

MANUAL
for use with
CHECKLIST OF SCHIZOTYPIC SIGNS

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General Remarks*

1. The purpose of this checklist is to semi-objectify and quantify the clinical assessment of schizoid tendency, by spelling out criteria for attributing each of 25 allegedly schizoid symptoms or traits, here called “schizotypic signs.” The observational data required for arriving at the listed judgments are gathered chiefly from the diagnostic interview (history-taking and mental status) and subsequent therapeutic interviews; additional data from informants, documents, and psychometric study may be used as supplementary if available. The diagnostic task for which the writer uses these signs is that of identifying schizotypic individuals who are largely free of those gross, obvious, or “textbook” symptoms of a schizophrenic psychosis which, when present, render our diagnostic problem easy. This checklist is not intended for spotting cases of overt schizophrenic psychosis, or what Rado calls “disintegrated schizotypy.” Further, since the natural history of the disease typically involves a non-monotonic function of time for some symptoms, no claim is made for “validity” of these signs in discriminating clinically apparent psychotic cases. A patient who exhibits such phenomena as marked thought-disorder, grossly inappropriate affect, or catatonic posturing is readily identifiable without resorting to time-consuming formalized procedures (psychometrics, rating-scales, checklists, etc.) Florid schizophrenia can be recognized quickly and reliably by a junior medical clerk or a first-year psychology trainee, and I hope no one will waste his time or muddy the research literature by studying the “concurrent validity” of this checklist against a criterion group of state hospital schizophrenics!

The class of patients for which this checklist was constructed is that unfortunately large group variously labeled “pseudoneurotic schizophrenia,” “borderline cases,” “semi-compensated schizotype,” and the like. Most of these patients are seen in an out-patient setting, and would not be legally committable even if the clinician felt this was indicated. In addition to patients who, while not psychotic by conventional standards, do at least present psychiatric symptoms or complaints, the checklist is also intended to aid in the detection of better-compensated schizotypes who may be superficially “healthy” as far as the ordinary psychiatric criteria of neurosis are concerned. While I make no claim that the checklist will serve to spot well-compensated schizotypes, I do believe that it can be helpful in identifying “latent” or “sub-clinical” schizophrenia, “schizoid personality,” or “schizophrenia in remission.” Some of the signs (e.g., micropsychotic episodes) do not appear among them with appreciable frequency. Pending adequate statistical work on the checklist, I shall merely say that I believe it also has clinical utility in the semi-compensated range short of those diagnosable cases of pseudoneurotic schizophrenia from whom it was primarily devised.

2. For clinical convenience each sign is judged on a dichotomous (“present” versus “absent”) basis, although most of them would theoretically be continuous variables. Since

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such dichotomy involves unavoidable ambiguity in defining each clinician's subjective cutting score on what are presumably continuous dimensions, three attempts are made to anchor these cuts:

a. The instructions state that the clinician should check the symptom or trait only if he is highly confident of its presence in the patient, so that if the rater has even a moderate doubt as to an item's applicability, he should not check it as present. As soon as you find yourself wondering and vacillating as to whether a sign should be checked or not, this means that it should not be checked; since your wonderment proves at least moderate doubt exists, and the instructions are to leave doubtful signs blank.

b. A semi-objective anchoring to use here is, "Does this patient manifest more of the trait than the average patient in a mixed psychiatric out-patient population?" If not, the sign should not be checked; you need not consider it further. If he does, examine the possibility further in terms of the examples and elaborations provided under each rubric. Thus, a patient's showing the trait more strongly than the average amount found in a mixed psychiatric out-patient clientele is a necessary but not sufficient condition for checking the sign as present.

c. In the case of some of the items, modifiers of degree are added to the basic characterization of the dimension or quality, because the variable becomes diagnostically powerful only in certain regions of its quantitative distribution. Thus, "Ambivalence" should not be checked even if clearly present unless it is (clearly) "intense."

3. I have no quantitative evidence regarding the amount of clinical contact with the patient which is necessary in order to make these judgments acceptably reliable and valid. Obviously the signs will differ widely in this respect, some of them being often judgeable without even seeing the patient (e.g., "failure to achieve, gross, corrected for capacity"), whereas others might require a fairly extensive series of interviews to provide a sufficient behavior sample (e.g., "repetition of material").

As a rough rule of thumb, pending better empirical evidence as to the amount of contact needed for judgeability of these items, I would say that it is not safe to fill out this checklist for research or diagnostic purposes on a patient who has been seen less than 5 hours; and I wouldn't be very comfortable with it unless the patient had been seen 10 hours or more. (A possible exception to this rule is the kind of patient whose discourse ranges widely over the areas covered by these items in the course of a diagnostic study, or where the rater has access to other sources of information (informants, previous therapist, personal documents, psychological tests).

It is not possible to use this checklist on the basis of documents or informants, lacking direct interview contact with the patient himself. However, informant material may be used to supplement patient contact. For example, in rating the sign "Rage," a relative's description of the patient's behavior may provide the clinching evidence that the temper-outburst met the checklist criteria of a real "rage attack."

4. While there is no way to eliminate the subtle stereotyping tendency of the rater once he realizes that the checklist deals with schizotypy, it should be emphasized that Rado's term "schizotype" is not mere superfluous neologism but designates a theoretical entity distinct from the concept "schizophrenia," and its relationship to the latter clinical entity is

complex. You should avoid the tendency to think of schizotypy as a kind of “mild, watered-down” schizophrenia, because then the malignant implications of the term “schizophrenia” will tend to spill over (although somewhat attenuated) into your readiness to check each of the items. Usually a therapist who has optimistic therapeutic goals for a patient of whom he has grown fond is reluctant to say that his patient is schizophrenic, even “ambulatory” or “latent.” Therefore, in the interest of minimizing rater bias, one must keep in mind that schizophrenia is a diagnostic entity in clinical psychiatry, whereas schizotypy merely designates a personality makeup. The taxonomic theory which underlies the use of this checklist for research and clinical purposes postulates that all cases of clinical schizophrenia (when correctly diagnosed) are schizotypes who have decompensated to the point of being psychiatrically diagnosable. The theory does not entail the expectation that most schizotypes will ever decompensate, even to the extent that they will become at some time diagnosable under the rubric “pseudo-neurotic schizophrenia.” My own hunch is that well over half of all schizotypes remain clinically compensated throughout life; and I would not be greatly surprised to find that for every schizotype who decompensates even to the extent of being diagnosable as “pseudo-neurotic schizophrenia,” there may be as many as four or five others who remain permanently compensated. There is no point in your trying to make these checklist judgments if you have a strong negative feeling against the “schizo-” root which leads you to be inhibited as you examine each item on the list, because you feel as you check them through that your patient (whom you do not consider to be schizophrenic) is “piling up too many adverse points.” For this reason I have deliberately avoided revealing either the armchair item-weights or my own provisional “cutting score” in connection with these rater instructions.

5. Most of the items in the checklist are at the phenotypic level rather than in terms of inferred psychodynamics, and this has been done in the interest of judgeability, especially by raters who may differ one from another (and from myself) in their psychodynamic and etiological opinions.

6. I make no claims for the completeness of this list, and in some ways the verbal form is not optimal. The reason for retaining it is that data have already been collected using the present form and I would prefer to maintain comparability with future data, since the sample I have would be a rather difficult one to duplicate in the foreseeable future. For the same reason I have permitted some overlap in sign-evidences, which you should take in stride while rating.

7. Amount of space devoted to the spelling out of a sign is not an indication of its weight or criticality, but merely reflects the fact that some of these signs are more in need of clarification than others, being (a) less well known in the literature, (b) more subject to clinical confusion with similar—but different—symptoms often found in neurotics, or (c) more heterogeneous as to the behavior-facets subsumed. For some of the obvious “objective” and well-known signs I have therefore provided minimal exposition. The order of the signs is merely alphabetical.

8. At present this checklist should be conceived as (a) a research tool, (b) a researchable clinical device, and (c) an aid to the diagnostic interviewer (e.g., to jog his memory). The construct validity of a checklist of psychiatric signs involves difficult methodological issues, since this class of behavior-dispositions is the class conventionally accepted as the

“criterion”—or, as I would prefer to put it, conventionally assigned the heaviest initial indicator-weights (Meehl, 1959)—on the basis of which other more dubious indicators (e.g., a new psychological test) are validated. Aside from content validity, which necessarily plays a privileged role here, the construct validation problem is to tie such dispositions into a ramified network with multiple strands converging on each “node” in the network (Cronbach & Meehl, 1955). The best way to do this is, of course, to get a number of clinicians and researchers interested in collecting diverse kinds of correlates. Hence my decision to make the checklist available at this time. My own subjective conviction that it has enough construct validity to warrant researching it lies mainly in its performance on a small sample (N = 52) of patients drawn from my own therapeutic practice over the last decade. Data on internal consistency and factor composition are currently being gathered in several Twin City clinics and will be reported shortly. Meanwhile it goes without saying that this is not a psychometric instrument, and not even a “validated” rating device. It is therefore not proposed for routine clinical use except as in (c) above; which is another reason why I have refrained from indicating either the a priori item-weights or diagnostic “cutting score” that I myself currently employ.*

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* Meehl’s “armchair weights” are now included as an Appendix to this manual. Thanks to Mark F. Lenzenweger for suggestions to clarify the use of weights given there. —LJY

Name _____ Sex ____ No. _____ Date _____

Rater _____ Hours contact _____ D_x _____

Check (X) those symptoms or traits which you are highly confident are present, and in the degree implied by the phrase and its modifiers. Thus, if “Ambivalence” is present, but is not clearly “intense,” this sign should not be checked. Scoring, weighting, cutting, and validation are based on such strict rating instructions. Whatever your views about the diagnostic meaning of these signs, please try to set all such thoughts aside, judging each item “by itself” as objectively as possible.

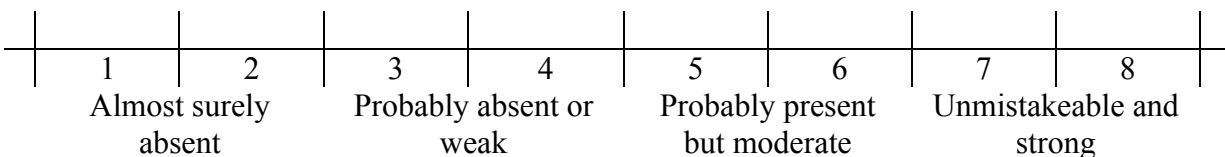
- | | |
|--|--|
| 1 ___ Ambivalence, intense | 14 ___ Magical ideation or action |
| 2 ___ Anhedonia [pleasure-deficit] | 15 ___ Micropsychotic episodes [include “drift-outs” in interview] |
| 3 ___ Body-image aberrations | 16 ___ Narcissism, extreme |
| 4 ___ Chaotic sexuality | 17 ___ Pan-anxiety |
| 5 ___ Cognitive slippage | 18 ___ Poor outcome [include clearly premature termination] |
| 6 ___ Countertransference strain on you | 19 ___ Psychosomatic or neurological signs [See next page] |
| 7 ___ Deflated self-esteem: Severe + inappropriate + diffuse | 20 ___ Rage: Intense, phenotypic, verbalized, disproportionate |
| 8 ___ Dependency, demandingness | 21 ___ Repetition of material |
| 9 ___ “Different from others” feeling explicitly stated | 22 ___ Self-injury (physical, social, professional, sexual) |
| 10 ___ Distrust, testing operations, closeness-panic | 23 ___ Social fear [include <u>marked</u> preference to “be alone”] |
| 11 ___ Failure to achieve, gross [corrected for capacity] | 24 ___ Special signs [See next page] |
| 12 ___ Flat or spotty affectivity | 25 ___ Suicidal [attempt, <u>or</u> dread, <u>or</u> chronic “thoughts”] |
| 13 ___ Hatred of mother, manifest, expressed | |

===== Column 1 sum

===== Column 2 sum

w_c = _____

SCHIZOID TENDENCY, YOUR JUDGMENT



19. Psychosomatic or neurological signs

___ a. Psychosomatic

___ 1. Skin (urticaria, neurodermatitis, eczema, dermatographia, excoriation, acne)

___ 2. Weight-loss due to anorexia

___ 3. Psychosomatic fever

___ 4. Vasomotor dyscontrol

___ b. Conversion symptom

___ c. Neurological signs

24. Special signs

___ a. Hopelessness

___ b. Hypochondriasis

___ c. Sensory input compulsion

___ d. Noise oversensitivity

___ e. Touch aversion

___ f. "Night owl" syndrome

___ g. Energy-depletion

___ h. Gullible-suspicious paradox

___ i. Spatial-motoric-kinesthetic defect ("proprioceptive diathesis")

___ j. Humor defect

___ k. "Paranoid headlights"

___ l. Panic when alone

___ m. Sleeping with clothes on; or on couch, chair, floor; or with light on

___ n. Photophobia

___ o. Name or address depersonalization

___ p. Facial asymmetry

___ q. "Inappropriate appearance"

Detailed Description of Signs

CHECK ONLY SIGNS WHICH YOU ARE CONFIDENT THE PATIENT SHOWS MORE THAN THE AVERAGE OF A MIXED PSYCHIATRIC OUT-PATIENT POPULATION.

1. **Ambivalence, intense:**

The essential feature here is the existence of simultaneous or rapidly interchangeable positive and negative feelings toward the same object or activity, with the added proviso that both the positive and negative feelings be strong.

- a. Avoid the temptation to check this sign merely because the patient has some “mixed feelings” or “changes in attitude,” since mixed feelings and changes in attitude are found in most of us with regard to some persons or situations.
- b. Appropriateness is also a consideration; when the combination of strong positive and negative feelings is inappropriate from the standpoint of the external observer, there is more justification for checking “Ambivalence” as present. Example: A patient has strong positive feelings toward his girl friend because of her affectional warmth, shared esthetic interests, and healthy sexuality. But from time to time he finds she is secretly stepping out on him, which makes him angry at her. This is not ambivalence, but merely the individual’s reaction to different facets of his reality, some of which are gratifying and others frustrating. By contrast, consider the following example: During the course of treatment a patient recounts a series of episodes in her life and also brings in several current instances, in which a too-rapid, uncritical, and intense positive response was made to a new acquaintance. After a short “honeymoon” period, the patient begins to bring in rather minor or trivial incidents or remarks made by this new acquaintance, and manifests real hatred toward the person in recounting them. Nevertheless the patient is greatly concerned about the correct interpretation of these little episodes and continues to show a gross over-reaction to signs of affection or disinterest by the other party. The whole thing is greatly blown up out of proportion to the realities and has the earmarks of schizotypic ambivalence.
- c. The most important domain of appearance of ambivalence is in the case of social objects. However, it is also detectable with regard to apparently impersonal objects such as activities, topics, viewpoints or theories, and the like. The patient’s tasks, responsibilities, and even self-selected hobbies may show a remarkable tendency to carry a double positive-negative loading.
- d. The most dramatic and directly available evidence of intense ambivalence is, of course, found in the transference relationship. If signs of intense ambivalence do not appear in the therapeutic relationship and quite unmistakably so, the ambivalence sign should not be checked as present. The therapist’s recipathy must be used here to some extent, although often even without it the behavior is pretty clear. One characteristically feels over-loved and over-hated, simultaneously admired and depreciated, depended upon and rejected, trusted and distrusted.
- e. Definite ambivalence involves really concurrent (parallel, simultaneous, “inconsistent”) positive and negative feelings of high intensity. However, extreme lability (instability,

shifting, fluctuation) is a modified form of it. Since “attitudes” are essentially dispositional constructs anyhow, it is not always easy to distinguish between concurrent and fluctuating positive-negative combinations. In evaluating shifts or fluctuations rather than concurrence as evidence of ambivalence, I take into account such features as:

- (1) Rapidity of shift. A sign which I consider almost pathognomonic is a pronounced change, especially from positive to negative, during a matter of seconds in the course of the therapeutic hour.
 - (2) Endogenous shifts are more likely reflections of true ambivalence than externally precipitated ones. One often gets the feeling that the patient’s changes in affective attitude are sort of “spooky,” in the sense of being unfathomable, subject to mysterious powers, beyond control, or even beyond genuine psychological understanding.
 - (3) The more “unreasonable” and “uninfluenceable” the shifts, the more appropriate it is for ambivalence to be checked.
 - (4) Correlation over time, the positive and negative feelings actually tending to go up and down together. This is, of course, especially characteristic of the therapeutic relationship. As is well known by all therapists who have worked with schizotypic patients, the closeness and dependency produces fear and rage in the patient, so that no offer of help and no manifestation of affection or willingness to be “close” can be reacted to unambivalently.
- f. I’m not sure whether to list this next point under ambivalence, but it is as good a place as any, and I personally tend to use it as evidence for ambivalence. As one learns more about the patient he is struck by the fact that with the passage of time everything tends to get some negative loading. You get the feeling that all activities and relationships are somehow subtly “poisoned” as soon as the patient tries to make them his own. No person remains a “good figure”; no idea remains clearly acceptable; no interest or hobby can retain its appeal. The patient’s psyche seems to have kind of a “reverse Midas touch”—everything he touches turns to garbage.
- g. An affective phenomenon which I have subsumed, although arguably, under “Ambivalence” for checklist purposes is pain-dependency. What ever may be the historical and psychodynamic explanation of its origin and maintenance, its phenotypic appearance is that of an intimate linkage, amounting literally to a kind of fusion, between negative and positive components in the patient’s “hedonic regulation” system. Its concrete manifestation is that painful affects, and the situational elicitors thereof, seem to be pre-conditions for experiencing even attenuated pleasure. Objectively, the patient tends to “set up” situations and carry out activities in such a way that aversive inputs are present concurrently with the opportunity for pleasure or gratification. For example, erotic pleasure-seeking is set in contexts providing features of danger, guilt, sordidness, etc.; pride-related strivings occur in settings or forms that precipitate loss of face, shame, danger of retaliation, and the like. Corresponding to these behavioral trends (discernible “objectively” as statistical outcomes of situation-choice and probable consequences of action modes and the patient’s instrumental “style”) there is a correlated subjective side, namely, the ensuing hedonic state is itself pervasively infected with an aversive quality. It is not merely that the rigged aversive

input has its concurrent phenomenal consequence, existing, so to speak, “parallel” with the pleasure-quality (as in the neurotic who regretfully “pays the price” to his punitive super-ego for a bit of forbidden pleasure). Rather you form a distinct impression that the “painful” component is somehow part of the pseudo-pleasure, being inextricably intertwined with it to such an extent that the hedonic quality itself has been subjectively transformed. At times the non-schizotypic therapist will have real difficulty empathizing with the patient, to such an extent that real doubt arises whether the patient’s report is qualitatively “pleasure” or “pain,” or is a mysterious sort of mixed state hardly communicable by shared language.

2. Anhedonia [pleasure-deficit]:

A psychometric or more objective technique for assessing pleasure capacity is badly needed for diagnostic purposes. Regardless of one’s theory as to its origin, the clinical manifestation of anhedonia is (as the etymology suggests) a deficiency in the capacity to experience pleasure. The hard question is how to distinguish true anhedonia from the common neurotic problem that pleasure is “interfered with” by neurotic counterforces. I wish I knew how to objectify the distinction, which I am subjectively convinced I can make clinically. As an overall clinical impression, I would put it something like this: Everybody has problems, and everybody we see in therapy is having his gratifications impaired by reality or by internal conflict or constraint. Nevertheless, non-schizotypic neurotics do manage to have some fun, to get some kicks, to escape transitorily from their inhibitions, and to arrange the reality situation semi-satisfactorily from time to time; hence they can give a few strong, definite, zestful “pleasure-reports.” By contrast, after many hours of treating a schizotype one realizes that whereas the patient’s mood may have fluctuated, his objective situation may have changed, and his performance may have improved, the poor fellow just doesn’t have any fun. There appears to be a radical, pronounced, pervasive, and relatively unmodifiable deficiency in the ability to experience pleasure. To an animal psychologist, the person seems rather like a white rat who is operating entirely on an aversive regime—he presses the lever to keep the shock turned off but he rarely or never seems to get any food pellets.

Difficult as it is to spell out, the following are some of the indications which I have found useful in assessing anhedonia:

- a. Situation-Independence. It is obviously wrong to diagnose a person as anhedonic merely because his actual situation provides very little positive input from the standpoint of external reinforcement. The distinguishing point here is not whether he has control over the reality-situation, since a neurotic may systematically arrange (or avoid) situations in such a fashion that he gives himself no objective opportunity for payoff in terms of pleasure experiences. Whether the reality-situation is unusually unkind, or the patient has constricted his activities neurotically so that reinforcing events are unavailable, we would not consider either of these evidence of anhedonia. The critical question is whether, when (however rarely) the external world delivers a reward, does the patient receive a “subjective charge,” does he have a real “pleasure-experience”? The assessment of anhedonia must therefore be made with proper reference to what would normally be considered pleasurable inputs, whatever may have been responsible for the low frequency with which these external rewards actually occur in the patient’s current life. In rating, we therefore correct as well as we

can for the incidence of objective reward-type inputs for this patient—and this rarity may be slightly, moderately, or mainly due to his own behavior—and when we confine our attention to these rare reward-type inputs, do they yield subjective reward-experiences in him? If not, he is probably anhedonic.

- b. Interfering affect or content is not regularly detectable on the surface. I have to say “on the surface,” because the question whether anhedonia is fundamentally due to interfering aversive learnings is an open and arguable etiological question, which I do not wish the clinical description to prejudice. However, what makes anhedonia seem like a more “radical, basic” defect in pleasure “capacity” is that many of the episodes which the patient narrates during treatment are ones in which he fails to report negative feelings, and such negative feelings cannot be readily elicited by moderate probing; and yet there is a failure to report distinct pleasure-experience. By contrast, the non-schizotypic neurotic, when he fails to experience pleasure in what would prima facie be a pleasure-giving situation, can usually report the interfering content or affect; and even when he can’t, it is generally easy for the therapist to arrive at an interpretation of what it was. After you have listened for hours to a person with anhedonia discuss his behavior and experiences, you become struck with the fact that he isn’t getting any charges, isn’t receiving adequate kicks, isn’t having any fun, isn’t experiencing real pleasure of even moderate (let alone high) intensity, even in situations and from experiences where negative components can be attributed only on theoretical grounds, and not because they are visible in the clinical material. It’s very hard to draw the line here between the therapist’s ability to discern negative counterforces, which we can always do with any patient’s material if we set our minds to it; and the opposite mistake of taking a pleasure-deficit at face value because we have not been sufficiently sensitive to the aversive elements in the context. All I can say is that you have to take a whole batch of episodes into account, and if without much speculative interpreting or moving into the level of unconscious processes, you find that impaired pleasure can usually be explained rather readily on the basis of fairly obvious interfering negative factors, then these episodes do not constitute evidence of anhedonia. On the other hand, if in addition to the presence of the usual mixed positive-negative factors—common to both schizotypes and non-schizotypic neurotics—you find that you have heard at least a few episodes which should prima facie have provided pleasure experiences but which did not; and in which you cannot discern negative factors on the surface or slightly beneath the surface but would have to attribute them only on largely theoretical grounds; then you probably have justification for checking anhedonia as present.
- c. Pervasiveness of the pleasure deficit. Whether anhedonia is really completely general, so that what would for a normal or neurotic person be rewarding, pleasurable, gratifying experiences are much less so regardless of the life-domain involved, is a matter of disagreement even among clinicians who have been influenced by Rado. Personally, I am on the fence in this matter, although I was initially inclined to believe in the generality of the anhedonia in these patients. Lacking any research data, one can only do his best to summarize clinical experience. I have the impression that some, perhaps most, anhedonic patients are capable of a fairly adequate pleasure experience in certain esthetic and intellectual domains, provided that the content and the setting (context) is almost completely impersonal, involving neither relatedness to others, nor

any kind of “performing” or “achieving” by the patient himself which would gear into the problem of his self-concept of inadequacy feelings. One difficulty in evaluating this matter is that the patient’s reports about pleasure experiences in such things as listening to music or solving a chess problem must be somehow corrected for the baseline of anhedonia and a consequent altered semantics for pleasure-words. Furthermore, the kinds of expressions we normally employ to talk about positive feelings in the esthetic and intellectual areas are conventionally less colorful or highly charged expressions, so that one often hears a rather washed-out or formalized mode of expressing pleasure in these domains even from a healthy person. Nevertheless, without dogmatizing about the unsettled question of whether true anhedonia has complete generality, it is quite clear that it spreads over a much wider area and has fewer exceptions than in the neurotic or normal person. Descriptively, the clinician finds that he has to search for life domains which seem to furnish the patient with anything like even a moderate hedonic charge; whereas in the normal or neurotic person several such will usually come to light without too much searching being required. So that if I find myself saying about a patient, “There is almost no area of experience in which this person seems ever to get a real wallop of pleasure, even when he does things, or things befall him, that normally would, and which he himself thinks should (and perhaps expected would); at most there are few areas where the reported episodes of pleasure are weak or in doubt.” Under these circumstances true anhedonia is the most likely guess.

- d. Self-description as anhedonic. Some patients, if intelligent and introspective, have actually drawn the inference to their own anhedonia without knowing the technical term, and are distressed by it. There are different ways in which the patient may verbalize this insight, but many anhedonic patients practically describe the sign in so many words. The patients say such things as, “One reason I think about suicide is that even when things are going all right, so I couldn’t say I am suffering or particularly unhappy, life just doesn’t seem worth it. I mean, you have to get up in the morning and meet all your damn responsibilities and deal with people and solve things but what do you get out of it? I look at other people and it puzzles me why they seem to be having a good time. I just have never been like that, and—I hate to say this—I don’t think I ever will be!” When you get to exploring the patient’s feeling of “I am different from ‘the others’,” which some can report having concluded very early in their life history, one of the sources of this feeling of difference is that the patient perceives that others get more pleasure out of activities and experiences than he does. Some schizotypes defend against the anxiety produced by this recognition of pleasure deficit by intellectualizing along lines of cynicism or superior reality-perception; but even these cases usually show a wistful yearning to get a kick out of the “stupid” things that ordinary mortals enjoy. Another defense is to locate the problem in some unmodifiable aspect of the reality-situation (e.g., “I would be happy if I were a man, but of course that’s impossible”). A dramatic form of this defense is often seen in schizotypic women who have focused their dissatisfaction upon the career-family-housewife cluster, the patient having anticipated for years that as soon as the children were old enough she could “go back to school” or “get a job” or “enter political activity” or “take up music seriously.” When the hoped-for freedom develops, she attempts to realize the fantasy, is confronted with persisting anhedonia, and may be

catastrophically threatened by the discovery that “life still isn’t any fun, after all.” In general, I have learned to be alert to anhedonia whenever a patient concentrates attention on a problem which, while perhaps genuine as far as it goes, is made the focus of exaggerated and unrealistic complaint, with the magical idea that “If only this terrible thing could be taken care of, I’d be all right and could be happy like other people.” The patient puts all his eggs in one misery-basket, and you as therapist come to realize that the diffuse wretchedness and non-gratification is out of all proportion to the problem focus. The patient whose life is ruined and hopeless because, e.g., “We never had a boy child,” or “I wanted to be called to Harvard,” or “I got married before finishing my B.A. degree,” or “I am flat-chested,” or “My wife refuses to go camping with me,” or “I really should have been a musician instead of an accountant, although I kind of like accounting” is often heroically defending against the unbearable recognition of his own anhedonia.

I have also found, when an intimate informant such as a spouse is available for questioning, that without my suggesting anhedonia but providing opportunity through general questioning for the informant to examine the patient’s pleasure-potential, an observant relative will frequently describe the anhedonia without knowing what to call it.

When a patient tells me in so many words that he had never been a “happy person,” even as a child; that he isn’t happy now as an adult; and that he is afraid, no matter what happens in his life situation, or in the therapeutic interviews, that for some reason he isn’t ever going to be happy—I look upon this as a strong anhedonic indicator. Even a profound psychotic depression, who is convinced that the future is going to remain black, will more often than not be able to say retrospectively that some time in his life has been “happy.”

- e. More important than an overall self-assessment as to pleasure, which the patient may fail to provide, the interviewer must remain alert for clear positive hedonic reports over a series of sessions. A nonschizotypic patient should, over a series of hours, spontaneously report at least a few things that have happened to him currently, and some things he remembers from earlier (especially from childhood), in a way that sounds like unfeigned, unintellectualized pleasure. Failure of a patient spontaneously to produce such positive hedonic reports over several hours of contact probably justifies checking the anhedonia sign as present.
- f. Distinguishing “pseudo-pleasure” from “genuine pleasure” reports: It is important to avoid mistaking “success,” “performance,” or “failure-avoidance” with pleasure. The fact that a patient reports to you that he did well, felt free of anxiety, performed adequately, escaped criticism, was accepted by others, proved his competence, and the like are all irrelevant to the question of whether he experienced pleasure in the sense germane to the anhedonia rating. In fact, while this may seem a rather fine line to draw, the combination of such “performance” reports in the absence of a real wallop of subjective pleasure-experience is one of the most valuable patterns in detecting anhedonia. Example: A patient has been feeling inadequate and ashamed for not “entertaining people” more than she does. As a result of working on this problem in the course of psychotherapy, during which some of her social fears are desensitized and some of the avoidant patterns interpreted, she decides to expand her field of social operations. She gives a party and it is a “success”; but how does she report this success experience? She reports that everybody had a good time (it seemed); that she was not

unduly anxious about the food she prepared; that it seemed clear that she had done a skillful job in selecting the particular combination of guests; that people were effusive upon leaving and stayed until quite late, leaving her to conclude that they were not just being courteous but were really enjoying themselves; and so forth. There is certainly a sense in which she is proud of this objective social attainment, and she may spend a good portion of the hour recounting it. Nevertheless, by the end of the session the therapist realizes that she has nowhere actually said anything about whether she had a good time. She performed effectively as a hostess; she was free of crippling anxiety; she genuinely believed that the thing was a “success”; but she hasn’t at any point given you the slightest reason to suppose that she was having any fun. Now this kind of thing is ambiguous if it was the first party she had given in a long time, and one would not conclude too much from it. But when she gives two or three more parties and continues to report objective success and a relative freedom from subjective distress, somewhere in these accounts there should be evidence of positive pleasure.

It is dangerous to get too specific about the patient’s choice of language since so much of this is cultural and stylistic and varies from individual to individual quite apart from pleasure-capacity. Nevertheless, there is a kind of flat, wooden, formalized or intellectualized way of talking about pseudo-positive experiences which may be mistaken for a hedonic report if we are not careful. A pleasure-capable patient will from time to time give you some good language about hedonic experiences, even if it’s describing a beefsteak or a passing sexual affair. By contrast, I have treated relatively compensated schizotypes who in the course of 200 hours have not one single time spontaneously said anything like, “Boy, that was a terrific party! I haven’t had so much fun in months. It was partly because I liked this girl so much, right off; but it wasn’t only that....” Anhedonics just don’t talk this way, because they don’t have this much fun. An anhedonic individual might say, “So I took this girl out, and we related well together; and I am pleased to say that my sexual performance was very satisfactory. All things considered, I would classify that party as a success, definitely so.”

- g. Anhedonia is really “hypo-hedonia.” In all of the above I have stressed the severity and the pervasivity of the pleasure-deficit, and must now counteract this impression by a warning. It is unfortunate that Rado employed the term “anhedonia,” which, taken literally, would mean that the person “lacks the pleasure-capacity.” But, presumably no psychologist could take this literally, for any patient. Regardless of whether the hedonic deficit is primary or derived from interfering counterforces such as unreportable chronic anxiety, we must presume that the anhedonic patient has a deficient amount of pleasure, that he has an aberrated reinforcement-parameter which leads various objective inputs to generate markedly reduced subjective pleasure experiences in him. But we cannot require that anhedonia should be taken to mean zero pleasure; for clinical experience shows that if we did this, we could not properly classify anybody as literally anhedonic. Even the most apathetic, washed-out, chronic, deteriorated, backward schizophrenic in a state hospital can be induced to perform certain actions to get candy or cigarettes, and is likely to show at least some degree of autoerotic behavior; and these manifestations of the control of operants by their stimulus consequences may be taken as indicators of at least some degree of subjective pleasure on the phenomenal side. This is an important consideration in deciding whether to check the anhedonic sign as present, since if we meant literally anhedonia in the sense of “no pleasure,” we

would be restrained from ever rating anybody as anhedonic. I can only appeal to the rater's clinical experience by saying that, in my experience, this dimension is bimodal; and that once you have been alerted to listen for it, patients are fairly readily classified as in the anhedonic distribution or the hedonic one.

3. **Body-image aberrations:**

The clinically gross forms of body-image aberration are too well known to need lengthy discussion. A patient who reports even a single episode definitely involving marked alteration in his experience of his body as a formed object in space—its size, or shape; the relation of its parts to one another; or its relation to external objects (including inanimate objects and the bodies of other people)—should be checked as having this sign. Examples of such concrete, marked episodes are experiences in which it seems to the patient that all or part of his body had become larger, or smaller, or somehow distorted; or that one of his limbs was in some way “disconnected” or “belonged to somebody else”; or that an external object was connected with his body, or had in some sense become momentarily fused with it or “belonged” to it. It is of course difficult for the clinician to understand precisely what kind of subjective experience is being described in such language, but I do not consider this difficulty of sharing the percepts a reason for ambiguity about whether the sign should be checked. On the contrary, if you have a hard time understanding adequately what must have been the subjective structure and quality of the body-experience the patient is trying to convey, this in itself is evidence for the occurrence of a body-image aberration. The essential element in what I am calling “clinically gross” body-image aberration is an experienced (perceived or quasi-believed) distortion of the body as to size, shape, connection, or causal relation to other bodies or objects. Examples: “It seemed I was expanded”; “Somehow I felt as if I was somehow connected to the chandelier”; “I am terrified by a feeling that I am sort of melting into you, that I am really getting mixed with you somehow—it’s hard to explain.”

Short of these dramatic phenomena are some less extreme manifestations, harder to evaluate. One of them is distorted experience of one's body along “value” dimensions rather than the physical features of size, shape, connections, or causality. I am strongly inclined to check body-image aberration as present when a patient says that his or her body is “disgusting,” “loathsome,” or “seems dirty” or “is permeated with decay.” Doubt arises because statements of this kind are not typically expressed as beliefs which the patient holds and are therefore not properly delusional; they are rather his choice of extreme language to express the intensity of the patient's somatic self-distaste. Most out-patient cases will of course not maintain that their bodies are really rotting away; instead they will intermittently complain that it seems as if they are disgusting, dirty, rotten, and the like. When such highly charged negative language is employed, I regularly score the body-image sign as present.

Even greater difficulty occurs in evaluating more “indirect” or “peripheral” forms of body-image disturbance of a subtle kind. Extreme, subjective magnification of the social visibility of a minor anatomical defect I would usually record as sign present. Thus, a patient with the tiniest protuberance at the tip of the nose, discernible by the therapist only upon looking very carefully with the patient in profile, and which no one would even “see” unless set to look for it by the patient's complaint, is described by the patient as “This awful big bulge at the end of my nose.” A focusing of personal inadequacy feelings

about such an imagined bodily defect, or around a real but slight and socially unimportant defect, should usually be scored; as should serious contemplation or carrying out of needless cosmetic surgery.

When we get to extensions of the body image, the scoring becomes so difficult and subjective that I would advise caution to any but the most experienced clinician. I have in mind the patient's attitude to clothing and personal possessions associated with the body, its functions, its cleanliness, its attractiveness, its "value," and the like. As is well known, in females frequently the home and furniture are unconsciously experienced by the patient as being part of her own body. I do not check these forms unless they are very definitely present, chronic, unrealistic, and markedly exaggerated in intensity. "Housewife guilt" is so widespread in American culture (especially in upper-class and better-educated women) that mere complaints of "I don't keep on top of my housework" do not suffice to justify checking the body-image sign as symbolically present. But there are some "body-symbolic" complaints that justify scoring (e.g., female patient who dares not open a certain closet door during her menstrual period, "because it's such a mess"; male patient who cannot write with a fountain pen if he has recently masturbated).

4. Chaotic sexuality:

While most patients will, under careful scrutiny, show some disturbances or dissatisfactions in sexual life, the strong term "chaotic" is obviously inapplicable to the majority of normal or neurotic sexual difficulties. The occurrence of either acted-out or fantasied episodes in which the erotic impulse shows overtly a mixture of explicitly polymorph-perverse sexual components—a scrambling of heterosexual, homosexual, autoerotic, voyeuristic-exhibitionistic, sado-masochistic, oral, anal and genital components—is what one requires before checking this sign. As described by one clinician, "The patient's sexual life, fantasy, ruminations, or fears sounds like a recital of *psychopathia sexualis*" Elicitation of the patient's masturbation fantasy, or fantasies employed as aids to potency or orgasm in coitus, are very helpful in this respect. (I am inclined to agree with Wilhelm Reich that a psychotherapist who does not, at some stage of the proceedings, elicit a fairly detailed account of the patient's masturbation fantasy is not doing an adequate job of exploring his patient's psyche.)

I suppose that the most serious source of false positives in checking the chaotic-sexuality sign is the danger of checking it merely because one "compulsive condition" of sexual excitement, pleasure, or performance happens to strike the particular therapist as unusually aberrated. This is a matter of individual differences and probably reflects the sexual predilections and personal sexual history of the rater. (No rater should check this sign without having read Kinsey's statistics!) It is difficult to be very explicit about the positive criteria for this sign, beyond emphasizing that the word "chaotic" is a pretty strong word and is probably not applicable unless one finds a good deal of mixture or scrambling of various psychosexual components in the behavior or fantasy. When I find myself thinking, after listening to a patient's account of his sexual activities or masturbation fantasy, "This person's sexuality is a looney-sounding scrambled mass of hazy, overlapping, infantile gunk," then I am inclined to check the chaotic sexuality sign as present.

Masturbation (either sex) with a non-sexual fantasy content (e.g., patient masturbates while fantasizing two trucks colliding); or (in males) masturbation with no attendant

fantasy at all, I consider sufficient in itself to check the chaotic-sexuality sign as present. In evaluating the sign when the sexuality is not grossly and floridly chaotic but in which several polymorph-perverse components play an important part, you should take into account the base rates in our culture of certain characteristic sexual preconditions, including the relatively normal “fetishes” found (especially in males). Thus, if a male patient’s condition for sexual arousal or performance involves the partner’s secondary sex characteristic such as size of breasts, length and style of hair, and the like, this is close enough to garden-variety normal sexual fetishes that are hardly more than “preferences,” that you should not give it much weight. On the other hand, if the performance or fantasy specifies that the erotic situation must include a brass bed, a bottle of coca-cola, and a partner whose breath smells of cough drops, this is beginning to get rather looney and is stronger evidence for checking the sign as present.

5. Cognitive slippage:

The concept of cognitive slippage has admittedly a certain vagueness about it. I would be reluctant at this stage of our knowledge to propose an explicit definition, and the best I can offer by way of explication is that a person with cognitive slippage is unusually aberrated in regard to accurately he perceives and thinks about reality. Cognitive slippage will therefore not make much sense to a clinician who is fond of talking about “everybody’s personal reality.” If you don’t believe that there is some kind of reality that is different from what each of us experiences, you better skip this item; because its meaning hinges on the distinction between reality and fantasy. (It is not a powerful or incisive locution to talk of a person who thinks he is Napoleon by referring to his “personal Napoleonic reality.” This kind of semantics serves to make psychopathology an even more hazy and confused enterprise than it has to be.)

- a. The clear clinical forms of cognitive slippage represent those gross breakdowns of ego-function which are well-recognized among the accessory symptoms of florid psychotic schizophrenia—i.e., delusions and hallucinations. I do not suppose there is much that needs to be said about these, other than the importance of attempting to distinguish, if necessary by persistent and probing “cross-examination” whether or not the patient has started to cross that fine line between an obsessional idea and a delusional belief. Sophisticated and cagey patients may at times pay lip-service to the abstract possibility of their being mistaken when careful questioning (with special attention to the patient’s manner) will show that this is purely a matter of lip-service and that, experientially and behaviorally speaking, the patient has a pretty strong belief, or at least “quasi-belief,” in the content of his aberrated ideation. Example: A usually well-compensated schizotype calls me up in a state of panic to make a special emergency appointment. Upon entering the office, she remains standing while telling me that her husband, who has taken a short trip away from the city, is having her followed by a private detective. She immediately adds the “insightful” comment, “Do you think I am going crazy or something? People have told me that I am paranoid, and of course it is quite possible that I am reading too much into the things that have been happening.” This comment shows that the patient is managing to retain a considerable criticality toward her own ideation and has a grasp, however tenuous, of external reality; but it would be quite incorrect to conclude from this that the patient is therefore, by virtue of her insight, free of cognitive slippage. She is deathly afraid to leave my office for fear

that the hypothetical detective may be lurking in the corridor. As she recounts the particular incidents which led her to formulate this idea—incidents which individually and collectively could not possibly impress a rational mind and which, a few days hence, she retrospectively sees rationally—it is evident that by most of the usual standards of “genuine belief” she momentarily believes in the private detective hypothesis. Her comments about her own possible over-interpreting are a sop to her rational ego, and an attempt to show herself (and the therapist) that she is quite capable of being reasonable and engaging in critical thought. But she does not really, substantively, at the feeling and acting level, entertain very strong doubts about the truth of her momentary private detective notion. In what she sees and hears, in how she feels, and in how she acts, it is “as if” she fully believed in the existence and menace of the detective. The critical, self doubting comments are not insincere; but they are the only indicators of disbelief. She makes them because her rational ego is not utterly shattered or suspended, and therefore she can hardly avoid having at least the thought that “error may occur,” even to her. But she is, momentarily, at least a 75% believer in the detective.

- b. A second form of cognitive slippage, well-recognized in the literature, is Bleuler’s schizoid “disturbance of association.” In its extreme forms (schizophasia, neologisms, incoherence, etc.) it is as readily spotted as delusions and hallucinations. The more subtle forms of thought disorder or associative dyscontrol are a matter of clinical experience and very hard to specify in general terms. There are peculiarities in the choice of language which do not violate any laws of grammar or semantics, which are too attenuated to be called “bizarre” or “incoherent,” and which probably do not involve anything more than the occurrence of a word at a certain point in a sequence of words which in the normal non-schizoid laws of association would have a very low transitional probability of appearing at that precise locus. So that when we look at the individual sentence it is hard to say exactly what is “wrong” with it and yet hearing such a person talk for an hour one has a very strong clinical impulse to say, “This individual somehow speaks ‘differently,’ ‘strangely,’ ‘oddly,’ or ‘unusually,’ but I don’t know just why I say that.” There is no mystery about this, although admittedly it needs quantitative researching. Presumably the clinician’s own brain has stored up certain expectancies regarding intra-verbal linkages or transitional probabilities from listening to hundreds of thousands of consecutive verbal operants in normal speech; and without being able to state the probabilities or formulate the general laws of intraverbal linkage, he nevertheless is capable of reacting to deviations from those expectancies which the current stream of the patient’s speech had aroused in him. When this tendency is strong enough, the speech sounds somehow “odd” or “strange.” The rater who has listened to a lot of mildly schizoid speech will know what I am talking about here; and the one who hasn’t, I am afraid, would not profit by my saying anything further.
- c. Another indication of cognitive slippage is based not upon observable evidence of associative dyscontrol or thought-disorder, but upon the patient’s reiteration of subjective complaints along this line. Some patients emphasize features of perplexity, confusion, “getting mixed up in my thinking” in a way, and with a frequency, which indicates that this is by no means a minor or peripheral aspect of their problem but is a major feature of their adjustment difficulty; and one which is understandably quite

frightening to the patient himself. Here again, it is necessary to listen carefully for their choice of words and sometimes to interrogate systematically because the complaint of not being “able to think straight” or being “mixed up” has multiple meanings. A non-schizotypic neurotic may complain of being “mixed up,” and what you discover upon pursuing this is that he means he finds himself conflicted and has been unable to make up his mind what to do, what way to turn, by way of problem-solving or getting out of his situation. Another patient whose initial choice of words is the same, saying that he is “mixed up,” turns out to be trying to communicate that he “can’t keep his thoughts going straight” (because irrelevant ideas obtrude), or he finds himself becoming very unclear as to what reality is, or even as to what certain words “mean.” Behind the particular choice of language, which of course can by itself at times be very revealing, it is necessary to assess the real character of the patient’s phenomenology so far as it can be reconstructed from the character of his verbal account. And when you do this, it is sometimes evident that certain patients complain of being “mixed up” or “confused in my thinking” for the excellent reason that that is precisely what is going on inside. In such cases the sign “cognitive slippage” should be checked as present. One joint rule of thumb is:

- (1) Do not check as slippage a mere “conflict” or “vacillation” of thoughts (e.g., being pulled toward two different resolutions of a problem, or hesitating between two alternative interpretations of facts) when each competing idea is itself fairly definite or clear; require instead that
 - (2) The thoughts or ideas seem to be vague, hazy, scrambled, intermingled, or unclear separately, so that you have a hard time getting clear, as you listen, just what the content or form of the phenomenology is; in which case check the sign as present.
- d. One special form of cognitive slippage is so-called “thought deprivation.” When this occurs within the interview itself, it is rather striking and easily judged in most instances. But sometimes you will have to rely, especially early in the interview series when the phenomenon has not yet actually taken place in your presence, upon the patient’s report of it. It means just what it says: The patient’s mental life is suddenly interrupted—his mind goes literally “blank”—and the subjective experience is apparently so distinctive and disturbing as to be readily attached to the terminology “thought deprivation” by the patient, even though he may not have heard the phrase before. (In patients with overtly delusional mentation this experience sometimes appears in the form, “My thoughts are being stolen from me.”) True thought-deprivation is easy to detect, but there occur less clearcut forms of the phenomenon in which you get the impression that the patient’s mental state somehow “shifted gears” for a short period, whether into blankness, rumination, or fantasy being difficult to determine. The patient emerges from this transitory state with a feeling (often shown chiefly by manner, facial expression, and a kind of “sleepy” tone of voice) of “coming to,” and a real difficulty in his immediate retrospection as to just what was going on during the interval.
- e. I come now to manifestations of cognitive slippage which I realize some clinicians would refuse to list under this category but which I urge you (in the interest of checklist comparability) to include even if you have a theoretical dislike for so doing. Short of delusions, hallucinations, gross or subtle disturbances in associative linkages

in discourse, subjectively experienced confusion or perplexity, and such striking phenomena as drift-outs and thought deprivation; there is a more subtle form of thought-disorder which is what makes necessary my use of a terminology implying less than the conventional clinical term “thought-disorder” and which is difficult to characterize except by saying that the patient reveals an unusual capacity, usually under emotional and motivational pressures, to “think crookedly.” Everybody makes mistakes in reasoning, but some patients display a much greater talent for it than others; and this difference persists even after the clinician takes account of the intensity of their momentary affects and motives. It transcends the ordinary capacity-achievement-skill differences in intellect, culture, formal education, and the like. Due to our conventional emphasis upon the motivated and defensive character of aberrated behavior and cognition, we clinicians have a tendency to minimize or “explain away” all aberrated thought, on the grounds that if we understand the patient’s momentary situation in relation to his need-structure, we can understand why his ideation is thus aberrated. This is often an inadequate account of the range of individual differences we see; although it is a valid element in accounting for the occurrence and direction of mistakes in thinking.

When we point to a person’s motives and affects by way of explaining a bit of aberrated ideation, we may be saying any or all of the following:

- (1) The heightened affect or motive explains why the person slipped on this particular occasion, although usually he would not under otherwise comparable (cognitive) circumstances. Example: Jones made an elementary error in addition during his physics exam because he was so anxious during the test that he was not functioning efficiently.
- (2) The “direction” or “content” of the cognitive distortion was influenced by the nature of the dominant affect or motive. Example: In adding up the points of a bridge score, one is more likely to make arithmetical errors increasing his own score and decreasing the score of the opponents.
- (3) The magnitude of a particular bit of cognitive slippage can be satisfactorily explained by reference to the intensity of momentary affects and motives, i.e., without hypothesizing a habitual or structural weakness in ego-function. Example: A shipwrecked survivor dying of thirst on a life raft momentarily misperceives a small cloud on the horizon as a rescue ship. We would not conclude from this that he was disposed to errors in perception or thinking, or that he had a “weak ego,” but we would rather say that this degree of distortion of an admittedly ambiguous sensory input, occurring under conditions of abnormally heightened drive, and with the absence of opportunity for consensual validation, is “normal for the circumstances.”

One needs clinically to distinguish among these three related but different aspects of the motive-cognition influence. It is absurd to suppose that all error is motivated in sense (2), for example. There is a vast experimental literature, going back at least to Ebbinghaus, which deals with the quantitative phenomenon of human error and establishes that the human organism, like other organisms, is characterized by fallibility. No psychologist assumes that cul-entries by a white rat running a maze represent his death instinct, nor that Ebbinghaus’ curves represent (primarily) changes

in motivation or affectivity! Nor dare we assume that the vast range of individual differences in the cognitive apparatus, which have been much more adequately researched and supported by quantitative evidence than anything we know in the field of psychodynamics, suddenly ceases to be relevant when we begin to talk about the motivations and feelings of patients. The plain fact is that some people don't think very well, and that there are wide individual differences in cognitive control as there are in every other aspect of the human mind that has been subjected to scientific study. It is a "clinician's fallacy" to mix up points (1) and (2) with (3). In assessing the presence or absence of the sign "cognitive slippage," it is imperative not to make this mistake. We do not decide as to the presence or absence of cognitive slippage by inquiring whether the patient had motivations to distort, since everybody always has motivations to distort. The difference which is critical in evaluating this particular sign is the difference between those of us who are able to distort given our momentary motivational and affective condition, and those of us who are not. It is pretty clear that, most of the time, most of us are literally unable to distort reality into high accord with our desires. Furthermore, extreme degrees of motivational and affective pressure can often be brought to bear upon normal and neurotic individuals without producing more than a minimal amount of cognitive distortion. A young mother who by a momentary carelessness has "caused" the death of her baby (e.g., she answers the telephone and the baby pulls over a pot of boiling water upon itself), has tremendous motivation to deny that reality is the way her senses and reason tell her it is. Hardly any of the thousands of mothers to whom such things have happened were able to accomplish anything but the slightest degree of distortion; and if a mother persisted in believing that the baby was still alive, or asserting that she was not in the house at the time the event happened, we would consider her psychotic. When a student who is about to be drafted if he doesn't stay in the university and whose parents have threatened to cut him off without further support if he doesn't do well, receives the information that he has just flunked all of his courses, you don't need to put a psychogalvanometer on him to demonstrate that he suffers a severe access of anxiety and that this arises from a collision of his own intense motives in one direction with the hard facts on the other. Almost all students under these circumstances are, willy-nilly, constrained by the input of reality and are not able to twist the world and make it "nearer to the heart's desire." The levels of affect and motivation involved in examples of this kind are extreme, and there is no cogent clinical or experimental evidence to substantiate the claim that the intensity of motives and affects in the schizophrenic are more intense or more pervasive. Some clinicians say that "they must be," but this is a pure dogma based upon unsubstantiated theory, not adequately supported by clinical observations. My point is that when a person engages in a marked and refractory distortion of reality in the presence of only slightly ambiguous stimulus inputs and with opportunity for consensual validation (especially by the therapist), even though the drives are moderately strong or the affects moderately severe, his ability to achieve this distortion testifies not primarily to the strength of the motivational and affective variables but testifies primarily to his defect in cognitive control. The presence of such a defect, the individual's talent—however he acquired it—for distorting, is an important aspect of the cognitive slippage sign. What some clinicians forget in this respect is the necessity

to evaluate degree of distortion in addition to asserting the qualitative truism that “all behavior is motivated.”

Let me give an example of these distinctions from my own therapeutic practice. The patient, a semi-compensated schizotype, is a woman of high intelligence, having an advanced degree in one of the documentary social sciences, and a fairly wide acquaintance with abnormal psychology from her associates and her avocational reading. She has had a couple of hundred hours of intensive psychotherapy with two different therapists. One day another patient of mine, with whom the first patient is not personally acquainted but whose name and appearance are familiar to her, is circumstantially forced to change her appointment time. I call the first patient on the telephone and find out whether it will be convenient for her to come one hour later than usual, which it is. As she is waiting for her interview, she sees the other woman emerge and recognizes her. She begins the session in a somewhat “sulky” manner, avoiding looking at me, and with her body slightly turned away as she speaks. To my tentative interpretation that she is angry with me but doesn’t wish to say why, she blurts out “Of course I am—and you know very well why! You changed the appointment because you like Mrs. X more than you like me, so you wanted to see her first.” The rest of the hour is spent on ramifications of this bit of cognitive slippage, and neither interpretation, nor gentle (but authoritative) attempts at reality-definition by the therapist, seem to have the slightest effect. I want to emphasize that for this 50-minute period, the patient believes that I changed the hour because of my personal preference for the other patient, and that this is not merely a funny kind of obtrusive, obsessive thought which she is unable to get rid of. There is a critical difference between a neurotic’s saying, “I can’t get rid of the silly idea that you prefer the other patient, but I know that is nonsense,” and this schizotypic patient who says, “You’re just not telling me the truth, but I know that’s why you changed the hour.” In the first case, the intrusive thought is rejected by the rational ego and experienced as part of one’s symptomatology; in the second case, the rational ego fails to screen the thought for its absurdity and makes it its own, including a determined advocacy during the remainder of the hour. In the next interview, the patient avoids bringing up the subject, and when I bring it up in the course of the hour, she rather shamefacedly says that she was “probably exaggerating things a bit” and that “it was of no importance anyway.” The fact remains that during the session she believed it, and she believed it—so far as her verbal output and ancillary manifestations of feeling and attitude could reveal—as firmly as the state hospital patient who insists that he is Napoleon. In considering an episode of this kind one may be tempted to dismiss it as “merely part of the patient’s transference phenomena.” Of course this is a correct statement as it goes; but it doesn’t go far enough, because there is an important clinical difference between a transference phenomenon which is neurotic and a transference phenomenon which is essentially “crazy.” The present transference phenomenon is essentially “crazy.” I lapse into the vernacular because I don’t know a technical non-theoretical word which quite captures the flavor of the lay word “crazy” in expressing the quality of this kind of cognitive slippage. I admit that I would have a hard time spelling out scientifically the features of a transference reaction that make it somehow “crazy.” I am inclined to believe that such explication will not be possible to do until the whole field of inductive logic has been better formalized by logicians than is true at the present time, since the slippage

involved in this kind of “crazy thinking” is not a matter of violating formal rules of the syllogism, but is a much more complicated defect in assessing probabilities and attaching inappropriate weights to corroborating (and especially dis corroborating) empirical evidence. We have the same problem in distinguishing a hypochondriacal neurotic concern from a somatic delusion. It is neurotic to worry about excessive smoking while meanwhile taking no steps to cut down; but it is not crazy to do so. To think that one’s insides are missing, or that one has a glass liver, is crazy. It may be objected that intrinsic bizarreness (or antecedent improbability) should not be given much greater weight than resistance to evidence. A non-psychotic hypochondriac who insists, in spite of all medical evidence and negative diagnostic statements by different physicians, that he has cancer or syphilis which they are simply failing to discover or are unwilling to tell him the truth about, is showing a severe degree of cognitive slippage almost as great as that of one who believes he has a glass liver. I would quite agree with this, since I believe that antecedent improbability boosted by only slight corroborating experiences is a more sensitive indicator of poor thinking than mis-evaluation of evidence among antecedently plausible competing hypotheses. But the example doesn’t bother me, because it is my own view that really thoroughly consolidated hypochondriacs of the type described do have major cognitive slippage and that many, perhaps most, of such cases are in fact schizotypic.

The essential features of “unreasonableness” (this is a better word rather than “illogicality,” since inductive inference and construction is involved rather than tight deductive syllogistic reasoning) seem to include the following:

- 1) Content of construction or hypotheses intrinsically improbable.
- 2) Systematic failure to consider alternative hypothesis of higher antecedent probability which would explain the same allegedly “corroborating” facts.
- 3) Confusion between “observation” and “immediate inference” in the verbal description of an allegedly corroborating fact (e.g., patient persistently fails to consider that his perceptions of other people’s thoughts, motives or affects are, strictly speaking, not observations but inferences).
- 4) Handling of dis corroborative data by subsuming them under multiple alternative and ad hoc hypotheses, instead of re-examining the main one.
- 5) At the time, definite belief, as contrasted with admittedly unreasonable, obsessional concern or preoccupation.

If these features are present in the patient’s thinking, it should be considered evidence of cognitive slippage and the sign checked as present, regardless of whether you as therapist can understand or empathize with the motivation for the slippage.

- f. One form of subtle cognitive slippage is hardly more than a childlike, unrealistic defect of “practical judgment.” It therefore has to be evaluated in the light of the patient’s general intellectual, educational and cultural level. The striking feature of this manifestation of cognitive slippage is that the patient embarks upon some kind of concrete action with the intention to bring about a certain end, and you realize that 99% of people in all walks of life, whether sympathetic to the end or not, would see immediately that this line of action is grossly inappropriate in terms of its extremely

small likelihood of the intended effect (even though the probability is not strictly zero). One detects here the two-fold aberration—first, that the patient even came up with this particular line of action, which a less aberrant mind finds an “unlikely thing to think of”; and secondly, having once come up with it, the fact that the patient was unable or unwilling to exert sufficient critical editorial powers upon his own production to set it aside as foolish, or at least to see that it had a much lower priority as a potential problem-solving tack.

An example of this manifestation of cognitive slippage in the form of a defective practical judgment is the following, reported to me by a rather well-compensated schizotype (who, however, had a clearly psychotic MMPI profile when seen and who subsequently was hospitalized with a gross psychotic breakdown). His presenting complaints were depression, loss of interest in his studies, a diffuse feeling of guilt and unworthiness, and a religious conflict which took the form of doubt whether he should remain a student of theology in the particular Lutheran Synod which he belonged to or transfer his membership to another Lutheran Synod which he viewed as more “conservative.” Having temporarily dropped out of school for these reasons, he had for some months worked as assistant editor of a small Canadian regional weekly newspaper. He conceived the idea that his personal ecclesiastical dilemma would be solved if the major Lutheran bodies would speed up their movement toward unification. Believing that he saw more clearly than most Lutheran leaders what were the real foci of disagreement, he decided to accelerate the progress of Lutheran union by writing an identical letter to the major ecclesiastical officials in each Synod setting forth his views, and he hoped that these opinions would be received with due weight because he was able to sign his name with the title “assistant editor,” followed by the name of this little known Canadian weekly paper. He expressed to me considerable surprise and disappointment over the fact that only one of these officials had even bothered to reply in a perfunctory manner. Now the point of this example is that there is nothing clearly delusional about this thinking, at least in the usual sense of that word. Yet the social inappropriateness of his expectations is obvious to anyone of common sense who has even a superficial familiarity with the history of American Lutheranism. Even though he did not perceive himself in so many words as the “great solver of the problem,” some such conception of his possible role lay at the basis of the concrete steps he took in an effort to solve his individual problem of Synodical affiliation. I want to argue that the thinking involved here as a basis for concrete action is profoundly aberrated and represents a severe degree of cognitive dyscontrol.

It is my impression that the most important source of “false negatives” in judging the cognitive slippage sign, i.e., of failure on the clinician’s part to explicitly recognize the presence of cognitive slippage, are the following:

- (1) Clinician defends against perceiving or labeling patient’s cognitive slippage because he views it as a malignant sign and is currently optimistic about the patient’s therapeutic progress and outlook.
- (2) Clinician confuses the intrinsic severity of patient’s cognitive slippage, which has to be assessed substantively, (i.e., by the ordinary criteria of rational thought in relation to evidence) with administrative, medical, or social questions concerning the practical consequences thereof. These considerations are clinically important in handling the case, but they ought not to play any appreciable role in assessing the

- cognitive slippage factor itself. Whether the content and direction of cognitive slippage leads to something socially critical, such as beliefs that other people are dangerous to one's life and must be defended against by drastic measures, is not a valid criterion for deciding how much slippage is present.
- (3) As mentioned above, overstressing the "dynamic understandability" of a patient's cognitive slippage, whereby the clinician deceives himself into supposing that because the slippage is motivated in a way that the clinician can comprehend psychologically, therefore the slippage is somehow less extreme than it seems to be in terms of its content and evidence.
- g. A minor but striking bit of cognitive slippage found in schizotypes with paranoid defenses is "assumed mutual knowledge." The patient refers to episodes or persons without explaining or narrating what would be essential for you to understand his discourse, as if somehow you must already know. This sign is most easily judgeable during early sessions, of course, since later in the interview series it shades into the "I-already-told-you-that" error found in neurotics, not to mention the therapist's own defects in recollection. If you have any doubt as to which it is, do not check the sign. The easy-to-spot variants are illustrated by the patient who, during the initial interview, says "So of course I connected this up with the check-book fracas," not having as yet told you anything about the "check-book fracas," and continuing his discourse without clarifying this phrase. It's hard to convey the full flavor of this, except to repeat that it is done in a way that gives you a distinct impression of assumed shared knowledge rather than mere carelessness or forgetfulness. Nor does inquiry always reveal a delusional basis (e.g., patient assumes "the others" have told you). My own impression is that the paranoid schizotype's hypercathexis of his own ideation, the terrible cosmic importance of the conceptualized event-schema, his own constant immersion in it, leads quite directly and "naively" to the error—rather like the healthy baseball fan who talks to strangers about "How the Yankees did today" because it hardly occurs to him that anyone wouldn't be cognizant of this so-important datum!
- h. Finally, if psychometrics or projective test data are available to the rater, they can sometimes be used as a basis for deciding if cognitive slippage is present. As a psychologist I would like to give this indicator the heaviest weight, but I am reluctant to do so because I am unconvinced that current psychological tests are sufficiently subtle for detecting minimal slippage (in relatively intact patients) to be used powerfully. I am rather inclined to put more faith in psychometrics as an inclusion test than as an exclusion test. That is, barring special cultural and educational disabilities, I think one finds that psychometric indications of cognitive slippage are regularly paralleled by non-psychometric interview manifestations of it; but the reverse does not hold, i.e., persons who show quite clear and dramatic slippage from time to time in the course of therapy, leaving one without any real doubt as to the magnitude of the patient's potential for aberrated perception and thought, will at times be completely free of "objective" psychometric signs of cognitive slippage. Nor is it possible to make any definite statements as to the direction of patterns (such as have been claimed in the clinical literature), since the kind of thought disorder found in schizotypes is not that consistent in its direction. In addition to the more obvious classical signs of cognitive slippage in Rorschach and intelligence test performance, I believe that any marked

internal discrepancies in the total mass of psychometric evidence, when not otherwise readily explainable, should be taken as at least moderately strong evidence for cognitive slippage.

6. Countertransference strain on you:

I would prefer not to elaborate this sign because the straightforward criterion for whether you check it as present or not is intended in the checklist to be your emotional reaction to the patient. The individual differences among therapists are such that a listing of what seem to be the specific aspects of patient-behavior that cause strain in the therapist would particularize the checking of this item more than is desirable. So in evaluating the presence or absence of this item, ask yourself simply whether working with this patient is a strain upon you. If so, check the sign as present.

7. Deflated self-esteem:

Since feelings of inadequacy are almost universal among persons seeking psychological or psychiatric help, and since the very nature of therapeutic conversations is such as to concentrate patient's and therapist's attention upon weaknesses, failures, ineptitudes, deviations, and defects rather than upon areas of success, health, and "adjustment"; unless this sign is suitably hedged about with restrictions for its attribution, it can hardly function discriminatively. Therefore, at the risk of losing some valid instances of its presence, I am stipulating for checklist purposes, first, that the deflated self-esteem should be conscious and verbalized by the patient, with only very minimal probing or interpreting by the therapist being required to elicit this attitude; secondly, that the deflated self esteem conjoin the three properties severe, inappropriate, and diffuse. Therefore, if you have a patient who reports conscious feelings of low self-esteem but which meet only two of these three hurdles, the sign should not be checked as present, no matter how much this rather arbitrary stipulation offends you. If your patient has even one major sector of life in which his self-esteem is moderate-to-good as indicated by therapeutic exploration, then the sign should not be checked as present, no matter how many other life domains are deflated severely and inappropriately. Of course, I do not mean that the merest superficial claim to security or self-satisfaction prior to any exploration in depth should be taken as definite evidence of adequate self-esteem. But the kind of diffuse, inappropriate, and severe deflation which I have in mind in defining this sign is such that the patient who has it will show clear evidence of it in a superficially "secure" area as soon as you begin to explore it in any detail and depth. Example: A patient's presenting complaint is sexual impotence. Diagnostic and early therapeutic interviews elicit further complaints or admissions of inadequacy feelings as to his social skills, financial status, and physical appearance. The patient claims that he at least feels confident about his vocational performance, suggesting that this area is one of adequate self-esteem. However, by the tenth session you have learned that he (a) Fears all new employees' competition; (b) Wonders why the boss "doesn't see through me"; (c) Worries about novel job assignments; (d) Fantasies inheriting a million dollars so he can retire and be "free of job strain"; (e) Has nightmares about getting fired for incompetence. So his vocational self-esteem is of a very superficial and unstable nature, and need not be taken as an exception to the diffuseness of his self-esteem deflation.

8. Dependency, demandingness:

Do not check this sign as present solely on the basis of your constructions as to the patient's unconscious processes. Nor should it be checked on the basis of the patient's reported, or your inferred, dependency or demandingness with regard to other significant persons. The intended stipulation of this item is the patient's dependency and demandingness specifically with regard to you, as overtly manifested in the therapeutic relationship. Even in this direct interpersonal context most accessible to your observation, do not rely upon subtle or symbolic transference phenomena as an adequate basis for checking the sign as being present. To be scorable, the patient must manifest overt dependency of a childlike nature in forms as: Asking for advice about decisions and life activities when such advice is inappropriate either because it cannot reasonably be provided or because the "answer" is obvious; explicit requests for reassurance about the therapist's affection or esteem (e.g., "Do you really like me?"); gross over-readiness to accept therapist's views, interpretations, values or opinions in a docile manner; demands upon the therapist in the form of telephone calls, pronounced resistance to ending the hour on time, urgent requests for "emergency" interviews, and the like. One striking manifestation of dependency-demandingness is the patient's equating of therapeutic interpretations with nurturant giving, whereby he becomes deeply hurt and resentful if comments by you are not provided in "return" for his production of material. He may "freeze up" or "run down" during a session when you are relatively silent; or begin the succeeding hour by speculating why you were "angry" at him last time.

9. "Different from others" feeling explicitly stated:

This means just what it says. But in order to count in checking the sign as present, the statement must be made spontaneously, not by mere acceptance of a therapist's suggestion to this effect. The patient must express the idea that (a) he is, and always has been, "different from other people" in the way he feels or thinks; (b) this difference is one that he himself perceives as somehow basic or fundamental; and (c) the difference is, on the whole, in an unhealthy, abnormal, aberrated, or undesirable direction. The language used, which in my experience is quite likely to include the specific word "different," will vary with psychological sophistication and the degree of defensiveness or frankness present.

Checking the sign as present is not contraindicated by the patient's offering one or more meliorating points in connection with the effects of this difference, or being ambivalent about changing it. For example, a patient may spontaneously introduce the notion that his "feelings about people" have seemed "kind of peculiar" for as far back as he can remember, and that this has "bothered" him; but he may go on to add that, on the other hand, he suffers less from external circumstances enforcing solitude than seems to be true of most other people. Nevertheless he shows rather clearly in his way of describing this difference that he views it, on balance, as something not quite "as it should be."

A frequent but not invariable concomitant of this complaint is that other people seem somehow to know that there is a difference, and therefore have a tendency to treat the patient in a special way. The "difference" must in its content be something in the area of how he feels—especially about interpersonal matters—or, less often stressed but frequently mixed into the report, how he thinks about himself, others, and the world generally. Reported differences in ability, skill, knowledge, energy, strength of specific drives, interests, tastes, beliefs, values and the like should not be scored.

It is my impression that at times the feeling of “being different” is quite strong and reportable as going back to an early age, and yet the qualitative nature of this felt difference from others may be extremely difficult for the patient to put into words. Approximately synonymous expressions are “somehow funny,” “peculiar,” “not like others,” “strange,” “separate,” “alien,” “alone,” “loner,” “odd-ball,” and other ways of indicating the element of strangeness, oddity, queerness, unusualness, or alienation.

A very common complaint is that the patient has repeated experiences of unintentionally angering or frightening people by actions and communications made on his part with good intentions, as a result of which he forms the generalization that other people are for some reason very hard to understand, or that they have an unaccountable tendency to misunderstand him.

Finally, I routinely score this sign when the patient spontaneously verbalizes, in these words, “There is something basically [= ‘radically,’ ‘terribly,’ ‘awfully’] wrong with my mind, always has been, and I’m afraid always will be.”

10. Distrust, testing-operations, closeness-panic:

The core of this sign is the patient’s intense and pervasive expectation of being unloved and unaccepted, with the attendant conviction that if anyone appears to be accepting, loving, or helping, this is a fake and that he is inevitably doomed to be disappointed by other people when the chips are down. On the part of the therapist, this is often experienced as being “tested” and is one of the main contributors to Sign 6: “Countertransference strain.” While the most dramatic and easily identified forms of this sign appear in the therapeutic relationship itself, usually there is pretty good corroborating evidence in the patient’s reports about his other interpersonal relationships, such as a history of being profoundly disappointed by people, such that they turned out to be unfriendly, unaccepting, and (especially) insincere under special situations which the patient perceived as critical or diagnostic of the nature of the relationship. Sometimes it is apparent from the patient’s account of the breakdown of the relationship that it was an unconsciously arranged “test” of the sincerity and depth of positive feelings on the other person’s part, but this cannot always be discerned directly from the patient’s narrative. If relationships to others seem to be of this nature but the phenomenon is not present in the patient’s reactions within the therapy situation itself, I have adopted an arbitrary convention that this sign should not be checked as present.

One sign, relatively objective and atomistic, which I have found useful in assessing the presence of closeness-panic is the patient’s reaction to physical contact with the therapist. One has no impressionistic norms for this unless he feels free to touch patients from time to time under various circumstances, however. But if you do, over-reaction to a handshake or a touch on the shoulder is one of the easiest and most reliable behavioral indicators.

More generally, a fairly consistent over-reaction (e.g., weeping, sudden physical or social withdrawal, facial expression of fear or distrust) to minimal expressions of kindness, affection, approval, sympathy, or nurturance by the therapist will usually justify checking the sign as present.

11. Failure to achieve, gross:

Mere under-achievement is not sufficient to judge this sign. I have in mind by “gross failure to achieve” a person who flunks out of school with an IQ of 130, or who after a

college education and some graduate study occupies a job far lower in the economic and intellectual hierarchy. In judging this sign, I adopt the convention that gross underachievement should be checked as present regardless of whether the patient or therapist can give a plausible account of “why.” That is, the sign should be treated as an objective “historical” fact, present whenever a marked disparity exists between ability and realistic, socially-defined attainment or status.

12. Flat or spotty affectivity:

Since this is one of the classic textbook signs and is so widely emphasized in clinical teaching, there is little to say about it here. I would merely point out that general flatness is not found in schizotypes sufficiently intact psychiatrically to present any diagnostic problem so that in the clinical population for which this checklist has any use one cannot profitably define the sign as a consistent, general, overall flatness. It is particularly important to distinguish the positive and negative affects, since the “emergency” emotions of rage and fear are typically present to a normal (or even supernormal) degree. It is in the positive domain, and especially in the interpersonal domain, that the flatness or marked variation (“spottiness”) appears. The occurrence of intense anxiety or rage responses should not be taken as contrary evidence to checking the sign as present.

13. Hatred of mother, manifest, expressed:

This sign may be checked when the patient spontaneously, or in answer to a fairly non-directive lead requesting attitude to parents, uses a clearcut negative term ranging anywhere from “dislike” to “hate” in describing his feelings about mother. The sign should not be checked on the basis of a mere characterization of mother in regard to her weaknesses, even though she may appear a somewhat black figure from such an account. It is critical in checking this sign that the patient reports his emotional response to mother either formerly or now, and in so doing employs language clearly scoreable as negative. The only exception to this that I have made in using the checklist is in cases where the patient uses primarily non-descriptive terminology to characterize mother and the attending affect in the interview is very strong. Example: “She always hated me, and frankly I think the old bitch would have been just as pleased if I had died that time I was so sick.” Even though this sentence does not contain the verb “dislike” or “hate” in the patient-to-mother direction, the non-descriptive characterization of mother as “an old bitch,” with attendant strong affect in voice and manner, I have scored as manifest expressed hatred of mother. But if you have any doubt about such communications when they do not explicitly use a word descriptive of the patient’s own feeling, the overall principle applies, i.e., do not check the sign as present.

14. Magical ideation or action:

The essential element here is the patient’s belief, quasi-belief or, as I score the sign, semi-serious entertainment of the possibility that events which, according to the causal concepts of this culture, cannot have a causal relation with each other, might somehow nevertheless do so. Needless to say, it is imperative that the patient’s education, information, and cultural background be considered. Some clinicians fail to take adequate account in practice—although they give it lip-service in principle—of the patient’s sub-

culture. Example: I knew a clinician who considered that his patient had “magical ideation” because the patient construed a certain coincidence of thoughts with objective events as possibly due to mental telepathy. Now in general I admit that this would make me suspect that magical ideation was present. However, the particular coincidence of events and details of mental content was one that the clinician himself considered extraordinarily unlikely; and he told me that if he—the clinician—allowed the bare possibility of telepathy into his own world picture, he would rationally consider that the patient’s hypothesis was the most parsimonious. The patient, an educated woman, had read some of the technical literature of psychology on ESP experiments, and held that the evidence for the reality of telepathy (at least in certain people) was scientifically strong enough to make this an admissible hypothesis. Unlike her therapist, I happen to agree with her on the scientific evidence as it stands. I therefore think that in the absence of other evidence of magical ideation in this patient, it was incorrect for her therapist to check her as having this trait, considering all of these educational and cultural circumstances; because it amounted essentially to the clinician’s failing to distinguish between a legitimate philosophical disagreement on world-view between him and the patient, and a breakdown in the patient’s application of a world-view normally her own. I admit that this is very difficult to assess in borderline cases (especially among ruminative intellectuals who think excessively about such matters). My own convention in using the checklist is of course that such doubts require one to leave the sign unchecked.

In general the defining property of this sign is fairly obvious and easily judged as present or absent. The most difficult matter is that of distinguishing between obsessive ideation and seriously entertained belief. Here my convention in checking the sign is “looser,” which is why I use the phrase above, “quasi-belief or semi-serious entertainment of belief.” I have become convinced, perhaps erroneously (but I will ask you to follow this convention for consistency in the statistical use of the sign list) that serious contemplation of the possibility of a causal connection which the western world-frame of causality—as customarily held by the patient—would not permit, should be taken as definite evidence for checking the magical ideation sign as present. So that if a patient says “I always arrange the books that way before I leave my apartment, just to make sure that nothing happened,” and further exploration shows that he really means this, i.e., he is making sure (rather than merely assuaging a tension by doing something he is perfectly clear is pointless and foolish)—then he has magical ideation and the sign should be checked as present.

Furthermore, I check such magical ideation as present even if it is transitory, disappearing spontaneously or as a result of therapeutic intervention. In my view, the critical value is not a point lying between slight or weak belief and moderate belief, or between moderate transitory belief and a fixed delusion. The critical point lies between disbelief (essentially “zero strength of conviction”) and slight belief or serious entertainment of magic as a form of causality. On one side of the line we have the true obsessional thought; on the other side of the line, anywhere from serious (although perhaps transitory) entertainment onward, we have magical ideation. Unfortunately the variations in “belief”-language are such that sometimes this distinction can only be elicited by systematic probing. Without such probing, one is often at a loss how to score; but my experience is that with such probing, I rarely find myself in doubt as to whether the patient at least “foolishly entertains” a magical connection between thoughts and

events or between causally unrelateable events. A patient's expression of puzzlement as to just how two things can be related is not critical in checking this sign; the decisive question is whether the patient seriously entertains or actually believes, however transitorily, that they may in fact be causally related. If, for example, a patient says, "I don't understand how I could be making her have headaches by thinking of her when I don't see her or even talk to her on the phone, but that seems the way it works, somehow," I would have little hesitation in checking the presence of magical ideation.

The textbook and extreme forms of magical ideation are well known, and require no elaboration here.

15. Micropsychotic episodes:

The characterization of "micropsychotic episodes" by Hoch and Polatin was as follows:

"Quite a number of the patients with this pseudoneurotic symptomatology develop psychotic episodes which are, however, often of short duration and the reintegration of the patients can be so complete that if one does not see them in the psychotic episode one does not believe that they were psychotic. This is probably also the reason why some examiners find the diagnosis of schizophrenia easy, while others insist that they are dealing with psychoneurotics, depending upon the phase of the sickness in which they see the patient. It is very important in these patients, not only to investigate the quality of the symptoms, but also the quantity. The quantitative aspect in psychiatry concerning symptom formation, and the reaction of the patient to it is markedly neglected in contrast to the qualitative investigation. In these patients we often see imperceptibly a daydream emerging into a hallucination or a vague hypochondriacal idea becoming a somatic delusion, ideas on relationship with other people, in the framework of social anxiety, developing into ideas of reference. To follow these gradual changes in these patients is fascinating from a psychological point of view, and would probably yield in the future a better insight into the formation of delusions and hallucinations. Many of these patients at first treat their hallucinations and delusions as overvalued ideas or perceptions. They say "it is as if I were to hear a voice," or "as if I were to be observed." When the emotional charge becomes more intense, they suddenly say, "I hear a voice," or "I am observed." Many of these patients zig-zag repeatedly over the reality line. One does not observe these changes in neurotics, not even in states of intense panic. In these short-lived psychotic attacks (micropsychosis) usually three elements appear simultaneously which are very significant. The patient expresses hypochondriacal ideas, ideas of reference, and feelings of depersonalization. They are often interlocked." (Hoch & Polatin, 1949)

I am rather inclined to doubt that micropsychotic episodes differ in any qualitative essential from psychosis and that the difference is a matter of duration and degree of obviousness (especially to other observers who are not given intimate access to the patient's mental content during the micropsychotic period).

I include under micropsychotic episodes those (apparently) non-delusional states of grossly aberrated consciousness which are described by such words as "clouded" and "confusional." A patient may narrate an episode, lasting anywhere from a matter of several minutes up to hours or even days, in which he was mixed up in his perceiving and

thinking to such an extent that he hardly “knew what was going on,” and this occurred in the absence of any parsimonious organic explanation (e.g., infection with high fever, alcoholic intoxication, prolonged extreme physical stress or lack of sleep). For checklist purposes such a marked disturbance in mental content, stream of thought, or sensorium and intellect should be scored as a micropsychotic episode.

It is important to avoid checking ordinary puzzlement about a complex inter-personal situation. You should not check a micropsychotic episode as having occurred merely because something happened in the patient’s interpersonal relations which he “did not understand.” Elements of confusion, or altered consciousness, or delusional distortion, must be present to make the sign scorable.

I personally place a considerable emphasis upon the patient’s own spontaneous choice of words suggesting clouding, confusion, or perplexity (e.g., “I got all fouled up, all mixed up in the head there, I didn’t know what the hell was going on, or even hardly who or where I was”). But the presence of such introspective references to the state of mental confusion is not necessary for the sign to be checked as present, provided that the patient’s account of what “occurred” shows unmistakable features of confusional or distorted inference or perception.

One form of micropsychotic state which must be judged cautiously because something similar occurs under great access of anxiety in many people (and also with some frequency in the hysterics), is the patient’s report of a period in which the chief defining property is that the therapist finds himself unable to elicit anything like an adequate account of just what was the patient’s subjective experience like, structurally and qualitatively. You get a distinct impression that there is some kind or alteration in the patient’s state of consciousness during a circumscribed interval, an alteration sufficiently striking that he spontaneously reports it and obviously was disturbed by it enough to consider it important. Yet your most patient, persistent leads and questioning, together with apparent cooperation and genuine desire by the patient to communicate, leaves you with the feeling that you have by no means captured the essential descriptive features of the experience, that you really don’t know quite what was “going on inside.” The reason you can’t find out what was going on is that the patient himself doesn’t “know,” at least in a way that can be put into shared language. Because of the extreme subjectivity of making this judgment, I incline not to score this sign as present on the basis of one such incommunicable episode but to score it only if several are brought to my attention. The critical distinction is that between reported confusional or distorted mentation, which I score as micropsychotic if a single instance occurs; and a report whose main feature is negative in that one is unable to get an even moderately clear picture of the patient’s subjective state during the episode and infers from this, given a patient who is normally or usually fairly effective in communicating the quality of his psychic events, that the episode was confusional because of his lack of ability to communicate its character. This latter kind of report requires several instances for sign-scorability.

Finally, while it is perhaps not the right rubric to categorize it, I score as a micropsychotic episode that peculiar kind of “drift-out” that sometimes occurs during the interview itself. The dramatic form of this phenomenon, in which the patient appears to be literally out of interpersonal contact with you, needs no elaboration and is pretty obvious to even an unskilled interviewer the first time he observes it. When the duration of such drift-outs is very short, as a matter of a minute or less, such as is sometimes touched off by

a therapeutic interpretation or the patient's own approach to highly charged material, there is some danger of failing to notice it. Anytime the patient seems disengaged from you or what you are saying, and thereafter seems genuinely unable to report what he was "engaged in," the occurrence of such a drift-out is a very good possibility. Because of the difficulty of discriminating this from ordinary mind-wandering, crude resistance to reporting an interfering train of thought, or well-developed automatic hysterical defense mechanisms, this form of the micropsychotic sign should be scored with caution; and (as in the previous form) I would not score any marginal case of interview drift-out lasting for a very short interval unless the phenomenon occurred repeatedly.

16. Narcissism, extreme:

The adjective "narcissistic" has become so broadly used, both at the level of phenotypic traits and inferred psychodynamics, that this sign should be scored very conservatively. My practice is not to score it unless the overtly narcissistic features in the patient's personality are extraordinarily marked and would strike any moderately sensitive observer as being one of the most salient features of the patient's makeup, without requiring any deep theoretical construction. Like the others, this sign should be construed in terms of the descriptive trait level rather than in terms of the constructs like narcissistic libido etc. Perhaps a better term for this sign would be "egocentric orientation," except for the fact that this phrase has an irrelevant ethical connotation in ordinary English.

The descriptive feature of the patient's behavior and attitudes is that practically everything is made to revolve around himself, whether in a positive or negative fashion. Other persons are characterized in his spontaneous productions primarily in terms of their effect upon him as actual or potential helpers, attackers, critics, evaluators, audience, etc. The patient evaluates a human relationship by putting emphasis mostly on the other person's attitude toward himself, e.g., "Did he regard me highly?" "Am I in any danger from her?" and so on.

Another important facet of this extreme narcissism is excessive concern about the body, either in its "condition" (health, cleanliness, personal care) or its "attractiveness." There is overlap between this aspect of narcissism and what was discussed under Sign #3: "Body-image aberrations."

In the sexual area, I generally score a preference for autoerotic over heterosexual or homosexual gratification as indicative of extreme narcissism. The obvious danger in so scoring it is, of course, the difficulty of distinguishing between a true "preference" for the autoerotic, and the interference with alloerotic goal-seeking behavior by severe interpersonal anxieties. When in doubt as to this distinction, do not score the narcissism sign if the sexual domain would be the sole basis for scoring it. My experience is that non-schizotypes who are inhibited by social fear or sexual guilt from interpersonal sexual expression suffer both chronically and intensely from this inhibition; and they are likely to report spontaneously, and early in treatment, this feeling of constraint at a quite conscious phenomenal level which is experienced as very frustrating. In such cases the substitutionary character of autoerotic activity is usually rather obvious at the phenotypic level and more often than not is so reportable by the patient himself. By contrast, sexually narcissistic individuals generally do not show such signs of subjective frustration, and very minimal amounts of inconvenience or social inhibitions readily suffice to confine their sexual expression to the autoerotic. It is important here to distinguish sexual-

affectional frustration from a patient's mere complaint that his autoerotic sexual life is "unhealthy," "not normal," "something to be ashamed of," "bad for me," and the like. These complaints express a wish for alloerotic sexuality on essentially narcissistic grounds, and are therefore quite compatible with a truly narcissistic sexual orientation.

Some assessment of this dimension is also possible by careful attention to the details of autoerotic behavior and especially the accompanying fantasy. Masturbation without fantasy should be routinely scored in male patients as evidence of the extreme narcissism sign. In female patients this is not sufficient taken by itself, although in them also I include it as evidence of extreme narcissism and give it a sizable weight in making the judgment. The pattern of masturbatory activity is also relevant, such as emphasis upon nudity, use of a mirror in preference to fantasy or pornographic materials, stimulation of non-genital erogenous zones and the like. Accompanying fantasy of a primarily masochistic and exhibitionistic nature are not definitive, but should be given heavy weight. Even manifestly heterosexual fantasies will at times turn out to be very narcissistic when examined in sufficient detail, if it becomes apparent that the fantasy's erotic charge derives largely from the patient's identification with the imagined sexual partner. This indication of narcissism should not be scored unless the rater has considerable clinical experience in eliciting the details of sexual activity and has established a clinical baseline for the amount of narcissism normally present in masturbation fantasies.

17. Pan-anxiety:

The necessary and sufficient condition for checking this sign as present is that all major domains of the patient's life are clearly tinged with an abnormal amount of anxiety or anxiety-readiness. I refer here to manifest, phenotypic, clinically apparent anxiety or disposition-to-anxiety, whether indicated by (a) clear physiological symptoms of the autonomic type; (b) strong subjective reports of experienced uneasiness, fear, dread, or panic; or (c) exaggerated, rigid, compulsive avoidant behavior. This third form, in which both manifest somatic anxiety as well as reportable subjective anxiety-experience may be fairly successfully avoided by suitable instrumental responses, must be rated with caution since it is of course a rather common tendency in many types of patients and in some ways reflects a core feature of every neurotic character structure. The mere fact that a person has a number of avoidant patterns does not justify checking "Pan-anxiety" as present. It is necessary to satisfy yourself that the following additional requirements are met, before pan-anxiety can be checked in the absence of manifest somatic symptoms or introspective reports:

- a. The avoidant pattern must be discernible in every major area of the patient's life. Socially, sexually, vocationally and educationally, it should be clear that the patient has developed a highly routinized set of patterns and has systematically "restricted" his exposure to life-situations in the interest of avoiding the anxiety-signal.
- b. The restrictions of situations and responses must be rigid and compulsive, as shown by the fact that the patient is extremely resistive to departing from these patterns either for therapeutic purposes or under pressure of strong positive drives combined with objective opportunities for gratification. Although the patient recognizes that departure from the rigid pattern through variation and expansion of activities would be

appropriate, he nevertheless continues to be avoidant in the presence of what is objectively a minimal or low-probability threat.

A striking manifestation of this diffuse and rigid avoidance-pattern is seen in the patient's reaction to "novelty." Accustomed activities, tasks, acquaintances, even physically familiar objects, times, and places, are the only ones which seem to be met with reasonable equanimity. The typical "pan-anxious" patient will over-react markedly, sometimes to the point of arranging his affairs with great inconvenience, and sometimes with actual panic, to such a trivial change as having to take a different bus route to work in the morning or having to go to a different barber to get his hair cut.

A form of pan-anxiety which is relatively easier to rate is that in which the phobic pattern has been only partially successful in achieving anxiety-avoidance, so that while not incapacitated, the patient experiences more or less chronically, and in all life-areas, a nagging sense of danger, fear, tension, and insecurity. Many pan-anxious patients will spontaneously report this as a complaint, saying "I never seem to be quite relaxed no matter what is happening—always feel vaguely tense or uncomfortable or a little scared." Do not, however, check the sign as present merely because a patient makes a general statement about insecurity, since this kind of remark is frequently heard from sophisticated neurotics with a "plus-getting" (low-K) attitude, and in such cases is easily refuted over a series of interviews by noticing that both in the sessions and in the narration about events outside the sessions there are areas of life and rather extended time intervals in which the anxiety experience is absent.

As a rough rule of thumb for raters not accustomed to judging this matter, I suggest that a patient who shows manifest anxiety at least once practically every day (which you may inquire into systematically or, more slowly, conclude on the basis of the sample of days the patient recounts spontaneously), he should be checked as having the sign, unless he is in an unusually stressful external situation as the latter would be judged by "objective" standards.

Chronic free-floating anxiety, in which the patient is generally and usually anxious without reporting any specifiable content, justifies checking this sign as present. Less sophisticated patients may fail to use the word "anxious" or any clear synonym of it, but may show somatic signs of anxiety or report an imperfectly recognized anxiety-experience using such terms as "all-bound-up," "nerves," "strained," "tense," and the like.

18. Poor outcome:

Since the evaluation of "outcome" is difficult at best even in a research investigation of psychotherapy, it will not be possible for you to assess this sign if you are rating the patient early or in the midst of treatment; therefore in most cases where you are rating during the course of treatment and not contemplating termination in the near future, the "outcome" will be in doubt and following the overall rating requirement that a sign in doubt should not be checked, you will have to treat this sign as not present.

An exception to this rule of leaving the sign unchecked when you are rating at the beginning or in the midst of therapeutic series, but which should be used with great caution, is the situation in which the patient has shown no appreciable movement either symptomatically or in the nature of the material he is producing, but continues to come in for treatment reciting a rather stereotyped list of problems and complaints, giving you the strong feeling that "nothing is happening." A certain poverty of material, especially when

observed in a patient with good intelligence and verbal ability, may produce in you a distinct impression of “I have been listening to this patient attentively and sympathetically for many hours, but somehow it seems that I don’t understand much of what is going on and am not learning much of anything about him as I continue to listen.” The combination of this lack of development in the interview material with a lack of anything but the most minor and transitory changes in extra-interview behavior and experience may justify checking this sign as present prior to termination.

If you are rating the patient at or after termination, or with termination in the immediate offing, I will not try the impossible task of setting criteria for when an outcome is “poor,” but will specify this much, that the sign should not be checked as present unless you consider the results are poor in all three of the following sectors:

- a. Symptom relief
- b. Social effectiveness
- c. Subjective distress

That is, I am stipulating that a good outcome with regard to psychiatric or medical symptoms, or with regard to improved performance in social, sexual, vocational or educational behavior patterns, or a sizable reduction in subjective distress should be considered as a good therapeutic result. Unless, of course, one of these three has become better at the expense of another which has meanwhile become considerably worse, leaving the patient no better off than before.

Finally, for our present purposes you may check as a “poor outcome” termination of treatment by the patient against your better judgment, if you are satisfied that this termination occurred because he wanted to quit and not because of some valid reality factors beyond his control (e.g., financial, parental, geographic).

19. Psychosomatic or neurological signs:

The rationale of lumping this hotch-potch of symptoms together under a single rubric is threefold. First, I am relatively less confident of their discriminating power and therefore prefer not to assign any one of them full status with the other checklist items. Secondly, most of them occur so rarely even among schizotypes that they can probably function better as a disjunctive set. Thirdly, some of them would not be reliably judgeable by non-medical clinicians functioning in a non-medical context.

The rule for scoring this “sign” as present is to score if anyone of the sub-signs is present. The list of sub-signs is as follows:

- a. Psychosomatic
 - (1) Skin (giant urticaria, neurodermatitis, eczema, dermatographia, excoriation, acne over age 20)
 - (2) Weight-loss due to anorexia
 - (3) Psychosomatic fever
 - (4) Vasomotor dyscontrol (cyanotic tendency, “cold, clammy” extremities, skin-temperature asymmetry, complaints of heat or cold, areal blanching, flushing, mottling, etc.)
- b. Conversion symptom (striped muscle or sensory) provided patient shows concern and secondary gains are minimal.

- c. Neurological: Any “soft” or “hard” neurological sign or complaint, if neurological disease is finally excluded on all the evidence.

As I said above, there is a problem in expositing some of these psychosomatic signs for use of psychologists or social workers rather than physicians, especially when the non-physician is evaluating clients or patient outside of a medical setting so he cannot even consult medical chart staff notes. What follows cannot really pretend to anything like adequacy by way of explaining the meanings or the criteria for checking the psychosomatic signs. Any such exposition will on the one hand not suffice to produce reliable judgeability by non-physicians, and on the other hand is likely to impress the physician—especially one in such a specialty as dermatology, neurology, or psychosomatic medicine—as crude and superficial. With these qualifications in mind I shall, however, try to say a little bit by way of expansion and delineation of the signs on the psychosomatic-neurological list.

Skin

It seems conceded by many clinicians experienced in dealing with schizotypes that they often have a kind of “skin diathesis” so that the presence of certain dermatological symptoms or complaints should be given at least some diagnostic weight in identifying the schizotypic character. Among the chief dermatologic sub-signs, the presence of any one of which may be used to justify a scoring of the “psychosomatic sign” as present, are giant urticaria (“hives,” “nettle rash,” angioneurotic edema), a vascular reaction pattern of the skin in which there transitorily appear smooth, slightly elevated patches which are redder or paler than the surrounding skin and are attended by itching; sometimes the phenomenon is confined to the sudden appearance of a temporary edematous area. The appearance is typically that of wheals or welts with an elevated, usually white center and a surrounding area of redness; they are likely to appear in crops widely distributed over the body surface, and tend to disappear in a day or two.

A vague and broad but nevertheless useful concept in the skin domain is neurodermatitis, in which the patient shows localized patches of irritated, itching skin, most characteristically showing a symmetrical location on the neck, in front of the elbow, or behind the knees. It is much more characteristic of females.

Also scored is “eczema,” a generic term for an acute or chronic non-contagious, itching, inflammatory disease of the skin, usually characterized by some combination of fluid, swelling of the skin, formation of vesicles, papules or pustules, or by a scaling or exudative lesion.

Dermographia is a condition of peculiar susceptibility to local mechanical irritation, such that tracing a finger nail or key over the skin results in a residual mark consisting of a distinct reddened elevation or wheal.

Excoriation syndrome refers to the patient who is a physical self-excoriator, manifesting skin lesions which he has produced by scratching, picking, rubbing, digging, tearing, pinching, or biting himself.

Finally, moderate to severe acne in a patient over age 20 justifies scoring the psychosomatic sign.

Anorexia

It is well known that schizotypic individuals have special problems in the broad domain of orality, although statistical study in two Minnesota installations shows that it would be a mistake to weight generic upper GI symptoms or complaints (e.g., postprandial discomfort) diagnostically since it actually discriminates in the other direction (i.e., shows a higher incidence in neurotics than in schizotypes). However, when the patient displays anorexia of sufficient severity to lead to an actual loss of weight it is my practice to check the psychosomatic sign as present. "Hysterical" vomiting or broadly "dyspeptic" complaints should therefore not be checked, except insofar as the primary phenomenon seems to be the patient's disinclination to eat and the vomiting or nausea are invoked by him as the justification or rationalization for not wanting to eat. If in doubt about the causal sequence here, do not check. If the anorexia is merely a loss of appetite and is neither severe or prolonged enough to produce an actual loss of weight, the sign should not be checked on this basis. If the patient loses ten pounds or more as a result of a strong disinclination to eat, with or without an explanation in terms of "it makes me feel sick if I do," and you are convinced that the primary problem is the anorexia proper, then the sign may be checked as present. I myself consider it as particularly significant when the patient is not severely depressed nor nauseated and simply indicates that he does not want to eat, that food does not taste good to him, that he has no interest in it, that the idea of ingestion repels him and the like. Needless to say, if an explanation of the anorexia is offered by the patient that has a paranoid flavor to it, such as that the food tastes funny or that he has the "thought" that it is poisoned or otherwise tampered with, this may routinely be checked as sign present. As to the question how to check the sign in a patient who is actually diagnosable as a case of anorexia nervosa, I would answer in the affirmative.

Fever

With regard to psychosomatic fever this is necessarily a rather subjective judgment since there are so many bugs around which can make people mildly ill with fever as one of the symptoms. I follow the convention not to check "Psychosomatic sign" on this basis when my evidence is only a single episode. If, however, the patient has two or more episodes in which fever is present under conditions of unmistakable psychological stress, is experienced as a distressing symptom with appropriate concern by the patient and is not associated with other clinical evidences of infectious disease, then I check the sign. Presumably the ability to work up a psychosomatic fever is just one of the various manifestations of vegetative dyscontrol that have been so frequently noted over the years by perceptive psychiatrists familiar with the schizophrenic disorder.

Vasomotor Dyscontrol

I have also indicated a rather broad category of psychosomatic sign called "vasomotor dyscontrol," and the examples given in the sub-sign list [a. (4)] above do not purport to cover all of the possibilities but simply the ones that are more common in my experience or that of the clinicians with whom I have worked. It is well known that some disintegrated schizotypes (e.g., catatonic patients) show extreme and dramatic forms of vasomotor dyscontrol in connection with the psychosis, but I also believe that milder manifestations are found in non-disintegrated (compensated and pseudoneurotic) cases.

Cold, clammy hands and feet is one of the commonest. A patient who shows temperature asymmetry, not merely complained of but usually verifiable by touch, between the two hands is manifesting a vasomotor phenomenon which most normal or neurotic people can only develop under special conditions such as hypnosis. A patient who reports that upon getting into bed on a cold night, one foot remains cold long after the other one has been "warmed up," is another example. Some of these patients will complain of the uncomfortable temperature of a room in which normal individuals do not experience any discomfort; this may be either that the room is too hot or too cold, although in my experience it is somewhat more frequently experienced as too cold.

Visible manifestations (which admittedly are also found with some considerable frequency in non-schizotypic hysterics) still occur often enough that they should be considered evidence. Areal blanchings, flushings, spottings, mottlings of extremities of face and especially neck I consider to warrant checking the sign.

This list, as I said, is not intended to be exhaustive; and for present purposes in the disjunctive use of "psychosomatic signs," if you discern in a patient other manifestations of malfunction or dyscontrol via the vegetative nervous system in its influence upon blood vessels when it seems to have no other kind of origin, is stress-connected, and is not employed by the patient to get secondary gain but is a source of concern and discomfort to him (i.e., his reaction to this physical symptom is rather like a normal person's would be) you may check the sign as present.

One rather frequent and striking vasomotor phenomenon, similar to the angioneurotic edema sign listed under the dermatological rubric above, is stress-induced fluid imbalance which I have also included as an example under checklist item #24 "Special signs." The patient shows a transitory increase in fluid retention which is "objective" in that it produces an easily detectable change in facial appearance and frequently an objective change in weight occurring far too quickly to be attributed to increased food intake. Some schizotypic mental content about body-image distortion, such as the patient's feeling that he is getting to look "different," "distorted," "unwholesome," "ugly," "all puffed up," "disfigured," or "bloated," are apparently induced by the patient's realistic recognition that his appearance sometimes undergoes considerable changes on the basis of psychosomatic, stress-induced fluid imbalance.

A peculiar kind of "puffiness," associated with a muddy, blue or slate skin coloration has been noted by many clinical observers and was, for instance, one of the danger signals that Adolf Hitler's associates had learned to notice because it was predictive of his quasi-psychotic episodes of rage, impulsiveness, and poor judgment.

It is important to avoid checking the fluid-retention sub-sign as present in females when it is no more than the usual alteration in fluid balance associated with the menstrual cycle. But when psychosomatic transitory edema occurs stress-induced and out of phase with the menstrual cycle I routinely check the overall sign as being present. Secondly, even in the case of cycle-correlated edema, when it is very markedly exaggerated and appears to be greatly potentiated by stress I believe it appropriate to check the sign as present.

Conversion Symptom

I am myself accustomed, partly on psychodynamic considerations and partly on the basis of Skinnerian learning theory, to make a rather sharp distinction between psychosomatic and conversion phenomena. Whether you agree with me about this or not,

for purposes of the present checklist I am adopting the convention that the phrase “conversion symptom” is to be construed narrowly meaning a hysterical phenomenon in striped muscle or, more rarely, on the sensory side, such as hysterical paralysis, contracture, tremor, aphonia, blindness, deafness, and some (not most!) stress-induced headaches. If a conversion symptom occurs with obvious psychodynamic and clearcut secondary gain as a symptom maintainer, and with the classical hysterical belle indifference, the sign should not be checked as present. If, however, the patient shows a conversion symptom with appropriate (or in these cases, for some reason, even exaggerated) concern such as anxiety about danger of death or incapacitation, and the symptom has minimal or no detectable episodic gain, you may check Sign 19 as being present.

Neurological

Since I am persuaded that all schizotypes have something fundamentally wrong with the way their nervous system functions, I incline to give weight to any neurological sign, either “soft” or “hard,” in cases where recognized neurological disease is finally excluded on the basis of all the evidence. Obviously it would be absurd to give a patient a point for a schizotypic sign on the grounds that he had asymmetrical tendon reflexes if one had meanwhile concluded on the basis of history and all of the findings that he was suffering from multiple sclerosis! Some of the commoner forms of neurological signs which I score under Sign 19 are: Variable tremor unassociated with manifest anxiety or at least not confined to episodes of anxiety of such severity as would normally be expected to produce tremor. Naturally one pays particular attention to a tremor which is asymmetrical. I have had several unquestionably schizotypic patients who would come in complaining of a tremor in one hand—which they might or might not demonstrate during the interview—and which persist for a matter of hours or days, would be mysterious in the eyes of a top caliber neurological consultant, and which would—very importantly—be a source of concern with the patient and would not be in any obvious way expressing any particular dynamic content nor utilized for purposes of secondary gain. In other words, the patient develops a neurological symptom “out of the blue”; shows a normal or even exaggerated emotional reaction to it in terms of its possible health meaning; shows no associated phenomena that lead the neurologist to diagnose organic pathology; makes no psychological or social use of the symptom; and then after a couple of days the symptom disappears. I am convinced that schizotypes have a peculiar neurological talent for evidencing this type of phenomenon. Other examples are diplopia or a vaguely described “blurring” of vision; muscular stiffness or weakness; vertigo; ringing, roaring, or buzzing in the ears; episodes of objective disequilibrium, in which the patient unaccountably sways or actually falls down; a reported cloudiness of the sensorium or mental content; episodes of disarticulation or dysarthria (slurring, huskiness, thickening, “weakness of my vocal chords,” aphonia); discoordination; petit-mal-like experiences; paresthesias (numbness, tingling, prickling, episodic areal hypersensitivity, e.g., “I can’t stand to have my skin rubbing against anything today”); and needless to say—although these are of course more often found in persons who have a recognized neurological disease—such “hard” signs as positive Romberg, past-pointing, dysdiadokokinesis, transitory strabismus, pupillary inequality, nystagmus, and the like.

20. Rage: Intense, phenotypic, verbalized, and disproportionate:

This sign may be checked either on the basis of overt rage-behavior occurring within the interview, or on the basis of the patient's report of several such episodes occurring outside the interview. Rage episodes occurring during interviews may be scored whether they develop in the context of the patient discussing other people, or are directed toward the therapist himself.

I employ the strong term "rage" to emphasize the overt and intense character of the reaction, meaning that the episode in question should have the quality of a real emotional "storm," "explosion," or "tantrum," of such a nature that an ordinary layman would have no hesitation in describing it by the word "rage." Purely verbal content of a hostile or aggressive nature, such as the making of a sarcastic comment or an expression of malevolent wishes towards somebody, does not suffice in the absence of clear and intense display of affectivity. Thus, a cold, controlled remark like, "I'd like to kill that son-of-a-bitch" is not scorable for this sign.

No matter how strongly you are convinced that a certain verbal or other instrumental response is being emitted under the influence of a latent hostile impulse, this does not constitute a justification for checking the sign, because the essence of this sign is a momentary break down of defense, a failure of controls normally confining to indirect and compromise expressions of hostility, with the eruption instead of a direct, uninhibited emotional storm.

If an emotional storm occurs during the session, there must be readily observable signs, instrumental and autonomic, of the anger affect as an intense experienced feeling-state which has momentarily taken over control of the speech and gestural behavior. Look for such overt signs of intense emotion as shouting or markedly increased loudness of the voice, voice shaking or gratingly harsh, flushing or blanching of the face, clenching of teeth, glaring or protrusion of eyeballs, pounding of furniture or of patient's own body, facial twitching, trembling of extremities, difficult articulation, gross signs of disruption in verbal sequence (incoherence, blocking for words, stuttering, disturbances of syntax, phrase repetition).

If you have serious doubt as to whether an intelligent layman would describe the episode as an "outburst" or "temper tantrum," do not classify the episode as an instance of "rage" sufficient for checking the item on this basis.

It goes without saying that relatively few situations occurring in either ordinary life or during the hour would, by our cultural standards, make such an intense overt rage response "appropriate" or "proportionate." Thus you may regularly classify such a response as "disproportionate" on the basis of its intensity and quality, unless there is quite strong countervailing evidence to show that the provocation was really extreme.

In evaluating this sign on the basis of the patient's report of behavior outside the hour, it is not sufficient that he complains of having a "bad temper," or even that he reports that he "became very angry" in a certain situation. It is necessary to inquire into the specific behavioral details of how he acted, to permit a judgment as to whether there did occur an overt rage-explosion. What precisely did he say and do? If his detailed account leaves you still in doubt as to whether the emotional response was sufficiently uncontrolled to qualify as a genuine rage attack, it is inadequate evidence to check the sign.

A single clear-cut rage-episode occurring during the therapeutic session suffices to check the sign as present. In regard to episodes occurring outside the hour, I do not check

the sign as present on the basis of a single episode reported, unless it was so extreme that the patient cannot even clearly remember what he did or said, or experienced perceptual dysfunction (e.g., visual-field constriction as in “blind rage”), or manifested an overt act of physical violence (smashing an object, striking or scratching a person).

A special quality to be alert for in identifying these rage episodes is that they typically have the quality of “attacks,” in the sense that the patient seems to have been “seized” or “possessed” by the affective storm and is, as the layman might say, “beside himself” or “out of his head” during the episode. While not conclusive, the patient’s or informant’s spontaneous choice of words is often helpful here, in that he may actually choose a word like “spell,” “fit,” or “attack” to denote the seizure-like quality of the experience.

An interesting form of response-disproportionateness is that in which it seems from the patient’s account or his behavior in the hour that he “worked himself up” into the rage-state from an initial condition of anxiety, depression, or diffuse inhibition—one has the feeling that he seizes upon a minor stimulus or a certain train of thought as a basis to precipitate the rage state which counteracts an aversive state characterized by feelings of helplessness, weakness, vulnerability, and constricted inactivity. As one insightful schizotype said to me, “The only time I feel strong is when I’m angry.”

21. **Repetition of Material:**

“Repeating more than the average outpatient does” is a necessary but not sufficient condition for checking the sign as present. Suppose that the repetition is concentrated mainly upon the persistence of a reality problem, something which in your judgment is an objectively present realistic threat or source of frustration, and of such a nature and intensity that it would probably make you or any moderately healthy person chronically dissatisfied; do not check the sign as present if this is your major source of evidence. It is irrelevant whether the present existence of this adverse reality-factor is historically attributable to the patient’s personality problem; nor does it matter whether the patient appears unwilling or unable to take plausible steps to modify his reality-situation. The question is merely whether you are convinced from all the evidence that he is presently in fact being subjected to a rather major reality stress or deprivation which you yourself feel would require more than the usual amount of stoicism (or hysteroid denial and repression) to keep a person from repeatedly mentioning it in a permissive, problem-oriented context. If this is your assessment, the sign should not be checked.

If you are confident that the patient’s repetitiousness exceeds that of the average outpatient, and that it consists mainly of discourse not directed at a major persisting problem in his objective life situation, two additional criteria should be fulfilled in order to justify checking the sign as present:

- a. The repetition of material should show a stereotyped rigidity in its form, content, and associated affect. If the patient modifies considerably his successive accounts of the repeated material (shifting his emphasis, beginning to leave out aspects which he originally stressed, introducing new aspects, clarifying thoughts or feelings, making various cross-connections of an “insightful” kind, and manifesting changes in emotional tone in connection with the content), the sign should not be checked as present; because such a patient, although he does repeat the essence of the content, shows distinct evidence of change in the way he thinks or feels about it. “Something new is being added,” while some of the “old familiar stuff” is tending to drop out.

A particularly important manifestation of this rigidity, which however may not become available until you have had quite a sizable number of sessions, is the “complete backsliding” type of response. I do not mean, of course, the mere occurrence of “bad days,” or expressions of discouragement following a down phase, an exacerbation of symptoms, or a reality-disappointment. By “complete backsliding” with respect to the repeated material, I mean that the patient speaks about this material as if certain previous insights and (apparent) workings-through had never occurred, reverting to his original language and affect, and showing no indication that anything significant in the domain has ever taken place during the intervening sessions. One is particularly struck by the fact that this lack extends to the patient’s self-observation, i.e., he fails to mention that he is currently feeling and thinking exactly as originally; and any attempt to re-direct his attention to the intervening developments is met with denial, dismissal, or by-passing through flimsy rationalizations and evasions. One gets the impression that either no “movement” occurs, or that what had appeared to be significant movement can be completely undone by a mysterious “shifting of the gears” which puts the patient right back where he was.

- b. On the subjective side, you should be able to detect in yourself at least some tendency to feel discouraged, baffled, bored, or irritated by the repetition—a distinct subjective feeling, however skillfully you handle it or however quickly and easily you can turn it off, of “here we go again, playing the same old record in the same old way.” While no doubt there are wide individual differences in therapists in their readiness to experience this response, I include it as a necessary condition for checking the sign; so that if, with the most honest effort at introspection you can detect no such spontaneous reaction within yourself, the sign should not be checked.

22. Self-injury (physical, social, professional, sexual):

The tendency of the patient to act in such a way as to cause himself pain, damage, non-gratification, degradation, or objective worsening of his reality-situation should be sufficiently widespread and intense to give you the definite impression that he somehow “rigs” things so that he will be hurt or fail. Mere “inefficiency” due to inadequate learning of requisite social skills, or the paralysis of problem-solving behavior on the basis of crippling inhibition or anxiety, does not suffice. There must be evidence that the patient actually says or does something of a “positive” nature which would normally stand a pretty good chance of bringing about an adverse result. A striking indicator of this trend is your development of an expectation, when things appear to be going fairly well, that it is now about time for the patient to “do something self-destructive.” Such a generalization will sometimes have been noted by the patient himself, although often less insightfully in the form of reporting an unaccountable feeling of apprehension, anxiety, or even “doom” because “things are going too well, something bad is certain to happen.”

Perhaps the most obvious manifestation of this tendency to self sabotage is the time-correlation between “success”-experiences and the patient’s bringing about of a self-injurious event. You find that whenever the patient reports what is for him an unusual experience of gratification, success, self-expression or aggression, more often than not you will be correct in predicting the occurrence shortly thereafter of a definitely “bad” episode to which the patient made a definite contribution by setting it up.

The mode of self-injury may be in any form or life-domain. Do not confine your

attention to the interpersonal domain, but make note also of phenomena in the psychopathology of everyday life, such as the patient's pounding his thumb with a hammer, walking into a door, cutting himself inexplicably while shaving, unintentionally throwing away his only copy of a term paper, losing his wallet, smashing up his car and the like.

Excoriation syndrome, in which the patient has skin lesions produced by scratching, tearing, pinching, picking, rubbing, biting or digging at himself, should be regularly taken as sufficient by itself to check the sign as present.

Although it may have a rather different dynamic meaning, for present purposes we include under this sign the interpersonal "testing" operation, in which the patient subjects a new and potentially gratifying interpersonal relationship to a "test" of such rigor that one could say in advance that there is at least an even chance that the other party will "fail the test." This may be acted out in relationship to you in the transference situation, and if clearly present, justifies checking the sign. With regard to the patient's narration of his other interpersonal relationships, whether such behavior is reportable will depend upon the extent to which he makes new extra-therapeutic contacts, so you may not have an opportunity to learn of any current episodes in the course of a short therapeutic series. However, it is sometimes possible to gather sufficient evidence for this solely through the anamnesis. In such cases, however, do not rely merely on the patient's generalization to the effect that "it seems that somehow people always disappoint me, sooner or later." It is necessary, in checking the sign as present on the basis of pre-therapeutic history, to obtain a reasonably detailed account of several specific examples of such interpersonal disappointments, such that you may conclude in good probability that these disappointments were "rigged for failure" by the patient. If over an extended series of interviews, you develop the expectation that whenever the patient enters into a new interpersonal relation which is actually or potentially gratifying, you are able to predict more often than not that within a short time, he will come in with a report of having seriously misjudged and over-valued the other party, as shown by failure of the other party to "pass the test," this would usually justify checking the sign as present.

In female patients, a frequent manifestation of the self-injury pattern is one of getting herself involved in heterosexually dangerous or exploitative situations from which she can extricate herself only with considerable difficulty, embarrassment, or psychic pain. Many of these schizotypic women are the victims of rape or "semi-rape," in that they put themselves in situations with sexually exploitative men by showing an amazing obtuseness to what a normal or neurotic woman would quickly perceive as obvious signs of the man's sexually aggressive intentions. You will be struck by the almost childlike naiveté or masochistic vulnerability displayed, sometimes repeatedly, in failing to see the obvious sexual potential in a developing situation. The phenomenon is particularly striking when the patient is unable to give any plausible phenomenological account of her rather obvious "overt willingness," i.e., the man may have been a near stranger, not personally or erotically attractive to her, and she does not report any strong sexual hunger as having been operative. After eliciting the most detailed account she seems able to provide, you find yourself puzzled about "how—and why—it happened." I routinely score the self-injury sign whenever a female patient has a history of being seduced or [quasi-] raped as an adult, and the episode has a puzzling quality of the patient being a passive, confused, suggestible little girl who is "used" by an adult male without much wanting to

or knowing quite what is going on.

I regularly score the self-injury sign as present whenever the patient has clearly married an inappropriate partner and can offer only the haziest account of why. This does not, of course, include those garden-variety marital mistakes found in normal and neurotic people which occur because of infatuation, deception by the partner, insufficient experience, financial motives, intense wish to leave the parental home, overpowering sexual passion, rebound, and the like. What I am talking about is a marriage which had no reportable motivation at the time, so that the patient says, in effect (and sometimes in so many words) “I didn’t love him when I married him, and I sort of knew that it was a dumb thing to do. I don’t know what made me do it—I just did it.”

23. Social fear [include marked preference to “be alone”]

Since some degree of shyness, social anxiety, interpersonal aversiveness, and expectation of rejection by others is likely to be found in most individuals seeking psychotherapeutic help, this sign should not be considered for checking unless the patient shows it to an extent distinctly above the average of a mixed outpatient population of patients, and you view it as one of his most salient, conspicuous problems. The mere presence of a complaint such as “I am shy” or “I am insecure,” or a tendency of the patient to avoid social interaction, does not suffice. If you are satisfied that the patient’s experienced anxiety in interpersonal contacts is distinctly above the average for psychiatric outpatients generally, or that such social anxiety is avoided only by means of a marked restriction of the patient’s life which minimizes such interpersonal contacts, the sign may be checked as present, provided at least one of the following further specifications is clearly met:

- a. Patient reports a marked tendency to want to “be alone.” He finds that ordinary, routine, familiar daily demands involving interaction with others produce a strain, a chronic pressure, a wear-and-tear on his psyche from which he must recuperate by intervals of solitude. Sometimes this involves actual physical withdrawal such as failing to show up for work, staying home or going to bed on the basis of a minor illness, going for long solitary walks or a drive into the country, and the like. Or he may have fantasies about taking a different type of job involving mostly solitary activity (e.g., being a forest ranger), or moving to a different community or foreign country where “nobody knows me or would make any demands upon me.” Sometimes the patient will show exaggerated irritation, approximating rage, when talking about how other people make demands—it infuriates him that he has to be “bothered all the time,” that people are always “pestering” or “intruding” or “interrupting,” that it seems so tiresome never to be “let alone for a change,” and the like.
- b. Patient reports episodes in which the anxiety anticipated in an interpersonal situation was sufficiently great that he reluctantly “got out of it,” on some kind of pretext, or by a piece of psychopathology of everyday life, or by psychosomatic or semi-consciously exaggerated illness, in spite of recognizing that the situation realistically contained the possibility of positive gratification, or that he was morally or socially obligated to go through with it and therefore experiences guilt or shame because of his avoidance.
- c. The patient reports episodes in which he actually went so far as to put himself in a threatening interpersonal situation with the intention to remain in it and function

adequately in spite of his subjective distress, but once there, found himself experiencing mounting anxiety approaching panic to such an extent that he had to “flee the field” at the expense of lying, feigning illness, or putting himself or others in an embarrassing social situation by an unplausible excuse or an unexplained disappearance.

- d. Patient reports occurrence of marked social anxiety resulting in socially inappropriate or self-defeating behavior in a situation which is not intrinsically novel, would not be objectively threatening in terms of the actual behavior of the other parties concerned, and in which the other people involved are not strangers to the patient nor the demands or expectations put upon him by the situation in any way exacting or unfamiliar.
- e. Appearance of a strong anxious affect, lacking content, in an interpersonal situation, and relieved by escaping from it. The patient reports that he became unaccountably afraid, felt he “just couldn’t stay there any longer,” but is unable to give anything but the vaguest account of what it was he thought might happen if he remained in the situation. All he knows is that it was somehow brought on by being with the other people and was relieved by getting away from them.
- f. Episodes in which the patient “explains” his social anxiety in terms of a minor social sign (ambiguous remark, facial expression, gesture) which he, so far as you can tell, has markedly over-interpreted and distorted as an indication of hostile, critical, or rejective attitudes or intention to somehow “attack” him.
- g. Displays physical affection for pets but not for people.

24. Special signs:

As in Sign 19 above, I have grouped together under this rubric a qualitatively heterogeneous collection of phenomena which share only the common property of being schizotypic indicators but each of which occurs too often in non-schizotypes, or else with insufficient frequency even among schizotypes, to justify listing it separately as a major sign in the checklist. Check “Special Signs” as present if any of the following are definitely present:

- a. Hopelessness (explicitly and spontaneously verbalized, without severe clinical depression)
- b. Hypochondriasis
- c. Sensory input compulsion
- d. Noise oversensitivity
- e. Touch aversion
- f. “Night owl” syndrome
- g. Energy-depletion
- h. Gullible-suspicious paradox
- i. Spatial-motoric-kinesthetic defect (“proprioceptive diathesis”)
- j. Humor defect

- k. “Paranoid headlights”
- l. Panic when alone
- m. Sleeping with clothes on; or on couch, chair, or floor; or with light on
- n. Photophobia
- o. Name or address depersonalization
- p. Facial asymmetry
- q. “Inappropriate appearance”

The meanings and criteria for these special signs are as follows:

a. Hopelessness (explicitly and spontaneously verbalized without severe clinical depression):

The essential feature here is that the patient states in so many words and without special probing or suggestion from you that he has never been a happy person and—a critical feature of the remark—he feels convinced that he never will be. It is remarkable how many schizotypes will spontaneously verbalize this insight and sometimes in quite extreme terms. Even a psychotically depressed non-schizotype is usually able to admit that he has been happy at various times in the past; and a sizable minority are capable of realizing even though they may not “feel” it, that they will get over being depressed and will come to feel good again in the future. However, to be on the safe side against false positive checkings here, I have specifically excluded from consideration individuals who are severely depressed by usual clinical criteria. Any patient who is lacking in a depression of such clinical severity as to be properly hospitalizable—in other words, anybody short of what we would ordinarily consider a psychotic depression—but who states in so many words that he has never been happy as far back as he can remember, and feels somehow certain that he is never going to be happy, should be checked as having special sign “Hopelessness.” It is interesting that even when asked to contemplate possible changes in the reality-situation, or possible results of psychotherapeutic intervention, many schizotypic patients will insist that no matter what happens in job or marriage or financial affairs or whatever, “I feel sure for some reason that I will always be more or less miserable just as I have always been since I was a little kid.” There is a quality of “doom” about their verbalizations in this respect, and in my experience it is not typically uttered as part of the transference phenomena of demanding help but is uttered with real discouragement and regret, as if the person had faced up willy-nilly to an unpleasant truth about himself and which he considers somehow, although quite without any good reason available to him, as an unchangeable personal feature like the color of his eyes.

b. Hypochondriasis:

It is well known since Bleuler and even before, that hypochondriacal ideas and concerns are very frequent among schizoid individuals and experienced clinicians usually report that actually they are more often present than not. Because the hypochondriacal concern (except at certain points in the natural history of some paranoid schizophrenic developments, e.g., Magnan sequence) is typically not the main focus of a presenting complaint, and because certain other aspects of the clinical picture tend to strike the observer as more dramatic and malignant, it is easy to overlook or fail to elicit the schizoid

somatic concern. For checklist purposes you should score hypochondriasis as being present whenever there is evidence of hypochondriacal thoughts, worries, or concerns which are productive of manifest anxiety, or which verge on belief or quasi-belief (however momentary), even though not actually “delusional”; I personally score even weaker degrees of hypochondriacal ideation, lacking either marked anxiety or quasi-conviction, whenever their content involves the notions of (1) impending death, (2) brain disease, (3) cancer, (4) becoming blind, or (5) venereal disease.

c. Sensory input compulsion:

Patient undergoes periods in which he seems compelled to provide himself with some kind of sensory input of almost any quality or content, giving the distinct impression—or even reporting spontaneously—that he would be unable to tolerate having his mind otherwise unoccupied. Examples: Sitting for hours watching an unselected sequence of TV programs which he finds boring or even irksome; listlessly playing solitaire; getting dressed and going out to the drugstore to buy a half dozen cheap, haphazardly chosen paperbacks lest he should be “caught without anything to read”; sitting through several movies consecutively to “keep my mind occupied.”

d. Noise oversensitivity:

More than mere “irritability,” this involves an over-reaction to auditory stimulation producing anxiety, rage, or taking exaggerated steps to escape the auditory input. E.g., the patient purchases ear plugs, or has a big dispute with his landlord, or changes his place of residence because he “cannot bear” an amount of noise that falls well within the usual range for many city-dwellers. Particularly striking is intolerance for the barely audible human voice, where the patient cannot clearly hear all of what is being said and is unable to cease attending to it.

e. Touch aversion:

Ordinary, common, non-intimate bodily contact, such as brushing against another, being pressed against a stranger in a crowded elevator, shaking hands, getting a haircut or manicure, having shoes or clothing fitted, being examined by a physician or dentist arouses anxiety or irritation. Depending upon your own practice regarding physical contact with patients, you may also have opportunity to observe a pronounced over-reaction (typically intensely ambivalent rather than purely aversive in this context) to being touched by you.

f. “Night-owl” syndrome:

The most objective form is a chronic partial reversal of the sleep cycle, in which the patient customarily stays up past midnight without a compelling reality-basis for so doing and either sleeps during part of the day, or complains of being chronically sleepy while persisting in staying up into the wee small hours. A milder, less clearcut form is found in patients who by reason of necessity or stern self-control are prevented from following what seems to be their “natural, temperamental” disposition, and who therefore do not show an overt reversal or semi-reversal of sleep cycle but nevertheless show rather clear indications of what they would do if left to their own devices. Thus, for example, the patient complains (or informants observe) that it is unusually hard for him to wake up in the morning; and that this is not merely the familiar subjective distaste for arising upon demand but that the patient is actually almost non-functional cognitively and executively

for a rather extended period upon arising. These patients will frequently drink tremendous quantities of coffee or resort to some type of medication such as Dexedrine to help counteract a morning state which frequently lasts into the early afternoon, in which they feel sluggish, detached, depressed and actually a bit “cloudy” or “confused.” There may be a pronounced alteration in mood taking place at nightfall and not dependent upon reality-factors such as freedom from work demands or special social stimulation but apparently simply a function of the time of day, such that the patient regularly feels depressed, listless, or apathetic and can hardly drag himself to interact with other persons or to carry out even simple tasks during the daylight hours but begins to feel energetic, active and even emotionally “good” in affective tone at night.

While this pronounced dependence of efficiency, energy level, and mood, amounting almost to a chronic inversion of the sleep cycle in which the patient is—at least if he does what comes naturally—generally “out of phase” with night and day and with the rest of us, is frequently seen and scorable, the “night owl” phenomenon is not invariably associated with favorable mood states. Staying up into the wee small hours under the influence of an anxious or agitated mood is also scorable (unless, of course, you are convinced on the basis of the whole body of evidence that the patient’s diagnosis is agitated psychotic depression). Finally, some schizotypes will stay up all or most of the night working “feverishly” on some project or other with the mood predominantly positive, although “elated” would not be quite as apt a description of its flavor as would be the more neutral term “excited.”

Needless to say, in some persons there will be compelling reality factors such as a student’s end of quarter cramming for finals and you have to use your judgment in assessing the objective cogency of these reality-factors on the merits.

g. Energy-depletion:

The way some schizotypes talk about their reaction to life’s tasks makes it difficult not to conceive of some kind of notion like “available psychic energy” which is more or less chronically depleted. The patient will often actually employ the word “energy” in verbalizing this complaint and, depending upon his education and sophistication, may or may not give it a certain hypochondriacal coloring in the way he conceives of it. In my experience (especially with educated, intellectual schizotypes) it is frequently not given any somatic reference and the patient even thinks of it in broadly “psychic energy” terms. It is hard to describe behaviorally except when thus voiced as an explicit complaint; but the general idea is that the person seems often or chronically unable to mobilize enough psychological resources to handle what are objectively rather minor and routine stresses and demands of ordinary life—especially those involving interpersonal dealings—without feeling greatly pressed and “exhausted.” My own hunch is that part of this feeling of exhaustion is based upon actual feedback from a chronically tense musculature in persons for whom minimal demands are elicitors of the anxiety-signal, but you need not accept this hypothesis of mine to rate the item reliably. The patient expresses a need to get out from under, to “get away from it all,” to chuck responsibilities; and there is frequently associated a considerable amount of irritation about the theme of “they [or the world, or life] won’t let me alone.” The patient experiences common and minimal tasks as infinitely demanding and stress-producing. You notice repeated interviews in which the patient emphasizes how tiresome life is, and how hard it is to meet all of the tasks and expectations put upon him, and how he just doesn’t have enough mental energy to deal

with all of this and so on; but the fact is that the actual tasks and demands he is alluding to are rather minor and that in terms of his objective behavioral functioning he may very well have mastered them quite successfully; if you were not a psychotherapist you would have the impulse to ask what all the terrible fuss is about? For example, the patient comes in displaying a very harassed facial expression (not histrionic but spontaneous and genuinely expressive of his marked tension state) and launches into a description of what a “terrible day” it has been thus far and that he just doesn’t see how he is going to cope if things go on this way and he would like to go home and go to bed. He tells you that things just seem to pile up to the point that it’s more than a person can be expected to handle. What is this great catastrophe that has befallen him? It turns out that he had an appointment with the dentist and just as he was about to leave the house someone called him on the telephone and took about five minutes of time getting some information out of him. When he arrived downtown he found that his usual parking lot was full so he had to drive around the block a couple of times before he found one that still had space for another car. Then it turned out that the dentist had a new girl working as a dental technician who was more talkative than the old one and he felt obliged to engage her in conversation although he wasn’t much interested in what she had to say. When he came back to his office, he found a letter on his desk making a request which he wished to refuse to the unknown sender but wanted to do so tactfully so that he was presented with a slight problem in choice of phraseology when dictating his reply.

Now I am not saying that it is pathological to react with some irritation to such a sequence of events. But there is a difference between a flutter of neurotic irritation or a semi-jocose attitude of “better I should of stayed in bed—what a day, what a day!” and a response such as our hypothetical patient is displaying. He says that he is just about at the end of his tether; and the combination of his face, gesture, voice, and content reveals that this reaction is not histrionic exaggeration or a transference-motivated plea for sympathy, but a spontaneous expression on his part of an extreme degree of subjective distress and a desperate feeling of being unable to cope. But, after all, objectively only four events—each of which occupied only a small percent of the total morning time—have occurred; none of them has been realistically damaging or threatening, either physically or socially; and all of them have been successfully negotiated by him. Yet to look at him you would think that he had just lost his entire fortune in the stock market, learned that one of his children had leukemia, and that his wife has decided to divorce him and marry the milkman.

This sign should not be scored when there is a specific neurotic content associated with the threats, even if they are exaggerated for dynamic reasons. The point here is that almost regardless of the content and social context and almost regardless of how adequately the patient handles it and how quickly it is over with, the mere making of a demand that was unexpected—that he talk on the phone when he wasn’t ready to, that he look for another place to park, that he engage a strange person in light conversation while she cleans his teeth, and the like—are experienced as terribly onerous and leave the person feeling “psychologically exhausted.” It is not necessary that manifest anxiety be displayed or reported in order to check “energy-depletion” as present. The complained-of state may be simply one of feeling that the demands for cognitive and executive function are “too much,” that the patient somehow feels unable to mobilize sufficient resources to think, decide, or take action. A vague undercurrent of either cognitive confusion or response

inhibition is often detectable in the manner or choice of words, although “I don’t have the energy” is the clearest indicator of all.

h. Gullible-suspicious paradox:

The paradox here is a combination of two traits which one would ordinarily think of as psychologically opposed, namely, gullibility and suspiciousness. The paranoid character of a non-schizotypic kind does not, in my experience, show this phenomenon. But the schizotype (with or without clinically “paranoid” features) often displays a peculiar mixture of oversensitivity, suspiciousness or mistrust in some situations with a naive and childlike gullibility such that he is readily “kidded,” “taken in,” or made the butt of a practical joke or of conversational “stringing along” which would be obvious to most people of his intelligence and social experience.

i. Spatial-motoric-kinesthetic defect (“proprioceptive diathesis”):

Since childhood the patient has been noted for a peculiar, pervasive, and inexplicable defect in what might be broadly called the “spatial-motoric-kinesthetic” sphere. His executive ego function is noticeably weak as regards, roughly, “mechanical,” “manipulative,” “coordinative,” activities; and even his cognitive ego-function may seem impaired in the domain of “three-dimensional space” relationships. As far back as recollection or informant observations provide data, it seems that the patient has been graceless, clumsy, bumbling, inept, or ineffectual in dealing with mechanical objects, spatial relations, tasks involving smooth timing and integration of movement; typically he was always markedly poor at sports, motoric games, dancing, auto mobile driving, machine operation, kitchen or yard work, mechanical puzzles, and the like. A specific defect in spatial cognition which, while not always part of the overall defect is very striking when it does occur, is in respect to self-location, spatial directions, and the pattern or lay-out of places or positions. The patient’s tendency to “get lost,” to learn slowly where a place is and how to get there, to have a “poor sense of direction,” is at times so glaring that it seems almost of organic or feebleminded proportions.

Because of the subjectivity in evaluating this facet and its moderate occurrence in non-schizotypic clinical populations, I do not suggest scoring it as an instance of major Sign #24 unless it is quite extreme in degree and duration and is brought up spontaneously by the patient or by an informant rather than as a result of your own inquiry. Roughly speaking, the phenomenon consists of a long history, going back to earliest childhood and manifested in many life-domains, of the patient’s having a peculiar ineptitude in what might be called the simple physical problems of orienting, locomoting, and manipulating the objects of his physical environment. One of the commonest and earliest manifestations of this pervasive “spatial-kinesthetic-motoric coordinative” deficiency is in the domain of athletics. Unfortunately many non-schizotypic neurotic children, especially the “sissy” type of boy, may also have this complaint. Nevertheless, it is one of the first places that the defect is likely to be noticed by the patient or other people and is therefore a useful lead to follow up in the diagnostic and therapeutic interviewing to see how generalizable it may be as a trait. Even though the patient may lack any “hard” neurological symptoms, and may not show a quantitative deficiency in standard tests of space perception, motor coordination, mechanical abilities, etc., he has become aware, either on his own or because other people have pointed it out to him, that he has a special knack of being inefficient with regard to the manipulation of the physical environment. Common expressions of this

are remarks like “I have never been able to do anything with my hands even if it was simple,” or “I don’t see how somebody as bright as I am can be such an idiot when it comes to practical things like finding my way around the city,” or “I have always been embarrassed since I was a kid about the fact that I was clumsy—and it’s not just that I am not ‘good’ at certain games—I mean I am really clumsy.” Accident proneness is one form in which this trait may show up, either as self-injury or as a tendency to break objects (e.g., glassware, ornaments, clothing and so on). Lacking adequate experimental analysis of the nature of the defect, I would not hazard an impression as to how much of it is on the perceptual side (although I am convinced that in regard to abilities like depth-perception or the estimation of the speed of objects and the like, these patients really are frequently deficient apart from the confounding phenomenon of “performance anxiety”) and how much is motor-coordinative (although I believe they also have something rather radically wrong in this respect as is suggested by the experimental findings of King).

While it overlaps with sub-facets of major checklist Sign 19: “Psychosomatic and neurological,” you may include the soft neurological sign of discoordination as a manifestation. General clumsiness may be manifested by episodes of quasi-apraxia, motor dyscontrol, puzzling instances of mis-stepping, bumping into a door, dropping objects, misjudging the placement or stability of an object (e.g., patient tips over beer glass, or inexplicably “misses” it, pouring beer alongside it). Bleuler was said to recognize a “schizophrenic walk,” and it is my impression that even semi-compensated schizotypes often manage to move their feet when locomoting in a “clumsy, bumbling, shuffling” manner. (Somebody should make a statistical study of their tendency to walk, and especially to stand, “pigeon-toed.”) The schizotype is remarkably able to “get his feet in his own way,” and I would lay money on the outcome of a statistical study of their greater tendency to stumble or actually trip and fall when there’s nothing to trip over.

Summarizing, the sign may be checked as present when the patient or informant spontaneously reports, and can cite examples from several life domains, that the patient has from childhood manifested a striking, chronic, pervasive defect in dealing with the objects of his physical environment and the coordinated movements of his own body.

j. Humor defect:

The patient has a weakness or deficiency in the appreciation of humor, which probably involves a mixture of cognitive and affective factors. It seems to be partly a deficiency in social role-taking ability, partly an over-determination of mental content by internal processes with diminished influence of external social inputs, and partly the widespread (although often subtle) communicative defect so characteristic of schizotypes. The most striking form of the defect is that in which the patient is genuinely amused by something but subsequently finds out—or the therapist is able to make a confident judgment from hearing the account—that what the patient saw as being funny was radically different from what the others were laughing at and what the maker of the joke obviously intended. Any appreciable tendency for the patient to do this misperceiving of the basis of humor (e.g., reporting or displaying more than one or two examples of it in an extended series of contacts) justifies scoring the sign as present.

A less clearcut form, which may also justify scoring when it is sufficiently clear and pronounced, is the mere lack of response to a joke or a witticism; provided that it is associated with cognitive perplexity. I.e., don’t score the sign on this basis if the patient knows what the others think is funny but he doesn’t think it is funny—only score it on this

basis if the patient does not understand what the others think is funny.

k. “Paranoid headlights”:

This phrase covers a set of related eye-signs any one of which justifies scoring the sign as present. First we have a mannerism (not a tic in the usual sense) in which the patient momentarily over-widens the palpebral fissure, “bugging out the eyes,” giving the impression of a transitory, episodic, functional exopthalmos. The bugging out of the eyes is sometimes followed (or, less often, preceded) by a brief narrowing of the palpebral fissure which lasts only a second or less and has the topography of the clinically familiar “paranoid squint.”

An automatized, rapid-fire, tic-like variant of this mannerism is the scleral flash,* a high-speed momentary widening of the palpebral fissure chiefly by raising the upper lid but without an appreciable associated eyebrow elevation, and producing a perception of “flashing eye” in the observer. Another eye-sign, similar and perhaps related to the preceding, is a distinct temporal variability in the palpebral distance and what appears to be an actual protuberance (although it may not be anatomically such) of the eyeballs. covarying with the patient’s mood. It is not safe to score “paranoid headlights” unless fluctuation over time is observed, because of the marked individual differences among persons in anatomy and physiology influencing the apparent amount of eyeball protrusion. But, if anxious affect or threatening content is associated with a distinct appearance of increased eyeball protrusion, the sign may be scored.

An eye-sign difficult to describe objectively but well-known to most clinicians is what may be called “gimlet eye,” a feature of the eye or its surrounding musculature in which the patient’s gaze has a peculiar intensity which can give you the subjective feeling that the eyes are, so to speak, “boring into or through you.” Persistence of this intense, gimlet-like gaze when the lower part of the face is in repose or smiling is particularly significant.

l. Panic when alone:

The patient experiences episodes of acute anxiety, sufficiently intense to be properly classified as “panic states,” on being alone. Sometimes such states may not have occurred recently, or happened only once or twice in the history, but one finds that the patient currently manages to avoid such episodes of aloneness-panic when, upon detecting the beginning signs of such an attack, he employs some stratagem such as calling a person up on the telephone or merely going to “where other people are,” even though the interpersonal contact is not intrinsically gratifying or adiently sought but merely meets the negative condition of avoiding aloneness. Oddly enough, alone-ness panic can be found along with interpersonal aversiveness in the same patient.

m. Sleeping with clothes on; or on couch, chair, or floor; or with light on:

A single episode of this kind, if definitely established, suffices to check the sign as present. The patient deliberately sleeps with his clothes on, or in a chair, or on a couch, or on the floor, even though his bed is unoccupied and he can provide no rational explanation (or only the feeblest of implausible rationalizations) for so doing. I include sleeping in bed but with the light on under this sign. Do not of course count an isolated instance of mere “dozing off,” if this seems a plausible reconstruction of what actually happened. But if this

* So named by my colleague Dr. Richard Magraw, who considers it pathognomonic and has studied it cinematographically.

alleged “dozing off” occurred in a context in which the patient realized that he was getting sleepy and appears to have shown a reluctance or anxiety about undressing, turning off the light, and getting into bed, you may check the sign as present. If an affect is reported in connection with this kind of episode it will characteristically be of anxiety, but it will not always be the case that the anxiety is reportable.

n. Photophobia:

This may be evidenced either by subjective complaints concerning bright lights, a kind of “shock” upon opening one’s eyes on a bright morning, dislike of winter because of the bright snow, and the like. You may routinely score the wearing of dark or tinted glasses if the impulse to do so came from the patient rather than from his physician; and I score a marked tendency to wear dark glasses in a considerable variety of situations where most people would not do so (e.g., other than at the beach, or while driving across country). Probably the dark glasses tendency is only partly photophobic, but score it here anyway.

o. Name or address depersonalization:

1) Patient refers to himself by using his name, as if speaking of a third person, rather than by saying “I.” This little affectation, usually semi-humorously followed, is probably a subclinical variant of the cognitive-slippage third-person pronoun usage sometimes observed in disintegrated schizotypes.

2) Patient habitually refers to his place of residence by mentioning the address rather than saying “my house” (i.e., he says “... out at 345 Hudson Avenue, things are going fair these days...”).

p. Facial asymmetry:

While this is most clearly demonstrable by fusing half-photographs to get two composite pictures of the “full” face, it is sometimes sufficiently pronounced to be noted by ordinary clinical observation. A marked difference in expression, tonicity, fullness, vascularity, mimetic modulation, or the facial lineaments that are a residue of previous expressive patterns between the two sides of the face, justifies scoring the sign as present. Needless to say traumatic, dental, or neurological causes of facial asymmetry must be excluded.

q. “Inappropriate appearance”:

While this is somewhat subjective and might depend unduly upon the taste of the particular rater, it can sometimes be so striking that there would be very little disagreement that the patient’s appearance was “inappropriate.” It is hard to spell out the details but the essential point is that somehow the patient manages to put together a gestalt of hair style, shoes, clothing, and cosmetics which just doesn’t “go well together.” The phenomenon is of course much more easily detectable in female patients than in males. It is interesting to note that somehow each of the individual facets or articles may be all right and may even be moderately expensive and singly “in style,” but the patient has shown some sort of deficiency in social perception, or a latent tendency to spoil her own physical appearance, or perhaps to ward off sexuality, but in any case the net effect is one of disharmonious or even bizarre mismatching of elements. Sometimes the oddball appearance can be achieved by extremely minor “flaws in the picture,” such as what the patient systematically does with a single lock of hair. The typifying but extreme examples of this are the incongruous get-ups chosen as the costuming of an eccentric old maid

character in a high school play; or the effect one gets in looking at the women patients on the grounds of a state hospital which is, somehow, over and above the fact that the clothes are cheap or cast-offs. Of course in evaluating this sign due account must be taken of the patient's social class, intelligence and financial resources. And merely looking "dowdy," "plain," or "ugly" is not the same as "inappropriate."

25. Suicidal [attempt, or dread, or chronic "thoughts"]:

It is not sufficient in checking this sign for the patient to make mention of the possibility of suicide, the fact that it is an "available out" as the last resort, or that from time to time the notion of suicide has passed through his mind. Perhaps the majority of psychiatric patients have at least thought of the possibility, and in spite of the extreme rarity of the actual carrying out of such thoughts, even in a psychiatric population, one should remember Schopenhauer's famous remark that "knowledge of the possibility of suicide has helped many a man to get through a bad night." The sign should be checked as present only if a strong suicidal trend is in evidence, which for present purposes can be defined semi-objectively, as a disjunction of the following three criteria:

- a. Overt and, in your judgment, genuine suicidal attempt. Do not count an attempt as genuine if the patient "changed his mind" after an initial step (e.g., called up his physician after swallowing a batch of sleeping pills). Failure of a genuine attempt should be due either to the occurrence of something which the patient could not reasonably foresee happening, such as a relative coming home unexpectedly; or to a factor involving lack of information as to the efficacy of a plausible suicide technique. Needless to say, the fact that the motivation was mixed and involved controlling or vindictive features as well as a "genuine" motivation for death should not prevent you from checking this sign, provided the evidence satisfies you that the motivation for death was sincere. One such genuine suicidal attempt is sufficient to check the sign as present.
- b. Fear reported by the patient that he might kill himself, of such intensity that the associated affect could be properly called "dread" or "panic"; or the taking of embarrassing or inconvenient overt action to forestall the possibility of making an attempt (e.g., taking a cab or bus instead of driving his car, for fear of "bringing about a fatal accident"; throwing away a bottle of sleeping pills or selling a revolver; calling up an acquaintance or going to an otherwise non-attractive gathering, to prevent the possibility of being left alone). A telephone call to the therapist about current suicidal impulse, or the request for a special therapeutic appointment on this basis, will also qualify provided you are pretty sure that the patient's felt need to use the therapist as a controlling suicide-preventive agent preponderates over his use of a suicide threat as leverage for dependency gratification or as a "testing" operation on the therapist's availability.
- c. Even in the absence of overt suicidal attempt or anxiety about making such an attempt sufficiently strong to be classified as "dread," I also score the suicidal sign as being present if the patient has a long history of recurring thoughts about suicide. By long history, however, I really mean "long," in the sense that it should antedate the inception of the therapeutic contact and should antedate whatever current exacerbation of depression or anxiety may have brought the patient to treatment. A statement by the

patient, either spontaneously or in answer to questioning, that he has had thoughts about suicide for several years and more or less chronically rather than intermittently (i.e., not confined to transitory stress situations), suffices to score the sign as present. If an adult patient states that he had frequent thoughts about suicide in adolescence or even childhood this suffices to justify checking the sign.

A history of suicidal pre-occupation in the absence of acute psychic distress (depression, anxiety) or bad reality-problems is, in my experience, almost pathognomic of schizotypy, and certainly justifies checking the suicidal sign.

The “Global” Rating Scale

Following the signs proper the rating sheet includes at bottom an 8-step graphic rating scale of “schizoid tendency, your judgment.” This is mainly for research purposes, and permits the rater an expression of his overall assessment as to the patient’s schizoid tendency. By marking (↔) a point on this scale, you have an opportunity to express your clinical appraisal in a semi-quantitative form. The phrase “your judgment” is intended to leave you free in expressing a global judgment of schizoid tendency, based upon your conception of schizophrenia and your preferred set of indicators. In other words, when you get to the graphic rating scale, pay as much or as little attention to the checklist as you normally would rely on these signs in making a clinical assessment of schizoid tendency as you use the concept. If you think of the schizoid component as a matter of degree, reflecting no underlying “category” or “class” construct, the quantitative adjectives anchoring the scale apply (“weak,” “moderate,” “strong”). If—like the author—you view the schizotype as truly a type, so that the concept of class-membership in one of two latent etiologically-defined groups is literally involved, then the relevant anchoring words are those of probability [-of-schizotypy], that is, “absent,” “probably present,” “unmistakable.” This double basis of anchoring is unavoidable if raters of different theoretical opinions are to apply the global rating scale meaningfully.

Appendix

Armchair Weights Used by P. E. Meehl

As Meehl made clear in the “General Remarks” at the beginning of this *Manual*, he recommended clinical use of the Checklist only as a diagnostic reminder for the interviewer (Point 8.c, pp. 4-5). However, in pre-Internet days, when requests for the *Manual* were filled by mail, he always included this handwritten copy of the “armchair” weights he himself used, developed in his own clinical practice. The base rate indicated was his estimate of the base rate of schizotypy in his clinical population, and his cut-score (12/13) was based on the weighted total of the scores (a maximum of 46 possible with these weights). *These weights do not reflect analyses of subsequently collected data.* Thus, users of the Checklist could:

- use it as initially described in this *Manual*, making dichotomous present/absent ratings for each item, and generating an unweighted total sum (25 maximum possible);
- apply Meehl's weights to the dichotomous ratings and add them to get a weighted total score;
- develop their own local weights and cut-score based on an estimate of the local base rate of schizotypy.

H

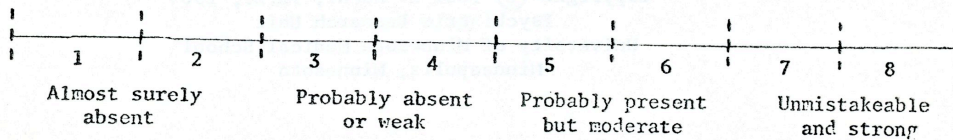
Name ARMCHAIR WEIGHTS Sex _____ No. _____ Date _____
 Rater BY MEEHL Hours Contact _____ Dx _____

Check (X) those symptoms or traits which you are highly confident are present, and in the degree implied by the phrase and its modifiers. Thus, if 'Ambivalence' is present, but is not clearly 'intense,' this sign should not be checked. Scoring, weighting, cutting, and validation are based on such strict rating instructions. Whatever your views about the diagnostic meaning of these signs, please try to set all such thoughts aside, judging each item "by itself" as objectively as possible.

- | | |
|---|---|
| 1 <u>1</u> Ambivalence, intense | 14 <u>2</u> Magical ideation or action |
| 2 <u>3</u> Anhedonia [pleasure-deficit] | 15 <u>6</u> Micropsychotic episodes [include "drift-outs" in interview] |
| 3 <u>3</u> Body-image aberrations | 16 <u>1</u> Narcissism, extreme |
| 4 <u>1</u> Chaotic sexuality | 17 <u>1</u> Pan-anxiety |
| 5 <u>3</u> Cognitive slippage | 18 <u>1</u> Poor outcome [include clearly premature termination] |
| 6 <u>1</u> Countertransference strain on you | 19 <u>1</u> Psychosomatic or neurological signs [see next page] |
| 7 <u>1</u> Deflated self-esteem: Severe + inappropriate + diffuse | 20 <u>2</u> Rage: Intense, phenotypic, verbalized, disproportionate |
| 8 <u>3</u> Dependency, demandingness | 21 <u>2</u> Repetition of material |
| 9 <u>2</u> "Different from others" feeling explicitly stated | 22 <u>1</u> Self-injury (physical, social, professional, sexual) |
| 10 <u>2</u> Distrust, testing operations, closeness-panic | 23 <u>1</u> Social fear [include marked preference to "be alone"] |
| 11 <u>1</u> Failure to achieve, gross [corrected for capacity] | 24 <u>2</u> Special signs [see next page] |
| 12 <u>2</u> Flat or spotty affectivity | 25 <u>2</u> Suicidal [attempt, or dread, or chronic "thoughts"] |
| 13 <u>1</u> Hatred of mother, manifest, expressed | |
| ____ Column 1 sum | ____ Column 2 sum |

$w_c =$ _____

SCHIZOID TENDENCY, YOUR JUDGMENT



Cut at $w_c = 12/13$ for base rate $\approx .40$

Sub-signs under Signs 19 and 24

19. Psychosomatic or neurological signs
- a. Psychosomatic
 - 1. Skin (urticaria, neurodermatitis, eczema, dermatographia, excoriation, acne)
 - 2. Weight-loss due to anorexia
 - 3. Psychosomatic fever
 - 4. Vasomotor dyscontrol
 - b. Conversion symptom
 - c. Neurological signs
24. Special signs
- a. Hopelessness
 - b. Hypochondriasis
 - c. Sensory input compulsion
 - d. Noise oversensitivity
 - e. Touch aversion
 - f. "Night owl" syndrome
 - g. Energy-depletion
 - h. Gullible-suspicious paradox
 - i. Spatial-motoric-kinesthetic defect ("proprioceptive diathesis")
 - j. Humor defect
 - k. "Paranoid headlights"
 - l. Panic when alone
 - m. Sleeping with clothes on; or on couch, chair, floor; or with light on
 - n. Photophobia
 - o. Name or address depersonalization
 - p. Facial asymmetry
 - q. "Inappropriate appearance"

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