MULTILEVEL MEASUREMENT

OF

INTERPERSONAL BEHAVIOR

TIMOTHY LEARY, PH.D.

Multilevel Measurement of Interpersonal Behavior

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A MANUAL FOR THE USE OF THE INTERPERSONAL SYSTEM OF PERSONALITY

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Clinical versus Research Use of the Interpersonal System

There are two major applications of the interpersonal system—in clinical diagnosis (either individual, group, or familial) and in research.

The use of the system differs dramatically depending on whether the goals are clinical or research.

For clinical purposes the eight-digit diagnostic code is of minor importance. The diagnostic formulation should be made from a study of the unilevel profiles supported by inspection of the test protocols. The qualitative aspects of the individual are preserved and combined with the systematic measurements. No eight-digit code can summarize the richness of an individual. The summary points may fall very close to the octant divisions so that a patient diagnosed as masochistic may be bordering on schizoid distrust or bordering on docile dependency. The single diagnostic digit does not reflect these shadings. Other summary points are misleading because they are resolutions of conflicting tendencies. The resultant falls near the center of the grid. The unilevel circles pick up these ambivalences. Do not formulate the clinical picture from the diagnostic code alone.

For research purposes the codes become extremely useful. When samples rather than individuals are being studied the over-simplifications due to measurement artifacts tend to balance out. What is a slightly perceptible tendency in one case (e.g., discrepancy between two moderate scores) becomes a significant difference if many cases pile up in the same direction.

Clinical diagnosis demands the greatest detailed respect paid to the individual case. Research usually looks for trends and the summary codes are a great advantage.

TIMOTHY LEARY

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Part I
The Interpersonal System of Personality

Chapter 1
THE INTERPERSONAL SYSTEM OF PERSONALITY

The Interpersonal System of Personality is a complex combination of methods and measures for assessment of personality. This system is objective, employing reliable ratings of units of behavior which are then manipulated by standardized statistical methods. The system is interpersonal since it selects for analysis those aspects of personality which concern a subject's relationship to others. The system is multilevel in that it studies how a person acts with others, how he describes his actions with others, how he fantasies his actions with others, how he idealizes his actions with others. The system is functional — since it is aimed at predicting interpersonal behavior in specified, crucial situations, particularly in psychotherapy.

This system is used to accomplish the interpersonal diagnosis of personality. The purpose of interpersonal diagnosis is to summarize the patient's behavior reliably and objectively at all measurable levels of personality. The resulting multilevel diagnostic formulation is used to assess his relationship to the therapist, present and future, his motivation for treatment, the flexibility and adaptability of his interpersonal security operations, the amount and kind of conflicts. The most important use of interpersonal diagnosis is in the prediction of the future course of treatment.

A set of sixteen interpersonal variables (*i.e.,* the circular continuum to be described below) is used to categorize behavior at all levels. The use of the same variable system at all levels allows comparison between levels and the definition of objective indices of discrepancy and conflict. Different tests and rating procedures are employed to measure the sixteen interpersonal variables at different levels of personality. This book describes the exact procedures for the administration and scoring of these tests and for converting the scores into interpersonal diagnostic categories. The tests which this book discusses are the Interpersonal Check List, the MMPI and the TAT. The Interpersonal Check List is specifically designed to fit the interpersonal system of variables. The MMPI and TAT are standard psychological tests, the scores of which are converted into interpersonal categories.

The theoretical background of this system of personality, the current research findings, and its clinical application are described in detail in a book, "The Interpersonal Diagnosis of Personality."[1] The use of the interpersonal system and of this manual will be

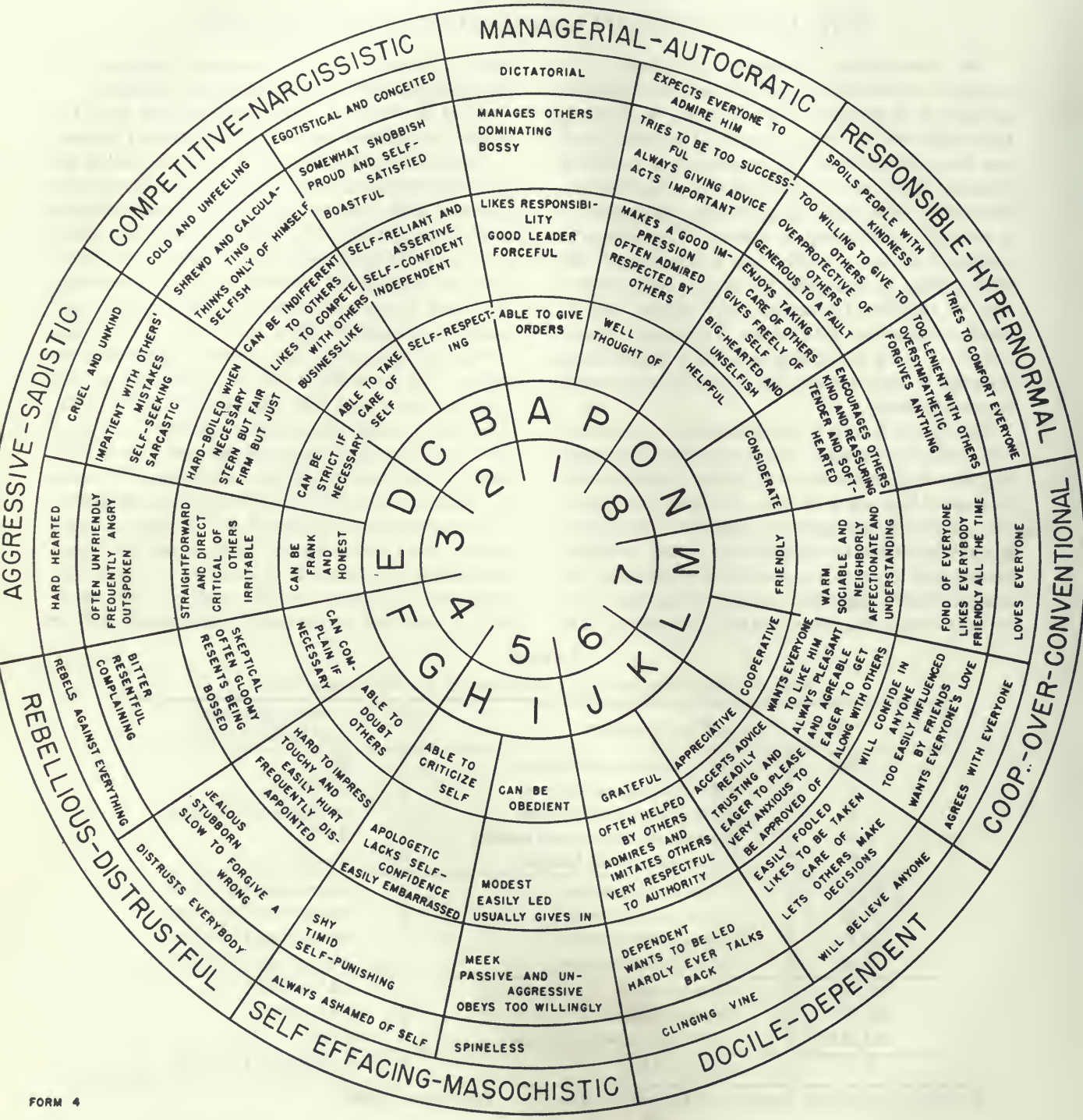
TABLE 1
Four Levels of Behavior and Instruments for Measuring Them

Level and Sublevel		*Testing Instrument or Source of Data*
I S	Public interpersonal behavior	MMPI
I S	Public interpersonal behavior	Sociometric
I R	Public interpersonal behavior	Ratings by psychologists
I P	Future public interpersonal behavior	MMPI
I T	Public interpersonal behavior	Situation test
II S	Private self description	Interpersonal Check List
II M	Subject's view of mother	Interpersonal Check List
II F	Subject's view of father	Interpersonal Check List
II Sp	Subject's view of spouse	Interpersonal Check List
III H	Fantasy Heroes	TAT or IFT
III O	Fantasy "Others"	TAT or IFT
III MM	Underlying character structure	MMPI
V	Conscious Ideal	Interpersonal Check List

[1] T. Leary, *Interpersonal Diagnosis of Personality,* New York: Ronald Press, 1956.

FIGURE 1

INTERPERSONAL CHECK LIST ILLUSTRATING THE CLASSIFICATION OF INTERPERSONAL BEHAVIORS INTO 16 VARIABLE CATEGORIES



FORM 4

greatly facilitated by an acquaintance with this book.

The interpersonal system at the present time studies behavior at four levels. The levels are operationally defined; personality data are assigned to a level automatically according to the source, *i.e.*, the way it is produced by the patient or a rater of the patient. Level I considers how a person presents himself to or is described by others. Level II is comprised of his descriptions of himself and his interpersonal relationships. Level III considers fantasy or "projective" material, and Level V, his ego ideal. Each of these four general levels is divided into sublevels which are defined by the specific test stimulus or mode of expression. Thus, for example, dreams, TAT stories, and waking fantasies each comprise three separate sublevels because they are three different ways of expressing indirect, projective material. The four levels and the empirical methods for measuring them can now be listed (see Table 1).

The interpersonal expressions of the subject at all levels (and on all test instruments) are scored in terms of the same basic list of sixteen variables. These variables are given alphabetical code designations and are listed in a circular continuum. All the varieties of motives which characterize human interaction can, we believe, be described by the circle. Figure 1 presents the sixteen-variable circle and items from the Interpersonal Check List which illustrate the meaning of each variable. An intensity dimension has been built into the circle and the check list. It will be noted that the items increase in intensity in four steps as they move toward the perimeter of the circle.

There are many ways in which scores on the interpersonal variable system can be handled statistically and clerically. The most simple procedure is to count and graph on the circle the number of raw score items falling in each octant (*i.e.*, a section of the circle containing two adjacent variables). Figure 2 presents the Level II self description of a patient measured by the Interpersonal Check List. The number of words in each octant checked as descriptive of self are shaded in the appropriate sector. The radius of the circle is sixteen words. This illustrative subject sees herself as docile-dependent (JK), friendly (LM) and submissive (Hi). She completely denies hostile or competitive feelings.

FIGURE 2

Level II Self-Description of an Illustrative Patient

In addition to this raw score circular profile, it is useful to have a single summary point which reflects the subject's position in relation to the mean of a normative group. The circle is seen as a two-dimensional grid, the center of which is the mean of the normative population. The direction and distance of the summary point from the center thus reflects the kind and intensity of the interpersonal behavior.

There are many formal (algebraic) properties which can be assigned to the sixteen variables or the eight combined octant variables in order to determine a summary point. After considerable experimentation the following procedure was selected. "Each circle was conceived to be a set of eight vectors or points in a two-dimensional space. We selected the center of gravity or vector mean of these points as a measure of central tendency.

"A vector in two-dimensional space may be represented numerically by the magnitude of its components in two arbitrarily selected directions. We chose the vertical and horizontal sectors (AP and LM) as reference directions, giving the designations Dom (Dominance) and Lov (Love) respectively to the components of the vector sum in these two directions. Representation of the eight or sixteen scores comprising a patient's circle by a single point in two-dimensional space is a considerable simplification. What is preserved in this simplification is the general tendency of the circle. What is lost are the individual fluctuations around the circle.

"The present procedure uses octant scores and .7 was taken as the value of sin 45°; the following simplified formulas resulted:

$$\text{Dom} = \text{AP} - \text{Hi} + .7(\text{NO} + \text{BC} - \text{FG} - \text{JK})$$

$$\text{Lov} = \text{LM} - \text{DE} + .7(\text{NO} - \text{BC} - \text{FG} + \text{JK})$$

where AP = score in octant AP, etc."[1]

[1] LaForge, R., Leary, T., Naboisek, H., Coffey, H. The interpersonal dimension of personality: II. An objective study of repression. *J. Pers.*, 1954, *23*, No. 2, 139–140.

It is thus possible to convert the pattern of scores on the sixteen variables into two numerical indices which locate a subject's interpersonal behavior on a diagnostic grid. These indices are converted to standard scores and plotted on a diagnostic circle. Figure 3 presents the descriptive summary point for the patient whose behavior has been previously diagrammed in Figure 2. We note that the two summary indices (standardized) place her in the "JK" octant; they thus become a simplified and numerical summary of the circular diagram. The vertical and horizontal lines represent varying discrepancies from the mean (the center point of the circle). We obtain in this manner a circular grid, every point on which is statistically defined. We determine the summary point of the patient's interpersonal behavior as rated by the 16 variables in relationship to the population studied—which in this case was 800 randomly selected psychiatric clinic admission patients. Our subject (labeled "S" in Figure 3) is seen as considerably more docile and dependent than the average clinic patient.

The great advantage of the latter circular grid method of summarization is that many summary points can be graphed on the same diagram, facilitating comparison among levels of any individual's personality or comparisons among different individuals. In this illustration the patient claims to be friendly and docile while her private fantasies stress sadism (TAT Hero labeled "H" in Figure 3). This system of single summary points provides a way of measuring (objectively) the differences between levels of personality. The linear distance between the summary points for Level II and Level III indicates the kind and amount of private feelings which are denied conscious self description.

These interlevel discrepancies are called interpersonal or interlevel *Variability Indices*. They are, in some respects, operational redefinitions of certain Freudian "defense mechanisms," since they systematically and objectively indicate the conflicts among different levels. We have tended to see these interlevel relationships as indices which reflect the structure of

FIGURE 3

Multilevel Diagnostic Summary Points for an Illustrative Patient

personality organization. They indicate the kind and amount of interlevel conflict. They have important clinical predictive meanings.

Multilevel Interpersonal Diagnosis

The procedure for interpersonal diagnosis can now be summarized, as follows. The raw score data are scored in terms of the 16 variables. The sums for each octant are fed into the formulae. The resulting indices are converted into standard scores and plotted on a diagnostic grid. The octant in which the summary score for each level falls is the diagnosis for that level. The interpersonal diagnostic system allows for the diagnosis of adjustive (or moderate) interpersonal behavior as well as maladaptive (or extreme) behavior. There are, therefore, 16 categories for diagnosis at each level (one moderate and one extreme category for each octant). These are given numerical (instead of double-lettered) designations so that a multilevel diagnostic code can be given to the subject. Table 2 lists the 16 categories for interpersonal diagnosis and the corresponding code numbers.

An interpersonal diagnosis is calculated for each level and for each test administered to the subject. The diagnoses are usually listed in the form of a numerical formula. The eight diagnostic codes are listed in the following order: Level I Self; Level II Self; Level III Hero; Level III "Other"; Level II Mother, Father and Spouse, and Level V Ideal.

This eight-digit diagnostic code gives a shorthand summary of the patient's interpersonal repertoire. There are 16 possibilities for each digit of the diagnostic code (8 adaptive and 8 maladaptive diagnoses at each level). Therefore a staggering number of 8 digit types exists (16^8). The chance expectation of any two patients having the same eight-digit diagnostic formula is, thus, very slim. For many clinical and research purposes it is convenient to work with a three-level or three-digit diagnostic code—focusing on Level I Self, Level II Self and III Hero. This provides (if the intensity or maladjustment factor is disregarded) a typology of 512 categories ($8 \times 8 \times 8$). A patient with the triple level diagnosis **111** is solidly power-oriented and managerial. A patient with the code **115** has a two-layer facade of strength with underlying passivity. The code **553** designates a masochist with underlying feelings of sadism.

It is important to note that this complex diagnostic system is so designed that it requires no professional time or energy. The tests are administered, scored, converted into standard score indices, and plotted by highly trained intelligent technicians who need possess no psychological knowledge to produce a multilevel diagnosis of high reliability. The professional clinician is, of course, required to interpret and apply the meaning of the eight-digit code, but he need never see the patient nor the test forms. The machinery for diagnosis is designed by the professional psychologist; he

TABLE 2

The Categories Employed for Interpersonal Diagnosis of Adaptive and Maladaptive Behavior at All Levels

Numerical Diagnostic Code (Black)	*Adaptive Interpersonal Diagnostic Categories*	*Letter Code*	*Maladaptive Interpersonal Diagnostic Categories*	*Numerical Diagnostic Code (Red)*
1	Managerial	AP	Autocratic	**1**
2	Competitive	BC	Narcissistic	**2**
3	Critical	DE	Sadistic	**3**
4	Skeptical	FG	Distrustful	**4**
5	Self-effacing	HI	Masochistic	**5**
6	Docile	JK	Dependent	**6**
7	Conventional	LM	Over-conventional	**7**
8	Responsible	NO	Hypernormal	**8**

Key: The intense diagnostic categories are designated on work sheets and clinic records by red numerals and in printed publications by roman-face digits. The moderate diagnostic categories are designated by black numerals and/or italic numerals.

interprets the end product; but the routine summary of the diagnostic machinery is in the hands of the technical staff.

Variability Diagnosis

The essential and basic aspect of the interpersonal system is the multilevel conception which holds that personality is a relatively stable organization of different, conflicted interpersonal motives. The measurement of the interpersonal dimension has been discussed and the procedures for interpersonal diagnosis have been outlined. We shall now consider the measurement of the variability dimension. We have found it convenient to distinguish between three kinds of variability:

a. Structural (inconsistencies between conscious self description, behavioral expression, and symbolic expression)
b. Temporal (inconsistencies in the same level of behavior over a time span)
c. Situational (differences in behavior in response to different social or environmental factors).

The multilevel structure of our model is geared to measure some of this variability. The eight-digit diagnostic code is a crude attempt to pay some respect to the complexity of human nature. Thus, instead of a single diagnostic term, the system provides an eight-part formulation.

Once we have funneled the diffuse fluidity of human behavior into eight clusters, the next step is to consider the relationship among these levels and measures. The organization of personality is defined (in this system) by indices which express the kind and amount of variability or conflict among the levels and areas of personality. These interlevel relationships we call variability indices — objective, numerical indices which reflect the discrepancy or concordance among the establishments of personality.

There are three general classes of structural variability indices: 1. those reflecting conflict between levels of self behavior; 2. those reflecting the similarity or differences between self and others (at the same and at different levels); and 3. those reflecting the differences between the ego ideal and either self or others. These might be called indices of conflict, indices of identification (conscious or preconscious) and indices of idealization (conscious or preconscious).

The indices of conflict include repression (Level II Self vs. Level III Hero), misperception (Level I Self vs. II Self). The indices of identification include conscious identification with mother (II Self vs. II Mother), preconscious identification with mother (Level II Mother vs. Level III Hero). Similar identification patterns can be defined for Father, Spouse, Therapist. Similarity between conscious descriptions of others (*e.g.,* Father vs. Mother) are labeled Equation. The indices of Idealization include self acceptance (Level II Self vs. Level V Ideal) and Idealization (*e.g.,* Level II Mother vs. Level V Ideal).

At the present time over 32 of these variability indices are defined; 19 of them have been validated. Most of these indices of conflict have important theoretical and clinical correlates. Consider, for example, the index of repression. This is defined as the difference between conscious self diagnosis and Level III fantasies. Different psychoneurotic groups show significantly different indices of repression. Ulcer patients repress passivity, hypertensive patients resentment and anger.[1] There are many clinical correlates of the index of repression. The kind and amount of repressed themes indicate, for example, the kind and amount of change to be expected in psychotherapy.

These indices of variability can be measured in several ways — by inspection-rating of interpersonal profiles, by measuring the linear distance between summary points, or by mathematical manipulation of the eight-digit summary diagnostic code. The latter method is now routinely employed and will be described in this manual.

Application of the Interpersonal System of Personality

The interpersonal system has four major applications. It can be useful in

1. Multilevel clinical diagnosis of the individual
2. Analysis of group dynamics
3. Family diagnosis (child guidance or marriage evaluation)
4. Research

In the subsequent sections of this manual, a typical case of each of these four applications will be presented in detail.

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[1] T. Leary, *Interpersonal Diagnosis of Personality,* New York: Ronald Press, 1956.

Part II
Multilevel Clinical Diagnosis of the Individual

INTRODUCTION TO PART II

A major goal of functional diagnosis is to summarize, before treatment, the aspects of the personality which have a bearing on the choice of treatment. What is the motivation of the patient in coming to the clinic? Does he come with self depreciation, ready to unburden his innermost thoughts and expecting some kind of mystical cure to follow his confidences? Disappointment and bitter reproach may be the easily predicted outcome if this motivation is not perceived and planned for. Does he come under pressure from someone else (*e.g.,* a physician), defensively mobilized against any self examination? A stubborn power struggle and angry departure may be predicted if this motivation is not recognized and responded to.

Clinical diagnosis concerns "ego" factors which influence the choice of treatment. How much anxiety is manifested? What are the security operations by which the patient handles anxiety? What is the interpersonal pressure put on the clinic by the patient?

The first aim of functional diagnosis is, then, to assess motivation for treatment. The second aim is prognosis of treatment—to summarize the kind of behavior which will appear in future therapy. How fast or slow will be the course of therapy? Many patients who are well motivated for change (thus satisfying the first criterion of functional diagnosis) also manifest chronic, deeply rooted security operations which are the most resistant to change, or underlying distrust which had perhaps best be left unexplored.

Another aspect of prognosis concerns the nature of the intrapsychic conflicts. In many cases it is possible to point to private or preconscious motives which will probably affect the later treatment relationship. Differences in the transference relationship and prognosis can be expected depending on whether the underlying themes involve distrustful, passive resistance, independent autonomy, or nurturant tenderness.

In making our prediction about the first (or motivational) aspect of functional diagnosis we are mainly interested in what might be called "ego" factors. In making the second prediction, we concentrate on the deeper, preconscious aspects of personality and their relationship to the more overt or public factors. We use the total interpersonal profile to map out areas of anxiety, the security operations by which it is handled, and the transference phenomenon which these interpersonal operations will tend to elicit during psychotherapy.

The test forms employed for multilevel interpersonal diagnosis are the MMPI, the Interpersonal Check List, the TAT and the diagnostic booklet. The use of each of these will now be illustrated. The descriptions will be followed by a diagnostic report demonstrating the clinical use of the system.

Chapter 2

INTERPERSONAL DIAGNOSIS OF LEVEL I BEHAVIOR

Level I behavior defines the overt or public impact of the patient upon others. The particular Level I picture manifested by a patient depends upon the environmental context and the specific "other" with whom he is interacting. A list of five methods for measuring Level I behavior was presented in Table 1. For clinical diagnosis we currently employ the Level I S measure. This is based on responses to the MMPI. The MMPI taps (among other things) the symptomatic aspects of the patient's facade. This test can be seen as a complex language by means of which the patient puts symptomatic pressure on the clinician. We shall now describe and illustrate interpersonal diagnosis at Level I S. Diagnosis employing the other Level I measures will be discussed in subsequent sections of this manual.

Administration

The MMPI is administered and scored in the standard manner,[1] and the "T" (standard) score for each scale is computed. The omission of more than 30 items renders the test invalid.

Computation of Horizontal and Vertical Indices

Use the "T" scores in the following arithmetical formulae and derive the vertical (dominance-submission) and horizontal (love-hostility) indices.

$$\text{Dom} = (\text{MA} - \text{D}) + (\text{Hs} - \text{Pt})$$

$$\text{Lov} = (\text{K} - \text{F}) + (\text{Hy} - \text{Sc})$$

The resulting figures are called the MMPI "raw score" indices. These indices should be written on the MMPI profile sheet. They will later be picked up and entered in the diagnostic booklet.

Illustration of the Computation of Level I S Diagnostic Indices

Figure 4 presents the MMPI profile of the sample case whose multilevel diagnosis is being derived. The formulae for converting MMPI scales to interpersonal indices are written in on the right. The "raw score" indices Dom = –52, and Lov = –10 are entered on the MMPI profile sheet, awaiting conversion to the booklet.

Reliability of Level I S Ratings

The derivation of each Level I index is based on the pooled weights of four MMPI scales. The process of translating the MMPI to interpersonal language is a straight arithmetical and clerical task. No ratings or judgments are involved. For this reason we have not attempted to determine reliability of the Level I S indices.

Validity of Level I S Diagnosis

The relationship of the Level I S diagnosis to other clinical variables has been discussed in several other research publications.[2] Examples of these studies will be found below in the research section of this manual.

---

[1] S. R. Hathaway and J. C. McKinley, *The Minnesota Multiphasic Personality Inventory.* Manual for Administration and scoring. (Rev.) New York: The Psychological Corp., 1951.

[2] T. Leary, *Interpersonal Diagnosis of Personality.* New York: Ronald Press, 1956.

T. Leary and H. S. Coffey, The prediction of interpersonal behavior in group psychotherapy. *Psychodr. & Grp. Psychother. Mono.* 1955, *28,* 3–47.

T. Leary and Joan S. Harvey, A methodology for measuring personality changes in psychotherapy. *J. Clin. Psychol.* 1956, *12,* No. 3, 123–132.

FIGURE 4

The Minnesota Multiphasic Personality Inventory

Starke R. Hathaway and J. Charnley McKinley

F
Female

Name _____

Address _____

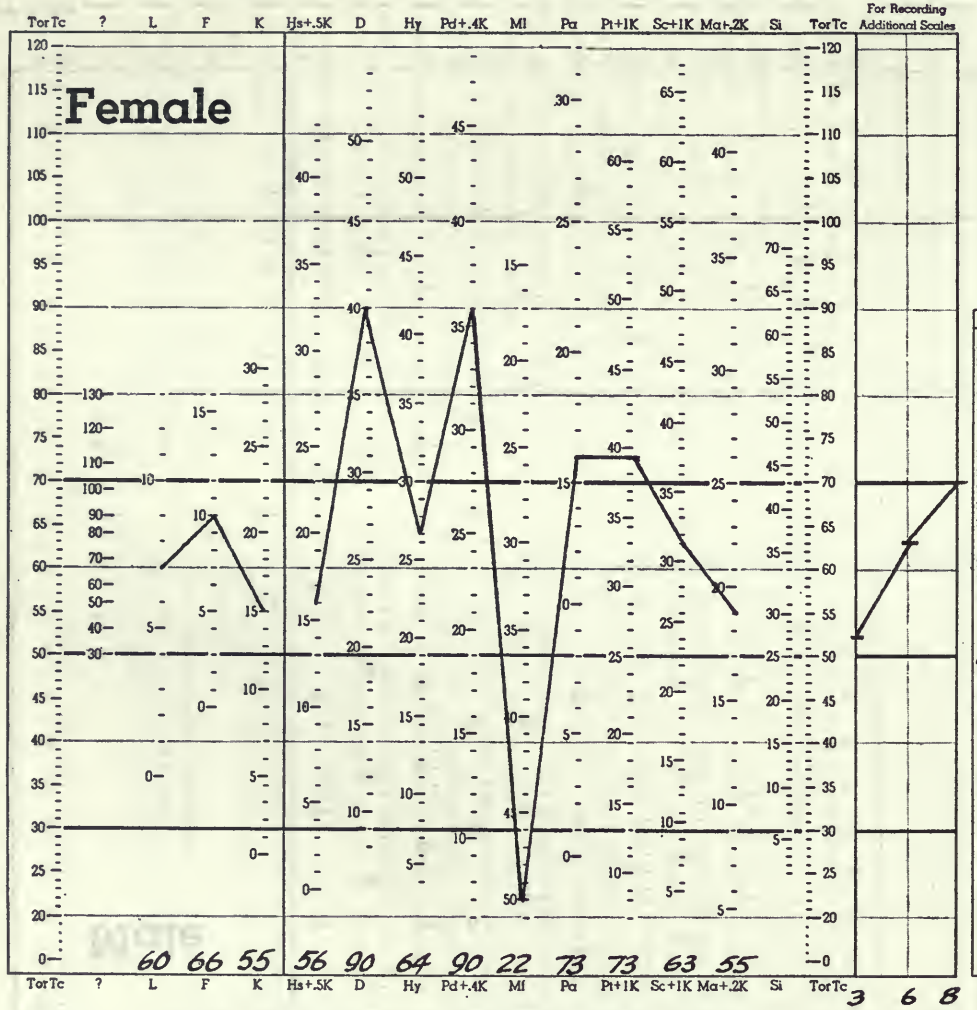
Occupation _____ Date Tested _____

Education _____ Age _____

Marital Status _____ Referred by _____

NOTES

Scorer's Initials _____



	TorTc	?	L	F	K	Hs+.5K	D	Hy	Pd+.4K	Mf	Pa	Pt+1K	Sc+1K	Ma+.2K	Si	TorTc	3	6	8
Raw Score		7	10	15	8	40	27	30	50	16	24	16	16						
K to be added					8			6			15	15	3						
Raw Score with K					16			36			39	31	19						

K	.5	.4	.3
30	15	12	6
29	15	12	6
28	14	11	6
27	14	11	5
26	13	10	5
25	13	10	5
24	12	10	5
23	12	9	5
22	11	9	4
21	11	8	4
20	10	8	4
19	10	8	4
18	9	7	4
17	9	7	3
16	8	6	3
15	8	6	3
14	7	6	3
13	7	5	3
12	6	5	2
11	6	4	2
10	5	4	2
9	5	4	2
8	4	3	2
7	4	3	1
6	3	2	1
5	3	2	1
4	2	2	1
3	2	2	1
2	1	1	0
1	1	1	0
0	0	0	0

DOM = Ma - D = 55-90 = -35

Hs - Pt = 56-73 = -17

TOTAL = -52

LOV = K - F = 55-66 = -11

Hy - Sc = 64-63 = +1

TOTAL = -10

RAW SCORE INDICES FOR LEVEL I:

DOM = -52

LOV = -10

PgB - 40

HyD - 11

The Minnesota Multiphasic Personality Inventory

Starke R. Hathaway and J. Charnley McKinley

M
Male

Name _____

Address _____

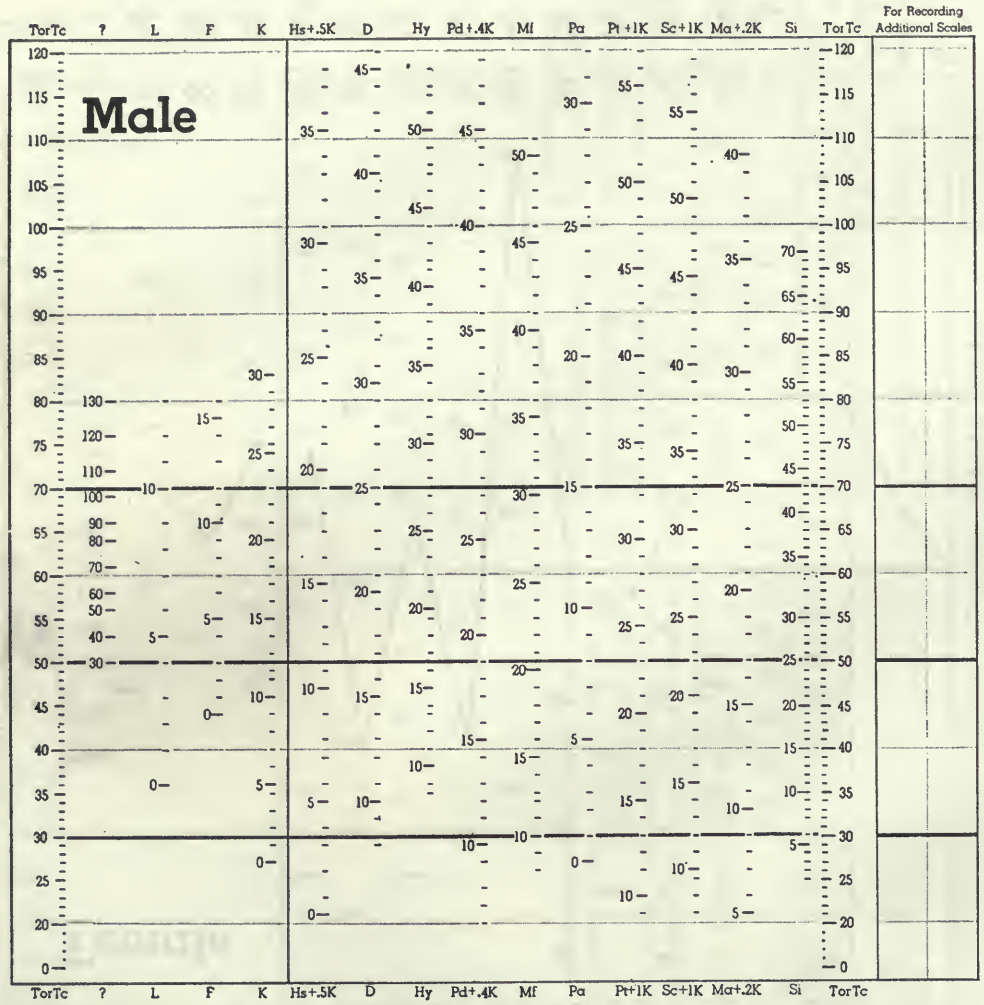
Occupation _____ Date Tested _____

Education _____ Age _____

Marital Status _____ Referred by _____

NOTES

Scorer's Initials _____



Raw Score																
K to be added																
Raw Score with K																

Fractions of K			
K	.5	.4	.2
30	15	12	6
29	15	12	6
28	14	11	6
27	14	11	5
26	13	10	5
25	13	10	5
24	12	10	5
23	12	9	5
22	11	9	4
21	11	8	4
20	10	8	4
19	10	8	4
18	9	7	4
17	9	7	3
16	8	6	3
15	8	6	3
14	7	6	3
13	7	5	3
12	6	5	2
11	6	4	2
10	5	4	2
9	5	4	2
8	4	3	2
7	4	3	1
6	3	2	1
5	3	2	1
4	2	2	1
3	2	2	1
2	1	1	0
1	1	1	0
0	0	0	0

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Signature _____ D _____

Chapter 3

INTERPERSONAL DIAGNOSIS OF LEVEL II AND LEVEL V BEHAVIOR

Level II behavior refers to the patient's conscious descriptions of self and specified others. There are several ways of collecting Level II data—interviews, autobiographies, etc. The method employed for routine diagnosis is the Interpersonal Check List. The construction and statistical properties of this instrument have been described elsewhere.[1] It comprises 128 items—eight for each of the sixteen interpersonal variables.

The check list is presented in Figure 5. It will be noted that the alphabetical variable designations assigned to each item are listed on the extreme left and the extreme right of the four columns of items. An intensity dimension is built into the check list. The items in the left column are the most moderate aspects of the interpersonal trait and the items in each of the rows increase in intensity as they move toward the right. "Well thought of" (on the extreme left) is a moderate item for the variable "P" (prestige). "Tries to be too successful" (on the far right) is an intense or maladaptive "P" item.

The first page of the check list provides space for the identifying data and gives the instructions for the test. On the inside pages the subject checks in his answers and the scorer performs his calculations.

Administration of the Interpersonal Check List

The test administrator asks the subject to describe himself and members of his family or group. The subject always describes himself in column 1. He should write his name in the space at the top of the inside page. The names of the additional people he is to describe will be written in the appropriate spaces in the order in which he will describe them. For example, for clinical diagnostic purposes where the subject is describing himself and family members, he will describe himself in column 1, his mother in column 2, his father in column 3, spouse in column 4, and ideal in column 5.

Occasionally the subject will be in doubt as to whether to describe his parents or parent-substitutes as they are now or as he remembers them when he was growing up. In view of changes due to illness, old age, etc., it is best to have the subject describe them as he remembers them while he was growing up. As for the subject himself, he should describe himself as of the time of test taking.

The test should be gone through separately for each person described, *i.e.*, column by column, rather than applying the same word or phrase to more than one person at a time. If one word or phrase applies in general, it should be marked, if the patient cannot make up his mind, it should be left blank.

In describing the Ideal the subject should pick out the descriptive words or phrases that go together to make up what he considers to be an ideal person. He should not select an admired family member or friend, but think of a generalized ideal.

In the case of the subject who is not married, column 4, ordinarily assigned to spouse, should be used for describing his "ideal-of-spouse." In much the same way as describing Ideal, he should select the words and phrases that would go together to make up, for him, the ideal mate.

The subject should be instructed to work quickly and not concern himself about contradictions or duplications. If, after starting, he has further questions, he can refer to the directions on the front of the booklet.

Scoring of the Interpersonal Check List

There are two methods for scoring the Interpersonal Check List. The first involves the use of a plastic template,[2] the second is by inspection.

The Inspection Method

For an individual's self description, there are 16 possible AP items which the subject could have marked for himself. In the sample booklet following, a line has been drawn below the AP items (the first four rows all across the page) to simplify the explanation. For individual #1, rating himself, count the items marked under the small numeral "1" in this area (three such items are marked in this example) and write the sum in the box at the right under "Col. 1" and above the letters AP. For this individual's ratings of his mother (Col. 2) count the items checked in the P, P, A, A row under the numeral "2" and write the sum under "Col. 2" and above the letters AP (in this instance, 6). In like manner total the B, B, C, C items checked for each person rated and write the sum in the appropriate columns above the letters BC. Repeat for DDEE, FFGG, HHII, LLMM and NNOO.

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[1] R. LaForge and R. Suczek. The interpersonal dimension of personality: III. An interpersonal check list. *J. Pers.*, 1955, *24*, No. 1, 94–112.

[2] This template which simplifies scoring of the check list can be ordered for $3.00 from the Psychological Consultation Service, 1230 Queens Rd., Berkeley.

FIGURE 5

The Interpersonal Check List

Name_____ Age___ Sex_____ Date_____ Testing #_____

Address_____ City_____ Phone_____ Education_____

Occupation_____ Marital Status_____ Referred by_____

Group_____ Other_____

DIRECTIONS: This booklet contains a list of descriptive words and phrases which you will use in describing yourself and members of your family or members of your group. The test administrator will indicate which persons you are to describe. Write their names in the spaces prepared at the top of the inside pages. In front of each item are columns of answer spaces. The first column is for yourself, and there is another column for each of the persons you will describe.

Read the items quickly and fill in the first circle in front of each item you consider to be generally descriptive of yourself at the present time. Leave the answer space blank when an item does not describe you. In the example below, the subject (Column 1) has indicated that Item A is true and and item B is false as applied to him.

Item

	1	2	3	4	5	6	7	8	
A	●	○	○	○	○	○	○	○	**well-behaved**
B	○	○	○	○	○	○	○	○	**suspicious**

After you have gone through the list marking those items which apply to you, return to the beginning and consider the next person you have been asked to describe, marking the second column of answer spaces for every item you consider to be descriptive of him (or her). Proceed in the same way to describe the other persons indicated by the test administrator. Always complete your description of one person before starting the next.

Your first impression is generally the best so work quickly and don't be concerned about duplications, contradictions, or being exact. If you feel much doubt whether an item applies, leave it blank.

This booklet has been prepared by Timothy Leary, Ph.D., and published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, California. The Interpersonal Check List was developed by Rolfe LaForge, Ph.D., and Robert Suczek, Ph.D., and other staff members of the Kaiser Foundation Research Project in Psychology.

Column 1 _____ SUBJECT'S NAME

Col. 2 Mother Col. 4 Spouse Col.

Col. 3 Father Col. 5 Ideal Col.

SAMPLE:

	1	2	3	4	5	6	7	8	
A	●	○	●	○	●	●	○	○	well-behaved

	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	
P	●	●	○	●	●	○	○	○	1 well thought of	○	○	○	○	●	○	○	○	33 often admired	○	○	○	●	○	○	○	○	65 always									
P	○	●	○	○	●	○	○	○	2 makes a good impression	○	●	○	○	●	○	○	○	34 respected by others	○	○	●	○	○	○	○	○	66 acts i									
A	○	●	○	●	●	○	○	○	3 able to give orders	○	○	○	○	●	○	○	○	35 good leader	○	○	●	●	○	○	○	○	67 bossy									
A	○	○	●	○	●	○	○	○	4 forceful	○	●	○	○	●	○	○	○	36 likes responsibility	○	○	●	●	○	○	○	○	68 domin									
B	●	●	○	●	○	○	○	○	5 self-respecting	○	●	○	○	●	○	○	○	37 self-confident	○	○	○	○	○	○	○	○	69 boastf									
B	○	●	○	○	○	○	○	○	6 independent	○	●	○	○	●	○	○	○	38 self-reliant and assertive	○	○	○	○	○	○	○	○	70 proud									
C	●	●	○	●	●	○	○	○	7 able to take care of self	○	●	○	○	●	○	○	○	39 businesslike	○	○	○	●	○	○	○	○	71 thinks									
C	○	●	○	●	○	○	○	○	8 can be indifferent to others	○	●	●	○	○	○	○	○	40 likes to compete with others	○	○	●	○	○	○	○	○	72 shrew									
D	○	●	○	●	●	○	○	○	9 can be strict if necessary	○	●	●	●	○	○	○	○	41 hard-boiled when necessary	○	○	○	○	○	○	○	○	73 impati									
D	○	●	○	○	●	○	○	○	10 firm but just	○	●	○	○	○	○	○	○	42 stern but fair	○	○	○	●	○	○	○	○	74 self-s									
E	●	●	○	●	●	○	○	○	11 can be frank and honest	○	○	●	●	●	○	○	○	43 irritable	○	○	●	●	○	○	○	○	75 outspo									
E	○	○	○	●	●	○	○	○	12 critical of others	○	●	○	○	●	○	○	○	44 straightforward and direct	○	○	●	○	○	○	○	○	76 often									
F	●	●	○	●	●	○	○	○	13 can complain if necessary	○	○	○	●	●	○	○	○	45 resents being bossed	○	○	●	●	○	○	○	○	77 bitter									
F	●	○	●	●	●	○	○	○	14 often gloomy	○	●	●	●	○	○	○	○	46 skeptical	○	○	●	●	○	○	○	○	78 compl									
G	●	●	○	●	●	○	○	○	15 able to doubt others	○	●	○	○	○	○	○	○	47 hard to impress	○	○	●	○	○	○	○	○	79 jealou									
G	●	○	●	●	●	○	○	○	16 frequently disappointed	○	○	●	●	●	○	○	○	48 touchy and easily hurt	○	●	○	○	○	○	○	○	80 slow t									
H	○	●	○	○	●	○	○	○	17 able to criticize self	●	○	○	○	○	○	○	○	49 easily embarrassed	○	○	○	○	○	○	○	○	81 self-p									
H	●	●	○	○	○	○	○	○	18 apologetic	●	○	○	●	○	○	○	○	50 lacks self-confidence	●	○	○	○	○	○	○	○	82 shy									
I	●	●	○	●	●	○	○	○	19 can be obedient	●	○	●	○	○	○	○	○	51 easily led	●	○	●	●	○	○	○	○	83 passiv									
I	●	●	○	○	○	○	○	○	20 usually gives in	●	●	○	○	○	○	○	○	52 modest	○	○	○	○	○	○	○	○	84 meek									
J	●	●	○	○	●	○	○	○	21 grateful	●	●	○	●	○	○	○	○	53 often helped by others	●	○	○	○	○	○	○	○	85 depen									
J	●	○	●	○	○	○	○	○	22 admires and imitates others	●	●	○	●	○	○	○	○	54 very respectful to authority	○	○	●	○	○	○	○	○	86 wants									
K	●	●	○	○	●	○	○	○	23 appreciative	●	●	○	○	○	○	○	○	55 accepts advice readily	●	○	○	○	○	○	○	○	87 lets o									
K	●	●	○	●	○	○	○	○	24 very anxious to be approved of	●	●	○	○	○	○	○	○	56 trusting and eager to please	○	○	○	○	○	○	○	○	88 easily									
L	●	●	○	○	○	○	○	○	25 cooperative	○	○	○	○	○	○	○	○	57 always pleasant and agreeable	●	○	○	○	○	○	○	○	89 too ea									
L	●	●	○	●	●	○	○	○	26 eager to get along with others	●	●	○	●	○	○	○	○	58 wants everyone to like him	○	○	○	○	○	○	○	○	90 will c									
M	●	●	○	●	●	○	○	○	27 friendly	●	●	○	●	●	○	○	○	59 sociable and neighborly	●	○	○	○	○	○	○	○	91 fond o									
M	○	●	○	○	●	○	○	○	28 affectionate and understanding	●	●	○	○	●	○	○	○	60 warm	●	●	○	○	○	○	○	○	92 likes									
N	●	●	○	○	●	○	○	○	29 considerate	●	●	○	○	●	○	○	○	61 kind and reassuring	○	○	○	○	●	○	○	○	93 forgive									
N	○	●	○	○	●	○	○	○	30 encourages others	●	●	○	○	○	○	○	○	62 tender and soft-hearted	○	○	○	○	○	○	○	○	94 oversy									
O	●	●	○	○	●	○	○	○	31 helpful	●	○	○	○	●	○	○	○	63 enjoys taking care of others	○	●	○	○	○	○	○	○	95 genero									
O	●	●	○	○	●	○	○	○	32 big-hearted and unselfish	○	●	○	○	●	○	○	○	64 gives freely of self	●	○	○	○	○	○	○	○	96 overpr									

Col. 8 _____

Date _____

			Col. 1 Self	Col. 2 Mo.	Col. 3 Fa	Col. 4 Sp	Col. 5 ID	Col. 6	Col. 7	Col. 8
			Initials	Initials	Initials	Initials	Initials	Initials	Initials	Initials
1 2 3 4 5 6 7 8 ● ● ○ ○ ○ ○ ○ ○	97 tries to be too successful	P	3	6	6	6	9			
1 2 3 4 5 6 7 8 ● ○ ● ○ ○ ○ ○ ○	98 expects everyone to admire him	P	AP	AP	AP	AP	AP	AP	AP	AP
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ● ○ ○ ○	99 manages others	A	2	8	5	5	4			
1 2 3 4 5 6 7 8 ○ ○ ● ● ○ ○ ○ ○	100 dictatorial	A	BC	BC	BC	BC	BC	BC	BC	BC
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	101 somewhat snobbish	B	3	6	8	8	6			
1 2 3 4 5 6 7 8 ○ ○ ● ○ ○ ○ ○ ○	102 egotistical and conceited	B	DE	DE	DE	DE	DE	DE	DE	DE
1 2 3 4 5 6 7 8 ○ ○ ● ● ○ ○ ○ ○	103 selfish	C	6	6	9	9	6			
1 2 3 4 5 6 7 8 ○ ○ ● ○ ○ ○ ○ ○	104 cold and unfeeling	C	FG	FG	FG	FG	FG	FG	FG	FG
akes 1 2 3 4 5 6 7 8 ● ○ ● ○ ○ ○ ○ ○	105 sarcastic	D	10	5	3	4	2			
1 2 3 4 5 6 7 8 ○ ○ ● ○ ○ ○ ○ ○	106 cruel and unkind	D	HI	HI	HI	HI	HI	HI	HI	HI
1 2 3 4 5 6 7 8 ● ○ ● ● ○ ○ ○ ○	107 frequently angry	E	11	8	3	4	2			
1 2 3 4 5 6 7 8 ○ ○ ● ○ ○ ○ ○ ○	108 hard-hearted	E	JK	JK	JK	JK	JK	JK	JK	JK
1 2 3 4 5 6 7 8 ● ○ ● ○ ○ ○ ○ ○	109 resentful	F	10	8	0	4	6			
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	110 rebels against everything	F	LM	LM	LM	LM	LM	LM	LM	LM
1 2 3 4 5 6 7 8 ● ● ○ ○ ○ ○ ○ ○	111 stubborn	G	7	10	0	0	8			
1 2 3 4 5 6 7 8 ○ ○ ● ○ ○ ○ ○ ○	112 distrusts everybody	G	NO	NO	NO	NO	NO	NO	NO	NO
1 2 3 4 5 6 7 8 ● ○ ○ ○ ○ ○ ○ ○	113 timid	H	D 9.3	18.6	9.5	9.5	17.4			
1 2 3 4 5 6 7 8 ○ ○ ● ○ ○ ○ ○ ○	114 always ashamed of self	H	S 21.9	14.8	11.4	13.1	7.6			
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	115 obeys too willingly	I	L 22.6	20.6	2.1	6.8	13.0			
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	116 spineless	I	H 8.6	15.8	17.8	17.8	13.0			
1 2 3 4 5 6 7 8 ● ● ○ ○ ○ ○ ○ ○	117 hardly ever talks back	J								
1 2 3 4 5 6 7 8 ○ ○ ● ○ ○ ○ ○ ○	118 clinging vine	J	DOM	DOM	DOM	DOM	DOM	DOM	DOM	DOM
ns 1 2 3 4 5 6 7 8 ○ ○ ○ ● ○ ○ ○ ○	119 likes to be taken care of	K								
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	120 will believe anyone	K	LOV	LOV	LOV	LOV	LOV	LOV	LOV	LOV
friends 1 2 3 4 5 6 7 8 ● ○ ○ ○ ○ ○ ○ ○	121 wants everyone's love	L	-12.6	+3.8	-1.9	-3.6	+9.8			
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	122 agrees with everyone	L	+14.0	+4.8	-15.7	-11.0	0.0			
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	123 friendly all the time	M								
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	124 loves everyone	M								
1 2 3 4 5 6 7 8 ○ ● ○ ○ ○ ○ ○ ○	125 too lenient with others	N								
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	126 tries to comfort everyone	N								
1 2 3 4 5 6 7 8 ○ ● ○ ○ ○ ○ ○ ○	127 too willing to give to others	O								
1 2 3 4 5 6 7 8 ○ ○ ○ ○ ○ ○ ○ ○	128 spoils people with kindness	O								

Template Scoring of the Interpersonal Check List

Align the template with the bottom of the answer sheet so that all column 1 items (*i.e.,* the patient's self checks) are visible. The template is divided horizontally into eight parts; sixteen small circles should now be visible in each part. Add up all the blackened circles in the topmost (PPAA) row of the template. Place the sum in column 1 on the right-hand side of the page, in the box above the letters "AP." Then add all blackened items in the second horizontal eighth of the template, and place the sum in the box above the letters "BC." In like manner, find the sum for each row of column 1. Identify the individual rated (the patient's self description is coded "S") at the top of the column of figures.

Now move the template to the right so that all items which the patient has marked in vertical column 2 are visible. Repeat the counting process for column 2 and then for each succeeding column.

Computation of Vertical and Horizontal Indices

Solve the following equations for column 1, *i.e.,* the "S" or self column, substituting the number which appears *above* each pair of letters in column 1:

$$\text{Dom} = 0.7(\text{BC} + \text{NO} - \text{FG} - \text{JK}) + \text{AP} - \text{Hi}$$
$$\text{Lov} = 0.7(\text{JK} + \text{NO} - \text{BC} - \text{FG}) + \text{LM} - \text{DE}$$

Space is provided on the booklet to break down each formula into two parts, thus simplifying the calculation. The following equations are an alternative method:

$$\text{D (dominance)} = 0.7(\text{BC} + \text{NO}) + \text{AP}$$
$$\text{S (submission)} = 0.7(\text{FG} + \text{JK}) + \text{Hi}$$
$$\text{L (love)} = 0.7(\text{JK} + \text{NO}) + \text{LM}$$
$$\text{H (hostility)} = 0.7(\text{BC} + \text{FG}) + \text{DE}$$

$$\text{Dom} = \text{D} - \text{S}$$
$$\text{Lov} = \text{L} - \text{H}$$

Write the solutions above the designations "Dom" and "Lov," respectively, in the boxes at the foot of column 1. Repeat for each remaining column.

The Dom and Lov figures entered at the bottom of the check list for each person rated are called the "raw score" indices. They will later be picked up and entered in the diagnostic booklet.

Illustration of the Computation of Level II S and Level V (Ideal) Indices

Figure 5 presents the actual check list form filled out by the illustrative patient. In the column on the right, the scorer has entered the octant totals for each person rated. The "raw score" indices have been calculated according to the formulae and entered at the bottom of each column. For example, the raw score indices for Level II Self are −12.6 and +14.0. The indices for Level V Ideal are located in the fifth column and will later be picked up and entered in the appropriate slot in the diagnostic booklet.

Reliability of Level II Indices

"Test-retest reliability correlations are available on 77 of the obesity sample who were retested after an interval of two weeks. Because this sample is a somewhat homogeneous all-female group, these correlations are not likely to be larger than ones obtainable with other groups. On the other hand, obese women may have more stable self-pictures than many individuals. The sort of unreliability which results from changes in one's view of self is not of course undesirable in a test designed to depict view of self. Therefore the correlations in *(Table 3),* which average .73 for sixteenth

TABLE 3

Test-Retest Correlations, Form IIIA by Octant and Sixteenth
(Obesity Sample, N = 77)

Octants

AP	*BC*	*DE*	*FG*	*HI*	*JK*	*LM*	*NO*
.76	.76	.81	.73	.78	.83	.75	.80

Average = .78

Sixteenths

A	*B*	*C*	*D*	*E*	*F*	*G*	*H*	*I*	*J*	*K*	*L*	*M*	*N*	*O*	*P*
.75	.68	.74	.83	.76	.64	.77	.65	.76	.73	.76	.66	.73	.75	.74	.69

Average = .73

reliability and .78 for octant reliability may be thought of as suggesting that ICL scores can have sufficient stability to be useful in personality research and clinical evaluation.

"Perhaps more important than reliabilities are the intervariable correlations. As in most theories, certain relationships among variables are postulated, but in the Interpersonal System these relationships are particularly accessible to the psychometrician. For example, adjacent variables on the circular continuum are more closely related than nonadjacent, and the relationship between two variables is a monotonic decreasing function of their separation. Empirical measures of relationship, such as the correlation coefficient, offer an opportunity to check how well the postulated order holds. Interoctant and intersixteenth correlations have been obtained on several samples and these correlations are summarized in *(Table 4)*. In *(Table 4)*, the average of the correlations for variables one step apart, two steps apart, etc., are shown. It is evident that these averages decrease as more distant variables are correlated. Thus observations made with the check list confirm that a roughly circular arrangement of the variables can be used to describe their degree of relationship to one another.

"One might ask why no appreciable negative correlations are reported among raw scores, even though variables opposite in meaning are correlated. The answer is to be found in the fact that all variables are contaminated by a common factor, the over-all likelihood of a "yes" response, regardless of item content. When this factor is removed by dividing each raw score by the total number of "yes" responses made by a subject, negative correlations do in fact appear whenever variables with opposite components of meaning are correlated. (Compare the last two lines of *(Table 4)*.) There does not seem to be any particular advantage to the division of scores by number of words used if the effect of this over-all "yes" tendency is kept in mind. For example, the correlations of raw or divided scores with MMPI variables have the same *average* absolute value, although in individual situations one or the other type of score may yield a higher correlation."[1]

TABLE 4

Average Intervariable Correlation as a Function of Separation Around the Circle

Data Recorded in Sixteenths (Raw Scores)

Sample	*Form*	*Intervariable Distance*								
		N	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
Obesity Females	III	77	.46	.37	.34	.28	.24	.21	.19	.12
Psychiatric Outpatient Males	IIIa	76	.56	.48	.36	.26	.13	.11	.06	.06
Psychiatric Outpatient Females	IIIa	122	.51	.39	.25	.13	.03	–.06	–.14	–.19

Data Recorded in Octants

Sample	*Form*	*Type of Score*	*N*	*Intervariable Distance*			
				1	*2*	*3*	*4*
Obesity Females	III	Raw Scores	77	.51	.37	.22	.12
Psychiatric Outpatients—Males and Females	II	Raw Scores	83	.60	.35	.24	.11
Psychiatric Outpatients—Males and Females	II	Divided by Number of Words Checked	83	.28	–.08	–.44	–.48

[1] LaForge and R. Suczek. The interpersonal dimension of personality: III. An interpersonal check list. *J. Pers.* 1955, *24*, No. 1, 94–112.

Chapter 4

INTERPERSONAL DIAGNOSIS OF LEVEL III BEHAVIOR[1]

Level III comprises the interpersonal themes expressed by the subject in the form of fantasies, projective test stories, dreams and the like. The standard test instrument currently employed for Level III diagnosis is the TAT.[2] The interpersonal system employs 10 of the TAT cards. The stories are scored in terms of the interpersonal variables. These ratings are then summarized into vertical and horizontal indices and plotted on the diagnostic grid—thus yielding an interpersonal diagnosis at the level of fantasy and indirect expression.

Administration

The TAT cards used are: a) for women, cards 1, 2, 3GF, 4, 6 BM, 6GF, 7GF, 12M, 13MF, and 18GF; b) for men, cards 1, 2, 3BM, 4, 6BM, 6GF, 7BM, 12M, 13MF, and 18BM, in that order. The subject writes his stories either alone or in a group, with pencil on ordinary paper.

The instructions to the subject are designed to keep his stories within certain word limits while at the same time encouraging spontaneity. The test administrator looks over the stories periodically as the subject writes them and suggests additional material if necessary to clarify the story, *e.g.*, a specific relationship or a more definite outcome. The task of the test administrator is to direct the subject to respond with ratable stories.

Instructions for Administering the TAT

"This test consists of 10 cards with pictures on them. What I want you to do is to write a very short story about each picture as you come to it. Please make your stories as brief as possible; 3 or 4 sentences will be fine.

"There are no right or wrong answers about the pictures, and I want you to use your imagination to tell your story about what is going on in the picture. Try to tell what the *situation* is which the picture suggests to you. Also, include something about the *feelings* of the people in your story, either about each other or about the situation. Finally, please give your stories a definite ending. In other words, what is the outcome of this situation. Maybe you can do this in one sentence.

"We aren't interested in the stories from a literary point of view; so don't worry about your spelling, punctuation, and so forth. During the test I will look at your stories and perhaps make some suggestions for additions or changes, so it is a good idea to leave about an inch of space between each story. Write on just one side of a page, and number your stories with the same numbers as are on the back of the pictures so I will know which one you are writing about."

Scoring of the TAT

The scoring sheet used to rate TATs is presented in Table 7. Each TAT story is scored as a separate unit and no attempt is made to single out from any one story themes which may emerge as results of reading over the entire protocol.

The first step in rating a story is to select the Hero. This is the character in the story in whom the subject seems to be most interested and with whom he is most identified. Selecting the Hero is a task which involves the intuitive judgment of the rater, once he has taken into account the following criteria.

The Hero is most likely to be the character:

1. With whom he seems to identify
2. About whom the subject writes most
3. Whom he mentions first
4. Who is of the same sex as the subject and most similar in age and status.

On the TAT rating sheet, write an identifying term for the Hero in the box in column "Hero" opposite the appropriate card number. (Such a term might be daughter, husband, man or older woman.) Similarly enter the "Other" in the box in the column "Other." The "Other" refers to any character, except the Hero, involved in the story, to whom feelings or actions are explicitly assigned by the subject. There may be as many as three or four "Other"s entered in the box, and each is entered separately. (See sample rating sheet, Table 7.) Generally, the "Other" is described, as is "Hero," by such terms as "Mother," "Boss," etc. However, the other may be designated by such terms as "World" or "Law" whenever, as an outside force or agency, a clear-cut interpersonal motive is ascribed to it.

A character who is already dead when the story begins is not considered part of the interpersonal world and is neither "Hero" nor an "Other." If two or more

[1] A method of diagnosing "underlying character" from the MMPI (which is referred to as Level III MM) is described in Appendix K.

[2] The Thematic Apperception Test (TAT) is a standard projective test. The stimulus cards comprise magazine-type illustrations about which the subject makes up imaginary stories.

characters are given the same interpersonal role in a story and are considered by the patient to be acting as a unit, they can be combined into one "Other." For example, a mother and father to whom identical interpersonal behavior is attributed may be designated by the single term "Parents."

A rating in terms of the letter codes from the interpersonal circle is assigned to the "Hero" and to each "Other." A list of common interpersonal fantasy themes appropriate to the 16 coded sectors of the circle is presented in Table 5. These words reflect the degree of dominance or submission, and love or hostility that accrues to a particular code. The list of words is not intended to be exhaustive but rather to serve as a guide in assigning a code to any interpersonal activity. An interpersonal rating, in the sense in which it is used here, can be applied to all material which is descriptive of a character, as long as that material is relevant to the character's behavior, feelings, or motivations, and/or to the reactions he pulls from others, including society in general.

It can be seen from Table 5, for example, that to "criticize" is rated with the code E, "to be nurturant" with O, and "to be docile" with J. The rating system, however, is also used to code certain descriptive material which is not so obviously interpersonal, for example:

a. A character is ill. He (she) gets a rating of "i" or "J" since his interpersonal pressure is of weakness and the need to be succored. The rating is in recognition of his interpersonal role in the story, regardless of how dominant his personality (or behavior) may be.

b. A character is illustrious in profession or position. He is given the code "P," by the reasoning in the preceding example, *i.e.*, the role assigned him establishes him as one to be admired and respected.

c. A character is drunk. He is rated "F" for this since "F" is the code for all unconventional or antisocial behavior, as such. Almost all subjects, whether they condemn or condone drunkenness, recognize its unconventional quality. Likewise, drug addiction, homosexuality, and illicit sexual relations are usually coded "F."

d. A character is docilely engaged in some conventional job, is morally conventional, or is "old fashioned." The code for this is "J," which is the opposite of "F" (see preceding example) as a response to the pressures of society to conform. However, the rating system is not oriented toward tapping conventionality as such (except as appropriate unconventionality is absent from the stories), and a code is assigned to it *only* when it has an interpersonal effect on characters in the story. It is scored, for example, when the docile conformity of the parents in Card 2 is seen as a frustration to the rebellious daughter, or as a type of security with which she identifies.

TABLE 5

Illustrative Classification of Interpersonal Behavior at the Symbolic or Projective Level

A. The code "A" is assigned to themes of *Power:* Leadership, Command, Direction, Authority.

B. Assigned to themes of *Narcissism:* Independence, Self-expression, Power Struggle.

C. Assigned to themes of *Exploitation:* Seduction, Rape, Rejection, Depriving, Selfishness, Keeping away from, Keeping children to self.

D. Assigned to themes of *Punitive Hostility:* Punishment, Coercion, Brutality, Quarreling, Threat, Sarcasm.

E. Assigned to themes for *All Forms of Pure Hostility:* Disaffiliation, Murder, Anger, Fighting, Criticism.

F. Assigned to themes of *Unconventional Activity:* Passive Resistance, Rebellion, Generic Crimes *vs.* Authority, Pure Jealousy, Drunkenness, Stealing covertly, Offended, Bitterness.

G. Assigned to themes of *Deprivation:* Distrust, Disappointment, Rejectedness, Suspicion, Bad things are done to one.

H. Assigned to themes of *Masochism:* Grief, Suicide, Withdrawal, Guilt, Provoking Punishment, Self-punishment, Fear, Anxiety, Insanity (unspecified), Loneliness, Running away.

I. Assigned to themes of *Weakness:* Obedience, Submission, Unconsciousness, Indecision, Ambivalence, Immobilization, Illness, Passivity.

J. Assigned to themes of *Conformity:* Accepting advice, Provoking advice, Being a Student, Docility, Followership, Positive Passivity.

K. Assigned to themes of *Trust:* Cling, Good things come to one, Good Luck, Being taken care of, Dependence, Gratitude.

L. Assigned to themes of *Collaboration and Agreeability:* Congeniality, Cooperation, "Generic happy ending" caused by people working things out, Adjustment in general.

M. Assigned to themes of *All Forms of Pure Love:* Affiliation, Marriage, Friendship.

N. Assigned to themes of *Tenderness:* Support, Kindness, Encouragement, Solace, Pity.

O. Assigned to themes of *Generosity:* Help, Curing Someone, Taking care of someone, Giving, Nurturant.

P. Assigned to themes of *Success:* Heroism, Popularity, Acclaim, Achievement, Wisdom, Teaching, Explaining.

Ratings are assigned on the basis of a character's interpersonal impact on the story situation as a whole, and very often only one code is necessary to define the part played by any one character. An effort is made to represent the character's role by as few codes as possible; that is, to use a molar approach rather than a molecular one. Still, it is common for a character to be assigned two codes and occasionally as many as 4 or 5. The three most common ways in which a character earns more than one code are:

a. The character acts or feels in different ways toward different people in the situation, *e.g.,* he may be deferential toward his boss (J) and rejecting toward his wife (C).

b. The character acts or feels in different ways at different times in the situation, *e.g.,* he may be bitter and resentful at first (F) later coming to accept the situation as all for the best (J).

c. The character's actions or feelings may be such that they express different interpersonal pressure at the same time, *e.g.,* he is a respected scientist (P) who is asking advice from a colleague (J).

When two characters are involved in an interpersonal transaction, it is not inevitable that for each code assigned to a character, a complementary code is assigned to the other character. Not all interpersonal pressures or pulls are successful in eliciting the appropriate response. Consider the preceding example of the scientist asking advice of a colleague: the colleague does not automatically get a code of "P" for his "being someone of whom advice is asked." His code, rather, is contingent upon how he responds to the scientist's pressure. He might react to the "J" quality and give advice, in which case he does get a "P." He might react to the "P" quality of the scientist's prestige and respond deferentially, declining to give advice because of his own perception of the scientist's superiority to himself (J). Or, he might passively resist giving advice out of some jealousy or other resentment toward the scientist (F).

It is best for the rater to limit himself to rating only those feelings, motivations, and relationships which are made explicit by the subject. Thus, he would avoid selecting a code which would be appropriate only to his interpretation of "what the subject is *really* saying," or to the *"implications"* of a particular interpersonal action. Likewise, the rater should consider the stories in so far as possible from the value system of the subject and "take him at his word." For example, a sad, clinging mother whose poignant dependence on her son keeps him from accepting a good job is given a passive score (i or J) *if* the subject expresses no recognition of the coercive, exploitive (C) quality of the behavior.

Appendix J, the TAT Scoring "Cookbook," can serve as a guide to rating the stories. The most common themes for each card are listed with the codes conventionally assigned to them. Such factors as emphasis and complexity will affect any of these themes as they appear in different subject's stories, and clearly the codes should be assigned by a flexible system and not be a literal reliance on the "cookbook."

There are two methods for rating TAT themes. The first employs the 16 variable lettered code (B = narcissism, C = exploitation, etc.). The second employs the numerical octant codes (2 = BC, that is, both narcissism, B, and exploitation, C, etc.).

A strict legislative procedure has been developed for the judging process. The first two raters make their scoring decisions independently. The judge then inspects these ratings and makes a third and decisive rating only when the first two independent raters are in disagreement. The judge cannot change a rating if the first two raters agree on the same octant score. If the first two raters disagree on the octant score, the judge then has the authority to agree with either of the raters, or to substitute a third rating. The judge's ruling is final.

In some cases the first two raters assign more than one score to a TAT figure. They may agree on one score but disagree on the second score. A rule has been developed to handle this eventuality. If there is any disagreement in scores assigned to a TAT figure, the judge has the right to change all the scores assigned to that figure.

The "triple rating" system (two raters and a judge) is used only for research purposes. For routine clinical diagnosis, rating by a trained technician whose accuracy and reliability have been established is sufficient.

Computation of Vertical and Horizontal Indices

The columns "Hero Role" and "Other Role" on the rating sheet provide space for the codes assigned to each character (see sample rating sheet). At the bottom right hand side of the sheet is a space for tallying or summing the codes for "Hero" and "Other." Count the number of A and P codes assigned in all 10 stories for "Hero" and enter this figure in "Hero" column opposite AP. In the same way get sums for the other octants and enter them. Get sums for each octant from all codes assigned to "Other" and enter these in the "Other" column. The following formula

is applied to these octant sums to yield a Dom and Lov score for "Hero" and "Other." Consider the "Hero" and "Other" sums separately.

Formulae:

$$\text{Dom} = 0.7(\text{BC} + \text{NO} - \text{FG} - \text{JK}) + \text{AP} - \text{Hi}$$
$$\text{Lov} = 0.7(\text{JK} + \text{NO} - \text{BC} - \text{FG}) + \text{LM} - \text{DE}$$

or a breakdown of these formulae as listed on page 15 may be used.

The resulting "raw score" indices are entered in the appropriate boxes at the bottom of the rating sheet. They are later transferred to the diagnostic booklet.

Reliability of the Level III TAT Diagnosis

The reliability of the TAT diagnosis can be estimated in two ways. The percentage of agreement between two independent raters in making unit ratings of individual stories can be determined. A second method is to calculate the agreement between the summary TAT diagnoses of independent raters. The latter is the more meaningful statistic, because most of the research and clinical procedures involve manipulation of the summary Level III diagnostic score. Agreement between two independent Level III diagnoses occurs when the raters place the subject in the same or an adjacent octant. This is a variability index of 0–44. Disagreement between the two diagnosticians occurs when summary Level III indices are more than one octant apart. Independent raters average 85% agreement.

The final Level III diagnosis, it will be recalled, is based on the ratings of a judge who resolves disagreements between the two independent raters. The operating agreement figure we are most concerned with is, therefore, that between any rater and the judged criterion. This averages 90%. These agreement percentages are higher than those usually reported for personality diagnosis or for ratings of projective material. We have, therefore, considered the diagnoses based on TAT ratings to possess adequate reliability.

Illustration of the Scoring of the TAT and of the Computation of Level III "Raw Score" Indices

The TAT protocol of an illustrative case is presented in Table 6. Ratings assigned to these stories are listed in the sample TAT scoring sheet (Table 7).

There are three sets of ratings assigned to these stories — the first two were made by independent raters "A" and "B." The third rating (on the right), was made by the judge who settled differences between the first two raters. It will be noted that on story "2," the first rater saw the girl as "F," *i.e.*, rebellious, whereas the second rater saw her as rebellious and

TABLE 6
Sample TAT Stories

1. A little boy sits staring at his violin, hating the thought of having to stay indoors and practice when he would rather be out playing baseball with his friends.

2. A young girl lives on a farm with her brother and his wife. On this particular day, she resents having to go to school because she would rather sit and dream on the side of a hill, but she reluctantly goes.

3GF. Joanne comes weeping out of the room and leans against the door for support. Finally she decides to take revenge on someone she feels has insulted her.

4. The young man wants to go out and fight someone. He starts to leave but the dark haired girl holds him, begging him not to go because she loves him. But he feels that he must because his anger is so great and he leaves.

6BM. The mother's life now seems completely empty. Her son has just come to tell her he is leaving. He has taken a position many miles away. He feels very bad about causing his mother any unhappiness but has decided that this is the best way for them both.

6GF. Betty is very unhappy, her husband has been gone for weeks and she is sitting alone in the living room wondering what has become of him. She is quite startled when her father comes in unexpectedly to comfort her but feels better after they have talked for a while.

7GF. The little girl is annoyed because her mother has just told her she is too old to be playing with dolls, and sits brooding about it. The mother has made up her mind, however, and won't give in, so the poor little girl is broken hearted.

12M. A dishonest hypnotist puts a young boy under his spell and has the child steal for him while in this state. The boy is caught, of course, still in the trance, and when brought out of it identifies this low crook.

13MF. John has been at work all evening and when he arrives home, he finds his wife Mary has been shot and killed. He is completely grief stricken and horrified. They eventually find the man who did it and he is sent to a mental hospital.

18GF. Jean is not permitted to go out on dates even though eighteen. Her mother thinks it is wicked. Of course she does anyway, and when caught, her mother flies into a rage and almost chokes her to death. The next day she goes to live with her aunt.

docile (F and J). The judge, after reading the story, agreed with the second rater, the final score, then, is "FJ."

The octant tallies (*eg.*, AP, BC, etc.) are made from the judge's ratings. The "raw score" indices for Hero are: Dom = –3.7; Lov = –5.5. The "raw score" indices for TAT "Other" are –2.0 and –1.6. The next section of this manual will describe the process of converting these raw scores to standard scores and the subsequent diagnosis by means of the booklet.

TABLE 7
TAT Molar Rating Sheet

SUBJECT.....*Sample Case*..... GROUP..... TAT No.....*I*.....DATE.....

RATER.....*A*..... RATER.....*B*..... JUDGE.....*Judge*.....

#	*Hero*	*Hero Role*	*Other*	*Other Role*	*Hero*	*Hero Role*	*Other*	*Other Role*	*Hero*	*Hero Role*	*Other*	*Other Role*
1	Boy	F			Boy	F			Boy	F	—	—
2	Girl	F			Girl	FJ			Girl	FJ	—	—
3 ~~BM~~ GF	Girl	HD			Girl	HD			Girl	HD	—	—
4	Man	CE	Girl	K	Man	BD	Girl	K	Man	EB	Girl	K
6 BM	Mother	H	Son	B	Son	BH	Mother	H	Son	B	Mother	H
6 GF	Woman	GJ	Father	N	Woman	HJ	Father	N	Woman	HJ	Father	N
7 ~~BM~~ GF	Girl	G	Mother	B	Girl	FH	Mother	A	Girl	G	Mother	B
12 M	Hypno-tist	C	Boy	i	Hypno-tist	C	Law Boy	D iJ	Hypno-tist	C	Boy	iJ
13 MF	Man	G	Man World	E D	Man	H	Man Law	E D	Man	H	Man Law	E D
18 ~~BM~~ GF	Woman	B	Mother	D	Daughter	FB	Mother	D	Daughter	B	Mother	D

	Maternal Id.		*Paternal Id.*		*Parental Id.*		Cross Sex	
	Hero	*Mother*	Hero	Father	Hero	Parents	Hero	Other
Dom								
Lov								

	Hero	*Other*	*Total*
AP	—	—	
BC	4	1	
DE	2	3	
FG	3	—	
HI	3	2	
JK	2	2	
LM	—	—	
NO	—	1	
TOTAL	14	9	
Dom	–3.7	–2.0	
Lov	–5.5	–1.6	

Chapter 5

MULTILEVEL INTERPERSONAL DIAGNOSIS: THE DIAGNOSTIC BOOKLET

The three preceding sections have outlined the administration and scoring of the tests used at Level I, II and III and the computation of the raw score indices for each level. At this point in the diagnostic process, the "Record Booklet for Interpersonal Diagnosis of Personality" is employed. The illustrative copy of this booklet (Figure 6) should now be consulted.

In the upper right hand of Page 2 of the booklet will be found a table for summarizing these raw score indices. The first column of this table defines the Level and persons being scored, I S means Level I Self; III H indicates Level III Hero, etc. The second column denotes the test employed, MMPI, ICL, TAT, IFT.[1] In columns 1 and 2 there are three blank spaces for entering additional persons or tests. In columns 3 and 4 are entered the raw score indices for each test. We now transfer from the scoring sheets all the indices which have been computed at each level for the illustrative patient.

The next step is to convert all raw score indices to standard scores. The mean and sigmas for large samples of routine psychiatric clinic admissions are used for the norms at all levels. The raw scores from each test are thus converted into scores which compare the subject's behavior at each level to the mean of the same normative group (*ie.,* the routine clinic admission sample).

All the check list scores for self, parents, and spouse are converted to standard scores, based on the "self scores" of 800 routine clinic admission patients. In interpreting the standard score placements for parents and spouse, one should keep in mind that the diagnosis is not in terms of a mean of "mothers" or a mean of "fathers" but in relationship to the mean of "self" perceptions.

Heretofore, the Level V (Ideal) indices were converted to standard scores by means of Level II norms (as has been done in the illustrative case in Figure 6). However, when Level V (Ideal) indices are converted to standard scores by Level II norms, over 90% of "Ideals" fall in the upper right hand quadrant. A stereotyped measure of ego ideal results. For this reason ideal indices have recently been standardized in terms of their own mean, resulting in a much more diffuse distribution. This new set of norms is listed in Appendix D.

The norms for converting Level I (MMPI) raw score indices to standard scores are listed in Appendix A. The norms for the check list indices (self, parents, and spouse) are listed in Appendix C. The norms for Level III Hero and Level III "Other" are found in Appendix E and F, respectively. The new norms for Level V are listed in Appendix D. These five tables of norms make it possible to convert the eight sets of raw score indices to standard scores.

For the illustrative case, the raw score indices at Level I S were: Dom = –52 and Lov = –10 (see Figure 4). The standard scores for these indices (from Appendix A) are 39 and 49. The Level II Self indices were –12.6 and +14.0 (see Figure 5). Reference to Appendix C yields standard scores of Dom = 38 and Lov = 64. The raw score indices for mother, father and spouse are also converted to standard scores using Appendix C.

The standard scores are then used to plot the location of the summary point on the diagnostic grid. The grid is the large circle in the upper left hand corner of Page 2 of the diagnostic booklet. Both the vertical and horizontal axes of this circle are calibrated in standard score units. The center of the circle is the intersection of the means of the vertical and horizontal distributions. The "D" column locates the vertical placement and the "L" column locates the horizontal placement, and the intersection of the two standard score placements determines the summary point for that level.

The summary point for Level I S is indicated by a dot next to which is entered the label "I." The Level II self summary point is labeled "S." Conscious view of mother is labeled "M"; father is labeled "F"; spouse, "Sp"; and ideal, "Id." The TAT Hero summary point is denoted by the code "H" and the TAT "Other" by the code "O."

It will be noted that on the large diagnostic grid a small dotted-lined circle has been drawn one-half inch from the center. The circle intersects the horizontal and vertical axes at the one sigma point (*i.e.,*

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[1] The Interpersonal Fantasy Test is a Level III instrument developed by the Kaiser Foundation Psychology Research Project to fit the interpersonal system. It is a TAT-type test in which the cards are designed to explore, systematically, the subject's fantasies about interpersonal relationships between fantasy self, and paternal, maternal, cross-sex and same-sex figures.

FIGURE 6

Record Booklet For Interpersonal Diagnosis of Personality

Subject _____ (LAST NAME) _____ (FIRST NAME) Age ____ Sex ____ Date _____ Testing # _____

Address _____ City _____ Phone _____ Education _____

Occupation _____ Marital Status _____ Occupation of Spouse _____

Referred by _____ Therapist _____ Group _____

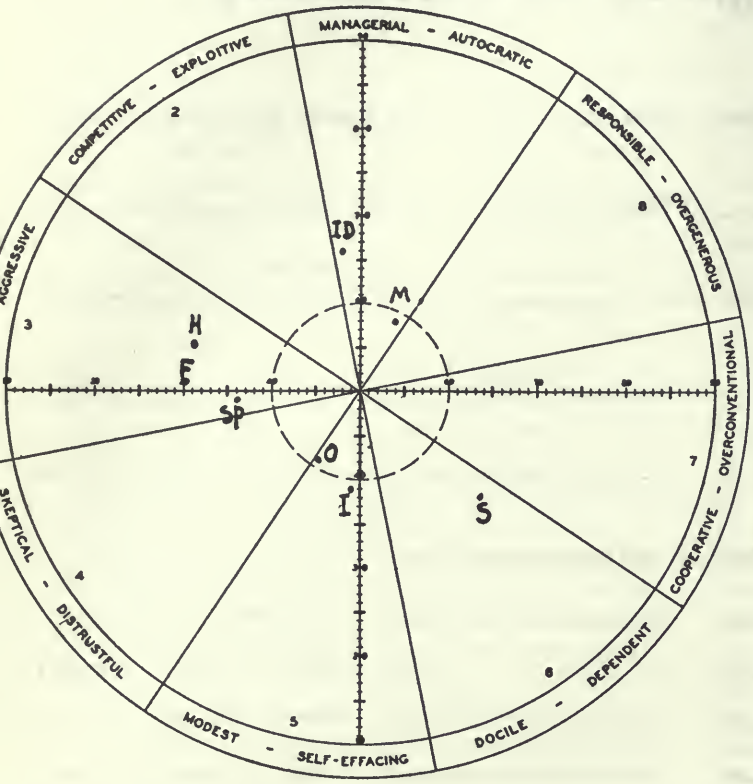
Other _____

Identifying Codes for Clinical and Sociological Data

Sex	1	Therapist	17		33	Tests covered by this record:	
Age	2	Type of Therapy	18		34	Name / Form / Testing #	
Religion	3	Times Seen	19		35	MMPI	
Number of Siblings	4	Disposition	20		36	ICL	
Marital Status	5	Condition	21		37	IFT / TAT	
Number of Children	6				38		
			22		39		
Subject's Occupation	7		23		40		
Occupation of Mother	8		24		41		
Occupation of Father	9		25			Remarks:	
Occupation of Spouse	10				42		
			26		43		
Subject's Education	11		27		44		
Mother's Education	12		28		45		
Father's Education	13				46		
Spouse's Education	14		29		47		
			30		48		
Referred by	15		31		49		
Previous Consultations	16		32		50		

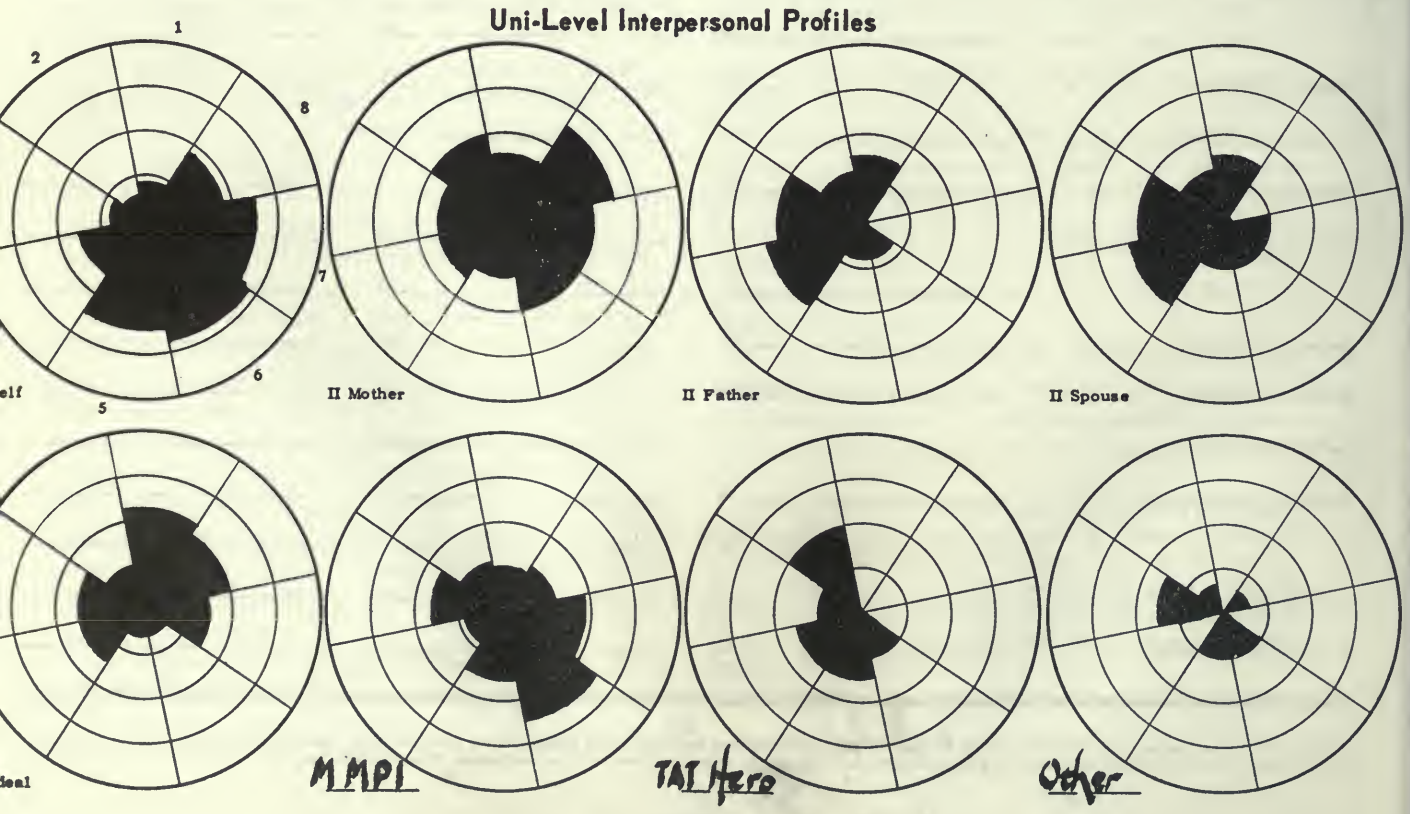
This booklet was prepared by Timothy Leary, Ph.D., and published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, California. Checklists, booklets, templates, norms, and instruction manuals can be obtained from the Psychological Consultation Service.

Interpersonal Diagnosis
Multi-Level Personality Pattern



Level and Person	Test	Raw Score D	Raw Score L	Standard Score D	Standard Score L	IP Diagnosis
I S	MMPI	-52	-10	39	49	5
I S	Socio.					
I S	———					
II S	ICL	-12.6	+14.0	38	64	6
III H	IFT TAT	-3.7	-5.5	56	31	3
V	ICL	+9.8	0.0	51	37	1
II M	ICL	+3.8	+4.8	58	54	1
II F	ICL	-1.9	-15.7	51	30	3
II Sp	ICL	-3.6	-11.0	49	36	3
II ___	ICL					
III 0	IFT TAT	-2.0	-1.6	42	45	5
III M	IFT TAT					
III F	IFT TAT					
III Sp	IFT TAT					
III ___	———					
III ___	———					

Uni-Level Interpersonal Profiles



Indices of Variability Among Levels of Personality

Verbal Definition of Index	Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy	RIGID (30)	STABLE (40)	CONFLICTED (50)	OSCILLATING (60)
SELF-DECEPTION	IS IIS	56	+9	+43	44	P		X		
REPRESSION Hero	IIS IIIH	63	+58	-88	105	Rep				X
REPRESSION Other	IIS IIIO	65	+14	-38	41	Dil		X		
CONSCIOUS IDENTIFICATION Maternal	IIS IIIM	61	+80	-26	84	DiSi				X
CONSCIOUS IDENTIFICATION Paternal	IIS IIIF	63	+58	-88	105	DiSi				X
CONSCIOUS IDENTIFICATION Marital	IIS IIISp	63	+58	-88	105	DiSi				X
CONSCIOUS IDENTIFICATION	IIS II_									
EQUATION Mother-Father	IIM IIIF	13	-22	-62	66	LEq			X	
EQUATION Mother-Spouse	IIM IIISp	13	-22	-62	66	LEq			X	
EQUATION Father-Spouse	IIF IIISp	33	0	0	00	E	X			
CONSCIOUS SELF-ACCEPTANCE	IIS V	61	+103	-21	105	SR				X
SELF ACTUALIZATION	IS V	51	+112	+22	114	LSA				X
PRECONSCIOUS SELF-ACCEPTANCE	IIIH V	31	+45	+67	81	SR				X
PRECONSCIOUS SELF-ACCEPTANCE	IIIO V	51	+89	+17	91	SR				X
MATERNAL IDEALIZATION	IIM V	11	+23	+5	23	IDL	X			
PATERNAL IDEALIZATION	IIF V	31	+45	+67	81	DEV				X
SPOUSE IDEALIZATION	IISp V	31	+45	+67	81	DEV				X
PRECONSCIOUS IDENTIFICATION—Maternal	IIS IIIM									
PRECONSCIOUS IDENTIFICATION—Paternal	IIS IIIF									
PRECONSCIOUS IDENTIFICATION—Marital	IIS IIISp									
PRECONSCIOUS IDENTIFICATION—Maternal	IIIH IIIM	31	+22	+62	66	DiSi			X	
PRECONSCIOUS IDENTIFICATION—Paternal	IIIH IIIF	33	0	0	00	ID	X			
PRECONSCIOUS IDENTIFICATION—Marital	IIIH IIISp	33	0	0	00	ID	X			
FUSION Maternal	IIM IIIM									
FUSION Paternal	IIF IIIF									
FUSION Spouse	IISp IIISp									
DISPLACEMENT Maternal—Paternal	IIM IIIF									
DISPLACEMENT Maternal—Cross-sex	IIM IIISp									
DISPLACEMENT Paternal—Maternal	IIF IIIM									
DISPLACEMENT Paternal—Cross-sex	IIF IIISp									
DISPLACEMENT Spouse—Maternal	IISp IIIM									
DISPLACEMENT Spouse—Paternal	IISp IIIF									

Verbal Summaries of Variability Indices

Subject misperceives his own hostility.

Subject is consciously identified with no one.

Subject is consciously disidentified with mother, father, husband.

Subject represses power and hostility.

Subject represses (deeper) hostility.

Subject consciously equates father with husband.

Subject's conscious acceptance of self is low.

Subject's self-actualization is low.

Subject displaces his preconscious image of —

Subject's preconscious acceptance of self is low.

Subject's preconscious acceptance of self (deeper) is low.

Subject consciously idealizes mother.

Subject consciously devaluates father and husband.

Subject is preconsciously identified with father and husband.

Subject is preconsciously disidentified with mother.

Subject fuses his conscious and preconscious images of —.

Subject diffuses his conscious and preconscious images of —.

onto his conscious perception of —.

Clinical Notes

standard scores 40 and 60). Summary points which fall within the small pie-shaped sectors bounded by this dotted circle are assigned the moderate diagnosis. Scores which fall in the outer sector are assigned extreme diagnosis. Moderate diagnoses are written in black pencil while extreme diagnoses are designated by red pencil. In this manual the black or moderate diagnostic code numbers are italicized while intense diagnostic codes are in roman type.

The Level I S summary point of the illustrative case falls in the outer ring of the "**5**" octant. This defines *extreme modest-self-effacing* or masochistic behavior. The numeral "**5**" is therefore entered in the appropriate box in the "Interpersonal Diagnosis" column in the upper right of Page 2. Red pencil would ordinarily be used for this extreme diagnosis.

The Level II self description (S) for the sample case is located in the outer sector of the *"Docile-Dependent"* octant. The diagnostic code "**6**" is written in the diagnosis column in the II S row. The patient's description of her mother is located within the inner sector of the *"Managerial-Autocratic"* octant. The code ***1*** has therefore been entered in the diagnosis column. In actual practice this would be a black ***1*** to indicate the moderate diagnosis. In the illustrative booklets in this book underlining has been used to designate moderate diagnoses, in print italics are used.

Each summary point is converted to an interpersonal diagnostic category in this manner. The numerical diagnosis can then be presented in terms of a *diagnostic formula.*

The diagnostic formula is a listing of the diagnostic code in the following order: Level I S; Level II S; Level III H and Level III O. These four scores are separated from the family-member diagnoses by a dash. Level II Mother, Father, Spouse then follow. A dash separates the Level V Ideal from these scores. The eight-code diagnosis for the illustrative case is: **5635–*133*–1**.

The Unilevel Interpersonal Profile

At the bottom of Page 2 of the booklet will be found eight circles. The top four are assigned the labels of the four Level II personages rated at Level II. The bottom row of circles is used for Level V Ideal, Level I and for the Level III measures. The Level I circle is a graphic representation of MMPI scales and is described below. The words "TAT Hero" and "TAT Other" should be written in under two of the bottom circles. These are "raw score octant" circles. The four Level II circles and the Level V circle are shaded according to the octant totals on the Interpersonal Check List. For these measures the radius of the circle is 16 items and each ring represents four items. The check list is constructed so that there are eight items for each of the 16 interpersonal variables or 16 items for each octant. If the subject checks every word in the "AP" octant as descriptive of himself, then octant #1 on the unilevel profile is completely filled in. The illustrative patient checked three "DE" words for "self" (see Figure 5) so that in octant 3 of the self profile, three-fourths of the first ring is shaded. The unilevel profiles are, therefore, direct graphic representations of the number of items checked.

The TAT scores are similarly plotted for the octant summaries from the TAT scoring sheet. The total of TAT scores is always much lower than the check list. For this reason the TAT circles are calibrated so that the radius is equal to eight and each of the concentric rings marks off two raw score units.

The TAT Hero of the illustrative patient received four "BC" scores (see TAT rating sheet, Table 7). Octant 2 of the unilevel profile for TAT Hero is therefore shaded in up to the half-way point, *i.e.,* two concentric rings.

To diagram the Level I MMPI circle, refer to Tables 29 (Males) and 30 (Females) in Appendix B. These tables contain norms for converting scores on eight MMPI scales to standard score units which are plotted on a circle in the bottom row on Page 2 of the Diagnostic Booklet. Note that the two special scales (PgB and HyD) employ raw scores, and the remaining six scales employ T-scores (Ma, Sc and Pt are with K added).

Each concentric ring represents 10 standard score units. The center of the circle represents the standard score of 40 or below. Moving out from the center, the rings denote standard scores of 50, 60, 70 and 80, which is the outer rim of the circle.

Our sample case in Figure 6 has a raw score of 40 on the PgB scale. Using Table 30, this converts to a standard score of 50 and, therefore, octant 1 is shaded to the first concentric ring. Similarly, in octant 2, the subject's K-corrected T-score on the Ma scale is 55, which, using Table 30, converts to 51 and octant 2 is shaded a little beyond the first concentric ring.

The unilevel profiles are not employed in research since they do not lend themselves to direct quantification. They are used for clinical analysis. They portray the pattern of responses at each level. They show up conflicts or ambivalences within the level.

The summary point technique gives the center of gravity of any profile and is extremely useful for diagnosis and for measuring the discrepancy between levels. The disadvantage of the single summary point method is that it blurs ambivalence. A subject may express a great deal of extreme dominance and a great deal of extreme passivity; the extremity of both would be washed out by the formulae. The resulting summary point would locate closer to the center, and the richness of the unilevel ambivalence would be lost. The unilevel profile captures these factors and presents them in graphic form.

The instructions for filling in Page 2 of the diagnostic booklet are now completed. The raw scores for each octant are diagrammed in unilevel profiles for clinical analysis. The raw score indices for each level have been converted to standard scores and plotted on the diagnostic booklet, and the multilevel interpersonal diagnosis has been determined. It is now possible to proceed to an objective analysis of the interlevel conflicts among the levels of personality.

Indices of Variability Among Levels of Personality

One of the basic and most important aspects of the interpersonal system of diagnosis is that the same system of variables is used to measure behavior at all levels. The advantage of this procedure is that it makes possible the objective comparison of scores at different levels. The great contribution of the diagnostic grid is that it allows us to plot scores for all levels on the same two-dimensional surface and makes graphically obvious the differences or conflicts which exist. A glance at the distribution of scores around the grid indicates how much conflict exists and where the scores tend to cluster. A brief inspection suffices for clinical diagnosis and clinical prediction. For research purposes, however, we require quantitative estimates of conflict.

There are several ways in which interlevel conflicts can be measured. The Kaiser Foundation project has experimented with several — including direct centimeter readings of the linear distance between summary points. This method is not optimal because distance between two points near the perimeter of the grid has a different meaning from the same amount of distance between points placed close to the center of the circle.

The method now employed to measure interlevel variability is based on differences between numerical code diagnoses. By means of mathematical procedures a table of weights has been constructed which expresses directly the amount and kind of discrepancy between any pair of diagnostic code numerals. These weights indicate how much more dominance or passivity or affiliation or hostility is expressed by one diagnostic code than by another.

The geometry of the diagnostic grid must be considered at this point. The distance between any two points on the diagnostic grid can be expressed in terms of the right triangle formed by moving horizontally and then vertically from one point to the other. The hypotenuse of this right triangle is the direct linear distance between the two points; the other sides of the right triangle represent the horizontal (love-hostility) and vertical (dominance-submission) difference between the two points. These three lines represent the amount of the two kinds of discrepancy—or interlevel conflict.

Page 3 of the diagnostic booklet is set up to facilitate the objective analysis of interlevel conflict. The first column (on the left) gives the verbal definition of each variability index. The second column presents the operational definition of each index. The first variability index is Self-deception, which is defined as the discrepancy between Level I Self and Level II Self. We are concerned here with the difference between self diagnosis and the diagnosis based on public behavior. A large discrepancy between these two scores indicates that the subject sees himself differently from his Level I public impact. This is called "misperception of self." A small discrepancy score is called "accurate self-perception."

The discrepancy indices are calculated as follows. In the third column (labeled Diagnostic Codes) are entered the numerical diagnoses for the levels indicated in the second (operational definition) column. These are obtained from Page 2. The diagnostic codes for self-deception in the case of the illustrative patient are I S = **5** and II S = **6**. The code **56** is entered in column **3**. The verbal meaning of the "**56**" code is that the patient acts masochistically but sees herself as "docile." A certain misperception of self is apparent. The quantitative estimate of the kind and amount of the discrepancy is obtained from Appendix G, "Table of Discrepancies Between Codes for Use with the Interpersonal Diagnostic System." The first page of Appendix G presents the weighted scores for discrepancies involving diagnoses of equal intensity: *i.e.*, both red or intense or both black or moderate scores. The left hand half of this table lists the weights for every one of the 64 possible combinations of red-extreme diagnoses. Opposite each pair

is listed the Dominance-Submission discrepancy index (D), the Love-Hostility (L) and the (d) score which is the index of the amount of change.

The right hand half of this table lists the weighted scores for all possible pairs of moderate-black scores. It will be noted that all the weighted values for moderate paired diagnoses are less than the same red or extreme codes. The weights for the self-deception index of the illustrative patient (diagnostic code **56**) are D = +9, L = +43 and d = 44. If this discrepancy had been between two moderate diagnoses (black ***56***) the weighted discrepancy values would be D = +5, L = +25 and d = 26.

The second page of Appendix G presents the weighted indices for conflicts involving codes of differing intensities; *i.e.,* between a black-red or a red-black discrepancy.

Using the code pairs in the same order as indicated in the second (operational definition) column of Page 3 of the diagnostic booklet, locate "D," "L" and "d" in Appendix G and enter the scores in columns 4, 5, and 6, under "Kind and Amount of Discrepancy."

It is important to retain the exact order of diagnostic code numbers in making any one interlevel comparison. For example, if the code numbers are entered in the "Diagnostic Codes" column as red **1**, black ***6***, they must not be considered equivalent to black ***1***, red **6**, to black ***6***, red **1**, or to red **6**, black ***1***, when finding the scores in the Table of Discrepancies. The D, L and d scores are wrong for any other arrangement of the numbers or their intensities.

On page 3 of the illustrative booklet are entered 19 pairs of diagnostic codes and the three discrepancy indices for each pair. These conflict indices include self-deception, two kinds of repression, three conscious identification indices, three equation indices (reflecting the similarity or differences in perceptions of family members) and seven scores comparing each of the other diagnoses with ideal. There are also three preconscious identification indices which reflect the closeness of Level II family members with Level III Hero. It will be noted that 13 variability indices are omitted from the sample case. One of these is an index of identification with a fourth person. This blank space can be filled in with the name of any person important in the patient's life, for example, stepfather, sibling, or the name of the therapist. The other 12 omitted indices involve scores for specific Level III personages—the fantasied maternal figure, paternal figure or cross-sex figure. The TAT as currently scored and tallied does not isolate out summary scores for these figures. The Interpersonal Fantasy Test, now being validated, is constructed so that it will be possible to get reliable summary points for Level III figures.

There is one column on Page 3 which has not been discussed. This is labeled standard score discrepancy. When the booklet was printed, it was anticipated that standard scores would eventually be determined for each of the points on the variability continuum. Experience with the distribution of indices has indicated the impossibility of this procedure. The indices are not normally distributed. For this reason the "standard score" column is used to indicate whether the variability index in question is "high" or "low." Different verbal titles are designated for the high or low aspect of each variability index. If the Level II self is close to Level II mother, the term identification is used. If this index is large, the term disidentification is used. Table 8 presents the formal titles for the high and low aspects of each variability index. Spaces in the "Standard Score Discrepancy" column are used for writing in the abbrevation for the appropriate (high or low) index.

TABLE 8

Titles Used for Verbal Summaries of High and Low Variability Indices

Low Discrepancy (Variability index = 0–44)	*Abbreviations*	*High Discrepancy (Variability index = 48–114)*	*Abbreviations*
Self perception	P	Self deception	D
Duplication	Du	Repression	Rep
Identification	Id	Disidentification	Disi
High Equation	HEq	Low Equation	LEq
Self Acceptance	SA	Self rejection	SR
High Self actualization	HSA	Low self actualization	LSA
Fusion	Fu	Diffusion	Dif
Displacement	Disp	Diffusion	Dif
Idealization	Idl	Devaluation	Dev
Accurate Perception	P	Misperception	M

There are 14 possible discrepancies, ranging at unequal intervals from 0–114, as can be seen in Appendix G. The cutting point which defines a high or low discrepancy is the point 44. This point represents a discrepancy between extreme (red) codes for adjacent octants. If the discrepancy is one octant or less, then no conflict is present. More than 44 defines a conflict of more than one octant and denotes a "high" discrepancy. This column is not vital to the use of the booklet. It can be filled in as an interpretive aid or for research purposes or it can be omitted.

Similarly the profile grid on the right hand side of Page 3 can be included optionally. This grid was intended for plotting in the standard scores. Like the "standard score" column, it will be omitted from later forms of the booklet. This grid can be used to yield a profile graph of the conflict pattern; instead of standard scores the graph can designate the quartile in which the variability index falls. To compare any sample with Kaiser Foundation Psychology Research samples, refer to Appendix H. For example, in a large sample of psychiatric clinic admissions, the self-deception discrepancies from 0–26 fall in the first quartile; from 41–44, in the second quartile, from 48–66 in the third, and from 68–114 in the fourth quartile. The calibration scale (on the top and bottom of the profile grid) originally would have designated the standard score points 35, 45, 55 and 65. To plot a profile, first determine in which quartile the index falls, and mark an X under the appropriate mid-point. The first quartile falls at the calibration point 35, the second falls at 45, the third quartile falls at 55, and the fourth at 65.

When the quartile estimates for each variability index have been graphed, connect the Xs with lines to obtain the profile. In the illustrative booklet (Page 3 of Figure 6), the self-deception index is 44. This falls in the second quartile and the "X" is plotted under the standard score 45.

The final page of the diagnostic booklet provides space for Verbal Summaries of Variability Indices. This is for the convenience of the clinician. The verbal designation given to any variability index depends on whether the "d" score falls above the point 44. Table 8 presented the formal titles for the high and low aspects of each variability index.

This concludes the detailed description of the use of the diagnostic booklet. At this point, the patient has been given a multilevel interpersonal diagnosis in terms of the eight-digit code, and nineteen variability indices have been calculated. Scores are now available on 27 variables (8 interpersonal and 19 indices of conflict). There are many clinical and theoretical correlates for each of these 27 variables. These empirical results are presented in other publications,[1] which should be consulted by the clinician using this system of diagnosis.

For the clinician, the completed diagnostic booklet summarizes the information required to write a descriptive and predictive diagnostic report. A sample diagnostic report for the illustrative patient will now be discussed.

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[1] T. Leary, *Interpersonal Diagnosis of Personality.* New York: Ronald Press, 1956.

R. LaForge, T. Leary, H. Naboisek, H. Coffey and M. Freedman. The interpersonal dimension of personality: II. An objective study of repression. *J. Pers.,* 1954, *23,* 129–153.

T. Leary and Joan S. Harvey. A methodology for measuring personality changes in psychotherapy. *J. Clin. Psychol.,* 1956, *12,* 123–132.

T. Leary. A theory and methodology for measuring fantasy and imaginative expression. *J. Pers.,* Dec. 1956.

Chapter 6
DIAGNOSTIC REPORT FOR ILLUSTRATIVE PATIENT

A diagnostic report based on the interpersonal system can be written in many ways. The outline currently employed by the Kaiser Foundation consists of two parts—a detailed multilevel diagnostic section followed by the clinical implications and prognostic statements. In building up the diagnostic picture, the diagnostician uses all the cues from the diagnostic booklet as well as from the raw test data. While the interpersonal system provides the core information for this report, the standard clinical techniques for interpreting the TAT, the MMPI and the items on the checklist are also included.

Personality Evaluation of Illustrative Patient

The Symptomatic Level (from MMPI). This patient presents a severely disturbed picture. The Level I–MMPI score locates in Octant 5. This represents a public manifestation of self-punishment, suffering, and grief. The interpersonal pressure of her symptoms on the clinic involves passivity and masochism. She is emphasizing her emotional symptoms and indicates clearly that she is suffering, unhappy, weak and confused. The message expressed by this symptomatic presentation is: "I am sick, depressed, helpless." The interpersonal diagnosis at the symptomatic level is *Masochistic personality.*

Turning to the unilevel diagram of the MMPI on Page 2 of the Diagnostic Booklet we see the Level I picture in more detail. Depression (Octant 6) is the outstanding symptom. Alienation (Octant 3) and obsessive guilt (Octant 5) are the next most prominent complaints.

The Level of Self Diagnosis. At the level of self description, a somewhat different picture emerges. The emphasis here is on docility, innocence, and sweet mildness. Looking over the items on the check list selected as self descriptive, we see that she considers herself to be appreciative, cooperative, friendly, considerate, warm, easily influenced, timid, passive and unaggressive. This trend is clearly obvious in the unilevel circle on page 2 of the booklet. She denies almost all tendencies to be strong (octant **1**), competitive (**2**) and hostile (**3**). The diagnosis at Level II is *Dependent Personality.*

The Level of Underlying Fantasy. The TAT provides a set of different interpersonal themes. An inspection of the unilevel circles on Page 2 of the booklet indicates that the heroes are narcissistic, hostile and bitter people. They are struggling with others who are hostile (**3**), weak (**5**) and docile (**6**).

The general trend of the TAT stories is reflected in the summary diagnosis for Level III Hero and Other. The Hero diagnosis is **3** and the Other is ***5***. This suggests that aggressive, sadistic heroes battle and conquer their weaker adversaries. Examination of the TAT protocols confirms this impression. Her heroes are bitter and resentful. They fight their way out of cruel circumstances and establish their aggressive autonomy. The interpersonal diagnosis at Level III Hero: *Masochistic Personality;* Level III Other: *Self-Effacing Personality.*

Familial Interpersonal Network. From the unilevel circles on Page 2, we see that the subject describes her mother as a well-balanced person who is mainly nurturant. The mother is secondarily seen as self-confident (**2**), friendly (**7**) and docile (**6**). The interpersonal diagnosis for Level II Mother is **1**. This is to say that the mother is diagnosed as a *Managerial Personality.* This score is of some interest. Actually the "AP" octant is not particularly emphasized on the check list. The unilevel circle reflects some ambivalence in the view of mother since she is seen as being both exploitive and nurturant. The summary point, however, simply reflects the resolution of the mixed perceptions of mother.

The patient describes her father as extremely unbalanced in the direction of bitter-distrust (**4**) and sadism (**3**). The unilevel circle shows that not one tender (**8**) or loving (**7**) item was attributed to father. He is diagnosed as a *Sadistic Personality.*

The description of spouse practically duplicates that of the father. He is diagnosed as a *Sadistic Personality.*

The ego ideal provides an interesting and different set of measures. The focus here is on power and hypernormality. There is in addition a slight tendency to idealize toughness (**3**) and skepticism (**4**).

Multilevel Patterns. The eight-digit code is **5635–*1*33–1**. This diagnosis indicates a facade of helplessness with underlying feelings of narcissism and bitterness. The male family figures are seen as sadistic and the mother as strong.

To clarify the meaning of the multilevel profile, we refer to the variability indices.

Self-Deception. The patient's symptomatic pres-

entation is pretty close to her self description, *i.e.*, Level I is close to Level II S. She fails to perceive the masochistic aspects of the former and "erroneously" emphasizes her positive, docile innocence. This is a fairly typical masochistic pattern. She complains about several symptoms and is very depressed. By claiming to be very meek and dependent, she fails to take responsibility for her symptoms. She may be saying, "I am a naive, good person who is suffering from painful symptoms." She may expect to have the symptoms removed and may fail to take her own interpersonal characteristics into account.

Repression. The conflict here is severe. She represses power and a large amount of hostility. She fails to perceive or accept her underlying narcissism and bitterness.

Conscious Identification. She is very disidentified with all family members. She is completely disidentified with the sadism attributed to father and husband and also fails to ally with her mother's strength.

Equation. She exactly equates her father and husband, which suggests an oedipal marriage. She mated with the duplicate of her feared and hated father. Her mother is not seen like the male family members. The maternal equation indices indicate that the mother is seen as strong and much less hostile.

Conscious Self Acceptance. The patient has a very high score on self rejection. She devaluates her own passivity.

Self Actualization. She has the lowest possible score (114) on self actualization. Her symptomatic helplessness is the exact opposite of the strength she idealizes.

Preconscious Self Acceptance. The TAT Hero and Other scores are distant from the Ideal, indicating that her underlying feelings conflict with her conscious ideal. She may feel guilty about her preconscious motives. This guilt may inhibit or complicate the process of their becoming conscious.

It is useful to work on the (unvalidated) hypothesis that a large conscious self rejection score indicates conscious guilt or devaluation while a large preconscious self rejection index refers to unconscious guilt which is connected with underlying feelings.

Idealization. The patient consciously idealizes her mother (low index) and devaluates her father and spouse (large index). The indices of *Fusion, Displacement* and three indices of *Preconscious Identification* are omitted. These measures require a diagnosis of preconscious images of mother, father and spouse. These scores are not currently included in the diagnostic system. We are awaiting the validation of the new Level III test expressly designed to fit the interpersonal system.

Preconscious Identification. The indices of preconscious identification reflect the tendency of the TAT Hero to be similar to or different from the conscious description of family members. The sample patient is very closely identified (preconsciously) with her father and husband and somewhat with her mother. Her own underlying narcissism is very close to the sadism of father and husband. This suggests either that she "projects" her own strong hostile feelings on to these male figures or that she may indirectly express these feelings by provoking these males to be cruel and cold to her. Although she consciously claims to be disidentified with them, she is preconsciously very linked to them.

Clinical Implications

In the routine diagnostic report, the clinical predictions are usually arranged under six headings:

1. Motivation for psychotherapy
2. Prediction of initial and later resistance to change
3. Summary of conscious and preconscious identification patterns and the predicted transference possibilities.
4. Preconscious conflicts and the associated defensive process
5. Prognosis of response to psychotherapy
6. Recommended type of psychotherapy

Motivation for Psychotherapy

This patient is fairly well motivated for psychotherapy. She is symptomatically upset and helpless and wants relief. Her self acceptance index is very low, indicating dissatisfaction with her character.

There are, however, some factors which complicate motivation. To a certain extent she may want symptomatic relief more than personality change. Her symptomatic Level I is to the left of Level II Self; this means she sees herself as an innocent, sweet person made very sick (symptomatically). We suspect that she attributes her symptoms to the evil-doing or hostility of others (male figures) and does not see that her masochistic tendencies probably lead her to seek out and provoke rejection. This hypothesis is partially supported by the MMPI profile. Her paranoid scale is high. Her K score and Hy are more elevated than one would expect for such an elevated record. These three findings suggest that there are

denial factors operating to project blame onto others and to avoid taking responsibility for her own symptoms and problems.

Motivation for help and therapy is, therefore, considered good, but motivation for change and insight is less strong.

Prediction of Initial and Later Resistance to Change

The first three digits of the diagnostic code are often useful in predicting the sequence of interpersonal resistances encountered in psychotherapy. The diagnoses for this patient are **563**. It is predicted that the initial interpersonal pressure will be masochistic and helpless (code **5**). Also present in the facade operations is the Level II formulation of docile, dependent, naive passivity (code **6**). These security operations communicate the message, "I am weak and good—I deserve sympathy, support and nurturance." The underlying themes (code **3**) suggest that aggressive and hostile feelings will emerge later in therapy. The expected sequence would be—the patient attempts to pull tender protection from the therapist, trying to get him to help, advise, counsel. This may be followed by an angry rejection of the therapist.

The three layer code suggests that although the patient appears on the surface to be weak and docile, there are sadistic feelings underneath which will probably express themselves in the therapeutic relationship. She will probably become angry because the therapist has not helped her.

Summary of Conscious and Preconscious Identification Patterns and the Predicted Transference Possibilities

The patient is consciously disidentified with all family members and is preconsciously identified with the sadism and coldness of the father and husband. She idealizes her mother's strength but is not identified with her mother at any level.

The following oedipal pattern is suggested. The patient probably developed a docile, admiring dependence on her mother, from whom she wants protection. She is involved in masochistic relationships with her father and husband. Although her facade is feminine and passive, she is secretly aligned with and admiring of the hostile masculinity she attributes to her male relations.

The transference possibilities can, of course, be influenced by external factors such as the sex and interpersonal reaction of the therapist. We might hazard the prediction that she will tend to see strength in a male therapist as sadistic (like her male relatives). Softness or tenderness in a male therapist she would eventually despise. Strength in a female therapist would be seen as maternal. Softness in a female therapist would elicit sadistic feelings and she would develop a contemptuous anger against the therapist.

A skillful therapist will, of course, be aware of the interpersonal pressure being exerted by the patient, will avoid being pulled into these interpersonal power-fields, and will help the patient understand the intensity and meaning of her masochistic-sadistic operations.

Preconscious Conflicts and the Associated Defensive Processes

The major conflicts are: 1. masochistic behavior *vs.* innocent-docile, abused self-image; 2. this two-layer passive facade *vs.* underlying sadistic tendencies; 3. sexual confusion between her ultra-feminine facade and her underlying identification with and admiration of hard, tough maleness.

The defense mechanisms (*ie.,* variability indices) which link up the personality organization are: 1. moderate misperception of own masochism; 2, repression of sadistic feelings; 3. preconscious identification with the aggressor.

Prognosis

This patient has a fairly good prognosis. She is severely disturbed, but her motivation is moderately high. The facade of passivity makes it easy for her to accept help initially. By the time the sadistic feelings emerge, she should be enough involved in therapy to tolerate their management.

On the negative side are the paranoid tendencies to project blame and responsibility and the pious self image. If she gets very anxious, she may project either evil or weakness onto the therapist. If a catastrophic breakdown occurs, it will come as a paranoid break (not a suicidal or a violent episode). The chances that this will occur in psychotherapy are slim, although this might militate against her being considered for psychoanalysis.

She is a long-term case. It might be predicted that therapy would have (at least) three steps: 1. initial masochism and passivity; 2. working through of sadistic reactions accompanied by self-derogation and guilt; 3. a final period of integration which might be

lengthy in duration. The three levels tapped by our measuring tools do not go far enough to predict the kind of resolution which would be worked out in such a final stage.

To summarize: the prognosis is good for long-term psychotherapy.

Recommended Type of Therapy

Supportive counseling is not recommended. It will increase her facade masochism and dependence. It will also make her contemptuous of the counselor and thus more guilty.

Psychoanalysis should be considered with great caution.

Long-term psychotherapy, either group or individual, is the treatment of choice. She has a severe interpersonal conflict which can be helped in psychotherapy. It is doubtful whether her paranoid tendencies could tolerate exploration of the underlying and basic sexual motivation.

Part III

Interpersonal Diagnosis of the Group and the Individual in the Group Situation

Chapter 7

ANALYSIS OF OVERT INTERACTION: THE SOCIOMETRIC BOOKLET

The Interpersonal System of Personality has been used in the diagnosis of the interpersonal structure of groups and the interpersonal diagnosis of individuals in relationship to the members of groups to which they belong. This procedure involves a sociometric technique using the Interpersonal Check List and the multilevel theory of variability. There are two methods of analysis; one involves the measurement of overt interactions; the other, covert attitudes present in the group. This will be discussed in a later chapter.

The analysis of group dynamics studies the pattern of Level I and II scores of the total group. Some groups are very homogeneous. All members use the same security operations at Levels I and II. The type of favored operations makes it possible to diagnose the total group as "power-oriented" or "hostile" or "competitive." Some groups, on the other hand, are very heterogeneous. There is no central tendency; the different members use widely differing interpersonal operations. This heterogeneity is, of course, important in understanding and dealing with the group. Depending on the kind and amount of homogeneity, different predictive and clinical statements can be made which will be of use to the leader or therapist of the group.

In addition to studying the interpersonal characteristics of a group, it is also useful to consider the overall group pattern in the Variability Dimension. Groups differ in the amount of identification among members, as well as the amount of misperception of others.

The health and competence of any group can therefore be diagnosed in terms of its overall interpersonal "tone," its heterogeneity and the amount of identification and misperception.

The sociometrics are also very useful in interpersonal diagnosis of the individual in relationship to his group. The preceding section described the process of individual clinical diagnosis employing three tests and the Diagnostic Booklet. The procedure for individual diagnosis which is described in this section involves the use of other people as diagnostic instruments of the patient and as stimuli for his perceptions and projections. This procedure requires that each subject in a group of from three to eight persons rate himself and each other group member on the Interpersonal Check List. The complex set of scoring and diagnostic steps which follow are accomplished by means of the "Booklet for Interpersonal Anaylsis of Group Dynamics" (see Figure 7).

Administration

The test can be taken in a group, or the individuals can fill out their answers separately.

Each member of the group to be tested is given an Interpersonal Check List. His name is written in the space labeled Column 1 (top left of the check list sheet). The names of the other members of the group are arranged in alphabetical order and the names are filled in Columns 2, 3, etc. There will be as many columns filled in as there are members of the group. If an outside person (*e.g.*, group therapist, teacher, leader) is to be rated by the members, his name is listed last, after the roster of members.

The subject rates himself in column one. When he finishes, he rates the member listed in column two. He then proceeds in serial order to rate each member of the group.

Scoring

The check list is scored in the manner described in Chapter 3. The initials of each person rated are coded in above the scoring column on the check list booklet. The raw score indices are then calculated for each person rated and entered at the bottom of the check list.

Use of the Record Booklet for Interpersonal Analysis of Group Dynamics

The Booklet for Analysis of Group Dynamics is presented in Figure 7. In order to illustrate the step-

FIGURE 7

Record Booklet For

Interpersonal Analysis of Group Dynamics

Subject Sales Manager Age 44 Sex M Date

Address City Phone

Education 14 years Occupation Sales Manager Marital Status M

Group Leader Date Group Began

Socio # 1 given after sessions. Date Group Ended

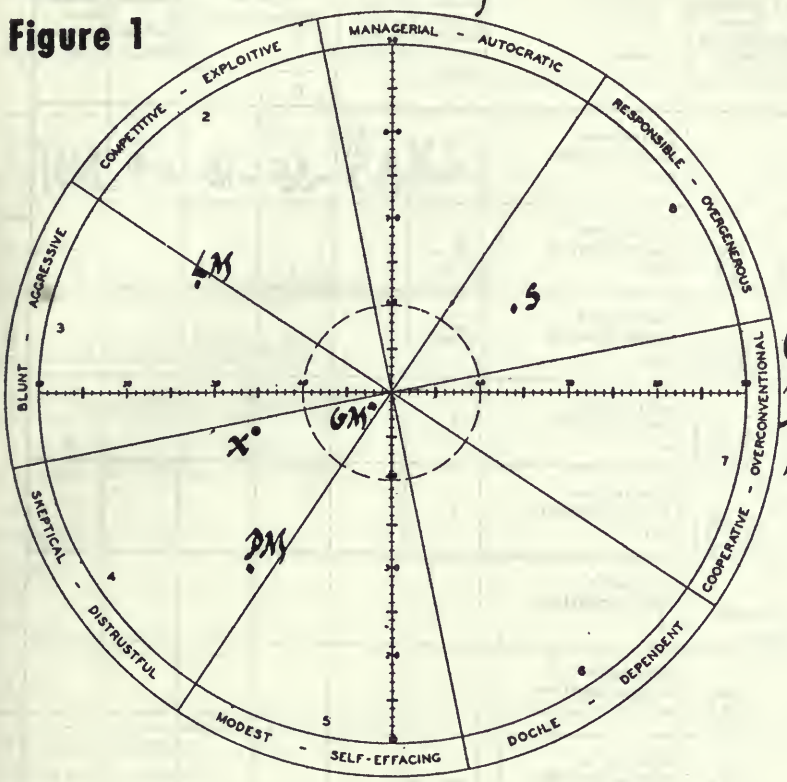
Meeting time:
Day Hour Total Number of Sessions

Members of Group	Initial	Remarks
Subject Sales Manager	SM	
Other Members (Arrange Alphabetically)		
General Manager	GM	
Production Manager	PM	
Personnel Manager	LM	

This booklet was prepared by Timothy Leary, Ph.D., and published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, California. Checklists, booklets, templates, norms, and instruction manuals can be obtained from the Psychological Consultation Service.

Subject Sales Manager as Seen by Members of Group

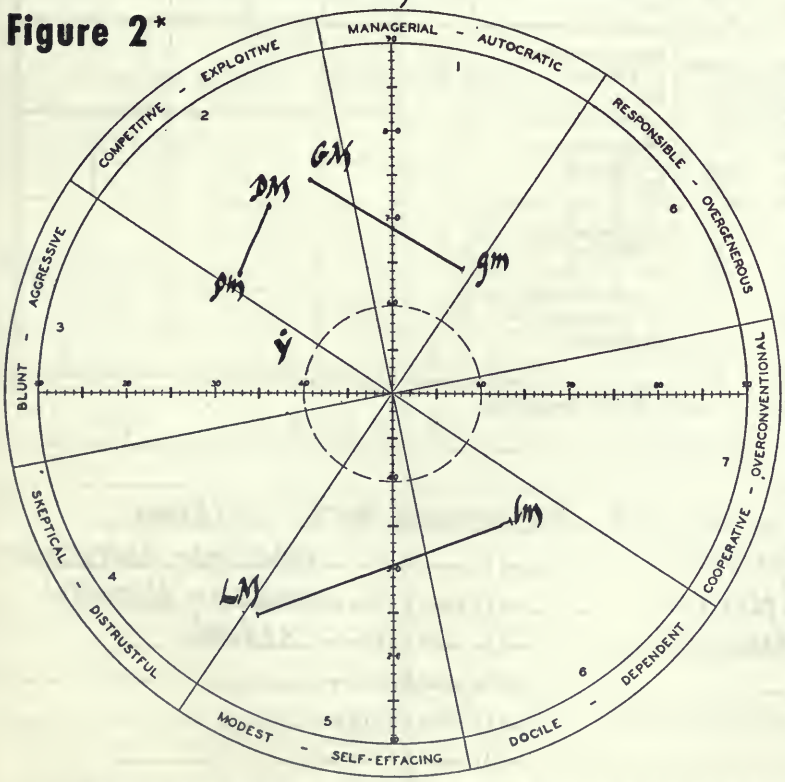
Figure 1



Key to Capital Letters in Figure 1	Interpersonal Diagnosis of Subject
X = Pooled total of group's perception of subject	4
S = Self-perception	8
GM = Subject by General Manager	4
PM = Subject by Production Manager	4
LM = Subject by Personnel Manager	3
___ = Subject by _____	___
___ = Subject by _____	___
___ = Subject by _____	___
___ = Subject by _____	___

Subject Sales Manager's Perceptions of Members of Group

Figure 2*



Key to Capital and Small Letters in Figure 2

Interpersonal Diagnosis of Fellow Group Members by Subject Sales Mgr. (From Table I--use capital letters)	Interpersonal Diagnosis of Fellow Group Members by Total Group (From Table III--use small letters)
Member GM = 2	Member gm = 1
Member PM = 2	Member pm = 2
Member LM = 5	Member lm = 6
Member ___ = ___	Member ___ = ___
Member ___ = ___	Member ___ = ___
Member ___ = ___	Member ___ = ___
Member ___ = ___	Member ___ = ___
Y (Total Group) = 3	
S (Self perception--same as above) = ___	

* The small letters represent the pooled total of the group's perceptions of each member, exclusive of his own self-rating. For example, "h" = the group's perception of the behavior of member "H". "H" = the subject's perception of member "H". The distance between "H" and "h" on the diagnostic grid is an index of the misperception by the subject of his fellow group member, "H".

Indices for Measuring Group Dynamics (Misperceptions of Self and Others)

Verbal Definition of Index	Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Standard Score Discrepancy	Verbal Definition of Index	Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Standard Score Discrepancy
Conscious Identification *Use capital letter initials from key to Figure 2*							Conscious Identification with	S LM	85	-88	-58	105	D151
Self Deception	SX	84	-64	-94	114	D	Conscious Identification with	S__					
Conscious Identification with Total Group	SY	83	-21	-103	105	D151	Conscious Identification with	S__					
Conscious Identification with	S gm	82	+15	-79	81	D151	Conscious Identification with	S__					
Conscious Identification with	S pm	82	+15	-79	81	D151	Conscious Identification with	S__					
Subject's Misperception *This misperception index is the distance between capital and small letter initials for any fellow group member in Figure 2.*							Subject's Misperception of	__					
Subject's Misperception of GM	GM gm	21	+9	+43	44	P	Subject's Misperception of	__					
Subject's Misperception of PM	PM pm	22	0	0	00	P	Subject's Misperception of	__					
Subject's Misperception of LM	LM lm	56	+9	+43	44	P	Subject's Misperception of	__					
Misperception of Subject by Others *This misperception index is the distance between X and the capital letter summary of the appropriate fellow group member from Figure 1. Fill in the blank with the appropriate capital letter*							Misperception of Subject by	X__					
Misperception of Subject by	X GM	44	+13	+19	23	P	Misperception of Subject by	X__					
Misperception of Subject by	X PM	44	0	0	00	P	Misperception of Subject by	X__					
Misperception of Subject by	X LM	43	+43	-9	44	P	Misperception of Subject by	X__					

Verbal Summaries of Group Dynamics

The subject misperceives his own Rebellions distrust

The subject is identified with No one -

The subject is disidentified with All three - most disidentified with personnel mgr's. weakness

The subject sees General Mgr. as exploitive [1] and is seen by him as rebellions - distrustful [2]

The subject sees Production Mgr. as exploitive and is seen by him as rebellions - distrustful

The subject sees Personnel Mgr. as masochistic and is seen by him as sadistic

The subject sees ____ as ____ and is seen by him as ____

The subject sees ____ as ____ and is seen by him as ____

The subject sees ____ as ____ and is seen by him as ____

The subject sees ____ as ____ and is seen by him as ____

[1] Fill in the name of the fellow group member and the verbal diagnosis for the sector in Figure 2 in which he falls.
[2] Fill in the verbal diagnosis for the sector in Figure 1 in which the group member saw the subject.

Tally Sheet: Table I

Subject Sales Manager 's Perceptions of Himself and of the Members of His Group
(Providing Capital Letter Locations for Figure 2)

Subject Sales Manager 's Perceptions of:		Octant Totals								Total Items Checked	Raw Score Formulae		Standard Scores	
Name	Initial	1	2	3	4	5	6	7	8		D-S	L-H	D-S	L-H
1. of Self Sales Manager	SM										+55	+14.0	61	64
2. of General Manager	GM										+15.8	-7.4	74	40
3. of Production Manager	PM										+14.7	-13.5	72	33
4. of Personnel Manager	LM										-21.4	-11.1	26	36
5. of														
6. of														
7. of														
8. of														
Total of perceptions of the group members											+9.1	-32.0		
Total divided by N – 1 = Y											+3.0	-10.7	57	36

Table II

The Perceptions of Subject Sales Manager BY the Members of His Group (Providing Capital Letter Locations for Figure 1)

Subject seen by:	Raw Scores		Standard Scores	
	D-S	L-H	D-S	L-H
By GM	-4.7	-0.8	48	47
By PM	-19.0	-15.7	30	30
By LM	+4.5	-19.9	59	26
By				
By				
By				
By				
Total	-19.2	-36.4		
Total divided by N – 1 = X	-6.4	-12.1	46	35

Table III

Summed Perceptions by Group of Each Member
(Providing Small Letter Locations for Figure 2)
Excluding Subject of Booklet and Member Considered

Group's Perceptions of:		Raw Totals		Raw Totals Divided by N-2		Standard Scores..	
Name	Initial (Small Letter)	D-S	L-H	D-S	L-H	D-S	L-H
Gen. Mgr.	gm	+15.6	+18.2	+7.8	+9.1	64	58
Prod. Mgr.	pm	+24.0	-26.8	+12.0	-13.4	69	33
Pers. Mgr.	lm	-26.4	+29.6	-13.2	+14.8	37	65

by-step derivation of group dynamic diagnoses and indices we have included the scores of a sample case. To conserve space, the booklet of only one member (the Sales Manager) is presented here. This subject rated himself and the three other members of an industrial management group. The group members involved are:

the Sales Manager (coded SM)
the Production Manager (coded PM)
the General Manager (Coded GM)
the Personnel Manager (coded LM)

The booklets of all members must be worked up simultaneously to determine the pattern of mutual identification and misperception.

In using the booklet, the first step is to fill out information on Page 1 using one record booklet for each individual in the group. Turn now to Table 1 on Page 4 of the booklet. Transfer the raw score indices from Page 3 of the ICL to Table 1 on page 4. List the Dominance scores in the boxes under "Raw Score Formulae D-S" and the Love scores under "Raw Score Formulae L-H."

Total the D-S raw scores *with the exception of the score for self* and enter the total under "Raw Score Formulae, D-S" and to the right of "Total perceptions of the group members." Repeat for the L-H column. Divide these Dominance and Love scores, respectively, by the total number of group members *minus one;* the result will be an average of total members' perception excluding self. Enter these averages in the boxes to the right of "Total divided by N – 1 = Y."

From column "Dom" in the table of norms for Level II (Appendix C) determine the standard scores for all items under "Raw Score Formulae D-S." Enter each standard score to the right of its corresponding raw score under "Standard Scores D-S." Using column "Lov" in the table of norms, find the standard score for each item under "Raw Score Formulae L-H" and enter it under "Standard Score L-H." Include the standard scores for N – 1 = Y items.

These steps have been followed for the illustrative case. His raw score indices for self perception (calculated on his check list booklet) are +5.5 and +14.0. These convert to the standard scores Dom = 61, Lov = 64. The raw score indices representing the Sales Manager's perceptions of his three colleagues add up to +9.1 and –32.0, respectively. We divide by N – 1, which figure indicates how many others were rated by the subject. The resulting quotients are +3.0 and –10.7. From Appendix C we find that these convert to the standard scores, Dom = 57 and Lov = 36.

On Page 2 of the booklet will be found the diagnostic circles for summarizing how the subject is seen by Self and others (Figure 1) and how the subject sees himself and the others in his group (Figure 2). To plot S (self perception) on Figure 1, use the standard scores from Line 1 of Table 1. With a transparent rule, locate standard score D-S on the vertical calibrated line of the graph. Locate standard score L-H on the horizontal line. Make a dot at the point where the two indices intersect, and label it "S." Copy this plotting of S on Figure 2.

In like manner on Figure 2 below, plot the other individuals listed in Table 1, labeling each, in capital letters with the initial of the person seen by the subject of the booklet. These capital letter scores summarize the subject's perceptions of each of his fellow group members.

The next step is to determine how the subject was seen by the other members. It is necessary to go to the record booklets of the other members, *i.e.,* their Table 1's, and to collect from their booklets the indices which reflect how those persons saw the subject. The scores from Table 1 of the other three subjects provided the scores for Table 2 of the Sales Manager's booklet. Using Table 1 in the record booklet of the illustrative subject (Sales Manager) we transferred his raw score and standard score ratings of the General Manager to Table 2 of the General Manager's booklet. These booklets are not reproduced in this manual. We similarly transferred the subject's ratings of the Production Manager from Table 1 of the subject's booklet to Table 2 of the Production Manager's booklet. Repeat until Table 2 of each member's booklet contains raw and standard scores of perceptions by every other member. The subject of the booklet will not appear in Table 2 of his own booklet.

Add the *raw scores* in Table 2 and divide the sum by the total number of members in the group, *minus one;* the result will be an average of all group members except the subject of the booklet. Enter the averages to the right of "N – 1 = X." Use these indices to determine the standard scores from the Interpersonal Check List table of norms (Appendix C). Plot the standard scores from Table 2 on Figure 1, labeling each in capital letters with the initial of the person who is viewing the subject.

Table 2 of the illustrative case indicates that the General Manager sees the subject as Dom = –4.7; Lov = –0.8. These convert (Appendix C) to the standard scores Dom = 48, Lov = 47. The raw score indices reflecting the perceptions by others of the subject total: Dom = –19.2 and Lov = –36.4. When divided by N – 1 the indices Dom = –6.4 and Lov = –12.1 result. These are converted to standard scores. This X score representing the consensual group picture of the subject is plotted in Figure 1.

Table 1 and Figure 2 of the booklet present the subject's perception of his fellow group members. We are interested in the accuracy of these perceptions. To measure the amount of misperception we must compare the subject's view of each other person with the pooled consensus of how all the other members rated each other. If the subject sees the Production Manager as exploitive and if the other members of the group (excepting the Production Manager's own self perception) agree that the Production Manager is exploitive, then our subject is perceiving the Production Manager accurately, *i.e.,* he agrees with the consensual diagnosis of the Production Manager.

To make this objective estimate of misperception it is necessary to determine the consensual diagnosis of each member by the group (omitting both the subject whose accuracy we are checking and the recipient of the rating).

On line 1 of Table 3 of Subject A's booklet enter the name of Subject B. Add the raw D-L scores of all the group members' ratings of Subject B except Subject A's rating of Subject B and Subject B's rating of himself. These are found in Table 1 of the booklets of the other members. Enter these sums under "Raw Totals" beside Subject B's name in Table 3 of Subject A's booklet. Divide these sums by the total number of group members *minus two.* Enter the dividends in the next column and use these figures to determine the respective D-S and L-H standard scores (from Appendix C). Enter these standard scores on Table 3 and plot them on Figure 2, using small (lower case) letters to label them.

Repeat for all other members of the group, always excluding ratings by the subject of the booklet and the group member under consideration.

Enter the diagnoses from Figure 2 under "Interpersonal Diagnosis of Fellow Group Members by Total Group" on Page 2 of the booklet, again identifying the scores with small letters.

For each summary point plotted in the two circles (Figures 1 and 2 of the booklet) a red or black diagnostic code is determined by inspection. This method has been described in the discussion of the individual diagnostic booklet. The diagnoses of the subject (from Figure 1) are listed at the top right of Page 2. The diagnoses of the other members by the subject and by group consensus are entered in the two columns to the right of Figure 2.

Turning to the illustrative case, we note (from Figure 1) that he diagnoses himself as **8**, is seen by the group consensus as **4**, that he is seen by the General Manager as a **4**, etc.

On Figure 2 we observe that the summed total of the Sales Manager's perception of his colleagues (Y) is **3**, indicating that he attributes sadistic tendencies to his fellow members. We also observe that the subject diagnoses the General Manager as a **2** whereas the group consensus labels the General Manager as a **1**.

At this point we have for each subject a complex set of interpersonal diagnoses. These code diagnoses summarize how he sees himself (S), how the total group sees him (X), how he sees the total group (Y), how each other individual diagnoses the subject and how the subject diagnoses the interpersonal behavior of each other person. This network of scores is of considerable value in understanding group dynamics. The diagnostic report presented in Chapter 9 will summarize how these scores are used.

The list of interpersonal diagnoses serves another important purpose. By systematically studying the differences among these coded summary scores, we obtain the variability indices for objectively measuring the group dynamics factors. These are calculated on Page 3 of the booklet. The procedure is the same as that employed in calculating interlevel variability indices for individual diagnosis. The verbal definition of each variability index is listed on the left. The operational definition indicates which pair of diagnostic codes is being compared.

The index of Self Deception measures the discrepancy between the subject's self diagnosis (S) and the pooled total of the group's perception of him (X). This index is calculated as follows: the symbols SX define the variability index. Enter in column 2 of Page 3 the diagnostic numerals found opposite S and X on Page 2. For the illustrative subject these codes are **8** and **4** respectively. Turn now to the "Table of Weighted Scores for Discrepancies" (Appendix G). The indices for the misperception **84** are Dom = –64, Lov = –94 and d = 114. This in-

dicates that the subject misperceives his own passivity (–64), his own hostility (–94), and that he is extremely self deceived (114).

The other indices of group dynamics are derived in the same fashion. Conscious identification with the total group compares S (which is **8** for the sample case) and Y (which is **3**).

There are seven spaces for deriving the indices of conscious identification with other group members. The diagnostic numeral for S remains the same throughout. The initials for the "others" are the capital letters taken from the column adjacent to Figure 2 on Page 2 in the order in which they appear.

Below the spaces for identification will be found seven spaces for calculating the indices of the subject's misperception of others. The diagnostic codes to be compared are taken from the capital and small letter columns adjacent to Figure 2.

Below these will be found seven spaces for deriving the misperceptions of the subject by other group members. Here we determine the discrepancy between the group consensus (X) and each group member's perception of the subject. The codes are found in the column opposite Figure 1 on Page 2.

The final column on Page 3 is labeled "Standard Score Discrepancy." Standard scores are not used for variability indices because the discrepancies are not normally distributed. The column can be used, if desired, to write in an abbreviation of the kind of discrepancy (see Table 8).

If the self deception index is 0–44, then the letter "P" representing accurate perception is coded in. If this index is greater than 44, the abbreviation "D" (indicating self-deception) is written in.

If the identification index is 44 or below, the initial "Id" is used; if greater than 44, use the abbreviation "Disi" (for disidentification). If the misperception indices (of subject and by subject) are 44 or below, use the code "P"; if larger, use "D."

At the bottom of Page 3 will be found verbal summaries of the major group dynamics factors. The criteria just cited provide verbal designations for a high or low discrepancy. The kind of misperception, identification and disidentification is indicated. For verbally summarizing the subject's relations with other group members, fill in the name of the other person, and the verbal diagnoses for the sectors in Figures 1 and 2 in which the perceptions fall.

To compare the variability indices of any group with the variability indices of groups studied by the Kaiser Foundation Psychology Research see Appendices H and I.

Chapter 8

MEASUREMENT OF COVERT INTERPERSONAL ATTITUDES IN THE GROUP

The preceding section has presented a detailed description of the procedure for diagnosing interpersonal behavior and measuring group dynamic factors. This technique provides very clear-cut results in heterogeneous groups where the members manifest different roles and where intense interpersonal emotions are present and fairly apparent. In the group therapy situation, great differences in interpersonal security operations generally appear, and dramatic projections and misperceptions are recorded. In homogeneous groups or in groups where free and frank descriptions of others is not the rule, the booklet analysis tends to pick up facade operations and fails to register the subtle, covert, interpersonal dynamics. In many industrial or occupational group settings there is a tendency for everyone to see everyone else for the most part as a "nice guy" or a "responsible executive." A tight island of mutual approval develops because the members of top level industrial groups tend to be more healthy, or stereotyped, or at least able to maintain efficient and apparently harmonious operating facades.

A straightforward and effective technique has been developed to bring out the underlying differences and misperceptions. This is called the Idiosyncratic Method for the Measurement of Covert Group Dynamics. This method involves a molecular analysis of idiosyncratic check list items, *i.e.,* items which a subject checks for just one or a few members and not for the majority, or items which he checks for almost everyone and significantly omits for one or a few fellow group members. This finer-meshed analysis will now be described and illustrated.

In the standard sociometric procedure, each subject checks for each item on the check list the persons whom he feels the word describes. For the purpose of idiosyncratic analysis, items which do not discriminate are discarded. For example, we discard an item if all members are checked on it. If a subject checks no member, the item is similarly discarded. If the subject checks a very large percentage (*i.e.,* 66% or more) of the members on any item, the omission of the item for the minority group is considered an idiosyncratic rating and is listed as a significant omission. If the subject assigns a check to only one of four, thus indicating that the word does not apply to the majority of the members, that item is included in the list of idiosyncratic items. In groups of more than four members, an item is considered idiosyncratic if it is assigned by a rater to no more than ⅓ of the members (*e.g.,* to 2 out of a group of 6–8, 3 out of 9–11, 4 out of 12–14, etc.).

The point of the procedure is to build up a list of idiosyncratic items which defines the unique perception of each person by each other person. These clusters of unique, differentiated items can then be analyzed for their interpersonal significance and become a new level of analysis.

Table 9 presents an illustration of the selection of idiosyncratic items for a group of four members. The words "forceful" and "spineless" are omitted from the study because they are not idiosyncratic. The word "critical" is included as idiosyncratic of the subject's (*i.e.,* Sales Manager's) view of Subject LM because LM is the only member not given this rating. The item "not critical" is entered in the cluster of words which define SM's unique view of LM. Notice that the negative term "not" is added as a prefix for significant omissions. The item "modest" is also included as uniquely descriptive of LM because he is the only member of the group given this rating by SM.

TABLE 9

Illustration of the Selection of Idiosyncratic Items from Interpersonal Sociometric Check List of Subject SM

SM (Self)	GM	PM	LM	
X	X	X	X	Forceful
				Spineless
X	X	X		Critical
			X	Modest

The list of idiosyncratic items characterizing the Sales Manager's perception of the Personnel Manager (LM) are: apologetic, **5**; (not) forceful, **5**; (not) outspoken, **5**; meek, **5**; usually gives in, **5**; modest, **5**; (cannot) be strict if necessary, **6**; (not) hard-boiled, **6**; (not) straightforward and direct, **6**; lets others make decisions, **6**; (not) firm but just, **6**; agrees with everyone, **7**; (not) critical, **7**.

The idiosyncratic items characterizing the Sales Manager's perception of the Production Manager

are: acts important, **1**; (not) helpful, **2**; (not) big-hearted and unselfish, **2**; (not) modest, **2**; boastful, **2**; proud and self-satisfied, **2**; somewhat snobbish, **2**; egotistical and conceited, **2**; (not) friendly, **3**; (not) trusting and eager to please, **3**; (not) sociable and neighborly, **3**; (not) warm, **3**; (not) kind and reassuring, **3**; doesn't enjoy taking care of others, **3**; cold and unfeeling, **3**; sarcastic, **3**; (not) friendly all the time, **3**; (not) well thought of, **4**; can complain if necessary, **4**; (not) appreciative, **4**; (not) respected by others, **5**.

After each item a numeral has been added. This is the octant rating. The number **5** follows the negative item "(not) forceful." This rating of **5** (which indicates self-effacing masochism) was assigned to this item by a team of judges. The judges believed that by not attributing the adjective "forceful" to the Personnel Manager (when he had checked it for all the others), the Sales Manager was indirectly diagnosing the Personnel Manager as "self-effacing." An octant rating was similarly assigned by the judges to each other significantly omitted item. For positive items the octant score printed in the check list is, of course, maintained. The item "easily embarrassed" for example, is number 49 on the check list and is located there in the Hi or **5** octant.

After the idiosyncratic items differentiating each rater-ratee combination have been listed, they are plotted on a circular diagnostic profile. The technician can either make his own circles or cut out the small unilevel circles from the individual diagnostic booklet. The items are then graphed or shaded in. Figure 8 presents the idiosyncratic perceptions by the Sales Manager of two of his colleagues.

Generally the pattern of idiosyncratic items tends to pile up in one octant of the circle. In many cases, particularly in homogeneous groups, the interpersonal diagnosis which results from an idiosyncratic analysis is very different from the booklet diagnosis. Everyone in a tight-knit homogeneous group may see a fellow member as hypernormal on the booklet diagnosis. Analysis of covert tendencies shows that two members tend to see him as being uniquely sadistic, two others as docile and another as narcissistic. These nuances or cues to covert relationships or private perceptions should be checked for validity by the clinician using the method.

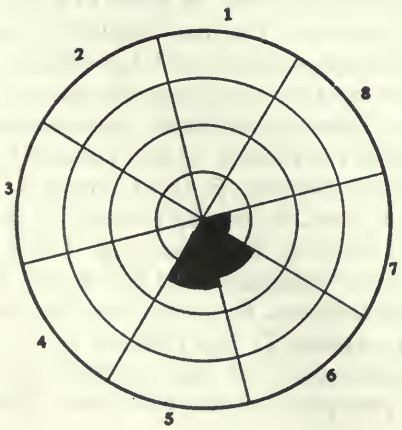
Even more frequent and more impressive are those cases where all the members give a fellow member a booklet diagnosis of hypernormal or managerial, while all of them agree in their covert ratings on an entirely different diagnosis. They may unanimously place him on the idiosyncratic diagrams as sadistic or passive.

After the diagrams of idiosyncratic ratings have been graphed, it is usually helpful to add up all the idiosyncratic ratings given each member by the others. These ratings can be shaded in (using a

FIGURE 8

Diagrams Illustrating the Idiosyncratic Ratings by the Sales Manager of the Personnel Manager and the Production Manager

Sales Manager's View of Personnel Manager



Sales Manager's View of Production Manager

smaller radius for the circle). The resulting diagram represents the pooled total of covert perceptions. It can be compared with the booklet X score, which is the pooled consensual diagnosis of his facade.

In order to illustrate the use of the idiosyncratic techniques for analyzing covert interpersonal relations and the kinds of interpretations and information yielded by the group dynamics booklet, two sample writeups will now be presented. The first describes a group of top industrial executives, the second describes the pattern of interaction in a psychotherapy group. The purpose will be to illustrate a writeup of group dynamics of an industrial group based primarily on the idiosyncratic analysis of covert feelings and then the use of the sociometric method in a therapeutic situation.

Chapter 9
A HEALTHY MANAGEMENT GROUP

In a smooth functioning, harmonious group, the perceptions of self and others are more accurate and there is, in general, closer identification than in conflicted groups. That is, the members do not see extreme differences in social behavior between the members. This close consensus and shared-identification may be a facade phenomenon. The members do sense differences among each other and do have more intense and individual feelings about each other than they express. They are able, as it were, to control their special feelings of favoritism, disaffection and to maintain at the top level of operating behavior a "closed-ranks" unity.

The booklet method of group dynamics analysis measures this healthy facade directly in terms of the low scores on misperception and disidentification. Where the group maintains a unified operating front, the technique of idiosyncratic analysis can be employed to pick up what might be called "underlying" or marginal differentiating factors. We reanalyze the sociometric data to pick up clusters of cues which point to private (and perhaps preconscious) perceptions which do not appear in the surface analysis.

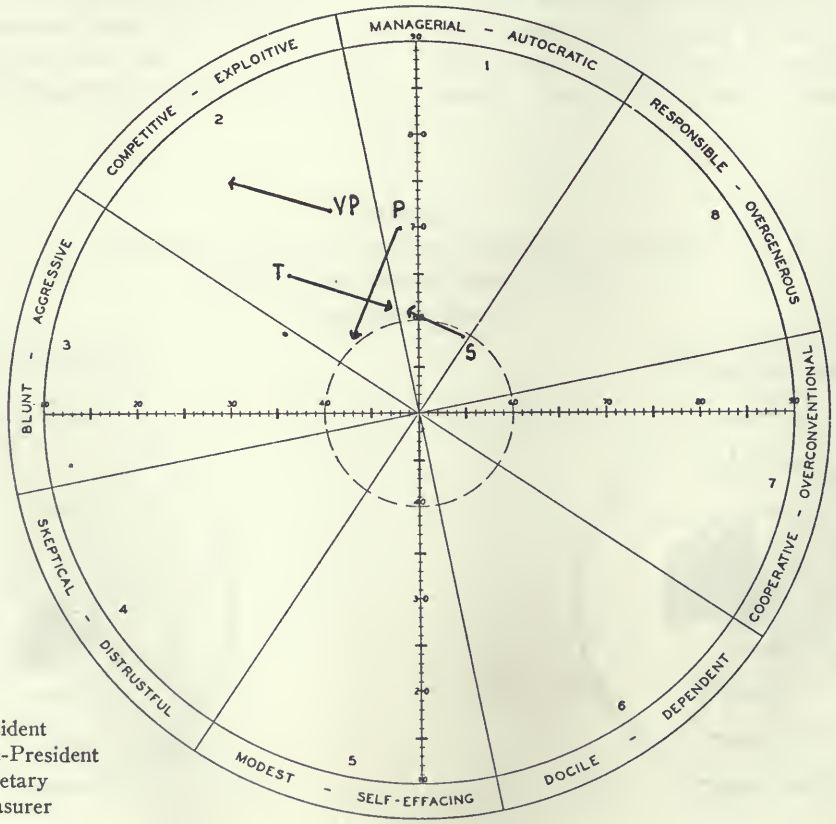
This method, which was described above, does not utilize the trigonometric techniques for summarizing the general pattern of ratings, but studies consistent patterns of idiosyncratic words on the Interpersonal Check List used by members to describe each other.

To illustrate the procedure for *analysis of underlying group dynamics,* we shall consider a group of four executives of a large department store. The subjects studied are:

P = President
VP = Vice-President
S = Secretary
T = Treasurer

Figure 9 presents the self-perceptions of each group member (arrowed points). These are connected by a

FIGURE 9
Self Perception and Consensual Summary Description of Four Executives



Key:
P = President
VP = Vice-President
S = Secretary
T = Treasurer

line to the location of the consensual perception of others (lettered points). It is apparent that this group is quite homogeneous. Three of the members diagnose themselves as in octant 2 (competitive-exploitive) and are in the neighboring octant (managerial-autocratic). All members agree that they share a strong, businesslike approach.

This group is reasonably accurate in its self-perception. The lines which separate self-diagnosis from diagnosis-by-others are short. The average index of self-deception is 6 which places this group three sigmas below the mean on the index of self-deception.

This is a well-adjusted, self-confident management team. It is a closely-knit group. They try to maintain a facade of mutual respect and a close identification with each other. There are underlying frictions and differences, but they are well controlled and probably do not interfere with an outwardly harmonious functioning.

The cohesive quality of this group derives from the shared feeling of pride, independence and competence. All members tend to emphasize a businesslike impersonal strength. They have considerable confidence in themselves and in each other. Although there is no intense conflict among them, neither is there a warm, friendly intimacy. They stress over and over again, self-reliance, competition, and a hard-boiled directness.

Another sign of healthy functioning is the accuracy with which these men view themselves and each other. These men are fairly well aware of their interpersonal machinery, and there is considerable agreement with the consensual picture. This is, in part, due to the way they "closed ranks" to present the uniform front of competence. There are underlying minor misperceptions, but one might suspect that these do not greatly interfere with their activities.

Although the group presents a unified facade, certain small differences are apparent even at the surface level. From Figure 9 we see that the Secretary is the least strong and most friendly, easy-going member of the group. The other three members are seen as very similar to each other, although there is some hint that the President is seen as strong, respected, and the Vice-President and Treasurer as more hostile.

This apparent homogeneity at the operational or conscious level diffuses considerably when the molecular analysis of idiosyncratic check list items is examined. This finer-meshed procedure was accomplished by an idiosyncratic analysis of the Interpersonal Check List form. When the idiosyncratic ratings of each member by each other member were listed, the following clusters appeared:

President of President (i.e., *self)*: can be indifferent, irritable, easily embarrassed, not sociable, doesn't give freely of self, outspoken, lacks self-confidence.

President of Treasurer: very anxious to be approved of, stern, resents being bossed, not modest, enjoys taking care of others, always giving advice, acts important, tries to be too successful, tries to comfort everyone.

President of Secretary: not forceful, not critical, cannot complain, unable to doubt others, doesn't admire, not often admired, not self reliant and assertive, doesn't like to compete, apologetic, always pleasant and agreeable, kind, helpful, likes everybody, hardly ever talks back, friendly all the time.

President of Vice-President: thinks only of himself, cold and unfeeling, not grateful, proud and self-satisfied, not appreciative, not eager to get along with others, not affectionate, big-hearted and unselfish, firm but just, straightforward and direct, hard to impress, not often helped by others, not warm, expects everyone to admire him, manages others, frequently angry, often unfriendly, slow to forgive a wrong, shy, somewhat snobbish, stubborn.

Treasurer of President: manages others, businesslike, irritable, respected by others.

Treasurer of Secretary: critical of others, big-hearted and unselfish, not a good leader, likes to compete with others, accepts advice readily, trusting and eager to please, kind and reassuring, not outspoken.

Treasurer of Vice-President: forceful, can be indifferent to others, often admired, resents being bossed, not sociable and neighborly.

Secretary of President: doesn't admire and imitate others, resents being bossed, hard to impress, not warm, not kind and reassuring, impatient with others' mistakes.

Secretary of Treasurer: frequently disappointed, anxious to be approved of, not stern but fair, skeptical, accepts advice readily, firm but just.

Secretary of Secretary (i.e., *self)*: not forceful, not critical of others, grateful, trusting and eager to please, not often admired, doesn't like to compete with others, modest, lets others make decisions, not shrewd and calculating.

Secretary of Vice-President: not often helped by others, not eager to get along with others, not friendly,

doesn't encourage others, stubborn, not sociable and neighborly, does not like everybody, not considerate.

Vice-President of President: not critical of others, warm, acts important, too lenient with others.

Vice-President of Treasurer: able to doubt others, apologetic, big-hearted and unselfish, friendly, gives freely of self, respected by others, fond of everyone, likes everybody, tries to be too successful, tries to comfort everyone.

Vice-President of Secretary: not straightforward and direct, doesn't enjoy taking care of others, not outspoken, easily embarrassed.

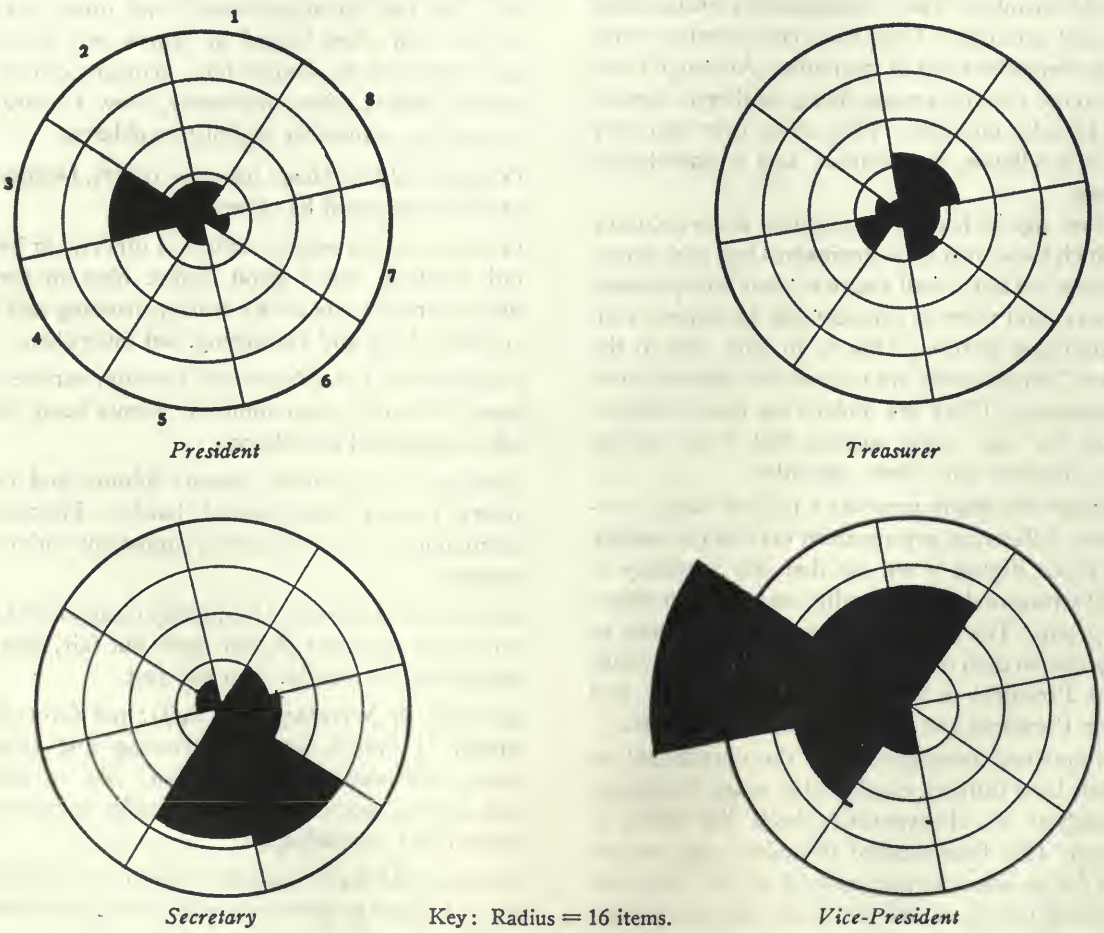
Vice-President of Vice-President (i.e., *self):* doesn't make a good impression, can be indifferent to others, frequently disappointed, not affectionate and understanding, stern but fair, irritable, hard to impress, not trusting and eager to please, not always pleasant and agreeable, not sociable and neighborly, always giving advice, expects everyone to admire him, bossy, dominating, impatient with others' mistakes, slow to forgive a wrong, self punishing, shy, often admired, dictatorial, somewhat snobbish, sarcastic, not friendly all the time.

A new, richer and more subtle picture of the network of relationships emerges from these clusters. The idiosyncratic ratings of each member by all the others were given octant ratings (as described in Chapter 8) and plotted on diagnostic circles. These results are presented in Figure 10 and should be compared with the Level I facade diagnoses from Figure 9.

The group consensual diagnosis of the President has not changed. He is still seen as strong and stern.

FIGURE 10

Illustration of Idiosyncratic Ratings of Each Member by Total Group



Key: Radius = 16 items.

The Treasurer is perceived as nurturant and supportive. The group is apparently more fond of and dependent on him than they reveal in the booklet diagnoses. The Vice-President takes on a much different appearance. He is described covertly as being sadistic, bitter and distrustful. Not one friendly rating is assigned. Intense underlying negative feelings exist which are only hinted at in the facade or booklet analysis. The Secretary is also revealed in a different light. An overwhelming amount of masochistic, self-effacing passivity is apparent. The members of the group apparently have covert attitudes of patronizing, tolerant superiority toward him.

It becomes clear in the light of the idiosyncratic analysis of covert trends that this group is not as homogeneous or closely-knit as it appears. Behind the effective operating front there are clear-cut differences which are summarized in the following reports.

Interpersonal Diagnosis of the President

Self Diagnosis

The President presents himself as a relatively successful self-confident person. He is aware, however, of certain negative traits and admits to being cold, indifferent to and critical of others. He also mentions private feelings of shyness and uncertainty. He sees himself as being more reserved and ill-at-ease than his colleagues. This is a misperception of self, because the others see his strength and self-confidence and do not seem to perceive his inner doubts. He is less inhibited than the Treasurer—more willing to expose himself or to look at himself critically. He (along with the Vice-President) would be the frankest person in talking to the psychologist and would be more receptive to developmental counseling.

Diagnosis of President by Group

The group likes and respects the President. Their consensual diagnosis of him is managerial personality — a forceful leader. They tend to focus on his strength, some emphasizing his cold, self-contained power, others, his likeability. None of them senses the self-doubt and loneliness which lie beneath the surface. This suggests that he has an effective, smooth-functioning facade and is not crippled by his mild conflicts.

The President's Relations With Others

The President has a moderate tendency to overestimate the strength of others and to underestimate the impact of his impressive facade. A mild sense of underlying lack of confidence accounts for his bias in perception.

The *President approves of the Treasurer* but is mildly critical of the treasurer's pompousness. He seems to sense some narcissistic self-centeredness in the Treasurer. The latter respects the President and sees him as strong and independent.

The *President likes the Secretary* despite his docile, apologetic manner, but tends to look down on his dependent passivity. He may tend to patronize the Secretary subtly. The Secretary seems to sense this and complains mildly that the President is hard to impress. He is a bit awed and fearful of the President.

The *President and Vice-President* have an interesting relationship. The Vice-President thinks that the President is too easy-going, this probably reflects the Vice-President's hard-boiled impatience and his avoidance of softness. The President admires and may fear the Vice-President's coldness. He is quite concerned with his hostile, critical behavior. Interestingly enough, the President is the only group member who senses the Vice-President's underlying shyness and lack of confidence. These two men may tend to have more open friction because they express feelings more directly. There are also the seeds of a close understanding because the President sees the Vice-President clearly and is in some ways closer to him than any other member.

Interpersonal Diagnosis of the Treasurer

Self Diagnosis

The Treasurer is a cautious, moderate, middle-of-the-road person. He was unable to take the test in a free manner and tended to stereotype his responses. He recognizes his inhibitions and senses that they keep him from being as strong and direct as the President and Vice-President. He is, on the surface, an over-conventional person, somewhat crippled by too much constriction.

Diagnosis of the Treasurer by Group

His social facade is that of a successful, self-confident person. The group agrees that he is not very forceful and expressive. They tend to vary quite a bit in their reaction to him. He is, in a way, a walking projective test. The group members seem to react to his colorlessness by projecting individual perceptions.

The Treasurer's Relations with Others

The Treasurer sees the President as a firm, stern, respected leader. The President sees the Treasurer as a successful person and attributes more power and prestige to him than do the others. This is a good relationship.

The Treasurer sees the Secretary as the mildest member of the group. The Secretary interprets the Treasurer's pastel facade as being a retiring reserve.

The Treasurer sees the Vice-President quite accurately and respects his assertive, aggressive power. The Vice-President projects warmth and nurturance onto the Treasurer.

To summarize this network of relationships, the Treasurer seems to have healthy contacts with the others—although his inhibition of feeling leads others to see him in different roles.

Interpersonal Diagnosis of the Secretary

Self Diagnosis

While the Secretary sees himself as a confident, outspoken, assertive, responsible person at the facade level, he is aware of the fact that he is less strong and more docile and yielding than any of his colleagues. He admits to being uncritical, eager for approval, not competitive, modest and less respected than the others. He does not realize the extent of his passivity and rates himself as stronger and less docile than the others see him.

Diagnosis of the Secretary by Group

The group is unanimous in their impression of the Secretary. He is clearly the most retiring, meek, sweet person in the group. They see him as eager for acceptance and approval. He is liked, but also patronized by the more hard-headed, independent members. Some see his passivity as a docile trust, others as a retiring shyness.

The Secretary's Relations with Others

The Secretary fears the President's aggressive facade and feels somewhat inferior to him. The President realizes the Secretary's docility, likes it, but patronizes it.

The Secretary manifests an interesting misperception of the Treasurer. He sees his reserve as being a weakness. The Treasurer is cautious in describing the Secretary, but betrays some superiority in looking down on him.

The Secretary is somewhat in awe and fear of the Vice-President's blunt lack of regard for others' opinions. He would like to receive more reassurance from him. The Vice-President, on the other hand, likes the Secretary. He recognizes his extroverted sociability, but does not react to it negatively.

Chapter 10

ANALYSIS OF INTERPERSONAL DYNAMICS IN A PSYCHOTHERAPY GROUP

One of the major uses of this system of analyzing group dynamics is its application to the group therapy situation. The theory of group therapy which has been developed by the Kaiser Foundation project holds that patients demonstrate in the therapeutic situation their characteristic interpersonal security operations for dealing with anxiety. We believe that from the opening moments of the first session the patients begin to exhibit their preferred interpersonal reflexes and to train the others to see them and react to them in typical ways. These maneuvers and the interpersonal relationships they create are usually directly related to the patient's symptom (*i.e.,* his reasons for being in therapy), to his underlying feelings and to the historical origins of his personality. The unique value of group therapy is that each patient can begin to learn about his impact on others. He perceives what he does to train others to react to him in a consistent way, and he can understand and clarify his reactions to others.

Many group therapists believe that discussion, analysis and clarification of the interpersonal reactions in the group constitute the major goal of treatment. Analysis of "process" is usually given preference to discussion of "content," and the latter is generally interpreted in the light of its immediate interpersonal meaning. Working from this assumption, the Kaiser Foundation project has from its beginnings focused on the measurement of interpersonal relationships in group therapy. The interpretation of the network of relationships is different from that used in industrial groups, because the goal and procedures in a therapy group are different.

The first step in analyzing group dynamics is to observe the over-all group tendency. After working with therapy groups for several years, the staff of the Kaiser Foundation found that it was possible to describe the "personality" of a group and to designate the group resistance. One group, for example, was anecdotally described as "slow and soggy," another was labeled "bitter and resistive," and another was called "centrifugal and lively."

Development of the Level I-S sociometric indices made it possible to objectify these clinical intuitions. In the "soggy" group, for example, five out of six patients were rated below the mean on dominance—their passivity and lethargy were clearly defined by plotting all the Level I-S scores on the same group diagnostic grid.

Several large-scale studies of interpersonal behavior and changes during psychotherapy have been accomplished by the Kaiser Foundation research project. The results of these investigations are beyond the scope of this manual and will be presented in a forthcoming publication. At this point we can state one conclusion which is pertinent to the present discussion. The more imbalanced or homogeneous the group, the less easy (and probably the less effective) the therapy. By this we mean that if a majority of the members of a group utilize the same interpersonal security operations, the task of the therapist is considerably complicated. If five members of a group are bland hysterics, they will tend to reinforce each others' reflexes, they will all like each other, they will all collaborate in denying and avoiding unpleasant emotions. The task of the therapist in facing a solid wall of "group-repression" can be discouraging. The group joins together to put the same interpersonal pressure on the therapist. If, however, a wise-cracking psychopath, a colorful, exhibitionistic narcissist, or a self-immolating masochist should be added, the pressure on the therapist is relieved. Intense interactions develop between the latter three and the hysterics. The therapist can observe or intervene with technical activities without bearing the brunt of a unified resistance.

The Illustrative Group

There were four women in this group. After the fifth session each member was administered the check list, on which she rated herself, each other member, and the therapist. Figure 11 presents the Level I (group consensus) and Level II Self diagnosis for each patient.

The Level I diagnosis from Figure 11 indicates that this is a passive group. Three of the four members fall below the horizontal line. Only one member (B) is seen as strong and independent. The two dependent patients (J and K) acted docilely like good patients presenting problems and asking for help and support. One member (H) was passively resistant, silent and self-effacing. She tended to be ignored by the group. Patient B is seen as competitive and narcissistic. She boasted, praised herself, established

her superiority over the others, told them loftily how to solve their situations. The therapist is consensually diagnosed as a strong, forceful and mildly supportive person (being a little to the right of the vertical line).

It is obvious that the members respect and depend on the therapist whom they expect to solve their problems. The three passive members envied and resented the narcissistic patient B.

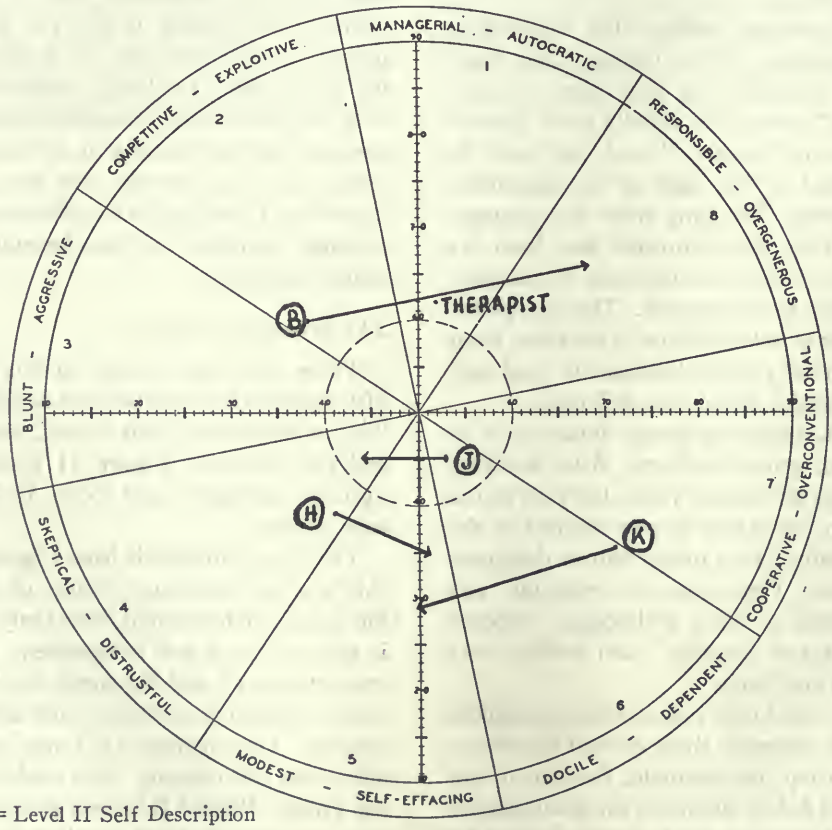
The self diagnoses are also plotted on Figure 11. The arrowed lines indicate the amount of self deception. Patient B is the most misperceptive of her own role. She claims to be a hypernormal, responsible, helpful person. She acts like a narcissistic snob. She thinks she is helping the others. They think she is looking down on them, and they resent and rebel against her. They also sense contempt and patronizing hostility in her behavior. A disastrous breakdown of communications exists here. Patient B expects admiration and gratitude. She is bound to be disappointed and righteously indignant when she receives passive hostility. She could be expected to get increasingly impatient with the others, while their resentment reciprocally builds up.

The therapeutic task is clear. This patient would benefit from an understanding of her impact on others. She was bitterly puzzled and disappointed in all her relationships because her displays of virtuous charity provoked rejection and anger. If she could accept the responsibility for provoking these reactions, she would then anticipate, understand and control her relationships with others. Her inability to take a docile or collaborative position, her insistence on an autocratic independence, and her inability to accept help or be a patient were standing in the way of rewarding contacts with others.

Patient K is also self-deceived. She sees herself as weak, guilty and self-effacing. She is seen as ex-

FIGURE 11

Self Description and Consensual Summary Description of Four Members of a Psychotherapy Group



Key:
Arrows = Level II Self Description
Circled letters =Level I (consensual summary description)

tremely sweet, docile and cooperative. The others like her, baby her and fondly protect her. A certain amount of tolerant superiority toward her goes along with these positive feelings.

It can be seen that this patient has developed masterful and powerful machinery for getting others to approve of her, through weakness. Her depression, fears, self-abasement bring her tremendous social rewards. But they also keep her weak and force her to perpetuate and increase her "neurotic-fearful" symptoms. She was getting approval at the price of a complete loss of self respect. She failed to recognize and refused to admit her childish popularity. She could not help others, lead others, stand realistically against others. She could only say and do what she thought others expected. The first goal is to help her see how she uses her docile-power to provoke support. The implications (the profits and losses) of such a role were discussed and made explicit in the subsequent sessions.

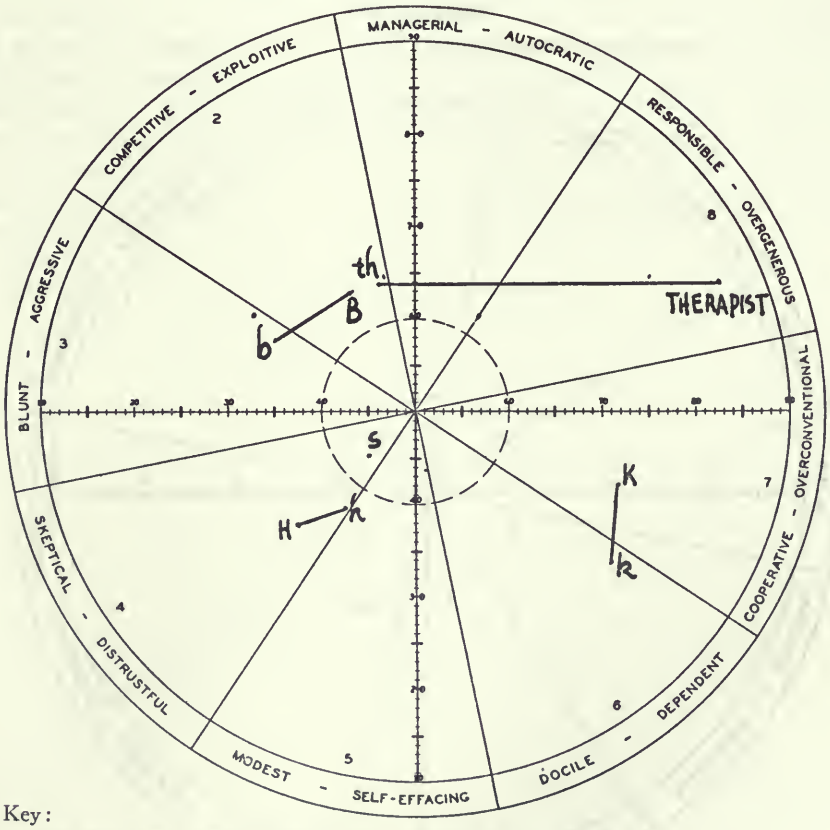
The other two members were much more perceptive about their interpersonal machinery. Patient J misperceives some of her docile popularity, while Patient H fails to recognize the passive hostility in her weakness.

The Therapeutic Application

These descriptive summaries of the interaction in a psychotherapy group are primarily diagnostic. The therapist is now equipped with information about the group resistance, about the roles of each member, and about the misperceptions which exist. His use of this information depends, of course, on his therapeutic goal and techniques. Some therapists report back

FIGURE 12

Perception by Patient J of Individual Group Members and Summary Perceptions of Members



Key:
Capital letters = J's perception of each member
Small letters = summary of group's perception of each member
S = Self perception

these sociometric results directly. They operate not as a wise interpreter, but rather as an instrument of communication—summarizing and reporting back to the members their own perceptions. The results are then discussed in terms of accuracy and implications. This procedure often stimulates considerable analysis of the reactions of members to each other and of the relationships between the behavior in the group and the behavior in the patient's outside life.

Other therapists do not report back the sociometric summaries of patients' perceptions, but use them to sharpen their own awareness of what the members are doing to each other. Knowing that the group is resentful and envious of Patient B, the therapist may be alert to marginal expressions of this feeling. The next time Patient B launches on a long, boastful narrative, he might be quicker to sense exasperation on the part of the others and interrupt to ask them how they felt when they were listening to B's narcissistic monologue.

Analysis of the Network of Relationships

A booklet analysis of the descriptions by each patient of each other patient is also a routine practice. To illustrate the application of this procedure, the perceptions of Patient J are used. This patient as plotted in Figure 11 saw herself as bitter and skeptical and was seen as docile. In Figures 12 and 13 will be found her perceptions of each individual group member and the perceptions by each member of her. From Figure 12 we see that she is extremely accurate in describing the other three members. All her capital letter scores are close to the small letter (group consensus) scores. Her perception of the therapist is (in linear distance) far removed from the group consensus. The other three tend to see the therapist as strong, and as a somewhat rejecting, exploiting figure. Patient J sees him as very nurturant and protective. She is more likely to agree with and try to please the therapist—as well as putting extreme dependent pressure on him.

FIGURE 13

Perception of Patient J by Individual Group Members

At this particular stage in the group, this patient will probably be very cooperative and of some therapeutic use to the therapist. She will docilely put into practice what she thinks he wants to be done. Her accurate perceptions of the others may be useful since she tends to project less than the others, and may serve as a central point to which the others' misperceptions can be compared. Her inaccurate or idiosyncratic, positive transference to the therapist, her attempt to be a "good girl" for him will, of course, have to be dealt with at the appropriate time.

Figure 13 indicates that the group members differ considerably in their reactions to Patient J. Patient K sees her as weak. Patient H sees her as docile, and Patient B interestingly enough sees her as nurturant and strong. This latter finding became a crucial factor in the treatment process. The narcissistic independent Patient B was able to lean and depend on Patient J. While the others recognized J's passivity, Patient B did not—or perhaps reacted to underlying power and strength in J. In any case B proceeded to use J as a strong, respected figure. The sociometric analysis informed the therapist of this situation. Patient B despised K and H and saw the therapist as a cold, critical, threatening person. When summaries and interpretations were made to B, the therapist was alert to encourage Patient J to be the "therapist." Patient B was able to accept J's interpretations and through her to become more trusting and accessible to treatment.

Other unique misperceptions and alliances existed in this group and were made apparent by inspection of the booklets of each member.

Idiosyncratic Analysis of Covert Dynamics in Group Therapy

The technique of idiosyncratic analysis of covert attitudes was designed for use in situations where homogeneity and mutual identification characterize the facade presentations of the group members. This close-knit similarity of perception generally characterizes groups who are in regular face-to-face relationships. A certain amount of repression of differences is typical of such groups. Such repression is probably necessary to facilitate and lubricate the day-to-day working together. The idiosyncratic analysis effectively picks up the covert, private, or repressed attitudes.

In most psychotherapy groups, patients are more willing to express divergent views and differential impressions of each other. For this reason, the finer-meshed idiosyncratic method may not be necessary. However, it sometimes reveals deeper and more sensitive patterns of interpersonal behavior and for that reason should be employed where time and clinical facilities make it possible. In cases where homogeneity characterizes the therapy group—*e.g.*, in groups comprising patients with the same symptom (ulcers) or the same diagnosis (hysterics) the idiosyncratic analysis should be used.

Part IV
Interpersonal Analysis of Family Dynamics

Chapter 11
FAMILY DIAGNOSIS

A third major use of the Interpersonal System is in the assessment of family relationships. In child guidance and in marriage counseling the tendency is to see the family members involved as comprising a unit. Nathan W. Ackerman[1] has urged the use of the concept of family diagnosis, which is consistent with the commonly accepted notion that the problems and the treatment of a marital or child guidance case intensely and intimately involve the other family members. Here again we deal with a multilevel operation. Several measurable relationships exist between any two people: the way they act toward each other (as observed directly or as expressed in ratings by the other person), the way they describe each other, the kind of covert image they have of each other.

The Interpersonal System is well suited to assist in the understanding of these multilevel familial networks. The general approach is the same as that discussed in the individual and group dynamics analysis. Family diagnosis is actually a combination of both techniques. We make a multilevel assessment of each adult family member including ratings by him of the other family members involved.

The standard procedure currently employed is to have the husband and wife take the MMPI, the TAT and the ICL. In the latter test they rate self, mother, father, spouse and children. The scores for both spouses are plotted, and multilevel diagnosis derived. The concept of *marriage diagnosis* can now be introduced. The interpersonal diagnosis of each spouse can be combined with the other's. If the husband presents a sadistic facade and the wife a masochistic facade, we speak of a sado-masochistic marriage. In most marriage assessment, however, it is not possible to make single hyphenated verbal diagnoses. The interlevel complexities of both partners require a numerical diagnosis and a detailed analysis of the diagnostic circles of both partners. When child guidance issues are involved, the complexities increase because the diagnoses of the children by both parents (who often disagree) must be added to the picture.

Like other interpersonal assessments, family diagnosis can involve as many levels as it is appropriate or economical to employ. The minimum testing requires check list descriptions by both husband and wife of self, mother, father, spouse and the children involved in the current problem. The MMPI adds another level of observation. The TAT makes it possible to relate underlying attitudes to the conscious perceptions of self and family members.

Family diagnosis is facilitated by the use of two psychometric instruments. The first is the *Record Booklet for Interpersonal Diagnosis of Family Dynamics*. This form records the multilevel diagnosis of both husband and wife and their perceptions of the children, and lists the complex pattern of indices which link the various levels of family members to each other. The steps employed in this procedure will be presented below. Another measure useful in Family Diagnosis is a new projective test or Level III instrument called the Interpersonal Fantasy Test. This is a TAT-type test. For each pair of familial relationships (*e.g.,* son with mother, son with father, etc.) there are three stimulus cards. The aim of the test is to yield scores at Level III for fantasy self, fantasy mother, fantasy father, fantasy spouse or cross-sex image, and fantasied doctor and patient. A description of the construction and use of this test will be found in Appendix L. This test is still in the developmental stage and has not been validated or standardized. For this reason the use of the test is not discussed in this section.

Multilevel Marriage Diagnosis

The procedures for marriage diagnosis will now be described. Both partners take the MMPI, TAT and Interpersonal Check List in the manner described above (individual diagnosis). The raw score indices on the MMPI profile, the check list form, and the TAT scoring blank are calculated as described above. These scores are then transferred to the "Record Booklet for Interpersonal Diagnosis of Family Dynamics" (see Figure 14).

[1] N. W. Ackerman. Interpersonal disturbances in the family. Some unsolved problems in psychotherapy. *Psychiat.,* 1954, *17,* No. 4, 359–368.

FIGURE 14

Record Booklet For Interpersonal Diagnosis of Family Dynamics

Husband _____ (LAST NAME) _____ (FIRST NAME) Age _____ Date _____ Testing # _____

Address _____ City _____ Phone _____ Referred by _____

Occupation _____ Education _____ How long married _____ Number of Children _____

Previous Marriages _____

Mother's Occupation _____ Mother's Education _____ Father's Occupation _____ Father's Education _____

Other _____

Wife _____ (LAST NAME) _____ (FIRST NAME) Age _____ Date _____ Testing # _____

Address _____ (IF DIFFERENT FROM HUSBAND) City _____ Phone _____ Referred by _____

Occupation _____ Former occupation if housewife _____ Education _____

Previous Marriages _____

Mother's Occupation _____ Mother's Education _____ Father's Occupation _____ Father's Education _____

Other _____

Children (and other persons included in this booklet)

	Name	Age	Sex	Education	Remarks (include relationship of stepchildren to each parent)
1.					
2.					
3.					
4.					

Identifying Codes for Clinical and Sociological Data

	Husband	Wife					
Age	_____	_____	1	_____	_____	_____	11
Religion	_____	_____	2	_____	_____	_____	12
Siblings	_____	_____	3	_____	_____	_____	13
Number of Children	_____	_____	4	_____	_____	_____	14
Occupation	_____	_____	5	_____	_____	_____	15
Occupation of Mother	_____	_____	6	_____	_____	_____	16
Occupation of Father	_____	_____	7	_____	_____	_____	17
Education	_____	_____	8	_____	_____	_____	18
Education of Mother	_____	_____	9	_____	_____	_____	19
Education of Father	_____	_____	10	_____	_____	_____	20

Tests Covered by this Record:

MMPI _____ _____

ICL _____ _____

IFT TAT _____ _____

_____ _____ _____

Remarks: _____

_____

_____

_____

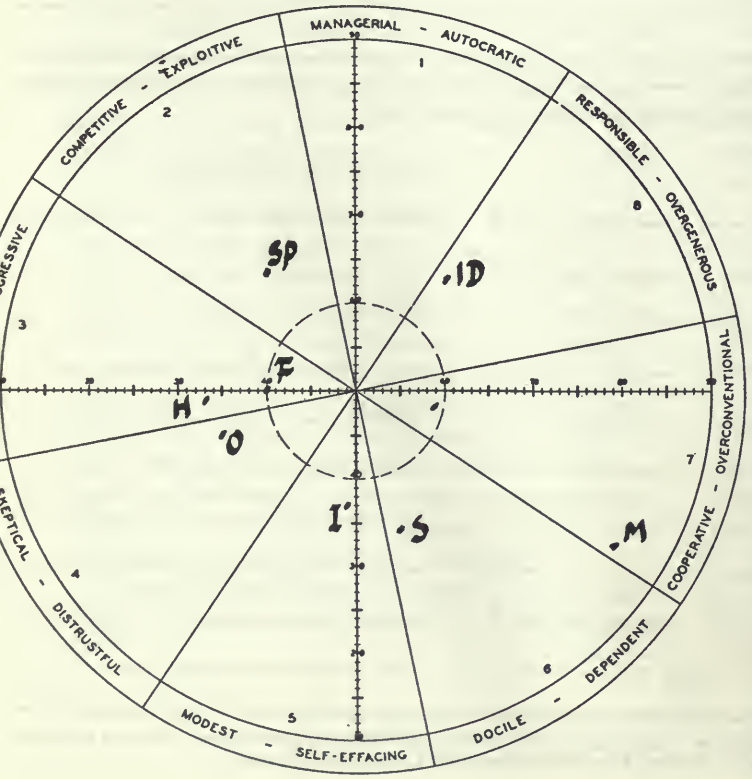
_____

This booklet was prepared by Timothy Leary, Ph. D., and published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, Calif. Checklists, booklets, templates, norms, and instruction manuals can be obtained from the Psychological Consultation Service.

Interpersonal Diagnosis
Multi–Level Personality Pattern of Husband

Level and Person	Test	Raw Score D	Raw Score L	Standard Score D	Standard Score L	IP Diagnosis
I S	MMPI	-1	-28	60	42	2
II S	ICL	+9.4	+19.8	66	70	8
II M	ICL	-24.5	-4.7	23	43	5
II F	ICL	+17.0	+7.8	75	57	1
II Sp	ICL	-16.5	-15.1	33	31	4
II Ch 1	ICL	-8.6	-4.2	43	43	4
II Ch 2	ICL					
II Ch 3	ICL					
V	ICL	+13.2	0	70	48	1
III H	~~IFT~~ TAT	-11.2	+0.7	34	52	5
III ~~HW~~ O	TAT ~~IFT~~	+0.8	-2.3	53	42	3
III M	IFT					
III F	IFT					
III Par	IFT					
III Son	IFT					
III Da	IFT					
III Ch	IFT					

Interpersonal Diagnosis
Multi–Level Personality Pattern of Wife



Level and Person	Test	Raw Score D	Raw Score L	Standard Score D	Standard Score L	IP Diagnosis
I S	MMPI	-55	-10	37	49	5
II S	ICL	-15.4	+6.2	34	55	6
II M	ICL	-16.9	+27.3	32	79	7
II F	ICL	-3.0	-7.0	50	40	3
II Sp	ICL	+12.1	-7.1	69	40	2
II Ch 1	ICL	-4.5	+9.9	48	59	7
II Ch 2	ICL					
II Ch 3	ICL					
V	ICL	+7.0	+10.5	63	60	8
III H	~~IFT~~ TAT	-6.0	-5.1	49	33	3
III ~~HW~~ O	TAT ~~IFT~~	-1.2	-4.1	45	35	4
III M	IFT					
III F	IFT					
III Par	IFT					
III Son	IFT					
III Da	IFT					
III Ch	IFT					

VERBAL SUMMARIES OF VARIABILITY INDICES FOR HUSBAND
(From Husband's Diagnostic Circle)

Husband is Consciously Identified with FA.

Husband is Consciously Disidentified with MO, Wife, Child.

Husband Consciously Equates MO, Wife, Child.

Husband Consciously Disequates Self, FA from MO Wife, Child

Husband Idealizes his Conscious view of Self, Fa.

Husband Devaluates his Conscious view of Mo., Wife, Child.

Husband's Conscious view of self is Identified with his Preconscious view of _____.

Husband's Conscious view of self is Disidentified with his Preconscious view of TAT Hero, other.

Husband's Preconscious Hero is Identified with his Preconscious view of _____.

Husband's Preconscious Hero is Disidentified with his Preconscious view of _____.

Husband Idealizes his Preconscious view of _____.

Husband Devaluates his Preconscious view of TAT, Hero, Other.

Husband Fuses his Conscious and Preconscious view of _____.

Husband Diffuses his Conscious and Preconscious view of Self, TAT Hero.

Husband Preconsciously Equates _____.

Husband Preconsciously Disequates _____.

Husband Displaces his Preconscious view of _____ on to his Conscious view of _____.

Husband Displaces his Preconscious view of _____ on to his Conscious-view of _____.

Husband Displaces his Preconscious view of _____ on to his Conscious view of _____.

VERBAL SUMMARIES OF VARIABILITY INDICES FOR WIFE
(From Wife's Diagnostic Circle)

Wife is Consciously Identified with Mo., Child.

Wife is Consciously Disidentified with Fa., Husb.

Wife Consciously Equates Mo., Child.

Wife Consciously Disequates Mo., Child from Fa., Husb.

Wife Idealizes her Conscious view of Mo., Child.

Wife Devaluates her Conscious view of Self, Fa., Husb.

Wife's Conscious view of self is Identified with her Preconscious view of _____.

Wife's Conscious view of self is Disidentified with her Preconscious view of TAT Hero, Other.

Wife's Preconscious Hero is Identified with her Preconscious view of _____.

Wife's Preconscious Hero is Disidentified with her Preconscious view of _____.

Wife Idealizes her Preconscious view of _____.

Wife Devaluates her Preconscious view of TAT Hero, Other.

Wife Fuses her Conscious and Preconscious view of _____.

Wife Diffuses her Conscious and Preconscious view of Self, TAT Hero.

Wife Preconsciously Equates _____.

Wife Preconsciously Disequates _____.

Wife Displaces her Preconscious view of _____ on to her Conscious view of _____.

Wife Displaces her Preconscious view of _____ on to her Conscious view of _____.

Wife Displaces her Preconscious view of _____ on to her Conscious view of _____.

VERBAL SUMMARIES OF VARIABILITY INDICES FOR FAMILY

Husband sees self as Overgenerous; wife sees husband as Exploitive. Agreement is Low (81)

Wife sees self as Dependent; husband sees wife as Distrustful. Agreement is Low (81)

Husband sees Child as Skeptical; wife sees Child as Cooperative. Agreement is Low (62)

Husband sees _____ as _____; wife sees _____ as _____. Agreement is _____.

Husband sees _____ as _____; wife sees _____ as _____. Agreement is _____.

Indices of Variability Among Levels of Personality for Husband

Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy
SELF PERCEPTION–SELF DECEPTION					
IS IIS	28	-15	+79	81	
CONSCIOUS IDENTIFICATION					
IIS IIM	85	-88	-58	105	
IIS IIF	81	+24	-36	44	
IIS IISp	84	-64	-94	114	
IIS IICH	84	-51	-75	91	
IIS II___					
IIS II___					
CONSCIOUS EQUATION					
IIM IIF	51	+112	+22	114	
IIM IISp	54	+24	-36	44	
IIF IISp	14	-88	-58	105	
IIM IICH	54	+37	-17	41	
IIM II___					
IIM II___					
IIF IICH	14	-75	-39	84	
IIF II___					
IIF II___					
IISp IICH	44	+13	+19	23	
IISp II___					
IISp II___					
II___ II___					
II___ II___					
II___ II___					
CONSCIOUS IDEALIZATION					
IS V	21	+9	+43	44	
IIS V	81	+24	-36	44	
IIM V	51	+112	+22	114	
IIF V	11	0	0	0	
IISp V	41	+88	+58	105	
IICH V	41	+75	+39	84	
II___ V					
II___ V					
PRECONSCIOUS IDENTIFICATION					
IIS IIIH	85	-88	-58	105	
IIS IIIM	83	-26	-80	84	
IIS IIIM					
IIS IIIF					
IIS IIIPar					

Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy
PRECONSCIOUS IDENTIFICATION (Cont'd)					
IIS IIISon					
IIS IIIDa					
IIS IIICh					
IIS III___					
IIS III___					
IIIH IIM	55	0	0	0	
IIIH IIF	51	+112	+22	114	
IIIH IISp	54	+24	-36	44	
IIIH IICH	54	+37	-17	41	
IIIH II___					
IIIH II___					
PRECONSCIOUS IDEALIZATION					
IIIH V	51	+112	+22	114	
IIIH V	31	+50	+44	66	
IIIM V					
IIIF V					
IIIPar V					
IIISon V					
IIIDa V					
IIICh V					
III___ V					
III___ V					
FUSION–REPRESSION					
IIS IIIH					
IIM IIIM					
IIF IIIF					
IISp IIIXX					
II___ III___					
II___ III___					
II___ III___					
DISPLACEMENT					
IIIM IIF					
IIIM IISp					
IIIM II___					
IIIM II___					
IIIM II___					
IIIF IIM					
IIIF IISp					
IIIF II___					

Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy
DISPLACEMENT (Cont'd)					
IIIF II___					
IIIF II___					
IIIXX IIM					
IIIXX IIF					
IIIXX II___					
IIIXX II___					
IIIXX II___					
IIISon IIM					
IIISon IIF					
IIISon IISp					
IIISon II___					
IIISon II___					
IIISon II___					
IIIDa IIM					
IIIDa IIF					
IIIDa IISp					
IIIDa II___					
IIIDa II___					
IIIDa II___					
PRECONSCIOUS EQUATION					
IIIM IIIF					
IIIM IIIXX					
IIIM IIISon					
IIIM IIIDa					
IIIF IIIXX					
IIIF IIISon					
IIIF IIIDa					
IIIXX IIISon					
IIIXX IIIDa					
IIISon IIIDa					
FAMILIAL MISPERCEPTIONS					
I by Sp IIS	28	-15	+79	81	
___by___II___					
___by___II___					
IICH IICH	47	+13	+61	62	

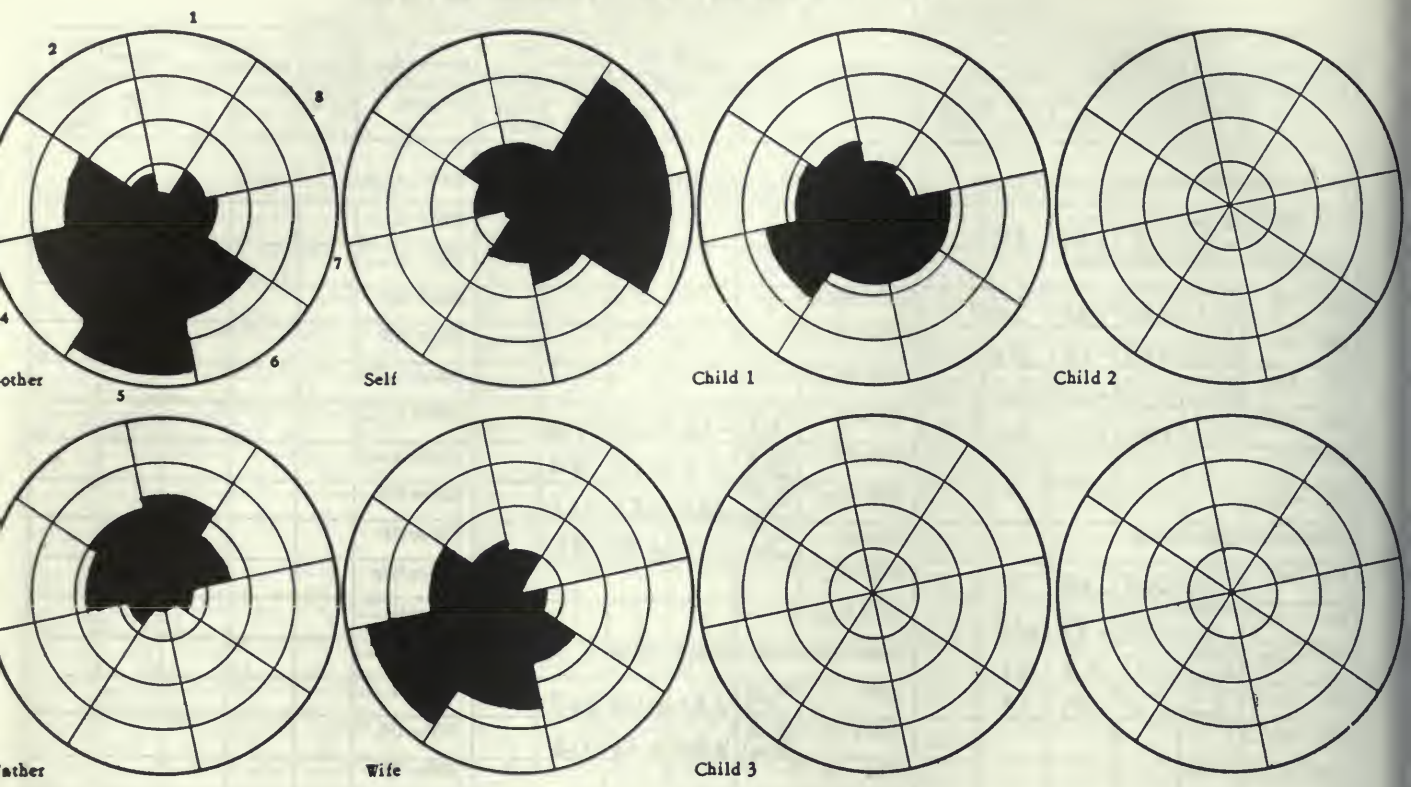
Indices of Variability Among Levels of Personality for Wife

Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy
SELF PERCEPTION–SELF DECEPTION					
IS IIS	56	+9	+43	44	
CONSCIOUS IDENTIFICATION					
IIS IIM	67	+36	+24	44	
IIS IIF	63	+53	-65	84	
IIS IISp	62	+94	-64	114	
IIS II CH	67	+41	+1	41	
IIS II___					
IIS II___					
CONSCIOUS EQUATION					
IIM IIF	73	+17	-89	91	
IIM IISp	72	+58	-88	105	
IIF IISp	32	+41	+1	41	
IIM II___	77	+5	-23	23	
IIM II___					
IIM II___					
IIF II CH	37	-12	+66	68	
IIF II___					
IIF II___					
IISp II CH	27	-53	+65	84	
IISp II___					
IISp II___					
II___ II___					
II___ II___					
CONSCIOUS IDEALIZATION					
IS V	58	+88	+58	105	
IIS V	68	+79	+15	81	
IIM V	78	+43	-9	44	
IIF V	38	+26	+80	84	
IISp V	28	-15	+79	81	
II___ V	78	+38	+14	41	
II___ V					
II___ V					
PRECONSCIOUS IDENTIFICATION					
IIS IIIH	63	+58	-88	105	
IIS IIIXX	64	+15	-79	81	
IIS IIIM					
IIS IIIF					
IIS IIIPar					

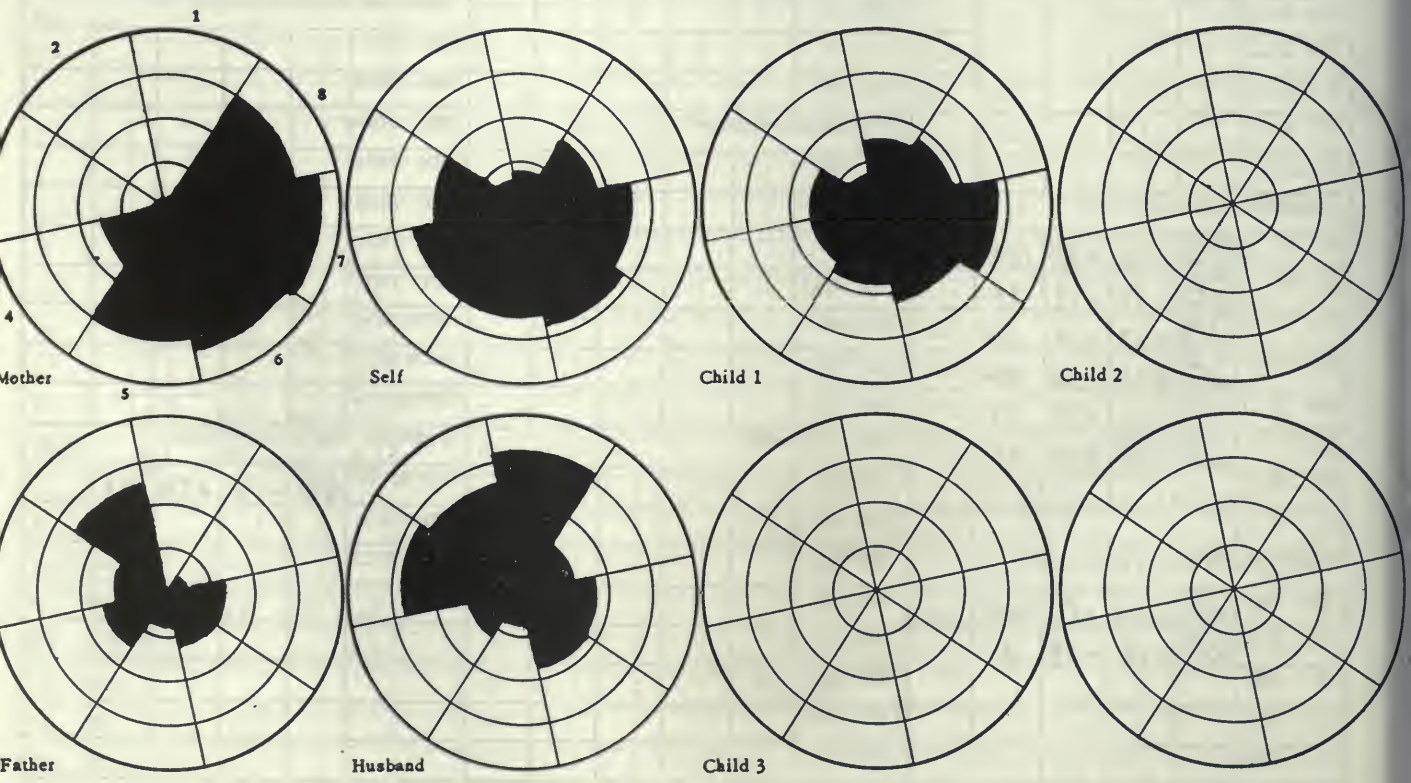
Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy
PRECONSCIOUS IDENTIFICATION (Cont'd)					
IIS IIISon					
IIS IIIDa					
IIS IIICh					
IIS III___					
IIS III___					
IIIH IIM	37	-22	+112	114	
IIIH IIF	33	-5	+23	23	
IIIH IISp	32	+36	+24	44	
IIIH II___	37	-17	+89	91	
IIIH II___					
IIIH II___					
PRECONSCIOUS IDEALIZATION					
IIIH V	38	+21	+103	105	
IIIXX V	48	+64	+94	114	
IIIM V					
IIIF V					
IIIPar V					
IIISon V					
IIIDa V					
IIICh V					
III___ V					
III___ V					
FUSION–REPRESSION					
IIS IIIH					
IIM IIIM					
IIF. IIIF					
IISp IIIXX					
II___ III___					
II___ III___					
II___ III___					
DISPLACEMENT					
IIIM IIF					
IIIM IISp					
IIIM II___					
IIIM II___					
IIIM II___					
IIIF IIM					
IIIF IISp					
IIIF II___					

Operational Definition of Index	Diagnostic Codes	Kind of Discrepancy D	Kind of Discrepancy L	Amount of Discrepancy	Std. Score Discrepancy
DISPLACEMENT (Cont'd)					
IIIF II___					
IIIF II___					
IIIXX IIM					
IIIXX IIF					
IIIXX II___					
IIIXX II___					
IIIXX II___					
IIISon IIM					
IIISon IIF					
IIISon IISp					
IIISon II___					
IIISon II___					
IIISon II___					
IIIDa IIM					
IIIDa IIF					
IIIDa IISp					
IIIDa II___					
IIIDa II___					
IIIDa II___					
PRECONSCIOUS EQUATION					
IIIM IIIF					
IIIM IIIXX					
IIIM IIISon					
IIIM IIIDa					
IIIF IIIXX					
IIIF IIISon					
IIIF IIIDa					
IIIXX IIISon					
IIIXX IIIDa					
IIISon IIIDa					
FAMILIAL MISPERCEPTIONS					
I by Sp IIS	46	-15	+79	81	
___by___II___					
___by___II___					

Husband's Uni–Level Interpersonal Profiles



Wife's Uni–Level Interpersonal Profiles



Page 2 of this booklet provides space for recording the raw score indices, and for converting them to standard scores for both the husband (top) and wife (bottom). These standard scores are then plotted and coded, and the interpersonal diagnosis listed in the appropriate column. For the illustrative cases the multilevel diagnoses with child omitted are:

Husband	**2853–514–1**
Wife:	**5634–732–8**

The diagnoses of the child are not included in the standard eight-digit formulae. From the booklet it will be seen that the husband describes the child as distrustful-rebellious (*4*), and the wife sees him as cooperative and friendly (*7*). The procedures for arriving at these diagnoses are the same as those described above for the "Individual Diagnostic Booklet."

Page 6 is devoted to the unilevel profiles. Each of these circles is shaded in with the raw total of items per octant from the check list. The procedure is exactly that described in the individual diagnostic section above.

For marriage diagnosis (where children are not being described) the children's circles are not used. The unlabeled circles on the bottom right can be used for "ideal" or for any other personages, *e.g.*, therapist, ex-spouse, etc. The network of oedipal relationships is revealed in these diagrams as well as in the two multilevel diagnostic circles on Page 2. The significance of the similarities and differences will be obvious to the clinician interpreting the results. The unilevel profiles pick up ambivalent and mixed perceptions. The multilevel circles (Page 2) portray the summary patterns.

The task of the interpreter is complicated by the fact that he may be required to make comparisons between eight (or more) diagnoses for the husband and to compare these with the eight corresponding measures of the wife. This task is simplified somewhat by means of the "Verbal Summaries of Variability Indices" which are found on Page 3. These summaries are based on estimates from visual inspection and are primarily for clinical use. The precise calculation of variability indices in family diagnosis is described below.

In assigning a variability index term from visual inspection, use the following criteria. If the two scores being compared are in the same or adjacent octants, use the non-conflicted or low discrepancy term. If the two scores are more than one octant apart, use the conflicted or large discrepancy term. Disregard the intensity factor. The procedure for filling out the "Verbal Summaries" is as follows.

Identification-Disidentification

The first indices listed are conscious identification and disidentification. Locate the husband's self score (S) on the circle for "Multilevel Personality Pattern of Husband." Next compare this score with the other family member scores. The only family member close to S is father. The word "father" is therefore written in the first line. The husband's S is clearly different from the mother, wife (Sp), and child (Ch) scores, and he is therefore consciously disidentified with them.

Equation-Disequation

The equation scores involve a comparison between mother, father, spouse and children. Inspection of the booklet indicates that the husband equates his mother and his wife, both of whom are seen as passive. He also equates his son with these female relatives. He disequates father from wife, mother and his son.

Idealization

The idealization index involves a comparison between the Ideal and all the Level II scores (*i.e.*, self, mother, father, spouse, child). It will be observed that the husband consciously idealizes himself and his father, since their two scores are close to the ideal. He consciously devaluates his mother, his son, and his wife, since their passivity is far distant from the ideal of strength.

Identification with Preconscious Figures

This index is designed for use with the IFT where scores are obtained for preconscious views of hero, cross-sex hero, mother, father, son, daughter, etc. The Level II self is then compared with these fantasied persons. Where the TAT is the Level III instrument, the self can only be compared with the Hero and Other scores. The husband is very disidentified with TAT Hero and moderately disidentified with TAT Other.

Preconscious Identification

These indices involve a comparison between Level III Hero and the other Level III persons as measured on the IFT. Where the TAT is used, these two lines can be omitted.

Preconscious Idealization

Here we inspect the discrepancy between the Ideal and the Level III scores. When the IFT is used, all the Level III persons can be compared. For the TAT we contrast Ideal with Level III Hero and Other. The husband devaluates his fantasy Hero and Other.

Fusion-Repression

The variability indices of fusion-repression reflect the similarity between any person at Level II *vs.* the same person at Level III. For instance, if the Level III view of Hero is like the Level II self, we say that he fuses his two images. If they are different, we consider that he has repressed his underlying image of that person. When the TAT is employed, there is only one such comparison, that between Level II self and Level III Hero. The husband in this case represses the passivity of his Level III Hero by consciously claiming hypernormal strength.

Preconscious Equation

These variability indices contrast the Level III persons as measured on the IFT. Where the TAT is used, there are no preconscious equation scores and these two lines are left blank.

Displacement

The indices of displacement reflect the tendency to assign to certain Level II persons the interpersonal themes which are attributed to different Level III persons. For example, if Level III mother is hostile and Level II father is hostile, the subject is said to have displaced his preconscious impression of mother onto his conscious view of father. The indices of displacement are based on IFT scores and these lines are left blank if the TAT is used.

Calculation of Variability Indices for Family

The verbal summaries of variability indices are for routine clinical use. For some clinical applications and for all research purposes it is advisable to calculate the variability indices in a precise quantitative manner. This is done on Pages 4 and 5 of the Family Diagnosis booklet. One page is for the husband's variability indices and one for the wife's. The operational definition of each index is listed on the left (*e.g.,* I S II S). In the second column are listed the diagnostic codes for the two scores being compared. These codes are obtained from the interpersonal diagnosis column on Page 2. The husband's Level I self is **2** and his Level II self is **8**. The code **28** is looked up in Appendix G and the Dom, Lov and d indices (–15, +79 and 81, respectively) are entered in the appropriate slots. This procedure for deriving variability indices has been spelled out in detail in Chapter 5.

The conscious identification indices involve the comparison of II S with each other Level II family member. Conscious idealization indices compare each Level I and II diagnosis with the diagnosis of the Level V Ideal. The rest of the indices are calculated in the same manner. Where the TAT is used, the indices involving Level III mother, father, cross-sex, and children must be omitted.

At the bottom right of Pages 4 and 5 of the booklet will be found certain indices which have not been described before and which are unique to Family Diagnosis: Familial Misperceptions. These indices measure the discrepancy between the husband's view of himself (II S for husband on Page 2) and his wife's view of him (II Sp from wife's scores on Page 2). It should be pointed out that the husband as viewed by wife is his Level I. For the illustrative case the husband's Level II S is **8** and the wife's view of the husband (Level II Sp from wife's scores) is **2**. The discrepancy **28** is entered on Page 4 next to "I by Sp II S," and the indices are calculated in the standard manner. The scores for both partner's view of the wife are computed in the same way. The perceptions of the husband and wife of each child can also be compared, as in the sample copy. The complicating factor in these misperception comparisons is that one score comes from the husband's diagnoses on Page 2 and the other comes from the wife's scores at the bottom of Page 2.

Chapter 12
ILLUSTRATIVE REPORT FOR FAMILY DIAGNOSIS

It is now possible to interpret the data organized in the Family Diagnosis booklet (see Figure 14) and to summarize it in a clinical report. There are two sections—the first is on marriage diagnosis and the second includes the diagnoses of the children.

Marriage Diagnosis

From every standpoint this is a conflicted marriage characterized by misperception of self, disagreement in mutual perceptions, and multilevel sado-masochistic relationships made more intense by oedipal factors.

The husband's diagnosis is **2853–514–1**. He is narcissistic and self confident in denying symptoms. He sees himself, however, as a generous person. Underlying this strong (although conflicted) facade are intense feelings of masochism.

The wife's diagnosis is **5634–732–8**. She is symptomatically very disturbed, anxious and depressed. She is emphasizing suffering. Her self descriptions claim docility and bland conformity. Feelings of intense sadism underlie her overt passivity.

Perceptions of Each Other

The husband sees his wife as a distrustful, complaining, whining person. This is in disagreement with her own self regard; she sees herself as good, sweet and innocently abused. She fails to recognize the resentful, reproachful pressure she puts on her husband and upon the clinic (as reflected on her MMPI).

The wife sees her husband as a cold, selfish narcissist, quite different from the hypernormal, kind, responsible image which the husband claims for himself. He fails to recognize the impression of smug, self satisfied egocentricity which is registered by the wife and the MMPI.

An unhealthy marital situation is revealed. Both partners deceive themselves by their own claims of virtue—and both fail to recognize the hostility (active on the husband's part, passive on the wife's) which they express. Neither partner takes any responsibility for the marital conflict. The husband is saying, "I am a fine, loving, strong man, and my wife is a neurotic, nagging person." The wife is saying, "I am a sweet, cooperative, patient person abused by my selfish, exploitive husband."

Multilevel Relationships

When the Level III measures are brought into focus, new and significant dimensions appear. The husband has underlying feelings of guilt, shame and masochism. The wife has covert feelings of rage and anger. We may speculate that the wife's martyred reproachfulness is really used to punish her husband and make him feel guilty. Her symptoms are a savage retaliatory weapon. "See how badly you have made me suffer." The husband apparently fits into this multilevel pattern because he privately feels very weak and guilty. If the husband's complaints about his neurotic, whining, suspicious wife were countered by the question, "Why do you stay with her?" he would probably give a pious, self enhancing explanation, "to help her" or "she is too sick for me to desert," etc. The multilevel profile suggests that he is bound to her on the facade level because he feels superior and strong; he is tied to her at the covert level by the knots of a masochistic-sadistic relationship.

The wife's rewards from this symbiotic alliance are probably two-fold. She consciously feels righteously and innocently abused. She is further furnished with a made-to-order target for her private feelings of rage and plaintive criticism by her husband's covert tendencies toward guilt. While on the surface it would appear that the husband is the self confident superior, at another level it can be seen that the wife holds the husband in a close and painful embrace.

Multilevel symbiotic locks of this sort are not uncommon. They explain the tenacity which characterizes matings in which both partners are apparently dedicated to giving each other a bad time at the expense of considerable symptomatic upheaval and apparently with no real intention of separation.

Oedipal Backgrounds of the Marriage

In many marriages, particularly those marked by intense, painful symbiotic attachments, oedipal entanglements play a major role.

The use of the interpersonal system of diagnosis brings oedipal factors into clear relief. To analyze these connections, one studies the relationship between each spouse's view of parents and of his (or her) mate. The variability indices of *equation* (Page 4) are really indices of oedipal relationships. They indicate how closely the subject links his spouse to either his mother or his father.

The husband (*cf.* top circle on Page 2 of booklet)

sees his wife as being fairly close to his mother. They are both diagnosed as passive, weak people. He consciously identifies with and idealizes his father. From the standpoint of conscious description it is clear that this man has married his mother. He also lives out via his wife's passivity his preconscious identification with his mother—indicated by the closeness of his Level III Hero to his mother.

The wife is identified with her mother, whom she sees as sweet and loving. She equates her father and spouse, indicating that she has also made an oedipal marriage. She also lives out with her mate the preconscious hostility.

If the IFT had been administered, it would have been possible to test the hypothesis that the wife's preconscious image of her mother is punitive and strong and that her fantasy father is seen as derogated and guilt-ridden. The husband's preconscious images of mother, father and spouse would probably have been the same. Both partners are probably committed to the private expectation that wives and mothers are stern, guilt provoking people. At the facade level they have reacted with different solutions, the husband attempting to maintain superiority and the wife, passivity.

Clinical Implications

This marriage is constructed (in an overdetermined manner) into a most tightly-knit, smoothly functioning, reciprocal relationship. The wife can rule and coerce her husband by her symptoms—maintaining all the while a docile, innocent self picture. The husband can overtly rule his wife, maintain a hypernormal righteousness, and still receive the punishment which her underlying masochism tends to provoke.

Marriage counseling can probably do little to change the existing tendencies, although it would be therapeutic if both partners could see their own overt behavior more clearly and accept responsibility for the hostility they express. Such behavior would diminish their tendency to project blame onto the other.

Any basic change in either mate or in the marriage relationship would require long term treatment for both. There are strong pressures on both sides to maintain the current equilibrium.

Illustrative Report on the Child Guidance Factors

The preceding report was restricted to a survey of the marital factors. The case history material and impressions of the clinician would, of course, be added to complete the diagnosis of the marriage.

We shall now append a summary of the child guidance factors as reflected in the booklet.

There is one child in this marriage. From the top circle (Page 2) of the booklet we observe that the father sees the son as resentful, complaining and rebellious. The mother describes the son as sweet, friendly and cooperative. A marked disagreement is apparent. It is clear that very faulty communication exists between the parents. When they discuss their son, they are talking about two different people. It is obvious that the father feels contempt, anger, and punitive criticism toward the son. The mother sees him as a model of sweetness. The mother, we suspect, showers the son with affection and over-protection. The father probably considers the son spoiled and resents the mother's tender regard for him.

The parents' attitudes and reactions toward the child are rooted in their own personality conflicts and in their own childhood experiences. The father sees the boy as being very unlike himself, and identifies the son with his mother and his wife, whose weakness he despises. He also projects onto the son his own underlying passivity. He probably rejects the son because the son is seen as representing the passivity and femininity which the father tries so hard to deny. A vicious repetitive cycle is set up. As the father tends to disaffiliate and reject the son, he drives him closer to the mother. The son is very likely awed by and afraid of the cold, strong father and leans upon the mother's protectiveness.

The mother identifies the son with herself and with her mother. She sees this trio in alliance against the feared husband and her own father. She may sense the father's frustration and anger at the feminization of the son and may secretly use the son (as well as her own symptoms) as an indirect weapon against the husband.

The variability indices (Page 3 of the booklet) spell out these trends. The father is *disidentified* with the son, *devaluates* him and *equates* him with the females. The mother is *identified* with the son and *equates* him with the females.

The father *displaces* his own underlying passivity onto his conscious view of his son. The mother is quite disidentified at the preconscious level with the son (her TAT Hero is quite different), and one senses that she may have covert feelings of contempt for the son's soft sweetness.

The child is in danger of being forced by both part-

ners to act out aspects of their own interlevel conflicts.

When the perceptions of children are added to the diagnostic picture, it is often possible to see how patients visualize their sex roles. Many men, for example, tend to see all females as sweet, loving and affectionate, placing all males on the left hand or hostile side of the circle. This suggests that positive feelings are seen as feminine and threatening to one's masculinity. Similarly, many women tend to put all males, including their sons, on the left hand side of the circle, indicating that they cannot allow females to be hostile; or they may see all males as below the middle line, indicating they consistently depreciate masculinity and see femininity as strong and independent.

Part V

Research Applications of the Interpersonal System

Chapter 13

ORGANIZATION OF RESEARCH PROJECTS EMPLOYING THE INTERPERSONAL SYSTEM

Some general and pedestrian comments about the organization of psychological research projects may be useful at this point. Many research groups are inefficiently constituted and administered. It probably requires as much administrative experience and knowledge to organize and manage a research project as it does a business or an educational institution. Relatively little attention has been devoted to this aspect of research; this neglect is unfortunate because faulty organization can paralyze or confuse the development of a promising research design.

The administrative design of research projects varies, of course, depending on the tasks, goals, measures and subjects. No set of rules or principles can hold for all projects. Many research groups, particularly those planning to use the interpersonal system, can benefit from a summary of the procedures painfully developed by the Kaiser Foundation Project.

Basic to our organization is the conception of the role of the research psychologist or psychiatrist. We see this role as that of theoretician, creative designer and interpreter of results. Nonprofessional workers are employed to administer the research, to give, score and rate tests, to accomplish all the steps involved in multilevel diagnoses and variability diagnoses. The professional worker designs the research, trains the technicians in the required steps, spot-checks their work, interprets and writes up the results.

In many research projects he need never see a subject or lay his hand on a test protocol. He constructs the machinery, selects the raw materials, trains the technicians to operate the diagnostic equipment. He then studies the summary tallies and profiles. He does not run the machinery, *i.e.,* he does not operate as tester, scoring clerk, computer.

In contrast to this set-up, many psychological research projects are organized the way a dinner party would be planned. The personnel include one or two guests of honor, four or five best friends and a part-time maid relegated to the kitchen. The research equivalent would be one or two high-priced consultants, four or five respected and liked colleagues or graduate students and one part-time secretary relegated to typing manuscripts. Many projects are thus characterized by an overweight of creative minds and no competent hands. The result is much good conversation, as at a successful dinner party, and less effective manipulation of data.

Our experience has led us to diagnose professional personnel as being strong on theory and design, weak on ratings, and impossible for clerical tasks. Intelligent nonprofessionals (college or high school graduates) can be quickly trained to perform all routine diagnostic tasks—including the rating of TATs—in a surprisingly brief period. They can do routine work with greater reliability, dependability and morale than professionals. In rating TATs, for example, technicians rapidly learn the range of stories given in response to each TAT card. They can quickly and reliably assign the appropriate rating for the interpersonal theme expressed. The more sophisticated and skillful clinician is likely to perceive multilevel meanings in a TAT story, therefore, his rating is complex and unreliable. The complexity is handled by the system of levels and it is undesirable to obtain multilevel ratings for any one level. The general strategy of the interpersonal system is to accumulate hundreds of molecular scores at each level and to compare the interlevel clusters.

For research projects employing the interpersonal system, we have found that a ratio of two or three clerical-technical workers to one professional worker is a minimum. For the last few years the Kaiser Foundation project has been able to carry on six large-scale research investigations concurrently on a budget of $25,000, utilizing one half-time professional person and five technical workers. Table 10 presents our organization chart for a project which has tested, diagnosed and worked up research results on 500 to 1000 subjects a year within the limits of a $25,000 budget. An illustrative budget for one or

two large-scale studies involving 200 to 500 subjects is also presented in Table 10.[1]

TABLE 10

Illustrative Budget for Research Project with Annual Budget of $25,000

Principal investigator—Psychologist ½ time	$ 4,500
Office Manager	4,000
Technician	3,500
Technician	3,500
Clerk typist	2,750
Clerk	2,750
Total Salaries	$21,000
Rent, supplies, phone, publishing expenses, etc.	$ 4,000
Grand Total	$25,000

Illustrative Budget for Research Project with Annual Budget of $12,500

Principal Investigator—Psychologist ½ time	$ 4,500
Office Manager—technician	3,500
Clerk typist	3,000
Total Salaries	$11,000
Operating expenses	1,500
Grand Total	$12,500

The functions of the office manager and technician listed in these budgets are illustrated in the following job-classification reports. Job descriptions for typists and scoring clerks are not included.

JOB DESCRIPTIONS

Position: Project Administrator

Primary purpose of position:
Administrator on Psychology Research Project.

Duties and responsibilities of position: *% of time*

1. Manage business affairs of research project 20
   A. Plan budgets for research grant applications (up to 2 years in advance)
      1) Determine on basis of research outlined, funds needed for
         a. Professional and nonprofessional personnel (anticipating salary rates, job classifications, union contract increases).
         b. Operating expenses, *i.e.*, rent, telephone, office furniture and equipment, recording and transcribing equipment, supplies, etc.
         c. Publication costs (drafting, photostating, verityping, printing).
      2) Correspond with grant conferring institutions *re* business and technical aspects of awards.
   B. Allocate available research grant funds keeping within amounts awarded or initiating requests for supplementary funds.
      1) Plan and manage expenditures of funds to maximize project operations.
         a. Schedule employee hours to be covered by various budgets.
         b. Supervise ordering of capital equipment and supplies with knowledge of budgets to be charged.
      2) Report periodically to Kaiser Foundation Chairman of Research Committees on funds expended and balances available.
   C. Conduct liaison between Psychology Research Department and various other departments (Executive, Administrative, Purchasing, Accounting, Payroll, etc.).
2. Manage research project office 20
   A. Solicit, interview, and select nonprofessional job applicants and train or supervise training of new employees.
   B. Supervise payroll and keeping of payroll, sick leave and vacation records.
   C. Advise on technical details of eight years of research grant budgets, administration of psychological tests, collection of data, scientific publications, and liaisons with other psychologists and institutions.
   D. Execute and supervise execution of secretarial work for professional staff.
3. Coordinate work on eleven separate research projects, seven of which are supported by or in collaboration with outside institutions 15
4. Coordinate preparation of manuscripts for publication (books, scientific articles) 20
   A. Edit manuscripts.
   B. Assign tasks to typists, draftsmen, library research technicians and proofreaders, and supervise execution of work.
   C. Arrange layout of figures and tables, coordinate footnote and reference material.
   D. Correspond with publishers *re* business and technical details of publication.
5. Assume complete executive responsibility for publication of manuals, booklets, psychological tests and test forms 5
   A. Organize and edit sequences of material to be published.
   B. Determine most feasible methods of reproduction, consulting printers, production men, etc.
   C. Contact and engage printers, draftsmen, verityper, etc., and supervise step-by-step execution of work.
   D. Supervise distribution, storage, and inventory of published material.
6. Assume executive and supervisory responsibility for research projects 10
   A. Set up research designs in consultation with professional psychologists.
   B. Select data fitting criteria outlined.

[1] In presenting these illustrative budgets, we do not imply that this is the ideal or best way to organize a project. They represent two sample projects administered by the Kaiser Foundation Research.

Duties and responsibilities of position: *% of time*

C. Set up form for tabulating data.
D. Establish priorities between and within several research studies.
E. Organize tasks and assign work to tabulating clerks; supervise execution.
F. Collate completed tasks, supervise recording of numerical results and filing of assembled data and statistical results.

7. Supervise psychological testing program, assign tasks and schedules to testing and scoring technicians..... 5
8. Analyze projective test data. Analyze patient-therapist interactions in recorded and transcribed interviews in study of process in psychotherapy assigning theoretical conceptual ratings 5

Position: Psychological Technician

Primary purpose of position:
To direct and execute research studies.

Duties and responsibilities of position: *% of time*

1. Assume executive and supervisory responsibility for several research projects 60
   A. Set up research design in consultation with professional psychologists.
   B. Select data that fit criteria of the particular research design.
   C. Set up forms for tabulating data (*e.g.*, graphs and charts) that present it most clearly and comprehensively.
   D. Organize tasks and assign work to tabulating clerks.
   E. Supervise work of tabulating clerks.
   G. Collate completed tasks, supervise recording of numerical results and filing of assembled data and statistical results.
2. Write for publication 5
   Explanation of methodology of test administration, scoring and analysis.
3. Under professional supervision perform routine statistical work for all projects 15
4. Administer personality tests..... 5
   Distribute test materials, describe procedure for taking tests, examine responses and make suggestions to elicit material suitable for clinical diagnosis and research workup.
5. Under professional supervision analyze projective test data and assign theoretical and conceptual ratings 5
   A. Evaluate test protocols in accordance with interpersonal criteria.
   B. Analyze patient-therapist interactions in recorded and transcribed interviews in study of process in psychotherapy, assigning theoretical and conceptual ratings.
6. Summarize charts from various installations for large samples of subjects with respect to special information useful to the particular research..... 10
   Study charts of psychiatric clinic patients, summarizing symptoms, attitudes, the patient's use of clinic facilities and the therapist's impression, diagnosis, and prognosis for treatment.

Chapter 14

MULTILEVEL RESEARCH IN PERSONALITY STRUCTURE

The major application of the interpersonal system of diagnosis is in personality and clinical research. The system was originally designed as a research tool. The system does have practical, clinical advantages and has been used extensively as a diagnostic and prognostic device. We have held to the belief that knowledge is valuable to the extent that it is useful, to the extent that it can be brought to bear on practical issues involving human happiness and human welfare.

This accounts for our emphasis on prediction. The aim of our endeavor is to provide people—patients, therapists, employers, supervisors, husbands and wives—with information about their own interpersonal machinery and about the interpersonal machinery of those with whom they deal. We believe that they can then make their life decisions and work at their resolutions with more conscious control and a better understanding of their impact upon others.

For this reason most of our research enterprises attempt to translate the results (which are in personality measures) into probability statements about practical, critical life events. Our studies on dermatological conditions, for example, demonstrated that there were three general groups of patients with skin symptoms which manifested three different modal personality structures. One cluster of dermatological symptoms was clearly related to the multilevel interpersonal behavior manifested by psychiatric patients. Another cluster of skin diseases was related to other certain psychosomatic groups (*e.g.,* hypertensives). A third was like normal controls. These findings have a certain significance for psychosomatic theory, since they may be connected to the neurological and physiological bases for the symptoms. The findings can also be studied from the standpoint of clinical implications. The dermatologist can be told that the chances of a patient in the first group accepting and following through on a psychiatric reference will be seven times greater than a patient in the other two groups. For instance, an acne patient is much more likely to accept a psychiatric referral than a patient with pruritis. When the personality findings are translated into probability predictions about behavior, the findings can thus sharpen the perceptions and clarify the therapeutic approach of the medical practitioner.

The efficacy of these clinical predictions depends, of course, on the adequacy and extensiveness of the basic research. The continuing aim of our research is to discover the functional correlates of the complex multilevel patterns produced by the test procedures.

When the individual diagnostic booklet is completed, the end product includes eight interpersonal diagnoses and approximately 20 variability indices. These 28 scores constitute the basic research variables. The routine research design compares any or all of these 28 variables with each other, with independent criteria or combines certain of these variables into multilevel categories. The multilevel pattern can then be compared with outside criteria, such as functional, diagnostic, symptomatic or administrative variables.

The basic research strategy can now be stated. The first step is to formulate a hypothesis about the relationship of interpersonal behavior at a specified level to either: 1) interpersonal behavior at another level, or, 2) to a variable which is external to the system. The second step is to execute in the appropriate booklet the measurement of the interpersonal variables. If the hypothesis involves the relationship of two aspects of the interpersonal system (*e.g.,* Level I *vs.* Level III or Level II before therapy *vs.* Level II after therapy) the comparison of the relationship is made and checked for statistical significance. If the hypothesis involves the relationship of an interpersonal variable (a pattern of variables) and an external criteria, the measurement of the latter must be accomplished. The statistical comparison of the two variables then follows.

The task of validating a multilevel system of personality is complex. The two most typical methods are presented in Table 11: 1) the use of the multilevel pattern to predict changes in time in its own structure. We have found, for example, that the discrepancy between Level II self and Level III predicts the kind and amount of change to expect in Level II. 2) the study of the relationships of the multilevel pattern to criteria external to the system.

For each of the numbered items in Table 11 there are hundreds of possible research designs employing different criteria and different combinations of interpersonal scores. There is, in addition, a variety of methods for handling the interpersonal data from the booklet. It is possible to deal with the raw responses, the items themselves or with the dominance or hostility indices (either raw or in standard score

TABLE 11

Illustrative List of Criteria Which Have Been Used to Validate or Empirically Study the Interpersonal System of Diagnosis

Comparison Within the Interpersonal System

1. Level I diagnosis *vs.* diagnoses at Levels II and III
2. Diagnoses at Levels I, II or III *vs.* conscious description of parents or spouse
3. Diagnoses at Levels I, II or III *vs.* the 20± variability indices
4. One variability index *vs.* any other variability index
5. Diagnoses at Levels I, II or III before therapy *vs.* diagnoses at Levels I, II or III after therapy
6. Variability indices before therapy *vs.* change at Levels I, II or III after therapy
7. Variability indices before therapy *vs.* variability indices after therapy

Criteria External to the Interpersonal System

(To be compared with diagnoses at Levels I, II or III or with any variability indices)

1. Number of times seen in therapy
2. Accept or reject therapy
3. Kind of therapy to which assigned
4. Ratings of improvement in therapy
5. Patient's questionnaire response about reactions to clinic
6. Psychiatric diagnosis
7. Medical (psychosomatic) diagnosis
8. Number of visits to medical clinic before and after psychiatric consultation
9. Cultural or intellectual group in which subject was tested
10. Ratings of success on job or in training program
11. Intellectual level or intellectual efficiency
12. Educational level
13. Socio-economic status
14. Marital status
15. Physical characteristics (*e.g.*, % of obesity, body type, etc.)
16. Success in specific tasks (*e.g.*, weight lost in obesity program, increase in sales volume for salesman, etc.)
17. Characteristics of marriage
18. Characteristics of children

form). For most research purposes, however, the diagnostic codes are employed. The following section provides detailed "How-to-do-it" illustrations of the standard research methods for interpersonal diagnoses, measurement of change, group dynamics diagnosis, change in group dynamics, marriage and family diagnoses. The standard forms and formats for handling several typical research projects will be listed and illustrated. There are, of course, innumerable ways to handle the data from the booklets; the ones described below represent only the most straightforward and simple approaches. There is no implication that these are the best ways of setting up research studies.

Research on Unilevel and Multilevel Interpersonal Behavior

The basic sources of research data are the interpersonal diagnosis column on Page 2 and the variability indices columns on Page 3 of the Individual Diagnostic Booklet. These data provide the eight interpersonal diagnoses and the 20± variability indices which are involved in all hypotheses. We shall first illustrate research on the diagnoses for Level I, II and III from Page 2. While the essence of the interpersonal system is its multilevel nature, we are often required to violate this conception and to study performance at one level at a time. After the unilevel data have been compared with the criteria, it is usually possible to reconstruct the multilevel pattern.

Research at Level I S

In unilevel research the diagnosis for every subject in the sample is transferred from Page 2 of the booklet to a summary sheet which has a summary box for each octant. The number of cases in each sample falling in each octant (disregarding the red or black intensity factor) are entered in each box. Table 12

TABLE 12

Level I Diagnoses of 100 Patients Who Accepted Psychiatric Help and 100 Patients Who Refused Psychiatric Help

	Number of Patients having Level I Diagnoses of:							
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*
Patients accepting help	5	10	18	27	11	19	7	3
Patients rejecting help	31	12	3	7	2	2	16	27

Help acceptors = 4 or more visits.
Help rejectors = 3 or less visits.

illustrates the results of a study in which Level I diagnosis was compared with number of times seen in the psychiatric clinic. The clinic sample was divided into those making 3 or less visits and those making four or more visits.

There are many ways in which these data can be used to test the hypothesis that help rejectors are different at Level I from help acceptors. The number of cases in each octant can be plotted on a unilevel profile to give a visual picture. This profile can be rated by inspection procedures. A preferable technique is to establish the point which summarizes the tendency of each group and plot both points on the same master diagnostic grid. This is done by feeding the octant summaries (from Table 12) into the standard formulae

$$\text{Dom} = 1 - 5 + .7(8 + 2 - 4 - 6)$$

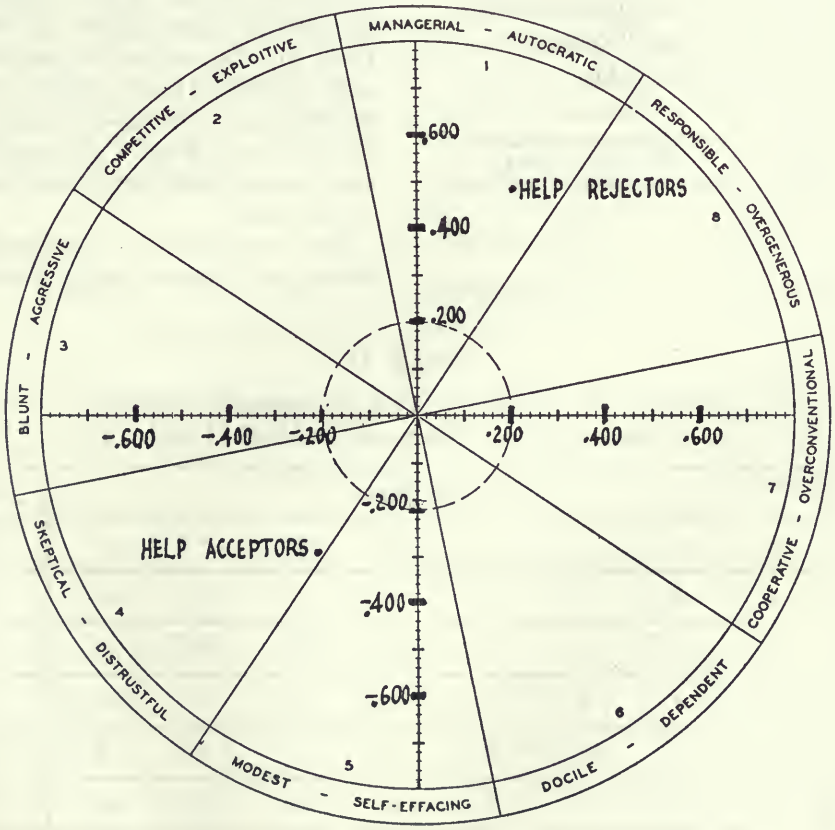
and

$$\text{Lov} = 7 - 3 + .7(6 + 8 - 4 - 2)$$

(the whole numbers referring to the octants). The summary indices from the Table 12 distribution are: help acceptors, Dom = −29.1; Lov = −21.5; help rejectors, Dom = +50.0; Lov = +20.0. These indices are then divided by N (to eliminate the effect of the number of cases) and plotted on a diagnostic grid in which the center of the circle is the 000 point and one inch of radius = .200 points. This procedure is illustrated in Figure 15, where it will be seen that the help rejectors locate in the strong, responsible sector of the circle and the help acceptors in the distrustful, masochistic sector. These plots are used to give the group trend and are not usually used for research purposes. The tendency of the two groups is clear. The help rejectors do not stay in treatment because they present themselves as hypernormal people not consciously bothered by emotional symptoms and stressing their healthy internal adjustment. Those who remain in treatment admit to fear, passivity, guilt, alienation and depression at the symptomatic level.

For research purposes, a statistical test of the difference between groups is required. There are several ways of establishing a statistically significant differ-

FIGURE 15



ence. The simplest method routinely employed is to divide the diagnostic circle in half by combining four adjacent octants and to use a X^2 test of significance. The decision as to which octants are combined (*i.e.,* how to divide the circle in half) is left to the discretion of the researchers. If the researcher wants to study the differences between strength and passivity, he can compare the octants 3218 *vs.* 4567. If hostility *vs.* friendliness is a key factor, the split can be 2345 *vs.* 1876. This decision should be made before the data are worked up—on the basis of the hypothesis—to avoid being misled by chance loadings into octants. If this is not done, then a split-half or cross validation technique should be employed to rule out artifacts due to accidental characteristics of the sample.

In the study of help-acceptance, the division used was 2187 *vs.* 6543. This division is a standard cut which combines the idealized "virtues" of strength, responsibility and conventionality *vs.* the more "neurotic" factors of dependence, submission, distrust and anger. Table 13 presents the combination of data in this way.

TABLE 13

Number of Help-Rejectors and Help-Acceptors Who Present "Healthy" and "Neurotic" Symptoms at Level I–M

	"Healthy" symptomatic behavior (i.e., 2178)	*"Neurotic" symptomatic behavior (i.e., 6543)*
Help Rejectors	86	14
Help Acceptors	25	75

This difference is significant (P is beyond .0001) and indicates that those patients who remain in psychotherapy manifest a characteristic symptomatic facade. The plotting of summary points a la Figure 15 tells us what the difference is, and the X^2 test tells us that it is significant.

It is not necessary to use a 50–50 cut in comparing groups. In some cases the hypothesis at stake involves a specific variable, *e.g.,* hostility. Here the researcher may use only the octants which have a loading of this variable. The cut would be 234 *vs.* 678. If independence *vs.* dependence is the central issue, the comparison might be between 12 *vs.* 56. Where less than 8 octants are used, the N's should be larger.

Research at Level II–ICL

Research at the level of conscious self description can involve the self diagnosis or the rating of others. From the interpersonal diagnosis column on Page 2 of the individual booklet, the appropriate Level II diagnostic code is taken. These diagnoses are summarized in octant boxes as described above.

Any unilevel study can compare several clinical or criteria groups. Table 14 illustrates this use of the system. Five samples are being compared at Level II. The number of subjects falling in each octant at Level II self is listed. The cut for dividing the circle is the strong–hypernormal (2178) *vs.* the weak–hostile (3456). The number of subjects in each sample falling into these two groups is listed on the right.

The significance of differences at Level II between these groups can be determined by X^2 and

TABLE 14

Number of Subjects in Five Symptomatic Samples Receiving Octant Diagnoses at Level II Self

Symptomatic Groups	*Diagnostic Octant*								*Octant Summaries*	
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*1278*	*3456*
Psychotic	6	4	2	1	1	7	1	4	15	11
Neurotic	7	3	7	8	15	11	10	6	26	41
Normal Control	3	4	7	3	2	2	9	11	27	14
Ulcer	14	6	10	3	1	1	1	6	27	15
Hypertensive	16	6	2	0	0	3	6	16	44	5

listed in tabular form (see Table 15). The table of X^2's indicates which groups differ significantly at this level, and plotting the indices indicates what the differences are.

The same method can be used to test differences in perceptions of mother, father and spouse. It is also possible to compare the same group's perceptions of mother *vs.* its perceptions of father. In this way we have demonstrated that certain dermatological symptom groups perceive their fathers as significantly more hostile than their mothers.

Research at Level III

All the procedures available for statistical analysis of data at Level I and II can be used for Level III materials. In many cases, groups which are similar in the facade Level (I and II) turn out to be significantly different at Level III. Normal controls and hypertensive patients, for example, do not show any difference at Levels I and II, both presenting a facade of hypernormality. At Level III, however, the groups do split, hypertensive patients being more hostile and passive, controls maintaining at the covert level the strength they manifest overtly. In one study in which the octant split was strong hypernormality (128) *vs.* bitter passivity (456), 25 of the normal controls were the former and only 2 the latter. Hypertension patients appeared quite differently—only 6 falling in the 128 octants and 11 in the 456 sector. The underlying tests thus pick up the differences which were controlled at the facade level.

Research on Variability Indices

The diagnostic column on Page 2 of the individual diagnostic booklet provides material for innumerable studies of interpersonal behavior at different levels. The variability indices on Page 3 are another source of research data.

Two general types of studies suggest themselves: those concerned with the *amount* of interlevel variability and those which focus on the *kind* of variability. Many statistical techniques can be employed to organize the variability indices. We shall consider here the simplest routine methods.

A sample hypothesis about the *amount* of variability is presented as follows: hypertensive patients are more closely identified with their mothers than are ulcer patients. We are interested in the "Amount of Discrepancy" column on Page 3. It will be recalled that this variable is measured on a 14 point continuum running from 0–114. Table 16 illustrates the testing of this hypothesis. The 14 points are listed horizontally, and the number of subjects in each sample receiving each distance value is summarized.

Inspection of this table indicates that ulcer patients tend to have large indices of disidentification while hypertensive patients have low indices. To test the significance of this difference X^2 can be used. It will be noted that the mode for both groups is 44. For this reason we omit this category and compare the number of subjects in each sample falling above and

TABLE 15

Chi Square Tables Testing the Significance of Differences Between Symptomatic Groups in Level II Self Description

	1278	*3456*
Psychotic	15	11
Neurotic	26	41

$X^2 = 2.71$
$P = .10$

	1278	*3456*
Normal Controls	27	14
Neurotic	26	41

$X^2 = 7.45$
$P = .01$

	1278	*3456*
Hyper-tensives	44	5
Neurotic	26	41

$X^2 = 30.74$
$P = .001$

	1278	*3456*
Ulcer	27	15
Neurotic	26	41

$X^2 = 6.71$
$P = .01$

	1278	*3456*
Hyper-tensives	44	5
Ulcer	27	15

$X^2 = 8.58$
$P = .01$

below the mode. Seven ulcer patients and 12 hypertensive patients are identified with their mothers (below the mode). Sixteen ulcer patients are disidentified, whereas only three hypertensive patients fall above the mode. Differences in this fourfold table are significant at the .01 level when X^2 test is applied. It is thus possible to accept the hypothesis that hypertensive patients are consciously more identified with their mothers than ulcer patients.

The *kind* of interlevel variability is often a crucial research issue. The D or L columns on Page 3 of the diagnostic booklet are used to test this kind of hypothesis. Consider the assertion that ulcer patients repress tender feelings and hypertensive patients repress hostile feelings. Here we are concerned with the "L" column on Page 3. A plus or minus score is assigned to each D and L index. Where II S is being compared III H (the operational definition of repression) a plus score in the "L" column means that the subject represses tender feelings. This is to say, his Level II self is to the left of his Level III Hero. His self description is more hostile and his underlying feelings more loving.

The hypothesis about the kind of repression characterizing the two psychosomatic groups can now be stated in operational terms. Ulcer patients will have significantly more positive indices and hypertensive patients more negative indices on the II S–III H discrepancy. The next step was to count the number of plus and minus indices in the "L" columns of the subjects involved in the study. Hypertensives clearly repress hostility: 23 had — indices and only 4 had + indices. Ulcer patients by and large tend to repress tenderness: 9 had + and only 5 had — indices in the "L" column. The X^2 is significant at close to the .001 level.

Each of the variability indices has been related to many different types of external criteria—some of these being diagnostic, others administrative or functional variables, *e.g.*, number of times seen in therapy. In this way, the predictive meaning of each index becomes clearer and more precise.

Multilevel Research

The results of unilevel research can be combined into multilevel patterns which can then be summarized in verbal description. Thus it can be said that the typical or modal ulcer patient is hypernormal at the level of symptomatic behavior, competitive at the level of conscious self description, and masochistic or docile at the level of private motivation; that he is consciously disidentified with his mother, that he represses dependent and docile feelings, etc. These reports add up the significant results from the unilevel and variability analyses.

A more rigorous type of multilevel research involves direct manipulation of double or triple level diagnostic codes. This multiplies the number of types or categories and usually requires additional methods for recombining scores. When we deal with triple level diagnosis, for example, we are involved with 512 types ($8 \times 8 \times 8$), if intensity ratings are ignored. If we wish to compare the triple level diagnosis of obesity patients with neurotics, we face the task of comparing 512 pairs of possibilities. One way to meet this research problem is to do unilevel studies (as described above) and fit them together into a multilevel pattern. Another way is to make multilevel categories which summarize the various patterns.

A method of approaching this task will now be outlined. First the diagnoses of 127 and 8 were combined into a *strong* (or conventional) category and the diagnoses 3456 as *weak* (or unconventional). The diagnosis of any subject at any level can thus be assigned to one of two categories. It is possible for a subject to be *strong* at all three levels (I, II and III Hero). This would be coded SSS—indicating strong at all levels. If a subject is weak at all levels, the code WWW is assigned. Interlevel conflicts can

TABLE 16

The Amount of Maternal Identification or Disidentification Discrepancy Indices for 33 Ulcer and 21 Hypertensive Patients

		IDENTIFICATION (small discrepancy)						DISIDENTIFICATION (large discrepancy)							
Sample	*N*	*0*	*23*	*26*	*41*	*44*	*48*	*62*	*66*	*68*	*81*	*84*	*91*	*105*	*114*
Ulcer	33	2	2		3	10		1			4	2	1	5	3
Hypert.	21	5	2		5	6			2			1			

be similarly coded. The code SSW refers to a patient who is strong at both overt levels, but who has a Level III score falling in the 3456 sector. Four general multilevel categories can now be defined:

A = SSS Solid Strong
B = SSW Strong Facade and Weak Underneath
C = WWS Weak Facade and Strong Underneath
D = WWW Solid Weak

These categories combine Level I and II and compare the facade with Level III. Where there is a conflict between the facade scores (Levels I and II), then the Level II score is taken as the anchor facade score, and the code X is added to indicate that the Level I score is divergent. This categorization was applied to 97 obese females and 93 females in psychotherapy. The results are presented in Table 17. These results indicate that very few obese females (7 + 2 = 9) have weak facades (WWW or WWS) whereas more than half of the psychotherapy patients (28 + 19 = 48) do have these facades. The majority of the obese women have solid triple layer structures of strength and independence. The differences between these two symptom groups stand out quite clearly by means of this method for multilevel analysis.

TABLE 17

Number of Obese and Psychotherapy Females Falling in Multilevel Diagnostic Summary Categories

Category	*Code*	*Obese Females*		*Psychotherapy Females*	
A	SSS	54		19	
AX	WSS	3		9	
Sum of solid strong types			57		28
B	SSW	24		12	
BX	WSW	7		6	
Sum of strong-weak conflicted types			31		18
C	WWS	4		21	
CX	SWS	3		7	
Sum of weak-strong conflicted types			7		28
D	WWW	0		17	
DX	SWW	2		2	
Sum of weak-weak types			2		19
Grand Total			97		93

Predictions invariably become more precise and accurate when data from other levels are added to unilevel results. The following study illustrates this

TABLE 18

Number of Psychotherapy Appointments for Pure and Conflicted Diagnostic Types (Level I MMPI)

	Sum of Level I Diagnostic Types (Pure and Conflicted)			*Pure Diagnostic Types (No Level II Conflict)*			*Conflicted Diagnostic Types*		
Level I Diagnosis	*No. Visits*	*No. Patients*	*Mean*	*No. Visits*	*No. Patients*	*Mean*	*No. Visits*	*No. Patients*	*Mean*
1	44	8	5.5	44	8	5.5	—	—	—
2	78	13	6.0	69	9	7.7	9	4	2.3
3	239	20	12.0	230	14	16.4	9	6	1.5
4	305	28	10.9	231	21	11.0	74	7	10.6
5	173	18	9.6	119	11	10.8	54	7	7.7
6	232	22	10.5	215	15	14.3	17	7	2.4
7	399	46	8.7	239	28	8.5	160	18	8.9
8	152	25	6.1	108	21	5.1	44	4	11.0
1278	673	92	7.3	460	66	7.0	213	26	8.2
3456	949	88	10.8	795	61	13.0	154	27	5.7

situation. A sample of 180 patients in psychotherapy were diagnosed at Level I (MMPI), and the number of therapeutic appointments for each patient was recorded. It was found (see Table 18) that sadists, schizoids, masochists and dependents (345 and 6) had an average of 10.8 therapeutic appointments. Managerial, hypernormal and conventional patients (2187) averaged 7.3 interviews. When the Level II diagnoses were added to the picture, an interesting amplification of the results developed. It was found that if the Level II self diagnosis duplicated or was close to the Level I diagnosis, the trends mentioned above remained the same or were strengthened. If the Level II diagnosis differed from the Level I diagnosis, the trend was reversed. Patients with a Level I diagnosis of sadism averaged 12 visits. If the Level II diagnosis was also sadistic, then the average number of visits jumped to 16.4. If the Level II diagnosis was different, the number of visits dropped to 1.5, even though the symptomatic picture remained sadistic.

The definition of conflict and no conflict was based on the size of the discrepancy between Level I S and II S. If this variability was greater than 44, conflict between Level I and II was defined. An index of 44 or less defined no conflict.

The addition of Level II data greatly increased the differences among groups, thus sharpening the accuracy of predictions. Table 18 presents the number of visits for the pure (unconflicted) and conflicted interpersonal types. The independent, strong and conventional patients who are unconflicted remain in therapy about one-half as long as the unconflicted, weak and hostile patients (6543). When conflicted cases are considered, the trend is reversed. The conflicted 1278 group remains in treatment an average of 8.2 visits, while the conflicted 3456 group drops to an average of 5.7 visits.

Chapter 15
RESEARCH ON CHANGE IN PERSONALITY

The interpersonal system was designed specifically to measure change in personality — particularly changes during psychotherapy. The measurement procedure is essentially the same as that used for measuring interlevel discrepancies, although the design of a "change" study is slightly different.

The patient takes a multilevel test battery before therapy (or a control waiting period) and repeats the tests after therapy.

A numerical diagnosis is obtained for each test before and after therapy. Here is a sample multilevel diagnosis of a patient before and after therapy.

Before therapy: **5 5 3 3—3 6 2—1**

After therapy: ***1 7 6 5—1 7 8—8***

In Level I public behavior this patient changed from masochism, **5**, to a managerial power, ***1***; in Level II self description from self-effacement, **5**, to a conventional friendliness, ***7***; his fantasy heroes shifted from sadism, **3**, to dependence, **6**; his TAT "other" figures from sadism, **3**, to masochism, **5**; his mother who was described as sadistic, **3**, is now seen as autocratic, **1**; his view of father shifts from dependence, **6**, to friendliness, **7**; his perceptions of his wife from narcissism, **2**, to responsible tenderness, ***8***; his ego-ideal from power, **1**, to hypernormal tenderness, **8**.

The standard method is used for measuring variability—*i.e.,* for converting these code discrepancies at any level into numerical indices which tell how much and what kind of change took place. The illustrative patient changed at Level I–MMPI from **5** to ***1***. From Appendix G we see that this discrepancy is D = +89, L = + 17, d = 91.

In order to study the changes in personality due to psychotherapy, we believe it necessary to measure several levels of personality before and after therapy. Changes in one level may take on a greater or less significance in the light of changes in another level.

A decrease in depression at the symptomatic level may or may not be considered an "improvement" depending on the events at other levels. If such a change were accompanied by an intensification of a rigid, self-satisfied, pious self-perception and an increase in the tendency to project blame and sadism onto fantasied "Other" figures, a movement toward a morbid, paranoid prepsychotic state might be suspected. If, on the other hand, a decrease in depression is accompanied by a more balanced and flexible set of conscious and preconscious scores, a more durable adjustment might be predicted.

Here is a typical "change" study which compares the Level I (MMPI) change of 42 patients tested after 6–10 months of therapy with a group of 23 controls tested after being on a "waiting list" for 5–9 months. The variability indices for Level I change were computed and tallied (see Table 19).

TABLE 19

Tally of Indices of Change at the Symptomatic Level of 42 Individual Therapy Patients and 23 Control Cases

Discrepancy	*Change in Individual Therapy Patients (N = 42)*	*Change in Control Patients (N = 23)*
0	x x x x x x x x x x x	x x x x x x x x x
23	x x	x x
26	x x x	x x x x
41	x x x x x x x	x x
44	x x x x x x x	x x x
48	x x	x
62	x x	x x
66	x x	
68		
81	x x x	
84	x	
91	x	
105		
114	x	

It will be noted that the therapy patients tend to show greater amounts of personality change than the controls. If the index figure of 26 is taken as a cutting point, all patients at or below this figure can be defined as showing little or no change, while those falling above 26 can be defined as manifesting moderate or extreme change. A chi square test between

the control and therapy sample based on this cutting point is significant at the .05 level. This difference justifies the summary statement that the experience of being in individual psychotherapy for a period of approximately six months leads to significantly greater change in personality (at the symptomatic level) than does the experience of being on a waiting list but receiving no psychotherapy during an equivalent period.

The code system of interpersonal diagnosis lends itself to a variety of clinical and research applications. Comparison of the pre-therapy and post-therapy codes yields an index of the amount of change as described in the preceding section. Rearranging the same diagnostic code data in a different way makes it possible to determine which personality types change and in which direction they change. This is accomplished graphically by constructing a table in which the pre-therapy diagnostic categories are ranged on the vertical axis and the post-therapy categories along the top or horizontal axis. Any combination of pre-post scores can be located in the appropriate box. In Table 20 the pre-post diagnostic score combinations for each female individual therapy patient are plotted.[1] Table 21 presents the same data for the male therapy patients. In Table 20 the upper left hand box contains the figure "2," indicating that there were two female patients who were diagnosed (at the symptomatic level) as "managerial-autocratic" both before and after treatment. In the same row, six units to the right, there is the figure "1" indicating that there was one female patient who was diagnosed "managerial-autocratic" before therapy and received the diagnosis of "hysterical-conventional" personality after treatment.

We consider patients who manifest a shift of more than one unit along the diagnostic continuum to have "changed" and those who show a shift of one or no units to have "not changed."[2] The number of patients in each pre-therapy diagnostic category who did and did not change during treatment is listed in the extreme right columns of Tables 20 and 21. In Table 20, for example, we see that of the seven women diagnosed (before therapy) as narcissistic (code 2),

[1] It should be noted that Tables 20 and 21 are not correlational matrices and should not be interpreted as such. The variables are arranged in a circular order.

[2] This method for estimating change is different from and less precise than the diagnostic code discrepancy method described above. The intensity rating is discarded and red and black scores are combined for each octant. The definition of "change" is not used in general studies of discrepancies but is useful in studies where the relationship between diagnosis and change is the issue. It will be noted that this cutting point of one unit is equivalent to a code-discrepancy score of 44.

TABLE 20

Interpersonal Diagnosis of 33 Female Patients Before and After Individual Psychotherapy

Pre-therapy Diagnosis	*Post-therapy Diagnosis* 1	2	3	4	5	6	7	8	*Change*	*No Change*
Managerial-Compulsive 1	2						1		1	2
Competitive-Narcissistic 2	2	2	2					1	1	6
Sadistic-Psychopathic 3						1			1	0
Skeptical-Schizoid 4				2	1				0	3
Masochistic-Obsessive 5	1			2	3	1			1	6
Docile-Phobic 6	1			1	2	1		1	3	3
Conventional-Hysteric 7	1		1		1			1	3	1
Responsible-Hypernormal 8						1		1	1	1

TABLE 21

Interpersonal Diagnosis of 18 Male Patients Before and After Individual Psychotherapy

Pre-therapy Diagnosis	*Post-therapy Diagnosis* 1	2	3	4	5	6	7	8	*Change*	*No Change*
Managerial-Compulsive 1										
Competitive-Narcissistic 2										
Sadistic-Psychopathic 3	1		1						1	1
Skeptical-Schizoid 4	1	1	1		1				2	2
Masochistic-Obsessive 5		1	1	1					2	1
Docile-Phobic 6					2	1	2		0	5
Conventional-Hysteric 7							1		0	1
Responsible-Hypernormal 8	1							2	0	3

six did not change appreciably while one did change to a post-therapy diagnosis of hypernormal personality. Of the four female hysterics (code 7), three did change, one becoming a managerial personality, one becoming sadistic and one masochistic.

Summarizing pre-post therapy data in tables of this sort makes possible predictive statements about the anticipated course of therapy. Table 20 suggests that female patients who are obsessive or schizoid have one chance in ten of changing during individual psychotherapy. Table 21, on the contrary, suggests that male patients who are obsessive or schizoid have four chances out of seven of changing in psychotherapy. The findings presented in Tables 20 and 21 are based on too few cases to be used for predictive purposes. They do, however, suggest specific hypotheses about which personality types in men and women are most likely to change. When the diagnostic data from the other levels are added, both the complexity and the accuracy of prediction increase many-fold.

Even when the measurements are restricted to one level of personality, as in the case here, significant trends can be sensed. The data in Tables 20 and 21, for example, can be combined into two categories, one involving patients who were initially hostile and weak (diagnostic codes 3, 4, 5) and the other, those who were initially conforming and affiliative (codes 6, 7, 8). Applying this categorization to the data in Tables 20 and 21, the breakdown is presented in Table 22. Men who are hostile or weak (at the symptomatic level) are more likely to change than women with the same pre-therapy diagnosis. On the other hand, men who are conventional and bland (at the symptomatic level) are less likely to be helped than women with the same initial diagnosis. The trend for change to occur in the case of weak, hostile men is significant at the .03 level, and the same trend for conventional women is significant at the .05 level.

TABLE 22

Personality Change in Psychotherapy for Males and Females With Initial Diagnoses of Hostile-Weak or Conforming-Affiliative

Factor	*Males*		*Females*	
	Change	*No Change*	*Change*	*No Change*
Hostile and weak	5	4	2	9
Conforming and Affiliative	0	9	7	5

A most important use of the methodology for measuring change is to isolate the indices and scores from the pre-therapy test battery which predict the kind and amount of change.

One such study worked with the hypothesis that Level III can point to changes to be expected in the future. The Level of Private Expression thus can be seen as a potential for future behavior. Structural variability (defined in this case as Level II *vs.* Level III) predicts to temporal variability (in Level II self description).

The subjects were 81 obese females who were tested before and after a four-month period during which they attended lectures and group discussions on weight-reduction. The variables concerned in this study are Level II self and TAT Hero diagnoses before and Level II self diagnosis after the four-month period. The numerical code discrepancy between the diagnoses at Levels II and III was determined for each subject. The discrepancy between the Level II diagnosis before and after the four-month period was also calculated.

There are two sets of results: those which reflect the ability of the TAT to predict the *kind* of change to be expected over time, and those which test the TAT's accuracy in predicting the *amount* of change. In the former study two measures are involved, the Dominance-Submission discrepancy and the Love-Hostility. If the TAT expressed more dominance

TABLE 23

Chi Square Tables Relating the Kind of Initial Discrepancy on Dominance-Submission Between Conscious Self Diagnosis and TAT Diagnosis to the Kind of Change in Self Diagnosis of Dominance-Submission on Pre-Post Tests for 40 Discussion Group Controls.

		TAT More Dominant Than Initial Conscious Self Description	*TAT More Submissive Than Initial Conscious Self Description*
		+	—
Post Self Diagnosis More Dominant Than Initial Self Diagnosis....	+	16	7
Post Self Diagnosis More Submissive Than Initial Self Diagnosis....	—	5	12

$X^2 = 6.32$; $p = .02$

than the initial self description a + score is obtained. If the pre-post discrepancy in the self description yielded a + score on dominance, the patient became stronger in his self-appraisal, and the TAT was considered to have predicted the kind of change. The same type of + and — measures for the Love-Hostility axis were similarly compared.

The results are presented in Tables 23 and 24. The TAT predicts change in Dominance ($p = .02$) and in Hostility ($p = .05$).

TABLE 24

Chi Square Tables Relating the Kind of Initial Discrepancy on Love-Hostility Between Conscious Self Diagnosis and TAT Diagnosis to the Kind of Change in Self Diagnosis of Love-Hostility on Pre-Post Tests for 40 Discussion Group Controls.

		TAT Less Hostile Than Initial Conscious Self Description	*TAT More Hostile Than Initial Conscious Self Description*
		+	—
Post Self Diagnosis Less Hostile Than Initial Self Diagnosis....	+	11	10
Post Self Diagnosis More Hostile Than Initial Self Diagnosis....	—	4	15

$X^2 = 4.18$; $p = .05$

The second hypothesis concerned the ability of the TAT to predict the *amount* of change. It will be recalled that the third discrepancy score (d) mentioned above reflects the linear distance on the diagnostic grid between the initial self description score and the TAT, or the distance between any pre-*vs.*-post comparison.

If the second hypothesis is correct, the greater the conflict or discrepancy within the pre-test personality, the greater the change over time. Conversely, the more rigid and tightly organized the pre-test personality, the smaller the change to be expected. Defined operationally: a large "d" score between Level II and Level III in the pre-testing predicts to a large "d" score between the pre and post testing at Level II.

The "d" indices range from 0 to 114. The score 44 was selected as a cutting point. Subjects with "d" indices below 44 on the II–III or the pre–post comparisons were considered to have a small discrepancy. Above 44 was defined as a large discrepancy.

As seen in Table 25 there is a positive relationship between the II–III discrepancy and the pre–post change index which is significant at the .05 level.

TABLE 25

Relationship Between Amount of Temporal Change in Self Rating and Amount of Discrepancy Between Self Rating and TAT Score (for 81 Discussion Group Controls)

		Discrepancy (d) Between Self Rating and TAT in Initial Testing	
		Small	*Large*
Discrepancy (d) Between Pre and Post Self Diagnosis	Small	27	15
	Large	16	23

$X^2 = 4.40$; $p = .05$

The greater the conflict between self-diagnosis and the TAT in the first testing the greater the change in Level II self-diagnosis over time. To this extent it can be said that structural variability in personality predicts to temporal variability.

Chapter 16
RESEARCH IN GROUP DYNAMICS AND FAMILY DIAGNOSIS

The record booklet for group dynamics provides innumerable sources of research data. Each subject is assigned an X score, which is the Level I diagnosis based on the pooled total of the group's perceptions. To compare the interpersonal roles of the members of the group or one sample *vs.* another, the X scores are compared. The mean Dom and Lov totals (from Table 2 Page 4 of the booklet) of 50 obese females can be compared with the mean Dom and Lov indices for a neurotic sample (by means of a T test). A simple method would be to compare the distribution of X diagnoses around the circle by X^2 as described above.

The X score can also be used to validate devices used to predict interpersonal behavior in social situations. The Dom and Lov indices on the predictive instrument (*e.g.,* MMPI formulae) are correlated with the Dom and Lov X scores.

The variability indices of group dynamics (Page 3) are often used for research purposes. Any interpersonal diagnosis or variability index from the pre-group or pre-therapy test battery can be compared with any variability index from the group dynamics booklet. The Level I diagnosis can be compared with self-deception (Lov) to test the hypothesis that over-conventional patients misperceive their own hostility. The index of repression (Level II *vs.* Level III self) can be compared with the several "d" scores for misperception of others, to test the hypothesis that the more repressive the patient, the more likely he is to distort his views of others.

TABLE 26

Number of Women in Each Diagnostic Quadrant Married to Men in Each Diagnostic Quadrant (N = 163 Marriages or 326 Subjects)

	Wife's Diagnosis			
Husband's Diagnosis	*Hypernormal Octants (1 & 8)*	*Sadistic Octants (2 & 3)*	*Masochistic Octants (4 & 5)*	*Docile Octants (6 & 7)*
Hypernormal	79	8	11	18
Sadistic	3	1	3	5
Masochistic	8	1	3	1
Docile	15	3	3	1

The techniques used to manage the data, make comparisons and test significance of differences can be similar to those described above—or can be tailored and adjusted to meet the research design.

Research on Family Diagnosis

The "Family Diagnosis" booklet is designed so that more than 140 variables can be calculated and listed. These include the interpersonal diagnoses from the husband, appraising himself and family members, and the same from the wife.

Any or all of these 100+ variables can be compared with any number of variables from other booklets or with variables independent of the interpersonal system. The techniques can be those used above or can be designed for the specific research.

There is one aspect of marriage diagnosis which is worth comment. This involves the issues: who marries whom, what personality types (at what levels) mate, and which marriage combinations tend not to mate.

Here is a sample study which focuses on Level I marriages. The Level I (MMPI) diagnoses for the husband and wife are located (on Page 2 of the booklet) and entered on a two-by-two table. Unless the sample is very large (over 200 marriages, *i.e.,* 400 subjects) it is best to combine adjacent octants. Table 26 indicates that 79 hypernormal men married hypernormal women, 8 hypernormal men married sadistic women, etc. Since this sample is not com-

TABLE 27

Percentage of Women in Each Diagnostic Quadrant Marrying Men of Each Diagnostic Type (N = 163 Marriages)

	Wife's Diagnosis: % of			
Diagnosis Husband's	*Hypernormal (1 & 8)*	*Sadistic (2 & 3)*	*Masochistic (4 & 5)*	*Docile (6 & 7)*
Hypernormal	73	58	55	73
Sadistic	4	13	15	20
Masochistic	8	6	15	4
Docile	16	24	15	4
	101	101	100	101

posed of psychiatric patients, there is an overloading of hypernormal individuals. To eliminate this factor, the percentage of each diagnostic group of wives marrying different types is calculated. Table 27 presents these percentage figures.

The results of this table are translated into the following verbal summaries: in this sample, hypernormal men marry 73% of the hypernormal women, 58% of the sadistic women, etc. The trends which seem noteworthy are: from the standpoint of Level I (MMPI) hypernormal men tend to marry hypernormal or docile women. Sadistic men tend to marry weak (*i.e.,* masochistic or docile) women. Docile men do not marry docile women, but seem to prefer hostile women. A similar table can be drawn up indicating the percentage of men in each diagnostic type married by women of each type.

The same kind of tables can be drawn up to study marriage combinations at other levels and to compare interlevel symbiotic mating, *e.g.,* the number of men in each diagnostic category at Level II who marry different types of women at Level III. A typical hypothesis would be: women who are covertly sadistic tend to marry men who are overtly sadistic, thus living out their own hostility vicariously through their husband's behavior.

Chapter 17

POSTSCRIPT TO FUTURE USERS OF THE INTERPERSONAL SYSTEM

The interpersonal system of personality diagnosis was developed as a research tool. The main criteria which guided the construction of this model were that it should be objective and that it should pay respect to the complexity of human nature. The hope of the Kaiser Foundation Psychology Research Staff is that a widespread use of the system will be made by scientists working in the fields of clinical psychology, psychiatry and personality.

For those researchers who intend to experiment with the interpersonal system, there are two practical advantages which should be discussed. The first involves the use of the data already assembled by previous workers. The second involves the consultative facilities of the Kaiser Foundation staff.

Availability and Use of Previously Collected Data

The careful use of this manual makes it possible for a research worker to duplicate the testing and diagnostic procedures carried out at the Kaiser Foundation project. The methods of administration, scoring, and diagnosing are uniform. Use of the norms published in the Appendices means that new samples can be compared directly with the normative samples and, in addition, with all other research samples collected by the Kaiser Foundation project.

The Kaiser Foundation project has diagnosed several different samples of neurotic, psychotic and psychosomatic patients. In addition, normal subjects tested in different institutional settings have been studied.

For each sample we have determined the number of subjects receiving diagnoses at each level of personality. And for each sample we have determined the number of subjects manifesting each amount and kind of variability index. These data are presented in the tables in Appendices H and I.

These data can be of considerable importance to researchers using the interpersonal system. It is possible to compare the multilevel patterns of any new sample with any or all of those listed in the summary appendix tables. It is possible to run tests on the significance of difference between any new sample and the several samples already studied and diagnosed by the Kaiser Foundation project. The total N of any new experiment can be multiplied many-fold by comparing the new sample with the listed samples.

Consider, for example, the research worker who obtains multilevel tests on 50 male asthma patients. This is a symptom group never before studied by use of the interpersonal system. The number of asthmatics diagnosed in each octant at Level I (MMPI) is determined. The research worker then turns to Appendix H where the Level I diagnoses of several other samples are listed. He can determine the kind and significance of differences in Level I behavior between his asthma sample and the ulcer, hypertensive, dermatitis, normal and neurotic samples listed. Appendices H and I make possible a tremendous economy in the testing of hypotheses. Several years of work (involving over $100,000 of research funds) have been required to assemble the data in Appendices H and I which are now available for comparisons (or rechecks) with new samples.

Several factors, of course, limit the generalizations made from such comparative procedures. Countless sampling issues and complexities caused by the institutional and motivational context influence all data. Ulcer patients in a veterans' hospital in Chicago may manifest different interpersonal behavior at any or all levels from ulcer patients tested at the Kaiser Foundation Hospital in Oakland. These institutional factors, however, are not just negative nuisances handicapping smooth research designs. They are, on the contrary, central issues in functional research and may add valuable information if judiciously interpreted and retested.

As further data about the interpersonal system are collected by the Kaiser Foundation group, or published by other researchers, an expanding storehouse of comparable multilevel diagnostic data can be expected to accumulate. A standardized body of knowledge about the interpersonal and variability dimensions of personality will develop.

The Consultative Resources of the Kaiser Foundation Psychology Research Project

The interpersonal system is complex and it is novel. For these reasons the Kaiser Foundation project has made its research facilities available for consultation. Clinicians or researchers using the system are invited to communicate with the Kaiser Foundation Psychology Research office. If the general nature of the research is described, it may be possible for the Kaiser Foundation staff to suggest specific methods and to refer to previous results obtained in this area (if such exist).

Appendices

Appendix A

LEVEL I—MMPI STANDARD SCORE CONVERSION TABLE

The Level I–MMPI is employed to diagnose the symptomatic pressure exerted by the patient. Chapter 2 describes the procedure for converting MMPI scales into the two raw score indices. After they have been calculated they must be converted to standard scores—so that Level I diagnosis can be compared with the diagnosis at other levels.

Table 28 contains the norms used to convert raw scores for Dom and Lov to standard scores. They are based on eight hundred routine admissions to the Kaiser Foundation Psychiatric Clinic. The standard scores are printed in bold face. To the left of each standard score will be found the corresponding raw score indices for Dom; and to the right will be found the corresponding raw score Lov indices.

Consider, for example, a case in which the MMPI formulae yield the following score: Dom = —24; Lov = —33. The standard scores are Dom = 50; Lov = 40. These standard scores are then plotted on the circular grid (see Figure 6) to determine the Level I–MMPI diagnosis.

Table 28

NORMS FOR CONVERTING RAW SCORES (Dom and Lov) TO STANDARD SCORES AT LEVEL I–MMPI
(Standardized on Kaiser Foundation Psychology Research Samples B, Cl. 1, Cl. 2)

DOM	STANDARD SCORE	LOV	DOM	STANDARD SCORE	LOV
+47, 48, 49	**80**	+74, 75, 76			
+45, 46	**79**	+72, 73	—26, 27	**49**	—8, 9, 10
+42, 43, 44	**78**	+69, 70, 71	—28, 29, 30	**48**	—11, 12
+40, 41	**77**	+66, 67, 68	—31, 32	**47**	—13, 14, 15
+38, 39	**76**	+64, 65	—33, 34, 35	**46**	—16, 17, 18
+35, 36, 37	**75**	+61, 62, 63	—36, 37	**45**	—19, 20, 21
+33, 34	**74**	+58, 59, 60	—38, 39, 40	**44**	—22, 23
+30, 31, 32	**73**	+55, 56, 57	—41, 42	**43**	—24, 25, 26
+28, 29	**72**	+53, 54	—43, 44	**42**	—27, 28, 29
+25, 26, 27	**71**	+50, 51, 52	—45, 46, 47	**41**	—30, 31
+23, 24	**70**	+47, 48, 49	—48, 49	**40**	—32, 33, 34
+21, 22	**69**	+45, 46	—50, 51, 52	**39**	—35, 36
+18, 19, 20	**68**	+42, 43, 44	—53, 54	**38**	—37, 38, 39
+16, 17	**67**	+39, 40, 41	—55, 56	**37**	—40, 41, 42
+13, 14, 15	**66**	+37, 38	—57, 58, 59	**36**	—43, 44, 45
+11, 12	**65**	+34, 35, 36	—60, 61	**35**	—46, 47, 48
+9, 10	**64**	+31, 32, 33	—62, 63, 64	**34**	—49, 50
+6, 7, 8	**63**	+28, 29, 30	—65, 66	**33**	—51, 52, 53
+4, 5	**62**	+26, 27	—67, 68	**32**	—54, 55, 56
+1, 2, 3	**61**	+23, 24, 25	—69, 70, 71	**31**	—57, 58
—1, 0	**60**	+20, 21, 22	—72, 73	**30**	—59, 60, 61
—2, 3	**59**	+17, 18, 19	—74, 75, 76	**29**	—62, 63, 64
—4, 5, 6	**58**	+15, 16	—77, 78	**28**	—65, 66, 67
—7, 8	**57**	+12, 13, 14	—79, 80, 81	**27**	—68, 69
—9, 10, 11	**56**	+9, 10, 11	—82, 83	**26**	—70, 71, 72
—12, 13	**55**	+7, 8	—84, 85	**25**	—73, 74, 75
—14, 15	**54**	+4, 5, 6	—86, 87, 88	**24**	—76, 77
—16, 17, 18	**53**	+1, 2, 3	—89, 90	**23**	—78, 79, 80
—19, 20	**52**	0, —1, 2	—91, 92, 93	**22**	—81, 82, 83
—21, 22, 23	**51**	—3, 4	—94, 95	**21**	—84, 85, 86
—24, 25	**50**	—5, 6, 7	—96, 97, 98	**20**	—87, 88

Formulas for Computing Dom and Lov Raw Scores from MMPI T-Scores

Dom (Vertical Index) = (Ma — D) + (Hs — Pt)

Lov (Horizontal Index) = (K — F) + (Hy — Sc)

Appendix B

MMPI—GRAPHIC REPRESENTATION: MALE NORMS, FEMALE NORMS

To enrich the over-all diagnostic picture, a method has been developed for diagramming at each level a profile based on the circular interpersonal schema. At Level II (Interpersonal Check List) we plot the actual raw total of items checked for each octant. At Level III, we plot the sum of ratings assigned to each octant for "Hero" and "Other." At Level I–MMPI a similar procedure is employed.

The graphic representation of the MMPI scales reflects the patient's interpersonal pressure on the clinic. The MMPI scale which seemed to be the best measure of each octant was determined by studying the correlations between Level I Sociometric and all the standard and special MMPI scales.[1] The scales selected are:

For octant 1: PgB, Barron's Ego Strength Scale
For octant 2: The Ma Scale
For octant 3: The F Scale
For octant 4: The Sc Scale
For octant 5: The Pt Scale
For octant 6: The D Scale
For octant 7: HyD, Denial of Hysteria Scale[2]
For octant 8: The K Scale.

The mean and sigma of each scale for a large sample of psychiatric clinic admission cases were determined. The K-corrected T-scores for six MMPI scales were then converted into new standard scores based on our samples. The Barron Ego Strength and HyD standard scores are based on the raw scores. These new standard scores are used to plot the graphic representation profile. The procedure for plotting is presented in Chapter 5. The standard score tables employed to convert MMPI scales into graphic interpersonal profiles are presented in Table 29 (for males) and Table 30 (for females).

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[1] Coffey, Hubert S., and T. Leary. "The prediction of interpersonal behavior in group psychotherapy." *Psychodr. and Grp. Psychother. Monogr.* No. 28, 1955. Note that these MMPI scales are not the same as the scales used in the formulae to determine the Level I–MMPI summary point. The Barron Ego Strength scale is the best measure of interpersonal power (i.e., octant 1) and the HyD scale is a superior measure of affiliation and conventionality (octant 7).

[2] Developed by Little and Fisher at Fort Miley, VA Hospital, San Francisco, Calif.

Table 29

STANDARD SCORE CONVERSION TABLE FOR GRAPHIC REPRESENTATION OF THE MMPI—MALE NORMS

(Based on Psychiatric Clinic Admission Samples)

STANDARD SCORE	OCTANT 1 PgB	2 Ma	3 F	4 Sc	5 Pt	6 D	7 HyD	8 K	STANDARD SCORE
80	64	—	95, 96	111	—	118	—	—	80
79	—	88	94	109	110	—	—	79	79
78	63	—	93	—	—	116	—	—	78
77	—	86	92	107	107	—	—	77	77
76	62	—	91	105	105	113	—	—	76
75	61	83	90	103	103	111	—	75	75
74	—	—	89	—	—	—	—	74	74
73	60	81	87, 88	101	101	108	—	—	73
72	59	—	86	99	99	106	—	—	72
71	—	—	85	97	—	—	—	72	71
70	58	78	84	96	97	104	19	—	70
69	57	—	83	94	95	—	—	70	69
68	—	75	82	92	93	101	18	—	68
67	56	—	80, 81	—	—	99	—	68	67
66	—	73	—	90	91	—	—	—	66
65	55	—	78	88	89	96	17	66	65
64	54	—	—	86	—	94	—	—	64
63	—	70	76	—	87	—	—	—	63
62	53	68	—	84	85	92	16	64	62
61	52	—	73	82	83	—	—	—	61
60	—	—	—	80	—	89	15	62	60
59	51	65	—	—	81	87	—	61	59
58	50	—	70	78	79	—	—	—	58
57	—	63	—	76	—	84	14	59	57
56	49	—	68	74	77	82	—	—	56
55	—	—	—	73	75	—	13	—	55
54	48	60	66	71	73	80	—	57	54
53	47	58	64	—	—	—	—	—	53
52	—	—	—	69	71	77	12	55	52
51	46	—	62	67	69	75	—	—	51
50	45	55	—	65	—	—	11	53	50
49	—	—	60	—	66	72	—	—	49
48	44	53	58	63	—	70	—	51	48
47	43	—	—	61	64	—	10	—	47
46	—	—	—	59	62	68	—	—	46
45	42	50	55	—	—	—	9	49	45
44	—	48	—	57	60	65	—	48	44
43	41	—	53	55	58	63	—	—	43
42	40	—	—	53	56	—	8	46	42
41	—	45	50	51	—	60	—	—	41

PgB and HyD are raw scores. All others are T-scores (Ma, Sc, and Pt are with K added).

Table 30

STANDARD SCORE CONVERSION TABLE FOR GRAPHIC REPRESENTATION OF THE MMPI—FEMALE NORMS

(Based on Psychiatric Clinic Admission Samples)

STANDARD SCORE	OCTANT 1 PgB	2 Ma	3 F	4 Sc	5 Pt	6 D	7 HyD	8 K	STANDARD SCORE
80	—	—	90	107	104	—	—	79	**80**
79	62	—	89	106	—	109	—	—	**79**
78	61	83	88	104	101, 102	107	—	—	**78**
77	60	—	87	103	—	—	—	77	**77**
76	—	81	86	—	99	105	—	—	**76**
75	59	—	85	100, 101	98	103	—	75	**75**
74	58	—	84	—	96	102	—	74	**74**
73	57	78	83	97, 98	—	—	—	—	**73**
72	—	—	82	—	94	100	—	72	**72**
71	56	—	81	95	93	98	—	—	**71**
70	55	75	80	94	91	—	19	—	**70**
69	54	—	—	92	—	96	—	70	**69**
68	—	73	78	91	89	94	—	—	**68**
67	53	—	—	89	88	—	18	68	**67**
66	52	—	76	—	86	92	—	—	**66**
65	51	70	—	86, 87	—	90	—	66	**65**
64	—	68	—	—	84	—	17	—	**64**
63	50	—	73	84	83	88	—	—	**63**
62	49	—	—	83	81	86	—	64	**62**
61	48	65	—	81	—	—	16	—	**61**
60	—	—	70	80	79	84	—	62	**60**
59	47	63	—	78	78	82	15	61	**59**
58	46	—	68	77	—	—	—	—	**58**
57	—	—	—	75	76	80	—	—	**57**
56	45	60	66	74	74	78	14	59	**56**
55	44	—	—	—	73	—	—	—	**55**
54	43	58	64	71, 72	—	76	—	57	**54**
53	—	—	—	—	71	75	13	—	**53**
52	42	—	62	69	69	73	—	55	**52**
51	41	55	—	67	68	—	12	—	**51**
50	40	—	60	66	—	71	—	53	**50**
49	—	53	—	64	65, 66	69	—	—	**49**
48	39	—	58	63	—	—	11	—	**48**
47	38	—	—	—	63	67	—	51	**47**
46	37	50	55	60, 61	—	65	—	—	**46**
45	—	—	—	—	60, 61	—	10	49	**45**
44	36	48	53	58	—	63	—	48	**44**
43	35	—	—	57	58	61	9	—	**43**
42	34	—	—	55	—	—	—	—	**42**
41	—	45	50	54	56	59	—	46	**41**

PgB and HyD are raw scores. All others are T-scores (Ma, Sc, and Pt are with K added).

Appendix C

LEVEL II—INTERPERSONAL CHECK LIST STANDARD SCORE CONVERSION TABLE

The Interpersonal Check List is used to measure behavior at three levels of personality. It is used at Level I–Sociometric when the subject is rated by another person—his therapist, a co-worker or a fellow group member. This reflects his social impact on the other. It is used at Level II—the patient checks his description of self and other. It is used at Level V when the patient checks his ego ideal.

The same set of norms is used for Level I–S and Level II check list scores. These are presented in Table 31. The Level V–Ideal scores can be standardized according to these norms or according to the Level V norms listed in Table 32. The Interpersonal Check List norms in Table 31 are for use with the Form 4 check list (see Figure 5).

For diagnosing Level II self and others, the raw indices for Dom and Lov are calculated (see Chapter 3). The standard scores are listed in bold face in Table 31. To the left of the standard scores are found the raw-score equivalents for Dom; to the right the Lov equivalents. For the raw score indices of +12.5 on Dom and —19.0 on Lov the standard scores are 70 and 27.

For diagnosing Level I–Sociometric the same procedure is followed.

Table 31

NORMS FOR CONVERTING RAW SCORES (Dom and Lov) TO STANDARD SCORES AT LEVEL I–SOCIOMETRIC AND LEVEL II–ICL

(For Use with Interpersonal Check List Form 4)

(Standardized on Kaiser Foundation Research Sample G)

DOM		STANDARD SCORE	LOV		STANDARD SCORE
+37.8	+38.4	**102**			
37.0	37.7	**101**			
+36.2	+36.9	**100**			
35.4	36.1	**99**			
34.6	35.3	**98**			
33.8	34.5	**97**			
33.0	33.7	**96**			
32.2	32.9	**95**			
31.5	32.1	**94**			
30.7	31.4	**93**			
29.9	30.6	**92**			
29.1	29.8	**91**	37.6	38.4	**91**
+28.3	+29.0	**90**	+36.7	+37.5	**90**
27.5	28.2	**89**	35.9	36.6	**89**
26.7	27.4	**88**	35.0	35.8	**88**
25.9	26.6	**87**	34.1	34.9	**87**
25.2	25.8	**86**	33.2	34.0	**86**
24.4	25.1	**85**	32.3	33.1	**85**
23.6	24.3	**84**	31.4	32.2	**84**
22.8	23.5	**83**	30.5	31.3	**83**
22.0	22.7	**82**	29.6	30.4	**82**
21.2	21.9	**81**	28.8	29.5	**81**
+20.4	+21.1	**80**	+27.9	+28.7	**80**
19.6	20.3	**79**	27.0	27.8	**79**
18.9	19.5	**78**	26.1	26.9	**78**
18.1	18.8	**77**	25.2	26.0	**77**
17.3	18.0	**76**	24.3	25.1	**76**
16.5	17.2	**75**	23.4	24.2	**75**
15.7	16.4	**74**	22.5	23.3	**74**
14.9	15.6	**73**	21.7	22.4	**73**
14.1	14.8	**72**	20.8	21.6	**72**
13.3	14.0	**71**	19.9	20.7	**71**
+12.5	+13.2	**70**	+19.0	+19.8	**70**
11.7	12.4	**69**	18.1	18.9	**69**
11.0	11.6	**68**	17.2	18.0	**68**
10.2	10.9	**67**	16.3	17.1	**67**
9.4	10.1	**66**	15.4	16.2	**66**
8.6	9.3	**65**	14.5	15.3	**65**
7.8	8.5	**64**	13.7	14.4	**64**
7.0	7.7	**63**	12.8	13.6	**63**
6.2	6.9	**62**	11.9	12.7	**62**
5.4	6.1	**61**	11.0	11.8	**61**
+ 4.7	+ 5.3	**60**	+10.1	+10.9	**60**
3.9	4.6	**59**	9.2	10.0	**59**
3.1	3.8	**58**	8.3	9.1	**58**
2.3	3.0	**57**	7.4	8.2	**57**
+ 1.5	+ 2.2	**56**	6.6	7.3	**56**
+ 0.7	+ 1.4	**55**	5.7	6.5	**55**
− 0.1	+ 0.6	**54**	4.8	5.6	**54**
− 0.2	− 0.9	**53**	3.9	4.7	**53**
− 1.0	− 1.6	**52**	3.0	3.8	**52**
− 1.7	− 2.4	**51**	2.1	2.9	**51**
− 2.5	− 3.2	**50**	1.2	2.0	**50**

DOM		STANDARD SCORE	LOV		STANDARD SCORE
− 3.3	− 4.0	**49**	+ 0.3	+ 1.1	**49**
− 4.1	− 4.8	**48**	+ 0.2	− 0.6	**48**
− 4.9	− 5.6	**47**	− 0.7	− 1.4	**47**
− 5.7	− 6.4	**46**	− 1.5	− 2.3	**46**
− 6.5	− 7.2	**45**	− 2.4	− 3.2	**45**
− 7.3	− 8.0	**44**	− 3.3	− 4.1	**44**
− 8.1	− 8.7	**43**	− 4.2	− 5.0	**43**
− 8.8	− 9.5	**42**	− 5.1	− 5.9	**42**
− 9.6	−10.3	**41**	− 6.0	− 6.8	**41**
−10.4	−11.1	**40**	− 6.9	− 7.7	**40**
−11.2	−11.9	**39**	− 7.8	− 8.5	**39**
−12.0	−12.7	**38**	− 8.6	− 9.4	**38**
−12.8	−13.5	**37**	− 9.5	−10.3	**37**
−13.6	−14.3	**36**	−10.4	−11.2	**36**
−14.4	−15.0	**35**	−11.3	−12.1	**35**
−15.1	−15.8	**34**	−12.2	−13.0	**34**
−15.9	−16.6	**33**	−13.1	−13.9	**33**
−16.7	−17.4	**32**	−14.0	−14.8	**32**
−17.5	−18.2	**31**	−14.9	−15.6	**31**
−18.3	−19.0	**30**	−15.7	−16.5	**30**
−19.1	−19.8	**29**	−16.6	−17.4	**29**
−19.9	−20.6	**28**	−17.5	−18.3	**28**
−20.7	−21.3	**27**	−18.4	−19.2	**27**
−21.4	−22.1	**26**	−19.3	−20.1	**26**
−22.2	−22.9	**25**	−20.2	−21.0	**25**
−23.0	−23.7	**24**	−21.1	−21.9	**24**
−23.8	−24.5	**23**	−22.0	−22.8	**23**
−24.6	−25.3	**22**	−22.9	−23.6	**22**
−25.4	−26.1	**21**	−23.7	−24.5	**21**
−26.2	−26.9	**20**	−24.6	−25.4	**20**
−27.0	−27.6	**19**	−25.5	−26.3	**19**
−27.7	−28.4	**18**	−26.4	−27.2	**18**
−28.5	−29.2	**17**	−27.3	−28.1	**17**
−29.3	−30.0	**16**	−28.2	−29.0	**16**
−30.1	−30.8	**15**	−29.1	−29.9	**15**
−30.9	−31.6	**14**	−30.0	−30.7	**14**
−31.7	−32.4	**13**	−30.8	−31.6	**13**
−32.5	−33.2	**12**	−31.7	−32.5	**12**
−33.3	−33.9	**11**	−32.6	−33.4	**11**
−34.0	−34.7	**10**	−33.5	−34.3	**10**
−34.8	−35.5	**9**	−34.4	−35.2	**9**
−35.6	−36.3	**8**	−35.3	−36.1	**8**
−36.4	−37.1	**7**	−36.2	−37.0	**7**
−37.2	−37.9	**6**	−37.1	−37.9	**6**
−38.0	−38.4	**5**	−38.0	−38.4	**5**

Appendix D

LEVEL V—IDEAL STANDARD SCORE CONVERSION TABLE

Although the Level V ideal is measured by means of the Interpersonal Check List, separate norms are used. When the Level II-Self norms are used the ideals cluster in the Managerial or Hypernormal octants. There is not enough spread and the ideal becomes a stereotype.

For this reason the raw score indices for Ideal are converted to standard scores based on the mean and sigmas of clinic admission samples at Level V.

These norms are presented in Table 32. Standard scores are bold face; raw Dom indices for Ideal are to the left and Lov indices to the right. For example, raw score indices for ideal of +12.7 on Dom and +1.7 on Lov convert to standard scores of 60 and 40.

Table 32

NORMS FOR CONVERTING RAW SCORES (Dom and Lov) TO STANDARD SCORES AT LEVEL V (Ideal)—ICL

(Standardized on Kaiser Foundation Research Sample 200 Id)
(For Use with Interpersonal Check List Form 4)

DOM		STANDARD SCORE	LOV		DOM		STANDARD SCORE	LOV	
					+ 9.2	+ 9.4	**49**	+ 5.7	+ 6.1
					8.9	9.1	**48**	5.2	5.6
					8.6	8.8	**47**	4.7	5.1
					8.3	8.5	**46**	4.2	4.6
+17.3	+17.5	**75**	+18.4	+18.7	7.9	8.2	**45**	3.7	4.1
17.0	17.2	**74**	17.9	18.3	7.6	7.8	**44**	3.3	3.6
16.7	16.9	**73**	17.4	17.8	7.3	7.5	**43**	2.8	3.2
16.4	16.6	**72**	16.9	17.3	7.0	7.2	**42**	2.3	2.7
16.1	16.3	**71**	16.3	16.8	6.7	6.9	**41**	1.8	2.2
15.7	16.0	**70**	15.9	16.2	6.4	6.6	**40**	1.3	1.7
+15.4	+15.6	**69**	+15.4	+15.8	+ 6.1	+ 6.3	**39**	+ 0.8	+ 1.2
15.1	15.3	**68**	15.0	15.3	5.8	6.0	**38**	+ 0.3	+ 0.7
14.8	15.0	**67**	14.5	14.9	5.4	5.7	**37**	+ 0.2	— 0.2
14.5	14.7	**66**	14.0	14.4	5.1	5.3	**36**	— 0.3	— 0.6
14.2	14.4	**65**	13.5	13.9	4.8	5.0	**35**	— 0.7	— 1.1
13.9	14.1	**64**	13.0	13.4	4.5	4.7	**34**	— 1.2	— 1.6
13.6	13.8	**63**	12.5	12.9	4.2	4.4	**33**	— 1.7	— 2.1
13.2	13.5	**62**	12.0	12.4	3.9	4.1	**32**	— 2.2	— 2.6
12.9	13.1	**61**	11.5	11.9	3.6	3.8	**31**	— 2.7	— 3.1
12.6	12.8	**60**	11.0	11.4	3.3	3.5	**30**	— 3.2	— 3.6
+12.3	+12.5	**59**	+10.6	+10.9	+ 3.0	+ 3.2	**29**	— 3.7	— 4.1
12.0	12.2	**58**	10.1	10.5	2.6	2.9	**28**	— 4.2	— 4.5
11.7	11.9	**57**	9.6	10.0	2.3	2.5	**27**	— 4.6	— 5.0
11.4	11.6	**56**	9.1	9.5	2.0	2.2	**26**	— 5.1	— 5.5
11.1	11.3	**55**	8.6	9.0	1.7	1.9	**25**	— 5.6	— 6.0
10.8	11.0	**54**	8.1	8.5	1.4	1.6	**24**	— 6.1	— 6.5
10.4	10.7	**53**	7.6	8.0	1.1	1.3	**23**	— 6.6	— 7.0
10.1	10.3	**52**	7.2	7.5	0.8	1.0	**22**	— 7.1	— 7.5
9.8	10.0	**51**	6.7	7.1	0.5	0.7	**21**	— 7.6	— 8.0
9.5	9.7	**50**	6.2	6.6	0.1	0.4	**20**	— 8.1	— 8.5

Appendix E

LEVEL III–TAT HERO STANDARD SCORE CONVERSION TABLE

The Level III Self or Hero diagnosis is obtained from the patient's stories on ten TAT cards. The Hero or central character of each story is determined and interpersonal ratings are assigned to his feelings or actions. These are then fed into the formulae and yield raw score indices of Dom and Lov. The scores of the "other" with whom the Hero deals are treated separately.

Table 33 presents the norms for converting raw score indices for Level III–TAT Hero to standard scores. The bold face figures are the standard scores. To the left are the corresponding raw scores for Dom. To the right are found the raw scores for Lov.

For example, TAT Hero raw score indices of —15.8 on Dom and —5.7 on Lov convert to the standard scores of 20 on Dom and 31 on Lov. These are plotted on the Diagnostic booklet to obtain the Level III Hero diagnosis.

Table 33

NORMS FOR CONVERTING RAW SCORES (Dom and Lov) TO STANDARD SCORES AT LEVEL III-TAT (Hero)
(Standardized on Kaiser Foundation Psychology Research Sample 100)

DOM		STANDARD SCORE	LOV		STANDARD SCORE	DOM		STANDARD SCORE	LOV		STANDARD SCORE
+ 7.7	+ 7.9	**90**	+11.9	+12.1	**90**						
7.4	7.6	**89**	11.6	11.8	**89**	— 5.9	— 6.1	**49**	— 0.1	— 0.3	**49**
7.0	7.3	**88**	11.3	11.5	**88**	— 6.2	— 6.5	**48**	— 0.4	— 0.6	**48**
6.7	6.9	**87**	11.0	11.2	**87**	— 6.6	— 6.8	**47**	— 0.7	— 0.9	**47**
6.3	6.6	**86**	10.7	10.9	**86**	— 6.9	— 7.1	**46**	— 1.0	— 1.2	**46**
6.0	6.2	**85**	10.4	10.6	**85**	— 7.2	— 7.5	**45**	— 1.3	— 1.5	**45**
5.7	5.9	**84**	10.1	10.3	**84**	— 7.6	— 7.8	**44**	— 1.6	— 1.8	**44**
5.3	5.6	**83**	9.8	10.0	**83**	— 7.9	— 8.1	**43**	— 1.9	— 2.1	**43**
5.0	5.2	**82**	9.5	9.7	**82**	— 8.2	— 8.5	**42**	— 2.2	— 2.4	**42**
4.7	4.9	**81**	9.2	9.4	**81**	— 8.6	— 8.8	**41**	— 2.5	— 2.7	**41**
4.3	4.6	**80**	8.9	9.1	**80**	— 8.9	— 9.2	**40**	— 2.8	— 3.0	**40**
+ 4.0	+ 4.2	**79**	+ 8.6	+ 8.8	**79**	— 9.3	— 9.5	**39**	— 3.1	— 3.3	**39**
3.6	3.9	**78**	8.3	8.5	**78**	— 9.6	— 9.8	**38**	— 3.4	— 3.6	**38**
3.3	3.5	**77**	8.0	8.2	**77**	— 9.9	—10.2	**37**	— 3.7	— 3.9	**37**
3.0	3.2	**76**	7.7	7.9	**76**	—10.3	—10.5	**36**	— 4.0	— 4.2	**36**
2.6	2.9	**75**	7.4	7.6	**75**	—10.6	—10.8	**35**	— 4.3	— 4.5	**35**
2.3	2.5	**74**	7.1	7.3	**74**	—10.9	—11.2	**34**	— 4.6	— 4.8	**34**
2.0	2.2	**73**	6.8	7.0	**73**	—11.3	—11.5	**33**	— 4.9	— 5.1	**33**
1.6	1.9	**72**	6.5	6.7	**72**	—11.6	—11.9	**32**	— 5.2	— 5.4	**32**
1.3	1.5	**71**	6.2	6.4	**71**	—12.0	—12.2	**31**	— 5.5	— 5.7	**31**
1.0	1.2	**70**	6.0	6.1	**70**	—12.3	—12.5	**30**	— 5.8	— 6.0	**30**
+ 0.6	+ 0.9	**69**	+ 5.7	+ 5.9	**69**	—12.6	—12.9	**29**	— 6.1	— 6.3	**29**
+ 0.3	+ 0.5	**68**	+ 5.4	+ 5.6	**68**	—13.0	—13.2	**28**	— 6.4	— 6.6	**28**
— 0.1	+ 0.2	**67**	+ 5.1	+ 5.3	**67**	—13.3	—13.5	**27**	— 6.7	— 6.9	**27**
— 0.2	— 0.4	**66**	+ 4.8	+ 5.0	**66**	—13.6	—13.9	**26**	— 7.0	— 7.2	**26**
— 0.5	— 0.7	**65**	+ 4.5	+ 4.7	**65**	—14.0	—14.2	**25**	— 7.3	— 7.5	**25**
— 0.8	— 1.1	**64**	+ 4.2	+ 4.4	**64**	—14.3	—14.6	**24**	— 7.6	— 7.8	**24**
— 1.2	— 1.4	**63**	+ 3.9	+ 4.1	**63**	—14.7	—14.9	**23**	— 7.9	— 8.1	**23**
— 1.5	— 1.7	**62**	+ 3.6	+ 3.8	**62**	—15.0	—15.2	**22**	— 8.2	— 8.4	**22**
— 1.8	— 2.1	**61**	+ 3.3	+ 3.5	**61**	—15.3	—15.6	**21**	— 8.5	— 8.7	**21**
— 2.2	— 2.4	**60**	+ 3.0	+ 3.2	**60**	—15.7	—15.9	**20**	— 8.8	— 8.9	**20**
— 2.5	— 2.8	**59**	+ 2.7	+ 2.9	**59**	—16.0	—16.2	**19**	— 9.0	— 9.2	**19**
— 2.9	— 3.1	**58**	+ 2.4	+ 2.6	**58**	—16.3	—16.6	**18**	— 9.3	— 9.5	**18**
— 3.2	— 3.4	**57**	+ 2.1	+ 2.3	**57**	—16.7	—16.9	**17**	— 9.6	— 9.8	**17**
— 3.5	— 3.8	**56**	+ 1.8	+ 2.0	**56**	—17.0	—17.2	**16**	— 9.9	—10.1	**16**
— 3.9	— 4.1	**55**	+ 1.5	+ 1.7	**55**	—17.3	—17.6	**15**	—10.2	—10.4	**15**
— 4.2	— 4.4	**54**	+ 1.2	+ 1.4	**54**	—17.7	—17.9	**14**	—10.5	—10.7	**14**
— 4.5	— 4.8	**53**	+ 0.9	+ 1.1	**53**	—18.0	—18.3	**13**	—10.8	—11.0	**13**
— 4.9	— 5.1	**52**	+ 0.6	+ 0.8	**52**	—18.4	—18.6	**12**	—11.1	—11.3	**12**
— 5.2	— 5.5	**51**	+ 0.3	+ 0.5	**51**	—18.5	—18.9	**11**	—11.4	—11.6	**11**
— 5.6	— 5.8	**50**	0.0	+ 0.2	**50**	—19.0	—19.3	**10**	—11.7	—11.9	**10**

Appendix F

LEVEL III–TAT "OTHER" STANDARD SCORE CONVERSION TABLE

The TAT "other" scores are treated in the same fashion as the Level III Hero scores described in Appendix E.

Table 34

NORMS FOR CONVERTING RAW SCORES (Dom and Lov) TO STANDARD SCORES AT LEVEL III-TAT (Other)
(Standardized on Kaiser Foundation Psychology Research Sample 100)

DOM		STANDARD SCORE	LOV		STANDARD SCORE	DOM		STANDARD SCORE	LOV		STANDARD SCORE
+ 9.5	+ 9.7	**90**	+10.0	+10.2	**90**						
9.3	9.4	**89**	9.8	9.9	**89**	— 0.2	— 0.4	**49**	— 0.4	— 0.6	**49**
9.0	9.2	**88**	9.5	9.7	**88**	— 0.5	— 0.6	**48**	— 0.7	— 0.9	**48**
8.8	8.9	**87**	9.2	9.4	**87**	— 0.7	— 0.8	**47**	— 1.0	— 1.1	**47**
8.6	8.7	**86**	9.0	9.1	**86**	— 0.9	— 1.1	**46**	— 1.2	— 1.4	**46**
8.3	8.5	**85**	8.7	8.9	**85**	— 1.2	— 1.3	**45**	— 1.5	— 1.6	**45**
8.1	8.2	**84**	8.5	8.6	**84**	— 1.4	— 1.6	**44**	— 1.7	— 1.9	**44**
7.8	8.0	**83**	8.2	8.4	**83**	— 1.7	— 1.8	**43**	— 2.0	— 2.2	**43**
7.6	7.7	**82**	7.9	8.1	**82**	— 1.9	— 2.0	**42**	— 2.3	— 2.4	**42**
7.4	7.5	**81**	7.7	7.8	**81**	— 2.1	— 2.3	**41**	— 2.5	— 2.7	**41**
7.1	7.3	**80**	7.4	7.6	**80**	— 2.4	— 2.5	**40**	— 2.8	— 2.9	**40**
+ 6.9	+ 7.0	**79**	+ 7.2	+ 7.3	**79**	— 2.6	— 2.8	**39**	— 3.0	— 3.2	**39**
6.6	6.8	**78**	6.9	7.1	**78**	— 2.9	— 3.0	**38**	— 3.3	— 3.4	**38**
6.4	6.5	**77**	6.7	6.8	**77**	— 3.1	— 3.2	**37**	— 3.5	— 3.7	**37**
6.2	6.3	**76**	6.4	6.6	**76**	— 3.3	— 3.5	**36**	— 3.8	— 4.0	**36**
5.9	6.1	**75**	6.1	6.3	**75**	— 3.6	— 3.7	**35**	— 4.1	— 4.2	**35**
5.7	5.8	**74**	5.9	6.0	**74**	— 3.8	— 4.0	**34**	— 4.3	— 4.5	**34**
5.4	5.6	**73**	5.6	5.8	**73**	— 4.1	— 4.2	**33**	— 4.6	— 4.7	**33**
5.2	5.3	**72**	5.4	5.5	**72**	— 4.3	— 4.4	**32**	— 4.8	— 5.0	**32**
5.0	5.1	**71**	5.1	5.3	**71**	— 4.5	— 4.7	**31**	— 5.1	— 5.3	**31**
4.7	4.9	**70**	4.8	5.0	**70**	— 4.8	— 4.9	**30**	— 5.4	— 5.5	**30**
+ 4.5	+ 4.6	**69**	+ 4.6	+ 4.7	**69**	— 5.0	— 5.2	**29**	— 5.6	— 5.8	**29**
4.2	4.4	**68**	4.3	4.5	**68**	— 5.3	— 5.4	**28**	— 5.9	— 6.0	**28**
4.0	4.1	**67**	4.1	4.2	**67**	— 5.5	— 5.7	**27**	— 6.1	— 6.3	**27**
3.7	3.9	**66**	3.8	4.0	**66**	— 5.8	— 5.9	**26**	— 6.4	— 6.6	**26**
3.5	3.6	**65**	3.5	3.7	**65**	— 6.0	— 6.1	**25**	— 6.7	— 6.8	**25**
3.3	3.4	**64**	3.3	3.4	**64**	— 6.2	— 6.4	**24**	— 6.9	— 7.1	**24**
3.0	3.2	**63**	3.0	3.2	**63**	— 6.5	— 6.6	**23**	— 7.2	— 7.3	**23**
2.8	2.9	**62**	2.8	2.9	**62**	— 6.7	— 6.9	**22**	— 7.4	— 7.6	**22**
2.5	2.7	**61**	2.5	2.7	**61**	— 7.0	— 7.1	**21**	— 7.7	— 7.9	**21**
2.3	2.4	**60**	2.3	2.4	**60**	— 7.2	— 7.3	**20**	— 8.0	— 8.1	**20**
+ 2.1	+ 2.2	**59**	+ 2.0	+ 2.2	**59**	— 7.4	— 7.6	**19**	— 8.2	— 8.4	**19**
1.8	2.0	**58**	1.7	1.9	**58**	— 7.7	— 7.8	**18**	— 8.5	— 8.6	**18**
1.6	1.7	**57**	1.5	1.6	**57**	— 7.9	— 8.1	**17**	— 8.7	— 8.9	**17**
1.3	1.5	**56**	1.2	1.4	**56**	— 8.2	— 8.3	**16**	— 9.0	— 9.1	**16**
1.1	1.2	**55**	1.0	1.1	**55**	— 8.4	— 8.5	**15**	— 9.2	— 9.4	**15**
0.9	1.0	**54**	0.7	0.9	**54**	— 8.6	— 8.8	**14**	— 9.5	— 9.7	**14**
0.6	0.8	**53**	0.4	0.6	**53**	— 8.9	— 9.0	**13**	— 9.8	— 9.9	**13**
+ 0.4	+ 0.5	**52**	+ 0.2	+ 0.3	**52**	— 9.1	— 9.3	**12**	—10.0	—10.2	**12**
+ 0.1	+ 0.3	**51**	— 0.1	+ 0.1	**51**	— 9.4	— 9.5	**11**	—10.3	—10.4	**11**
— 0.1	0.0	**50**	— 0.2	— 0.3	**50**	— 9.6	— 9.8	**10**	—10.5	—10.7	**10**

TABLE OF WEIGHTED SCORES INDICATING THE KIND AND THE AMOUNT OF INTERLEVEL DIFFERENCE

A single diagnostic code number serves to summarize the behavior at each level or sub-level of personality. Since the diagnosis at each level is based on standard scores relative to the mean of the same normative sample, it is possible to compare the scores at different levels in a systematic way. Numerical indices of interlevel conflict are available. These indicate how much and what kind of difference exists between the two levels.

On page 3 of the Record Booklet for Interpersonal Diagnosis of Personality are listed the common interlevel variability indices. The diagnostic codes of the two levels being compared are written in the appropriate column. This two-digit code is then located in Table 35 which lists the weighted score for every possible interlevel discrepancy. The D column indicates the difference in dominance-passivity between the two scores; the L column the love-hostility difference. The d column indicates the amount of interlevel conflict.

Different sections of Table 35 are used depending on whether the two diagnostic codes being compared are both intense diagnoses (red or roman face), or both moderate diagnoses (black or italic print) or an intense vs. a moderate score.

If two extreme diagnoses are being compared use the left half of Table 35. Consider, for example, the variability of repression (Level II Self vs. Level III Hero) where the scores being compared are **7** and **3**. This means that the subject sees himself as being friendly and conventional (**7**) whereas his TAT self is extremely hostile (**3**). The paired code **73** is located (bold face) in the lower left of Table 35. Opposite the code are three figures, D = +22; L = —112; d = 114. These are the variability indices for this interlevel conflict. They tell us that the patient represses a small amount of power (because D is slightly positive, +22), and that he represses a considerable amount of hostility (L is —112). The d score of 114 is the largest possible, indicating that he is very repressed.

For illustration let us compare two moderate diagnoses. Let the Level II Mother score be ***8*** and the Level II Father score be ***7***. The code ***87*** is located in the bottom right (bold face) of Table 35. The variability indices for this discrepancy are D = 25, L = +5 and d = 26. This means that the father is seen as a bit more passive (D is —25) and a fraction more friendly (L is +5) than the mother. The two parents are equated, i.e., seen as being alike—because the d score is only 26.

In addition to measuring interlevel conflict the weighted scores in Table 35 can also represent change in the same level over time. We shall illustrate the comparison of an intense (red) score with a moderate (black) using a pre-post therapy change. Assume that the pre-therapy Level self diagnosis is **7** and the post-therapy self diagnosis is ***3***. The code ***73*** represents this change in self perception. This combination is located in the lower left of the second page of Table 35. The indices are D = +17, L = —89, d = 91. This means the patient has become during therapy slightly stronger (+17) and considerably more hostile (—89). The amount of pre-post change at Level II Self is relatively great (d = 91).

If the first code of the pair being compared is moderate (italics or black) and the second intense (arabic or red) the right hand column of the second page of Table 35 is consulted.

The meaning of any interlevel variability index is amplified if the interpreter consults the results of several different samples listed in Tables 41 through 45 (Appendix H).

In order to distinguish more easily the extreme (roman face) from the moderate (italic) codes it is suggested that the clerical worker draw red lines around the columns of roman face figures.

Table 35

TABLE OF WEIGHTED SCORES FOR MEASURING DISCREPANCY BETWEEN TWO DIAGNOSTIC CODES INDICATING KIND AND AMOUNT OF DIFFERENCE BETWEEN LEVELS OR TESTS

Weighted Scores Used to Compare Diagnostic Codes of Extreme Intensity Both Codes Red (Roman Face)

Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d
11	00	00	00	**21**	+ 9	+ 43	44
12	— 9	— 43	44	**22**	00	00	00
13	— 45	— 67	81	**23**	— 36	— 24	44
14	— 88	— 58	105	**24**	— 79	— 15	81
15	—112	— 22	114	**25**	—103	+ 21	105
16	—103	+ 21	105	**26**	— 94	+ 64	114
17	— 67	+ 45	81	**27**	— 58	+ 88	105
18	— 24	+ 36	44	**28**	— 15	+ 79	81
31	+ 45	+ 67	81	**41**	+ 88	+ 58	105
32	+ 36	+ 24	44	**42**	+ 79	+ 15	81
33	00	00	00	**43**	+ 43	— 9	44
34	— 43	+ 9	44	**44**	00	00	00
35	— 67	+ 45	81	**45**	— 24	+ 36	44
36	— 58	+ 88	105	**46**	— 15	+ 79	81
37	— 22	+112	114	**47**	+ 21	+103	105
38	+ 21	+103	105	**48**	+ 64	+ 94	114
51	+112	+ 22	114	**61**	+103	— 21	105
52	+103	— 21	105	**62**	+ 94	— 64	114
53	+ 67	— 45	81	**63**	+ 58	— 88	105
54	+ 24	— 36	44	**64**	+ 15	— 79	81
55	00	00	00	**65**	— 9	— 43	44
56	+ 9	+ 43	44	**66**	00	00	00
57	+ 45	+ 67	81	**67**	+ 36	+ 24	44
58	+ 88	+ 58	105	**68**	+ 79	+ 15	81
71	+ 67	— 45	81	**81**	+ 24	— 36	44
72	+ 58	— 88	105	**82**	+ 15	— 79	81
73	+ 22	—112	114	**83**	— 21	—103	105
74	— 21	—103	105	**84**	— 64	— 94	114
75	— 45	— 67	81	**85**	— 88	— 58	105
76	— 36	— 24	44	**86**	— 79	— 15	81
77	00	00	00	**87**	— 43	+ 9	44
78	+ 43	— 9	44	**88**	00	00	00

Weighted Scores Used to Compare Diagnostic Codes of Moderate Intensity Both Codes Black (Italic)

Diagnostic Codes Being Compared	D	L	d	Diagnostic Codes Being Compared	D	L	d
11	00	00	00	***21***	+ 5	+ 25	26
12	— 5	— 25	26	***22***	00	00	00
13	— 27	— 39	48	***23***	— 22	— 14	26
14	— 52	— 34	62	***24***	— 47	— 9	48
15	— 66	— 12	68	***25***	— 61	+ 13	62
16	— 61	+ 13	62	***26***	— 56	+ 38	68
17	— 39	+ 27	48	***27***	— 34	+ 52	62
18	— 14	+ 22	26	***28***	— 9	+ 47	48
31	+ 27	+ 39	48	***41***	+ 52	+ 34	62
32	+ 22	+ 14	26	***42***	+ 47	+ 9	48
33	00	00	00	***43***	+ 25	— 5	26
34	— 25	+ 5	26	***44***	00	00	00
35	— 39	+ 27	48	***45***	— 14	+ 22	26
36	— 34	+ 52	62	***46***	— 9	+ 47	48
37	— 12	+ 66	68	***47***	+ 13	+ 61	62
38	+ 13	+ 61	62	***48***	+ 38	+ 56	68
51	+ 66	+ 12	68	***61***	+ 61	— 13	62
52	+ 61	— 13	62	***62***	+ 56	— 38	68
53	+ 39	— 27	48	***63***	+ 34	— 52	62
54	+ 14	— 22	26	***64***	+ 9	— 47	48
55	00	00	00	***65***	— 5	— 25	26
56	+ 5	+ 25	26	***66***	00	00	00
57	+ 27	+ 39	48	***67***	+ 22	+ 14	26
58	+ 52	+ 34	62	***68***	+ 47	+ 9	48
71	+ 39	— 27	48	***81***	+ 14	— 22	26
72	+ 34	— 52	62	***82***	+ 9	— 47	48
73	+ 12	— 66	68	***83***	— 13	— 61	62
74	— 13	— 61	62	***84***	— 38	— 56	68
75	— 27	— 39	48	***85***	— 52	— 34	62
76	— 22	— 14	26	***86***	— 47	— 9	48
77	00	00	00	***87***	— 25	+ 5	26
78	+ 25	— 5	26	***88***	00	00	00

(Table 35—Continued)

WEIGHTED SCORES USED TO COMPARE DIAGNOSTIC CODES WHERE ONE DIAGNOSTIC CODE IS OF EXTREME AND THE OTHER IS OF MODERATE INTENSITY

Extreme-Moderate Diagnostic Codes Being Compared	D	L	d	Extreme-Moderate Diagnostic Codes Being Compared	D	L	d	Moderate-Extreme Diagnostic Codes Being Compared	D	L	d	Moderate-Extreme Diagnostic Codes Being Compared	D	L	d
11	— 23	— 5	23	21	— 14	+ 38	41	11	+ 23	+ 5	23	21	+ 28	+ 30	41
12	— 28	— 30	41	22	— 19	+ 13	23	12	+ 14	— 38	41	22	+ 19	— 13	23
13	— 50	— 44	66	23	— 41	— 1	41	13	— 22	— 62	66	23	— 17	— 37	41
14	— 75	— 39	84	24	— 66	+ 4	66	14	— 65	— 53	84	24	— 60	— 28	66
15	— 89	— 17	91	25	— 80	+ 26	84	15	— 89	— 17	91	25	— 84	+ 8	84
16	— 84	+ 8	84	26	— 75	+ 51	91	16	— 80	+ 26	84	26	— 75	+ 51	91
17	— 62	+ 22	66	27	— 53	+ 65	84	17	— 44	+ 50	66	27	— 39	+ 75	84
18	— 37	+ 17	41	28	— 28	+ 60	66	18	— 1	+ 41	41	28	+ 4	+ 66	66
31	+ 22	+ 62	66	41	+ 65	+ 53	84	31	+ 50	+ 44	66	41	+ 75	+ 39	84
32	+ 17	+ 37	41	42	+ 60	+ 28	66	32	+ 41	+ 1	41	42	+ 66	— 4	66
33	— 5	+ 23	23	43	+ 38	+ 14	41	33	+ 5	— 23	23	43	+ 30	— 28	41
34	— 30	+ 28	41	44	+ 13	+ 19	23	34	— 38	— 14	41	44	— 13	— 19	23
35	— 44	+ 50	66	45	— 1	+ 41	41	35	— 62	+ 22	66	45	— 37	+ 17	41
36	— 39	+ 75	84	46	+ 4	+ 66	66	36	— 53	+ 65	84	46	— 28	+ 60	66
37	— 17	+ 89	91	47	+ 26	+ 80	84	37	— 17	+ 89	91	47	+ 8	+ 84	84
38	+ 8	+ 84	84	48	+ 51	+ 75	91	38	+ 26	+ 80	84	48	+ 51	+ 75	91
51	+ 89	+ 17	91	61	+ 80	— 26	84	51	+ 89	+ 17	91	61	+ 84	— 8	84
52	+ 84	— 8	84	62	+ 75	— 51	91	52	+ 80	— 26	84	62	+ 75	— 51	91
53	+ 62	— 22	66	63	+ 53	— 65	84	53	+ 44	— 50	66	63	+ 39	— 75	84
54	+ 37	— 17	41	64	+ 28	— 60	66	54	+ 1	— 41	41	64	— 4	— 66	66
55	+ 23	+ 5	23	65	+ 14	— 38	41	55	— 23	— 5	23	65	— 28	— 30	41
56	+ 28	+ 30	41	66	+ 19	— 13	23	56	— 14	+ 38	41	66	— 19	+ 13	23
57	+ 50	+ 44	66	67	+ 41	+ 1	41	57	+ 22	+ 62	66	67	+ 17	+ 37	41
58	+ 75	+ 39	84	68	+ 66	— 4	66	58	+ 65	+ 53	84	68	+ 60	+ 28	66
71	+ 44	— 50	66	81	+ 1	— 41	41	71	+ 62	— 22	66	81	+ 37	— 17	41
72	+ 39	— 75	84	82	— 4	— 66	66	72	+ 53	— 65	84	82	+ 28	— 60	66
73	+ 17	— 89	91	83	— 26	— 80	84	73	+ 17	— 89	91	83	— 8	— 84	84
74	— 8	— 84	84	84	— 51	— 75	91	74	— 26	— 80	84	84	— 51	— 75	91
75	— 22	— 62	66	85	— 65	— 53	84	75	— 50	— 44	66	85	— 75	— 39	84
76	— 17	— 37	41	86	— 60	— 28	66	76	— 41	— 1	41	86	— 66	+ 4	66
77	+ 5	— 23	23	87	— 38	— 14	41	77	— 5	+ 23	23	87	— 30	+ 28	41
78	+ 30	— 28	41	88	— 13	— 19	23	78	+ 38	+ 14	41	88	+ 13	+ 19	23

Appendix H

SUMMARY OF INTERPERSONAL DIAGNOSIS AT LEVELS I, II AND III FOR SEVERAL KAISER FOUNDATION SAMPLES

One of the advantages of the Interpersonal System of Personality is that it is objective, based on standardized procedures of measurement. A diagnostician in Pennsylvania, for example, uses the same test-rating technique and norms used in California. This means that it is possible to compare findings on any sample with the results on any previously studied sample. An ever-expanding storehouse of systematized diagnostic data is thus available.

Appendix H presents the interpersonal and variability data of several samples studied by the Kaiser Foundation research. For each sample we have listed the number of patients receiving each of the eight interpersonal diagnoses at Level I Self, Level II Self, Level II Mother and Father and Level III Hero.

Table 36 presents the Level I–MMPI data. There were 201 patients in the obesity sample. Of these, 63 were diagnosed as managerial-autocratic (octant 1) at Level I–MMPI.[1]

Only six of these patients were diagnosed as distrustful (octant 4). Table 36 can be used by any researcher using the Interpersonal system to compare the summary diagnostic trends of his sample with any or all of the Kaiser Foundation samples. The data in Table 36 can serve as control or comparative data. Tests of the significance of difference can be run—if the researcher remains aware of the situational factors involved.

Table 37 presents diagnoses of the same sample at Level II Self (Interpersonal Check List). Tables 38 and 39 list the Level II Mother and Father diagnoses, Table 40 the TAT Hero diagnoses.

Five variability indices are also summarized for the same samples. Table 41 presents the self-deception results. This is the discrepancy between Level I–MMPI and Level II Self (ICL). The obese sample numbered 101 cases. There was no Level I vs. II discrepancy for 17 cases. Thirteen subjects had a discrepancy of 23, etc.

The modal discrepancy index in normative samples is 44. It is convenient to group the number of cases falling above and below 44. There are 48 obesity subjects who have low self-deception scores (lower than 44) and 23 were considerably self deceived (above 44). The Clinic Admission Sample #2 is more self deceived—86 are above and 86 are below 44.

The right hand columns of Table 41 present the direction of discrepancy indices. Here we are concerned with the signs. A positive sign for Dom means that the subject claims too much strength; a negative sign—too much passivity. We observe that the obesity sample has as many subjects falsely claiming strength (40) as passivity (40). The ulcer sample has three times as many patients claiming hostility as friendliness (21:7). There are 20 obese patients and six ulcer patients who have no Level I vs. II conflict.

Table 42 presents the same data for the variability indices of maternal identification. Note that 48 obesity subjects see their mothers as more hostile than themselves, whereas more ulcer patients see their mothers as more loving than themselves (20 vs. 11).

Table 43 lists the results for paternal identification, Table 44 for repression and Table 45 for Maternal-Paternal equation.

[1] *Moderate and extreme diagnoses are lumped* together in these tables.

Table 36

SUMMARY OF INTERPERSONAL DIAGNOSES FOR SEVERAL KAISER FOUNDATION SAMPLES AT LEVEL I–MMPI

SAMPLE	N	DIAGNOSIS TALLY 1	2	3	4	5	6	7	8
Obese	201	63	18	8	6	5	8	20	73
Ulcer	39	8	2	3	0	1	2	4	19
Hypertensives	41	7	1	1	0	3	2	5	22
Dermatitis (unanxious)	72	26	5	2	2	5	3	8	21
Dermatitis (overtly neurotic)	36	8	0	3	6	5	3	3	8
Dermatitis (self-inflicted)	57	14	4	1	4	4	3	8	19
Medical Control Pts	40	11	6	2	1	2	1	1	16
Psychotics	26	4	3	3	3	3	6	1	3
Psychiatric Clinic Adm. #1	103	14	10	6	15	17	12	10	19
Psychiatric Clinic Adm. #2	207	31	11	24	22	28	24	15	52
Group Psychotherapy	114	17	5	10	26	17	8	6	25
Individual Psychotherapy	52	4	7	3	7	10	11	5	5

Table 37

SUMMARY OF INTERPERSONAL DIAGNOSES FOR SEVERAL KAISER FOUNDATION SAMPLES AT LEVEL II SELF (ICL)

SAMPLE	N	DIAGNOSIS TALLY 1	2	3	4	5	6	7	8
Obese	206	67	23	9	2	6	5	20	73
Ulcer	42	14	6	10	3	1	1	1	6
Hypertensives	49	16	6	2	0	0	3	6	16
Dermatitis (unanxious)	71	8	8	8	4	4	2	14	23
Dermatitis (overtly neurotic)	36	3	6	3	4	6	2	8	4
Dermatitis (self-inflicted)	56	7	5	8	5	4	7	8	12
Medical Control Pts	42	3	4	7	3	2	2	9	11
Psychotics	45	8	5	5	5	3	9	4	6
Psychiatric Clinic Adm. #1	102	21	18	14	10	11	14	7	7
Psychiatric Clinic Adm. #2	207	43	28	30	20	27	16	23	20
Group Psychotherapy	106	12	8	12	19	17	12	9	17
Individual Psychotherapy	39	3	4	3	3	8	7	7	4

Table 38

SUMMARY OF INTERPERSONAL DIAGNOSES FOR SEVERAL KAISER FOUNDATION SAMPLES AT LEVEL II MOTHER (ICL)

SAMPLE	N	DIAGNOSIS TALLY 1	2	3	4	5	6	7	8
Obese	197	62	33	11	2	1	4	12	72
Ulcer	33	8	5	4	0	1	0	6	9
Hypertensives	22	9	1	1	1	1	0	2	7
Dermatitis (unanxious)	67	10	13	8	0	2	1	11	22
Dermatitis (overtly neurotic)	34	7	5	3	1	0	2	8	8
Dermatitis (self-inflicted)	47	7	6	10	1	0	2	6	15
Medical Control Pts	37	5	6	4	2	1	0	3	16
Psychotics	19	7	1	3	0	0	0	3	5
Psychiatric Clinic Adm. #2	205	58	37	26	8	2	5	21	48
Group Psychotherapy	57	12	15	9	3	3	2	1	12
Individual Psychotherapy	38	6	2	7	2	1	3	8	9

Table 39

SUMMARY OF INTERPERSONAL DIAGNOSES FOR SEVERAL KAISER FOUNDATION SAMPLES AT LEVEL II FATHER (ICL)

SAMPLE	N	DIAGNOSIS TALLY 1	2	3	4	5	6	7	8
Obese	186	55	65	20	6	2	2	2	34
Ulcer	31	8	11	3	1	0	1	1	6
Hypertensives	21	6	9	2	0	0	0	1	3
Dermatitis (unanxious)	54	11	6	11	3	2	2	6	13
Dermatitis (overtly neurotic)	35	5	8	13	0	0	1	4	4
Dermatitis (self-inflicted)	45	5	16	11	2	0	0	3	8
Medical Control Pts	35	9	11	5	0	2	0	4	4
Psychotics	18	6	7	1	0	0	0	1	3
Psychiatric Clinic Adm. #2	200	62	52	24	8	4	7	9	34
Group Psychotherapy	55	8	17	10	0	2	7	4	7
Individual Psychotherapy	37	7	5	10	2	0	2	3	8

Table 40

SUMMARY OF INTERPERSONAL DIAGNOSES FOR SEVERAL KAISER FOUNDATION SAMPLES AT LEVEL III HERO (TAT)

SAMPLE	N	DIAGNOSIS TALLY 1	2	3	4	5	6	7	8
Obese	97	26	23	18	10	3	2	5	10
Ulcer	19	3	2	4	3	0	4	2	1
Hypertensives	27	3	6	4	7	1	3	2	1
Dermatitis (unanxious)	73	16	23	11	4	5	3	3	8
Dermatitis (overtly neurotic)	35	3	9	5	4	4	2	1	7
Dermatitis (self-inflicted)	57	12	14	14	9	5	0	1	2
Medical Control Pts	41	12	17	4	2	0	0	0	6
Psychotics	37	6	3	9	6	4	3	2	4
Psychiatric Clinic Adm. #1	103	15	10	12	14	12	14	6	20
Group Psychotherapy	38	5	6	6	6	2	3	5	5
Individual Psychotherapy	30	7	7	2	3	3	2	3	3

Table 41

VARIABILITY INDICES FROM "THE RECORD BOOKLET FOR INTERPERSONAL DIAGNOSIS OF PERSONALITY" FOR SEVERAL KAISER FOUNDATION SAMPLES

VERBAL DEFINITION OF INDEX—SELF-DECEPTION OPERATIONAL DEFINITION OF INDEX—I S–II S

SAMPLE	N	AMOUNT OF DISCREPANCY 0	23	26	41	44	48	62	66	68	81	84	91	105	114	DIRECTION OF DISCREPANCY Dom +	Dom —	Lov +	Lov —	0
Obese	101	17	13	5	13	30	2	4	5	1	3	3	2	3	0	40	40	41	39	20
Ulcer	34	6	4	0	0	6	1	1	5	1	2	5	3	0	0	16	12	7	21	6
Hypertensives	22	4	3	1	3	3	4	0	1	0	1	1	0	1	0	12	6	5	13	4
Dermatitis (unanxious)	69	12	5	2	11	16	3	0	4	1	4	4	2	4	1	19	38	30	27	12
Dermatitis (overtly neurotic)	36	6	4	3	1	9	1	0	5	1	2	3	1	0	0	13	17	15	15	6
Dermatitis (self-inflicted)	56	6	3	4	12	6	2	2	7	2	3	3	3	1	2	17	33	23	27	6
Medical Control Pts	39	3	4	4	4	9	1	1	3	1	3	3	0	2	1	8	28	17	19	3
Psychotics	26	3	2	2	2	7	1	3	1	0	2	1	0	2	0	13	10	11	12	3
Psychiatric Clinic Adm. #1	102	22	10	2	16	15	3	0	13	0	9	9	1	2	0	48	32	34	46	22
Psychiatric Clinic Adm. #2	207	24	19	15	28	35	12	9	18	6	15	17	3	4	2	104	79	73	110	24
Group Psychotherapy	106	16	13	12	14	17	3	2	9	1	8	4	4	1	2	38	52	44	46	16
Individual Psychotherapy	37	5	2	1	3	9	5	0	4	3	3	1	0	1	0	22	10	18	14	5

Table 42

VERBAL DEFINITION OF INDEX—CONSCIOUS IDENTIFICATION—MATERNAL
OPERATIONAL DEFINITION OF INDEX—II S–II M

SAMPLE	N	AMOUNT OF DISCREPANCY 0	23	26	41	44	48	62	66	68	81	84	91	105	114	DIRECTION OF DISCREPANCY Dom +	Dom —	Lov +	Lov —	0
Obese	99	15	12	1	14	26	0	1	4	0	11	7	2	3	3	47	37	36	48	15
Ulcer	33	2	2	0	3	10	0	1	0	0	4	2	1	5	3	18	13	20	11	2
Hypertensives	22	5	2	0	5	7	0	0	2	0	0	1	0	0	0	10	7	11	6	5
Dermatitis (unanxious)	66	14	4	2	11	12	4	1	4	0	6	2	2	4	0	33	19	28	24	14
Dermatitis (overtly neurotic)	34	4	4	1	1	7	4	3	1	0	1	3	2	1	2	19	11	15	15	4
Dermatitis (self-inflicted)	46	10	3	1	7	6	2	1	4	1	2	6	2	1	1	26	11	19	18	10
Medical Control Pts	37	3	4	3	5	6	1	2	1	0	2	3	2	4	1	23	11	17	17	3
Psychotics	19	2	4	1	0	1	0	1	2	1	1	1	3	1	1	12	5	12	5	2
Psychiatric Clinic Adm. #2	205	26	10	3	33	29	1	2	24	1	23	15	11	17	10	123	56	108	71	26
Group Psychotherapy	55	2	5	0	6	2	1	1	6	2	7	3	4	12	4	42	11	22	31	2
Individual Psychotherapy	35	2	2	1	4	8	0	0	4	0	5	3	2	3	1	21	12	21	12	2

Table 43

VERBAL DEFINITION OF INDEX—CONSCIOUS IDENTIFICATION—PATERNAL
OPERATIONAL DEFINITION OF INDEX—II S–II F

SAMPLE	N	AMOUNT OF DISCREPANCY 0	23	26	41	44	48	62	66	68	81	84	91	105	114	DIRECTION OF DISCREPANCY Dom +	Dom —	Lov +	Lov —	0
Obese	94	21	8	0	12	19	2	1	12	1	11	4	0	1	2	45	28	17	56	21
Ulcer	31	5	3	0	4	5	1	0	2	0	7	1	0	3	0	15	11	17	9	5
Hypertensives	21	5	1	2	2	5	1	0	2	0	1	0	1	1	0	10	6	5	11	5
Dermatitis (unanxious)	53	9	5	2	8	7	1	1	6	0	6	2	1	2	3	24	20	15	29	9
Dermatitis (overtly neurotic)	35	7	2	0	3	3	0	2	5	1	6	3	0	1	2	23	5	8	20	7
Dermatitis (self-inflicted)	45	9	4	3	6	5	3	0	2	2	2	2	1	4	2	27	9	11	25	9
Medical Control Pts	35	5	3	2	2	6	6	0	1	0	2	3	1	4	0	22	8	10	20	5
Psychotics	18	2	0	0	1	4	3	0	2	0	1	2	0	2	1	16	0	8	8	2
Psychiatric Clinic Adm. #2	200	27	19	3	24	33	3	5	13	3	26	18	10	9	7	130	43	91	82	27
Group Psychotherapy	52	2	4	2	2	5	0	1	7	3	9	4	5	7	1	38	12	25	25	2
Individual Psychotherapy	34	2	2	0	3	6	1	0	3	0	7	2	4	3	1	24	8	11	21	2

Table 44

VERBAL DEFINITION OF INDEX—REPRESSION—HERO
OPERATIONAL DEFINITION OF INDEX—II S–III H

SAMPLE	N	AMOUNT OF DISCREPANCY 0	23	26	41	44	48	62	66	68	81	84	91	105	114	DIRECTION OF DISCREPANCY Dom +	Dom —	Lov +	Lov —	0
Obese	97	8	9	5	14	15	2	2	10	3	10	8	5	4	2	39	50	25	64	8
Ulcer	18	4	1	0	2	2	0	0	1	0	4	2	0	2	0	7	7	9	5	4
Hypertensives	27	0	3	1	1	1	3	4	4	1	4	0	2	3	0	6	21	4	23	0
Dermatitis (unanxious)	70	5	4	3	11	3	5	5	9	0	9	6	2	4	4	37	28	17	48	5
Dermatitis (overtly neurotic)	35	3	4	2	1	4	6	2	0	2	3	6	0	1	1	18	14	12	20	3
Dermatitis (self-inflicted)	56	8	3	3	5	2	3	3	4	0	7	7	4	7	0	28	20	13	35	7
Medical Control Pts.	40	1	2	1	5	3	2	0	6	1	5	5	2	5	2	30	9	15	24	1
Psychotics	37	4	1	2	6	6	1	2	4	2	1	4	0	2	2	17	16	11	22	4
Psychiatric Clinic Adm. #1	102	3	4	1	15	15	5	3	13	0	12	13	6	9	3	41	58	54	45	3
Group Psychotherapy	38	2	1	0	6	3	0	2	4	2	5	4	4	5	0	24	12	18	18	2
Individual Psychotherapy	27	2	2	1	5	3	0	0	3	1	0	5	0	2	3	16	9	9	16	1

Table 45

VERBAL DEFINITION OF INDEX—EQUATION—MOTHER-FATHER
OPERATIONAL DEFINITION OF INDEX—II M–II F

SAMPLE	N	AMOUNT OF DISCREPANCY 0	23	26	41	44	48	62	66	68	81	84	91	105	114	DIRECTION OF DISCREPANCY Dom +	Dom —	Lov +	Lov —	0
Obese	98	19	3	0	10	29	0	1	1	0	19	4	1	7	4	43	36	28	51	19
Ulcer	30	4	0	1	3	8	0	1	0	0	6	0	0	5	2	15	11	9	17	4
Hypertensives	21	6	0	1	2	5	0	0	1	0	3	1	1	1	0	7	8	4	11	6
Dermatitis (unanxious)	53	11	6	0	6	10	0	1	4	0	4	3	1	4	3	20	22	17	25	11
Dermatitis (overtly neurotic)	34	4	2	1	4	6	1	0	2	0	4	1	1	5	3	18	12	8	22	4
Dermatitis (self-inflicted)	42	8	0	3	9	4	1	2	2	1	4	4	2	1	1	22	12	10	24	8
Medical Control Pts.	36	4	1	3	3	3	3	0	10	0	6	1	0	1	1	17	15	11	21	4
Psychotics	18	3	0	1	3	3	0	0	5	0	0	2	0	1	0	11	4	5	10	3
Psychiatric Clinic Adm. #2	198	43	8	1	16	38	2	0	10	0	37	8	4	22	9	84	71	67	88	43
Group Psychotherapy	53	5	5	1	4	7	0	1	2	1	10	3	1	7	6	19	29	24	24	5
Individual Psychotherapy	36	2	1	0	0	9	0	1	4	0	8	1	1	4	5	21	13	14	20	2

Appendix I

SUMMARY OF INTERPERSONAL SCORES AND GROUP DYNAMICS INDICES FOR SEVERAL KAISER FOUNDATION SAMPLES

The Record Booklet for Interpersonal Analysis of Group Dynamics yields two types of scores. These are interpersonal scores which are listed in terms of the eight diagnostic categories and variability indices which indicate the amount of self-deception, identification and misperception.

Tables 46 and 47 present the interpersonal and group dynamic indices for several different samples studied by the Kaiser Foundation research. Investigators can compare the results of the groups they measure with those presented in these tables.

Table 46 presents the interpersonal score summaries for four different types of groups: psychotherapy groups composed of "neurotic," patients, discussion groups of obese women, groups of seminary students who live and study together and top executives who work together.

The S score is the Level II self-diagnosis; the X score is the Level I pooled consensus of others' views of the subject. The Y score is the Level II–other score—the patient's pooled perceptions of his fellows.

Of the 48 group therapy patients seven were self-diagnosed (S) as managerial-autocatic (octant 1) and nine as schizoid (4). Considering the Level I diagnosis (X) seven therapy patients fell in octant 1, whereas 12 were diagnosed by their fellows as sadistic (octant 3).

The Y score measures the subject's tendency to assign interpersonal themes to others—to project or emphasize hostility, power, etc. Only one group therapy patient stressed power (octant 1) whereas 10 stressed schizoid distrust (octant 4).

Table 47 presents the summaries for two group dynamic variability indices, self-deception and conscious identification. These involve systematic comparisons of the S, Y and X scores defined above. Notice that the group therapy samples have relatively more self-deceived and disidentified subjects than the obesity and "normal" group.

DATA FROM "RECORD BOOKLET FOR INTERPERSONAL ANALYSIS OF GROUP DYNAMICS"
(For Four Samples)

Table 46

INTERPERSONAL DIAGNOSIS

Definition of Letter Code	Letter Code	Sample	N	Diagnosis 1	2	3	4	5	6	7	8
Self Perception	S	11 Psychotherapy Groups	48	7	2	3	9	8	6	10	3
Self Perception	S	4 Weight Reduction Groups of Obese Women	29	12	3	1	0	0	1	1	11
Self Perception	S	2 Groups of Seminary Students	13	6	4	1	0	0	0	0	2
Self Perception	S	1 Top Management Group	5	2	3	0	0	0	0	0	0
Pooled Total of Group's Perception of Subject	X	11 Psychotherapy Groups	48	7	3	12	6	6	6	7	1
Pooled Total of Group's Perception of Subject	X	4 Weight Reduction Groups	29	9	6	1	0	0	1	3	9
Pooled Total of Group's Perception of Subject	X	2 Groups Seminary Students	13	8	3	0	0	0	1	1	0
Pooled Total of Group's Perception of Subject	X	1 Top Management Group	5	3	2	0	0	0	0	0	0
Subject's Perception of Total Group	Y	11 Psychotherapy Groups	48	1	8	6	10	5	11	3	4
Subject's Perception of Total Group	Y	4 Weight Reduction Groups	29	8	4	3	0	0	0	5	9
Subject's Perception of Total Group	Y	2 Groups Seminary Students	13	8	5	0	0	0	0	0	0
Subject's Perception of Total Group	Y	1 Top Management Group	5	2	3	0	0	0	0	0	0

Table 47

DATA FROM "RECORD BOOKLET FOR INTERPERSONAL ANALYSIS OF GROUP DYNAMICS"
(For Four Samples)

Verbal Definition of Index	Operational Definition of Index	Sample	N	Amount of Discrepancy 0	23	26	41	44	48	62	66	68	81	84	91	105	114
Self Deception	SX	11 Psychotherapy Groups.....	48	7	4	2	9	8	1	1	5	2	5	2	0	1	0
Self Deception	SX	4 Weight Reduction Groups.....	29	5	4	1	10	1	1	0	3	0	3	1	0	0	0
Self Deception	SX	2 Groups Seminary Students....	13	3	0	1	2	5	0	0	1	0	1	0	0	0	0
Self Deception	SX	1 Top Management Group.....	5	2	0	0	2	1	0	0	0	0	0	0	0	0	0
Conscious Identification with Total Group	SY	11 Psychotherapy Groups.....	48	3	7	1	5	2	2	6	8	2	3	6	0	2	0
Conscious Identification with Total Group	SY	4 Weight Reduction Groups.....	29	8	4	2	5	4	1	0	2	0	1	0	1	1	0
Conscious Identification with Total Group	SY	2 Groups Seminary Students....	13	2	4	0	3	4	0	0	0	0	0	0	0	0	0
Conscious Identification with Total Group	SY	1 Top Management Group.....	5	1	0	1	0	3	0	0	0	0	0	0	0	0	0

TAT COOKBOOK

Table 48

CARD 1 HERO (LITTLE BOY)

	Role
a) The boy feels rebellious and passively resists his parents' wishes that he play the violin	F
b) He experiences success in later life	P
c) He is daydreaming	J
The score "J" is also assigned when the boy is conforming to his parents' wishes. If he is dreaming about success he gets the double score for passivity and achievement	J and P
d) He feels left out and unhappy	H
e) He has feelings of failure or impotence	i
f) He asserts his will actively, often against his parents	B

OTHER (PARENTS)

a) The parents are forcing the boy to play the violin	A
b) They give the boy the violin or support him in his efforts	N or O
c) They are punitive or unsympathetic	D or E

CARD 2 HERO (GIRL WITH BOOKS)

a) The girl feels or acts independently	B
b) She feels rebellious, resentful or deprived	F or G
c) She conforms and gives up her independent strivings	J
d) She adjusts herself agreeably and a happy ending results	L
e) She gives things to or supports her parents	O
f) She asserts independence but regrets decision in later life	B and H

OTHER

a) The family members are selfish or rejecting. (Most common score for neurotic groups)	B or C
b) They are generous and sympathetic	N or O
c) They are angry because the girl is rebellious	D
d) They are docile, conforming people	J

Comments

If the family members are mentioned in a descriptive sense they are not scored (*e.g.*, man plowing, woman is pregnant). If their activities put interpersonal pressure on the girl they are given the appropriate score (*e.g.*, the man's conformity contrasted to the heroine's desire for independence, etc.).

CARD 3 BM, 3 GF

HERO (SOLITARY FIGURE)

a) The Hero is depressed, defeated, suicidal, etc.	H
b) The Hero is bitter, disappointed, exploited	F or G
c) The Hero resolves the problem through conformity or trust	J or K
d) A happy ending	L

(The last 2 scores involve generally subsidiary or outcome themes)

OTHERS

	Role
a) The world is rejecting	C
b) The world is punitive or sadistic	D or E
c) The world is sympathetic and helpful	N or O

CARD 4

HERO (MAN OR WOMAN*)

a) The man is striving for independence or rejecting the woman	B or C
b) Feelings of despair, indecisiveness, guilt and immobility	H or I
c) The woman dependently pleads with the man	J or K
d) The man has angry or punitive feelings	D or E
e) The man is involved in rebellious or criminal activities	F or G
f) The woman forcibly (or in a wise manner) pleads with the man not to engage in impulse or rash activity	P

*Comment

The "Hero" "Other" distinction varies according to sex. We have therefore designated the most common themes without "Hero" "Other."

CARD 6 BM

HERO (MAN)

	Role
a) The man (son) strives for independence (*e.g.*, toward marriage, career, etc.)	B
b) The man feels guilt and unhappiness (often accompanying the separation from the mother)	H
c) The man is bitter, rebellious, engaged in crime, etc.	F or G
d) The man feels sorry for the woman	N

OTHER (WOMAN)

a) The mother is unhappy because of the son's departure or wrong doing (or because of bad news)	H
b) The mother attempts, directly or indirectly, to prevent the son from leaving her	C
c) The mother is hurt or bitter	F or G
d) The mother gives blessing	N
e) The mother eventually accepts situation	J
f) She learns to love daughter-in-law and all are happy	L

e) and f) scores assigned to outcome themes

CARD 6 GF

The Hero on this card generally varies according to the sex of the subject. The most typical responses for females will therefore be listed separately from the males.

Females	*Role*
a) The woman is fearfully surprised by the man	H
b) She is rejecting or refusing the man	B or C
c) She is pleasantly surprised by the man's offer	J or K
d) She has committed a rebellious or deceitful act. Feels bitter or dissatisfied	F or G

Males	
a) The man is surprising the woman for exploitive or seductive purposes	C
b) He is surprising the woman with an offer of tenderness or generosity or love	N or O or M
c) He is accusing her of crimes of omission or commission	D

CARD 7 BM

HERO (YOUNG MAN)

	Role
a) Young man is listening to or asking advice from older man	J or K
b) He is bitter or rebelling against unsought-for advice	F
c) He feels helpless or guilty	H or I
d) He is actively resisting, establishing independence or is involved in an exploitive maneuver	B or C

OTHER (OLDER MAN)

a) He is advising the young man	P
b) Themes of arrogance or exploitation are attributed to the older man	B or C
c) He is helping or supporting the young man	O

CARD 7 GF

HERO (DAUGHTER)

a) The girl is docilely listening to the older woman (or depending on her)	J or K
b) She feels rebellious, bitter, hurt, or passively resistant	F or G
c) She is unhappy or fearful	H
d) She grows up and attains success and motherhood	P

OTHER (OLDER WOMAN)

a) She is reading to or advising girl	P
b) She is comforting or helping the girl	N or O

CARD 12 M

HERO (BOY)

a) The boy is sick, unconscious, hypnotized, asleep	i
b) He docilely or dependently pulls help from the other	J or K

OTHER (MAN)

a) The man is hypnotizing or exerting power	A
b) He is helping, curing, praying over or tenderly ministering	N or O
c) He is selfishly exploiting the other	C
d) If the man is ineffectual in helping	i

CARD 13 MF

HERO (MAN)

	Role
a) The man is unhappy, despairing, guilty, immobilized	H or i
b) An unconventional or immoral act has occurred	F
c) A murderous or sadistic act	D or E
d) An exploitive or selfish action (*e.g.*, rape, seduction, taking by force from the other)	C

OTHER (WOMAN)

a) The woman is sick or exhausted	i
b) She is unconcerned or satisfied (usually in contrast to the man's sexual guilt)	J or K

CARD 18 BM

HERO (MAN)

a) The man is unconscious, passive, defenseless, etc.	i
b) He has committed a criminal, rebellious or antisocial (*e.g.*, is drunk) act	F
c) He is struggling with outside forces	B
d) He is dependent upon others	J or K

OTHER (HANDS)

a) Others are punishing, attacking or arresting the Hero	D or E
b) Others are exploiting or manipulating the Hero for their own purposes	C
c) Others are helping, protecting or rescuing the Hero	N or O
d) Others are restraining or exerting power over the Hero (where the power is neither clearly hostile nor helpful)	A

CARD 18 GF

Both figures in this card can play the Hero role. The typical themes attributed to each figure are as follows:

TOP FIGURE

	Role
a) The woman is unhappy because of the illness (or injury) of the other	H
b) The woman is angry or punitive toward the other	D or E
c) She is helping the injured or ill other	O
d) She is suspicious or bitter about the other's behavior	F or G

LOWER FIGURE

a) The lower figure is injured or ill	i
b) She is hostile to or fighting with the other	D or E
c) She has done something rebellious, "wrong" or sneaky	F

Appendix K

THE LEVEL III DIAGNOSIS OF UNDERLYING CHARACTER STRUCTURE BASED ON THE MMPI

The standard instrument used for clinical diagnosis at Level I is based on 8 symptomatic scales from the MMPI. These scales, when fed into the formulae (D = Ma — D etc.), reflect the impact of the patient's symptoms on the clinic.

It will be noted that three clinical MMPI scales are omitted from the Level I-M formulae. These are the Pa, Pd and Mf scales. The Pa scale, we believe, is related to Level II (claimed innocence and conventionality) and to certain variability indices (large discrepancy between Level II and Levels I and III). Because it goes along with conflict and interlevel oscillation, it is omitted from the unilevel measures. The other two scales (Pd and Mf) are considered to be characterological scales rather than symptom scales. We believe that the Pd scale measures (among other things) the amount of genetic trauma, chronic feelings of deprivation, underlying resentful rebellion, lack of ego identity, and basic disidentification with others. These factors we see as being related to what might be called basic character structure and can underly any overt symptomatic adjustment.

The interpersonal meaning of the Mf scale is also seen as divorced from overt behavior. This scale is clearly related with passivity—but this can be characterological and does not necessarily predict overt behavior. Many bossy, pedantic, talkative, managerial facades can cover underlying dependence and passivity—reflected test-wise in a high Mf for males and a low Mf for females.

For this reason we use the Pd and Mf scales to arrive at an interpersonal diagnosis at the character-structure level. This measure is called Level III–MM —indicating that it taps underlying, indirect behavior by means of the MMPI.

The Level III–MM diagnosis is made as follows. The Mf scale is seen as measuring the amount of basic passivity. In terms of the circle as viewed in the abstract it is seen as a diameter connecting the upper left BC octant with the lower right JK octant. The mean Mf score for normative samples defines the center of the circle. A high Mf score (for males) falls toward the lower right. A low Mf score (for males) falls toward the upper left.

The Pd score is seen as running perpendicular to the Mf axis—linking the lower left to the upper right and the center of the circle is thus defined as the intersection of the means of the Pd and Mf distribution.

The Level III–MM diagnosis is determined by the intersection of the subject's Pd and Mf scores when plotted on the two dimensional grid. There is one complication. The octants for Level III–MM are located 45 degrees clockwise from the octants used for all other diagnoses. A special diagnostic grid—on which the diagnostic categories are all rotated 45 degrees is used for Level III–MM diagnosis (*cf.* Figures 16 and 17).

To establish the Level III–MM diagnosis, locate on the vertical axis the subject's Mf score and locate on the horizontal axis his Pd score. The sector in which the resultant summary point falls provides the Level III–MM diagnosis. To plot this point on the master circle in the diagnostic booklet, determine the octant number and the location of the point in the octant sector. Then disregarding the previous spatial location, plot the point in the correctly numbered octant in the booklet. To convert from Figures 16 and 17 to the conventional diagnostic circle, always move the summary point 45 degrees in a counter-clockwise direction.

As an illustration of Level III–MM diagnosis, consider the female subject whose Pd T–score is 90 and whose Mf is 39. When these two points are plotted on Figure 17 they intersect in the 5 octant. This diagnoses the underlying character as masochistic. This is plotted on the booklet circle by inspection-estimate. The point locates a little more than two sigmas out in the 5 octant. We are mainly interested in the diagnosis, *i.e.,* the sector. The precise accuracy in locating the Level III–MM point on the diagnostic booklet is, therefore, not of central importance.

The Level III–MM diagnosis seems to have considerable promise as a clinical and research tool. Its advantages are: 1. It can be obtained along with the Level I score from a single test — the MMPI; 2. Preliminary research has indicated that it does relate to the TAT and to basic underlying characterological factors. To illustrate this latter point: In one study of alcoholics it was found that the typical

subject presented a Level I facade of strength, conventionality and responsibility whereas the Level III–MM score was typically rebellious or masochistic. While the symptomatic scales did not differentiate alcoholics from more hypernormal samples, the Level III–MM diagnosis convincingly separated the alcoholic sample.

The Kaiser Foundation Research Project is now including the Level III–MM diagnosis as a routine personality measure.

FIGURE 16
Grid for Determining Level III–MM Diagnosis for Males

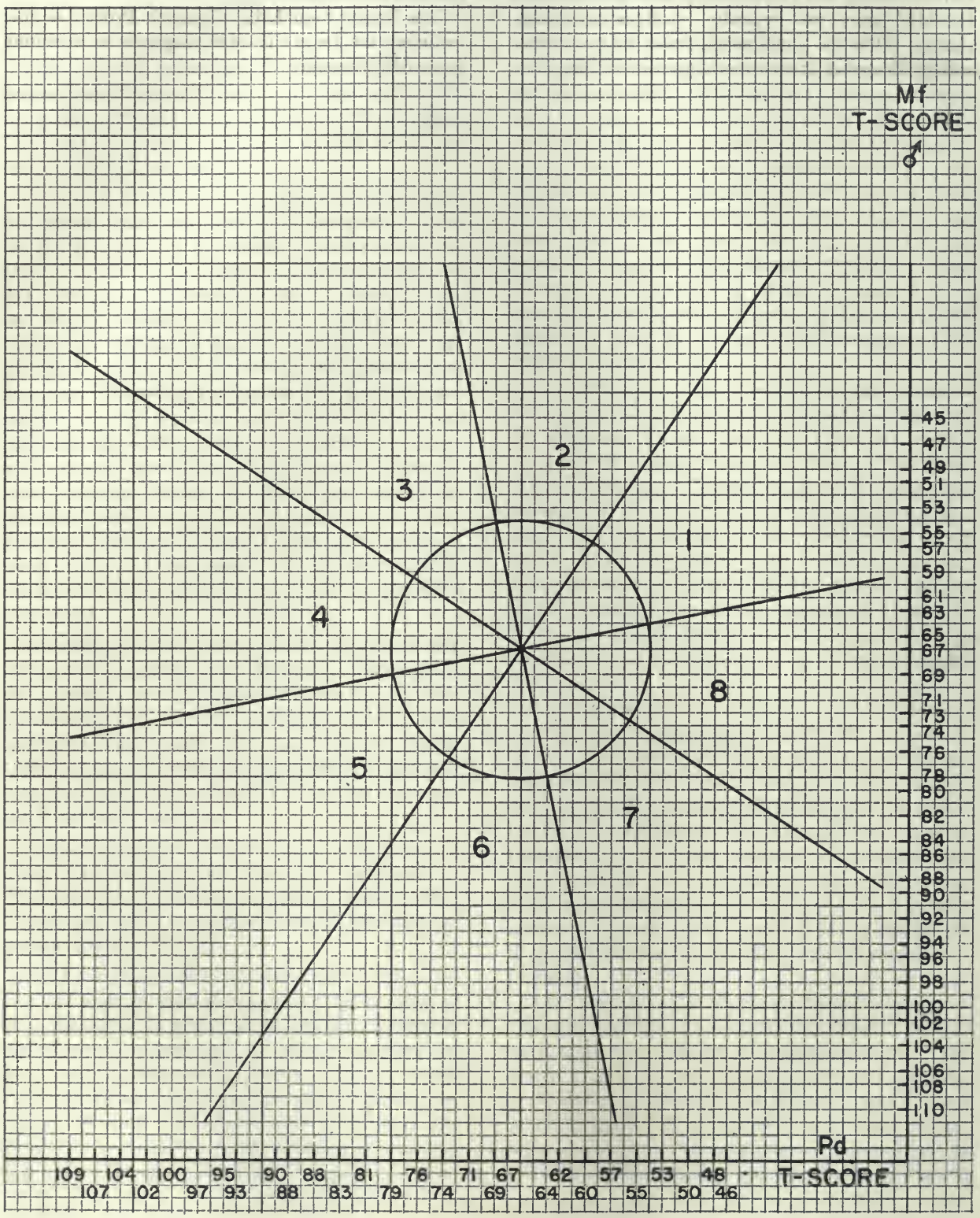
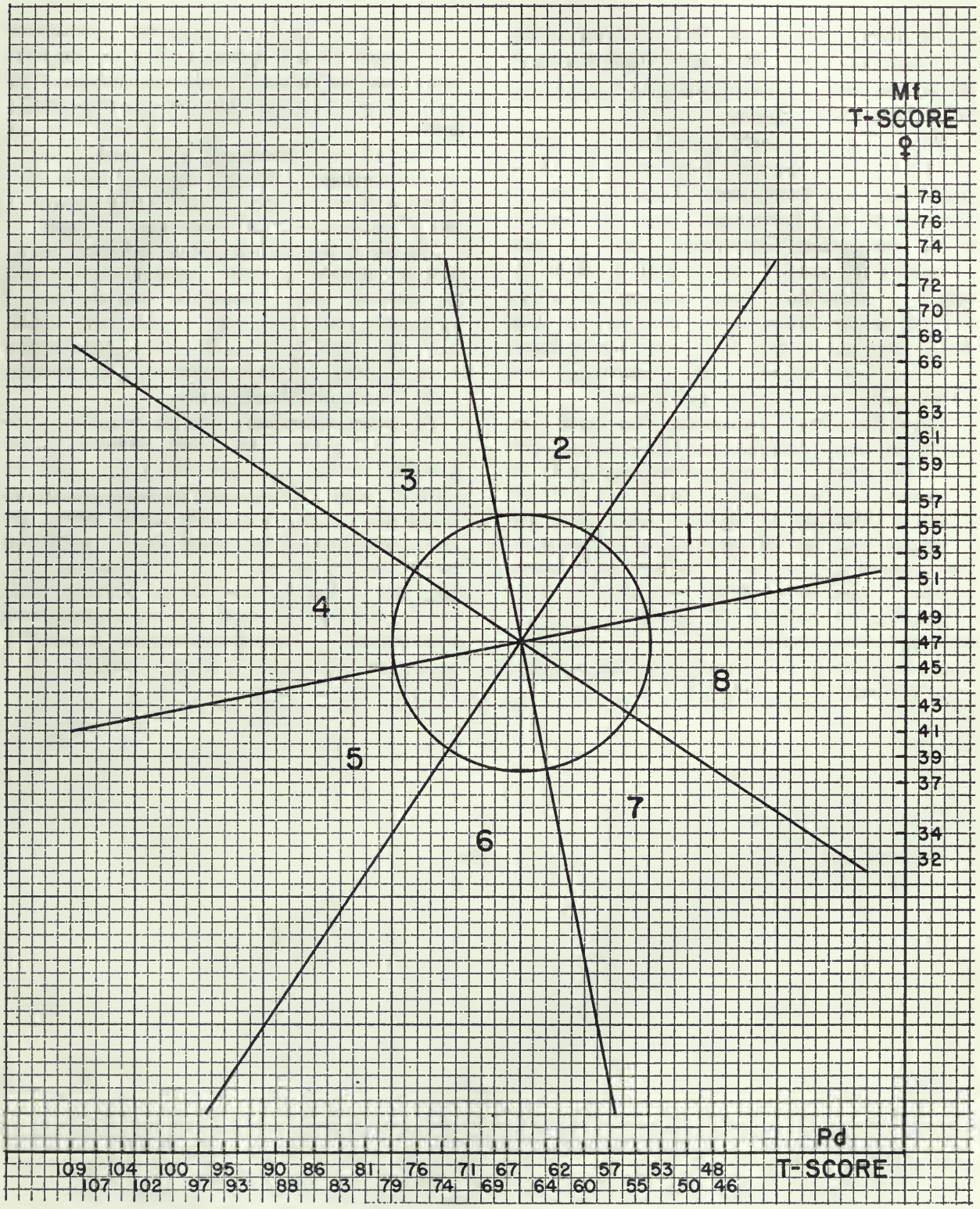


FIGURE 17
Grid for Determining Level III–MM Diagnosis for Females



Appendix L

THE INTERPERSONAL FANTASY TEST

The Interpersonal Fantasy Test is a Level III instrument developed by the Kaiser Foundation project and specifically designed to meet the requirements of the Interpersonal System.

The TAT has, for eight years, been the routine Level III test. We have considered the TAT the best projective test on the market. The TAT, however, does not tap in a systematic manner the range of crucial interpersonal relationships which we wish to measure at Level III. At Level II, it will be recalled, we can obtain a conscious description of the self, the mother, father, spouse and therapist. The IFT is designed to elicit preconscious interpersonal themes attributed to fantasy self, paternal figure, maternal figure, cross-sex figure and therapist.

Pictures have been drawn which portray all of these figures in crucial interpersonal relationships. Consider, for example, the son-mother relationship. There is an IFT card portraying a mother and son in a situation ambiguous as regards power. Both are so placed, next to a train, that it is possible to fantasy that either of them, or neither, or both might be departing. A second card places the mother in a position dominant to the son. The love-hate implication is ambiguous. A third card represents the son dominant over the mother, the hostility factor again being as neutral as the artist could manage.

For each of the four parent-child relationships (son-mother, son-father, daughter-mother, daughter-father), and for the male-female relationship and for the doctor-patient relationship, there are three similar cards.

There are, in addition, eight other cards: 2 cards, each portraying a lone male figure, 2 cards, each with a lone female figure, 2 cards, each showing a pair of females and 2 cards with a pair of males.

The test is divided into a male and female form, each set containing 16 cards. The male form includes the following cards: 3 son-father, 3 son-mother, 3 patient-therapist, 2 lone males, 3 male-female, 2 male-male. The female form includes: 3 daughter-mother, 3 daughter-father, 3 patient-therapist, 2 lone females, 3 male-female and 2 female-female.

The patient writes his stories for each in the manner of TAT stories. The themes attributed to each figure are scored as we score the TAT. Level III scores for seven personages are summarized and converted into indices. The seven fantasy figures are self, mother, father, cross-sex, parents, child and doctor. Indices for each of these are plotted on the diagnostic grid as described above. Norms for this test are now being developed. Research workers who wish to obtain level III diagnoses based on the IFT can communicate with the Kaiser Foundation Psychology Research offices.