CHAPTER III

PRESENT STUDY

The basic perspective of this study is formulated from the phenomenological and humanistic growth oriented approaches to the study of the self-concept. Broadly, Fitts hypothesis; "In general, add other things being equal, the more optimal the individuals self-concept the more effectively he will function" (Fitts, 1972, V, p 4), served as the guiding assumption of this study.

In the previous chapter it may be recalled, it was stated that the present study would be in a clinical context involving the study of maladjusted individuals having to some extent implications for the better understanding, prediction and treatment of behavior. In this context, it is apparent that the prevailing Zeitgeist of a time serves as an important guiding force in the planning of a research. Further, it is interesting to observe that today more than at any previous point in time, in the psychological literature, the growth aspects or self-actualizing aspects of an individual is being increasingly recognized and emphasized (eg., Schultz, 1977; Coan, 1977c) which, incidentally, reflects a shift of perspective from merely a study of the adaptive aspects of the individual to a study of
the 'whole' individual i.e., the growth or self actualizing potential too. Consequently, one observes a growing trend in this direction as evidenced by increasing numbers embracing sensitivity sessions, T groups, and other forms of encounter therapy. As Schultz notes:

"... practitioners and followers of the human potential movement explore their own inner natures and apparently ... are finding the sense of identity, autonomy, and fulfilment that the older and traditional approaches to psychology fail to provide (or even to recognize)" (Schultz, 1977, p iii).

Another aspect that this study is responding to is the growing disillusionment with some of the prevailing diagnostic procedures (Eysenck, 1960,1975; Laing, 1967; Szasz, 1961, 1970). In view of this, it would be of value to examine the potential value of self concept dimensions in further elucidating the labels for various deviant conditions into data language that perhaps may be more meaningful and of functional value. This in turn could have to some extent more tangible implications for treatment in contrast to many of the existing approaches which incidentally appear to be at a juncture or perhaps process of "diminishing returns".

In the backdrop/the aforementioned scene the objectives of the present study were two-fold; the first was to study the nature of the self concept in the clinical groups as well as a normal control group...
in terms of several measures of the self-concept, and
the second was to throw more light on the type of vari-
ables that would have to be posited to effectively
differentiate the clinical groups from a normal group
and also between the clinical group themselves.

Statement of the Problem

The problem of this investigation is to study the
self concept in different clinical groups as compared
to a normal control group and to identify those vari-
ables that most probably differentiate these groups
from one another on the basis of the tools and techni-
ques employed for this scientific study.

In the above statement the following major terms
need to be defined operationally; self concept, clini-
cal and normal groups.

Self Concept

This term has been defined variously by different
self psychologists. For example, Wylie (1977) de-
fines it as follows:

"I have construed the term self-concept to
include the following (a) operations and
evaluations regarding specific aspects of
self.... (b) ideal self, which I see as
comprising not only the person's ideals
about specific self aspects such as being
scholastically able .... but also such
phenomenal goals as working to be a well-
educated person. ....(c) overall self re-
gard-my generic term to cover such global
constructs as self esteem, self-favourability and self-ideal discrepancies which are presumably determined by some combination of operations and evaluations of many attributes of self" (Wylie, 1977, p 3-4).

For Rogers (1951) self concept:

"may be thought of as an organised configuration of perceptions of the self. It is composed of such elements as the perceptions of one's characteristics and abilities; the percepts and concepts of self in relation to others and to the environment; the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive or negative valence" (Roger, 1951, p 136).

Epstein (1973) submits that the self concept is a self theory.

"It is a theory that the individual has unwittingly constructed about himself as an experiencing, functioning individual, and it is part of a broader theory which he holds with respect to his entire range of significant experience" (Epstein, 1973, p 407).

In addition to the above, there have been several other efforts at defining the self concept and some of these have been already dealt with in the review chapter.

The term self concept in the present investigation is employed to refer to a complex entity with many facets and dimensions and the following working definition is employed:

"...the self is both object and doer and that self perceptions relate to both these aspects of self. The total self, as experienced by the individual is aptly labelled "the phenomenal self" (Snygg and Combs, 1949; Combs and
Snygg, 1959). This phenomenal self is the self as observed, experienced, and judged by the individual himself; this is the self of which he is aware. The sum total of all these awarenesses or perceptions is his image of himself—his self concept" (Fitts, 1971, iii, p 14).

**Normal Groups**

The terms 'clinical' and 'normal' groups as construed here refer to the presence of psychopathological symptoms or the absence of such symptoms respectively. Further, in this investigation the subjects included in the clinical groups not only give evidence of psychopathological symptoms but also had sought psychiatric consultation. On the contrary, the normal group of subjects were not only free from any psychopathological symptoms but also had not sought psychiatric help at any time during their life till the time of the study. In this respect, Sabshin, (1967) in discussing the various 'psychiatric perspectives on normality' has pointed out that the particular perspective of 'normality as health' has been considered to have research and conceptual advantages, because disease is easier to measure than positive states of health" (Sabshin, 1967, p 260).

Finally it is to be noted that the clinical groups were treated as the experimental groups comprising of two samples of subjects, viz. Schizophrenics and Neurotics and the normal subjects constituted the control group.
HYPOTHESES

The hypotheses for the present study were stated in the null form in terms of a major and a minor hypotheses.

Major Hypothesis

No significant differences will be evident on the various measures of the self concept among the neurotics, schizophrenics and normal control group.

Minor Hypothesis

The neurotics, schizophrenics and normals cannot be significantly discriminated and classified on the basis of certain self-concept, socio-demographic and clinical case-history variables.

Research Design

In the process of framing the present research design cognizance was taken to the extent possible of the lacunae in the previous work related to the problem under study.

A matched-group design comprising of two experimental groups, namely, schizophrenics and neurotics and a normal control group have been utilized.

In this investigation, non-probability sampling had to be resorted to because of various limiting
factors inherent to clinical research. Nevertheless, care was taken to see that as homogenous groups as possible could be obtained by the control of a few of the variables relevant to the present study. This eventually ensured both between group and within group homogeneity in terms of the control variables for the two experimental groups and the normal control group.

One of the major forms of non probability sampling is the 'incidental' or 'accidental' sampling procedure in which the researcher includes in his sample all the 'satisfactory' cases that he comes across, continuing this process till the sample reaches a designated size (Selltiz, Jahoda and Cook, 1962). Here the term 'satisfactory' denotes the criteria employed specifically to a particular group—neurotic, schizophrenic and normal groups respectively— as well as that utilized across the 3 groups. More specifically, the latter refers to the control variables of age, sex, marital status and educational level, details of which now follow.

**Age**

The age range for selection was kept between 20 and 55 years (both years inclusive). As Thompson observes:

"For researchers, (studying self concept) age is a variable which must be controlled or accounted for in some fashion. The present
data show this to be true especially for young people (under 20) and the elderly (60 and over). Apparently, there are no great differences within the 20 to 60 year age span (Thompson, 1972, V, p 20-21).

In the light of this, an attempt was made to match the 3 groups on the age variable and subjects ranged from 20-55 years.

Sex

The present sample consisted of males. Sex-differences on psychological tests have been noted by many investigators (eg. Coan, 1974). However, in regard to overall self-regard the question remains unresolved (Wylie, 1974). In view of this it was considered appropriate to control for this variable and the present study consisted of males only. Females were excluded due to their availability in limited numbers in comparison to males when all the relevant criteria were enforced for purposes of selection.

Marital Status

Equal number of married and unmarried subjects were included in the 2 experimental groups and the control group. However, categories like widower, divorced, separated etc. were excluded due to their unavailability in sufficient numbers. The significance of marital status has been brought out in a few studies. For example, Richek (1969) found that
married college students perceive their phenomenal world more positively than do unmarried students in respect to both males and females. Ilfield (1978) found significant differences in self-esteem between married respondents and single respondents.

**Educational Level**

A minimum educational level of 10 years of formal schooling was fixed. Backman and O'Malley (1977) conclude that post high school educational attainment has no direct impact on self-esteem. Further, only those individuals who could easily understand and communicate in English language were included. This point was kept in mind as the study design required the subject to respond to the tests in English.

Finally, though Fitts (1965) notes that the effects of education are minimal on the self concept (The Tennessee Self-concept Scale) it was deemed appropriate to control for this variable so that no confounding effect could manifest itself when other test data was to be interpreted.

Each of the two experimental groups, namely, schizophrenics and neurotics and a normal control group consisted of 30 subjects. In all, 90 subjects had been included in the present study.
Source and Mode of Selection

Subjects for the 2 experimental groups were drawn from the National Institute of Mental Health and Neuro-Sciences, Bangalore, during a period of about 12 months from 21 March 1980 to 31 March 1981. The neurotics and schizophrenics were drawn from both the in-patient and out-patient departments. These cases were selected personally by the investigator herself according to the criteria laid down for this purpose, which now follows.

Neurotic Group. A primary diagnosis according to the ninth revision of the International Classification of Diseases (ICD-9) (W.H.O, 1977) by at least two consultant psychiatrists and one clinical psychologist was the main deciding factor for inclusion of a subject in this category. This procedure probably ensured higher inter-judge reliability and consensus in the diagnosis of neuroses. Finally, in addition to the above, the neurotics had to satisfy the other general criteria discussed earlier in this section pertaining to the control variables.

Schizophrenic Group. As in the case of neuroses, the main consideration for inclusion of a subject in this group was a diagnosis of schizophrenia according to ICD-9 by at least two consultant psychiatrists and one clinical psychologist. Similarly, as in the case of the neurotic group the various control variables
further delineated the manner by which a schizophrenic would be finally included or rejected for purposes of the present study.

Other factors considered in respect to the two experimental groups were that the subjects had to have no evidence of any chronic illnesses, organic impairment, epilepsy, mental-retardation, physical disability or sensory defect and alcoholism or drug addiction. Also, the clinical condition of the neurotic or schizophrenic had to be such that they would be in a position to be tested and intervieiwed.

The control group was studied during the same period as the two experimental groups. The criteria used for the selection of the control group is given below.

Normal Group. It is interesting to note that the problem of defining what is 'normal' or health on one side, and what is 'abnormal' on the other has been the subject of much debate (eg., Coan, 1974). However, for purposes of clinical research, normality has often been defined as not having sought psychiatric help at any time during one's life and this criterion was adopted in the present study for inclusion of subject in the normal group. In addition, the subjects had to satisfy the
criteria of not being in the mental health field\(^1\), of fulfilling the specifications in respect to the various control variables and agreeing for a willing participation in the present research project without any monetary recompense.

**DESCRIPTION OF THE STUDY GROUP**

Group matching technique was adopted to select the subjects for the 3 groups in the present investigation. The details regarding the variables are as follows:

**Age**

In the neurotic group the age range is 20-40 years with a mean of 30.5 and SD of 12.71. In the schizophrenic group the age range is 20-50 years with a mean of 30.9 and SD of 8.25. In the normal control group the age range is 20-40 years with a mean of 30.1 and SD of 4.43.

To see the comparability of the 3 groups with respect to age Chi-square test was applied and the results are presented in the following table (Table 2).

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\(^1\)Many psychologists have observed that students of psychology may not be a 'naive' sample in answering psychological tests.
TABLE 2

Showing age distribution in the 3 groups

<table>
<thead>
<tr>
<th>Age</th>
<th>Schizophrenics</th>
<th>Neurotics</th>
<th>Normals</th>
<th>Total</th>
<th>Chi-Sq</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>14</td>
<td>13</td>
<td>15</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>14</td>
<td>11</td>
<td>14</td>
<td>39</td>
<td>0.27</td>
</tr>
<tr>
<td>40-49</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>N.S.</td>
</tr>
<tr>
<td>50-59</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

As is evident from the foregoing table the obtained Chi-Sq value is not statistically significant and it can be concluded that the 3 groups are comparable on this variable.

The present study included only males, for reasons already discussed earlier.

The 3 groups consisted of equal number of married and unmarried subjects. This is highlighted in the following table (Table 3).
TABLE 3

Showing marital status distribution in the 3 groups

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Schizophrenics</th>
<th>Neurotics</th>
<th>Normals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Married</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

Educational level of the 3 groups was compared utilizing Chi-square test, the details of which are presented below in Table 4.

TABLE 4

Showing distribution of formal education in the 3 groups

<table>
<thead>
<tr>
<th>Education</th>
<th>Schizophrenics</th>
<th>Neurotics</th>
<th>Normals</th>
<th>Total</th>
<th>Chi-Sq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Graduate</td>
<td>19</td>
<td>19</td>
<td>10</td>
<td>47</td>
<td>6.15</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>7</td>
<td>6</td>
<td>11</td>
<td>24</td>
<td>N.S.</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>
As the obtained Chi-square value is not significant the 3 groups can be considered comparable on this variable.

The groups were also comparable with regard to their locale (urban/rural) and religious affiliation the details of which are given in appendix - A.

In summary, the above tables indicate that the neurotics, schizophrenics and normals are comparable amongst one another in regard to some of the relevant variables pertaining to researches in the area of self concept.

TOOLS AND TECHNIQUES OF THE INVESTIGATION

The selection of the tools in this study was guided by various considerations as noted in the review chapter. In addition, Wylie's (1974); Taylor's et al., (1974) proposition that all self-report techniques are measures of the individual's self concept served to delineate the technique of assessment. Taylor et al., (1974) noted that self information is organised by self-concepts and that these more abstract self concepts mediate specific responses to inventory items (Taylor, Carthiers and Coyne, 1976; Taylor, 1977). In addition, the selection of the tools was guided by the finding that multiple measures of the self-concept would provide a more adequate assessment of the self-concept than by any one test alone (Silber and Tipett, 1965; Tippett and Silber, 1965; Viney, 1966) which also the present study attempted to incorporate.
Keeping the above in mind the tests selected for the present investigation were of the self-report format. Further, as is usual in researches a personal data sheet comprising of socio-demographic information, case history and symptomatology data sheet had to be used. The data-sheet was especially adopted to suit the present purpose. The tools thus selected were as follows:

1. Case History, Symptomatology and Socio-demographic (Data Sheet).
2. The Tennessee Self-Concept Scale (TSCS). 
3. The Self Confidence Inventory (SCI).
4. The Personal Orientation Inventory (POI).
5. The Experience Inventory (EI).
6. The Personal Opinion Survey (POS).
7. The IPAT Anxiety Scale Questionnaire (Self-analysis Form) (IPAT - ASQ).

A description of the tools now follows:

**Case History and Symptomatology and Socio-Demographic (Data-Sheet)**

The case-history and symptomatology data sheet including the demographic aspects was designed to elicit relevant information from the study groups. It was intended to cover various aspects of the personal, social, and clinical history and symptomatology of the subject. For this purpose aid was taken of the case history proforma provided by Mayor-Gross (1970) and the
adaptation of this by Koshy (1978). On the basis of the preliminary try-out during the pilot study, a number of items were deleted and a few were added. In brief, it covered the following major areas with appropriate sub-sections (a) Family History, (b) Personal History, (c) Premorbid Personality and (d) Present illness.

The item-sheet was filled in by the investigator on the basis of the information obtained through an interview with the patient/subject as well as cut outs taken from the case files maintained for each of the patients. Appropriate details were filled in for the first 10 items and in regard to the other items most of which were dichotomous on the case-history sheet, they were recorded as either 'yes' or 'no' with qualitative remarks as and when required for the sake of clarity. For those items which could not be coded dichotomously appropriate coding of a multiple nature was employed.

For purposes of scoring most of the items were scored as either 1 or 0 depending on its presence or absence in the record. For those items where there was multiple choice appropriate numerical coding was followed.

The case history and symptomatology data is given in appendix - B.
2. The Tennessee Self Concept Scale (TSCS)

The TSCS was constructed by Fitts (1965) to measure an individual's self-concept. As Fitts observes, 'Over recent years a wide variety of instruments have been employed to measure the self concept. Nevertheless, a need has continued for a scale which is simple for the subject, widely applicable, well standardized and multidimensional in its description of the self-concept. The Tennessee Self-Concept Scale or simply the scale, was designed to meet this need' (Fitts, 1965, p 1).

The scale consists of 100 self descriptive statements which the subject uses to portray his own picture of himself on a 5 point response scale. The 5 points on the scale are: (1) Completely false, (3) Mostly false, (3) Partly false and partly true, (4) Mostly true, and (5) Completely true.

**Instructions:** The subject is instructed as follows:

"The statements in these pages are to help you to describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item, read each statement carefully, then select one of the five responses listed below. Put a circle around the response you choose. The responses are like: (1) Completely false, (2) Mostly false, (3) Partly false and partly true, (4) Mostly true, (5) Completely true. You will find these responses numbers separated at the bottom of each page to help you remember them".

Scoring of the answer sheet was done following the instructions given in the manual.
A brief description of the major scales of the TSCS follows:

A. The Self Criticism Score

This scale is composed of 10 items which were taken from the L-scale of the Minnesota Multiphasic Personality Inventory. These are all mildly derogatory statements that most people admit as being true for them. Individuals who deny most of these statements most often are being defensive and making a deliberate effort to present a favorable picture of themselves.

High scores generally indicate a normal, healthy openness and capacity for self-criticism. Extremely high scores (above the 99th percentile) indicate that the individual may be lacking in defenses and may in fact be pathologically undefended. Low scores indicate defensiveness, and suggest that the positive scores are probably artificially elevated by this defensiveness.

B. The Positive Scores P

These scores derive directly from the phenomenological classification scheme devised by Fitts viz, (1) This what I am , (2) This is how I feel about myself, and (3) This is what I do . On the basis of these three types of statements the three horizontal categories were formed. They appear on the score sheet as Row 1, Row 2, and Row 3. The Row scores comprise three sub-score which, when added, constitute the total Positive
or total positive score. This scores represent an internal frame of reference within which the individual is describing himself. Further study of the original items indicated that they also varied considerably in terms of a more external frame of reference. Even within the same row category the statements were found to vary widely in content. For example, with Row 1 (the what I am category the statements refer to what I am physically, morally, socially, etc. Thus the whole set of items was divided in two ways, vertically into columns (external frame of reference) and horizontally into rows (internal frame of reference) with each item and each cell contributing to different scores.

1. Total P score. This is the most important single score on the counseling form. It reflects the overall level of self-esteem. Persons with higher scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves.

If the self criticism (SC) score is low, higher P scores become suspect and are probably the result of defensive distortion. Extremely high scores (generally above the 99th percentile) are deviant and are usually
found only in such disturbed people as paranoid schizophrenics who as a group show many extreme scores, both high and low.

2. **Row 1 P score - Identity.** These are the 'What I am' items. Here the individual is describing his basic identity—what he is as he sees himself.

3. **Row 2 P scores - Self-Satisfaction.** This score comes from those items where the individual describes how he feels about the self he perceives. In general this score reflects the level of self-satisfaction or self-acceptance.

4. **Row 3 P Score Behavior.** This score comes from those items that say 'this is what I do or this is the way I act'. Thus this score measures the individual's perception of his own behavior or the way he functions.

Identity, Self-Satisfaction and Behavior represent self-perception from an internal frame of reference.

5. **Column A - Physical Self.** Here the individual is presenting his view of his body, his state of health, his physical appearance, skills and sexuality.

6. **Column B - Moral Ethical Self.** This score describes the self from a moral-ethical frame of reference—moral worth, relationship to god, feelings of being a 'good' or 'bad' person and satisfaction with one's religion or lack of it.
7. **Column C - Personal Self.** This score reflects the individual's sense of personal worth, his feeling of adequacy as a person and his evaluation of his personality apart from his body or his relationships to others.

8. **Column D - Family Self.** This score reflects one's feelings of adequacy, worth, and value as a family member. It refers to the individual's perception of self in reference to his closest and most immediate circle of associates.

9. **Column E - Social Self.** This is another 'self as perceived in relation to others' category but pertains to 'others' in a more general way. It reflects the person's sense of adequacy and worth in his social interaction with other people in general.

**C. The Variability Scores (V)**

The V scores provide a simple measure of the amount of variability, or inconsistency, from one area of self-perception to another. High scores mean that the subject is quite variable in this respect while low scores indicate low variability which may even approach rigidity if extremely low.

1. **Total V.** This represents the total amount of variability for the entire record. High scores mean that the person's self-concept is so variable from one area to another so as to reflect little unity or integration.
High scoring persons tend to compartmentalize certain areas of self and view these areas quite apart from the remainder of self. Well integrated people generally score below the mean on these scores but above the first percentile.

2. **Column Total V.** This score measures and summarizes the variations within the columns.

3. **Row Total V.** This score is the sum of the variation across the rows.

**D. The Distribution Score (D)**

This score is a summary score of the way one distributes his answers across the five available choices in responding to the items of the scale. It is also interpreted as a measure of still another aspect of self-perception; certainty about the way one sees himself. High scores indicate that the subject is very definite and certain in what he says about himself while low scores mean just the opposite. Low scores are found also at times with people who are being defensive and guarded. They hedge and avoid really committing themselves by employing '3' responses on the Answer Sheet.

Extreme scores on this variable are undesirable in either direction and are most often obtained from disturbed people. For example, schizophrenic patients often use '5' and '1' answers almost exclusively, thus creating very high D scores. Other disturbed patients
are extremely uncertain and non-committal in their self-descriptions with a predominance of '2', '3' and '4' responses and very low D scores.

E. The Time Score

This score is simply a measure of the time, to the nearest minutes, that the subject requires to complete the scale. The author has only recently made any study of this variable, and at this point little is known as to its meaning or significance.

This score was not taken into consideration for further analysis given the uncertainty of its meaning.

The Clinical and Research Form

The following additional scores of the clinical and research form are presented in the order in which they appear on the profile sheet.

A. The True-False Ratio (T/F)

This is a measure of response set or response bias, an indication of whether the subjects approach to the task involves any strong tendency to agree or disagree regardless of item content.

According to Fitts the actual meaning of T/F can be approached in three ways:

1. It can be considered solely as a measure of response set and interpreted in terms of the
finding about the meaning of deviating response sets.

2. It can be treated purely as a task approach or behavioral measure which has meaning only in terms of empirical validity. In this sense the T/F ratio was found to differentiate patients from non-patients and correlate significantly with other tests.

3. It can also be considered from the framework of self-theory. From this approach, high T/F scores indicate the individual is achieving self-definition or self description by focusing on what he is and is relatively unable to accomplish the same thing by eliminating or rejecting what he is not. Low T/F scores would mean the exact opposite, and scores in the middle range would indicate that the subject achieves self-definition by a more balanced employment of both tendencies—affirming what is self and eliminating what is not self.

B. Net Conflict Scores

These scores are highly correlated with the T/F score. More directly, however they measure the extent to which an individual's responses to positive items differ from or conflict with his responses to negative items in the same area of self perception. Thus, this
is a limited and purely operational definition and application of the term 'conflict'. There are two different kinds of conflict, namely:

1. **Acquiescence Conflict.** This phenomenon occurs when the P scores are greater than the N scores. This means that the subject is over-affirming his positive attributes.

2. **Denial Conflict.** This is the opposite of acquiescence conflict. This means that the subject is over-denying his negative attribute in relation to the way he affirms his positive characteristics. He concentrates on "eliminating the negative".

C. **Total Conflict Scores**

The foregoing net conflict scores were concerned only with directional trends. High scores indicate confusion, contradiction, and general conflict in self-perception. Low scores have the opposite interpretation, but extremely low scores (below the redline on the profile sheet) have a different meaning. The person with such low scores is presenting such an extremely tight and rigid self description that it becomes suspect as an artificial defensive stereotype rather than his true self image. Disturbed people generally score high on this variable, but some also have deviantly low scores depending on the nature and degree of their disorder.
D.

The scores on these scales are purely empirical and cut across the basic classification scheme of the scale.

1. **The Defensive positive scale (DP)**. This is a more subtle measure of defensiveness than the SC scores. The DP score stems from a basic hypothesis of self-theory; that individuals with established psychiatric difficulties do have negative self concepts at some level of awareness, regardless of how positively they describe themselves on an instrument of this type.

   The DP score has significance at both extremes. A high DP score indicates a positive self description stemming from defensive distortion. A significantly low DP score means that the person is lacking on the usual defenses for maintaining even minimal self-esteem.

2. **The General Maladjustment Scale (GM)**. This scale is composed of 24 items which differentiate psychiatric patients from non-patients but do not differentiate one patient group from another. Thus it serves as a general index of adjustment-maladjustment but provides no clues as to the nature of the pathology. This is an inverse scale on the profile sheet. Low raw scores result in high T scores, and vice-versa.
3. **The Psychosis Scale (Psy).** The Psychosis scale is based on 23 items which best differentiate psychotic patients from other groups.

4. **The Personality Disorder Scale (PD).** The 27 items of this scale, are those that differentiate this broad diagnostic category from the other groups. This category pertains to people with basic personality defects and weaknesses in contrast to psychotic states or the various neurotic reactions. The PD scale is again an inverse one.

5. **The Neurotic Scale (N)**

   This is an inverse scale composed of 27 items. As with the other inverse scales, high T-scores on the profile sheet mean high similarity to the group from which the scale was derived ... in this case neurotic patients.

6. **The Personality Integration Scale (PI).** The scale consists of the 25 items that differentiate the PI group from other groups. This group was composed of 75 people who, by a variety of criteria, were judged as average or better in terms of level of adjustment or degree of personality integration.

E. **The Number of Deviant Signs Score (NDS)**

The NDS score is a purely empirical measure, and is simply a count of the number of deviant features on
all other scores. This score is based upon the theoretical position of Berg (1957) as stated in his 'deviation hypothesis'. Fitts points out that the NDS score is the scales best index of psychological disturbance. This score alone identifies deviant individuals with about 80% accuracy. However, the NDS was not utilized in the present study due to certain procedural difficulties.

The test-retest reliability co-efficients of all major scores, on both forms are reported in the manual and found to be satisfactory (Fitts, 1965).

Validity for the TS CS also appears to be good. Fitts (1965, 1971, 111) reports on the TSCS's validity in terms of Cronback's (1960) four criteria. In brief, predictive validity (e.g., Fitts, 1972, V), concurrent validity (e.g., Gay, 1966, cited in Fitts 1971, 111, Christian, 1969; cited in Fitts, 1971, 111) construct validity (e.g., George, 1970; cited in Fitts, 1971, 111; Bealmer et al., 1965, cited in Fitts, 1971, 11) and factor analytic validity (e.g., Vacchiano and Strauss, 1968; Vincent, 1968; Grant 1966; cited in Fitts, 1971, 111 and Levin, Karni and Frankel, 1978) appears to be substantial. Further, Fitts (1965) reports highly significant differences between patients and non-patients for almost every score on this scale. Leake commenting on the TSCS observes that 'its validity rests upon a broader base of positive findings than any other self concept

One of the main considerations in choosing this scale is because it is simple for the subject, widely applicable, discriminating and multi-dimensional in the description of the self-concept (Fitts, 1965). Further, it is now widely used in self concept research and this makes the data from many different studies comparable and greatly facilitates the integration of findings in this area. Finally, it is worthwhile to mention at this juncture that the TSCS has been employed in the Indian set up and found to yield valuable information pertaining to the individual, in both the clinical and normal set-ups.

Further, the content validity of the scale was worked out by 3 clinical psychologists in an earlier effort and found to be satisfactory. The TSCS is provided in Appendix C.

3. The Self-Confidence Inventory (SCI). The SCI was constructed by Basavanna (1975) in an Indian population to estimate the phenomenological level of self-confidence among adolescents and adults. The author envisages it as a "generalised phenomenological construct. It encompasses several areas of an individual's self experience and his perceived adequacy or otherwise thereof" (Basavanna, 1975, p 1). This inventory provides a measure of self confidence within the frame work of
contemporary self theory.

The SCI consists of 100 statements which have to be answered as either true or false. It yields one general measure viz. an index or an individual’s level of self confidence.

Instructions: The subject is instructed as follows:

"Every person has some idea about how he feels or thinks about himself. It is the purpose of the present work to study how you feel or think about yourself. The following pages contain a series of numbered statements. These statements are true for some people and not true for others. Read each statement and decide how you feel or think about it and then mark your answer on the separate answer sheet. If the statement is true or usually true as applied to you, tick on the answer sheet 'True' in front of the number that agrees with the number that agrees with the number of the item. Try to answer every statement even if you have to guess sometimes. Change any answer you wish to change and cross completely the unwanted answer.

Please remember to give your own opinion about yourself.

Answer as quickly as possible and do not spend too much time on any one item.

While answering on the answer sheet make sure that the number of the statement agrees with the number on the answer sheet.

Your answers will be used only for research purpose and they will be kept strictly confidential. Therefore, please answer each statement honestly and thoughtfully. There are no right or wrong answers.

Kindly fill up your name and other particulars on the answer sheet. Do not make any marks on these pages. If you do not have any doubt, you can go ahead".

The odd-even split half reliability was calculated for a sample of 200 subjects drawn randomly from the
original group of 800. The reliability co-efficients, as corrected by the Spearman-Brown prophecy formula, was found to be 0.94. Validity was established in terms of item validity and construct validity. Item analysis indicated that the flanayan estimates of bi-serial correlation co-efficients ranged from .74 to .30. Further, several hypothesis concerning the self-confidence construct were derived from self theory and put to test (Basavanna, 1971; Aruna, 1975, cited in Basavanna, 1975). In general, satisfactory construct validity is reported in the manual.

One of the main considerations guiding the choice of this test is that a review of literature indicated that multiple measures of the self concept are to be preferred (eg: Silber and Tippett, 1965). In view of this the SCI appeared to be a sound instrument for use in this study. The SCI is given in Appendix

4. Personal Orientation Inventory (POI)

The POI was developed by Shostrom (1966) to provide a standardized instrument for the measurement of values and behavior hypothesized to be of paramount importance in the development of the self-actualizing person.

The POI consists of 150 two-choice (paired opposites) comparative value judgements. As the POI items are stated both positively and negatively, the particular end-poles of the dichotomy in question are
made explicitly clear. Coan noted in his review of the POI that "the use of double statement items makes the test seem a little monotonous, but it often provides the subject with more clearly delineated choice than he would otherwise have. Its advantages seem to outweigh its shortcomings" (Coan, 1972; cited in Knapp, 1976, p 4).

Instructions: The subject is instructed as follows:

"You are to select one of the statement in each pair that is mostly true of yourself. If the first statement of the pair is true or mostly true of yourself please tick the provided space for 'a' on the answer sheet. If the second statement of the pair is true or mostly true of yourself then tick the space provided for 'b' on the answer sheet, please do not omit any item. There are no right or wrong answers to these statements."

Scoring of the POI scales is accomplished in terms of the two major scales, Time Competence (TC) and inner-Directed (I), and the 10 sub-scales described below. Since the major scales are viewed as being clinically interpretable in relative or proportional terms, they are frequently seen as ratios covering the 2 major areas important in personal development and interpersonal interactions, time orientation and support orientation.

Time Orientation reflects the degree to which the individual lives in the present rather than the past or future. Self-actualizing persons are those living primarily in the present, with full awareness and contact and full feeling reactivity. They are able
to tie the past and the future to the present in meaningful continuity and their aspirations are tied meaningfully to present working goals. They are 'time competent'. In contrast, the 'time incompetent' person lives primarily in the past, with guilts, regrets, and resentments and/or in the future, with idealized goals, plans, expectations, and fears.

Support Orientation is designed to measure whether an individual's mode of reaction is characteristically 'self' oriented or 'other' oriented. Inner, or self-directed persons are guided primarily by 'internalized' principles and motivations, while other directed persons are to a great extent, influenced by their peer group or other external forces.

Scores on each of the 10 sub-scales are intended to reflect a particular facet important in the development of self-actualizing. The sub-scales are defined by Shostrom (1966) as follows:

1. **Self-Actualizing Value (SAV)**, measures the affirmation of primary values of self-actualizing people. A high score indicates that the individual holds and lives by values characteristic of self-actualizing people, while a low score suggests the rejection of such values. Items in this scale cut across many characteristics.

2. **Existentiality (Ex)** measures the ability to react situationally or existentially without rigid
adherence to principles. It measures one's flexibility in applying values or principles to one's life. It is a measure of one's ability to use good judgement in applying these general principles. Higher scores reflect flexibility in application of values, while low scores may suggest a tendency to hold to values so rigidly that they become compulsive or dogmatic.

3. **Feeling Reactivity (FR)** measures sensitivity or responsiveness to one's own needs and feelings: A high score indicates the presence of such sensitivity; a low score suggests insensitivity.

4. **Spontaneity (S)** measures freedom to react spontaneously or to be oneself. A high score measures the ability to express feelings in spontaneous action; a low score suggests that one is fearful of expressing feelings behaviorally.

5. **Self-Regard (SR)** measures affirmation of self because of worth or strength. A high score measures the ability to like oneself because of one's strength as a person. A low score suggests feelings of low self-worth.

6. **Self-Acceptance (SA)** measures the affirmation or acceptance of oneself in spite of one's weaknesses or deficiencies. A high score suggests acceptance of self and weaknesses, and a low score suggests inability to accept one's weaknesses. It is more difficult to achieve self-acceptance than self-regard, but self
actualizing requires both.

7. **Nature of Man-Constructive (NC)** measures the degree of one's constructive view of the nature of man. A high score suggests that one sees man as essentially good and can resolve the good-evil, masculine-feminine, selfish-unselfish, and spiritual-sensual dichotomies in the nature of man. A high score, therefore, measures the self-actualizing ability to be synergic in one's understanding of human nature. A low score suggests that one sees man as essentially bad or evil.

8. **Synergy (Sy)** measures the ability to be synergistic, and transcend dichotomies. A high score is a measure of the ability to see the opposites of life as meaningfully related. A low score suggests that one sees opposites of life as antagonistic. When one is synergistic, he sees that work and play are not different, that lust and love, selfishness and selflessness, etc. are not opposites at all.

9. **Acceptance of aggression (A)** measures the ability to accept one's natural aggressiveness as opposed to defensiveness, denial and repression of aggression within oneself as natural. A low score suggests the denial of such feelings.

10. **Capacity for Intimate Contact (C)** measures the ability to develop contactful intimate relationship with other human beings, unencumbered by expectations.
and obligations. A high score indicates the ability to develop meaningful contactful relationships with other human beings; a low score suggests that one has difficulty with warm inter-personal relationships.

Knapp (1976) commented ... the POI suitability noted that traditional concepts of reliability are in many instances inappropriate as the POI development was based on concepts of dynamic traits of personality. The POI is highly sensitive to experience which may occur during the administration interval. Knapp points out that this fact needs be kept in mind as a precautionary note when one is examining the findings of studies which relate to the stability of POI scores. On the whole studies pertaining to the reliability of the POI appear to be satisfactory (eg: Ilardi and May, 1968; cited in Knapp, 1976; Wise and Davis, 1975; Klavetter and Mogar, 1967; Lafferty, 1969; Bloxom, 1972; and Kaats, 1972, cited in Walker, 1977).

The validity of the POI has been reported in several studies and appears to be substantial. For example: Shrostrom's (1966) study on 2 groups consisting of self-actualizing and non-self actualizing adults, Shrostrom and Knapp (1966) on patients entering therapy and those in advance therapy, Knapp and Michael (1968) on a hospital sample, others like Pearson (1966) Weir and Gade (1969) and Zaccaria and Weir (1967) have tended
to support the validity of the POI as a measure of self-actualizing.

Coan (1972) reviewing the POI concludes as follows: "Since there have been relatively few attempts to measure components of self-actualization, the POI may be welcomed as an effort to fill a large and respectable void" (Coan, 1972, p. 121).

The choice of the POI in the present study was based on several factors. For instance the POI has been used extensively in research and it has gathered an impressive amount of correlational meanings. It has also been used in this culture by Walker (1977), Kumar (1981) and its utility here further confirmed. Finally, it is to be noted that the POI is one of the better standardized instruments to measure positive mental health and thus provides an ideal measure of the same in accordance with the basic perspective of this study. The POI is given in Appendix E.

5. The Experience Inventory (EI)

This instrument was constructed by Coan (1974, 1977a). The EI attempts to measure some of the components of openness to experience. As Coan (1977a) observes until recently, personality theorists have dealt with openness primarily in a negative form in terms of regression and related concepts. However, with the emergence of the contemporary humanistic
movement, he notes that psychologists have tended to concern themselves in a more direct way with the variable of openness.

The inventory has 83 true-false items that yield scores for seven scales. Instructions: The subject is instructed as follows:

"Below are some statements about different ideas and feelings that many people have experienced. You are to read each statement and decide whether it is true or false for you. Then put an appropriate tick in the appropriate space on the answer sheet. Mark either T (for True) or F (for false). Work quickly but try to be truthful. Neither answer is necessarily 'better' or 'healthier' than the other."

The inventory is scored in accordance with the scoring key provided in the manual to yield scores for the following 7 scales, a brief description of which now follows.

1. **Aesthetic Sensitivity Vs Insensitivity.** The high scorer represents a variety of aesthetic experiences. The low scorer experiences a more prosaic orientation, which emphasizes clear representation and denotation.

2. **Unusual Perceptions and Associations.** The high scorer reports various unusual ways of experiencing himself, his body, and his physical surroundings.

3. **Openness to Theoretical or Hypothetical Ideas.** The high scorer enjoys abstract, novel, and unusual ideas and intellectual puzzles, while the low scorer is
repelled by such things.

4. Constructive Utilization of Fantasy and Dreams. A number of items suggest an access to unconscious processes or a willingness to rely on them for creative or constructive ends. The high scorer reports the use of dreams, daydreams, and undirected thought for problem-solving and other purposes.

5. Openness to Unconventional Views of Reality Vs adherence to Mundane Material Reality. The items concern the subject's willingness to entertain a variety of specific ideas in such realms as astrology, extrasensory perception, astral projection, and reincarnation.

6. Indulgence in Fantasy Vs avoidance of Fantasy. The high scorer reports that he spends a lot of time daydreaming and enjoys the content of his fantasies. The low scorer tries to avoid daydreaming and prefers to keep his thinking channeled along orderly, realistic, and constructive lines.

7. Deliberate and Systematic Thought. The high scorer reports a need for orderly and planful thinking and frequent indulgence in it. The item content implies most directly an openness to this kind of thought, rather than the use of it to avoid the kinds of thought embodied in other scales. The scale shows a slight tendency to correlate negatively with the others.
It is to be noted that the EI is a factor-analytically derived scale. Coan notes "This is a relatively new instrument and findings for the final version of the experience inventory are rather limited as yet" (Coan, 1977, p 6).

A number of correlational studies have been reported in the manual utilizing the EI that appear to be in the hypothesized direction thus supporting the scales validity. Further, Kumar (1981) has used the EI on 200 college students in India and his results have replicated the factors reported by Coan (1974).

The main consideration in choosing the EI in the present investigation is that it appears to be one of the few sophisticated tools that attempt to measure the construct of openness to experience in a relatively comprehensive manner. Further, the EI has the advantage of a demonstration of its factor structure being shown to be substantially invariant across cultures (Kumar, 1981). Finally, it is interesting to note that the EI has emanated from a humanistic frame-work which, as already mentioned, the present study also incorporates.

In view of these points its choice appeared to be axiomatic. The EI is given in Appendix F.

6. The Personal Opinion Survey (POS). The PO was constructed by Coan (1974, 1977b). It is designed to assess several major aspects of the experience of control.
As Coan observes, "This experience the sense that one actively chooses, successfully wills, or achieves mastery over himself and the circumstances in which he finds himself, is one of the most fundamental features of human awareness" (Coan, 1977b p 1).

The POS is a factor analytically derived questionnaire consisting of 120 items which have to be answered either as true or false on the answer sheet. It provides scores for seven factors.

Instructions: The subject is instructed as follows:

"The following statements are opinions about people and life in general. You will probably feel that some are true while others are false. Some of the statements are about your own feelings about yourself, or matters of health. There are no absolutely known 'Right or 'Wrong' answers to the general statements, and only you know the answers to the personal statements, but we are asking for your opinion about all the statements.

Please record your answers on the answer sheet. For each item, mark one of the spaces next to the appropriate number on the answer sheet. If the item is true, mark the space labeled 'T'. If the item is false, mark the space labeled 'F'.

Scoring of the answer sheet is accompanied with the aid of the scoring key provided in the handbook of POS.

The POS provides scores for the following seven factors:

1. **Achievement through Conscientious Effort.** The high scorer espouses the view that one can accomplish
many things if one tries hard enough. Success may be in the academic, social, or physical realm.

2. **Personal Confidence in Ability to Achieve Mastery.** Here the high scorer expresses confidence that he as an individual has the capacity for accomplishment in various realms—mathematical, mechanical, scientific, athletic, linguistic. Coan (1977b) notes that the areas of success with which this scale is concerned tend to be intellectual in character and tend to be deemed more appropriate for men than for women.

3. **Capacity of Mankind to Control its Destiny vs. Supernatural Power or Fate.** The items tap a general belief in man’s ability to build a just society, to control both his own evolution and natural physical phenomenon, and to act in a way that will permit the elimination of war.

4. **Successful Planning and Organization.** The items refer essentially to the planning, organization, and completion of tasks. The high scorer reports successful self-control in the realm of work.

5. **Self-Control over Internal Processes.** The high scorer reports control over somatic, affective, and cognitive processes. The low scorer may be afflicted with unavoidable itching, depression, ideas that run through his mind, muscular incoordination, twitching, tightening up of muscles, unexplainable cheerfulness, etc.
6. Control Over Large-Scale Social and Political Events. The score indicates the extent to which the subject believes that he himself and individual people in general can have an effect on major societal processes.

7. Control in Immediate Social Interaction. The items here are all concerned with whether the subjects himself is able to control social situations or secure desired responses from other people.

Coan (1977b) reports scale reliabilities/test retest reliability co-efficients for the POS. These are moderately high values especially when it is noted that the POS is a factor analytically derived scale with a set of relatively short factor scales. This is particularly pertinent when adjudging scale reliabilities (Coan, 1977b).

In terms of validity, Coan (1977b) observes that there is a growing body of research findings for the present scales of the POS which confirm the validity of the scales in an adequate manner.

In considering the POS for the present study a review of the pertinent literature on experience/locus of control had revealed that most extent measures of this personality dimension were open to several criticisms. Briefly, for example, Rotter's internal-external locus of control scale—which is one of the more extensively used tool for the above purpose has
been criticized on psychometric grounds (e.g., Guerin et al., 1969 Jr.; Keatenbaum, 1976; Dixon, McKee and McRee, 1976; Deynack, Hiers and Ross, 1976; Davidson and Bailey, 1978). In the light of this, the POS appeared to be more a fruitful measure of this construct as it is multidimensional, having a more comprehensive theoretical underpinning (Coan, 1977b) and evidencing good reliability and validity.

It is to be noted that the content validity of the POS was explored in this culture by 3 clinical psychologists. The results were satisfactory and upheld its further utilisation in this study. The POS is given in Appendix G.

7. The IPAT-Anxiety Scale Questionnaire (ASQ) (Self-analysis Form)

This scale was constructed by Cattell and Schierer (1965). It was primarily designed to measure free floating, manifest, anxiety level, whether it be situationally-determined or relatively independent of the immediate situation. As the authors note: "The IPAT Anxiety Scale was developed from extensive research and practice as a means of getting clinical anxiety information rapidly objectively, and in a standard manner" (Cattell and Schierer, 1965, p 5).

Instructions: The following instructions were given to the subject:
"Inside this booklet you will find forty questions, dealing with difficulties that most people experience at one time or another. It will help a lot in self-understanding if you check Yes, No, etc. to each frankly and truthfully, to describe any problems you may have.

Start with the two simple examples just below, for practice. As you see, each inquiry is actually put in the form of a sentence. By putting a cross, X in one of the three boxes on the right you show how it applies to you. Make your marks now.

About half the items inside and in A and B choices like this. B is always on the right. Remember, use the 'In between', or 'Uncertain' for only if you cannot possibly decide on A or B.

Now: Never pass over an item but give some answer to every single one. Your answers will be entirely confidential.

Do not spend time pondering. Answer each immediately, the way you want to at this moment (not last week or usually). You may have answered questions like this before, but answer them as you feel now.

Most people finish in five minutes, some in ten. Hand in this form as soon as you are through with it. As soon as the examiner signals, or tells you to, turn the page and begin."

Scoring of the answer sheet was accomplished in terms of the scoring key provided by the author.

The components of the ASQ are as follows:

1. **Lack of Self Sentiment Development Q3(-)**: At the healthy, non-anxious (low score) pole, the component represents the individual's motivation to integrate his behavior about an approved conscious self-sentiment, and socially approved standards. The Q 3 component score may be considered a measure also of the extent to which anxiety has become bound in socially-approved character
structures and habits, with more binding indicated by a lower Q 3 and free anxiety score.

2. **Ego Weakness (C—)**. According to the authors at its low score, nonanxious pole, this component represents the well known concept of ego strength - the capacity to control and express frustrative tensions in a suitably realistic way. The relation of ego weakness (high score on C) to anxiety, they note, could mean that an insecure ego, with many ego defenses, etc. generates anxiety. An alternative hypothesis putforth by them is that a high anxiety tension has caused some regression and prevented normal growth of ego strength.

3. **Suspiciousness, Paranoid-type Insecurity (L)**. The authors indicate that social difficulties caused by paranoid-type behavior would lead to isolation of anxiety, or anxiety might sometimes occur first and the Paranoid behavior develop as a defense against it.

4. **Guilt Proneness (O)**. Descriptively, this component is said to involve feelings of unworthiness, depression, and guilt. In Freudian terms, it is suggested that it is akin to the concept of anxiety as generated by super ego pressures and in extreme form, the pattern is to clinically resemble depressive reactions and other types of neurosis.

5. **Frustration Tension, and Id Pressure (Q4)**. According to the authors actual correlations and factor analysis
show this to be one of the largest and most central components in anxiety. It appears to represent the degree to which anxiety is generated by id pressure—by excited drives and unsatisfied (frustrated) needs of all kinds, sex drive excitation, need for recognition, and situational fear are among the drives found positively related to this component. It is said to show itself descriptively in proneness to emotionality, tension, irritability and 'jitteriness'.

In regard to part scores, the scale is divided into overt and covert subscales.

**Covert Anxiety Score (A).** This consists of the first 20 items which measure an unrealized, covert aspect of anxiety.

**Overt anxiety Score (B).** This consists of the last 20 items and represents an overt, symptomatic conscious, anxiety score.

The above part scores can also be organized in terms of a ratio of overt to covert (Score B/Score A).

**Total Anxiety Score.** This is based on all the 40 items. At the higher end of the poll it represents definite psychological morbidity and according to Cattell and Schierer almost certain to have adverse effects generally on work and social-emotional adjustments. The authors note that anxiety as measured here is more
highly and consistently associated with all forms of disorder than are any other factors.

Cattell and Schierer (1965) on the basis of various studies pertaining to reliability of the ASQ conclude that the reliability of the test is highly satisfactory.

The authors also report on construct (internal) validity and External, Concrete Validity. For example, the former is estimated at .85 to .90 for the total scale. In terms of the latter criteria a large amount of evidence is marshalled by them pointing to very satisfactory test validity (Cattell and Schierer, 1965).

One of the main considerations that entered in choosing the ASQ is that it is presented to the subject as a 'Self-Analysis Form' (Cattell and Schierer, 1965). Thus, by virtue of its format itself it appears to be an ideal measure to tap the phenomenological state of the subject in respect to anxiety. Further, the 'self-analysis form is a relatively short, easily comprehensible tool yielding a quick measure of anxiety. In addition, it has the advantage of having some of its psychometric properties examined in this culture (Venkataramaiah & Kumari, 1975) with satisfactory results. Finally, as Cattell and Schierer point out anxiety as measured here is 'the common element in all forms of mental disorder, and lack of anxiety (low scores on the scale) thus becomes an excellent operational definition
of mental health' (Cattell and Schierer, 1965, p 14). The IPAT - ASQ is given in Appendix H.

**Pilot Study**

Having decided about the study group and the tools to be employed keeping in mind the hypothesis to be tested a pilot study was undertaken.

The pilot study group consisted of 5 neurotics, 5 schizophrenics and 5 normals fulfilling the criteria set for selection of subjects for this research. The data was collected for each of these subjects individually using all the aforementioned tests. The pilot study helped in the following manner.

1. To work out and finalise the procedure, the exact instructions to be given to the subject and to get acquainted with the scoring system for each of the tools employed.

2. To find out such items on the questionnaire that were found difficulty by the subjects to comprehend, so as to modify the language of each without bringing about any change in its actual meaning or context. In this context the pilot study indicated that except for few items, the questionnaires employed were fairly well comprehended by the subjects. However, such of those items that caused difficulty were rephrased in consultation with 3 clinical psychologists. Care was
taken to see that the original meaning or context of the items was not lost.

3. Further, the pilot study helped in testing the efficacy of the data-sheet designed to obtain information on the history and symptomatology of the case with a view to find out if any items needed to be added or deleted.

4. It helped in deciding the number of sessions required for the administration of all the tools as well as arrange the order in which the tests were to be presented. This was done keeping in mind the total duration of the session so that fatigue would be minimized.

5. Finally, the pilot study provided not only experience of a practical kind pertaining to various aspects of research but it also instilled a further sense of confidence in the investigator - a vital ingredient in a research of any kind.

The modifications deemed necessary on the basis of the findings of this preliminary investigation were minimal and these were incorporated in the main study. The pilot study provided sufficient experience to the investigator to proceed to the data-collection.

Data Collection

Data-collection was spread over a period of 1 year. The tests were individually administered to the subjects
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Data Collection

Data-collection was spread over a period of 1 year. The tests were individually administered to the subjects
in the 3 groups after rapport was adequately established. The patients were told that the purpose of the administration of the tests was to understand the case better in a more objective manner so that subsequent help may be facilitated. In addition, both the experimental groups and the control group were told that their results would be used for research purpose. Jones (1966, cited in Pitts, 1971, iii) in the context of self concept research observes that social-desirability effects are least under these two conditions.

For the 2 experimental groups the tests were administered in 4 sessions and for the control group the same was done in 2 sessions. The order of presentation of tests for the collection of data for the experimental and control groups is given in Table 5.

**TABLE 5**

Showing the order of presentation of tests

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<td>a. Case history and symptomatology, data sheet.</td>
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<td>b. TSCS</td>
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<td><strong>Control group</strong></td>
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<tr>
<td>a. Case history &amp; a. POI symptomatology, data sheet</td>
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For the experimental groups, in total, approximately 240 man hours were spent in data gathering. In respect to the control group, approximately 90 man hours were spent for this purpose.

**Analysis of the Data**

Each of the test protocols of the 90 subjects was scored as suggested by the respective authors of the tools. In respect to the case history the procedure has been already explained. Consequent to this a master chart was prepared which included the demographic details of each of the subjects along with their scores on the various tools employed in the present study. The data of the present study was coded where necessary and punched on to IBM cards and fed into a DEC 10 system computer for the Analysis of Variance, Pearson Product Moment Correlations and Multiple Discriminant function analysis.

The obtained results are organized in the next chapter.