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Obsessionality and Self-Appraisal Questionnaires

By G. F. REED

In an authoritative paper, Sandler and Hazari (1960) examined the responses of 100 neurotic patients to a personality questionnaire. The latter was in fact the Tavistock Self-Assessment Inventory, which consists of 867 statements each of which the subject is required to mark as "True" or "False" in regard to himself. Sandler and Hazari extracted responses to forty of these statements which were regarded as having reference to obsessive/compulsive character traits and symptoms, and subjected the data to factor analysis. Two factors were identified, and the original items were then classified according to their projection on two reference vectors, A and B, obtained through rotation of the Centroid factor axes through 45°. The two groups of items represented "two tendencies which, in their appearance in this group of patients, appear to be more or less unrelated".

The A-type items (16 in all) include such statements as:

"I take great care in hanging or folding my clothes at night."

"I hate dirt or dirty things."

"I try to be perfect in my work."

Taken together they "present a picture of an exceedingly systematic, methodical and thorough person, who likes a well-ordered mode of life, is consistent, punctual and meticulous in his use of words. He dislikes half-done tasks, and finds interruptions irksome. He pays much attention to detail and has a strong aversion to dirt." As the authors point out this is very similar to descriptions of the obsessional or anal-reactive character. The descriptive statements are ego-syntonic, representing "traits of character which conform to the possessor's ideal standards for himself".

The 17 B-type items include such statements as:

"I am often inwardly compelled to do certain things even though my reason tells me it is not necessary."

"I often have to check up to see whether I have closed a door or switched off a light."

"I am troubled by bad and dirty thoughts."

Taken together they suggest "a person whose daily life is disturbed through the intrusion of unwanted thoughts and impulses into his conscious experience. Thus he is compelled to do things which his reason tells him are unnecessary, to perform certain rituals as part of his everyday behaviour, to memorize trivia, and to struggle with persistent 'bad' thoughts." These B-type items, in fact, all suggest the symptoms of obsessional neurosis.

It is clear that Sandler and Hazari's primary concern was to examine the inter-relationship, if any, between obsessional *personality traits* and obsessional *symptoms*. They were not attempting to construct a quantitative scale, and did not refer to their questionnaire as a "test". Nevertheless, it would now seem to have been allotted that status and to be in use in the clinical field as a diagnostic aide. But there appears to be no evidence as yet that the questionnaire, if used as a "scored" inventory (like the E.P.I., for example) has any validity. Orme (1965) has reported some relevant data from a clinical population, but he used only 13 of the original 40 items. Kline (1967) has reported a factor-analytic study, but his subjects were normal students and teachers. Both these studies were concerned with the relationship (if any) between obsessional traits and emotional instability. In fact, it has not been conclusively demonstrated that the Sandler–Hazari questionnaire can (*i*) differentiate patients of obsessional personality from those displaying frank obsessional symptoms or, indeed, that it can (*ii*) identify patients suffering from obsessional disorder. The present report offers a simple test of these functions by comparing the Sandler–Hazari questionnaire "scores" of groups of obsessional patients and a group of non-obsessional patients.

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Method

Subjects

The patients studied had all been admitted during a three-year period to the University Department of Psychiatry, Manchester Royal Infirmary, under the care of Professor E. W. Anderson. In all cases, diagnoses had been made only after intensive study and final assessment at case conferences conducted by senior members of the staff.

Three groups were established in the following way. Twenty patients (ten men and ten women) were identified as presenting clear obsessional/compulsive symptomatology. In each case an "obsessional personality" subject and a "non-obsessional control" subject of the same sex were drawn from the admission register, the first patients in the appropriate categories to be admitted after each "symptom" subject being selected.

The composition of each group was as follows:

(*a*) *The obsessional symptom group*

All twenty members of this group suffered from obsessional ruminations, unwanted ideas and/or fears. Nine of them also displayed compulsive motor rituals or gross checking. Two others were also crippled by extreme indecision and doubts, two others were also suffering from depersonalization or derealization, and two others were also handicapped by stammers.

All had been diagnosed as "obsessional states" or "severe anankastic disorder". In all cases psychosis and "organic" pathology had been excluded.

(*b*) *The obsessional personality trait group*

None of the members of this group complained of obsessional symptoms or displayed compulsive behaviour associated with their illness. But in all twenty cases their premorbid personalities had been characterized by obsessional traits such as perfectionism, excessive scrupulosity, overconscientiousness, etc. They had all been classified as being anankasts according to Schneider's (1958, 1959) criteria. By definition, of course, their obsessional traits were ego-syntonic (cf. Foulds, 1965) and, as far as they were concerned, unrelated to the problems which brought them to the clinic. All had received a primary diagnosis of "depressive illness".

(*c*) *The non-obsessional control group*

These twenty patients all displayed personality disorders or abnormal psychogenic reactions, but were characterized by the absence of compulsive phenomena, either in their premorbid personalities or as regards their symptoms. None were psychotic or of "organic" pathology. Eight of the group had been diagnosed as hysterics, eight as "Attention-seeking psychopaths", two as "Explosive psychopaths" and two as "Weak-willed delinquent psychopaths".

Procedure

Sandler and Hazari's forty items were presented on cyclostyled sheets, subjects being requested to mark each statement as being "True" or "False" with regard to themselves. This was done individually and subjects worked at their own rates. Members of the "traits" group were tested only after recovery from their depressive illness.

Results

A "score" of 2 was allotted for each item marked as "True", 1 for each item question marked or modified, and 0 for each item marked as "False". Means and standard deviations were computed for each group, and group results compared by analysis of variance. This was done separately for:

(*a*) Sandler and Hazari's 16 A-type statements (i.e. those with high projections on their Vector A, interpreted as reflecting obsessional character *traits*).

(*b*) Their 17 B-type statements (reflecting obsessional *symptoms*).

(*c*) Total scores over all 40 statements.

Results are presented in Tables I, II and III. No significant differences were found.

Discussion

Interpretation of results from a study of this kind is crucially dependent upon the criteria employed in classifying the subjects. In the present case some of the nosological conventions

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TABLE I

Comparison of Group Scores—Sandler–Hazari 16 "A" Type Items (Obsessional Character Traits)

(*a*) *Group mean scores and standard deviations*

Group		Mean	S.D.
Obsessional symptoms	(n = 20)	23·45	6·48
Obsessional traits	(n = 20)	22·90	5·79
Control	(n = 20)	22·60	6·59

(*b*) *Analysis of variance*

Source	S.S.	D.F.	M.S.	F	P
Between groups	7·44	2	3·72	10·65	N.S.
Within groups	2,259·55	57	39·64	—	—

TABLE II

Comparison of Group Scores—Sandler–Hazari 17 "B" Type Items (Obsessional Neurotic Symptoms)

(*a*) *Group mean scores and standard deviations*

Group		Mean	S.D.
Obsessional symptoms	(n = 20)	18·65	5·76
Obsessional traits	(n = 20)	17·10	6·84
Control	(n = 20)	17·60	7·01

(*b*) *Analysis of variance*

Source	S.S.	D.F.	M.S.	F	P
Between groups	25·03	2	12·51	3·43	N.S.
Within groups	2,453·15	57	43·03	—	—

TABLE III

Comparison of Group Scores—Sandler–Hazari. Total (40) Items

(*a*) *Group mean scores and standard deviations*

Group		Mean	S.D.
Obsessional symptoms	(n = 20)	47·90	13·03
Obsessional traits	(n = 20)	46·85	10·10
Control	(n = 20)	45·55	9·80

(*b*) *Analysis of variance*

Source	S.S.	D.F.	M.S.	F	P
Between groups	55·44	2	27·72	4·42	N.S.
Within groups	6,991·30	57	122·65	—	—

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used might not meet with the approval of psychiatrists from other schools of thought. But care was taken in the selection of the original "obsessional symptoms" group to exclude any patients whose diagnosis might arouse controversy among workers of different outlooks and preferred terminology. The case material was such as to render it extremely unlikely that any clinician could deny that each member of the group was suffering from obsessional illness characterized by classical obsessional symptoms. These patients were clearly suffering from the identical symptoms featured in Sandler and Hazari's B-type items (their "symptoms of obsessional neurosis"). Meanwhile, the Schneiderian criteria by which the members of the present "obsessional traits" group were classified as anankasts involve the very traits reflected in Sandler and Hazari's A-type items (their "reactive-narcissistic character"). On the other hand the members of the control group, whilst including a mixture of diagnostic categories, had in common the fact that intensive investigation had failed to elicit any evidence of either obsessional symptoms or traits.

Thus it is fair to assert that differences in psychiatric nomenclature or outlook cannot be taken to prejudice the present findings. There is one limiting feature of the present grouping, however, which deserves mention. The members of the "symptoms" group were themselves all anankasts. It would have been possible to assemble a group of non-anankasts displaying obsessional symptoms; but this would have been mainly composed of patients suffering from schizophrenia or neurological disorders. For many reasons it had been decided to restrict the group to classical obsessional states. The fact that these all turned out to be of anankastic personality is itself of interest in view of the long controversy as to whether there is a relationship between obsessional illness and premorbid obsessional personality (Freud, 1913; Mayer-Gross *et al.*, 1960; Schneider, 1959. But cf. Curran and Guttman, 1949; Lewis, 1965).

Taking this latter restriction into account, the conclusions to be drawn from the present study are as follows:

The Sandler–Hazari questionnaire, used as a scored "test" has completely failed to (*a*) discriminate between patients with obsessional personality traits but without obsessional symptoms and those displaying gross obsessional symptoms, or (*b*) discriminate between obsessional and non-obsessional patients. The present "symptom" group did not "score" at a significantly higher level than the other groups on the B-type items, the "traits" group did not "score" at a significantly higher level on the A-type items, and neither group showed a significantly higher "score" than the controls on the full, 40-item questionnaire.

These negative findings cast serious doubt on the validity of using the Sandler–Hazari questionnaire as a diagnostic "test". This is not so surprising as it may at first appear. What was not aimed for in Sandler and Hazari's study was *criterion validity*. In fact, their original experimental group *was not differentiated at all*. The material had been collected from patients admitted to the Tavistock Clinic over a period of two years. Differential diagnoses were not taken into consideration: "The population studies consisted of the first 50 men and the first 50 women to complete the Inventory." The authors, of course, were not primarily concerned with cross-validating clinical diagnoses, so that it might be argued that the identification of criterion sub-groups was irrelevant. But this argument can scarcely be maintained. If the original population happened to be composed of hysterics or attention-seeking psychopaths, for instance, the conclusions of the study could scarcely be taken at their face value. The results themselves would still be of interest, but only in so far as they demonstrated self-deception or simulation in the assumption of obsessional traits and symptoms by non-obsessional patients.

Furthermore, the present findings may have considerable theoretical significance. In what ways, and to what extent, is the arithmetic summation of behavioural/experimental descriptive items of value in the study of disorders such as obsessionality? The self-appraisal questionnaire provides a convenient check list of clinical observations. But without the application of sophisticated rating techniques it is quite unable to elicit or balance the qualitative material afforded by the phenomenological interview. In the present instance crude binary "scoring" may

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be actually misleading. To take a concrete example, a severely anankastic patient with gross obsessional symptoms involving many hours of hand-washing daily would "score" on item 26—"I am 'fussy' about keeping my hands clean." Every self-respecting, normal physician or baker should make the same "score" on that particular item. The difficulty here is partly to do with semantics but also with the *quality* of experience. The Sandler–Hazari statements, if *elicited* spontaneously, would provide valuable diagnostic data. But it may be argued that the situation is very different when they are *presented*, ready-made, for recognition or denial. Semantic factors as well as ones related to suggestibility immediately intrude. In any case such statements, by their nature, cannot elicit evidence of true compulsive experience. A properly constructed scale would not be required to do this, of course, if it could be shown to be capable of identifying compulsive groups. This has not been demonstrated with the Sandler–Hazari statements; their standardization (suggested by Kline, 1967) would be pointless without initial validation studies.

Finally in clinical and personality assessment the factor of "acquiescence" probably biases questionnaire-answering in at least two directions. The subject is reluctant to admit the truth of any socially unacceptable statements about himself. But the psychiatric patient may also wish to make a "good" showing of quite a different type. The attention-seeking psychopath, in particular, is wont to lay claim to every symptom suggested. A number of the Sandler-Hazari statements invite acquiescence because they bear reference to socially desirable traits, such as cleanliness and punctuality. A number of others invite acquiescence because they represent to the psychiatric patient the sort of problems and suffering which seem to merit psychiatric treatment. So that it is highly likely that the Sandler–Hazari questionnaire may have value as a general measure of neuroticism (or at least of being a neurotic patient). In this respect the present writer is in partial agreement with Orme (1965). The latter, as Kline (1967) points out, seems to confuse traits and symptoms. It cannot be accepted that, as Orme suggests, "obsessional traits are intimately related to the admission of general instability." The suggestion becomes much more acceptable if the word "symptoms" is substituted for "traits". It becomes even more so if transposed: "The admission of obsessional symptoms is intimately related to general instability."

Summary

The Sandler–Hazari (1960) obsessionality questionnaire items, when used as a scored "test", failed to discriminate between three groups of patients: (*a*) 20 obsessional states displaying severe, classical symptoms, (*b*) 20 patients of premorbid obsessional personality but without obsessional symptoms, (*c*) 20 non-obsessional control patients (hysterics and personality disorders). The implications of this are discussed.

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