IMPRESSION MANAGEMENT IN CHRONIC SCHIZOPHRENICS AND SCHIZO-AFFECTIVE DISORDERS AS A FUNCTION OF INDUCTION CONDITION

A THESIS

PRESENTED to

the FACULTY of the GRADUATE SCHOOL

APPALACHIAN STATE UNIVERSITY

In PARTIAL FULFILLMENT

of the REQUIREMENTS for the DEGREE

MASTER OF ARTS

BY

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September 1980

IMPRESSION MANAGEMENT IN CHRONIC SCHIZOPHRENICS

AND SCHIZO-AFFECTIVE DISORDERS

CONSIDERING INDUCTION CONDITION

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Abstract

In order to study Goffman's (1961) concept of impression management thirty-five psychiatric in-patients were screened using the Research Diagnostic Criteria (RDC) for the diagnosis of either schizophrenia or schizo-affective disorder. The thirty subjects meeting the RDC criteria for these diagnoses were randomly assigned to either the treatment or the control group. Subjects in the control group were told that they were participating in a research project while subjects in the treatment group were told that they were going to be given a test to measure psychopathology, and it was intimated that the test could possibly affect their status in the hospital. Both groups were administered the Psychological Screening Inventory (PSI). It was predicted that, consistent with the findings of Braginsky & Braginsky (1967), the subjects in the treatment condition would "fake bad" on the PSI to avoid a change in hospital status. The dependent variable was scores on the Defensiveness scale of the PSI. Contrary to the hypothesis, no significant impression management was evidenced in the treatment condition. Though scores were altered in the predicted direction, this trend was not significant. It was noted that this lack of significance was, in part, due to subject inductions being less powerful than those of previous researchers (Braginsky & Braginsky 1967) due to ethical considerations.

Goffman (1961) postulated that institutionalized persons are not ineffectual and helpless but are capable of goal oriented behavior. Goffman further observed that this behavior was purposeful and was directed at providing a positive outcome for the patient within the environment of the institution. According to Goffman, the environmental manipulation of the mental patient is necessarily subtle in order to achieve both the positive outcome and to allow the patient to retain his status as a person who merits the simpler lifestyle of the institution. Two assumptions were made; that the hospital environment required less effort in terms of adjustment and adaptation than the work-a-day world and that some mental patients were able to function well in the simpler hospital environment. Goffman used the term "impression management" to describe the process by which persons control their affect in order to alter the impressions which others form of them. Such a manipulation resulted in the patient being treated in a special manner. Some examples of this were: a patient who functions relatively well being given a special placement on a low-functioning ward, simply because he refused to cooperate with the psychologist (Goffman, 1961, p. 227), or as Goffman points out (1961, p. 258), some patients fake an infirmity such as mutism in order to avoid responsibility and further simplify their daily routine.

Braginsky, Gross, & Ring (1966) tested Goffman's assumptions on a clinical population. Braginsky et al., presented 30 items from the MMPI to forty mental patients, twenty of whom had been hospitalized more than three months (chronic patients) and twenty who had been hospitalized less than three months (new admissions). The two groups were randomly sub-divided into two additional sub-groups. Half of each group was told that the more true answers it had, the longer the members would be hospitalized. The other half of both groups was told that the more true answers they had, the shorter their

length of hospitalization would be. Braginsky, et al. hypothesized that the chronic patients would avoid discharge in order to retain the simpler lifestyle of the hospital. In accordance with their hypothesis it was found that chronic patients did "fake bad" (manage impressions) to avoid discharge. The chronic patients altered their answers in a manner consistent with appearing mentally ill and consistent with desiring to remain hospitalized.

The above study was designed to directly test Goffman's proposal that mental patients view discharge as a negative event. The study supported Goffman's thesis. Two factors limit the generalizations to be made from the study. The first was that the subject population was not specified in terms of diagnosis. The second factor was that the subjects were instructed how to respond to questions. These two factors are important for comparisons with the following studies and in the design of the present study.

In further testing of the assumption that mental patients seek to actively manipulate the institutional environment, Braginsky, Holzberg, Finison, & Ring (1967) studied patient's selective acquisition of hospital information. Their thesis was that patients oriented towards discharge acquired knowledge of staff and treatment while patients oriented towards taking advantage of the institution as an alternative to a complex lifestyle acquired knowledge of their residential environment. In a correlation of demographic variables (including length of hospitalization) and scores on the Hospital Information Test (HIT) it was found that short-term patients rated high on staff information while long-term patients rated high on residential knowledge. The authors interpreted the results as short-term patients seeking staff cooperation in order to be discharged while long-term patients did not seek a means of being discharged, but rather looked for information that improved their simplified lifestyle within the institution.

Braginsky, Holzberg, Finison, and Ring (1967) further established Goffman's thesis that discharge is viewed negatively by long-term mental patients. As with Braginsky et al. (1966), the subject population was heterogenous in regards to diagnosis. The researchers interpreted the high residential knowledge of long-term patients as an avoidance of discharge and as a desire to facilitate their adaptation to hospital life. It is possible that the longer hospitalization of long-term patients naturally facilitated the acquisition of residential knowledge.

Braginsky, Holzberg, Ridley, & Braginsky (1968) administered the Hospital Information Test II (HIT II) and the Patient Attitudes Test (PAT) to 100 mental patients, and interviewed and observed them within the institution. The hypothesis was that patients developed interaction styles or roles that correlated with the discharge and non-discharge orientations that were indicated in the research of Braginsky et al. (1967). In support of Baginsky et al. (1967) they found that residential information that patients acquired increased with length of hospitalization while staff information does not and that this increase in residential knowledge correlated positively with identifiable patient lifestyles within the institution. The most notable of these styles was that of long-term patients. The majority of the chronic patients assumed a role that the researchers labelled as a "worker." In this role or style, the patient assumed a stable position in the hierarchy of the institution by working a job within the institution. In effect, he had a home (the hospital) and a career (his work within the institution).

Braginsky, Holzberg, Ridley, and Braginsky (1968), gave closer examination to the differences between short-term and long-term patients. While

correlations supported the postulate that long-term patients show more adaptation to the hospital lifestyle and possibly view discharge as a negative occurence, the patient population was heterogeneous in regards to diagnosis. Braginsky et al, (1967) (1968) did not address impression management in patient populations. These studies simply served to establish the thesis that long-term patients view discharge negatively.

In 1967, Braginsky & Braginsky examined thirty long-term mental patients as to their ability to manage impressions, using an interview situation and an interviewer who was blind to subject induction. The subjects were told that the test was either; 1) to qualify them for open ward privileges, 2) a routine status evaluation, or 3) to determine whether they should be discharged. Based on previous research, Braginsky & Braginsky predicted that the patients would score significantly more "healthy" in the interview situation if they were led to believe that a "healthy" score led to ward privileges. The researchers did not list the criteria on which a "healthy" score was based. This hypothesis was supported. The conclusion was reached that schizophrenics exhibit goal oriented behavior to further their self interests, in face to face interviews.

The 1967 study of Braginsky & Braginsky directly addressed impression management, based on the postulate of discharge being viewed negatively by long-term mental patients, as established in previous research, (Braginsky et al. 1966, 1967). Two shortcomings in this study were the lack of clear diagnostic criteria and the use of a non-standardized measurement. The subjects were labelled as schizophrenics but no indication was given as to how strictly diagnostic criteria were followed. Again the homogeneity of the population is suspect. The interview format led to more subjective errors that would a standardized instrument.

In a study similar to that of Braginsky & Braginsky (1967), Watson (1972) found no significant amount of impression management in a schizophrenic population. Watson randomly assigned 101 schizophrenics to three treatment groups. Each was interviewed and given the Shipley-Hartford, the Gorham Proverbs, and the short-form MMPI. The three conditions were: 1) examination for closed ward induction, 2) a routine status evaluation, and 3) discharge. The author found that scores on these measures were not affected by the conditions given. He inferred that the subjects did not manage impressions.

One explanation for Watson's data is that the sample was heterogeneous in respect to length of hospitalization. Braginsky's previous research indicated that new admissions may have a cancelling effect because they exhibit less impression management (less institutional adaptation). Another variable may have been how the induction conditions were viewed by the patients. Braginsky's previous research indicated that chronic patients viewed discharge as a negative event while new admissions viewed discharge as positive. The closed ward induction could have been viewed as negative by all patients. As in previous studies (Braginsky et al. 1966, 1967) Watson's study lacked specificity as to the diagnostic criteria for the label schizophrenia. Watson's 1972 study did use stardardized tests to infer impression management. This was an improvement over non-standardized interviews.

In a 1973 study, Watson found that schizophrenics did not manage impressions in terms of conspicuous psychotic behavior. His thesis was that if behavior of schizophrenics was intended to be manipulatory, it would occur more frequently in the presence of an authority figure. Forty-four male schizophrenics, who were identified by the staff as being the most "conspicuously psychotic," made up the subject population. The subjects were to see "Dr. A" and were left in a waiting room for ten minutes. The subjects were then

told that the reason for the appointment was 1) some problem (threat), or 2) they were told nothing (non-threat). For five of the ten minutes, their ward psychologist came into the waiting room to wait to see "Dr. A." The subjects were videotaped. In both groups, psychotic behavior increased in frequency when the authority figure was present. This increase was significant for all subjects and there was no difference between treatment groups. The author stated in his conclusion that though schizophrenics can manage impressions, they do not do so as a means of manipulation in the presence of authority figures.

In the above study, Watson failed to define what specific psychotic behavior the subjects engaged in and the subjects had no identified goal to be achieved through impression management. The undifferentiated effect across both groups was possibly due to the uniform anxiety aroused by the presence of the authority figure in both settings. Watson also did not differentiate between chronic patients and new admissions. Again Watson failed to specify the diagnosis of schizophrenia, other than that the subjects were viewed by the staff as "conspicuously psychotic." Also no standard measure of impression management was used.

In 1975, Watson compared the ability of schizophrenics in impression management with the ability of other populations to manage impressions. Eighty schizophrenics, forty neurotics, forty alcoholics and character disorders, and forty normals were administered the Interpersonal Interview Situation at two different times. One group (threat condition) was administered a slight electric shock at the beginning of the test and informed that more shocks would be the penalty for inadequate performance on the test (no further shocks were administered). The second group had no shocks. Ratings were taken by the interviewer and a non-reactive observer. Watson found that while all groups

were able to increase their scores between the two administrations to a significant degree, the schizophrenics were the least adept in this manipulation. The scores in the threat condition were not significantly different from the non-threat group. While Watson's study indicated that schizophrenics were not as adept at impression management as some other populations in this given situation, it did not indicate that schizophrenics do not use impression management as a means of attaining goals within the institutional setting.

Once again, Watson did not differentiate between chronic patients and new admissions. It can also be argued that the threat condition of this study cannot be compared with the psycho-social aversion which Braginsky feels that discharge represents. This study had the advantage of a standardized test, but the criteria for diagnostic labels was not specified.

Fontana & Gessner (1969) administered thirty-five psychotic and forty non-psychotic patients the SD 18 (Social Desirability 18 Scale, Fontana et al. 1968) and the C-test (Chronicity Test, Anker, 1961). Three groups were run; 1) research testing (control), 2) ward transfer (loss of privilege), and 3) discharge (negative). The results supported the prediction that all patients would present less pathological behavior to avoid transfer.

Another finding was that the effect of the discharge condition, in a Veteran's Administration Hospital, was greatly biased due to varying Veteran's Administration disability payment schedules that were dependent on hospitalization. Neither Braginsky et al. nor Watson et al. controlled for this variable. Fontana et al. (1969) also used standard tests to measure impression management. As in previously reported studies, (Braginsky, et al. 1966, 1967, 1968; Watson 1972, 1973, 1975) the criteria for the label of psychosis was not listed.

Statement of Problem

Though patients who are labelled as schizophrenics are hospitalized, they exhibit goal oriented behavior and this behavior can best be studied in terms of adaptations to the lifestyle of the institution. One such adaptation is impression management. The question of the existence of a paradox between the diagnosis of schizophrenia, which is based on the patient's loss of contact with reality, and the reality based adaptive behaviors which they manifest, is an important question in this research. The present study is intended to incorporate the factors of induction condition on chronic patients using a standard measurement of pathology and a more reliable diagnostic system to determine if impression management is a factor in schizophrenia.

Two significant factors in the present study were the standardized diagnosis and the standardized measure of pathology. The aforementioned studies used subject populations described as mental patients, schizophrenics or psychotics. The subjects in the present study fulfilled the Research Diagnotic Criteria (RDC)[1] for the diagnosis of schizophrenia or schizoaffective disorder. This set of criteria was developed in order to standardize diagnosis between various research projects using patient populations. This instrument helped insure homogeneity in regards to diagnosis and will aid in future replications of this research as well as clarifying the application of the findings to patient population. The standardized measure of pathology was the Psychological Screening Inventory (PSI) (Lanyon, 1974). In addition to being a standard screening device for psychopathology, this instrument had a scale (De) which measures the "fake-good, fake-bad" tendencies of the respondent. The De scale of the PSI represents a measurement of "impression management" within the standardized test. This measure of impression is non-obtrusive in that it is included in the test.

The performance of long-term schizophrenics under two induction conditions was considered in a one-way analysis of variance. The neutral induction served as a control group while the treatment induction evidenced the main effect of impression management. The subject population was drawn from a state hospital so that Veteran's Administration benefits did not affect the subject's perception of discharge.

Consistent with previous research, (Braginsky et al. 1967) it was predicted that a significant (at the .05 level) main effect of impression management would be evidenced in the treatment condition. This was to be indicated by significantly lower scores on the Defensiveness scale of the PSI by subjects in the treatment condition. This was based on the assumption that the control group would not feel threatened by the interview situation and would attempt to lessen their appearance of pathology.

In this study impression management was considered the ability of the subject to alter the scores of the testing instrument in the predicted direction. This was evaluated by comparison of group means.

Method

Subjects: Subjects were thirty patients from Broughton Hospital who fulfilled the Research Diagnostic Criteria (RDC) for the diagnosis of Schizophrenia and/or Schizo-Affective Disorder. The subject population included; thirteen undifferentiated schizophrenics, seven paranoid schizophrenics, one hebephrenic schizophrenic, and ine schizo-affective disorders. Subjects had at least one year total hospitalization or more than three hospitalizations in the past year. The total number of hospitalizations ranged from three to fourteen. The median was five hospitalizations. Due to increased efforts to treat patients on an outpatient basis, lengthy psychiatric admissions were almost non-existent. Therefore, information as to length of hospitalization is not available. Subjects were referred by the ward psychologist and/or physician. At the time of referral, the treatment team of each patient determined if participation in this study would be detrimental to his or her treatment plan. If so, referral for participation was contra-indicated. The subjects were administered an interview to determine if they met the RDC criteria. This interview was administered by the primary researcher. At the outset of this initial interview, the primary researcher obtained a statement of informed consent from the subject. If this was not obtained, the subject did not participate. Subjects were randomly assigned to either the treatment or control groups. De-briefing of subjects is elaborated in the procedure section. A total of thirty-six subjects were screened, for this study. Five were rejected because they did not meet the RDC criteria for the diagnosis of schizophrenic or schizo-affective disorder. One subject was rejected because he was unwilling to sign the consent form. This subject was diagnosed as a schizo-affective disorder.

Material: The apparatus was the Psychological Screening Inventory (PSI) (Lanyon, 1974). The PSI was a 130-item, true-false inventory which

measured psychopathology. The PSI consisted of five scales. The Alienation scale (Al) was a measure of problems of a psychological nature. A high Al scored indicated that the score was comparable to that of a hospitalized psychiatric patient. The Social Nonconformity scale (Sn) was a measure of anti-social behavior. A high Sn score indicated a similarity between the respondent and incarcerated prisoners. The Discomfort scale (Di) assessed anxiety. The higher the Di scale, the more susceptable the subject was to anxiety. The Expression scale (Ex) indicated extroversion. The higher the Ex scale the more extroverted or outgoing a person was. The Defensiveness scale (De) indicated the tendencies of the respondent to "faking" good or bad, on the PSI. The results of all five scales were examined. The De scale indicated whether the subjects attempted to alter their test scores to control how they were perceived. Using the Kuder-Richardson Formula 20, it was reported that the PSI compared favorably with reliability coefficients for the Minnesota Multiphasic Personality Inventory (MMPI). Correlations between the PSI and the MMPI supported the overall validity of the PSI (for a correlation for each scale, refer to the Psychological Screening Inventory Manual, Lanyon, 1973). The interviewer presented the PSI questions verbally in order to retain the interview format of previous researchers. The subject population was randomly assigned to either the treatment or the control sub-group.

Procedure: Four subjects were evaluated in each session. Two interviewers were used in this study. Neither interviewer had worked with the patients in the subject population. One interviewer was male and one was female. To avoid confounds due to personal differences, subjects were randomly assigned to interviewers. In addition, the two interviewers were randomly assigned to administer the treatment or control condition in each

evaluation session. Interviews were conducted in available offices on the ward from which each of the four subjects were taken. Each interviewer adminsitered the PSI to two subjects. The second subject was tested immediately after the first. This prevented discussion between prospective subjects and those who had been tested. Subjects were chosen from a different ward in each testing session. This limited discussion between prospective subjects and those already tested. Each interview lasted approximately thirty minutes.

Subjects in the control group were read the following induction:

> This interview is for research purposes only. Any information that you give during the course of the interview is kept strictly confidential and will have no bearing on your present or future status in this or any other institution.

The interviewer then read the PSI to the subject and the subject was asked to respond verbally to each item. The answers were recorded on a computer score sheet by the interviewer.

The subjects in the treatment group were read the following induction:

> I am going to give you an interview. This is an instrument by which we judge psycho-pathology or mental health. An interview of this type is sometimes used to determine a person's status of mental condition at this institution.

(It is noted that this induction was less powerful as a "threat condition" than the inductions of previous researchers (Braginsky et al. 1967). This reduction in threat was due to ethical considerations. It was the opinion of this researcher and the Human Research, Review & Development Committee of Broughton Hospital, that a more powerful induction would not be ethical because the mental patient would be subjected to an anxiety

producing situation which could be detrimental to his or her mental status. The less powerful induction of the present study could possibly have reduced the magnitude of effect in the treatment condition.)

The interviewer then read the PSI to the subject and the subject was asked to respond verbally to each item. The answers were recorded on a computer sheet by the interviewer during the interview.

After the interview was completed, the interviewers de-briefed the subjects. The de-briefing read:

> This interview is the second part of the study in which you agreed to participate. Irregardless of any previous information that you may have been given, the only purpose of this interview is as a research tool. This study is designed to evaluate the interview format taking into consideration various conditions. If you have any questions I will try to answer them and if I am unable to do so, the primary researcher will try to answer them. This interview has no significance other than as research data. It has no bearing on your status in regard to Broughton Hospital. Confidentiality is guaranteed and this interview will be identified by a number to further protect your rights.

At the completion of the study the interviewers were de-briefed and allowed to ask questions concerning the study. Upon termination of the study, all assistants, Broughton Hospital, and all interested parties were provided copies of the study.

Results

The following is a presentation of the analysis of variance and group means for each scale of the PSI by treatment conditions. Tabular presentation of these findings are given in the indicated appendices.

The A1 scale of the PSI measures psychopathology. The mean score (70.0333) for the entire population was two standard deviations above the test mean of fifty. This indicated a significant level of psychopathology in the subject population. There was no significant difference in scores between the treatment ($\overline{X}$ = 70.4286) and control ($\overline{X}$ = 69.6875) groups (see Appendix B, Tables 1 and 2). The subjects in the treatment condition evidenced no measurable impression management on the A1 scale of the PSI.

The Sn scale of the PSI is indicative of anti-social tendencies in the respondent. As a group, the subject population in the present study scored one standard deviation above the mean on this scale. This indicated significant anti-social tendencies for the subject population as a whole. As in the A1 scale, there was no significant difference between treatment ($\overline{X}$ = 62.8571) and control ($\overline{X}$ = 59.0625) groups on the Sn scale (see Appendix C, Tables 1 and 2). The lack of differences in mean scores between the treatment and control groups indicated that the treatment condition did not elicit impression management.

The levels of manifest anxiety, as measured by the Di scale of the PSI, are the same for both treatment and control groups. Scores on this scale were within one standard deviation of the test mean. No significant level of impression management was present (see Appendix D, Tables 1 and 2).

The Ex scale of the PSI assessed extroversion. Both the treatment and control groups scored within the normal range on this scale. There was no significant difference between mean scores for the control and treatment groups. The subjects in the treatment condition did not successfully alter

their scores in order to manage impressions (see Appendix E, Tables 1 and 2).

In Appendix E, Tables 1 and 2, the analysis of variance and subsequent breakdown of induction condition by the De scale of the PSI were presented. The De scale measures the respondent's tendencies to "fake" good or bad on the PSI and in this study the De scale was chosen as the main measure of impression management. The breakdown (Table 2) indicated that the main effect of impression management, as measured by a lowered mean score on the De scale in the treatment condition was not significant. The mean scores on the De scale of the PSI were 50.18 for subjects in the control condition and 45.00 for subjects in the treatment condition. Subjects in the treatment condition scored in the predicted direction, but not significantly so. In considering all five PSI scales, the De scale evidenced the largest effect due to treatment.

The overall profile developed from the mean scores of the present subject population on the PSI were normal for a hospitalized (psychiatric) group. The elevated Al scale indicated a high probability of psychopathology with some significant degree of social-nonconformity as indicated by the elevated Sn scale. The De and Ex scales were within the normal range which is typical on a psychiatric patient's profile. The only trend toward divergence between the treatment and control groups was on the De scale. On this scale scores in the predicted direction were evidenced in the treatment condition. This effect was not significant.

Discussion

The hypothesis that a significant main effect of impression management would be evidenced in the treatment condition was not supported by this study. Subjects in the treatment condition scored in the predicted direction on the De scale of the PSI, but this effect was not significant.

The present study was a replication of Braginsky & Braginsky's 1967 study, with the incorporation of a standardized diagnostic criterion (Research Diagnostic Criteria) and a standardized measure of the "fake good -- fake bad" tendency (De scale of the PSI). The use of the RDC in the present study for the diagnosis of schizophrenia and schizo-affective disorders insured a homogeneous subject population. The RDC reduced the chance of error due to variance within the subject population. The result was that an objective replication of this study is possible and that research conclusions can be applied to defined populations. The De scale of the PSI is a measure of impression management within a standardized test. The De scale measures the "fake good -- fake bad" tendencies of the respondent. The above two factors were introduced in order to reduce variance in diagnostic criteria (therefore yielding a homogeneous subject population) and subjectivity of an interview format.

The major difference between the studies lay in the subject inductions. The control conditions in the two studies were comparable. The treatment condition of the present study described the interview as a "measure of psychopathology...sometimes used to determine a person's status...at this institution", whereas the treatment condition of Braginsky & Braginsky (1967) described the interview as determining whether or not the subject will be discharged. The change in the treatment induction was required to meet with ethical research requirements in dealing with hospitalized subjects. It is

possible that the implicit threat of the change of status in the present study was less likely to affect scores than the explicit threat in the inductions of the Braginsky & Braginsky (1967) study.

Another consideration was that the present interviewers were not on the staff at the hospital in which this study was conducted. Their being viewed as persons responsible for a given patient's change of status was probably reduced. This reduced the threat, and therefore the need to manage impressions, for all patients.

In the present study, the change of scores on the De scale in the predicted direction followed the line of that reported by Braginsky & Braginsky (1967). The lack of significance, however, supported the findings of Watson (1973, 1975). Watson (1975) found that while schizophrenics did attempt to manage impressions, the effectiveness of these efforts are limited. The present study showed some support for the existence of impression management in psychotic populations, but it also supported Watson's assertions that this effect is limited.

Previous research (Braginsky & Braginsky, 1967) indicated that impression management was a factor in schizophrenia. The present did not support these previous findings. The present findings may have been due, in part, to the treatment induction being a less explicit threat than the treatment induction in earlier studies. Future replications should consider using a "threat" induction which is explicit, but which is also ethical.

Footnotes

[1] Developed by Robert L. Spitzer, M.D., Jean Endicott, Ph.D., and Eli Robins, M.D. with the assistance of the other participants in the NIMH Clinical Research Branch Collaborative Program on the Psychobiology of Depression. These diagnostic criteria are an expansion and elaboration of some of the criteria developed by the Renard Hospital group in St. Louis.

Investigators wishing to use these criteria should contact Drs. Sptizer and Endicott at Biometrics Research, New York State Psychiatric Institute, 722 West 168th Street, New York, New York, 10032.

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APPENDIX A

Statement of Informed Consent

The study in which you are being asked to participate is for partial fulfillment of the requirements of an M.A. program in Clinical Psychology at ASU, for J. Michael Bramble. The study consists of two interviews. Both interviews will contain questions which deal with your mental status. Confidentiality is guaranteed. You are free to discontinue the study at any point. Your involvement is voluntary. Any data which is taken out of the hospital will be identified by a code number only, thus assuring that your identity will not be known in relation to this material. An explanation of the purpose of the study and a thorough de-briefing will be provided upon completion.

If you understand the above explanation and are willing to take part in this study, please sign below.

_____ _____

I understand the above description of the study and I agree to participate, being aware that confidentiality is guaranteed and that I have the option to discontinue at any point.

Signed:_____ Date:_____

Witness:_____ Date:_____

APPENDIX B

Table 1

Analysis of Variance

Al by Treatment

Source of Variance	Sum of Squares	DF	Mean Square	F	Signif of F
Tr.	4.101	1	4.101	0.019	0.890
Residual (Error)	5890.855	28	210.388		
Total	5894.957	29	203.274		

APPENDIX B

Table 2

Breakdown

A1 by Treatment

Variable	Mean	Std. Dev.	N
For Entire Population	70.0333	14.2674	(30)
Control	69.6875	10.5686	(16)
Treatment	70.4286	18.0073	(14)

APPENDIX C

Table 1

Analysis of Variance

Sn by Treatment

Source of Variance	Sum of Squares	DF	Mean Square	F	Signif of F
Tr.	107.515	1	107.515	1.107	0.302
Residual (Error)	2720.649	28	97.166		
Total	2828.164	29	97.523		

APPENDIX C

Table 2

Breakdown

Sn by Treatment

Variable	Mean	Std. Dev.	N
For Entire Population	60.8333	9.8754	(30)
Control	59.0625	7.8695	(16)
Treatment	62.8571	11.7399	(14)

APPENDIX D

Table 1

Analysis of Variance

Di by Treatment

Source of Variance	Sum of Squares	DF	Mean Square	F	Signif of F.
Tr	5.952	1	5.952	0.051	0.822
Residual (Error)	3248.211	28	116.008		
Total	3254.164	29	112.213		

APPENDIX D

Table 2

Breakdown

Di by Treatment

Variable	Mean	Std. Dev.	N
For Entire Population	57.8333	10.5930	(30)
Control	58.2500	10.4976	(16)
Treatment	57.3571	11.0774	(14)

APPENDIX E

Table 1

Analysis of Variance

Ex by Treatment

Source of Variance	Sum of Squares	DF	Mean Square	F	Signif of F
Tr	66.402	1	66.402	0.923	0.345
Residual (Error)	2014.961	28	71.963		
Total	2081.364	29	71.771		

APPENDIX E

Table 2

Breakdown

Ex by Treatment

Variable	Mean	Std. Dev.	N
For Entire Population	48.2333	8.4718	(30)
Control	49.6250	9.3515	(16)
Treatment	46.6429	7.3548	(14)

APPENDIX F

Table 1

Analysis of Variance

De by Treatment

Source of Variance	Sum of Squares	DF	Mean Square	F	Signif of F
Tr	252.262	1	252.262	1.752	0.196
Residual (Error)	4032.433	28	144.015		
Total	4284.695	29	147.748		

APPENDIX F

Table 2

Breakdown

De by Treatment

Variable	Mean	Std. Dev.	N
For Entire Population	48.1000	12.1552	(30)
Control	50.8125	12.1228	(16)
Treatment	45.0000	11.8581	(14)