AN INVESTIGATION OF ROLE-TAKING IN HISTRIONIC PERSONALITY DISORDER

DEBORAH LYNNE SMITH

CANADIAN THESES ON MICROFICHE

I.S.B.N.

THESES CANADIENNES SUR MICROFICHE

National Library of Canada
Collections Development Branch

Canadian Theses on
Microfiche Service

Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada
Direction du développement des collections

Service des thèses canadiennes
sur microfiche

NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us a poor photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30. Please read the authorization forms which accompany this thesis.

THIS DISSERTATION
HAS BEEN MICROFILMED
EXACTLY AS RECEIVED

AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de mauvaise qualité.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30. Veuillez prendre connaissance des formules d'autorisation qui accompagnent cette thèse.

LA THÈSE A ÉTÉ
MICROFILMÉE TELLE QUE
NOUS L'AVONS REÇUE

NL-339 (r. 82/08)

Canada

AN INVESTIGATION OF ROLE-TAKING IN HISTRIONIC PERSONALITY DISORDER

by

DEBORAH LYNNE SMITH

A Thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science

Faculty of Medicine

MEMORIAL UNIVERSITY OF NEWFOUNDLAND

July, 1982

St. John's Newfoundland

ABSTRACT

This research focuses its attention on role-taking ability, how a person interprets another's impression of her. Gough proposed a theory of psychopathy in which he found that psychopaths are deficient in this ability. Genetic studies have linked psychopaths with hysterical personality disorder. Therefore, it was decided to investigate role-taking ability in hysterical personality disorders. Females, only, were considered for the study, since this is a diagnosis used primarily in females. A control group of treated depressives was used. All subjects were in-patients on two psychiatric units of general hospitals.

Subjects were given a test battery: 1. Socialization Scale 2. Meta-Impression Test (Bilsbury, 1978). These were tests to measure role-taking. 3. Beck Depression Inventory. This was used to detect the presence of depression in the groups.

Results showed that females with hysterical personality disorder are deficient in role-taking ability while the control group demonstrated normal role-taking ability. The difference was significant at the $p=0.0001$ level for the Socialization Scale. The Meta-Impression Test did not yield significant results and recommendations have been made for its improvement.

The significant results have important implications for diagnosis and treatment of hysterical personality disordered patients and the Socialization Scale has potential value for detection of hysterical traits in depressed women.

ACKNOWLEDGEMENTS

I wish to express my heartfelt gratitude to Dr. K. Standage, my thesis supervisor, for his initial direction in selecting a research area, and his continued support and careful guidance throughout the research project and during preparation of the manuscript. I am also grateful to the members of my thesis committee, Drs. C. Bilsbury and S. C. Jain, for their assistance.

In addition, I am indebted to Mr. J. Woodrow, who gave many hours of his time to instruct and assist in the application of computer methods in statistics and to Dr. R. Jain for being statistical consultant; Drs. C. Mellor, J. Hoenig, G. O'Brien, and V. K. Jain for referring patients and lastly to my husband, Jerry for his patience and support.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

Role-taking - Theoretical Background and Definition

The cognitive-development concept of role-taking has its roots in Piaget's theory (1950) of intellectual development. Piaget claims that young children under seven years old are 'egocentric', that is they cannot see another's perspective and he feels that complete comprehension of another's perspective does not occur until a child is nine years of age (Trower, Bryant and Argyle, 1978). Piaget's theory was extended by Feffer (1959,1970). Kitano, Stiehl, and Cole (1978) states that this viewpoint posits two broad areas of cognition: impersonal (person to object) and interpersonal or social (person to person). Impersonal cognition refers to children's structuring of the physical, inanimate world as seen for example in their developing conceptions of quantity, space and number (Feffer, 1959). Interpersonal cognition refers to individuals' cognitive structuring of the social world (Feffer, 1959), that is how individuals come to perceive others and make inferences about their inner states. These perceptions and inferences are made by means of role-taking.

Mead (1934) developed a role-taking theory. He described how during childhood "the generalized other" is created by integration of the experiences of interpersonal interaction into a cognitive scheme. This is made possible by a 'role-taking ability', which is described as the ability to perceive and evaluate one's own behaviour as it is perceived and evaluated by others in the same culture. Mead describes

role-taking as being related to empathy, it is assumed to provide the individual with means of achieving self-understanding and self-control. He sees thinking as a consequence and product of social processes which develops by successive forms of role-taking in which the subject meaningfully constructs, reconstructs, and interprets his social environment.

Feffer and Scuhotliff (1966) found that people who did well in a role-taking test also did well in a test of social interaction. This implies that the inability to take the role of another is related to social inadequacy.

It is important to differentiate role-taking from role-playing. Kitano, et al., (1978) described role-playing as an overt enactment of the role attributes (characteristics and behaviours) of another person whereas role-taking is a covert cognitive process of predicting another person's perspective. Kitano et al. distinguish role-taking ability from role-taking activity as well. Role-taking ability is the individual's cognitive capacity to anticipate another's perspective when it differs, or is independent from one's own. Role-taking activity concerns the individual's employment of role-taking ability in a particular situation.

Role-taking ability, in the social cognitive-development literature has been described as developing in stages. Feffer (1959, 1970) identified three levels of the development of role-taking ability, commencing at approximately six years of age. Prior to this age, the child can differentiate self and others as entities but does not

differentiate their points of view. Feffer states that beginning at age six, the child enters the first level of role-taking - simple refocusing. In this level, the child realizes that self and others may have different interpretations of the same social situation, but is unable to coordinate these perspectives. The child may therefore have a distorted perception of the situation. Feffer's second level - consistent elaboration, which occurs between seven and eight years of age, the child can coordinate different perspectives in a sequential manner, i.e. can consider different points of view but focuses on them one at a time. In level three - change of perspective, beginning at age nine, the child can coordinate perspectives simultaneously. The child at this stage can be considered as having role-taking ability.

Selman and Byrne (1974) found support for a sequence of stages in the development of role-taking ability that closely parallels Feffer's and conforms to his age norms.

Flavell (1968) investigated 'social decentering' with age in children. He found that younger children gave descriptions from their own point of view only whereas older children gave less egocentric responses.

In view of the obvious implication of the importance of role-taking to social development, Chandler (1973) used the procedure devised by Flavell (1968) to compare the role-taking skills of 45 chronically delinquent boys was 45 non-delinquents between the ages of eleven and thirteen. Ten sequences were used following the format of Flavell (1968). A five-point scoring system reflecting different levels of egocentric

intrusion was developed. Results showed that delinquents demonstrated marked deficiencies in their ability to differentiate their own point of view from that of others whereas the non-delinquent boys did not demonstrate this difficulty.

Another term which has been used in the studies of role-taking is the term "meta-impression". Laing, Philipson, and Lee (1966) used this term to refer to one person's perception of another person's perception of him or her. This term is conceptually similar to role-taking, but is used most frequently in adult studies. Bilsbury (1978) found that meta-impressions were more affective and egocentric among patients with personality disorders than among normal people.

Livesley and Bromley (1973) studied person perception in young children and adolescents. They observed that younger children form impressions of others that are egocentric whereas older children (adolescents) can detach a situation from themselves and be more objective demonstrating role-taking ability or meta-impressionability.

Trower et al. (1978) found that failure to take the role of the other appeared to be a common feature of psychiatric disorders. They saw role-taking ability as a cognitive ability which develops with age but which may fail to develop properly.

Given the weight of the preceeding evidence, it is reasonable to conclude that role-taking ability is a basic requirement for effective social interaction.

Psychopathy Defined

Theories have been proposed relating role-taking ability to psychopathy. It is first of extreme importance to define what is meant by the term psychopathy.

According to Spielberger, Kling, and O'Hogan (1978), the psychopathic personality has been described as an amoral, impulsive person who lacks restraining influences of anxiety and guilt. Psychopaths are also described as irresponsible and unreliable people who display poor judgement and are unable to profit from experience. In many cases, however, the relaxed manner and verbal facility of the psychopath may enable him or her to hide these faults and to obtain positions of responsibility and trust that are typically violated without feelings of guild or remorse.

Antisocial personality disorder and psychopathic personality disorder have come to be used as synonymous terms (Ziskind, 1978). The Diagnostic and Statistical Manual of Mental and Nervous Disorders, third edition classifies antisocial personality disorder as; the persistence into adult life of a pattern of antisocial behaviour that began before the age of fifteen, and failure to sustain good job performance over a period of several years (although this may not be evident in individuals who are self-employed or who have not been in a position to demonstrate this feature e.g. students or housewives). The antisocial behaviour is not due to either severe mental retardation, or psychosis.

Lying, stealing, fighting, truancy, and resisting authority are typical early childhood signs. In adolescence, unusually early or aggressive sexual behaviour, excessive drinking and use of illicit drugs are frequent. In adulthood, these kinds of behaviour continue, with the addition of inability to sustain consistent work performance or to function as a responsible parent and failure to accept social norms with respect to lawful behaviour. After age thirty, the more flagrant aspects may diminish, particularly sexual promiscuity, fighting, criminality and vagrance.

Associated features of psychopathy is a marked impairment in the capacity to sustain lasting, close, warm, and responsible relationships with family, friends or sexual partners. This disorder is much more common in males than females.

The Diagnostic and Statistical Manual of Mental and Nervous Disorders, third edition (DSM-III) estimates the prevalence of this disorder in males to be about 3% and notes that the disorder is more common in lower class populations, partly because it is associated with impaired earning capacity and partly because fathers of those with the disorder frequently have the disorder themselves and consequently their children grow up in impoverished homes.

According to DSM-III, this continuous antisocial behaviour when a person is over the age of fifteen, must exist for at least five years for it to be considered psychopathic personality disorder or antisocial personality disorder.

Psychopathy - Its Relation to Role-Taking Ability

In 1948, Harrison G. Gough proposed a sociological theory of psychopathy based upon G. H. Mead's role-taking theory. Gough described a psychopath as a person who: 1. seems insensitive to social demands, 2. who refuses or cannot cooperate, 3. who is untrustworthy, impulsive, and improvident, 4. who shows poor judgement and shallow emotionality and 5. who seems unable to appreciate the reactions of others to the person's own behaviour. Gough felt that this behaviour could be attributed to a deficiency in role-taking ability. He and Peterson (1952) constructed the Delinquency Scale to measure role-taking. Subsequent revisions were made and an improved scale, named Socialization Scale, was incorporated in the California Personality Inventory. Studies of validity and reliability of the scale have been reviewed by Rosen and Schalling (1974).

Cleckley (1976) felt that present legal and medical conceptions of psychopathic personalities are inadequate. He contends that the asocial impulsive psychopath can escape legal retribution for delinquent acts by pleading insanity and then, after the briefest commitment, can secure release by establishing psychiatric competence. The psychopath can verbalize all the moral and social rules but does not seem to understand them they way that others do. Cleckley has called this "the mask of sanity".

Gough states that psychopaths are persons in whom role-taking ability is underdeveloped and all the characteristics of the psychopath are assumed in some way to be related to this basic deficit in role-

taking. The lack of role-taking ability in the psychopath implies that a lack of understanding of how the person's own behaviour influences other people and that person's expectations are not realistic. Psychopaths are also seen as being deficient in role-playing ability, the capacity to look on one's self as an object (Mead, 1934) or to identify with another's point of view.

Hysterical Personality Disorder - Its Relation to Psychopathy

Clinical studies suggest that personality types other than those described as 'psychopathic' may be deficient in role-taking. In particular, there are grounds to suspect a deficiency in role-taking in hysterical personalities. The traits which contribute to the formation of this type include egocentricity, exhibitionism, excessive emotionality, suggestibility and dependence (Lazare, Klerman and Armor, 1966). These traits are noted to be common to both disorders. Spalt (1980) describes sociopathy (psychopathy) and hysteria as having similar features and family backgrounds, with more hysteria in female relatives and more antisocial personality and alcoholism in male relatives of both individuals with hysteria and with sociopathy. He further records that female hysterics and male sociopaths tend to marry each other and produce hyperactive children who later demonstrate antisocial personality or hysteria. Warner (1978) suggests that the same etiological and pathogenetic factors may lead to different but overlapping clinical manifestations which may be shaped into different forms in the two sexes by the same cultural forces which determine masculine and feminine identity and stereotypes. Guze (1975) showed an association existed between sociopathy in fathers and hysteria in daughters even in families where the mother is not a

hysteric. These and other genetic studies (Woerner and Guze, 1968) have suggested that there may be a biological affinity between hysterical traits in women and psychopathic or 'anti-social' traits in men.

It was thought that since research studies have examined role-taking ability in male psychopaths, that it would be of interest to observe role-taking ability in females diagnosed with Hysterical Personality Disorder. A review of the literature suggests that this has not previously been done.

Hysterical Personality Disorder

It has been suggested that a close affinity exists between psychopathy and hysterical personality disorder. Because this study is focusing on the latter, it is necessary to give a brief history and to define the concept, hysterical personality disorder.

The concept 'hysteria' has a long history. The earliest sources of recorded medicine emanated from the two great cultural centers - the Egyptian and the Mesopotamian (Horowitz, 1977). Of these, the Egyptian records play the important part in the story of the evolution of the concepts of hysteria. They related hysteria to a uterine disorder and directed treatment to that organ.

The uterine concept of hysteria remained in force well into the middle ages and even beyond; it was somewhat eclipsed in medieval times as a result of St. Augustine's dictum: "There are no diseases that do not arise from witchery and hence from the mind" (Horowitz, p. 21).

This statement was considered particularly applicable to the recognition and treatment of hysteria and hence led to a curious dichotomy of attitudes in regard to the etiology and treatment of that disease. Treatment was no longer medical but was taken over by the clergy and consisted of exorcism and torture.

Syndenham first recorded that males can have hysteria too, but it is more subject to females. He also recognised conversion hysteria. He emphasized that these men and women were not insane, but recognized the manifestations to be of mental origin, (Horowitz, p.25).

Pinel's, in France, most important contribution to the understanding of hysteria was his deviation from the uterine etiology and from the increasingly sterile and repetitive neurological basis that had emanated from Great Britian and attributed it more to mental processes, (Horowitz, p. 38).

Freud discovered that hysterical patients were absolutely responsive to hypnotic suggestion. He also used psychoanalysis in the treatment of hysteria with success, (Horowitz, p.56).

Confusion about the concept hysteria and its terminology continues even today, since there are at least four ways in which the professional and lay publications use the related terms.

Tupin (1974) described the ways in which hysteria has been used. Hysteria may denote a transcient loss of control, usually with both affective and behaviour elements. This often results from overwhelming stress and is usually the laymen's version of hysteria.

Hysterical neurosis is another term used in connection with the concept hysteria. It was previously defined in the official American Psychiatric Association Nomenclature as a condition characterized by an involutary psychogenic loss or disorder of function. This diagnosis includes two syndrome types, conversion reaction and dissociative reaction.

Hysterical psychosis is not included in the American Psychiatric Association official nomenclature. However, the existence of the syndrome has been documented. The disorder is described as an episode having a sudden onset, with the existence of hallucinations, delusions, illusions, or depersonalization, thought disorder, and affective volatility. It rarely lasts longer than three weeks resulting in minimal psychological deterioration (Horowitz, 1977).

The prime concern for this study is the term "hysterical personality disorder". It has been classified in the Manual of the International and Statistical Classification of Diseases, Injuries, and Causes of Death, ninth edition as: a personality disorder characterized by shallow, labile affectivity, dependence on others, craving for appreciation and attention, suggestibility, and theatricality. There is often sexual immaturity e.g. frigidity and over-responsiveness to stimuli. Under stress, hysterical symptoms (neurosis) may develop.

There is a second type of personality disorder which is designated "hysteria" by some authorities. This syndrome was originally described by Briquet. The primary components of this

syndrome are recurrent ill health, physical complaints, frequent surgery and frequent visits to the doctor (Tupin, 1974).

Jaspers (1946, p. 443, English translation, 1963) described hysterical personalities as craving to appear "both to themselves and others, as more than they are and to experience more than they can ever be capable of".

Schneider (1949) accepted Jasper's definition and described such personalities as attention-seeking. They are characterized by trying to be more than one is, and by having a passion for attention.

In the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III), hysterical personaltiy disorder no longer appears, rather it is replaced with the term "histrionic personality disorder". The reason for its removal was confusion about the concept of the terminology (Tupin, 1974). The Diagnostic and Statistical Manual of Mental Disorders, third edition, has been used to describe Histrionic Personality Disorder for this study. It describes diagnostic criteria for histrionic personality disorder as follows:

> The following are characteristic of the individual's current and long term functioning, are not limited to episodes of illness, and cause either singificant impairment in social or occupational functioning or subjective distress.
>
> A. Behaviour that is overly dramatic, reactive, and intensely expressed by at least three of the following.
>
> 1. Self-dramatization
> 2. Incessant drawing of attention to oneself
> 3. Craving for activity and excitement
> 4. Overreaction to minor events
> 5. Irrational, angry outbursts, or tantrums.
>
> B. Characteristic disturbances in interpersonal relationships as indicated by at least two of the following:
>
> 1. Perceived by others as shallow and lacking genuineness even if superficially warm and charming

2. Egocentric, self-indulgent and inconsiderate of others
3. Vain and demanding
4. Dependent, helpless, constantly seeking reassurance
5. Prone to manipulative, suicidal threats, gestures, or attempts.

Basic treatment of histrionic personality disorder is psychotherapy. The healthier, good hysteric seems to respond well to psychoanalytically oriented psychotherapy and probably also benefits from appropriate group therapies. The more primitive, bad or sick hysteric may respond better to goal-limited supportive psychotherapy (Horowitz, 1977).

Use of DSM-III as Diagnostic Criteria

The DSM-III was used in this study because it has two major differences from other previous classifications of mental disorders. First, its disorders are classified on a multiaxial evaluation. A multiaxial classification requires that every case be assessed on each of several "axes", each of which refers to a different class of information. The DSM-III has five axes with personality disorders being coded on Axis II of the system. This seems to be an improvement from other classification systems since it allows one to separate the major mental disorders and conditions from the personality disorders while still ensuring that personality disorders are taken into consideration. Secondly, the DSM-III typology was preferred to that of the ICD-9 because the use of diagnostic criteria is believed to produce higher diagnostic reliability than general descriptions of disorders. The use of DSM-III necessitated a change in terminology, since that classification has excluded hysterical disorders as a matter of policy. Of the

personality types available, histrionic personality corresponds most closely to the type traditionally called 'hysterical' or 'attention-seeking'.

The DSM-III holds promise for increasingly discrete, uniform, and reliable identification of clinical entities. With this new diagnostic language, clinicians have the capacity to more accurately assess the prevalence of psychiatric disorder; such data are essential to treatment planning, program development, and psychotherapeutic and psychopharmocologic outcome research (Stangler, 1980).

It appears that the DSM-III does facilitate the diagnosis of personality disorders since it offers a more reliable approach for clinical assessment which explains why it has been used for this study.

HYPOTHESIS

Based on the symptomotology of histrionic personality disorder and its close affinity with psychopathy, it is hypothesized for this study that females with histrionic personality disorder are deficient in role-taking ability.

METHOD

Introduction

The purpose of this study is to determine whether females diagnosed with histrionic personality disorder are more deficient in role-taking ability than are females not having this diagnosis.

Experimental Design

The study was conducted over a period of approximately fifteen months. Two groups of twenty were selected for the study - twenty being experimental subjects and twenty were used as controls. These people were chosen from psychiatric units of two general hosptials.

All patients who were considered for this study were seen and asked if they would be willing to participate in the study. Once a verbal agreement was made, they were requested to sign a consent form.

Because of the delicate nature of psychiatric illness, the consent form was deemed necessary as a protection for the patient. The consent form contained a clause that enabled a patient to later withdraw from the study after it began if it was felt necessary by the patient. The consent form also assured the patient that whether or not they participated in the study would in no way affect the treatment that they would receive as a patient (Appendix A).

Subjects

All subjects for this study were inpatients on a psychiatric unit of 2 large general teaching hospitals. All subjects were female. The decision to confine the study to females was made in recognition of

the strong tendency of clinicians to diagnose hysterical traits most often in women. (Walton, Foulds, Littman and Presly, 1970). The inclusion of a small number of males in the study would lead to difficulties in interpreting the results. The diagnosis histrionic personality disorder is also used more frequently in females than males (DSM-III).

Prior to the study, the psychiatrists from both teaching hospitals were sent memoranda asking them to refer patients for the study. They were given criteria for inclusion in the study for both subjects and controls (Appendix B). For the subject group, they were asked to refer women with a diagnosis of histrionic personality disorder according to DSM-III. For the control group, they were asked to refer women with depression (all types) who do not meet the criteria for the diagnosis of histrionic personality disorder.

Those patients diagnosed as having histrionic personality disorder either as a primary or secondary diagnosis formed the experimental group. This diagnosis was rechecked by using the DSM-III criteria for histrionic personality disorder as a checklist, noting which of the traits existed in each patient. The control group was also checked with this list to ensure that histrionic traits did not exist in this group.

Since it was decided to control for psychiatric status in the selection of candidates, it was necessary to choose a control group that would be capable of completing the test battery without their illness being a major interference. On this basis, those female patients with depressive illness who were recovering and near discharge

and who did not meet the criteria for histrionic personality disorder were chosen as controls for the study.

The groups were matched retrospectively for age and intelligence. It was thought that if there were wide age differences between the two groups, that any difference in the results might be attributed to this. The same is true if differences in intelligence existed for the two groups. The age range for the experimental subjects was from 17 to 66 years. The ages of the control group ranged from 19 to 44 years.

Procedure

The measurement instruments used in this study were administered close to the discharge date in anticipation that the controls would be recovered from their depression. These measurement instruments consisted of:

1. Socialization Scale (So Scale) of the California Personality Inventory.
2. The Meta-Impression Test (M.I. Test). This test was developed by the supervisory committee.

Each patient was also interviewed and a brief history was taken. This was done by means of a data collection sheet (Appendix C).

Socialization Scale

The Socialization Scale of the California Personality Inventory was chosen because it was designed by Gough to measure the magnitude of tendencies of persons who show little or no internalization of rules and customs of society and they are generally unable to maintain bonds of loyalty or affiliation with other persons or groups. These traits measure the magnitude of role-taking ability.

Gough and Peterson (1952) constructed a Delinquency Scale (De Scale) which contained 64 items. This scale significantly differentiated delinquent males and females from non-delinquent male and female groups. Cross-validation led to a fifty-four item scale that was included with scoring revised, as the Socialization Scale (So Scale) of the California Personality Inventory (Rosen, 1977). Rosen states that the So Scale has proven to be one of the best functioning personality tests developed and its validity has been well documented in various aspects: empirical, as well as concurrent and predictive, and construct as well as convergent and discriminant, both in the United States and in non-English speaking countries. The Socialization Scale measures socialization as well as several aspects of role-taking (Appendix D).

The sociological theory of psychopathy forms the basis for the Socialization Scale and it emphasizes that negative early experiences in interpersonal interactions as a child, results in deficiencies in role-taking ability.

The Socialization Scale was extracted from the California Personality Inventory for this study and it is considered to be the prime instrument of measurement. Each subject was required to circle 'T' for 'True' or 'F' for 'False' for every item of the scale. As stated previously, the total items in this scale is fifty-four. Low scores indicate a deficiency in role-taking ability. High scores indicate adequate role-taking ability.

Meta-Impression Test

The Meta-Impression Test (M.I. Test) (Bilsbury, 1978) consists of four questions to which the participants in the study respond by

writing a few sentences about four people:

2 of whom like the subject
2 of whom dislike the subject
2 of whom are male
2 of whom are female.

In her responses, the subject was asked to explain why those people did or did not get along with her and her responses were scored for role-taking (Appendix E).

The idea of the Meta-Impression Test originated with Bilsbury (1978). He concluded from his research that in personality disordered patients, meta-impressions are more affective and egocentric than those of normal persons and that these characteristics are generally accepted as being typical of a low development level in social cognition. The results of Bilsbury's study are consistent with Gough's theory of deficiency of role-taking in psychopaths.

Because a highly significant difference was found when comparing personality disordered subjects with normal persons, it was felt that it would be a useful test in comparing a specific category of personality disorders namely histrionic personality disorders with a depressive control group.

Since the investigator could not score the results of the M.I. Test blind, two members of the supervisory committee acted as independent blind assessors. A three-point rating scale was used. Zero indicated no or inadequate role-taking ability. One (1) indicated the presence of role-taking ability but with a limited good/bad response e.g. "he likes me because I am kind" or," she dislikes

me because I am a better person than she is". Two (2) indicated adequate role-taking ability. These include more sophisticated responses. e.g. "He likes me because I am a trustworthy person. He sees me as someone who is capable of forming a lasting friendship" or "she doesn't get along with me because we do not share the same interests. She probably feels that I am not interested in her as a person". Scores were totalled across the four sub-tests (range 0-8) and the correlation of the total scores of the two raters provided the measure of inter-observer reliability (Appendix F). The average of the two scores was used in the subsequent analysis.

A pilot study using two groups of five non-patient, female volunteers using the Meta-Impression Test as an instrument in order to test its reliability. There was 95% agreement between the two raters in scoring these tests. The ratings of the independent raters were correlated and found to be reliable.

Reliability was tested for the main study as well. The observed correlation of 0.83 between the two sets ratings was felt to indicate an adequate level of inter-observer reliability.

Peabody Picture Vocabulary Test

To ensure that the verbal intelligence of the two groups were compatible, the Peabody Pciture Vocabulary Test was chosen to be administered as part of the test battery. The Peabody Picture Vocabulary Test is designed to provide an estimate of the subject's verbal intelligence through measuring his/her hearing vocabulary. It was desired to have a test in which scoring was objective and one

that could be administered taking a minimal amount of time. This particular test was chosen because it meets this criteria.

Beck Depression Inventory

A depression rating scale was included in the test battery to quantify depression in both groups of subjects at the time of administering the tests. The Beck Depression Inventory was the depression rating scale used. This inventory has 21-items. The subject is required to choose from four statements the one which she feels applies mostly to her. The higher the score, the more depressed the individual is assessed to be (Beck, et al. 1961) (Appendix G).

The battery of tests was administered in standardized fashion. Each subject who agreed to participate was requested to sign the consent form. Then the investigator administered the Peabody Picture Vocabulary Test. The subjects were then given the battery of tests:

1. Socialization Scale (So Scale) of the California Personality Inventory
2. Meta-Impression Test (M.I. Test) (Bilsbury, 1978)
3. Beck Depression Inventory

and were asked to complete each test given standardized directions. The average length of time required to complete the tests was ninty minutes, although participants were not given a time limit to complete the task.

RESULTS

Introduction

Forty-two patients were originally considered for the study - one candidate did not complete the battery of tests and one person was excluded because a diagnostic problem existed. This particular patient was given two different diagnoses, manic-depressive psychosis and hysterical personality disorder by two psychiatrists on two different occasions. The patient's psychiatrist at the time the study was being done disagreed that any hysterical traits existed in this patient. Of those patients approached, none refused to participate in the study.

Matched Variables

All forty cases in this study were female. Table one shows the means and standard deviations for the matched variables - age and intelligence.

TABLE 1

Scores on Matched Variables

Variables		E Group	C Group	Level of Significance
Age (years)	Mean	29.0	33.0	NS
	Standard Deviation	9.8	8.4	
Intelligence	Mean	95.8	94.8	NS
	Standard Deviation	11.5	12.9	

NS - not significant

The table shows that the mean age for the experimental group was 29 ± 9.8 S.D. The average age for the control groups was 33 ± 8.4 S.D. T-test analysis showed no significant difference between the two groups. The average I.Q. from the Peabody Picture Vocabulary Test was 95.8 ± 11.5 S.D. for the experimental group and 94.8 ± 12.9 S.D. for the control group. T-test analysis showed no significant difference in the two groups for intelligence.

Demographic and Clinical Data

The levels of education attainment within the two groups were similar. Table 2 summarizes the educational achievements of both groups.

TABLE 2

Education Status

	E Group	C Group
Education N/20 and % having high school or above	16 (80%)	16 (80%)

Eighty per cent of both groups had high school or above education. However, unemployment was reported significantly more frequently in the histrionic group. Table 3 shows the work status of both groups.

TABLE 3

Work Status

	E Group	C Group
N/20 and % employed	3 (15%)	18 (90%)
N/20 and % unemployed	17 (85%)	2 (10%)

$X^2 = 22.56$ df = 1 $p < 0.001$

Eighty-five per cent of the experimental group were unemployed at the time of the study while 10% of the control group were unemployed. This difference was a significant finding ($p < 0.001$).

The marital status of both groups was also dissimilar. Table 4 shows the marital status in both groups.

TABLE 4

Marital Status

	E Group	C Group
N/20 and % married	9 (45%)	16 (80%)
N/20 and % separated or divorced	5 (25%)	0
N/20 and per cent single	6 (30%)	4 (20%)

Forty-five percent of the experimental group were married. Eighty per cent of the control group were married. Twenty-five per cent of the experimental group were separated or divorced. None of the control group was separated or divorced. Thirty per cent of the experimental group and 20% of the control group were single.

The prevalence of items of clinical data is shown in Table 5.

TABLE 5

Prevalence of Clinical Items

	E Group	C Group	Level of Significance
N/20 & proportions 1st admission	5 (25%)	9 (45%)	$\chi^2 = 1.76$ NS
Mean No. Admissions	2.65	2.05	
N/20 & % attempting suicide	12 (60%)	4 (20%)	$\chi^2 = 6.67$ $p < 0.01$
Average Number	1.1	0.2	
N/20 & % with Drug or Alcohol Abuse	14 (70%)	5 (25%)	$\chi^2 = 8.12$ $p < 0.01$
N/20 & % with Sexual problems	12 (60%)	7 (35%)	$\chi^2 = 2.51$ NS

Proportionately more people in the control group were in hospital for a first admission than in the experimental group, but the difference was not statistically significant. The average number of admissions for the

for the experimental group was 2.65. The average number of admissions for the control group was 2.05. Sixty per cent of the experimental group attempted suicide at least once while 20% of the control group had attempted suicide once. This difference was significant at the $p = 0.01$ level. The average number of suicide attempts was 1.1 for the experimental group and 0.2 for the control group. In the experimental group, 14 (70%) were found to be alcohol or drug abusers while 5 (25%) of the control group were found to be alcohol or drug abusers, $p < 0.01$. In the control group, 35% reported having sexual problems while 60% of the experimental group reported having sexual problems. However, the difference was not statistically significant.

Histrionic Personality Disorder in the DSM-III was described in the introduction as having two categories of traits. These two categories were used as a checklist to note which traits existed in each person. The checklist was used to confirm the eligibility of the subject for inclusion in this study. The investigator was not blind at the time the checklists were completed. Thus it is not free from observer bias. However, the items supplement the other descriptive data available for the histrionic group. The data are consistent and suggest that the experimental group was representative of patients given that diagnosis. Table 6 shows the frequency to which each subject was noted to have histrionic traits.

TABLE 6

DSM-III checklist

Category		E Group	C Group
A.	1. self-dramatization	18 (90%)	3 (15%)
	2. incessant drawing of attention to oneself	11 (55%)	1 (5%)
	3. craving for activity and excitement	15 (75%)	3 (15%)
	4. overreaction to minor events	19 (95%)	4 (20%)
	5. irrational, angry outbursts or tantrums	13 (65%)	0
B.	1. perceived by other as shallow and lacking genuineness even if superficially warm and charming	15 (75%)	1 (5%)
	2. egocentric, self-indulgent and inconsiderate of others	9 (45%)	0
	3. vain and demanding	7 (35%)	0
	4. dependent, helpless, constantly seeking reassurance	13 (65%)	5 (25%)
	5. prone to manipulative suicidal threats, gestures or attempts	13 (65%)	2 (10%)

t = -9.550

p = .00000

Overall Mean Scores — E Mean = 6.65 C Mean = 0.95

Even though some traits were noted in the control group, none met the minimal criteria for inclusion into the histrionic group. T-test showed the differences in the overall item scores in the groups to be highly significant.

Table 7 shows the mean scores for the Beck Depression Inventory.

TABLE 7

Mean Scores for the Beck Depression Inventory

	E Group	C Group	t-scores
Mean Beck Depression Score	27.7	20.9	0.1223
Standam Deviation	15.2	11.8	NS

NS - not significant

Analysis of the Beck Depression Inventory showed the mean score for the experimental group was 27.7 $\pm$ 15.2 S.D. The mean score for the control group was 20.9 $\pm$ 11.8 S.D. The t-score was not significant. Scores for both groups were high.

Although there was no significant overall difference between the two groups on the Beck Depression Inventory, it was decided to do an item analysis to observe whether the two groups answered individual questions differently. Chi-square comparisions were made on each item in the inventory. Because of the relatively small sample sizes, fourfold

tables were used, indicating the proportions of subjects in each group who scored '0' on the item. There were only two items for which there was a significant association between the presence of the item and group membership. The first item was 'B' in which 5 (25%) reported not being particularly discouraged about the future in the experimental group while 13 (65%) of the control group answered they were not discouraged about the future ($x^2 = 6.46$, $p < 0.01$). Item 'I' was the second discriminating item. Only 20% (4) of the experimental group while 55% (11) of the control group said that they did not have any thoughts about killing themselves ($x^2 = 5.23$, $p < 0.05$).

More detailed analysis of Item 'I' showed that 50% of the experimental group and 35% of the control group said they had thoughts of killing themselves but would not carry them out. Twenty per cent of the experimental group said they would like to kill themselves. None of the control group answered to this. Ten per cent of both groups said they would kill themselves if they had the chance.

There were 21-items in the scale and the significant differences for two items barely exceeds chance expectation. The differences on these two particular items are consistent with the clinical data. The main conclusion drawn from the analysis was that the experimental and the control groups responded similarly to the questionnaire.

Dependent Variables

Socialization Scale

Table 8 lists the mean scores for each group on the Socialization Scale.

TABLE 8

Mean Scores for Socialization Scale

	Socialization Scale
Experimental Group	24.65
Standard Deviation	12.70
Control Group	40.65
Standard Deviation	11.70

$t = 4.156$ $p < 0.0001$

Table 8 shows that the experimental group obtained significantly lower scores, 24.65 ± 12.7 S.D. than the control group, 40.65 ± 11.7 S.D. T-test analysis was done on the scores of the Socialization Scale for both groups. The results showed $T = 4.156$. The test is significant at the $p = 0.0001$ level. These results show that the control group is significantly better at role-taking than is the experimental group. The scores of the control group are comparable to scores set forth for female high school "best citizens", $M = 41.51 \pm 4.55$ S.D. The scores for the experimental group are comparable to scores given for female prison inmates in studies previously done, $M = 26.83 \pm 7.04$ S.D. (California Personality Inventory Manual).

Meta-Impression Test (Bilsbury, 1978)

Table 9 lists the mean overall scores for both groups on the Meta-Impression Test averaged from both raters.

TABLE 9

M.I. Test Scores – means

	Mean Score–M.I. Test	
Experimental Group	3.30	NS
Control Group	4.15	

NS - not significant

The scores for the experimental group were lower than for the control group, but the difference was not statistically significant. As the M.I. Test scores were summed over four subtests, it was decided to examine the latter individually. Table 10 shows the distribution of scores on all 4 sub-tests for the experimental group.

TABLE 10

Distribution of scores on M.I. Subtests - Experimental Group

Scores		# of subjects			
Rater 1	Rater 2	Subtest 1	Subtest 2	Subtest 3	Subtest 4
0	0	7	10	2	13
0	1	1	2	7	0
1	1	4	1	1	0
1	2	0	1	4	2
2	2	7	4	6	2
0	2	1	2	0	3
	Total	20	20	20	20

Table 11 shows the distribution of scores on all four subtests for the control group.

TABLE 11

Distribution of scores on M.I. Tests - Control Group

Scores Rater 1	Rater 2	Subtest 1	Subtest 2	Subtest 3	Subtest 4
0	0	0	11	3	7
0	1	3	2	1	1
1	1	3	1	4	1
1	2	5	3	7	6
2	2	8	1	5	4
0	2	1	2	0	1
	Total	20	20	20	20

These results suggest that a difference exists between the experimental and control groups on subtest 1 and 4 but not 2 and 3. Subtest 1 required the subjects to write about a man who 'gets along well with' them. Seven (35%) of the experimental group could not do this subtest and received a score of '0' from each rater. No member of the control group fell into this category. This shows that the control group performed better on this subtest than the experimental group. Thirteen (65%) of the experimental group could not do subtest 4 which required the subjects to write about a 'woman who did not get along well with' them. Seven (35%) of the control group could not do the subtest receiving a score of '0' from both raters.

Table 12 shows the distribution of ratings on test 1 and 4 re-arranged according to the degree of role-taking ability shown.

TABLE 12

Ratings of Role-taking

With Role-taking				E Group	C Group
Ratings of subtests 1,4					
Rater 1,2		Rater 1,2			
2	2	2	2	2	3
2	2	2	1	1	4
2	2	2	0	2	0
2	2	1	1	0	2
2	1	1	1	0	0
2	1	1	0	0	2
2	2	0	0	2	2
2	1	0	0	1	2
				8 (40%)	15 (75%)

Without Role-taking				E Group	C Group
Ratings of subtests 1 4					
Rater 1,2		Rater 1,2			
1	1	1	1	0	1
1	1	1	0	0	0
1	1	0	0	5	2
2	0	0	0	2	1
1	0	0	0	0	1
0	0	0	0	5	0
				12 (60%)	5 (25%)

$X^2 = 5.01$ $p < 0.05$

Examination of the pattern of scores on the first and fourth subtests suggested a cut-off point above which role-taking ability had been demonstrated on at least one subtest. This category included 15 (75%) of controls but only 8 (40%) of subjects. This difference was significant at the 0.05 level.

Table 12 also records that there were 5 occasions in which the two raters awarded scores of '0' and '2' respectively on one subtest. In every instance, the raters gave identical scores on the other subtest. In two instances, the combined ratings placed the subject in the group with role-taking while, in the other three instances, they were assigned to the group without role-taking. Therefore, this arrangement of the data does not appear to have resulted in any serious decrease in the reliability of the observations.

Of the experimental group, 5 (25%) were given ratings of 0 by both raters on both subtests. Five more had scores of 0 on the fourth subtest and ratings of 1,1 on the first subtest (limited role-taking). Only three controls performed this badly as can be seen from the second part of Table 12. This suggests that the experimental group did perform worse on these measures of role-taking than the control group on subtests 1 and 4. The division of the table into 'with role-taking and without role-taking' was done with maximal standards set forth for role-taking. If it was argued that the first two rows of 'the without role-taking' (ratings 1,1,1,1 & 1,1,1,0) table meant the person could role-take, it would serve to strengthen the differences between the two groups and make the finding more significant.

Correlations of Socialization Scale and Meta-Impression Test with Matched Variables and Beck Depression Inventory

The design of the study matched the two samples for age and intelligence, variables which in theory might influence role-taking ability. Table 13 shows the values of correlation coefficients between So Scale and M.I. Test and the matched variables, calculated in the experimental and control groups combined.

TABLE 13

Correlations of So Scale and M.I. Test with matched variables

	So Scale	M.I. Test
Intelligence	+0.18	+0.30
Age	+0.21	-0.18

The correlation between age and So Scale, age and M.I. Test, and between intelligence and So Scale were minimal. A non-significant correlation of +0.30 was observed between M.I. Test and intelligence.

Correlation between the So Scale and the Beck Depression Inventory was -0.48. The correlation was significant at the five per cent level. Correlations of similar magnitude were found in both the experimental and control groups.

The correlation of the So Scale and M.I. Test was +0.25.

Analysis of Covariance - So Scale and Beck Depression Inventory

In view of the correlation of -0.48 observed between So scores and Beck Depression Inventory scores and the fact that both groups obtained unexpectedly higher mean scores in the Beck Depression Inventory, it was decided to investigate to what extent the Beck Depression Inventory Score was influencing the difference of the scores of the two groups for the So Scale. Analysis of covariance was the method chosen for this analysis. Analysis of covariance consists essentially of determining that a proportion of the variance of the criterion existed prior to the experiment, and this proportion is eliminated from the final analysis (Roscoe, 1969). Table 14 shows the result of the analysis of a summary for analysis of covariance.

TABLE 14

Summary Table for the Analysis of Covariance

Source	df	SS_x	SP	SS_y	df'	SS'y	MS'y
Among means	1	462.4	-1094.8	2592.1	1	1771.0	1771.0
Within groups	38	7006.0	-2431.4	4579.5	37	3735.7	101.0
Total		7468.4	-3526.2	7171.6		5506.7	

F = 17.54, df = 1.37 $p < 0.001$

Adjusted means So Scale = E Group = 25.9

C Group = 39.5

From the table, it is observed that the f-ratio equals 17.54 which is significant at the 0.001 level. Therefore, the difference in the adjusted means for So Scale, after removing the influence of the Beck Depression Inventory Scores, although decreased slightly, is still highly significant.

DISCUSSION

Introduction

In this study of role-taking ability, it was hypothesized that female psychiatric in-patients with a diagnosis of hysterical personality disorder would be more deficient in role-taking ability than a control group, without this disorder. A review of the literature on role-taking and its relation to psychopaths suggests that this study is the first to extend Gough's role-taking theory of psychopathic behaviour to other types of personality disorder.

Reliability of Diagnosis

The DSM-III typology was preferred to that of the ICD-9 because the use of diagnostic criteria is believed to produce higher diagnostic reliability than general descriptions of disorders. However, the use of the DSM-III necessitated a change in terminology, since that classification deliberately avoided the use of the term 'hysterical' because the term has been misused (Tupin, 1974). In the past, the term "hysteria" has been used to refer to both personality disorder and neurosis thus leading to confusion. Of the personality types available, histrionic personality disorder most closely corresponds to the type traditionally called 'hysterical'. It is hoped that any deviation from the accepted meaning of the latter term will be compensated for by easier replicibility of the study. The decision to confine the study to females was made in recognition of the strong tendency of clinicians to diagnose hysterical traits most often in women (Walton, et al., 1970). Chadoff (1980) says that the behaviour

of women who conform to the diagnosis of hysterical personality disorder is the product of cultural pressures, of which a major component is male domination and expectations. This would appear to support the observation that histrionic personality disorder is used primarily in females.

Patients with depressive disorders and without histrionic personality disorder were chosen as controls for the study. They were chosen on the grounds of their frequency among psychiatric in-patients in general hospitals. These patients were tested near the discharge date in attempt to avoid having their illness as an intervening variable. The control group was a sample of depressives.

Comparison of clinical and demographic features in the two samples described the hysterical group as being less stable, socially and emotionally than the depressives. While the educational backgrounds of the two groups were similar, the former group were more frequently unemployed and had less stable marriages. They were also more likely to have histories of drug and/or alcohol abuse and sexual problems. Their psychiatric histories were characterized by a high number of admissions and suicide attempts, although the lethality of the intent in the latter was not measured. These traits are characteristic of persons diagnosed with histrionic personality disorder. Those subjects appeared to be representative of patients given the diagnosis of hysterical personality disorder (Schneider, 1949).

Effect of Measurement Instruments

The Beck Depression Inventory was used to detect the existence of depression in both groups. An unexpected finding was that both groups had high scores on the Beck Depression Inventory even though they were tested near the date of their discharge. While there was no significant difference between the two groups, the experimental group scored higher than the control group. The high score of the depressives was surprising because these patients were preparing to be discharged home and it suggests that this event may constitute significant stress to such patients although it was not subjectively evident. The score of the experimental group may also have been distorted in this way. However, it is not unusual for hysterical personalities to score higher than depressives on the scale. This probably illustrates the tendency of such patients to dramatize their condition.

Scores on the Beck Depression Inventory were significantly correlated with the Socialization Scale ($r=-0.48$, $p<0.05$), suggesting that depression might have been a contaminating factor in the investigation. Although histrionic personalities were excluded from the control group, depression was not identified as a necessary exclusion criterion in the selection of experimental subjects. However, analysis of covariance showed that depression did not produce the observed difference in the mean So scores of the two groups.

As a method of measurement, the So scale was considered to be the most appropriate because: 1) It was designed for an adult population 2) It has established validity and reliability 3) It was originally

designed for a study of psychopaths 4) It was considered to be a good measure of role-taking. Rosen and Schalling (1974) say that So scores have been reported to be influenced neither by socioeconomic, educational and racial factors not by cultural factors in cross-cultural studies.

Other scales were considered for the study. Feffer designed a test (Role-Taking Task) and his materials for the test are taken from Schneidman's Maps Test. It consists of background scenes, for example, a living room, or a street corner, plus a variety of cardboard men, women and children which may be placed in various positions against these backgrounds. The initial task is to tell a story for each of three scenes using at least three of the cardboard figures in each story. Following this, the child is to retell a story from the point of view of each actor in turn i.e. "Now you are the mother here. How do you as a mother feel? How do you size up the situation?" Scoring is based on how well a child can assume the role of the actor and how appropriately he relates one actor to another. This test was developed as a measure of role-taking ability in children and therefore was not used in this study of adults.

Flavell (1968) also designed a test of role-taking. His method consisted of a cartoon sequence containing seven pictures which subjects were asked to describe first from their own point of view and then from the perspective of a coexperimenter who was shown only in an abbreviated version of the same stimulus materials. It was found that younger

children assumed that the other party would describe the story which they had themselves described from the original set of cartoon pictures whereas older children gave less egocentric responses. This, too, is a test geared for children and therefore was not considered as appropriate as the So scale.

The Meta-Impression Test (Bilsbury, 1978) was considered a good test for the study because it has been used successfully in adult subjects. Combining an objective measure with a subjective one should give a more complete measure of role-taking ability. A modified version with Bilsbury's recommendations was used in this investigation. In his original M.I. Test, Bilsbury conducted a tape recorded interview where the subject was asked to name a person for each category as follows: 1) Same sex, liked 2) Same sex, disliked 3) Same sex, neutral feeling 4) Opposite sex, liked 5) Opposite sex, disliked 6) Opposite sex, neutral. The subject was also encouraged by prompts and reinforcements to respond. For this study, the neutral feeling category was omitted, the subject was required to respond in writing instead of verbally and no prompting or reinforcement was given. These revisions were made on recommendation by Bilsbury, based upon his previous experiences with the original test (Bilsbury, personal communication).

The results of the Socialization Scale supports the hypothesis. Subjects in the experimental group obtained significantly lower scores than the control group indicating they are deficient in role-taking ability while the control group obtained normal scores.

The results obtained with the Meta-Impression Test (M.I. Test) were puzzling as it seemed to have high face validity. It was expected that the control group would perform better on this test than the experimental group. While this was true, for the test as a whole, the results were not significant. The sub-tests were then examined and a significant difference was found on sub-scales 1 and 4. It appeared that both groups of patients had difficulty in interpreting negative feelings. This problem did not appear in the pilot study where non-psychiatric patients volunteered to do the questionnaire. It is possible that psychiatric patients, in general, have difficulty in interpreting the opinion of people who do not get along well with them. The impression was gained that more intelligent people seem to do better on the test. However, the overall correlation between M.I. Test and intelligence was not significant (0.30).

Because of the results obtained on the M.I. Test in this study, the term 'person perception' cannot be regarded as synonymous with 'role-taking'. The correlations between the Socialization Scale and the Meta-Impression Test was +0.25. Since the So Scale is a powerful test, it seems likely that the source of error lies within the M.I. Test. It was found that some subtests measure role-taking while others do not. Therefore, the design of the test seems to generally be inadequate for measuring role-taking. Both groups showed difficulty on subtest 2- man who dislikes- indicating that maybe the subtest was too difficult. Also the method of administration may account for the insignificance of the test to measure role-taking. The test had written

instructions only and the subjects were not given any verbal instructions to reinforce this. It was entirely the person's own decision whether or not she even wrote a response to the questions. Since the test does require that a person give some thought to the questions asked, maybe the patients felt more threatened in answering in their own words rather than completing a 'true' or 'false' questionnaire like the So Scale. Lastly, there may have been biases from the two male raters who attempted to judge the responses of female subjects. One or any combination of the above may account for the low correlation between the two tests.

Since there is a significant finding on the Socialization Scale and due to its established validity and reliability, it can be said that the experimental group is deficient in role-taking even if the M.I. Test results were inconclusive. The experimental group obtained very low scores, comparable to norms set forth for prison inmates or youth authority cases in the California Personality Inventory Manual. The control group obtained normal response scores which can be compared to norms set forth for high school 'best citizens' or college students. According to the California Personality Inventory Manual, people who score high on the So Scale are seen as: serious, honest, industrious, modest, obliging, sincere, and steady; as being conscientious and responsible and as being self-denying and conforming people. Low scorers tend to be seen as: defensive, demanding, opinionated, resentful, stubborn, headstrong, rebellious, and undependable; as being guileful, and deceitful in dealing with others;

and as given to excess, exhibition and ostentation in their behaviour. These traits noted in low scorers could result from being deficient in role-taking ability. It was noted that the lowest scorers on the So Scale among both groups also obtained low scores on the M.I. Test indicating that possibly lower scorers cannot write an account of what others feel about them moreso than those who scored higher, although it was not attempted to measure this finding.

Implications for Future Treatment and Research

This study has shown that histrionic personalities show deficiencies in role-taking ability. If this finding were to be confirmed, it would suggest possibilities for improved diagnosis as well as for treatment of this disorder. The Socialization Scale has potential value as an indicator of hysterical traits in depressed women as well. It would seem particularly worthwhile to try to teach role-taking skills to histrionic personality disordered people. A possibility would be to teach socialization skills through group therapy. This may work for the patient whose disorder has not become limiting to her. For the more severe cases, long term psychoanalysis with a focus on interpersonal relationships might be an important approach. In practise sessions, the patient could be taught effective techniques of communicating to improve relationships with others.

It now seems important to determine whether role-taking deficiencies are found in all or only some personality disorders and to look for role-taking deficiencies in psychiatrically healthly people.

Ferguson (1979) compared role-taking ability in psychiatric versus medical patients and found no significant difference in the two groups. He indicated that there was no significant effects of psychiatric status on role-taking scores.

Criticism of Study

A possible criticism of the study is in the selection of experimental subjects. While histrionic traits were eliminated form the depressed group, the existence of depression was not checked in the histrionic group as the available literature on role-taking did not suggest the need to control for the presence of depression before the study began. Moreover, the high scores of the Beck Depression Inventory were not anticipated. Slavney and McHugh, (1974) showed that the majority of patients admitted with hysteria have an admitting diagnosis of depression, a finding which receives support from the present study. While it would probably not be feasible to omit all patients with depression from such a study, greater allowance should be made for the influence of this variable in studies of hospitalized hysterics. However, the members of the experimental group did appear to be representative of inpatients given the diagnosis of histrionic personality disorder.

In the method section, the Socialization Scale was found to measure several aspects of role-taking as well as socialization. To further strengthen this test, for future research, the items pertaining to role-taking only might be extracted from the scale and used to test role-taking ability.

While the experimental group was given the diagnosis histrionic personality disorder which is categorized as a "personality disorder diagnosis", the control group held an "illness diagnosis" namely depression. However, the control group were seen just prior to discharge and it was assumed that their illness at this time should be at a minimal level. Even though the group obtained high Beck Depression Inventory scores, their responses on the Socialization Scale were normal.

The results of the M.I. Test might have been strengthened if it had been used in its original format instead of being modified. It seems that administering the test verbally may be much more effective since the subject is more directly approached and may be given prompting to answer. Also, tape recording the subject's responses seems to provide a more objective approach for scoring than the method used in this study. These may be the key changes necessary for this test to attain its full potential.

The rating scale of the M.I. Test had a three point rating system, where '0' meant absence of role-taking, '1' meant a good/bad limited response and '2' meant role-taking ability. When the raters were debriefed, it was revealed that for '1' on this scale, one rater felt it meant the subject lacked role-taking, the other interpreted it as indicating that role-taking ability was present. Even though there was satisfactory rater reliability, this difference in opinion emphasizes the need to reduce the scale to a two point scale having '0' meaning absence of role-taking. This would be where the subject could not answer the question or answers it irrelevant to what was asked. e.g. Describe

what a man who likes you thinks of you as a person. Response: He is a good man and we like each other a lot. Here, the subject is obviously missing the point of the question and has instead given her opinion on the other person. This would warrant a score of '0'. On the two point scale, '1' would indicate the presence of role-taking.

e.g. Describe what a man who likes you thinks of you as a person.

Response: 1. He thinks I am good and a considerate person.

or 2. He sees me as a very compassionate person. He knows that he can count on me whenever he needs me. He feels I am trustworthy.

In the first example of role-taking, a limited response has been given but it still indicates that the person has interpreted the question correctly and the description is appropriate. The #2 example shows a more sophisticated role-taking response, but in the two point system, both would be given a score of '1' indicating presence of role-taking. This could possibly make the scoring more reliable. If the test were to be administered verbally, a rating scale such as this could still be employed but it then would be based on more direct observation.

SUMMARY AND CONCLUSIONS

An investigation of 'role-taking' in a representative sample of women with histrionic personality disorder produced evidence of a role-taking deficiency. The Socialization Scale produced the most significant data clearly discriminating between the two groups studied. The control group of women treated for depression demonstrated normal role-taking.

The Meta-Impression Test did not yield significant results overall. However, analysis of its sub-tests suggested that the instrument has potential as a clinical measure of role-taking.

According to the literature, much has been written about role-taking ability as it relates to the development of a child but a limited amount has been written about role-taking and the adult. The role-taking concept has established itself as being vital in normal maturation and in the development of socialization skills. It seems that it is now important to devote more time to the adults in which this ability has not developed, to discover why, and to research ways to develop the ability which has made the person deficient in social interaction.

BIBLIOGRAPHY

BIBLIOGRAPHY

Beck, A.T.; Ward, C.H.; Mendelson, M; Mock, J. and Erbauch, J.H. "An Inventory for Measuring Depression." Archives of General Psychiatry. 4 561-571. 1961.

Bilsbury, C. "The Processes of Meta-Impression Formation in Personality Disordered Patients with Severe Difficulties in Interpersonal Relationships." M. Phil. Thesis, University of London, 1978.

Blumer, Herbert. Symbolic Interactionism Perspective and Method. published by Prentice-Hall, Inc. 1969.

Bromley, D.B. Personality Description in Ordinary Language. Wiley & Sons, Inc. 1977.

Chandler, M.J. "Egocentrism and antisocial behavior. The assessment and training of social perspective-taking skills." Developmental Psychology. 9 326-332. 1973.

Chandler, M.J.; Greenspan, S.; and Barenboim, C. "Assessment and Training of Role-Taking and Referential Communication Skills in Institutionalized Emotionally Disturbed Children." Developmental Psychology. 10:4; 546-553. 1974.

Cleckley, H. The Mask of Sanity. 5th edition. St. Louis, Mo.: Mosby, 1976.

Clononger, R.; Reich, T. and Guze, S.B. "The Multifactorial Model of Disease Transmission: Familial Relationship between Sociopathy and Hysteria (Briquet's Syndrome)." British Journal of Psychiatry. 127 23-32. 1975.

Chodoff, P. "Hysteria and Women." American Journal of Psychiatry. 139:5 545-551. 1982.

_____. "The Diagnosis of Hysteria: An Overview." American Journal of Psychiatry. 131:10 1073-1078. 1974.

Feffer, M.H. "A developmental analysis of interpersonal behavior." Psychological Review. 77 197-214. 1970.

_____. "The cognitive implications of role-taking behavior." Journal of Personality. 27 152-168. 1959.

Feffer, M. and Gouvrevitch, V. "Cognitive aspects of role-taking in Children." Journal of Personality. 20:383-396. 1960.

Feffer, M. and Suchotliff, L. "Decentering implications of social interactions." Journal of Personality and Social Psychology. 4 (4) 415-422. 1966.

Ferguson, B. "Hospitalized Adults' Role-Taking Ability, Psychiatric Status and Reported Symptomatology." Psychological Reports. 44 319-324. 1979.

Flavell, J.H. The Development of Role-Taking and Communication Skills in Children. Wiley and Sons, Inc. 1968.

Forrest, A.D. "The differentiation of hysterical personality from hysterical psychopathy." British Journal of Medicine and Psychology. 40-65. 1967.

Freedman, A.M.; Kaplan, H.I.: Sadock, B.J. Modern Synopsis of Comprehensive Textbook of Psychiatry/II. The Williams and Wilkins Co., Baltimore. 1975.

Gough, H.G. "A Sociological Theory of Psychopathy." American Journal of Sociology. 53 359-366. 1948.

_____. Manual for the California Psychological Inventory. Consulting Psychologists Press, Inc. California. 1975.

Gough, H.G. and Peterson, D.R. "The Identification and Measurement of Predispositional Factors in Crime and Delinquency." Journal of Consulting Psychology. 16. 207-212. 1952.

Guze, S.B. "The Validity and Significance of the Clinical Diagnosis of Hysteria (Briquet's Syndrome)." American Journal of Psychiatry. 132:2 138-141. 1975.

Hare, R.D. Psychopathy: Theory and Research. New York: Wiley. 1970.

Henderson, S. "A Development in Social Psychiatry, The Systematic Study of Social Bonds." The Journal of Nervous and Mental Diseases. 168-2, 63-68. 1980.

Horowitz, M.J. Hysterical Personality. Jason Aronson, Inc. New York N.Y. 1977.

Jaspers, K. General Psychopathology. University of Chicago Press, Chicago, 1963.

Keller, M. "Development of Role-Taking Ability-Social Antecedents and Consequences for School Success." Human Development. 19:120-132. 1976.

Kitano, M; Stiehl, J. and Cole, J.T. "Role-Taking: Implications for Special Education." The Journal of Special Education. 12:1 59-74. 1978.

Laing, R.D.; Philipson, H; and Lee, A.R. Interpersonal Perception. London: Tavistock. 1966.

Lazare, A.; Klerman, G.L.; and Armor, D.J. "Oral, obsessive and hysterical personality patterns." Archives General Psychiatry. 14 624. 1966.

Lion, J.R. Personality Disorders Diagnosis and Management. The Williams and Wilkins Company, Baltimore. 1974.

Livesley, W.J. and Bromely, D.B. Person Perception in Childhood and Adolescence. John Wiley and Sons, Inc. 1973.

Manual of International Statistical Classification of Diseases, Injuries and Causes of Death, ninth revision. 1975.

Mai, F.M. and Merskey, J. "Briquet's Concept of Hysteria- An Historical Perspective." Canadian Journal of Psychiatry. 26 57-63. 1981.

Mead, G.J. Mind, Self, and Society. The University of Chicago Press, 1934. edited by Charles W. Morris. 1962.

Piaget, J. The Psychology of Intelligence. New York; Harcourt Brace. 1950.

Rabins, P.V. and Slavney, P.R. "Hysterical traits and variablity of mood in normal men." Psychological Medicine. 9 301-304. 1957.

Reed, C.F. and Cuardra, C. "The Role-Taking Hypothesis in Delinquency." Journal of Consulting Psychology. 21:5 386-390. 1957.

Rosen, A. and Schalling, D. "On the Validity of the California Psychological Inventory Socialization Scale: A Multivariate Approach." Journal of Consulting and Clinical Psychology. 42:6 757-765. 1974.

Rosen, A. "On the Dimensionality of the California Psychological Inventory Socialization Scale." Journal of Consulting and Clinical Psychology. 45 4 583-591. 1977.

Roscoe, J.T. Fundamental Research Statistics of the Behavioral Sciences. Holt, Rhinehart, and Winston, Inc. New York. 1969.

Schalling, D. "Psychopathy- Related Personality Variables and the Psychophysiology of Socialization." Psychopathic Behavior: Approaches to Research. ed. Hare and Schalling. John Wiley and Sons, Chichester. 1978.

Schneider, K. Psychopathic Personalities. Univeristy of Manchester. 1949.

Selman, R.L. and Byrne, D.T. "A structural-development analysis of levels of role-taking in middle childhood." Child Development. 45 803-806. 1974.

Slavney. P.R. and McHugh, P.R. "The Hysterical Personality- A Controlled Study." Archives of General Psychiatry. 30 325-329. 1974.

Spalt. L. "Hysteria and Antisocial Personality: A Single Disorder." The Journal of Nervous and Mental Disease. 168-8 456-464. 1980.

Spielberger, C.D.; Kling, J.K. and O'Hogan, S.E.J. "Dimensions of Psychopathic Personality: Antisocial Behaviour and Anxiety." Psychopathic Behaviour: Approaches to Research. ed: Hare and Schalling. John Wiley and Sons, Chichester. 1978.

Stangler, R. and Printz, A.M. "DSM-III: Psychiatric Diagnosis in a University Population." American Journal of Psychiatry. 137:8 937-950. 1980.

The Diagnostic and Statistical Manual of Mental and Nervous Diseases. third edition. 1981.

Trower. P.; Bryant, B. and Argyle, M. Social Skills and Mental Health. University of Pittsburgh Press. 1978.

Tupin, J.P. "Hysterical and Cyclothymic Personalities." Personality Disorders. ed. J. Lion. Williams/Wilkins. New York. 1974.

_____. "Histrionic Personality." Personality Disorders: Diagnosis and Management. ed. J.R. Lion. Williams and Wilkins, Baltimore/London. 1981.

Urbain, E.S. and Kendall, P.C. "Review of Social- Cognitive Problem-Solving and Interventions with Children." Psychological Bulletin. 88:1 109-143. 1980.

Van Den Berg, P.J. and Helstone, F.S. "Oral, Obsessive, and Hysterical Personality Patterns: A Dutch Replication." Journal Psychiatry Res. 12 319-327. 1975.

Walton, H.J.; Foulds, G.A.; Littman, S.K. and Presly, A.S. "Abnormal Personality." British Journal of Psychiatry. 116 497-510. 1970.

Warner, R. "The diagnosis of anti-social and hysterical personality disorders." Journal of Nervous and Mental Disorders. 166: 839. 1978.

Woerner, P.I. and Guze, S.B. "A Family and Marital Study of Hysteria." British Journal of Psychiatry. 114 161-168. 1968.

Ziskind, E. "The Diagnosis of Sociopathy." Psychopathic Behavior: Approaches to Research. ed: Hare and Schalling, John Wiley and Sons, Chichester. 1978.

APPENDIX A

CONSENT FORM

The purpose and nature of the study have been fully explained to me by Dr. (name of clinical investigator).

I understand that my participation in the study is entirely voluntary and that I may withdraw from it at any time without prejudice to the treatment I will receive.

I hereby consent to participate in the study.

Patient's Signature	Witnessed by
Date	
Clinical Investigator's Signature	Witnessed by
Date	

APPENDIX B

Criteria for inclusion (subjects and controls)

Subjects: Women with a diagnosis of hysterical personality disorder (Histrionic Personality Disorder, DSM III).

Controls: Women with depression (all types) who do NOT meet the criteria for diagnosis of Histrionic Personality Disorder.

Would you kindly supply the following information on discharge:

1. Discharge diagnosis
2. Note presence of 'Borderline' and/or /Narcissistic' personality traits/disorders (DSM III).

APPENDIX C

Identification:

Study number 1 - 3

Age (yrs) 4 - 5

Sex 6

Clinical data:

Family history:

No of sibs 7 - 8

Birth order 9 - 10

1st. degree relative with history of

suicide 11

suicide attempt 12

imprisonment 13

psychosis 14

alcoholism 15

one or both parents mentally ill 16

Developmental history:

Cogenital syndrome or birth injury 17

Delayed milestones 18

Neurotic symptoms in childhood 19

(Describe)

Behaviour disorder in childhood 20

(Describe)

Highest educational attainment 21

1. Under high school. 2.H.S. 3.Completed H.S. 4.Post-secondary

Work record - Never had regular employment 22

Work instability 23

More than one job past year 24

Present status: 25

1.Employed or H/W. 2.Unemployed

(2)

Marital Status:

(1) Married or widowed; (2) Single or separated 26

Number of times married 27

Psychosexual history: Sexual dysfunction 28

(Describe)

Sexual deviance 29

(Describe)

No. of pregnancies 30

Pre-menstrual syndrome 31

Therapeutic abortion 32

Sterilization 33

Hysterectomy 34

Medical History:

Psychiatric: No. of admissions 35-6

No. of suicidal attempts 37-8

Methods used in suicidal attempts:

overdose 39

cut wrists 40

other self-mutilation 41

Hanging or choking 42

Lethability of suicide attempts 43

(1) low (2) moderate (3) high

Parasuicide* 44

History of dissociative reaction 45

History of conversion reaction (specify) 46

History of psychogenic pain 47

History of somatization disorder (DSM III) 48

History of factitious disorder 49

(3)

History of unipolar affective disorder [ ] 50
History of bipolar affective disorder [ ] 51
History of depressive reaction [ ] 52

History of other psychosis(specify) [ ] 53
History of other non-psychotic disorder (specify) [ ] 54

Drinking status: [ ] 55

(1) non-drinker; (2) social; (3) excessive; (4) alc.addict; (5) chr.alcohol

Drinks because of social pressure [ ] 56
Finds alcohol increases sociability [ ] 57

Drug abuse - medical (specify) [ ] 58
- non-medical [ ] 59

Medical history:

CNS disorder (specify) [ ] 60
Sensory impairment (specify) [ ] 61
EEG: [ ] 62
(1)normal; (2)borderline; (3)abnormal

Personality: Self-description: Enjoys relationships [ ] 63
Self-confidence rating(-low;-5(high)) [ ] 64
Dependent [ ] 65
Empathy rating((cold)-5(romantic) [ ] 66
Lability of mood [ ] 67
Overdramatization [ ] 68

Observation** Relationships few [ ] 69
Relationships superficial [ ] 70
Relationships inappropriate(specify) [ ] 71
Dependent [ ] 72
Emotionally labile [ ] 73

**Includes information from informants, if available

Personality: Observations:

Exaggeration/over-dramatization		74
Dissociation		75
Denial		76
Hostile affect		77
Impulsivity		78
Grandiosity		79
Exploitative/manipulative		80
Other traits (describe)		81

Discharge diagnosis (DSM III)

Axis I		82-6
Axis II		87-91
Axis III		92
Axis IV		93
Axis V		94
Borderline features noted		95
Narcissistic features noted		96

Treatment given (present admission)

ECT		97
TCA		98
MAOI		99
Benzodiazepine		100
Neuroleptic		101
Lithium		102
Psychotherapy-Individual		103
Group		104
Conjoint		105
Behavioural		106

APPENDIX D

Please answer TRUE or FALSE to the following:

T	F	1.	I often feel that I made a wrong choice in my occupation.
T	F	2.	When I was going to school I played hooky quite often.
T	F	3.	I think Lincoln was greater than Washington.
T	F	4.	I would do almost anything on a dare.
T	F	5.	With things going as they are, it's pretty hard to keep up hope of amounting to something.
T	F	6.	I think I am stricter about right and wrong than most people.
T	F	7.	I am somewhat afraid of the dark.
T	F	8.	I hardly ever get excited or thrilled.
T	F	9.	My parents have often disapproved of my friends.
T	F	10.	My home life was always happy.
T	F	11.	I often act on the spur of the moment without stopping to think.
T	F	12.	My parents have generally let me make my own decisions.
T	F	13.	I would rather go without something than ask for a favor.
T	F	14.	I have had more than my share of things to worry about.
T	F	15.	When I meet a stranger I often think that he is better than I am.
T	F	16.	Before I do something I try to consider how my friends will react to it.
T	F	17.	I have never been in trouble with the law.
T	F	18.	In school I was sometimes sent to the principal for cutting up.
T	F	19.	I keep out of trouble at all costs.
T	F	20.	Most of the time I feel happy.
T	F	21.	I often feel as though I have done something wrong or wicked.
T	F	22.	It is hard for me to act natural when I am with new people.

T	F	23.	I have often gone against my parents' wishes.
T	F	24.	I often think about how I look and what impression I am making upon others.
T	F	25.	I have never done any heavy drinking.
T	F	26.	I find it easy to "drop" or "break with" a friend.
T	F	27.	I get nervous when I have to ask someone for a job.
T	F	28.	Sometimes I used to feel that I would like to leave home.
T	F	29.	I never worry about my looks.
T	F	30.	I have been trouble one or more times because of my sex behaviour.
T	F	31.	I go out of my way to meet trouble rather than try to escape it.
T	F	32.	My home life was always very pleasant.
T	F	33.	I seem to do things that I regret more often than other people do.
T	F	34.	My table manners are not quite as good at home as when I am out in company.
T	F	35.	It is pretty easy for people to win arguments with me.
T	F	36.	I know who is responsible for most of my troubles.
T	F	37.	I get pretty discouraged with the law when a smart lawyer gets a criminal free.
T	F	38.	I have used alcohol excessively.
T	F	39.	Even when I have gotten into trouble I was usually trying to do the right thing.
T	F	40.	It is very important to me to have enough friends and social life.
T	F	41.	I sometimes wanted to run away from home.
T	F	42.	Life usually hands me a pretty raw deal.
T	F	43.	People often talk about me behind my back.
T	F	44.	I would never play cards (poker) with a stranger.

T F 45. I don't think I'm quite as happy as others seem to be.

T F 46. I used to steal sometimes when I was a youngster.

T F 47. My home as a child was less peaceful and quiet than those of most other people.

T F 48. Even the idea of giving a talk in public makes me afraid.

T F 49. As a youngster in school I used to give the teachers lots of trouble.

T F 50. If the pay was right I would like to travel with a circus or carnival.

T F 51. I never cared much for school.

T F 52. The members of my family were always very close to each other.

T F 53. My parents never really understood me.

T F 54. A person is better off if he doesn't trust anyone.

APPENDIX E

Code: _____ M.I. Test Page 1.

Question 1: The initials of a man who gets along well with me are:

Now, write in the space below, what you believe he thinks about you, as a person. Try and give as good a description as you can.

Question 2: The initials of a man who doesn't get along well with me are:

Now, write in the space below, what you would imagine he thinks about you, as a person.

Question 3: The initials of a woman who gets along well with me are:

Now, write in the space below, what you would imagine she thinks about you, as a person.

Question 4: The initials of a woman who doesn't get along with me are:

Now, write in the space below, what you would imagine thinks about you, as a person.

APPENDIX F

RATING SCALE FOR M. T. TEST

	#1			#2			#3			#4				
SUBJECT	Rating 0	1	2	Rating 0	1	2	Rating 0	1	2	Rating 0	1	2	2**	COMMENTS

RATING:

0 = UNABLE TO ATTEMPT TASK OR ATTEMPTS TASK BUT ANSWERS INAPPROPRIATELY
1 = ANSWERS APPROPRIATELY BUT WITH A GOOD/BAD LIMITED ANSWER
2 = HAS ROLE-TAKING ABILITY

APPENDIX G

BECK'S DEPRESSION INVENTORY

A.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
B.	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
C.	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failure.
	3	I feel I am a complete failure as a person.
D.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
E.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
F.	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
G.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
H.	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
I.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
J.	0	I don't cry any more than usual.
	1	I cry more than usual.
	2	I cary all the time now.
	3	I used to be able to cry, but now I can't cary even though I want to.
K.	0	I am no more irritated now than I ever am.
	1	I get annoyed or irritated more easily than I used to.
	2	I feel irritated all the time now.
	3	I don't get irritated at all by the things that used to irritate me.
L.	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all my interest in other people.

M.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all any more.

N.
0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

O.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

P.
0 I can sleep as well as usual.
1 I don't sleep as well as usual.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

Q.
0 I don't get more tired than usual.
1 I get more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

R.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all any more.

S.
0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less.

YES_____ NO _____

T.
0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot thing about anything else.

U.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex than I used to be.
3 I have lost interest in sex completely.