -2

Presence of manic-depressive component
- Diagnosis of manic-depression or bipolar disorder = +2
- Mood swings but no diagnosis = +1

19. Failure under adversity
- Poor adaptation to problems/stress, life stays out of balance = -1 or -2

Success despite adversity
- Resumes normally, adapts = +1
- Maintains level of functioning or thrives despite problems = +2
- No comment = 0, little or no adversity = 0

20. Discrepancy between ability and achievement
(Interpret in terms of premorbid abilities)
- Lackadaisical behavior, minimal effort = -1
-Continually getting oneself into major problems (legal problems, repeated drop-out) = -2

Harmony between ability and achievement
- No comment and meeting your potential = +1
- Overachieving = +2

21. Awareness of change in self
- Person aware of change or acknowledge problems and need to change = -1 or -2

No sensation of change
- No comment = 0
- Person or family unaware of change in personality

22. Somatic delusions
- Mild delusions (doesn't interfere in the person's life in a major way) = -1
- Extreme delusions = -2, if reported and not qualified = -2

Absence of somatic delusions
- No comment = +1

24. Loss of decency
- Public nudity: one incident = -1, more than one incident = -2
- Public masturbation etc. = -2

Retention of decency
- No comment = +1
- Positive comment = +2
APPENDIX E

Introduction To Research Project
Appendix E

Introduction To Research Project

"This is a therapy study and your participation may help us to understand how a counselor can better help clients. I will ask you a question concerning yourself and write down some of the information that you give me. The information will be seen by two other people but nobody will know your name. This information will only be identifiable by a number. This study is not connected with MHMR but is part of a requirement for my schooling. Your decision whether or not to participate will not influence your treatment as a client of Denton County Mental Health and Mental Retardation (MHMR) or your relationship with any of the staff members while you are here. You would also be free to withdraw your participation at any time that you may wish. You may also withdraw after the interviews have been done if you so desire. Do you have any questions?"
APPENDIX F

Consent Form
Appendix F
Consent Form

I am conducting a project at MHMR Harmony House in which I would like you to participate. The purpose of this study is to learn more about how easily a person is able to shift perspective and in what way a person's past experiences may influence this. If you agree to participate you will be asked to take part in two 10 minute interviews which will include past history. In addition a copy of your social history will also be examined by two Harmony House staff members in order to see what types of qualities you have displayed in the past.

There is no physical or mental risk involved in this project but of course you may choose to stop participating at any time without fear of any negative consequences. You may even request to withdraw after the interviews have taken place, if you wish. Your participation is totally voluntary and no penalty will be assessed if you choose not to be involved. Nothing involved in any part of this study is in any way connected with your treatment while you are a client of MHMR.

These interviews are not connected with the regular treatment plan but they may give you some insight into your past history and ways that you might see it differently. This information is strictly confidential and no one besides myself and two graduate student raters will have access to it. The data gathered will be kept in my possession and a
statistical analysis will be conducted on a computer. There is also the possibility that published results will be shared with the scientific community but all possible safeguards will be taken in order to remove any possibility of identification. My name is Chuck Isler and I will be available if you have any questions either now or in the future.

Permission for Release of Information

1. I, ______________________, give my permission to MHMR Harmony House to release my social history (chart) to Chuck Isler. I realize that the scores gained from this will not be published in association with my name but will identified only by a number. I also authorize Chuck Isler of the University of North Texas and any research assistants designated by him to utilize the information gained during the interviews and that none of this will be identifiable except by a number. I understand that my participation will involve two, 10 minute interviews giving background information.

2. I understand that there is no physical and minimal psychological risk involved in any of this work and that I may terminate my participation in this study at any time.

3. All information in this study is completely confidential. Only Chuck Isler will be able to identify my individual responses during the study, using a code list of names and matched numbers. When the research is completed only the numbers will be retained to identify individual responses.
The interview information will not be written down in its entirety and only two research assistants will see it.

4. I also understand that if I have any questions concerning this study I will direct them to Chuck Isler. I am also aware that a written summary of the findings will be available when the project is completed and that I may be sent a copy at my request, provided that I supply a long term address below.

5. The procedures and investigation have been explained to me.

Participant's Signature: ____________________________

Date: _______________  

Address (optional if wish to receive summary)
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