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# An experimental study of the impact of clinical psychodiagnosis, diagnostic concept and dogmatism on the perception of psychopathology.

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AN EXPERIMENTAL STUDY OF THE IMPACT OF CLINICAL  
PSYCHODIAGNOSIS, DIAGNOSTIC CONCEPT AND DOGMATISM  
ON THE PERCEPTION OF PSYCHOPATHOLOGY

A Thesis

Presented to the

Department of Speech

and the

Faculty of the Graduate College

University of Nebraska at Omaha

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

by

Jane Ellen Stilwell Smith

July 1973

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Accepted for the faculty of the Graduate College of the  
University of Nebraska at Omaha, in partial fulfillment of the  
requirements for the degree Master of Arts.

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July 20, 1973

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## CHAPTER I

### INTRODUCTION

#### Genesis of the Problem

The subject of psychiatric diagnosis and the ramifications of a person being labeled as "mentally ill" has attracted increased attention in the past decade. Personal testimony from psychiatric patients about the difficulty in securing employment, returning to familiar abodes, and re-entering a scholastic environment because of rejection by a "normal" society, has been documented in confidential case files, witnessed by friends and relatives, and published for lay consumption (Rubin, 1960; Salinger, 1951; and Green, 1964). Other literature has been devoted to the apparently negative psychosocial aspects of being an in-patient in a mental institution (Caudill, 1958; Goffman, 1961; and Gordon, 1971). Some of the issues have been raised by young physicians at the commencement of their careers in psychiatry (Willner, 1971); however, much pressure is being exerted concerning the process of labeling a person with a clinical psychodiagnosis by the practicing psychiatrists (Menninger, 1963; Laing, 1971; and Szasz, 1961, 1968, 1970<sub>a</sub> and 1970<sub>b</sub>).

Thomas Szasz is a psychiatrist and psychoanalyst in private practice who is a professor of psychiatry at the Upstate Medical Center of the State University of New York in Syracuse. Although most of his work originally appealed to the professional worker in

the field of mental health/illness, his contention that mental illness is a myth has reached the general public in popular magazines.

Scarf (1972) writes that for more than a decade Szasz has "mounted a virtually single-handed and doggedly persistent attack on the view of mental illness as a disease." She translates his contention:

"The concept of mental illness is a metaphor run amuck. It is a mythical construct which, in common with most myths, serves to convert social purposes (p. 105)." Szasz (1967) concludes one of his articles with the statement that mental illness is a myth "whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations (p. 177)." Earlier (1966) he had stated that "to classify a person psychiatrically is to demean him, to rob him of his humanity, and thus to transform him into a thing (p. 217)." In the same article he draws similarities between the classificatory act of clinical psychodiagnosis to the stereotyping of black people into "niggers" and implies that the same prejudicial acts are perpetrated upon the "mentally ill".

Szasz's polemic has created a controversy in the psychiatric area about both himself and his ideas. In his Epilogue to The Manufacture of Madness (1970), which he entitles, "The Painted Bird", he writes that psychiatrists "paint" their patients with psychiatric diagnoses and that this is the "grand strategy of discrimination, invalidation and scapegoating (p. 292)."



Although some disagree with Szasz'a generalizations (e. g. Glaser, 1965, and Ausubel, 1970), others agree that psychiatric diagnosis may serve as a latent social control function (Miller, 1970); some call for vigilance (Schmideberg, 1970); and some call for empirical research in the area (Petroni & Griffin, 1969).

As a worker in the field of psychiatry, this writer has been aware of the many schools of thought concerning diagnostic classification and has been duly impressed with the problem. She has been impressed, also, with the paucity of empirical research concerning the social psychology of clinical diagnosis. Therefore, when her attention was directed to the work of Temerlin and Trousdale (1969), who concluded that the presence of a diagnosis given by a prestigious person influenced the perception of psychopathology in a "normal" person by observers, especially professionals, her interest increased. These researchers found that a diagnosis of "mental illness" ranged from a low of 84 percent among undergraduates to a high of 100 percent among psychiatrists. Results showed that 95 percent of the reports about the "normal" person who was being observed were inferential rather than descriptive, in spite of explicit instructions to the subjects to avoid inference-making. Diagnoses of normality ranged from 0 percent to 16 percent in the experimental groups (who had received the diagnosis from a prestigious person), as compared to 57 percent to 100 percent

in the control groups. The authors stated that the effects of their experiment were probably due to the interaction between the diagnostician (observer) and his concept of mental illness, and that this interaction may have predisposed the subjects towards inferences about the "normal" person. They concluded:

The susceptibility of psychiatric diagnosis to suggestion supports Szasz's contention (Szasz, 1961) that psychiatric diagnosis is a process of labeling social behavior, and suggests that Szasz's position be tested experimentally. Indeed, the social psychology of clinical diagnosis should be seriously explored. This study suggests that the concept of mental illness, combined with the practices of psychiatric diagnosis, may produce a special variety of demand characteristics which influence patient and practitioner in ways analogous to the demand characteristics of a psychological experiment (p. 290).

According to Orne (1970) the "demand characteristics" to which these authors refer are among "those factors which are apt to affect the subject's reaction to the well-defined stimuli in the situation (p. 4)."

In January 1972 this writer had the opportunity to test out the contention that labeling affects the perception of psychopathology. During a lecture, "Communication, Verbal and Nonverbal", which she gave to 82 junior medical students as part of "Basic Psychiatry 320" at the Nebraska Psychiatric Institute, the students were shown a seven-minute videotape recording of a patient being interviewed.

Under Condition 1 no clinical diagnosis was given. The students were asked to rate the psychopathology of the patient on the Overall and Gorham Brief Rating Scale (see Appendix A). In Condition 2 the students were asked to record their perceptions of the same patient on the same rating scale after having viewed the videotape a second time with these instructions: "Now let us watch the non-verbal communication of this schizophrenic patient." The diagnosis was inserted in Condition 2 and had not been given in Condition 1. It was hypothesized that if the diagnosis did, indeed, function as a demand characteristic in the perception of psychopathology, there would be a change in the ratings of those items commonly associated with schizophrenia, or at least a change of some sort would be recorded. The impact of the diagnosis, it was thought, would override the tendency of most raters not to change their ratings after so short a lapse of time. The hypothesis that raters do not routinely change ratings if conditions remain stable is supported by Rundquist (1950).

An interesting result of this pilot project was a change in ratings of only two items to a statistically significant degree. Those two items on the Rating scale -- No. 12, "Hallucinatory Behaviour", and No. 15, "Unusual Thought Content" -- are usually associated with the clinical entity schizophrenia (Coleman, 1964). It might be argued that a change in ratings was due to a change in

the conditions of the second experiment in which subjects were asked to watch the "nonverbal" productions of the patient and that the directions may have influenced the change. However, that premise may be refuted on the basis that observation of psychopathology called "Hallucinatory Behaviour" and "Unusual Thought Content" are primarily found in the verbal productions of the patient.

The pilot investigation of the impact of diagnostic labeling on the perception of psychopathology as recorded on a rating scale cannot be considered conclusive, nor can it be generalized; it does indicate the need for further investigation.

So as a result of personal experience, interest in both clinical and social psychology, and the opinions and research cited, it was decided to investigate experimentally the relationships of clinical diagnosis and the perception of psychopathology. It was felt that the results could add to empirical knowledge and might have important implications to workers in the field of mental health/illness.

## Review of the Literature

Perception of psychopathology has troubled mental health/illness practitioners in its diversity. Difficulty in arriving at uniform diagnoses has plagued clinicians. Consider the diverse findings from studies concerning a major mental illness, schizophrenia. Mosher (1971), in a report published by the National Institute of Mental Health, stated that the syndrome called schizophrenia costs this nation 14 billion dollars annually. Bannister (1971) reported that by 1958 over 5,000 papers on the subject had been published, and that since 1960 papers on schizophrenia had emerged at the rate of 300 a year, with an increase of about 10 percent yearly. He wrote: "Yet few, viewing the problem of schizophrenia in perspective, feel that any kind of breakthrough has been made (p. 72)." His contention is that much confusion exists concerning the diagnosis and cites some of the many studies which reflect the lack of agreement about the concept: lack of interjudge agreement concerning schizophrenia and its subcategories (Kreitman, 1961); low interjudge agreement for alleged attributes of schizophrenia (Hune & Jones, 1958); overlap between the characteristics of schizophrenia and other categories (Freudenberg & Robertson, 1956; and Wittenborn, Holzborg, & Simin, 1953); and influence of semantic uncertainties on judge characteristics (Arnhoff, 1954).

That there is a diversity between nations in the manner in

which similar patients are diagnosed is attested to by Black (1971), who states that similar patients in England and the United States receive different diagnoses. Similar patients are likely to receive a diagnosis of "manic-depressive" in England and "schizophrenic" in the United States. Research by Gurland et al. (1970, p. 24) which investigated national differences in the ratios of newly admitted patients given the diagnosis of "schizophrenia" or "affective disorder" concluded that the difference in diagnosis "appears to be primarily a result of differences in the way the two groups of hospital psychiatrists diagnose patients and only slightly a result of differences in the actual psychopathology exhibited by patients." Cross-national differences were also demonstrated by Sandifer et al. (1968). They concluded that these differences were attributable to differences in education and training.

Katz, Cole and Lowrey (1969, p. 937) found that the "disagreements among clinicians may be due to actual differences in their perceptions of certain kinds of pathology rather than to a semantic preference." They felt that the sources of these discrepancies in perception were traceable to "certain factors in the background of clinicians." The researchers concluded that ethnic background is a factor in the perception of symptomatology. In further research they discovered that older clinicians tended to diagnose categories that in recent years have been used less and

less, e. g. "catatonic schizophrenia", and a reluctance on the part of American psychiatrists to use the term "manic-depressive psychosis." Thus these authors named some factors which might influence perception: experience of the clinician, ethnic background, and psychiatric orientation.

Berry (1971) found that mental health workers, regardless of their psychiatric orientation, tended to choose the more complex labels or explanations of deviant child behavior when given the choice between complex or simple explanation. His study may indicate that the label of "schizophrenia" becomes the label that may be chosen when a series of complex behaviors is demonstrated by a patient.

Concepts play a major role in medical decision-making according to Kendell et al. (1971). These researchers found that the American concept of schizophrenia is much broader than the British concept and would include not only much of what their British colleagues would consider depressive illness, "but also substantial parts of several other diagnostic categories--manic illness, neurotic illness and personality disorder (p. 123)." The reason for this difference in diagnosis is attributed to the fact that the American concept of schizophrenia has broadened "greatly in the last 30 years without any corresponding enlargement of the British concept (p. 129)." The authors also state that most of the

American psychiatrists in their study were from the New York area and that statistics might suggest the schizophrenia is more readily diagnosed there than in other parts of the United States.

As Bannister (1971, p. 72) concluded, "the concept of schizophrenia, it has been argued, is a semantic Titanic, doomed before it sails--a concept so diffuse as to be unusable in the scientific context."

A review of the pertinent literature revealed plausible reasons for diversity of diagnostic procedures--education, experience, orientation, sophistication, ethnic background--but nothing experimentally to indicate that diagnosis is used as a method of social restraint; however, how could motives such as these be admitted to or proved? One suggestion in answer to this problem of diagnosis was given by J. Samuel Bois (1971), who made a connection between psychiatric diagnosis and man's urge to classify:

This difficulty in psychiatry I see as a broader difficulty within our culture--what I call our episteme. We are classifiers. We abstract with a totality of our semantic reactions--what we are with our experiences, our preferences. We use what I call the 'structured unconscious.' When we have a tendency to label and then to project, it is organized--we live that way.

That language is instrumental in the perceptual process was indicated by Korzybski, the general semanticist (1951, p. 176), when he wrote that language is not only an inventory of experience



but also ". . . actually defines experience for us by reason of its formal completeness and because of our unconscious projection of its implicit expectations into the field of experience." He added:

A "name" (label) involves for a given individual a whole constellation or configuration of labeling, defining, evaluation, etc., unique for each individual, according to his socio-cultural, linguistic environment and his heredity, connected with his wishes, interests, needs, etc. (p. 177).

Nunnally and Flaugher (1963) wrote that research on individual differences of word usage should continue because (1) a person's tendency to use certain words reflects his past experience, and (2) enough positive results have been obtained through research to "leave little doubt that there actually are correlations between individual differences in word usage and differences in learning, perception, and personality (p. 780)." Bois (1972, p. 300) also attested to the power of words: "Once we accept a word as proper to designate a person, a thing, a situation, or an operation, we adopt implicitly as real and effective all the relations that this word has with other words in our universe of discourse." Birch (1945), in an experiment which he said concerned the effect of socially disapproved labeling upon a well structured attitude, found that the basic effect obtained by the application of a label to a social position is the establishment or set of a given initial direction of thinking. The label functions as a stimulus which establishes a subject-

ive matrix within the materials are perceived. Bruner and Postman (1948, p. 71) explained that the set which an individual brings to a situation requiring perception is a function of his prevailing motives, needs, attitudes and personality structure.

That language usage and its influence on the concept of mental illness poses a special problem in psychiatry was recognized more than three decades ago by Campbell (1937, p. 792), who wrote that psychiatry deals mainly with behavioral disorders referable to symbolic functions and that "words and gestures are to the psychiatrist what instruments are to the surgeon. Our technology must include, then, a general theory of meaning and representation." But three decades later the worker in the field of psychiatry is still dependent upon a system of language--a nosology of terms--that endeavors to put some order into classification. He can choose to regard schizophrenia as a "fact" and have to discover its cause or etiological factors, assess a prognosis and treat its course (Laing, 1967); or "adopt a double standard of bookkeeping, one in which to state one's beliefs, the other in which to conform for the sake of official reporting and statistical tabulation (Willner, 1970, p. 11)."

Katz, Cole and Barton (1965) pointed out both the advantages and disadvantages of classification and quoted Grinker (p. 151) as to the necessity of classification: ". . . once we have made a decision that certain groups of cases are, with a high degree of reli-

ability, designated as a certain category, then we may analyze these categories in terms of their various traits." On the other hand, they quote Murphy (p. 189) as saying ". . . the major difficulty with classification and categorization is that it leads to rigidity, to reification, to a kind of nominal realism."

In order to bring some structure to this problem of classificatory labeling and the perception of psychopathology, and to avoid the individual differences in diagnostic classification which have been cited by workers, some professionals in the field of psychiatry have concentrated on behavior rating scales and have worked toward both reliability of the instruments and training for concordance of the raters. These rating scales are not without their drawbacks, as other variables impinge upon the rater's ability, such as motivation, reward, time and freedom from job pressures (Jensen & Morris, 1960) and the role of the rater (Wittenborn, Plante & Burgess, 1961).

For the purposes of this study, the rating scale chosen for the recording of perception of psychopathology was the Brief Rating Scale as conceptualized by Overall and Gorham (1962, see Appendix A). This scale was developed to offer a "rapid evaluation procedure for use in assessing treatment change of major symptom characteristics (p. 799)." The scale has been shown by its originators to be reliable in joint ratings that were made on patients in a drug

research project (range of correlation of individual items from .56 to .90) and later on newly admitted schizophrenic patients in a drug screening project. Addition of two items was made for the second testing and correlations ranged on individual items from .56 to .87. Validity was established by a second research program concerned with the general problem of developing a quantitative approach to psychiatric classification in which a computer program of diagnostic concepts was written. Psychiatrists' ratings of typical cases was found to be highly accurate. Research with real diagnostic cases is currently being done by these authors. One aspect of the scale which must be borne in mind by the researcher is that the intervals on the scale are not really equal (hallucinations "not present" is not equal to hallucinations "very mild", etc.). However, the authors state that "category scale values have been shown to be monotonically related to equal-interval values obtained from psychometric scaling methods (p. 807)," and on this basis they subject their data to interval statistical analyses.

A review of the literature thus far has demonstrated the need to investigate the influence of the diagnostic label, the observer's evaluation of the diagnosis or concept, and the observer's belief system on the perception of psychopathology.

In order to examine the manner in which the observers evaluated the concept of schizophrenia, a measuring instrument,

the Semantic Differential (see Appendix B), developed by Osgood et al. (1957), was selected for the present study. Nunnally (1961), who used this scale for measuring psychiatric labels which negatively influenced the general public, said: "The fundamental hypothesis underlying the Semantic Differential is that certain important components of meaning can be measured by the rating of objects or ideas in respect to bipolar adjectives (p. 383)." Each set of bipolar adjectives is called a scale and is rated for direction and intensity of the concept on the continuum of seven points. Research has shown that the scales emerge into a relatively small number of factors. Factor-analytic studies by Osgood and his associates (1955) have shown the following three factors to be consistently emergent: the Evaluation Factor identified by scales like good-bad, kind-cruel, clean-dirty, etc.; the Potency Factor identified by scales such as strong-weak, large-small, thick-thin, etc.; and the Activity Factor, identified by scales such as active-passive, fast-slow, sharp-dull, etc.. By averaging scores on the most highly loaded scales an average factor score for each individual or group may be obtained and the "meaning" of the concept can be determined.

For purposes of the present study only the Evaluation Factor was analyzed. Osgood reported that reliability was established by experiments done by himself and associates (1957, pp. 126-140)

and by Bopp (1955) in which immediate retest and delayed (two weeks) retest showed that the evaluation scales showed "consistently smaller deviations for both retest intervals and for both groups than do the potency and activity scales (p. 131)." As to validity of the Semantic Differential, Osgood stated that the Differential has shown face validity by high correlations between the location of concepts on the evaluative factor and scores on the attitude scales, relations between Semantic Differential results and judgments about psychotherapy, and in a thesis by Reeves (1954) in which the evaluative locations of TAT pictures which subjects judged against the Differential were found to correlate significantly with clinical judgments of stories told about the pictures by the same subjects. The Semantic Differential has been used successfully in a blind analysis of a person diagnosed as "multiple personality" (Osgood & Luria, 1954); in an examination of the statistical structure of concepts (Solley & Messick, 1957); and, most germane to this study, in the investigation of the meaning of certain concepts to medical students in evaluation of certain course curricula (Shaffer et al., 1965, and Kepler, 1970).

Lehmann, Ban and Donald (1965, p. 75) wrote that their experiments demonstrated the presence of an important factor in rater accuracy which seems to be an as yet unidentified personality characteristic. This may in certain cases either substitute for

theoretical knowledge and clinical experience or, conversely, may reduce the effect of these two factors significantly. For purposes of both this study and further research the "one important factor" cited above that was chosen for investigation was dogmatism.

Dogmatism has been described by Rokeach (1960), who has done much research on the construct, as being "a closed belief system" which is utilized by some personalities as a defense against anxiety. He stated (1954, p. 195): "Our construct of dogmatism involves the convergence of three highly interrelated sets of variables: closed cognitive systems, authoritarianism, and intolerance." His research with 1025 Ss in the United States and Britain revealed a close correlation between dogmatism and anxiety, ranging from .36 to .64; all were very significant (1960, p. 348). "

The following passage from Rokeach (1954, p. 196) explains how this personality construct might influence the perception of psychopathology in light of Szasz's contention that psychodiagnosis is a process of labeling social behavior:

With regard to the content of dogmatism, while the specific content of both central and peripheral parts may vary from one particular ideological system to another, it is possible to specify that in general the formal content of the central part of the system, to the extent it is closed, has to do with the absolute beliefs in and about authority, either external or internal, and related beliefs representing attempts on the part of such authority to

perpetuate itself. Furthermore, the central part can be conceived to provide a framework for the organization of other beliefs representing patterns of rejection and qualified acceptance of people in general according to their patterns of agreement and disagreement with the belief-disbelief system.

In the present study the concern was whether or not persons high in dogmatism who may perceive themselves as "mentally healthy" (by virtue of the fact that they are not labeled as "mentally ill") would perceive more pathology in the diagnosed patient than the undiagnosed patient as a function of intolerance. That attitudes and belief systems influence perception of mental health students was demonstrated in a study by Kurtz and Kurtz (1970) in which lower class case histories were judged more negatively than their middle class counterparts by more authoritarian students. In the present study, the social class of the patient was not identified to the Ss in order that social class would not contaminate the Ss' perceptions. Phillips (1967) found that when his subjects correctly identified mental illness, it did not increase acceptance, but rather was associated with rejection as measured on a social distance scale.

Dogmatism is measured by the instrument developed by Rokeach called the Dogmatism Scale Form E (see Appendix C). The reliability of the instrument was determined by administering and revising it through five editions until 40 items of the original



89 were considered reliable (Rokeach, 1960, p. 73). Validity of the instrument was established in work done by Rokeach and Frucher (1956, p. 360) in which they concluded that:

. . . dogmatism, as conceived and represented, measures something similar to authoritarianism but independently of the left-right dimension. It is also discriminable from rigidity, and ethnocentrism. Finally, it seems to be related to anxiety.

The presence of anxiety in the dogmatic person, who may perceive "the Other" as threatening to his belief system may be activated on receipt of new information (like a diagnostic label) after having perceived and judged the amount of psychopathology present. If so, he might record more psychopathology under the condition of a diagnosis in order to keep his own central belief system intact--that this person is somehow "different" from him and that this can be recorded.

Festinger (1957) has described a "dissonance" theory which may account for the rejection of the identified "mentally ill" found by Phillips (previously cited). This theory might account for the change in the perception of psychopathology by the medical students in the pilot project previously described. Festinger describes dissonance as a type of psychological tension or discomfort that arises when two cognitive elements are inconsistent with one another, e. g. one's opinion in opposition to that of a highly respected

person. Because of the tension, the person may try various mechanisms to reduce the dissonance: change his opinion of the other person, change his own opinion, devalue the importance of the discrepancy, etc. (Festinger, 1957, p. 203). The contention of Rokeach that highly dogmatic persons have a central belief system organized around a central set of beliefs about absolute authority poses an interesting problem for the researcher: does the diagnostic label represent an "authority" that would prejudice the observer of psychopathology who is highly dogmatic? Would a perception of greater psychopathology under the condition of diagnosis help resolve some of his dissonance or anxiety?

The major portion of the literature surveyed for this study has not supported Szasz's contention that the motive behind the clinical practice of psychodiagnosis is to control or restrain social behavior; but it has indicated that once labeled, the person is perceived in a manner different from that if he were not diagnosed.

### Statement of the Problem

The purpose of this study was to explore the impact of clinical psychodiagnosis on the Ss' perception of psychopathology. In order to do this, the study investigated the possible relationships among the use of diagnostic label, the untrained observer's evaluation of the diagnostic concept "schizophrenia", his degree of dogmatism and his perception of the observed patient's psychopathology.

The following questions were posed about relationships among the variables:

1. Is there a significant relationship between the presence or absence of diagnosis and the perception of psychopathology of a psychiatric patient by untrained observers?
2. Is there a significant relationship between the observer's evaluation of the concept of "schizophrenia" and his ratings of psychopathology under the conditions of both no diagnosis and diagnosis given?
3. Is there a significant correlation between the way the observer rates the concept of psychopathology and the observer's score on a dogmatism scale?
4. Is there a significant difference in the amount of change on scores of psychopathology under the conditions of no diagnosis and diagnosis given between the ratings by

untrained observers who scored high and those who scored low on a dogmatism scale?

## Hypotheses

- H<sub>1</sub> There is no significant difference in the degree of severity of psychopathology perceived by the Ss as measured by the Brief Psychiatric Rating Scale under conditions of no diagnosis and diagnosis in both selected items and in overall scores.
- H<sub>2</sub> There is no significant correlation between scores on the Brief Psychiatric Rating Scale and scores on the Evaluation Factor of the Semantic Differential for the concept "schizophrenia" under the conditions of no diagnosis and diagnosis.
- H<sub>3</sub> There is no significant correlation between scores of the subjects on the Brief Psychiatric Rating Scale and scores on the Dogmatism Scale Form E.
- H<sub>4</sub> There is no significant difference in mean ratings of psychopathology by high dogmatism subjects and by low dogmatism subjects under the conditions of both no diagnosis and diagnosis.

### Operational Definitions of the Variables

Psychodiagnostic label, or diagnosis, was defined operationally as the term "schizophrenia" that was either given or omitted under specified conditions.

Evaluation of the concept of "schizophrenia" was defined operationally as scores of the Evaluation Factor of the Semantic Differential as developed by Shaffer et al.

Dogmatism was defined operationally as scores on the Dogmatism Scale Form E created by Rokeach. High dogmatism refers to subjects who scored in the upper 20 percent of the range of their particular group. Low dogmatism refers to subjects who scored in the lower 20 percent of the range of their respective group.

Perception of psychopathology was defined operationally as scores on the Brief Psychiatric Rating Scale developed by Overall and Gorham.

## CHAPTER II

### METHOD AND PROCEDURES

#### Subjects for the Study

The subjects of this study were the total population of 145 medical students of the incoming freshman class at the University of Nebraska Medical College in July 1972.

#### Collection of Data

Data were collected during the lecture, "Society, Man and the Physician", given on July 11, 1972. This was the first lecture of the first day in medical school for these Ss. This timing was arranged so as to provide conditions under which the data could be collected without the bias of educational information concerning mental illness having been presented to the subjects.

The Ss, who already had been seated for the first part of the lecture, were given a booklet divided into two parts. The first part contained the Rokeach Dogmatism Scale Form E, the Semantic Differential Scales for four concepts (Minority Group, Patient, Mental Illness and Schizophrenia), and a Brief Psychiatric Rating Scale. The second part of the booklet, which was attached but could be separated at the designated time, contained a set of written directions and a Brief Psychiatric Rating Scale. The second part of the booklet was marked "2-0" or "2-D". The booklet marked "2-0" had the written directions, "Now watch the

nonverbal communications of this patient and rate him again after the videotape is completed." The Ss who received booklet "2-0" were considered the Control Group. The booklets marked "2-D" had the written directions, "Now watch the nonverbal communications of this schizophrenic patient and rate him again after the videotape is completed." The Ss who received booklet "2-D" were considered the Experimental Group. The booklets had been assembled randomly by the toss of a coin before being distributed to the subjects.

Subjects were asked to complete the Dogmatism Scale and the Semantic Differential Scales following directions that were read aloud to the group by this Experimenter (see Appendix D). The Ss then were shown a seven-minute videotape of an adolescent patient. The same tape had been used in the pilot project with junior medical students. Ss were told only that the patient had come to the hospital for a second admission. Following the viewing, the Ss were instructed to record their observations on the Brief Psychiatric Rating Scale in the first part of their booklets. After everyone had finished, Ss were asked to put the first part under their seats. Ss were then asked to read the written directions on the face sheet of the second part of their booklets. The videotape was shown a second time and Ss recorded their observations on the Brief Psychiatric Rating Scale that they found in the



second part of the booklet. Ss were asked to put both parts of the booklet together, were reminded to put their social security numbers on both parts of the booklets for identification purposes, and were asked to hand them in as they left the room.

### Analysis of the Data

- H<sub>1</sub> Scores of the individual items under the conditions of no diagnosis and diagnosis were analyzed for significant change by a t test. Summated scores of the Brief Psychiatric Rating Scale for "Total Pathology Score" (TPS) were analyzed for significant difference in means under the conditions of no diagnosis and diagnosis by a t test.
- H<sub>2</sub> Summated scores of the Brief Psychiatric Rating Scale (TPS) were analyzed for significant correlations with summated scores of the Evaluation Factor of the Semantic Differential. This factor was represented on the Differential by scales 1, 4, 7, 9, 11, 13, 16, and 19. Scales 9, 11, 13, and 19 were reversed in scoring.
- H<sub>3</sub> Summated scores on the Brief Psychiatric Rating Scale (TPS) of all Ss were analyzed for significant correlation with summated scores of the Dogmatism Scale Form E. The Pearson product-moment correlation r was used.
- H<sub>4</sub> Summated scores on the Brief Psychiatric Rating Scale (TPS) of subjects scoring both high and low on the Dogmatism Scale Form E were analyzed for significant difference between times 1 and 2. A 2 X 2 analysis of variance was conducted. The level of confidence for all analyses was set at  $p \leq .05$ . Although the original number of medical students was 145,

certain Ss had to be dropped from certain analyses because of failure to complete certain portions of the test instruments. In each analysis the N is reported.

## CHAPTER III

## RESULTS

Hypothesis 1 stated that there was no significant difference in the degree of severity of psychopathology perceived by the Ss as measured by the Brief Psychiatric Rating Scale under conditions of no diagnosis and diagnosis in both selected items and in overall scores of psychopathology. Analysis of the data revealed the following:

TABLE 1

t Test of Significance of Differences in Selected Items of the Brief Psychiatric Rating Scale under the Condition of No Diagnosis and Diagnosis

N=142

Item	<u>t</u> value	<u>P</u> <sub>a</sub>
1. Somatic Concern	4.2322	.01
2. Anxiety	3.2758	.01
3. Emotional Withdrawal	27.60	.01
4. Conceptual Disorganization	11.3333	.01
5. Guilt Feelings	b	
6. Tension	1.6969	ns
7. Mannerism & Posturing	b	
8. Grandiosity	.3508	ns
9. Depressive Mood	b	
10. Hostility	4.200	.01
11. Suspiciousness	b	
12. Hallucinatory Behavior	4.2000	.01
13. Motor Retardation	b	
14. Uncooperativeness	b	
15. Unusual Thought Content	3.4400	.01
16. Blunted Affect	.90	ns

Key:

- a. Significant values for  $t$ ,  $<.05$ , 1.976,  $<.01$ , 2.609
- b. The means were too close and could not be computed.

The results in Table 1 which show that selected items - Somatic Concern, Anxiety, Emotional Withdrawal, Conceptual Disorganization, Hostility, Hallucinatory Behavior, and Unusual Thought Content - were significantly different when viewed under the condition of diagnosis given from the condition of no diagnosis given. The findings were significant at not only the .05 level, but at the .01 level. Therefore, the first portion of the null hypothesis was rejected, since the findings indicated that there was a significant relationship between degree of pathology observed under the condition of diagnosis given in selected items of the Brief Psychiatric Rating Scale.

The second part of Hypothesis 1 that stated there is no difference in total pathology scores was accepted, since analysis of data revealed a  $t$  value of 1.474 which was not significant at the .05 level. The N was 71 for both the Control and Experimental Groups. The data suggest that if the psychiatric diagnosis indeed functions as a demand characteristic in the perception of psychopathology it does so for only specific items and does not influence the  $S_s$ ' rating of psychopathology in general.

Hypothesis 2 stated that there is no significant correlation between the scores on the Brief Psychiatric Rating Scale and scores

of the Evaluation Factor on the Semantic Differential Scale for the concept "schizophrenia" under the conditions of no diagnosis and diagnosis. Analysis of the data showed that there was a negative correlation of  $-.69$  under the condition of no diagnosis and  $-.42$  under the condition of diagnosis ( $N=65$ ). These negative correlations are both significant at the  $.05$  level. A low score on the Evaluation Factor of the Semantic Differential indicates that the Ss view the concept in a negative fashion. Therefore, the results indicate that a negative evaluation of the concept correlates with the perception of a more severe degree of psychopathology. The surprising finding that under the condition of diagnosis the negative correlation still held but was weaker is worthy of further investigation. The null hypothesis was rejected.

Hypothesis 3 stated that there is no significant correlation between the scores of subjects on the Brief Psychiatric Rating Scale and scores on the Dogmatism Scale Form E. The null hypothesis was accepted since a small positive correlation of  $.009$  was found to be not significant ( $N=141$ ). Whatever the influence of dogmatism is, it was found to be a weak variable.

Hypothesis 4 stated that there is no significant difference in mean ratings of psychopathology by high dogmatism subjects and by low dogmatism subjects under the conditions of both no diagnosis and diagnosis ( $N=28$  for both Control and Experimental

Groups). An analysis of variance of the data is presented in

Table 2.

TABLE 2

Analysis of Variance of Ratings of Psychopathology by Subjects Scoring both High and Low in Dogmatism under the Conditions of No Diagnosis and Diagnosis

N=56

Source	SS	df	MS	F	p
Diagnosis	20.642	1	20.642	.134	ns
Dogmatism	126.00	1	126.00	.847	ns
Interaction	468.642	1	468.642	3.153	ns
Error	7728.716	52	148.629		
Total	8344	55			

The null hypothesis was accepted since the data show no significant difference in mean ratings of psychopathology by high dogmatism subjects or by low dogmatism subjects under the conditions of both no diagnosis and diagnosis. Interaction, likewise, was not significant. A typing error which rendered one of the items on the scale invalid was discovered after the data was analyzed. Because of the insignificant correlation of the data it was deemed unnecessary to recalculate the data.

## CHAPTER IV

## SUMMARY

It appeared from this investigation that the clinical psychodiagnostic label did, indeed, have an impact upon the perception of selected items of psychopathology. The subjects' manner of evaluating the concept of the diagnosis correlated significantly in a negative fashion with Ss' perception of the degree of severity of psychopathology. The contention of Temerlin and Trousdale that the "concept of mental illness, combined with the practices of psychiatric diagnosis, may produce a special variety of demand characteristics . . ." was supported. Certainly the diagnosis had an impact on the perception of selected items associated with psychopathology in a significant way. It may be assumed, therefore, that the concept that the observer has of the diagnostic label will influence his perception of the pathology of the person carrying the diagnosis. However, since it was shown that the bias appears to be in specific items only, the prejudice cannot be thought of as general.

That dogmatism is not that "one important factor in rater accuracy which seems to be an as yet unidentified personality characteristic" (Lehmann, Ban & Donald, 1965) was shown in the case of these Ss. If it was the anxiety that is associated with dogmatism, it did not clearly show itself from the Dogmatism Scale



Form E. If, in fact, the clinical psychodiagnosis predisposes a subject to perceive psychopathology differently, it must be for some reason other than a closed belief system that leads to intolerance. These findings assume that all conditions were held stable and that the hypotheses were valid. One cannot generalize from these findings, for conditions may have been influenced by other variables. For instance, first year medical students in their first day of school were chosen as subjects with the idea that this fact rendered them more naive subjects than the junior medical students who were tested in the pilot project. It was thought that thereby the educational factor which might influence perception would be held constant. But one cannot know the influences of their premedical training on an undergraduate level. Also, there was no cognizance taken of their personal experience with mental illness, either in themselves, family, or friends which might have influenced their perceptions. There was no consideration of how they perceived male adolescent patients or persons before they were exposed to the videotape. Finally, the subjects may have realized that they were participating in an experimental situation by the time they recorded their perceptions under Condition 2 (diagnosis given) and this may have consciously or unconsciously biased their recordings.

Therefore, the results of this study cannot be generalized,

but they do point out the need for further research in this area.

## CHAPTER V

### CONCLUSIONS AND RECOMMENDATIONS

This study supported the claims of certain professionals that a clinical psychodiagnostic label biases the observer in some fashion in certain items related to psychopathology. It also supported the contention that the evaluation of the concept of the diagnosis selectively influences perception of psychopathology. It failed to find any consistent relationship between a closed belief system (dogmatism) and perception of psychopathology.

Before any generalizations are made it would be necessary to replicate this study with like Ss under conditions as similar as possible. The study should then be conducted with established mental health/illness practitioners who work with psychodiagnosis as part of their professional duties. In order to establish whether or not the diagnostic label is a method for labeling and controlling social behavior, as Szasz contends, different instruments should be used in ferreting out prejudice. Other work (Phillips, 1967) showed that the social distance scale can measure certain aspects of reactions about the "mentally ill". It would be interesting to see if there is a correlation between dogmatism, or a closed belief system, and the amount of social distance that is sought from the person diagnosed. In order to further investigate the implications of a psychiatric diagnosis, whether or not the social control is

consciously or unconsciously motivated, longitudinal studies should be conducted. Perhaps knowledge in this area could be enhanced by thorough investigation of mentally ill persons through the case study method. The influences on the personalities of those persons doing the perceiving would have to be considered in depth. For example, the group of medical students tested in this study may have already been influenced by the writings of Szasz, Menninger and others. The situational conditions on clinical and social judgment should be investigated. Bieri et al. (1966) have given an excellent set of conditional factors that may influence the manner in which patients are diagnosed and placed: the setting or clinic in which the patient is viewed and its prevailing philosophy of treatment, which may influence where the patient is referred; the 'type' of patient seeking help for a specific type of problem; and the availability of placement and whether or not there is another agency to which the patient could be transferred. These influences should be investigated empirically.

Along with the setting, these authors cite a second set of situational factors which should be investigated: (1) the intentionality of the observer or his goal and his "set" vis-a-vis the person judged, (2) the judge's involvement with the patient, and (3) the similarity-dissimilarity between the judge and the judged. These authors feel that similarity-dissimilarity research should

focus on three aspects of that concept: (1) the belief congruence (assumed or actual) between attitudes of the judge and object, (2) the social distance (or degree of acceptance), and (3) status differential (differences in social status). Research should be conducted with the idea that although three types of similarity-dissimilarity might be related, there are times when they are not related and they are not "unidimensional constructs".

The findings of this present study have implications for the worker in the field of mental health. Cognizance of one's evaluation of the concepts with which one deals (e. g. "mental illness", "mental health") and the various diagnostic categories would help the worker to evaluate the psychopathology with the knowledge in mind that most of us abstract and generalize without being consciously aware of how much of ourselves is involved in the practice of abstraction. To have knowledge of how one consciously perceives self-reflexively, perhaps with the aid of Semantic Differential Scales on the concept one was using, would enable the worker to be more consciously aware of his abstractions. As J. Samuel Bois advised:

Homo sapiens does not simply perceive as a camera perceives what it is focused upon; he perceives self-reflexively. As a semantic transactor, time-bound in a cultural heritage expressed mostly in the language he has learned to speak, he has first-order experiences that emerge in a definite pattern. This pattern

has the multi-dimensional structure of his semantic state at the moment. It involves attitudes, feelings, purposes, habits, electro-chemical conditions, anticipations of the future and pressures from the past. It is not merely a process of making a more or less accurate map of an assumed territory, the features of which would determine the characteristics of the map he is tracing.

If the worker in the field of psychiatry could learn to be consciously aware of his methods of abstracting from clinical data, thereby making his clinical and social judgments more self-reflexively, some of the evils of clinical psychodiagnosis to which Thomas Szasz alludes might, hopefully, be diminished.

This study also indicates the need for new terminology. Nunnally (1961, p. 148) concluded from his research on diagnostic labels that:

Basically we have found four things that are 'wrong' with the available terminology: (1) there is a shortage of terms available for communicating about mental-health phenomena; (2) the terms often suggest misleading explanations; (3) the terms are not well anchored semantically; and (4) the terms bear strong negative connotations.

He stated: ". . . one of the first orders of business is to improve the terms and concepts which are used." Two years later Menninger (1963) outlined a new structure of nosology based on the "dysfunction" levels of a patient. It was never adopted by the American Psychiatric Association. Since the traditional classificatory system has survived (with some refinements) in the face

of polemic, opinion and research it would seem that another approach might be tried. In the opinion of this writer the implication for the education and training of mental health/illness workers is clear: we must work toward an agreement of meanings of our concepts.

Appendix A

Brief Psychiatric Rating Scale

Overall and Gorham



## BRIEF PSYCHIATRIC RATING SCALE

## Overall and Gorham

**DIRECTIONS:** Draw a circle around the term under each symptom which best describes the patient's present condition. Be sure you understand the written directions beside each symptom before you rate it.

1. **SOMATIC CONCERN** - Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have realistic basis or not.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

2. **ANXIETY** - Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

3. **EMOTIONAL WITHDRAWAL** - Deficiency in relating to the interviewer and the interview situation. Rate only degree to which patient gives the impression of failing to be in emotional contact with other people in the interview situation.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

4. **CONCEPTUAL DISORGANIZATION** - Degree to which the thought processes are confused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of the patient's subjective impression of his own level of functioning.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

5. GUILT FEELINGS - Overconcern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

6. TENSION - Physical and motor manifestations of tension, "nervousness," and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experience of tension reported by the patient.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

7. MANNERISMS AND POSTURING - Unusual and unnatural motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

8. GRANDIOSITY - Exaggerated self-opinion. Conviction of unusual ability or powers. Rate only on the basis of the patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

9. DEPRESSIVE MOOD - Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

10. HOSTILITY - Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward

others; do not infer hostility from neurotic defenses, anxiety or somatic complaints. (Rate attitude toward interviewer under "Uncooperativeness").

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

11. SUSPICIOUSNESS - Belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal reports, rate only those suspicions which are currently held, whether they concern past or present circumstances.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

12. HALLUCINATORY BEHAVIOR - Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

13. MOTOR RETARDATION - Reduction in energy level evidenced in slowed movements and speech, reduced body tone, decreased number of movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

14. UNCOOPERATIVENESS - Evidences of resistance, unfriendliness, resentment and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

15. UNUSUAL THOUGHT CONTENT - Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness,

not the degree of disorganization of thought processes.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
-------------	-----------	------	----------	-------------------	--------	------------------

16. BLUNTED AFFECT - Reduced emotional tone, apparent lack of normal feeling or involvement.

Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe
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## Appendix B

### Semantic Differential Concept Scales











Appendix C

Dogmatism Scale Form E

## DOGMATISM SCALE FORM E

## DIRECTIONS

The following is a study of what the general public thinks and feels about a number of important social and personal questions. The best answer to each statement below is your personal opinion. We have tried to cover many different and opposing points of view; you may find yourself agreeing strongly with some of the statements, disagreeing just as strongly with others, and perhaps uncertain about others. Whether you agree or disagree with any statement, you can be sure that many people feel the same way you do.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one.

Write +1, +2, or +3 or -1, -2, or -3, depending on how much you feel in each case.

- |                         |                            |
|-------------------------|----------------------------|
| +1 I AGREE A LITTLE     | -1 I DISAGREE A LITTLE     |
| +2 I AGREE ON THE WHOLE | -2 I DISAGREE ON THE WHOLE |
| +3 I AGREE VERY MUCH    | -3 I DISAGREE VERY MUCH    |

- \_\_\_ 1. The United States and Russia have just about nothing in common.
- \_\_\_ 2. The highest form of government is a democracy and the highest form of democracy is a government run by those who are most intelligent.
- \_\_\_ 3. Even though freedom of speech for all groups is a worthwhile goal, it is unfortunately necessary to restrict the freedom of certain political groups.
- \_\_\_ 4. It is only natural that a person would have a much better acquaintance with ideas he believes in than with ideas he opposes.
- \_\_\_ 5. Man on his own is a helpless and miserable creature.
- \_\_\_ 6. Fundamentally, the world we live in is a pretty lonesome place.
- \_\_\_ 7. Most people just don't give a "damn" for others.

- |                         |                            |
|-------------------------|----------------------------|
| +1 I AGREE A LITTLE     | -1 I DISAGREE A LITTLE     |
| +2 I AGREE ON THE WHOLE | -2 I DISAGREE ON THE WHOLE |
| +3 I AGREE VERY MUCH    | -3 I DISAGREE VERY MUCH    |

- \_\_\_ 8. I'd like it if I could find someone who would tell me how to solve my personal problems.
- \_\_\_ 9. It is only natural for a person to be rather fearful of the future.
- \_\_\_ 10. There is so much to be done and so little time to do it.
- \_\_\_ 11. Once I get wound up in a heated discussion I just can't stop.
- \_\_\_ 12. In a discussion I generally become so absorbed in what I am going to say that I forget to listen to what the others are saying.
- \_\_\_ 13. In a discussion I often find it necessary to repeat myself several times to make sure I am being understood.
- \_\_\_ 14. It is better to be a dead hero than to be a live coward.
- \_\_\_ 15. While I don't like to admit this even to myself, my secret ambition is to become a great man, like Einstein, or Beethoven, or Shakespeare.
- \_\_\_ 16. The main thing in life is for a person to do something important.
- \_\_\_ 17. If given the chance, I would do something of great benefit to the world.
- \_\_\_ 18. In the history of mankind there have probably been just a handful of really great thinkers.
- \_\_\_ 19. There are a number of people I have come to hate because of the things they stand for.
- \_\_\_ 20. A man who does not believe in some great cause has not really lived.
- \_\_\_ 21. It is only when a person devotes himself to an ideal or cause that life becomes meaningful.

- |                         |                            |
|-------------------------|----------------------------|
| +1 I AGREE A LITTLE     | -1 I DISAGREE A LITTLE     |
| +2 I AGREE ON THE WHOLE | -2 I DISAGREE ON THE WHOLE |
| +3 I AGREE VERY MUCH    | -3 I DISAGREE VERY MUCH    |

- \_\_\_ 22. Of all the different philosophies which exist in this world there is probably only one which is correct.
- \_\_\_ 23. A person who gets enthusiastic about too many causes is likely to be a pretty "wishy-washy" sort of person.
- \_\_\_ 24. To compromise with our political opponents is dangerous because it usually leads to the betrayal of our own side.
- \_\_\_ 25. When it comes to differences of opinion in religion we must be careful not to compromise with those who believe differently from the way we do.
- \* \_\_\_ 26. In times like these, a person must be pretty selfish if he considers primarily his own happiness.
- \_\_\_ 27. The worst crime a person could commit is to attack publicly the people who believe in the same thing he does.
- \_\_\_ 28. In times like these it is often necessary to be more on guard against ideas put out by people or groups in one's own camp than by those in the opposing camp.
- \_\_\_ 29. A group which tolerates too much differences of opinion among its own members cannot exist for long.
- \_\_\_ 30. There are two kinds of people in this world: those who are for the truth and those who are against the truth.
- \_\_\_ 31. My blood boils whenever a person stubbornly refuses to admit he's wrong.
- \_\_\_ 32. A person who thinks primarily of his own happiness is beneath contempt.
- \_\_\_ 33. Most of the ideas which get printed nowadays aren't worth the paper they are printed on.

\* In the scale administered to Ss item 28 was repeated in place of item 26 due to typographical error.

+1 I AGREE A LITTLE

-1 I DISAGREE A LITTLE

+2 I AGREE ON THE WHOLE

-2 I DISAGREE ON THE WHOLE

+3 I AGREE VERY MUCH

-3 I DISAGREE VERY MUCH

- \_\_\_ 34. In this complicated world of ours the only way we can know what's going on is to rely on leaders or experts who can be trusted.
- \_\_\_ 35. It is often desirable to reserve judgment about what's going on until one has had a chance to hear the opinions of those one respects.
- \_\_\_ 36. In the long run the best way to live is to pick one's friends and associates whose tastes and beliefs are the same as one's own.
- \_\_\_ 37. The present is all too often full of unhappiness. It is only the future that counts.
- \_\_\_ 38. If a man is to accomplish his mission in life it is sometimes necessary to gamble "all or nothing at all. "
- \_\_\_ 39. Unfortunately, a good many people with whom I have discussed important social and moral problems don't understand what's going on.
- \_\_\_ 40. Most people just don't know what's good for them.

## Appendix D

### Oral Directions for Use of the Booklets

## APPENDIX D

Ladies and gentlemen, I shall need your close attention and cooperation. We are attempting to explore certain parameters of medical education with the eventual goal of improving our teaching methods.

On the face sheets of both booklets please place your social security number at the right hand top corner. All of this information is strictly confidential and will have no bearing on your grades or any aspect of your medical school progress. In the first part of the booklet is a study which is just a general opinion poll. The directions are at the beginning. Please take this now. Do not read on.

Now you will find four sheets of certain concepts. The purpose of this exercise is to discover the meaning of these concepts related to medicine by getting your ratings of them on a set of descriptive scales. Please rate them on the basis of what they mean to you. Place an X mark on each of the scales wherever you feel the word should be rated according to its proximity to one or other of the descriptive adjectives on the scale. For example, if it is very closely related place an X in the box next to that adjective, if quite closely related place an X in two boxes away, if only slightly related three boxes away, and if you consider the concept neutral or completely irrelevant place an X in the box located in the center of the scale. Make each item a separate and



independent judgment.

After you have completed the concept scales please indicate by turning your booklet face down. The rest of the directions will be given verbally at each portion of the exercise. You will see a videotape and be asked to rate the patient's behavior on a rating scale in the first part of your booklet. When you have finished this please place the booklet under your seats. We will proceed with the rest of the exercise when all students are finished with the first part.

You will then see the videotape a second time and be asked to rate the patient's behavior a second time on a rating scale found in the second part of the booklet. Be sure to read the written directions on the face sheet of the second part of your booklet. Be sure to put both parts of the booklet together before passing them in.

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