The Mental Patient as Machiavellian: An Exploratory Study

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THE MENTAL PATIENT AS MACHIAVELLIAN:
AN EXPLORATORY STUDY

by

Louise B. Leader

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Master of Arts

Western Michigan University
Kalamazoo, Michigan
April 1973
A basic question in the study of mental illness has been whether mental patients were victims of society or manipulators of their own careers. Four hypotheses were developed to investigate the manipulative aspect of this question. Patients were selected from three different mental institutions: a state hospital, a Veterans' Administration Hospital, and a private church-related hospital. The patients' records and a group-administered battery of test instruments provided the data used to test the hypotheses. Only one of the hypotheses was supported and the basic question remained unanswered. Lack of support for the remaining three hypotheses was not seen as conclusive refutation. Recommendations were offered to make future research more responsive to the peculiarities of the mental hospital environment and, hopefully, successful in resolving the basic issue.
ACKNOWLEDGEMENTS

The directors and other personnel of the institutions studied offered encouragement and easy access to data during the course of this investigation. The Medical Records staff of the Veterans' Administration Hospital, in particular, were helpful far beyond the call of duty. I wish it were possible to name all these persons and to thank them publicly; however, the preservation of hospital anonymity precluded this. Nonetheless, it should be understood that without their continued support this thesis would have been impossible.

Dr. Morton O. Wagenfeld, committee chairman, deftly guided all stages of this study, clarified the cloudy, insisted upon justification for every flight into the realm of possibility, and always provided a sympathetic ear. Mr. Robert Wait, second member of the committee, could always be depended upon for perceptive and helpful comments. His critical reviews unerringly identified those areas where my confidence was most lacking. Together, both members were constructive and kind. However, the shortcomings of this thesis, as well as its conclusions, lie at my door and not theirs.

It would be remiss not to acknowledge the assistance of Mr. Richard Houchard of the Western Michigan University Computer Center. His aid in traversing the labyrinth of computer usage and his skill in program writing were invaluable.

Finally, my most sincere and heartfelt thanks go to my
husband and my father, who know the reasons why.

Louise B. Leader
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CHAPTER 1

REVIEW OF THE LITERATURE

Mental illness and its ramifications have been the object of attention from philosophers, scientists and the "common man" for many years. However, the years since World War II have marked an increasing acceptance of the broad scope of the problem. London (1969:34) offered an omnibus statement that "Mental illness, perhaps always the vaguest of ailment classifications, has now become the broadest as well, gradually incorporating virtually any kind of personal ineffectiveness or disorder of character." Dr. David Rosenthal of NIMH (1972:A16) inferred from 1967 government statistics that "there is growing evidence that 'almost no family in the nation is entirely free of mental disorders'." Other data has suggested that some 60 million Americans may be borderline schizophrenics (Carey, 1972:A16), functioning within society in an impaired fashion. State institutions in the United States cared for some 570,000 mentally ill early in 1972 (Rensberger, 1972:35), while Veterans Administration facilities and private institutions labored to meet the needs of those seeking their aid.

Clearly, both economic and social costs attended the hospitalization of mental patients. In addition to the cost of maintenance for
hospitals and the personnel to staff them, there was the loss of the individual's productive and earning power for both the family and the community. The family group also suffered the rupture of its unity with attendant emotional strain and role disruption. Attempts to meet these problems have resulted in increased emphasis being placed on programs which treat patients intensively and move them out of the hospital and back into the community as rapidly as possible. Community mental health centers and outpatient clinics mushroomed to meet the needs of prevention/intervention programs. Nonetheless, it was difficult to keep from being overwhelmed.

Despite increased attention to the problem, available information has shown that not all persons who exhibited symptoms of mental illness were treated or hospitalized. The Midtown Manhattan study (Langner and Michael, 1963:76) reported that approximately 80% of its sample population exhibited at least one psychiatric symptom. Leighton's Stirling County study (1963:125) estimated 69% of its sample to be mentally ill. Pasmanick's data (1966:48-49) allowed the inference that for every case treated, there were 14 more untreated in the outside community.

How and why individuals became mental patients was one of the most intensively investigated areas in the past decade of sociological thought. The fundamental issue appeared to be whether the person who became a mental patient was the victim of physical and/or social
forces over which he had no control, or whether some degree of voluntarism was discernible.

Opinion has seemed to favor the victim designation, with labeling the foremost process. Sarbin (1969), Scheff (1966), Szasz (1970), and Goffman (1961) have offered arguments for the existence of labeling in their studies although their descriptions of the prepatient career differed somewhat in points of reference. They were in agreement, however, upon the minimal control the individual could exercise. Scheff (1966:129) stated that "the status of the mental patient is more often an ascribed status, with conditions for status entry and exit external to the patient, than an achieved status with conditions for status entry dependent upon the patient's own behavior."

Evidence for voluntarism has appeared in studies of the hospital careers of mental patients. Although some reports of precommitment behavior have raised the suspicion of a desire for hospitalization, empirical data from within the institutions themselves has most strongly buttressed this viewpoint. Ludwig and Farrelly (1967), Nadler et al (Winter 1966-Autumn 1967), Fontana et al (1968), and Braginsky et al (1969) have all cited evidence incongruent with the view of the mental patient as apathetic, helpless, and hopeless. In their classic study, Stanton and Schwartz (1954:167-170) summed up the traditional view of mental patients as follows: "To be a mental patient means to feel removed from the human race and to view
oneself as not quite human; it means the inability to think or to trust one's thoughts... to accept, at least externally, (one's) removal from society upon the judgment of others... to act (knowing) that (one) is entirely dependent upon strangers... (to) submit in some way to the power of the staff." Note how strongly this contrasted with Ludwig and Farrelly's (1967:5) unequivocal statement that "obviously we were not dealing with a group of fragile, broken-spirited persons but rather with tough, formidable adversaries who were 'pros'."

The investigation undertaken for this thesis evolved from the investigator's view that the mental patient's career was probably a mix of both orientations. He was removed from his normal environment and was the object of the ministrations and decisions of others. However, portraying him as defeated and helpless was neither necessary nor inevitable. The specific study reported here involved an investigation of one possible construct underlying the voluntarism viewpoint. First, however, a consideration of the rationale for victim and volunteer seemed in order.

The mentally ill person has typically been seen as the victim of a disease or some ramification of the labeling process. Where disease was posited, the family in conjunction with the physician ordinarily acted as prime agents in channeling the individual from the community into the hospital. Labeling, on the other hand, has been much more a function of the person's social environment. Mechanic
(1968:197) suggested that members of the primary group look for shared meanings in the individual's acts. They try to assume the role of the deviant member in order to understand his behavior. If they fail in this attempt, they are likely to label the member as insane. Blum was quoted by Cumming (1963:14) to the effect that "only in the final step of the social process of becoming a patient does a psychiatrist and perhaps an institution enter in, usually to concur in the lay judgment and to assign a diagnostic tag in accordance with the formal patient role."

Why society has found labeling a useful process warrants a comment in passing. Szasz (1970:210) characterized the mentally ill person as "a person who fails, or refuses, to assume a legitimate social role. This is not permitted in our culture, nor, for that matter, in any other culture. A person unclassified is unpredictable and not understandable, and hence a threat to the other members of society."

"Any classification, even a false one, promises hope of successful mastery; on the other hand, the lack of classification requires the admission of helplessness" (Szasz, 1970:198).

The pervasive power of the classification was neatly delineated by Sarbin (1969:10-11). "Every metaphor is potentially rich in connotations; each connotation is potentially rich in implications, each implication is a directive to action." "The assignment of a person to the class 'mentally ill' is its own warrant for decisions related to
management and treatment." Put very simply, sticks and stones notwithstanding, names do hurt.

Several current orientations have been associated with the general process of labeling. Sarbin saw it as a step toward the degradation of social identity. He held that the person who violated the requirements of his ascribed role risked being negatively valued and labeled. The negative responses of others to the label served to restrict his opportunities for roles which incorporated choice and reduced his social network to persons who faced the same limitations. Outlets for frustration reduction were narrowed and release activities became more intense. The label and the narrowed area of personal control combined, in Sarbin's view, to create the identity of a non-person, a degraded social being. The victim was then a prime candidate for the "diagnosing, judging, helping, and treatment facilities usually called 'mental health services'" (Sarbin, 1969:27).

Goffman (1961:139) recognized that there were wide variations in degree and kind of illness exhibited by persons who became mental patients. He felt, however, that they were faced by similar circumstances and steps on their way to hospitalization. These included an offense to face-to-face living, a complainant who initiated some sort of recorded action, career contingencies which might influence considerations and decisions at any point in the process, and a sense of alienation in the person based upon a feeling of betrayal by those
closest to him. Emphasis on career contingencies, a betrayal funnel, and the retroactive character of the prepatient's career were distinctive highpoints in Goffman's orientation.

Reconsideration of Rosenthal's statement at the beginning of this paper, and the data from the studies on Midtown, Stirling County, etc., provided a backdrop for the suggestion that "in the degree that the 'mentally ill' outside hospitals numerically approach or surpass those within hospitals, one could say that mental patients distinctively suffer not from mental illness, but from contingencies" (Goffman, 1961:135). These contingencies, which included socio-economic status, the visibility of the offense, the type of hospital facilities available and community attitude toward them, as well as family willingness to tolerate deviance, and employment after hospitalization, influenced whether a person was labeled mentally ill, whether he was hospitalized, and whether he was finally discharged.

Kitsuse (1968:51) also recognized these contingencies in his statement that "in modern society, the socially significant differentiation of deviants from the non-deviant population is increasingly contingent upon circumstances of situation, place, social and personal biography, and the bureaucratically organized activities of agencies of control." Both Goffman and Kitsuse clearly outlined their contingencies as operating upon the person rather than initiated or directed by him.
Goffman's betrayal funnel was another blow to the prepatient. It stemmed from the enlistment of a "next of relation" to help facilitate the person's movement into the hospital. Goffman assumed that the feeling that there was a supportive ally helped to minimize objections as unfamiliar agents and agencies were introduced into the situation and the individual was progressively stripped of his rights and liberties. The reality of hospitalization, however, served to fuse previous anxieties and confusions into a sense of betrayal and alienation. The patient had bargained in good faith but those on whom he relied had not.

The rationale for commitment to a hospital required an aura of coherent legitimacy so that the patient, staff, and agents or agencies involved could recognize and affirm it. The retroactive character of the prepatient career was essential here. According to Goffman (1961:145), "the fact of having had a prepatient career, starting with an effective complaint, becomes an important part of the mental patient's orientation, but this part can begin to be played only after hospitalization proves that what he had been having, but no longer has, is a career as a prepatient." The retroactive career which the patient did not control affirmed the legitimacy of his commitment which he could not control.

Szasz objected strongly to the labels of insanity and mental illness. He felt that these labels removed control over their lives from
the individuals involved. He claimed that such persons "have been robbed of their rights and powers to clarify themselves or others, and have been treated solely as the objects of classification by society, and especially by alienists, psychiatrists, and psychoanalysts" (1970: 53). Those classified as mentally ill were viewed by society as unable to defend themselves, of impaired capabilities, and requiring the help of outside agents (psychiatrists). In this position the role of patient could be assigned rather than assumed since it was clearly in the best interests of the individual and the society.

Szasz disputed the contention that the interests of the individual lay in preventing him from facing and dealing with his "problems in living." He said that society acted to prevent disruption to itself rather than to seek what was best for the individual. Deviance was considered within specific social and ethical contexts, and hospitalization was viewed as an opportunity to help the patient restructure his misunderstanding of appropriate social interaction and to reshape him to the acceptable mold.

Gralnick and D'Elia (Winter 1967-Autumn 1968:110) concurred with this view when they said "As the healthiest and most knowledgeable segment of the hospital community, the responsibility will fall largely to the medical team to define the healthy limits of feeling, thought and action." Sall et al (1966:22) were even more explicit. "The measuring stick for discharge in practically every public hospital
that cares for large numbers of patients was, and still remains, ability to handle one's self in a manner acceptable to the mores of the family and community from which the patient comes." In no sense was the issue a matter of what the patient saw as desirable. He could only "win" and regain some measure of self control when he accepted that he was ultimately under the control of others.

Scheff, like Goffman, found the question of who was labeled of great interest. He contributed a discussion of the concept of residual rule-breaking vs. the label of deviance. His framework conformed to Becker's distinction between rule-breaking and deviance, which saw the former as "a class of acts, violations of social norms," (Scheff, 1966:33) and the latter as "particular acts which have been publicly and officially labeled as norm violations" (Scheff, 1966:33). Residual rule-breaking covered norms governing decency and reality whose violation was unthinkable. The consequence of such violation was labeling as an "outsider" with the associated presumed loss of the "humanness" which accrued to group members. A person relegated to this category was seen as onewhom others should, or had to, control. Mental illness was a natural choice for this category of residual rule-breaking (Scheff, 1966:34).

Scheff (1966:40) suggested four sources for residual rule-breaking: organic, psychological, external stress, and volitional acts of innovation or defiance. In keeping with the victim viewpoint, it was
interesting to note that three of the four categories were beyond the individual's control. Scheff (1966:54) corroborated the lack of control, stating "the most important single factor (but not the only factor) in the stabilization of residual rule-breaking is the societal reaction." The labeling process was a crucial role definer for the deviant who tended to crystallize his behavior in conformity to the expectations for similarly labeled persons.

Cumming and Gruenberg both took positions on the prepatient career which stressed the impact of forces apart from individual control. Cumming (1963:9) assigned a pivotal role to the inadequacy syndrome under which symptoms of mental illness arose from an inadequate ego organization. He found that individuals in this category, whose deviance was not tolerated by their primary groups, appeared to exhibit a similar inability to obtain or keep a job, marry, or once married maintain the relationship, or to avoid difficulties with the law. These persons came to hospitalization as the result of a social expulsion process. The patient with an inadequate ego organization could not maintain himself successfully in normal social interaction and was not accepted when he tried. He required, Cumming affirmed, psychiatrically directed assistance and training for the acquisition of new skills to strengthen the ego in situations where environmental stress could not be controlled.

Gruenberg's (1967) social breakdown syndrome arose from a
situation in which the individual found discrepancies between what he was able to do and what he was expected to do. These discrepancies were blamed upon him directly rather than upon any factor in his environment. The stress engendered by this made him increasingly dependent upon outside cues for what was right or wrong and increasingly uncertain of his own ability to cope. As the situation worsened, members of his primary group recognized the existence of a problem beyond their competence and sought outside help. With this step, the individual was labeled as "different," and it became socially acceptable to see his difficulties as beyond his control. Without personal direction, the status of the individual was altered from an object of censure to an object of some compassion—and the key word was object. At the point of hospitalization, society decreed that the patient was "morally relieved of responsibility for his own failures at the price of being identified as one suffering from a condition which makes his own impulses, thoughts, and speech largely irrelevant to any practical activities of daily life" (Gruenberg, 1967:1484).

Even Gove, who recently questioned the whole societal reaction orientation, ignored any personal volition of the prepatient victim in his rebuttal of Scheff's and Goffman's arguments. His thesis was that "the evidence is that the vast majority of persons who become patients have a serious disturbance, and it is only when the situation
becomes untenable that action is taken. The public officials who perform the major screening role do not simply process all of the persons who come before them as mentally ill but instead screen out a large portion" (Gove, 1970:879). Although Gove said that "the evidence reviewed suggests that a person's behavior determines the expectations of others to a much greater degree than the reverse," (Gove, 1970:882), he was speaking of overt disturbed behavior rather than any form of intent.

To sum briefly, the sociologists considered to this point have viewed the prepatient career as profoundly influenced, in diverse ways, by societal reaction to deviant behavior. They have given little, if any, consideration to the possibility that the individual could exert some control or direction over what was happening to him. The mentally ill person served as the object of their study and perhaps, in this sense, to use Sarbin's term, a non-person.

Casting the mentally ill as objects or victims did not end at the hospital door. Much has been written about the effect of mental institutions on their inmates, Goffman's classic essays being perhaps the best known. Referring to the most basic levels of functioning as an unique person, he said, "On the outside, the individual can hold objects of self-feeling - such as his body, his immediate actions, his thoughts and some of his possessions - clear of contact with alien and contaminating things. But in total institutions these territories
of the self are violated; the boundary that the individual places
between his being and the environment is invaded and the embodi­ments of self profaned" (Goffman, 1961:23). Szasz (1970:126) pre­
sented the rationale for this invasion of privacy as "the basic
assumption of institutional psychiatry is that the mentally ill person
is psychologically and socially inferior to the mentally healthy. He
is like a child; he does not know what is in his best interests and
therefore needs others to control and protect him."

A polar view of the end product of this care function and per­
haps, until recently, the popular stereotype of mental patients, was
found in Barton's description of inmates: "apathy, lack of initiative,
loss of interest more marked in things and events not immediately
personal or present, submissiveness, and sometimes no expression
of feelings of resentment at harsh or unfair orders. There is also
a lack of interest in the future and an apparent inability to make prac­
tical plans for it, a deterioration in personal habits, toilet, and
standards generally, a loss of individuality, and a resigned acceptance
that things will go on as they are - unchangingly, inevitably, and in­
definitely" (Vail, 1966:141).

In few of the investigations reviewed for this present study was
the element of patient as object, if not victim, totally absent. How­
ever, the stress placed upon this viewpoint and the relative degree
of personal control accorded the patient showed considerable variation.
The four studies presented next occupied a middle ground in their view of the opportunities for an expression of patient direction and control.

Levinson and Gallagher (1964:x) defined patienthood as "a human condition, a state of being that has both situational aspects (stemming from the character of the hospital and the wider society) and interpersonal aspects (stemming from the character of the individual patient and his inner response to hospitalization)." The status of patient was defined psychiatrically and legally as someone suffering from a serious mental illness. It was defined as a client-member of the hospital and also as a category of membership in the hospital's organizational structure. It was defined, further, as a person who saw himself as ill, and was both an agent and an object of change (Levinson and Gallagher, 1964:34-35). Patienthood existed apart from any particular individual but each one in the role produced an unique interpretation.

Structuring this role allowed the patient to move from object to subject status. He himself had to determine the answers to several major questions: (1) What constituted an ideal mental hospital and an ideal patient; (2) In what ways was the hospital good or bad for him; (3) What was wrong with him; (4) What was the way to recovery; (5) What did he need in everyday hospital life; and (6) What were the other patients like (Levinson and Gallagher, 1964:218-230). The patient's
ability to carry on this type of activity did not seem to equate with Barton's apathetic, submissive, resigned reject.

Levinson and Gallagher saw hospitalized patients as responsible participants in organizational life despite limitations of personality, options, and position in the bureaucratic structure. They recognized also that the patient's goals might conflict with those of the hospital since he "may have a vested interest in maintaining those forms of behavior that cause him and others the most difficulty. They may yield important 'secondary gains'... his situation in the hospital may be so gratifying (for infantile and pathological as well as realistic reasons) that his energies are devoted more toward remaining than working for discharge to a less supportive environment." (Levinson and Gallagher, 1964:39). That the hospital would prevail over the patient in this situation was not a foregone conclusion.

Stanton and Schwartz (1954:408) described the mental hospital as having a tradition of viewing patients as nonpersons. "Built solidly into procedures, techniques, and even the language of the mental hospital is the assumption that patients are mere passive objects of treatment: they are to be 'cared for,' 'protected,' 'treated,' 'respected,' 'handled,' 'controlled.' Psychiatric administrative language consistently speaks of the patient as if he were not actively participant, as if he were an unconscious or half-unconscious body upon an operating table." In fact, as Levinson and Gallagher (1964:16) pointed out in...
regard to staff and patients, "The language of the hospital has no
word, technical or idiomatic, to embrace all who share its life and
history." Further, some common syndromes were blamed upon the
hospital as resulting from "the concurrence of particular environ­
mental circumstances and patients with particular vulnerabilities,"
(Stanton and Schwartz, 1954:343).

On the other hand, the investigators also offered evidence for
the existence of patient self control and informal social organiza­
tions. They noted that "it was common at the hospital under study
for patients to accept freedoms with the understanding with the psy­
chiatrist that, if the patient ever felt doubtful of his ability to exer­
cise them, he would report it to the nurse or the doctor so that these
freedoms might be temporarily withdrawn," (Stanton and Schwartz,
1954:259).

Patients in the Stanton and Schwartz study formed informal social
organizations, of varying duration, which afforded them some degree
of personal support as well as serving for information dissemination.
Rather than being apathetic, withdrawn, or uninterested, they mani­
fested an intense and ongoing concern with their social and physical
environment. "In their competitiveness with each other, the concern
which was uppermost was the fact that another patient was achieving
a value which they were not, rather than with the desirability of the
object itself. Such dissatisfaction was part of the general pattern of
noting, comparing, and equating the care, privileges, and values accorded each group member. This was prompted by a fear of losing out in the distribution of values," (Stanton and Schwartz, 1954:185).

It was noteworthy here that the informal organization reported by Stanton and Schwartz was recognized by them as not a new phenomenon. They cited as an example a report by Rowland in 1938 (Stanton and Schwartz, 1954:14-15) that "patients in a mental hospital organize themselves in an informal way for learning about events in the hospital, for mutual instruction on how to deal with physicians in staff conferences, on how to keep up appearance before physicians, and for other purposes related to their course in the hospital and in all likelihood to their illness." Since purposive behavior required organization, an understanding of future gains, and evaluative action; it was the province of the mental patient as subject not object.

Caudill (1958) suggested five reference points for the person entering a mental hospital: physicians, nurses and aides, physical space on the ward, other patients, himself. He observed that strongly held differences between staff as to therapeutic procedures, although not publicly voiced, resulted in a general atmosphere of unrest on the wards and in regressive behavior by many of the patients. In other words, the stability of their emotional environment was highly sensitive to the prevailing moods of their support system, the doctors,
nurses, and aides. However, with the emotional climate held constant, the patient structure could be seen operating in its own right.

Entrance into the hospital was ordinarily made in terms of a sick role; that is, a person in need of medical attention. Theoretically, there was a choice after hospitalization as to whether the patient role, which involved commitment to the institution, was accepted. The informal patient structure operated to prevent rejection of the patient role since the "different" inmate on a mental ward was as much of a disruption to the social whole as the deviant member in the larger non-hospital society. As Caudill (1958:222) said, "Patients are not simply an aggregate of individuals, but form themselves into a small society"... "They form a social group whose behavior is governed to a considerable extent by an implicit set of values that the patients have built up among themselves and which they impose on new arrivals." (Caudill, 1958:326). In return for accepting the patient role, the group offered the new inmate support in the maintenance of his personal role. Within the general limitations of the hospital situation, the inmates structured and maintained their own social environment.

Dunham and Weinberg saw the mental hospital as a network of personal relationships. "While patients, who make up a large part of this network, have various types of mental disorder, they also
have organized segments in their total personalities which enable them to communicate meaningfully and to participate socially."

(Dunham and Weinberg, 1960:8). However, both communication and participation were influenced by the nature of the institution which the investigators described as paranoid: "It is characterized by the personalized and suspicious attitude of members of the different classes, and this suspiciousness tends to take hold of the minds of new persons who are introduced into this milieu." (Dunham and Weinberg, 1960:63). The employee culture expected problems from the patients, since all behavior was seen as symptomatic of the mental condition, and maintained a system of punishments for rule-breaking. In the face of this, as one patient commented, "you soon learn what you should do and mainly what you should not do" (Dunham and Weinberg, 1960:66). Patient antagonism to the hospital redefinition of their public and private selves as insane presented a basis for collective denial and became a bulwark of the patient culture.

In general, the needs and goals of the two cultures were in opposition. The employee culture sought the complete subjugation and control of the patients. They saw them as objects to be handled with as little personal inconvenience as possible. Therapeutic methods which disturbed the smooth functioning of the wards during the "other" hours" were not valued and staff members who employed them were covertly undercut (Dunham and Weinberg, 1960:249-250).
The patient culture was divided by Dunham and Weinberg (1960:225) into four career types: disgusted departing, convalescent, institutional, and chronic. The disgusted departing considered a swift exit from the hospital as their greatest good. They attempted to assess the hospital situation quickly and accurately, and manipulated the elements to present an image of competence for discharge whether their presenting problems were resolved or not.

The convalescent patient "uses the hospital to escape from an unfriendly and hostile social environment in the outside world" (Dunham and Weinberg, 1960:217). He did not seek to incorporate himself as a worker in the hospital situation and attempted to remain uninvolved with his milieu. In this unsupported position, however, he was forced out of the hospital by his doctors and family.

The institutional and chronic patients formed the bulk of the hospital population. They presented little problem to the employee culture. They "furnish reliable workers for carrying on those activities essential to the operations of the hospital community." (Dunham and Weinberg, 1960:226). They were differentiated by the presence or absence of a settled psychosis. The institutional patient no longer presented symptoms of any abnormality but his personality had adapted to the hospital role. He knew the rules to obey and to ignore, which attendants to flatter or avoid, and how to escape conflict situations. He was "institutionally sophisticated."
Within the hospital situation, and despite the discrepancies in their ultimate goals, the patients were capable of developing and maintaining a cultural organization. "This organization functions to (a) ease their adjustment to the hospital world, (b) initiate them into the requirements and routine of hospital life, (c) protect them from the more undesirable practices of the attendant group, and (d) acquaint them with those devices and techniques which will facilitate their release" (Dunham and Weinberg, 1960:253). In connection with this latter point, the least toleration for deviance was found on the "hopeful" ward.

The dichotomous view of the patient as object and limited control agent served as a middle ground in the studies reported here. In the final investigations to be considered, the emphasis moved to more strongly underscore the possibility of voluntarism as a major element.

Nadler et al (Winter 1966-Autumn 1967) investigated patients whom they identified as choosing to live in the hospital. They felt that the "hospitalitis" syndrome developed within three to six weeks after admission, and questioned whether the hospital itself could exert sufficient influence in so brief a time to be accorded the blame for the condition. Their comparison of these patients with a group of "controls" yielded significant differences on only two attitudes: the patients avoided talking to staff or joining ward therapy groups. "By not talking to staff, 'Hospitalitis' patients reduce contact with those
who promote discharge, and as a likely consequence, reduce opportunities to be discharged. Refusing to join therapy groups may raise questions about 'Hospitalitis' patients readiness to leave, thereby decreasing the possibilities that they will even be considered for discharge. "Hospitalitis" patients make an idiosyncratic adjustment in the hospital, by creating distance between themselves and the therapeutic milieu of the hospital, and by using the open wards where they have maximum responsibility for their own behavior, to have little or no contact with the professional staff. This essentially non-interpersonal existence appears to prolong hospitalization by isolating them from the staff" (Nadler et al, Winter 1966 Autumn 1967: 156). The evidence indicated that these mental patients chose their preferred life style and carefully selected or avoided the appropriate activities to achieve it.

Bohr (1970:152), disputing the victim view of prolonged hospitalization, said that studies "indicate that mental patients do not lack the desire to 'give off' impressions in order to achieve desired ends. For example, it has been found that chronic patients avoid contact with physicians, resist rehabilitation programs, and provide 'sick' responses to attitude questionnaires, presumably in an attempt to stay hospitalized." Statements in both these studies raised the nagging question as to why any person would wish to remain hospitalized. Gordon and
Groth (1961:129) gave a provocative answer when they said, "We tend to think of the hospital as meaning control and life outside the hospital as freedom, but it may be the other way around for many rather inadequate and unambitious patients with some socially unacceptable habits."

Scheff, despite his espousal of the effect of societal reaction on the mentally ill, recognized the possibility of volitional behavior. He reported that "during the course of a study of a large public mental hospital, several patients told the author in confidence about their cynical use of symptoms - to frighten new personnel, to escape from unpleasant work details, and so on." (Scheff, 1966:58).

The mentally ill person who behaved in a way that appeared to the viewer as illogical or irrational was often dismissed as psychotic or out of contact with reality. However, if one assumed that this behavior might have been functional in achieving a desired end, a different interpretation could be put upon it. Fontana et al (1968:110) suggested precisely this. "The basic premise of this view is that a substantial amount of 'psychopathological' behavior is maintained and elicited in accordance with the characteristics of the person's current social situation. The creation of a sick incompetent impression on others is an intermediate goal which is instrumental to the attainment of other goals." They clarified these latter goals as follows. "There are several interrelated goals which might motivate
a person to present himself to others as a crazy, sick, incompetent person. If a person is seen in this way, people are not likely to make demands on him or are not likely to persist in their demands. He cannot justifiably be held accountable for his actions, because no one can expect an irresponsible crazy person to know what he is doing. Passivity and gratification of dependency needs are legitimized, since society accepts the position that the sick cannot care for themselves and must be cared for. If the person is hospitalized, all these goals may be met by virtue of his status as a mental patient" (Fontana et al, 1968:111).

A study by Fontana et al (1968:118) which compared presentation of self as healthy (HP) or sick (SP) in schizophrenics produced interesting results. Their comparison of various background factors showed that current length of hospitalization was the only variable to differentiate HPs and SPs consistently. As might have been expected, in two of the three comparisons the HPs had the shorter current patient time.

A further investigation of differences between HPs and SPs involved level of performance as indicated by response time to an auditory stimulus. Attention was paid by the investigators to the effect of evaluation information on the response of HPs and SPs in the experimental group as contrasted with the control group. Fontana and Klein (1968:255-256) concluded that "the amount of schizophrenic
deficit is a function of self-presentation, and it can be markedly increased or it can be decreased to the point of elimination by mobilizing the patient's motivation to create the desired impressions...the data suggest that schizophrenics are indeed in contact with the reality of their present surroundings, but that they use environmental information in the service of deviant, 'pathological' goals."

Two studies by Ludwig and Farrelly provided further support for the view that mental patients were willing and able to influence or even control their hospital fate. In discussing their subject population of chronic schizophrenics, the authors made the following points. "First, these patients can use their insanity to control people and situations. Second, they have an indomitable will of their own and are hell-bent on getting their way. Third, one of the basic difficulties in rehabilitating these patients is not so much their 'lack of motivation' but their intense, negative motivation to remain hospitalized. Fourth, insanity and hospitalization effectively pay off for these patients in a variety of ways. Fifth, these patients are capable of demonstrating an animal cunning in provoking certain reactions on the part of staff, family and society at large which guarantee their continued hospitalization and its consequent rewards" (Ludwig and Farrelly, 1967:1). Far from being helpless or victimized, the patients made use of a multitude of behaviors (nuisance, sexual, aggressive,
self-destructive, withdrawal, and crazy-bizarre) to confuse, irritate, frustrate, and alienate the hospital staff. They achieved power, recognition, and control by indulging in behaviors for which they were not accountable since they were "mentally ill." (Ludwig and Farrelly, 1967:3).

A further problem was the difficulty of motivating any patients toward therapy in view of what Ludwig and Farrelly (1966) termed the "code of chronicity." This code "tends to perpetuate 'crazy' behavior, helps sustain a staff patient barrier, leads to the acceptance and rationalization of continued hospitalization, and thus effectively eliminates any incentive for change, improvement, and eventual discharge." (Ludwig and Farrelly, 1966:563). The patients viewed the staff as jailers and avoided close contact with them. Any defection from the accepted pattern was met with hostility from fellow patients. The model patient who desired the most privileges and fewest restrictions maintained a perfunctory participation in therapeutic activities, performed minimal work assignments and remained inconspicuous. He did not rock the boat and the staff gratefully accepted his "cooperation." (Ludwig and Farrelly, 1966:563). In such a situation the therapeutic function of the hospital was totally subverted and the staff rather than the patients could appropriately be designated the victims.

The final research considered in presenting the case for the mental
patient as "master of his fate" was the work of Braginsky et al. They suggested that "symptoms are behavior to control outcomes in a social situation - they are a form of social communication. As such, they represent no special category of behavior that needs to be distinguished from other behaviors serving the same function of controlling outcomes." (Braginsky et al, 1969:4).

The authors felt that the mental patient acted very much the way a normal person might behave in the outside community. They strongly rejected the description of the mental patient as disoriented, dependent, and socially inept. They suggested, in fact, that the utilization of symptoms "need not be outside of awareness but may reflect the deliberate efforts of the patient to attain his established goal with regard to institutionalization" (Braginsky et al, 1969:4).

Returning briefly to the several studies used to present the strongest indications for patient direction and control, it was of particular interest to note that the overwhelming majority of the subject population were diagnosed as schizophrenic. Since patients of this diagnosis "account for about 25 per cent of all occupied beds in those hospitals," (Gottlieb, 1972:1), this was not surprising. However, what did command attention was the discrepancy between the results found by the several investigators and the traditional view of the schizophrenic. It was posited that the schizophrenic was (a) fundamentally and undeniably different from other human beings; (b) suffered from a disintegrative
disease process that profoundly impaired almost all psychic functioning; and (c) was an involuntary victim of his illness over which he had no control. (Bragnisky et al, 1969:31-33). The patient described in these textbook terms cannot be the same one who practiced impression management, created and participated in an informal but powerful patient culture, and thwarted the therapeutic goals of highly trained professionals.

Braginsky et al stressed that the time had come for a new paradigm, if not for all mental patients, at least for the schizophrenic. As substantiation they presented data dealing with significant aspects of hospital life where the purposive nature of the patient's behavior could be seen clearly. Their investigation of impression management revealed that patients who answered a questionnaire measuring ingratiation gave more favorable responses if they had to sign their names than if it was anonymous. Directions for tests covering severity of illness and degree of insight used in the investigation were structured so that new and old patients had a "script" for impression management if they wished it. According to the researchers, the results were exactly what they expected - an impression of considerable mental health for the newcomers and mental illness for the old patients. They stated that "both classes of patients were quite capable of managing their behavior so as to influence the kind of decisions made about them," (Braginsky et al, 1969:63). A third situation
used a face-to-face interview with the result that the patients once again presented themselves convincingly as sick or healthy depending upon which mode seemed more likely to increase the probability of their desired outcomes. (Braginsky et al, 1969:72).

Another study investigated the life styles of the patients within the hospital. It concluded that they selectively acquired information about the physical and social environment in keeping with their own life style preferences. By and large, "patients, in general, selectively acquire more information about the recreational and hedonic aspects of the hospital than about the formal therapeutic aspects" (Braginsky et al, 1969:85). The end result, according to the authors, was that "mental patients are successful in utilizing their environment to their satisfaction; that they can and do initiate and maintain the life styles they value, even when these styles depart from those valued by the institution" (Braginsky et al, 1969:112).

Data on patient visibility was also compiled by the authors. They reasoned that the "invisible" patient would be less likely to be discharged and more likely to be free to "have a good time." The results showed that patients did vary in terms of visibility. The variability was a function of perceived patient-initiated approach or avoidance of psychiatrists and of styles of adaptation to hospital activities. It was not related to psychiatrist's ratings of patient psychopathology. Discharge rates were indeed highest for the visible patient (Braginsky et al, 1969:120).
At the beginning of this review, two orientations toward the mental patient were described. The first saw him as a victim of forces beyond his control, be they physical, societal, or both. The major unifying characteristic of these forces was that they cast the individual into the role of an object. In denying him choice, they stripped him of humanity. Though this attitude was most prevalent in the prepatient phase, it was prominent in custodial institutions and in the underlife of employee cultures.

The second orientation raised the question of voluntarism in the behavior of the mentally ill person. Although there were intimations of this possibility in literature dealing with the prepatient, hard data appeared primarily in hospital studies. The investigations reviewed in this chapter varied considerably in the type and amount of control they imputed to patients. The major point, however, was that they did attest to evidence that the patient was not just a pitiable, malleable blob. He emerged as an individual with unique needs and goals who employed diverse methods to satisfy them.

Acceptance of voluntarism as an option for the mental patient opened a Pandora's box of questions. One basic question dealt with whether all mental patients were equally willing and able to pursue a course of active voluntarism. Was there some personality dimension that could be identified as being more prominent in patients who successfully maintained their desired life styles within the hospital.
environment?

A careful review of the available literature suggested that a willingness to engage in manipulative behavior might be the essential mechanism for achieving valued goals. Chapter 2 will discuss recent research designed to cast light upon the manipulative personality. Behavior which might be expected of mental patients with such a personality structure will be suggested and the specific hypotheses of this investigation formulated.
CHAPTER 2

THE MACHIAVELLIAN CONCEPT AND THE FORMULATION OF HYPOTHESES

Chapter 1 presented opposing views of the mental patient as victim or active agent (manipulator). It should be noted that manipulation was not considered a derogatory concept. It was simply a factual description of a behavioral pattern. Furthermore, manipulation was not considered an exotic behavior pattern for the mental patient or, conversely, peculiar to him. Shostrom (1967:xii) commented that "The manipulator is legion. He is all of us..." Goffman (1959) defined man as a social manipulator who was busily engaged in controlling his interpersonal environment.

The writings of Niccolo Machiavelli (1940) have served as probably the clearest exposition of manipulative techniques. They have, in fact, given the name to the process: Machiavellianism. Since the typical reaction to this term has been expressive of distaste or disapproval, dispassionate comments were sought to provide a neutral perspective. Guterman (1970:93) stated that "Machiavellianism appears, by its nature, to be an instrumental orientation; the
Machiavellian is concerned with the most efficient means of achieving his goals, and he is willing to violate conventional moral norms and 'use' other people in order to do so." Parsons (1951:145) expressed a similar distinction when he outlined concepts of instrumental versus expressive action orientations. In the former, the actor was seen as goal-oriented and he related to others in the social system in a facilitative manner, as resources to be used for goal achievement. The expressive, non-Machiavellian orientation, on the other hand, was concerned with acting out need dispositions. The actor in this case sought to satisfy his needs for social approval and esteem. Guterman (1970:xiv) pointed out further that "There is... no one-to-one relationship between character on the one side, and behavioral conformity to the relevant ethical values, on the other."

Richard Christie and Florence Geis of Columbia University were responsible for a major investigation of the Machiavellian personality in the 1960s. Their subjects were primarily undergraduate and graduate college students, although one national sample was drawn for comparison on specific variables seven years after the initial analyses (Christie and Geis, 1970:360). They characterized the Machiavellian or manipulatively oriented individual (as he was termed for the present investigation) as showing a relative lack of affect in interpersonal relationships, as having a lack of concern for conventional morality, as having a low ideological commitment, and as
exhibiting a lack of gross psychopathology (Christie and Geis, 1970:3-4). Their investigations of the relationship between manipulative orientation and various personality measures revealed that no significant correlation existed with need achievement or anxiety measures. Some agreement was found with items indicative of hostility and with a negative view of other persons. Individuals with a strong manipulative orientation were also more likely to be found in unbalanced conditions, and to do better under ambiguous conditions (Christie and Geis, 1970:44-51).

Christie and Geis (1970:285) summed up their view of the Machiavellian stance as a "cool syndrome: (which included) resistance to social influence, orientations to cognition, (and) initiating and controlling structure." They underscored the lack of personal affect by saying that "high Machs are exploitive, not vicious or vindictive" (Christie and Geis, 1970:306).

A study by Guterman (1970) related Machiavellianism to solidarity. He formed an eclectic picture of the Machiavellian, drawing upon the writings of Freud, Cooley, and Toennies, as well as on Christie and Geis. He felt that "if outward aggression predominates in an individual's personality, he is more likely to be Machiavellian than if abasement predominates (Guterman, 1970:31). Guterman (1970:48) interpreted Cooley's stress on sympathy and sharing as "the greater a respondent's sensitivity to the good opinion of others, the less
Machiavellian he is inclined to be. " Toennies' Gesellschaft was seen as the milieu of the Machiavellian where a "stress on rationality and material values... leads to an instrumental orientation in which other individuals are viewed as means for realizing one's objectives. From this follows an amoral, manipulative, outlook." (Guterman, 1970:53). In sum, the Machiavellian held "an amoral, manipulative attitude toward other individuals, combined with a cynical view of men's motives and of their character" (Guterman, 1970:3).

Shostrom saw the manipulator as a loser in the human struggle to live a full life. He called him "a person who exploits, use, and/or controls himself and others as things in certain self-defeating ways" (Shostrom, 1967:15). He said a manipulator could be active, passive, competitive, or indifferent but he "can never be himself, nor can he ever relax because his system of games and maneuvers requires that he always play a role rather than be himself" (Shostrom, 1967:45-46).

Although Christie and Geis cited a lack of gross psychopathology as one requirement for their subjects of manipulative or Machiavellian orientation, Perls did not share in this view. In his Foreward to Shostrom's book, he said that the mentally ill person is one "who has problems of living and has developed manipulative patterns of behavior which are self-defeating" (Shostrom, 1967:9).
Klein (Winter 1968-Autumn 1969:219) compared Machiavellianism in psychiatrists and interns. His assumption that psychiatrists would show the higher manipulative orientation was confirmed by his results. He also felt that the conditions of their profession met Christie and Geis' (1970:285) requirements for an optimal situation for Machiavellians: face to face interaction, latitude for improvisation, and the arousal of irrelevant affect. Klein's (Winter 1968-Autumn 1969: 219) justification was that "of all medical specialties, psychiatry has more face to face contact (interaction) with patients than any other. Since diagnosis, treatment and criteria for 'success' varies so much in psychiatry the need for improvisation is also greatest in this discipline. Finally, and most importantly psychiatrists have chosen a profession which deals primarily with irrelevant affect (patients' overly emotional responses)..."Klein saw the manipulative psychiatrist as less alienated and authoritative than the internist, more aware of ambivalences and conflicts, more sensitive to subtle nuances of feeling, and more flexible in reality testing.

The impression of the manipulatively oriented person received from Christie and Geis, Guterman, and Klein was that of a strong, purposeful personality. Shostrom and Perls, on the other hand, suggested a flawed or incomplete character. Wietzel (1966:44) expanded upon this latter view calling the person with a strong manipulative orientation "an insecure, anxious person -- one who..."
idealizes himself as hard and devious, a manipulator of others."
In support of this characterization he discussed the results of the
Rotter Internal-External Scale administered to his subjects. "Rather
than obtaining the predicted, aggressive, self-assured, high I re-
response (internally controlled), the high Mach tends to answer signifi-
cantly less like I and more like E (externally controlled, belief that
his rewards are in the hands of others or fate, luck plays a large
role in success, etc.). E responses are hardly the kind of responses
one would expect a manipulator to endorse" (Weitzel, 1966:46).

Whether or not a manipulative orientation was viewed as compen-
satory in the studies cited, there was a basic necessity in all of
them to pinpoint its existence. It was also necessary to express this
orientation in some form which would discriminate between indivi-
duals. With the exception of Shostrom and Perls, all the investi-
gators used the Christie and Geis Mach V scale as the means to these
ends.

The Mach V scale (Christie and Geis, 1970:10ff) was the end re-
sult of an original pool of 71 items, winnowed and refined through
several formats to the final 20-item forced-choice instrument. The
test was deliberately constructed to minimize the influence of social
desirability. Attitude responses were elicited by the scale items and
scored in terms of their strength of agreement or disagreement with a
predetermined Machiavellian direction. Next, the scores were split
into three ranges: low, medium, and high. It was inferred that persons whose scores fell into the high Mach range possessed a strong Machiavellian orientation, a high willingness to manipulate.

Mach scores were correlated with several paper and pencil inventories by Christie and Geis in an attempt to discriminate between high and low Machs on conventional tests of individual differences. They stated that "no significant relationship was found between Mach scores and various measures of intellectual ability. Available evidence also indicates that Machiavellianism and political preference or ideology are unrelated. Although no correlations have been found to date between Mach scores and measures of psychopathy, there is overwhelming evidence that high Machs have a generally unflattering opinion of others, a cynical view of people in general... Positive relationships with measures of hostility and negative ones with social desirability indicate a perhaps surprising degree of candidness. It is unclear, however, whether this indicates that high Machs are actually more hostile or whether they are less inhibited in recognizing and expressing it," (Christie and Geis, 1970: 52).

The homogeneity of Christie and Geis' subjects did not seem to allow generalization from their results to other populations. However, their Mach V scale showed promise for identifying manipulative orientation in individuals. The language of the test was not difficult and
the items provocative. Problems arising in analysis from possible discrepancies in ranges or mean scores were not expected since no comparison between the subject populations was part of the hypotheses.

It should be noted here again that Christie and Geis specifically stated a reservation about the application of the manipulator concept to the mentally ill. They listed as an important characteristic "a lack of gross psychopathology. The manipulator was hypothesized as taking an instrumentalist or rational view of others. Such a person would make errors in evaluating other individuals and the situation if his emotional needs seriously distorted his perceptions. Presumably, most neurotics and psychotics show deficiencies in reality testing and, by and large, fail in crucial ways in relating to others. Note that we were not suggesting that manipulators are the epitome of mental health; we were proposing that their contact with at least the more objective aspects of reality would have to be, almost by definition, within the normal range" (Christie and Geis, 1970:3).

On the other hand, manipulation appeared to be only one of many human patterns of behavior, to be called forth when the situation warranted it. Staff at mental institutions with whom this investigator spoke or corresponded commented frequently on the ability of many patients to "con" those about them in order to achieve some desired goal. No conflict was seen, therefore, in the assumption that mental patients could be tested for a manipulative orientation. The question
became one of determining what clearly measurable data could be expected to show a positive relationship with a high Mach score on the Mach V scale. Braginsky et al (1969:9) reported Holzberg's comment that possibly most mental patients did not seek help but rather "the opportunity to escape and be released from the debilitating social conditions in which they are locked." A schizophrenic patient interviewed for the Braginsky et al (1969:216) study commented about the hospital that "It's a place you can go when you want to get away from all the stress, you want to hide from the world, and, in being this way, you're still acceptable to some people - like people here."

It was hypothesized that if mental patients looked upon the hospital as a haven, they would resist discharge as long as possible. It was expected that patients who were more manipulatively oriented would be more successful than others in maintaining their hospitalized status. Therefore, the first hypothesis investigated in this study was:

The greater his manipulative orientation, the more time a mental patient will spend in the hospital.

Braginsky et al (1969:78) found that "mental patients appear somewhat hedonic both in their attitudes and behavior in the hospital..." Their interviews with patients elicited accounts of quite personal and different life styles. The assumption drawn from this was that not
all aspects of hospital life were equally attractive to all patients. However, one striking similarity among their subjects was their opportunity to move quite freely about the hospital grounds. Upon reflection, it seemed to this investigator that the clearest evidence of successful manipulation was this privilege of moving about the hospital at will - a condition of minimal restrictions but still "safe" within the hospital walls. Thus, the second hypothesis investigated was:

The greater his manipulative orientation, the greater percentage of total hospital time a mental patient will spend on open wards or with ground permits.

Knowledge of the pertinent aspects of a situation has always been a prime requisite for successful manipulation. As Goffman (1961:211) commented, "In order to work a system effectively, one must have an intimate knowledge of it." Braginsky et al (1969:85) reported that their subjects had a fund of selective information about their institution which supported their recreational and hedonic leanings. Based upon this suggested relationship between manipulation and information acquisition, the third hypothesis investigated was:

The greater his manipulative orientation, the more a mental patient will know about his hospital environment.

Since some facets of hospital life were seen as more desirable than others, it also seemed likely that mental institutions themselves
would vary in their perceived desirability. A small private hospital with an intensive therapy program and close supervision of patients appeared less likely to appeal to a patient with a high manipulative orientation than a large traditional institution with its much greater ratio of patients to staff. The opportunity for the exercise of personal options almost necessarily was improved in the less closely supervised setting. Mental hospitals, generally, of course, offered what might be considered the traditional "advantages." Patients had the security of adequate food and shelter. A stable environmental routine provided a reasonable certainty for behavioral expectations. Social relationships were generally non-threatening. It was felt that a hospital which shared these advantages and also included the benefit of disability payments for hospitalization extending beyond a set period of time would be the most attractive to patients with high Mach scores. The fourth and final hypothesis, therefore, was framed as follows:

Mental patients with greater manipulative orientations will be overrepresented in VH and underrepresented in PH.

Chapter 2 has offered several views on the personality attributes of the Machiavellian or person with a high manipulative orientation. Christie and Geis' seminal investigations have been discussed briefly and a rational given for the use of their Mach V scale in this study.
Four hypotheses were formulated to investigate the relationship between a strong manipulative orientation and outcomes indicative of that orientation. The methodology employed in testing the hypothesis will be found in Chapter 3.
CHAPTER 3

METHODOLOGY

Research Design

This investigation employed an exploratory field study design. Subjects were tested once within their institutional setting and no control group was used. The test situation explored the relationship between the independent variable, manipulative orientation, and the dependent variables: length of time spent in the hospital, percent of time spent on an open ward and/or with a ground permit, knowledge of the hospital environment, and unequal representation in certain types of hospitals over others.

Research Setting

The field study was carried out in three mental hospitals in the Midwest. They were a private church-related hospital (PH), a regional state institution (SH), and a neuropsychiatric Veterans' Administration facility (VH).

PH was the smallest of the three institutions. Patients seen there were almost all members of the same religious denomination.
The staff philosophy, overlaid with a strong religious commitment, was frequently expressed as hospitalizing persons for as brief a period as possible. Every effort was made to treat and release the patients within a twelve-week period.

All new patients were housed in a modern attractive structure which also held the administrative offices. Recreational and therapeutic facilities were scattered throughout the building and patients moved between them freely. It was very difficult at times to distinguish between staff and patients since no distinctive forms of dress were employed.

Patients who did not respond adequately to the initial intensive treatment period faced a change in their physical surroundings. Quarters in the new building were limited in number and quite expensive. Unless the financial burden could be met, the patient was moved to one of several older and more traditional facilities on the grounds. Freedom of movement was correspondingly more limited although it did not necessarily cease to exist. In this study, subjects in the newer buildings were classified as on an open ward; subjects housed elsewhere were considered to hold a ground permit.

Clarification of these terms was one of the first problems of this investigation. An open ward patient was one who could move about with the fewest restrictions within the hospital setting. He could leave his immediate ward without signing out or otherwise
notifying the floor personnel of his intentions. He could not leave the hospital grounds but could visit any portion of the hospital facilities not specifically off-limits to patients.

Patients with ground permits signed out or notified ward staff when they left their "home" wards. They could move about the grounds without the company of an attendant but often were required to state their destination as well as their intent to leave the ward. There were individual variations between hospitals in the determination of exact limitations on open ward and ground permit privileges. The general pattern, however, was as described above.

The physical surroundings at SH were typical of state hospitals built early in this century. Large, utilitarian brick buildings dominated the grounds. The interiors were relative bare and institutional although every effort was made to keep them clean and in repair.

New patients were housed briefly in an intake building and then were distributed among the wards. With the exception of the physically ill or seriously disturbed, the choice of ward appeared to be determined by the availability of space. It was not uncommon for patients to be moved frequently from ward to ward for what appeared to be primarily administrative reasons. The mix of patients on many of the wards created a situation in which different limitations were set on freedom of movement for persons in the same physical setting.
Here, as at PH, subjects who took part in the study were either on open wards or had ground permits.

The staff at SH expressed a strong desire to reduce the length of hospitalization experienced by many of the patients in the institution. However, the realities of a greatly increased patient load, and proportionately fewer professionals to deal with it, resulted in less individual attention than was possible at the private hospital.

VH was a neuropsychiatric hospital; the only one in the state. Its facilities included special drug and alcohol programs for veterans as well as the more usual treatment programs. In the past several years the census at VH has dropped markedly, due to a concerted effort to move patients out into the community. On the grounds, substantial efforts were made by the staff to give the veterans the greatest possible freedom of movement and control over their own actions. No ground permits were used; wards were open or closed.

The physical setting at VH was not unlike SH, although the buildings were newer. There were two- and three-story stone units with utilitarian interiors generally lacking in color or warmth. The overall hospital atmosphere, however, seemed less institutional than at SH.

Directors and/or appropriate department heads of the hospitals involved were contacted and the purpose and scope of the study explained to them. A written research proposal was submitted to the
Research Committee of each hospital for its approval. After permission to conduct the study was received from the three hospitals, subjects were selected and the testing schedules set. Demographic data on the subjects were collected from the files of each hospital. The actual testing situation was carried out in one session at SH, one at VH, and two at PH. In each case, the subjects to be tested met in a room set aside for the purpose and apart from the ward setting.

Subject Sample

While it would theoretically have been desirable to randomly select from a total hospital population, this was not possible in actual practice. The use of paper and pencil tests required that the patients be competent to understand and respond to the material. Within this very general limitation, the further criteria were:

1. not hospitalized for observation,
2. not diagnosed as an organic disorder,
3. not hospitalized for alcoholism,
4. not hospitalized for drug addiction,
5. 20-60 years of age,
6. on an open ward or holding a ground permit,
7. native born,
8. male, an
9. white.
A further limitation, imposed by each hospital, was that the patient selected give a voluntary written consent to participation in the study.

Briefly, the reasons underlying criteria 1-9 were:

1. Persons hospitalized for observation could not be considered mental patients. Their status had not been determined and an arbitrary lumping of their cases with those diagnosed as mentally ill would have been, at the least, presumptuous. Classification under a specific diagnosis was required for identification as a mental patient.

2. The manipulative orientation, which implied using others to achieve personal goals, was viewed as a behavioral concept. It therefore seemed appropriate to investigate its relation to functional rather than organic symptomatology.

3 & 4. The emphasis in this study was upon mental patients. Alcholics and drug addicts exhibited problems of a special nature and were, therefore, exempted from the subject population.

5. The age limits could have been extended at both ends to include more persons able to function in the testing situation. However, 20-60 was an easy to determine hospital population which shared an "adult" environment as opposed to overlapping with a "juvenile" or "geriatric" setting.

6. All three hospitals had one or more open wards. Patients on these wards had maximal opportunities for freedom within
the hospital setting. In addition, PH and SH employed ground permits. These allowed the patient housed on a normally closed ward to move around the grounds without the restrictions imposed upon his wardmates.

It was felt by the investigator that the relative looseness of the open ward and ground permit conditions provided optimal settings for individuals with high manipulative orientation. Both the opportunity for extensive face to face interaction and the latitude for improvisation which Christie and Geis (1970:285) considered relevant situational characteristics were present. Personal options for the avoidance of irrelevant affect and for structuring interpersonal encounters also seemed inherent in these privileges. Therefore, the search for patients exhibiting high manipulative orientation was concentrated within these areas.

A comparison with closed ward patients would obviously have been of value. However, the staff at all three hospitals questioned whether those patients would be able to function in the test situation. It was decided, therefore, to restrict the scope of this exploratory study to patients on open wards or holding ground permits.

7, 8 & 9. Restriction of the subjects to native born white males reflected an attempt to avoid the confounding effects of culture, race and sex. No consensus has been reached on the relationship of these variables to manipulative orientation. It was felt that though
these relationships were undoubtedly important, investigation of them could be postponed beyond this initial exploratory study.

An attempt was made to identify the typical subject patient at each hospital. The PH subject was 34 years old. He had 14 years of schooling, was single and unemployed. His commitment was listed as voluntary and he was diagnosed as a schizophrenic. He had been hospitalized once before and had currently spent almost 4 months in PH. Ninety-five percent of his current stay had been spent on an open ward or with a ground permit.

The typical SH subject was 40 years old, had 10 years of schooling, was single and was employed as a laborer. He was listed as an involuntary commitment. He was diagnosed as a schizophrenic and had been hospitalized once before. During his current 99 month stay at SH, he had been on an open ward or held a ground permit for 49% of the time.

Finally, the typical VH subject was 37 years old, had 11 years of schooling, was single and was employed as a laborer. He was listed as a voluntary commitment. (Note: VH stressed voluntary commitments. Any conclusions involving this variable, therefore, were somewhat suspect.) The VH subject was diagnosed as schizophrenic and had been hospitalized three times before the current stay. He had been at VH for 19 months and had spent 66% of that time on an open ward.

All patients in each hospital who met the criteria outlined in
items 1-9, and who consented to take part, were selected to be subjects for the study. One hundred and fourteen subjects made up the final pool for testing at the three hospitals: 25 at PH, 54 at SH, and 35 at VH. However, at the actual testing sessions, there were 10 subjects at PH, 32 at SH, and 22 at VH. Table 3-1 presents the distribution of reasons why subjects failed to appear for the tests or were not included in the data analyzed.

Table 3-1. Distribution of Reasons for Non-Participation in Subject Sample.

<table>
<thead>
<tr>
<th></th>
<th>PH</th>
<th>SH</th>
<th>VH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Sample</td>
<td>25</td>
<td>54</td>
<td>35</td>
</tr>
<tr>
<td>Failed to Appear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused/No Show</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Discharged/Unauthorized Absence</td>
<td>11</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Leave of Absence</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Ill</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>15 (60%)</td>
<td>10 (19%)</td>
<td>6 (17%)</td>
</tr>
<tr>
<td>Questionnaires Administered</td>
<td>10</td>
<td>44</td>
<td>29</td>
</tr>
<tr>
<td>Unusable Data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Test Answers</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Insufficient Data</td>
<td>1 (4%)</td>
<td>15 (33%)</td>
<td>10 (37%)</td>
</tr>
<tr>
<td>Non-Subjects Total</td>
<td>16 (64%)</td>
<td>28 (52%)</td>
<td>19 (54%)</td>
</tr>
<tr>
<td>Sample Subjects Total</td>
<td>9 (36%)</td>
<td>26 (48%)</td>
<td>16 (46%)</td>
</tr>
</tbody>
</table>
The fact that 63 of the potential 114 subjects were not part of the final sample raised the question of a bias in the data. Did those who volunteered and actually served as subjects differ significantly from those who were selected but did not serve? The data in Tables 3-2 through 3-8 are relevant to the consideration of this question.

Table 3-2. A Comparison of Subjects and Non-Subjects by Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Subjects</th>
<th>Non-Subjects</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td></td>
</tr>
<tr>
<td>PH</td>
<td>9 (18%)</td>
<td>16 (26%)</td>
<td>25</td>
</tr>
<tr>
<td>SH</td>
<td>26 (51%)</td>
<td>28 (44%)</td>
<td>54</td>
</tr>
<tr>
<td>VH</td>
<td>16 (31%)</td>
<td>19 (30%)</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>51 (100%)</td>
<td>63 (100%)</td>
<td>114</td>
</tr>
</tbody>
</table>

\[ x^2 = 1.02, \text{ df} = 2 \]

Examination of Table 3-2 revealed that 18% of the subjects were found in PH as compared to 26% of the non-subjects. Fifty-one percent of the subjects were in SH as compared to 44% of the non-subjects. VH contributed 31% of the subjects and 30% of the non-subjects. The subjects were, then, slightly overrepresented in SH and underrepresented in PH. The \( x^2 \) of 1.02 (df = 2) testing these differences resulted in a non-significant \( p > .50 \).
Table 3-3. A Comparison of Subjects and Non-Subjects by Marital Status.

<table>
<thead>
<tr>
<th>Status</th>
<th>Subjects</th>
<th>Non-Subjects</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>31 (60%)</td>
<td>37 (58%)</td>
<td>68</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>9 (18%)</td>
<td>13 (21%)</td>
<td>22</td>
</tr>
<tr>
<td>Married</td>
<td>11 (22%)</td>
<td>13 (21%)</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>51 (100%)</td>
<td>63 (100%)</td>
<td>114</td>
</tr>
</tbody>
</table>

\[x^2 = 1.04, \text{ df} = 2\]

Sixty percent of the subjects were single, 18% were divorced or separated and 22% were married. Correspondingly, 58% of the non-subjects were single, 21% were divorced or separated, and 21% were married. These very slight differences yielded a \(x^2\) of 1.04 (df = 2) for a non-significant \(p > .50\).

Table 3-4. A Comparison of Subjects and Non-Subjects by Occupation.

<table>
<thead>
<tr>
<th>Status</th>
<th>Subjects</th>
<th>Non-Subjects</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>6 (12%)</td>
<td>8 (13%)</td>
<td>14</td>
</tr>
<tr>
<td>Laborer</td>
<td>22 (43%)</td>
<td>30 (48%)</td>
<td>52</td>
</tr>
<tr>
<td>Blue Collar</td>
<td>14 (27%)</td>
<td>22 (35%)</td>
<td>36</td>
</tr>
<tr>
<td>White Collar/Professional</td>
<td>9 (18%)</td>
<td>3 (4%)</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>51 (100%)</td>
<td>63 (100%)</td>
<td>114</td>
</tr>
</tbody>
</table>

\[x^2 = 3.87, \text{ df} = 3\]
Slightly more of the non-subjects were unemployed or laborers than were the subjects, 13% and 48% as compared to 12% and 43%.

A greater discrepancy existed for blue collar workers with non-subjects accounting for 35% and subjects for 27%. White collar and professional persons, however, showed a different loading - subjects 18% and non-subjects only 4%. Although these differences were more marked, the $x^2$ of 3.87 (df = 3) yielded a non-significant $p > .20$.

Table 3-5. A Comparison of Subjects and Non-Subjects by Social Class (Hollingshead Two Factor Index of Social Position)

<table>
<thead>
<tr>
<th>Class</th>
<th>Subjects</th>
<th>Non-Subjects</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td></td>
</tr>
<tr>
<td>I, II, III</td>
<td>11 (22%)</td>
<td>4 (6%)</td>
<td>15</td>
</tr>
<tr>
<td>IV</td>
<td>14 (27%)</td>
<td>15 (24%)</td>
<td>29</td>
</tr>
<tr>
<td>V</td>
<td>26 (51%)</td>
<td>44 (70%)</td>
<td>70</td>
</tr>
<tr>
<td>Total</td>
<td>51 (100%)</td>
<td>63 (100%)</td>
<td>114</td>
</tr>
</tbody>
</table>

$x^2 = 6.18$, df = 3

It appeared from a comparison of subjects and non-subjects by social class that subjects were overrepresented in the higher classes (I, II, III) and non-subjects in the lower classes (IV and V).

Classes I-III accounted for 22% of the subjects but only 6% of the non-subjects. The division in Class IV was more nearly equal with...
27% subjects and 24% non-subjects. However, Class V encompassed a greater percent of non-subjects (70%) than subjects (51%). These differences approached but did not reach significance with a $x^2$ of 6.18 (df = 3) yielding a $p > .10$.

Table 3-6. A Comparison of Subjects and Non-Subjects by Type of Commitment.

<table>
<thead>
<tr>
<th>Type of Commitment</th>
<th>Subjects</th>
<th>Non-Subjects</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Voluntary</td>
<td>25 (49%)</td>
<td>32 (51%)</td>
<td>57</td>
</tr>
<tr>
<td>Involuntary</td>
<td>26 (51%)</td>
<td>31 (49%)</td>
<td>57</td>
</tr>
<tr>
<td>Total</td>
<td>51 (100%)</td>
<td>63 (100%)</td>
<td>114</td>
</tr>
</tbody>
</table>

$x^2 = 0.04$, df = 1

The distribution of subjects and non-subjects by form of commitment was almost identical. Forty-nine percent of the subjects and 51% of the non-subjects were voluntary commitments; 51% of the subjects and 49% of the non-subjects were involuntary commitments. The $x^2$ of 0.04 (df = 1) yielded a $p > .90$ which strongly indicated no significant difference.

None of the variables summarized in Table 3-7 (see the following page) yielded a significant difference between subjects and non-subjects. Therefore, it was tentatively assumed that the absence of the non-subjects from the final sample did not introduce a bias.
Table 3-7. Summary of Comparisons between Subjects and Non-Subjects on Selected Variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>$x^2$</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1.02</td>
<td>2</td>
<td>&gt; .50</td>
</tr>
<tr>
<td>Marital Status</td>
<td>1.04</td>
<td>2</td>
<td>&gt; .50</td>
</tr>
<tr>
<td>Occupation</td>
<td>3.87</td>
<td>3</td>
<td>&gt; .20</td>
</tr>
<tr>
<td>Social Class</td>
<td>6.18</td>
<td>3</td>
<td>&gt; .10</td>
</tr>
<tr>
<td>Voluntary/Involuntary</td>
<td>0.04</td>
<td>1</td>
<td>&gt; .90</td>
</tr>
</tbody>
</table>

As shown in Table 3-8, education was the only variable to differ significantly between the two groups. Subjects had a mean of 12.12 years of schooling, while non-subjects had a mean of 10.22 years.

Although the differences were not significant, subjects as described by the mean were younger, took more tranquilizing drugs but fewer energizing and non-psychotropic drugs, and had fewer previous hospitalizations. The mean number of months between the current and last hospitalization was lower for subjects, as was the mean number of months of current hospitalization. The means also indicated that subjects spent a greater percent of their time in the hospital on an open ward or with some combination of
Table 3-8. Descriptive Statistics for Subjects and Non-Subjects.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Subjects (n=51)</th>
<th>Non-Subjects (n=63)</th>
<th>( t^* )</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Min. 20</td>
<td>Max. 59</td>
<td>Mean 37.82</td>
<td>S. D. 11.64</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Min. 7</td>
<td>Max. 17</td>
<td>Mean 12.12</td>
<td>S. D. 2.85</td>
</tr>
<tr>
<td><strong>No. of Tranquilizing Drugs</strong></td>
<td>Min. 0</td>
<td>Max. 2</td>
<td>Mean 1.26</td>
<td>S. D. 0.69</td>
</tr>
<tr>
<td><strong>No. of Energizing Drugs</strong></td>
<td>Min. 0</td>
<td>Max. 1</td>
<td>Mean 0.12</td>
<td>S. D. 0.33</td>
</tr>
<tr>
<td><strong>No. of Non-Psychotropic Drugs</strong></td>
<td>Min. 0</td>
<td>Max. 3</td>
<td>Mean 0.51</td>
<td>S. D. 0.70</td>
</tr>
<tr>
<td><strong>No. of Previous Hospitalizations</strong></td>
<td>Min. 0</td>
<td>Max. 9</td>
<td>Mean 2.26</td>
<td>S. D. 2.32</td>
</tr>
<tr>
<td><strong>No. of Months between Current and last Hospitalization</strong></td>
<td>Min. 0</td>
<td>Max. 6</td>
<td>Mean 1.26</td>
<td>S. D. 1.55</td>
</tr>
<tr>
<td><strong>No. of Months of Current Hospitalization</strong></td>
<td>Min. 0</td>
<td>Max. 356</td>
<td>Mean 52.51</td>
<td>S. D. 81.41</td>
</tr>
<tr>
<td><strong>% of Time on an Open Ward</strong></td>
<td>Min. 0</td>
<td>Max. 100</td>
<td>Mean 0.52</td>
<td>S. D. 0.37</td>
</tr>
<tr>
<td><strong>% of Time with a Ground Permit</strong></td>
<td>Min. 0</td>
<td>Max. 100</td>
<td>Mean 0.23</td>
<td>S. D. 0.35</td>
</tr>
<tr>
<td><strong>% of Time on Open Ward/ Ground Permit Combined</strong></td>
<td>Min. 0</td>
<td>Max. 4</td>
<td>Mean 0.67</td>
<td>S. D. 0.28</td>
</tr>
</tbody>
</table>

*df = 113
open ward and ground permit privileges than did the non-subjects. The mean percent of time spent with a ground permit, however, was identical for the two groups.

Determination of an appropriate significance level was an inescapable problem. Type 1 errors, which accepted false premises as true, wasted time, energy and resources. Type 2 errors, true data described as false, might have nipped insight in the bud. It was felt that use of the conventionally accepted .05 level of significance for this study avoided most of the pitfalls inherent in each type of error.

Only one of the t statistics between subjects and non-subjects reached .05 or less. The mean education for subjects (12.12 years) differed from that of non-subjects (10.22 years) beyond the .001 level of significance. All the other variables, as shown in Tables 3-2 and 3-3, indicated no significant differences between the two populations. Consequently, the hypothesis of no confounding bias in the sample was supported. It should be understood, however, that this study dealt with the relationship between variables. No effort was made to achieve representativeness across a specific population, or to achieve a base that would allow generalization to other populations.

Instruments

Five variables were measured for the purposes of this study. A sixth variable, suggested by the reading, was included to make the
fullest use of the subject pool.

1. Manipulative orientation was determined through administration of the Mach V scale*. This scale was developed by Richard Christie (1970) at Columbia University, and was suggested by statements in THE PRINCE and THE DISCOURSES by Niccolo Machiavelli. Diverse populations of college students were used to standardize the scale, which passed through several versions. The final version was a forced-choice format of 20 three-part questions which were deliberately structured to avoid correlation with external measures of social desirability (Christie and Geis, 1970:33). The range of scores possible for the Mach V scale was 40-160.

2. Time spent in the hospital was expressed as the total number of months of current hospitalization.

3. Time spent on an open ward or with a ground permit was expressed as a percent of the total number of months of current hospitalization.

4. Knowledge of the hospital environment was determined through administration of modified forms of the Braginsky et al (1969:82) Hospital Information Test **. This test was developed to measure two general areas of patient information: hospital staff, and residential aspects of the institution. Only those items were selected by the

* See Appendix A for a sample of the Mach V Scale
** See Appendix B for a sample of the Hospital Information Test.
authors whose answers were potentially obvious. That is information required to respond to them had to be available without necessi-
tating personal contact with a staff member. Additionally, the items had to be easily comprehended so that score variation would not be an artifact of intelligence.

Three modified forms of the HIT were developed*. This procedure was necessary since many items on the original test were specific to its first eastern setting. The forms used in this study were tailored through consultation with staff members at each of the subject hospitals to fit their particular institutional environment. Since the total number of items varied slightly between forms, individual scores were expressed as a percentage of the total.

5. General demographic data were compiled by the investigator from the central files on each subject. These data included, but were not limited to, age, marital status, education, occupation, type of commitment (voluntary/involuntary), diagnosis, type of medication, number of previous hospitalizations, number of months elapsed between the current hospitalization and the most recent previous one, the length of the current hospitalization, and the percent of time spent on open wards and/or with ground permits.

6 The Kuhn (1954) Twenty Statements Test was included as part of the test package. However, it was not viewed as part of the

* See Appendix C for samples of the modified Hospital Information Test.
relevant data and no analysis of it was prepared for this study.

Data Collection

Data were collected through administration of group paper and pencil tests. Tests for each hospital were identified by a letter and number series which corresponded to a master list of subjects. At each session, a hospital staff member privately identified the subjects for the investigator so that no one received another person's set of questionnaires.

Data were collected at SH and VH in one session each. PH required two sessions due to scheduling difficulties for the patients.

Subjects were given their questionnaires and a pencil as they entered the room. When everyone was seated, the investigator made a brief statement which outlined the purported purpose of the study and stressed the anonymity of the replies*. The subjects were then allowed to work at their own speed and to leave the room when they completed the questionnaires. During the course of the testing, the investigator answered questions about the form for completing the items but not about their content. A limit of 2 1/2 hours was set for responding to the tests. In only one case, at PH, did a subject take the full time; in no case did a subject request more time.

Data Analysis

It was expected that a significant positive correlation would be

* See Appendix D for the investigator's statement to the patients.
found between Mach V scale scores and the total number of months of current hospitalization. This hypothesis was tested by calculating a Pearsonian product-moment coefficient of correlation.

It was expected that a significant positive correlation would be found between Mach V scale scores and the percent of total time spent on open wards and/or with ground permits. A Pearsonian product-moment coefficient of correlation was used to test this hypothesis.

An expected significant positive correlation between Mach V scale scores and HIT scores was also tested by a Pearsonian product-moment coefficient of correlation. A partial correlation was run to determine the effect of several additional variables upon this relationship.

An analysis of variance was run across the three hospitals to discover whether there were differences in the distribution of subjects by Mach V scale scores.

It would have been instructive to compare the scores of mental hospital patients with other populations for which Mach V scale norms were known. Unfortunately, there were no published norms which offered meaningful comparisons. The original testing was done on college students and, according to Dr. Christie (1972:telephone conversation), the test has not been administered to sufficiently varied populations to provide a range of "normal" scores.
To recapitulate briefly, an exploratory field study was conducted in three mental hospitals in the Midwest. The purpose of the study was to investigate the relationship between manipulative orientation as the independent variable and four dependent variables: length of time spent in the hospital, the percent of time spent on an open ward and/or with a ground permit, knowledge of the hospital environment, and unequal representation in one hospital over another. Criteria were developed for the patient sample and those persons who met the requirements and gave voluntary written consent to participation were included in the subject population. The subjects were given a battery of paper and pencil tests in group sessions at their hospitals. The data collected were analyzed by a variety of statistical techniques which included the Pearsonian product-moment coefficient of correlation, partial correlations, analysis of variance, and the student's t. The result of the analyses will be discussed in Chapter 4.
The data collected were analyzed for their bearing on the four hypotheses under investigation.

**Hypothesis #1**

The greater his manipulative orientation, the more time a mental patient will spend in the hospital.

Tables 4-1 and 4-2 present descriptive statistics by hospitals for the Mach V scale scores and the number of months of current hospitalization.

<table>
<thead>
<tr>
<th>Table 4-1. Mach V Scale Scores by Hospitals.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>PH</td>
</tr>
<tr>
<td>SH</td>
</tr>
<tr>
<td>VH</td>
</tr>
<tr>
<td>All Hospitals</td>
</tr>
</tbody>
</table>

The greatest difference in mean Mach V scale scores, as shown in Table 4-1, was between VH (91.63) and SH (86.00). This difference of 5.63 between means was not significant. None of the
Table 4-2. Number of Months of Current Hospitalization by Hospitals.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>N</th>
<th>Min.</th>
<th>Max.</th>
<th>Mean</th>
<th>S. D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH</td>
<td>9</td>
<td>0*</td>
<td>24</td>
<td>4.22</td>
<td>7.50</td>
</tr>
<tr>
<td>SH</td>
<td>26</td>
<td>2</td>
<td>356</td>
<td>95.46</td>
<td>95.79</td>
</tr>
<tr>
<td>VH</td>
<td>16</td>
<td>0*</td>
<td>62</td>
<td>9.88</td>
<td>15.32</td>
</tr>
<tr>
<td>All Hospitals</td>
<td>51</td>
<td>0*</td>
<td>356</td>
<td>52.51</td>
<td>81.41</td>
</tr>
</tbody>
</table>

* 0 indicates a period of less than one month.

differences in mean MachV scale scores between hospitals, therefore, was significant. On the other hand, Table 4-2 showed marked differences between hospitals in mean length of current hospitalization. The briefest stay was found at PH (4.22 months); SH patients were hospitalized, on the average, over 20 times as long (95.46 months). The mean length of stay at VH was 9.88 months, slightly more than twice the PH figure. The variances associated with each of the hospitals were also quite different, ranging from a low of 7.50 at PH to a high of 95.79 at SH. It was clear that the data for SH reflected the effect of the inclusion of several patients who had been hospitalized for unusually long periods. In general, it appeared that the differences between hospitals were the result of the unique pressures and policies under which they functioned.

The lack of uniformity in release patterns between hospitals raised the question of legitimacy in combining their data for analysis. The interpretations that dealt with combined data in this thesis, therefore, were considered tentative and suggestive in keeping with
its exploratory nature.

Table 4-3 presents the relationship between Mach V scale scores and the number of months of current hospitalization.

Table 4-3. Relationship between Months of Current Hospitalization and Mach V Scale Scores.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>PH (N=9)</th>
<th>SH (N=26)</th>
<th>VH (N=16)</th>
<th>Hospitals Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>r</td>
<td>0.284</td>
<td>-0.011</td>
<td>-0.052</td>
<td>-0.094</td>
</tr>
<tr>
<td>p</td>
<td>&gt;.05</td>
<td>&gt;.05</td>
<td>&gt;.05</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

The hypothesized relationship between number of months of hospitalization and manipulative orientation was not supported, as shown by a product-moment correlation of -0.094 which was not significant at the required .05 level. As indicated in Table 4-3, the hypothesized relationship was not found in even one of the participating hospitals, none of the coefficients of correlation being significant at the .05 level. Hypothesis #1 was rejected.

Hypothesis #2

The greater his manipulative orientation, the greater percentage of total hospital time a mental patient will spend on open wards and/or with ground permits.

During the pre-data collection period of familiarization with the hospitals, it became clear that how personnel utilized open ward
assignments and ground permit privileges was partially administrative in nature. Data were collected on both open ward and ground permit categories and their analyses proceeded along parallel lines since in practice they appeared to be substitutes for each other. This conclusion was drawn from the following observations. At PH and at SH both open wards and ground permits were used. Open wards were housed at PH in the new modern administration building. The other buildings served patients with ground permits or on closed wards. All new patients were assigned to the main building upon admission and remained there for up to a twelve-week period of observation, diagnosis, and treatment. At the end of this time those patients who were not clearly close to being discharged were moved to other buildings. It was not impossible for arrangements to be made for a patient to remain in the main building. Generally, however, this did not appear to be the case. The opportunity for families to ease their financial burden markedly by accepting patient placement in another building may have been an important factor. It followed that patients who had held open ward privileges now found themselves with ground permits more as a result of changing their quarters than of an alteration in their behavior.

At SH some patients were given ground permits while others were housed on open wards. Indeed, some patients were listed in the central records as having both ground permits and open ward
privileges concurrently. The investigator assumed that this reflected some error in the record notation procedure. However, in these cases, the subjects were arbitrarily assigned to the open ward category as the more inclusive statement. Faced with the partially extra-medical nature of these two categories, it was decided to combine the two experiences and consider the data as a third category of "time spent on open ward and/or with ground permit."

Table 4-4. Percent of Time on Open Ward, with Ground Permit, and in Combination by Hospitals.

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Open Ward</th>
<th>Ground Permit</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Min. Max. Mean S. D.</td>
<td>Min. Max. Mean S. D.</td>
<td>Min. Max. Mean S. D.</td>
</tr>
<tr>
<td>PH</td>
<td>9 0 100 56 53</td>
<td>0 100 61 49</td>
<td>50 100 94 17</td>
</tr>
<tr>
<td>SH</td>
<td>26 0 94 35 30</td>
<td>0 66 15 17</td>
<td>4 98 51 26</td>
</tr>
<tr>
<td>VH</td>
<td>16 50 100 78 20</td>
<td>* * * *</td>
<td>50 100 78 20</td>
</tr>
<tr>
<td>All Hosp.</td>
<td>51 0 100 52 37</td>
<td>0 100 23 35</td>
<td>4 100 67 28</td>
</tr>
<tr>
<td>*No ground permits used.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that all of the subjects selected for this study were currently either on open wards or held ground permits. For this reason it was logically consistent for the minimum percentage of time spent in either of these two separate conditions to be zero for any single patient, but impossible for the time spent in either open wards or with ground permits combined and expressed as a percent to be zero. The means for the combined condition were 94% for PH, 51%.
for SH, and 78% for VH.

Considerable variation in the usage of open wards was evident in Table 4-4. While all three hospitals utilized open wards, the mean usage varied from 35% at SH to 78% at VH. PH fell half-way between with a mean of 56%. PH was the leader, however, in mean percent of time with ground permits - 61% as compared with 15% at SH.

Tables 4-5, 4-6, and 4-7 present the results of the specific data analyses.

Table 4-5. Relationship between Percent of Time Spent on Open Wards and Mach V Scale Scores.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PH (N=9)</td>
</tr>
<tr>
<td>r</td>
<td>-0.351</td>
</tr>
<tr>
<td>p</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

Table 4-6. Relationship between Percent of Time Spent with Ground Permits and Mach V Scale Scores.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PH (N=9)</td>
</tr>
<tr>
<td>r</td>
<td>0.327</td>
</tr>
<tr>
<td>p</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

*No ground permits used.

Table 4-5, percent of time spent on open wards and Mach V scale scores, showed a product moment coefficient of correlation of
Table 4-7. Relationship between Percent of Combined Time Spent on Open Ward/Ground Permit and Mach V Scale Scores.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>PH (N=9)</th>
<th>SH (N=26)</th>
<th>VH (N=16)</th>
<th>Hospitals Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>( r )</td>
<td>0.053</td>
<td>-0.125</td>
<td>0.598</td>
<td>0.147</td>
</tr>
<tr>
<td>( p )</td>
<td>&gt; .05</td>
<td>&gt; .05</td>
<td>&lt; .01</td>
<td>&gt; .05</td>
</tr>
</tbody>
</table>

0.598 at VH, significant beyond the .01 level. The relationships for PH and SH were not significant, nor was the correlation for the three hospitals combined. Table 4-6 made it clear that no significant relationship existed for ground permits in either hospital that utilized them, or for the hospitals combined.

The best test of Hypothesis #2 was provided by Table 4-7 in which open ward and ground permit experiences were combined. Although VH showed a strong relationship (\( r = 0.598 \)), it was insufficient to produce a significant correlation for all the hospitals combined (\( r = 0.147 \)). The relationships at PH and SH did not approach significance. The hypothesis was rejected.

Once again, it was apparent that a consistent pattern across hospitals was lacking. At VH ground permits were not used; in addition, a concerted effort on the part of the hospital staff to transform closed wards into open ones greatly increased the patients' opportunities and rewards for manipulation. These opportunities were more circumscribed at PH and SH where financial problems and administra-
tive patient placement were limiting factors.

Hypothesis #3:

The greater his manipulative orientation, the more a mental patient will know about his hospital environment.

Table 4-8 presents descriptive statistics for the Hospital Information Test scores by hospitals. Table 4-9 gives the relationship between these HIT scores and the Mach V scale scores.

Table 4-8. Hospital Information Test Scores* by Hospitals.

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>N</th>
<th>Min.</th>
<th>Max.</th>
<th>Mean</th>
<th>S. D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH</td>
<td>9</td>
<td>24</td>
<td>64</td>
<td>44.22</td>
<td>13.27</td>
</tr>
<tr>
<td>SH</td>
<td>26</td>
<td>0</td>
<td>89</td>
<td>48.19</td>
<td>25.82</td>
</tr>
<tr>
<td>VH</td>
<td>16</td>
<td>34</td>
<td>81</td>
<td>55.63</td>
<td>14.27</td>
</tr>
<tr>
<td>All Hospitals</td>
<td>51</td>
<td>0</td>
<td>89</td>
<td>49.82</td>
<td>20.99</td>
</tr>
</tbody>
</table>

*As explained in Chapter 3, three forms of the HIT were necessary to ensure its applicability to the specific hospital. A concommitant result of this "tailoring" was that the total number of questions differed slightly between tests. The scores were expressed as a percentage of the possible number correct.

Table 4-9. Relationship between HIT Scores and Mach V Scale Scores.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>PH (N=9)</th>
<th>SH (N=26)</th>
<th>VH (N=16)</th>
<th>Hospitals Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>r</td>
<td>-0.812</td>
<td>0.324</td>
<td>0.290</td>
<td>0.250</td>
</tr>
<tr>
<td>p</td>
<td>&lt; .005</td>
<td>&lt; .05</td>
<td>&gt; .05</td>
<td>&lt; .05</td>
</tr>
</tbody>
</table>
The posited relationship was supported at SH at the .05 level and was maintained for the group of three hospitals combined. However, once again the data indicated a marked difference between hospitals with PH showing a significant negative relationship.

The variation in HIT scores at SH was greater than at the other hospitals; at the same time, the Mach V scale scores (see Table 4-1) were lower in mean value and more dispersed. A careful and intensive investigation of the differences between hospitals was outside the scope of this study. Nonetheless, a recognition of gross differences had to be included to guard against misinterpretation and the natural tendency to use these three hospitals as representative of their types. Clearly, any generalization to other hospitals would be inappropriate.

The significant relationship, $r = 0.250$, found between manipulative orientation and amount of information about the hospital environment deserved some further analysis. Was the observed relationship due to some other variable(s)? Was it merely a spurious correlation?

The question was attacked by calculating partial correlations between HIT scores and Mach V scale scores with a series of other variables held constant. Age and education were classic choices for investigation as confounding variables. Drugs in the form of tranquilizers, energizers, or non-psychotropics were part of the all-pervading hospital environment. The psychotropic drugs provided fringe benefits of simplified patient management and fewer physical restraints for the
hospital while serving a therapeutic value for the patient. Non-psycho-
tropic drugs also served to improve the patients' feelings of well-being. However, taking any form of drug implied some restrictions on personal freedom since most patients received medication on their wards at set times. The number of previous hospitalizations and the number of months of current hospitalization were seen as factors influencing the opportunity to learn about the hospital environment, as were the percent of time spent on an open ward or with a ground permit.

The results of successively partialling out each of these variables are presented in Table 4-10.

Table 4-10. Partial Correlations between HIT Scores and Mach V Scale Scores with Selected Variables Held Constant. (HIT • Mach V = 0.250)

<table>
<thead>
<tr>
<th>Variable Held Constant</th>
<th>P Corr</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.294</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Education</td>
<td>0.256</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Number of Tranquilizing Drugs</td>
<td>0.266</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Number of Energizing Drugs</td>
<td>0.242</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Number of Non-Psychotropic Drugs</td>
<td>0.238</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Number of Previous Hospitalizations</td>
<td>0.279</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Number of Months of Current Hospitalization</td>
<td>0.262</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Percent of Time on Open Ward</td>
<td>0.227</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Percent of Time with Ground Permit</td>
<td>0.276</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Percent of Time on OW/GP Combined</td>
<td>0.247</td>
<td>&lt;.05</td>
</tr>
</tbody>
</table>

*p refers to the significance of the increment.

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HIT scores and Mach V scale scores showed a coefficient of correlation of 0.250. This association was reduced when the number of energizing drugs, number of non-psychotropic drugs, percent of time on an open ward, and the combination of open ward and ground permit experiences were held constant. The association was increased when age, education, number of tranquilizing drugs, the number of previous hospitalizations, the number of months of current hospitalization, and the percent of time spent with a ground permit were held constant. However, although the changes from the original coefficient of correlation (0.250) ranged from a low of 0.227 to a high of 0.294, only one shift was significant at the .05 level. This shift occurred when age was held constant, resulting in a partial correlation of 0.294. The relationship between HIT scores and Mach V scale scores, therefore, was not a result of some other combination of variables but a direct linkage in its own right. Hypothesis #3 was supported, although clearly the coefficient of correlation was of low magnitude.

Hypothesis #4

Mental patients with greater manipulative orientation will be overrepresented in VH and underrepresented in PH.

A one-way analysis of variance was run to test this hypothesis. Table 4-11 presents the results of the analysis.

The hypothesized difference in concentration by hospitals of patients with varying degrees of manipulative orientation was not
found. The analysis of variance yielded a $F$ value of 0.62 with an associated probability in excess of .05. Hypothesis #4, which posited a significant order of $VH > SH > PH$ was rejected.

Table 4-11. One-Way Analysis of Variance of Mach V Scale Scores by Hospitals.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>$N$</th>
<th>Sum of $X$'s</th>
<th>Mean</th>
<th>S. D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH</td>
<td>9</td>
<td>823.0</td>
<td>91.4</td>
<td>10.28483</td>
</tr>
<tr>
<td>SH</td>
<td>26</td>
<td>2236.0</td>
<td>86.0</td>
<td>20.33912</td>
</tr>
<tr>
<td>VH</td>
<td>16</td>
<td>1466.0</td>
<td>91.6</td>
<td>16.30900</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of sq.</th>
<th>df.</th>
<th>Mean sq.</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>394.1836</td>
<td>2</td>
<td>197.0918</td>
<td>0.62</td>
</tr>
<tr>
<td>Within</td>
<td>15177.9726</td>
<td>48</td>
<td>316.2078</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15572.1562</td>
<td>50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chapter 4 considered the data collected in the light of four hypotheses. Hypothesis #1 suggested that persons with higher manipulative orientation spent more time as mental patients than did other members of the hospital population. A product-moment coefficient of correlation of -0.094 between Mach V scale scores and the number of months of hospitalization was not significant and led to the rejection of the hypothesis. This lack of an identifiable association was also consistent for all three hospitals independently.

Hypothesis #2 suggested that patients with a higher manipula-
tive orientation spent a greater percent of their total hospital time on open wards or with ground permits. In actual practice VH did not use ground permits. In the other two hospitals, whether a patient was given a ground permit or housed on an open ward appeared related to administrative convenience and financial strength as well as to medical judgment. Accordingly, the time spent in either of these two situations was summed and treated in combination. No significant relationship for either of the conditions separately or in combination was found at PH or at SH. A significant correlation coefficient of 0.598 between time on an open ward and Mach V scale scores was found at VH. This relationship was not sufficiently strong, however, to result in a significant coefficient of correlation for the combined condition in the three hospitals. The hypothesis was rejected. It was clear that at least in the mental hospitals studied, some refinement of the hypothesis or of the methodology was required for a better understanding of the implications of manipulative orientations.

Hypothesis #3 suggested that patients with higher manipulative orientation knew more about their hospital environment than did other mental patients. A product-moment correlation between HIT scores and Mach V scale scores yielded significant coefficients at both PH and SH, and for all three hospitals taken in combination. The correlation was not significant at VH. An analysis of the partial correlations for ten possible confounding variables was run to investigate the
strength and nature of the relationship. Only one variable, age, was found to effect a significant change in the relationship. Manipulative orientation and information about the hospital were, therefore, assumed to be related and the hypothesis was supported.

Hypothesis #4 suggested unequal concentrations of persons with high manipulative orientations in the three hospitals. An analysis of variance revealed no significant difference between the hospitals and the hypothesis was rejected.

An interpretation of these findings, their theoretical significance, and suggestions for further research will be found in Chapter 5.
CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

The question originally posed in this investigation was whether mental patients were victims of society or exhibited a recognizable degree of control and direction over their own lives. In the course of data collection and analysis this investigator's view of the polarity of these stances underwent a change. What was first envisioned as black and white developed a strong gray hue since neither position was found to be free of elements of the other. The impossibility of considering them as independent entities was underscored by Zusman (1966:636). He stated quite simply that mental illness was operationally defined when two people came together and, as a result of their encounter, one called the other mentally ill. Whether the motivation for the labeled person's behavior was deliberate and controlled was the unanswerable moot point. It therefore seemed more reasonable to assume that the careers of mental patients incorporated aspects of both the victim and the manipulator roles which varied in strength according to the individuals involved.

However, it was possible to draw an interesting distinction from the literature. The view of the patient as victim (the labeling approach) drew the greater part of its support from situations and conditions in the prehospitalization period. On the other hand, recog-
nition of the mentally ill person's ability to exert control over his own life was found primarily in studies done within hospital settings.

As stated in Chapter 2, it was the question of control by mental patients over aspects of their hospitalization which guided this investigation. The assumption was made that patients would differ in the degree to which they could affect control: their willingness to do so was to be inferred from their Mach V scale scores. It was felt that the correlation between these scores and four simple variables representing some degree of individual control would offer an initial insight into the problem.

The results of the investigation have not provided any clear data either supporting or demolishing the contention that the mental patients studied were willing and able to exert control over their lives. One hundred and fourteen patients agreed voluntarily to take part in the investigation. However, only 83 actually appeared at the testing sessions. Of the 31 who were absent, 11 had been discharged. Ten of the remaining non-subjects (32%) refused to participate or simply did not appear. Their withdrawal from participation could easily be interpreted as exhibiting control over the situation, just as their earlier consent to be subjects might have been a manipulative ploy to present a favorable image. Whatever their motivation, however, their loss was not viewed as a biasing factor. As noted in Chapter 3, no significant differences were found between subjects and non-subjects.
on the variables it was possible to measure.

Christie and Geis, as quoted in Chapter 2, expressed themselves as doubtful of the application of the manipulator concept to the mentally ill. This was consistent with the tradition of viewing mental patients as inferior, inadequate personalities. However, subjects who found difficulty with the Mach V scale, almost to a man, questioned the wording of the instructions rather than voiced any misunderstanding of the items. Six patients, out of 32 whose questionnaires were not included in the data analyzed, answered none of the items. Most of the remaining 26 forms had to be eliminated because the patients entered evaluations for each part of the Mach V scale questions rather than limiting themselves to two out of three. The speculation surfaced here that some manipulative patients might have deliberately erred in their responses.

Christie and Geis (1970:21) felt that the intricate scoring system and hidden nature of the forced choice in their scale made it difficult, if not impossible, for respondents to isolate the "right" answers. However, in a mental hospital setting, the patients' views of "right" and "wrong" answers may have proceeded from a totally different prospective and rationale.

Pursuing the suggestion of deliberate error led to consideration of two different explanations for the same end result. First, patients who agreed to take part in the investigation would have appeared as
good, participative ward members to the hospital staff. Goffman (1961) referred to such behavior as exhibiting engrossment in organizational activities. However, at the same time the patients were then in a position to confuse the test results in case the responses were not really anonymous. This would have conformed to Braginsky at al's (1969:64-65) description of impression management.

Second, if anonymity did exist, the test offered an opportunity to play a trick on the test givers, to get back at the "establishment." The patient-subjects had the power to alter the test results at will without the fear of personally unpleasant consequences. The possibility of this motivation did not seem far-fetched. Rosenhan (1973:256) stressed that "Neither anecdotal nor 'hard' data can convey the overwhelming sense of powerlessness which invades the individual as he is continually exposed to the depersonalization of the psychiatric hospital." Goffman (1961:186) said, "To engage in a particular activity in the prescribed spirit is to accept being a particular kind of person who dwells in a particular kind of world." Perhaps the anonymous test situation was an ideal setting for the patients to break out of the prescription and to engage in untraceable acts of defiance or self-assertion.

It was possible here to question whether mental patients had sufficient test sophistication to recognize the opportunity to confuse the results. The mean number of years of education for the subject
sample was 12, 12, the equivalent of graduation from high school. Test taking, an accepted part of our public school education, was obviously not an exotic situation for the subjects. Furthermore, most patients underwent batteries of tests as part of their diagnostic and commitment experiences. Conversations with hospital personnel and the results found by Braginsky et al (1969:59ff) for impression management strengthened the investigator's opinion that the possibility of tampering with the results was both feasible and likely.

Neither of the foregoing speculations about the patients' behavior in the test situation could be buttressed with hard data. Investigation of these possibilities was not included in the study. On the other hand, neither the literature reviewed in Chapters 1 and 2 nor the data collected in the study specifically disproved or discredited these alternatives. The rationale for their inclusion lay in two areas: one, it underscored the opportunity to raise questions of motivation in regard to even the most quantitative of measurements; two, it suggested again that there might be little difference between the behavior of mental patients and that of "normals" in any other institutional setting. In fact, there was no reason to assume that a patient with great manipulative orientation could not behave in a completely normal fashion and still be considered mentally ill. Rosenhan's study (1973: 252) showed clearly that his "pseudopatients" were never detected by the professional staff. Even though, after admission, they made a
point of behaving completely sanely, the hospital personnel still saw them as "ill." Significantly, it was the other patients, apparently very much "tuned in" to their world, who saw through the masquerade.

The data compiled for this study were associated specifically with the four hypotheses advanced in Chapter 2. As such, they were expected to cast some light on the question of patient as victim or manipulator. A positive relationship was hypothesized between Mach V scale scores and the length of time patients were hospitalized. The inference here was that patients with greater manipulative orientation were more successful in maintaining their hospitalized status. Fontana et al (1968:118) found that current length of hospitalization was the only variable which differentiated consistently between their healthy presenter (HP) and sick presenter (SP) subjects. The expectation in this study was that patients with greater manipulative orientation were analogous to the sick presenter category. Therefore, it seemed likely that a comparable differentiation in length of current hospitalization would be found. This was not the case. The results suggested that no relationship existed between the two variables.

Reconsideration of the data offered few clues as to why the relationship between Mach V scale scores and length of hospitalization was not present. It was possible, of course, that manipulative patients held different views on the value of extended hospitalization. Frequent, brief stays rather than longer periods of residence may have best
served their personal preferences. On the other hand, it was also necessary to recognize the strong staff pressures at PH and VH to return patients rapidly to the community. This may have effectively neutralized any thrust on the part of the patients to remain hospitalized.

The absence of an observable relationship between Mach V scale score and length of current hospitalization gave no support to either the concept of personal control or that of victimization. Certainly the desire of hospital staff to return their patients to a normal environment could not be considered indicative of the latter position. At best, therefore, the relevance of these results to the patient as victim or manipulator was inconclusive.

A positive relationship was also hypothesized between greater manipulative orientation and the percentage of current hospitalization spent on open wards or with ground permits. Data for the hospitals combined did not support this position, although there was evidence in its favor at VH. There, however, the staff strongly encouraged patients to think and act for themselves. This atmosphere provided a structural context in which the personality variable (Mach) could operate. In other, more restrictive structural contexts, personality may have made little difference. This clouded any interpretation of the significant relationship as indicative of successful manipulation.

It should be remembered that patients at SH were moved
freely between different ward settings. The seeming impersonality of the decisions appeared in line with Stanton and Schwartz' (1954:408) description of the administrative view that patients were not active participants in their own lives but cases to be handled. However, there was no evidence that assignment of open ward or ground permit privileges was capricious. Once again, the data did not contribute to resolution of the victim/manipulator dilemma.

These relationships just reviewed quite clearly involved a personality variable which was operationalized as the Mach V scale score. It was important, however, when considering this variable, not to lose sight of the fact that it did not operate in a vacuum. The milieu in which the patient found himself was a prime factor. In no sense could the institution be considered a tabula rasa into which the individual freely carved his path. Each hospital had an impact of its own upon its patients. There was necessary adaptation to the environment as well as, presumably, manipulation of it. The inconclusive results of several of the hypotheses may well have accurately reflected a lack of patient ability to manipulate successfully. These same results may have served to mask the intensity of intent and attempt which accompanied these failures.

Another point for examination was the suggestion that greater manipulative orientation was positively related to the amount of knowledge about the hospital environment. It seemed to this inves-
tigator that this relationship was the key one studied. It was possible for greater manipulative orientation to show a positive relationship with length of current hospitalization and/or the percent of time spent on open wards or with ground permits and yet still be in question. Unless there was also a positive relationship with amount of knowledge about the hospital, the other associations could not be considered credible. It was not logical to believe that patients could exert control over their hospital situation without first-hand, detailed knowledge of the staff and surroundings relevant to them. (Caudill underscored the importance of this knowledge when he listed physicians, nurses, and physical space as important reference points for mental patients.) On the other hand, it was possible to imagine situations in which control by patients was thwarted or severely limited despite this information.

The correlation found between greater manipulative orientation and knowledge about the hospital, although small, was both positive and significant. It was interesting to recall here that 41 of the 51 subjects were diagnosed as schizophrenic. As frequently cited in Chapter 1, such persons have traditionally been viewed as withdrawn, apathetic, and somehow lacking in interest in the world about them. Nonetheless, the mean percent of items correct for the Hospital Information Test at the three hospitals ran between 44.22% and 55.63%. The mean percent correct for the hospitals combined was 49.82% and
individual scores ran as high as 89%. It appeared quite clear that these mental patients did pay attention to and internalize information about their surroundings. This was seen as support for the proposition that patients were capable of behavior essential to the successful direction of their own lives.

Evidence of selection by patients of their hospital was sought in the distribution of those exhibiting greater manipulative orientation. It was expected that VH would be most attractive and PH least attractive on the basis of perceived individual supervision and "fringe" benefits. This proved not to be the case. It seemed likely that hospital choice was not primarily a personal decision. Rather, it was strongly influenced by the advice of physicians and/or families as well as by available financial support. While not necessarily victims, the patients were not free to choose their own institutions.

The data did reveal a difference in overall commitment patterns. The subjects in PH and VH were largely voluntary commitments, while those in SH were largely involuntary. This split raised the question of whether still another factor was operative here. Did entering patients react differently to the perceived prestige of a particular mental hospital and accept or reject participation in the hospitalization process based on that perception? Again, no pertinent data were available.

In sum, the study did not uncover links between inferred
strength of manipulative orientation and three of the four dependent variables. One relationship was found to exist, although its magnitude was slight. It appeared that neither the argument for patient as victim nor for patient as manipulator received any conclusive support.

In all three hospitals the investigator had some minimal opportunity to personally observe relationships between staff and patients on the wards. The extensive literature, which described mental patients as victims of impersonality at best and subject to cruel treatment at worst, did not seem to apply to these institutions. Patients were referred to and addressed as individuals. The general attitude expressed was that the inmates were ill, but not that they were inferior or helpless. Since the wards visited were essentially open, this attitude may not have been duplicated in other areas. However, within these limits, Labels and Szasz' (1970:126) statement that the mentally ill person was treated like a child did not seem operative.

Recognizing that three of the four hypotheses were rejected, did this mean that the case for the existence of control by mental patients of their milieu was necessarily totally invalidated? The answer to this question was - no. The wisdom of hindsight revealed that there was latitude for error in the structure of the study, in the nature of the organizations involved, and possibly in the major instrument, all of which combined to obscure rather than illuminate the premise under consideration.
At the onset of this investigation, it seemed best to pick clearly quantifiable dependent variables. It was felt that this action would avoid the pitfalls inherent in interpretations by an untrained observer. Unfortunately, at least three of the variables chosen (length of hospitalization, percent of time spent on an open ward or with a ground permit, and the hospital of residence) were subject to confounding pressures, primarily of an institutional-administrative nature. These pressures were not foreseen or adjusted for by the investigator. It was, therefore, impossible in the analysis of the data to state definitively how much, if any, influence could be ascribed to the subjects and how much to the hospital itself.

In retrospect, another structural error appeared likely in the limitations on the subject sample. An effort was made to keep the sample quite homogeneous so that it would be easier to assign any relationship uncovered to the effect of manipulative orientation. However, Christie and Geis stated that they found no relationship between high Mach scores and a host of the usual intellectual, personality, and demographic variables. They said, "The one safe conclusion is that the marked individual differences in Machiavellianism are attributable to a very complex social learning process, and that the parameters have not yet been clearly identified." (Christie and Geis, 1970:338). It would seem that the study sample was probably unnecessarily truncated through the restrictions employed. (In at least one hospital,
to the investigator's knowledge, this resulted in a sample represen-
tation of probably less than 25% of the total patient population.) A
better course would have been to ignore differences in age, country
of birth, sex, color, and ward placement. Selection criteria could
have been limited to the following: not hospitalized for observation,
alcoholism, or drug addiction, and not diagnosed as an organic dis-
order.

If Christie and Geis were correct that high Mach scores were
unrelated to the usual descriptive variables, than an unknown number
of acceptable subjects were eliminated from this study. Thus, the
selection criteria used may have altered the relationships to be found.
It was also possible that the hospitals' requirement of a voluntary
written consent form acted as an initial screening device or biased
the test results. Patients with strong manipulative orientations may
have seen the testing situation as counter-productive and refused any
contact with it, or otherwise invalidated their responses.

In this study, a great deal of reliance was placed upon the Mach
V scale. It was the sole instrument from which degree of manipulative
orientation was inferred. An obvious question, therefore, was
whether the scale scores really reflected a willingness to manipulate
and some ability to do so. A number of recent studies (Christie and
Geis, 1970: Chapter XV) have used the Mach V scale to distinguish
between subjects as an aid to relating willingness to manipulate to
some other variable. The validity of the distinction, however, has not been generally questioned.

One investigator, Weitzel (1966), has taken issue with Christie and Geis' (1970:285) characterization of the high Mach as exhibiting a "cool syndrome." The results of Weitzel's study did not confirm their description of high Mach behavior as resistant to social influence, oriented to cognitions, and initiating and controlling structure. On the contrary, Weitzel (1966:43) called the high Mach "an insecure, anxious person . . . one who idealizes himself as hard and devious, a manipulator of others." He cited the relationship between scores on the Mach V scale and Rotter's I-E (internal-external) Scale to support this position. "Rather than obtaining the predicted, aggressive, self-assured, high I response (internally controlled), the high Mach tends to answer significantly less like I and more like E (externally controlled, belief that his rewards are in the hands of others or fate, luck plays a large role in success, etc.). E responses are hardly the kind of responses one would expect a manipulator to endorse" (Weitzel, 1966:46).

It seemed clear that the Mach V scale data lay open to several interpretations. High scores may have identified those persons most competent or willing to manipulate. They may have singled out insecure persons who admired the manipulative image and strongly wished to be identified with it. Finally, they may have been accurate
in designating those with strong manipulative orientation but valueless in terms of estimating their likelihood of success. That is, a greater manipulative orientation in no way guaranteed goal achievement, especially in a context where manipulative possibilities were restricted.

The data gathered for this study did not clearly favor any of these interpretations. Apart from the problems previously discussed which limited the applicability of the data, it seemed that further investigation of the Mach V scale itself was desirable. Exactly what information could realistically be inferred from its scores? What variable(s) did it really measure? As Weitzel (1966:43) commented, "It does not seem reasonable for a 'deceitful, manipulatory, deceptive and unprincipled Mach' to answer honestly and thus to expose himself. This is hardly the Machiavellian thing to do." Perhaps the strongest impression this investigator derived from using the Mach V scale was of the necessity for devising additional measures to isolate manipulative orientation. Some combination of approaches seemed to be indicated to pinpoint this elusive variable.

It would have been desirable to compare the degree of manipulative orientation expressed by mental patients with that of a standard population. Such a comparison might have provided data to support a decision on the patient's role as victim or manipulator. Unfortunately, standardized Mach V scale scores were not available. Scores were available for Christie and Geis' (1970:32) college population, broken
down into a Caucasian male category which partially met the requirements of the sample used for this mental patient study. The patient Mach V scale mean score of 88.73 was 10.54 points lower than the Caucasian male college student mean score of 99.27. This difference was significant at less than the .001 level (t = 5.80, df = 813).

It was possible to speculate that if the mean Mach V scale score of 88.73 had represented all those mental patients initially selected to be subjects, it would have been strongly suggestive of the view that patients were, indeed, victims. That is, they were railroaded into mental hospitals because they were less manipulative than a normal population and lacked the orientation and skill to save themselves.

In Chapter 3, the subjects and non-subjects were compared across all available demographic variables and all pertinent hospital-based records. T tests revealed no significant differences. On that basis, the null hypothesis of no differences between subjects and non-subjects could not be rejected. The next logical question was whether the investigator could reject the hypothesis of a difference between subjects and non-subjects on a variable for which data was not available, the Mach V scale scores. If these scores were independent of other existing measures, then the answer was negative. It was impossible to tell whether the selected patient subjects for whom Mach V scale scores were not available would have clustered around the same mean or
whether they might have revealed significantly greater manipulative orientation. Therefore, the possible bias introduced by the refusal of some acceptable subjects to sign the volunteer form, the failure of others to appear at the scheduled time, and the "inability" of still others to complete the scale properly vitiated this conclusion.

The apparently low mean Mach V scale score for patients was at least partially offset by the significant positive relationship found with knowledge of the hospital environment. The relevance of this relationship in terms of the subjects and their hypothesized manipulative orientation was discussed briefly in Chapter 2 and earlier in this chapter. It was also possible to speculate that patients who were selected as subjects but for some reason failed to participate appropriately (excluding, of course, those who were discharged) exhibited a subtle but accurate knowledge of the hospital's sociological environment. They may have recognized the possibility that their participation and the use made of their responses might militate against their image/status maintenance. The decision to participate or not, and the point at which withdrawal from the subject pool occurred, could be viewed as instances of the exercise of personal control.

The Mach V scale score range was 40-160, with 100 considered a neutral score. In the Christie and Geis experiments, high and low Mach divisions were usually determined by using the median score as the separation point. Translated into the data of this study,
with a median score of 92, 27 subjects fell into the high Mach category and 24 into the low Mach one. However, only 7 subjects (14%) had scores above the neutral 100. It seemed, therefore, that any high/low division would be a meaningless one.

The conclusions derived from consideration of this latter point and the relationship between the Mach V scale scores and the HIT were twofold. The first was that the patients either lacked sufficiently strong manipulative orientation or were unable to express it in effective action to control the course of their hospital commitment. The second was that, within the institution itself, the subjects who were more oriented toward manipulation were able to act to maximize their possibilities for management. That is, the degree of manipulative orientation inadequate in one situation functioned successfully in another.

A case was made in Chapter 1 for two divergent views of the mental patient as victim or manipulator. The data gathered and observations made in the course of this study modified the investigator's original viewpoint to the position that elements of both were probably present in most patient careers. The implication drawn from this in terms of sociological thought was that no absolutist theory, no matter how beautifully spun, was acceptable as an ultimate truth.

Further research is clearly needed to assign relative strengths to the positions of victim and manipulator in mental patient careers. Appropriate methodologies should certainly include more precise
measures of manipulative orientation and skill (possibly administered on an individual basis), unobtrusive measures to support test results, participant observation of the behaviors which cannot be uncovered in brief testing situations, and anecdotal evidence from hospital personnel.

As noted previously, a broader subject sample should be used. Studies of manipulative orientation using comparative populations outside the hospital setting would assist in the interpretation of mental patient scores. Personal interviews, rather than paper and pencil tests, might elicit more information where minimal education poses a problem.

Alternative ways of determining the patient's knowledge about the hospital environment should be considered. Also, hospital personnel should be asked to generate a list of patient privileges which might reflect success in manipulation more precisely than the open ward/ground permit classifications used in this study. Ideally, such a list could be ranked from least to most preferred privileges.

It would theoretically be possible, in a research situation, to interview mental patients and ask them questions specifically designed to "finger" manipulators among their wardmates. However, the ethics of such a procedure are debatable. In the hospital setting, the manipulator is a potential problem against whom some action will quite possibly be taken. To use other patients to bring about his undoing strikes this investigator as inappropriate.
The problems involved in treating mental patients have not lessened over time. The manipulative patient is not a hypothetical issue to hospital personnel. He does create a resource drain which is potentially unfair to other patients, and his early identification is a matter of therapeutic and economic urgency.

This study has examined one personality variable, manipulative orientation, in the hope of contributing to this identification. Although three of the four hypotheses were not supported, it was possible that relationships did exist which were not uncovered by the methodology employed. Further research in this area is strongly suggested. Sociological thought can make an important contribution to the goals of minimal institutionalization and maximal reintegration of the manipulatively oriented mental patient.
APPENDICES
APPENDIX A

MACH V SCALE

You will find 20 groups of statements listed below. Each group is composed of three statements. Each statement refers to a way of thinking about people or things in general. They reflect opinions and not matters of fact — there are no right or wrong answers and different people have been found to agree with different statements.

Please read each of the three statements in each group. Then decide first which of the statements is most true or comes the closest to describing your own beliefs. Make an X in the most true column.

Then decide which of the remaining two statements is most false or is the farthest from your own beliefs. Make an X in the most false column.

Here is an example:

A. It is easy to persuade people but hard to keep them persuaded. 
   Most True False

B. Theories that run counter to common sense are a waste of time. 
   _ X _

C. It is only common sense to go along with what other people are doing and not be too different. 
   _ X _

In this case, statement B would be the one you believe in most strongly and A and C would be the ones that are not as characteristic of your opinion. Statement C would be the one you believe in least strongly and is least characteristic of your beliefs.

You will find some of the choices easy to make; others will be quite difficult. Do not fail to make a choice no matter how hard it may be. You will mark two statements in each group of three — the one that comes the closest to your own beliefs and the one farthest from your beliefs. The remaining statement should be left unmarked.

Do not omit any group of statements.

1. A. It takes more imagination to be a successful criminal than a successful business man. 
   _ _
Most True Most False

B. The phrase, "the road to hell is paved with good intentions" contains a lot of truth.

C. Most men forget more easily the death of their father than the loss of their property.

2. A. Men are more concerned with the car they drive than the clothes their wives wear.
B. It is very important that imagination and creativity in children be cultivated.
C. People suffering from incurable diseases should have the choice of being put painlessly to death.

3. A. Never tell anyone the real reason you did something unless it is useful to do so.
B. The well-being of the individual is the goal that should be worked for before anything else.
C. Once a truly intelligent person makes up his mind about the answer to a problem he rarely continues to think about it.

4. A. People are getting so lazy and self-indulgent that it is bad for our country.
B. The best way to handle people is to tell them what they want to hear.
C. It would be a good thing if people were kinder to others less fortunate than themselves.

5. A. Most people are basically good and kind.
B. The best criteria for a wife or husband is compatibility -- other characteristics are nice but not essential.
C. Only after a man has gotten what he wants from life should he concern himself with the injustices in the world.

6. A. Most people who get ahead in the world lead clean, moral lives.
B. Any man worth his salt shouldn't be blamed for putting his career above his family.
C. People would be better off if they were concerned less with how to do things and more with what to do.
7. A. A good teacher is one who points out unanswered questions rather than gives explicit answers.  
   B. When you ask someone to do something for you, it is best to give the real reasons for wanting it rather than giving reasons which might carry more weight.  
   C. A person's job is the best single guide as to the sort of person he is.  

8. A. The construction of such monumental works as the Egyptian pyramids was worth the enslavement of the workers who built them.  
   B. Once a way of handling problems has been worked out it is best to stick to it.  
   C. One should take action only when sure that it is morally right.  

9. A. The world would be a much better place to live in if people would let the future take care of itself and concern themselves only with enjoying the present.  
   B. It is wise to flatter important people.  
   C. Once a decision has been made, it is best to keep changing it as new circumstances arise.  

10. A. It is a good policy to act as if you are doing the things you do because you have no other choice.  
    B. The biggest difference between most criminals and other people is that criminals are stupid enough to get caught.  
    C. Even the most hardened and vicious criminal has a spark of decency somewhere within him.  

11. A. All in all, it is better to be humble and honest than to be important and dishonest.  
    B. A man who is able and willing to work hard has a good chance of succeeding in whatever he wants to do.  
    C. If a thing does not help us in our daily lives, it isn't very important.
12. A. A person shouldn't be punished for breaking a law which he thinks is unreasonable.  
   B. Too many criminals are not punished for their crimes.  
   C. There is no excuse for lying to someone else

13. A. Generally speaking, men won't work hard unless they're forced to do so.  
   B. Every person is entitled to a second chance, even after he commits a serious mistake.  
   C. People who can't make up their minds aren't worth bothering about.

14. A. A man's first responsibility is to his wife, not to his mother.  
   B. Most men are brave.  
   C. It's best to pick friends that are intellectually stimulating rather than ones it is comfortable to be around.

15. A. There are very few people in the world worth concerning oneself about.  
   B. It is hard to get ahead without cutting corners here and there.  
   C. A capable person motivated for his own gain is more useful to society than a well-meaning but ineffective one.

16. A. It is best to give others the impression that you can change your mind easily.  
   B. It is a good working policy to keep on good terms with everyone.  
   C. Honesty is the best policy in all cases.

17. A. It is possible to be good in all respects.  
   B. To help oneself is good; to help others even better.  
   C. War and threats of war are unchangeable facts of human life.

18. A. Barnum was probably right when he said that there's at least one sucker born every minute.  
   B. Life is pretty dull unless one deliberately stirs up some excitement.
19. A. Sensitivity to the feelings of others is worth more than poise in social situations.  

B. The ideal society is one where everybody knows his place and accepts it.  

C. It is safest to assume that all people have a vicious streak and it will come out when they are given a chance.

20. A. People who talk about abstract problems usually don't know what they are talking about.  

B. Anyone who completely trusts anyone else is asking for trouble.  

C. It is essential for the functioning of a democracy that everyone votes.
APPENDIX B

HOSPITAL INFORMATION TEST II

1. (a) What is the name of your psychiatrist?
   (b) What floor is his or her office on?

2. What is the name of a psychiatrist in
   a. Building "A"
   b. Building "B"
   c. Building "C"

3. (a) What is the name of a nurse in your building?
   (b) What floor is her office on?

4. What is the name of a nurse in
   a. Building "A"
   b. Building "B"
   c. Building "C"

5. (a) What is the name of the doctor in charge of your building?
   (b) What floor is his office on?

6. What is the name of the doctor in charge of
   a. Building "A"
   b. Building "B"
   c. Building "C"

7. (a) What is the name of the nursing supervisor in your building?
   (b) What floor is her office on?

8. What is the name of the nursing supervisor in
   a. Building "A"
   b. Building "B"
   c. Building "C"

9. (a) What is the name of the psychologist in your building?
   (b) What floor is his office on?

10. What is the name of a psychologist in
    a. Building "A"
    b. Building "B"
    c. Building "C"
11. (a) What is the name of the social worker in your building?  
   (b) What floor is his or her office on?  

12. What is the name of a social worker in  
   a. Building "A"  
   b. Building "B"  
   c. Building "C"  

13. (a) What is the name of the Superintendent of this hospital?  
   (b) What building is his office in?  

14. How many floors are in your building?  

15. What is the name of the chapel building?  

16. What is the name of the occupational therapy building (OT)?  

17. What is the name of the administrative office building?  

18. What is the name of the movie theatre building?  

19. What building is the canteen in?  

20. What are the visiting days?  

21. What are the visiting hours?  

22. Make a guess as to how many patients are living in your building.  

23. Make a guess as to how many patients are in the entire hospital.  

24. How much vacation time does a state employee get?  

25. (a) How many nursing shifts do they have in the hospital?  
   (b) What are their times?  

26. What is your diagnosis?  

27. What medication do you receive?  (Name and amount)  

28. Where can you get good used clothing in the hospital?  

29. (a) What is the name of the hospital magazine?  
   (b) How often is it published?
30. What are the library hours?
31. How many libraries are there in the hospital?
32. Where are they located?
33. Where are the patient dances held?
34. What is the name of the medical and surgical building?
35. Where is the out-patient clinic?
36. Where is the main dental office?
37. Who is the business manager?
38. Where is he?
39. Where is the hospital post office?
40. Where is the hospital garage?
41. Who is the head of the OT department?
42. Who is the head of the nursing department?
43. Where is the hospital pharmacy?
44. Where is the police department?
45. Who is head of social service?
46. Where is the hospital switchboard?
47. (a) Who is head of volunteers?  
(b) Where is she?
48. Where is the bowling alley?
49. Where is the gym?
50. Where is the pool?
51. Where is the music department?
52. Where is the school?
53. Where is the gift shop?
54. Where is the laboratory?
55. Where is the swank shop?
56. Where are the names of buildings in which employees live?
57. Where is the printing shop?
58. Where is the psychology department?
59. Where is the shoe repair shop?
60. Where is the tailor shop?
APPENDIX C

HOSPITAL INFORMATION TEST - PH

We would like to know how much information you have about various aspects of the hospital. Please answer all the questions as best you can in the spaces provided.

1. (a) What is the name of your psychiatrist? ______________________
    (b) What building is his or her office in? ______________________

2. What is the name of a psychiatrist in
   a. Building 1 ______________________
   b. Building 2 ______________________
   c. MTC __________________________

3. (a) What is the name of a nurse in your building? ________________
    (b) What floor is her office on? __________________________________

4. What is the name of a nurse in
   a. Building 1 ______________________
   b. Building 2 ______________________
   c. MTC __________________________

5. (a) What is the name of the doctor in charge of your unit? ________
    (b) What building is his office in? ______________________________

6. What is the name of the doctor in charge of
   a. Building 1 ______________________
   b. Building 2 ______________________
   c. MTC __________________________

7. (a) What is the name of the nursing supervisor in your building?
    ______________________________
    (b) What floor is his/her office on? ____________

8. What is the name of the nursing supervisor in
    a. Building 1 ______________________
    b. Building 2 ______________________
    c. MTC __________________________

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9. (a) What is the name of the psychologist on your unit? ____________  
(b) What building is his office in? ________________________________

10. What is the name of a psychologist in  
    a. Building 1 _________________________  
    b. Building 2 _________________________  
    c. MTC _______________________________

11. What is the name of the social worker on your unit? ____________  
What building is his or her office in? ______________________________

12. What is the name of a social worker in  
    a. Building 1 _________________________  
    b. Building 2 _________________________  
    c. MTC _______________________________

13. (a) What is the name of the Superintendent of this hospital? ______  
(b) What building is his office in? ________________________________

14. How many floors are in your building? ________________

15. What is the name of the building where religious services are held?  
______________________________

16. What is the name of the building where adjunctive therapy (AT)  
activities are held? ________________________________________

17. What is the name of the administrative office building? ________

18. What is the name of the building where movies are shown? ________

19. What building is the coffee shop in? ____________________________

20. What are visiting days? _______________________________________

21. What are visiting hours? ______________________________________

22. Make a guess as to how many patients are living in your building.  
____________________________

23. Make a guess as to how many patients are in the entire hospital.  
____________________________

24. (a) How many nursing shifts do they have in the hospital? ______ 
(b) What are their times? ________________________________
25. What is your diagnosis? __________________________

26. What medication do you receive (Name and amount)? __________

27. Where can you get good used clothing at the hospital? __________

28. (a) What is the name of the hospital magazine? ________________
    (b) How often is it published? _________________________________

29. What are the library hours? __________________________ 

30. How many libraries are there in the hospital? ______________

31. Where are they located? ________________________________

32. Where are the patient dances held? ________________

33. What is the name of the building housing the X-ray and laboratory 
    departments? ______________________________________

34. Where is the out-patient clinic? ________________

35. Where is the main dental office? ________________

36. Who is the business manager? ______________________

37. Where is he? __________________________________________

38. Where is the hospital garage? ______________________

39. Who is the head of the AT department? __________

40. Who is the head of the nursing department? ________________

41. Where is the hospital pharmacy? ______________________

42. Who is head of social services? ______________________

43. Where is the hospital switchboard? ______________________

44. (a) Who is head of volunteers? ______________________
    (b) Where is she? _________________________________________

45. Where is the bowling alley? ____________________________
46. Where is the gym? _________________________
47. Where is the pool? _________________________
48. Where is the music department? ______________
49. Where is the school? __________________________
50. Where is the laboratory? ______________________
51. What are the names of buildings in which employees live? _______
52. Where is the printing shop? ____________________
53. Where is the psychology department? ________________
54. Where is the barber shop? ______________________
We would like to know how much information you have about various aspects of the hospital. Please answer all the questions as best as you can in the spaces provided.

1. (a) What is the name of your psychiatrist? __________________
    (b) What building is his or her office in? __________________

2. What is the name of a psychiatrist in another building? ______

3. (a) What is the name of a nurse in your building? ____________
    (b) What floor is her office on? ________________

4. What is the name of a nurse in another building? ____________

5. (a) What is the name of the doctor in charge of your building?
    __________________
    (b) What floor is his office on? ________________________

6. What is the name of the doctor in charge of another building?
    __________________

7. (a) What is the name of the nursing supervisor in your building?
    __________________
    (b) What floor is her office on? ________________

8. What is the name of the nursing supervisor in another building?
    __________________

9. (a) What is the name of the psychologist in your building? ______
    (b) What floor is his office on? ________________________

10. What is the name of the psychologist in another building? ______

11. (a) What is the name of the social worker in your building?
    __________________
    (b) What floor is his or her office on? ________________

12. What is the name of a social worker in another building? ______

13. (a) What is the name of the Superintendent of this hospital? _____
    (b) What building is his office in? ________________________
14. How many floors are in your building? ________________
15. What is the name of the chapel building? ________________
16. What is the name of the occupational therapy building (OT)? _____
17. What is the name of the administrative office building? __________
18. What building is the canteen in? _________________________
19. What are the visiting days? _____________________________
20. What are the visiting hours? ____________________________
21. Make a guess as to how many patients are living in your building.
   __________
22. Make a guess as to how many patients are in the entire hospital.
   __________
23. How much vacation time does a state employee get? _________
24. (a) How many nursing shifts do they have in the hospital? _____
    (b) What are their times? ________________________________
25. What is your diagnosis? ________________________________
26. What medication do you receive? (Name and amount.) ________
27. Where can you get good used clothing in the hospital? ________
28. (a) What is the name of the hospital magazine? _____________
    (b) How often is it published ____________________________
29. What are the library hours? _____________________________
30. How many libraries are there in the hospital? _____________
31. Where are they located? _________________________________
32. Where are the patient dances held? ______________________
33. What is the name of the medical and surgical building? ________
34. Where is the out-patient clinic?
35. Where is the main dental office? _________________________
36. Who is the business manager? _________________________
37. Where is his office? _________________________
38. Where is the hospital post office? _________________________
39. Where is the hospital garage? _________________________
40. Who is head of the OT department? _________________________
41. Who is head of the nursing department? _________________________
42. Where is the hospital pharmacy? _________________________
43. Where is the safety department? _________________________
44. Who is head of social service? _________________________
45. Where is the hospital switchboard? _________________________
46. (a) Who is head of volunteers? _________________________
   (b) Where is she? _________________________
47. Who is head of patient affairs? _________________________
48. Where is the gym? _________________________
49. Where does your food come from? _________________________
50. Where is the music department? _________________________
51. Where is the children's unit? _________________________
52. Where is the laboratory? _________________________
53. Where is the printing shop? _________________________
54. Where is the psychology department? _________________________
55. Where is the shoe repair shop? _________________________
56. Where do you get your medication? _________________________
57. Name one of the chaplains. _________________________
We would like to know how much information you have about various aspects of the hospital. Please answer all the questions as best as you can in the spaces provided.

1. (a) What is the name of your doctor or ward administrator? _______
    (b) What floor is his or her office on? ____________________________

2. What is the name of your unit chief? __________________________

3. (a) What is the name of a nurse in your building? _________________
    (b) What floor is her office on? ________________________________

4. What is the name of a nurse in another building? ________________

5. (a) What is the name of the doctor in charge of your building? ____
    (b) What floor is his office on? _________________________________

6. What is the name of the doctor in charge of another building? ____

7. (a) What is the name of the nursing supervisor in your building?
    __________________________________________________________________
    (b) What floor is her office on? _________________________________

8. What is the name of the nursing supervisor in another building?
   __________________________________________________________________

9. (a) What is the name of the psychologist in your building? _______
    (b) What floor is his office on? _________________________________

10. What is the name of a psychologist in another building? _______

11. (a) What is the name of the social worker on your ward? _______
    (b) What floor is his or her office on? __________________________

12. What is the name of a social worker in another building? _______

13. (a) What is the name of the Director of this hospital? _______
    (b) What building is his office in? _____________________________

14. How many floors are in your building? ___________

15. What is the name of the chapel building? ___________

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16. Where is an occupational therapy clinic? ________________
17. What is the name of the administrative office building? ________
18. What is the name of the movie theatre building? ________________
19. In what building do you get your coffee and snacks? ______________
20. What are the visiting days? ____________________________
21. What are the visiting hours? ____________________________
22. Make a guess as to how many patients are living in your building. ______________
23. Make a guess as to how many patients are in the entire hospital. ______________
24. How much vacation time does a federal employee get? __________
25. (a) How many nursing shifts do they have in the hospital? ________
(b) What are their times? _________________________________
26. What is your diagnosis? ________________________________
27. What medication do you receive? ______________________
28. Where can you buy new clothing in the hospital? ______________
29. (a) What is the name of the hospital magazine? ________________
(b) How often is it published? ____________________________
30. What are the library hours? ____________________________
31. How many libraries are there in the hospital? ________________
32. Where are they located? ________________________________
33. Where are the patient dances held? ____________________________
34. What is the name of the medical building? ________________
35. Where is the outpatient clinic? ____________________________
36. Where is the main dental office? ____________________________
37. Who is the assistant director? ______________
38. Where is his office? ________________________
39. Where is the hospital post office? ___________
40. Where is the hospital garage? ______________
41. Who is the head of the OT department? ______
42. Who is the head of the nursing department? ___
43. Where is the hospital pharmacy? _____________
44. Where is the police department? ______________
45. Who is head of social service? _______________
46. Where is the hospital switchboard? __________
47. (a) Who is head of volunteers? ______________
    (b) Where is he? _____________________________
48. Where is the bowling alley? _________________
49. Where is the gym? __________________________
50. Where is the pool? _________________________
51. Where is the music department? _____________
52. Where is the school? _______________________ 
53. Where is the gift shop? _____________________
54. Where is the laboratory? ___________________
55. Where is the printing shop? ________________
56. Where is the psychology department? ________
57. Where is the shoe repair shop? ______________
58. Where is the tailor shop? __________________
59. Where is the patients' funds office? _________
60. How often can funds be withdrawn? ____________

61. Where is the travel clerk? _________________

62. Where is the personnel office for patient employment? ________

63. Where do you get your medication? _________________

64. Does your ward have a ward government? __________

65. Do you attend the ward government meetings? _________________

66. Where is the greenhouse?
APPENDIX D

PERSONAL DATA SHEET

Name _______________________________________

Hospital ______________________________________

Age___________

Marital Status ________________

Educational Background ________________

Last Occupation Before Hospitalization _____________________________

How Long Held ________________

Commitment: Voluntary _________ Other _________

Referred By ___________________________

Diagnosis __________________________________________________________________

Current Mental Status ___________________________________________

Type and Amount of Medication ___________________________________________

Number of Previous Hospitalizations _________________________________

When Occurred ___________________________

Length Of Time Between Hospitalizations _____________________________

Length of Present Hospitalization ______________________________________

Length Of Time On "Open" Ward Relative to Total Present Hospitalization ___________________________

If Veteran, Commitment Service Connected: Yes_____ No_____
## APPENDIX E

### INTERVAL DATA - SUBJECTS

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## Nominal and Ordinal Data - Non-Subjects

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APPENDIX G

STATEMENT TO SUBJECTS

Good afternoon (evening). My name is Louise Leader and I am a graduate student at Western Michigan University.

There has been a lot of talk lately about whether hospitals are really doing a good job of assisting the people in them. One of the problems seems to be whether the hospital staff understands the feelings, the attitudes, of the patients they are supposed to help. The staff here at __________ Hospital want to do the best job they can but they need your help. They need to know how you feel about all sorts of situations, what you know about the hospital and, if you want to tell them, what you think is done wrong.

The questionnaire you have volunteered to fill out will give the staff some direction. Please do not sign your name on any of the sheets. The important thing is the answer, not who makes it. There are no right or wrong answers. Just say exactly what you think. If you have additional comments, please write them on the back of the last page.

There are directions at the beginning of each section. Please follow them exactly. If you have a question about any directions, do not ask a friend. Let me know, and I will try to straighten it out. Please do not skip any section or question.

126
When you are all finished, please give the questionnaire and your pencil to me. You may then leave and we thank you for taking part in the study.

Please begin.
# APPENDIX H

## MACH V SCALE SCORES BY HOSPITALS

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### APPENDIX I

**HIT SCORES BY HOSPITALS (IN PERCENT)**

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Langner, T.

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Leighton, D., J. Harding, D. Macklin, A. Macmillan and A. Leighton

Levinson, D. and E. Gallagher

Levinson, D., J. Merrifield and K. Berg
Linn, L.

London, P.

Ludwig, A. and F. Farrelly

Machiavelli, N.

Manis, J., C. Hunt, M. Brawer and L. Kercher

Marks, E. and C. Lindsay

Mason, A., E. Tarpy, L. Sherman and D. Haefner

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Rensberger, B.

Robins, L.

Rose, A.

Rosenthal, D.

Ruesch, J.

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