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PROJECTIVE IDENTIFICATION: THE TIE THAT BINDS

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Lisa C. Kaley

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DEDICATION

This dissertation is dedicated to all of my friends and family who have loved and supported me through work and love and play. I am grateful that you have nurtured me with your creativity, generosity, and courage.

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ABSTRACT

The present study offers an exploratory method of assessing projective identification. Projective identification is an often-used psychoanalytic construct which has received minimal empirical investigation. The operational definition proposed by the study attempts to translate Ogden's (1979) theoretical definition of the construct into an empirical measure. The subjects were 11 families composed of two parents, a child in individual psychiatric treatment and a sibling not in psychiatric treatment. The hypothesis that the parents would project a greater number of traits onto the identified patients was not supported statistically. The fathers projected double the number of traits than mothers did onto both children. The hypothesis that the patient-children would identify with a significant number of the projected traits received mixed support: the patient-children identified with a significant number of the traits that both parents projected, but the siblings also identified with a significant number of traits the fathers projected. The surprising finding was that both parents projected a significantly greater number of socially desirable than undesirable traits onto the identified patients. Two interpretations were proposed to account for these findings. First, that the parents, especially the fathers, viewed the traits they projected as undesirable, even though they are generally considered desirable by others. The alternative hypothesis is that the parents, especially the fathers, project the affects that they cannot speak directly to their children. Thus, parents may be more able to criticize the patient-children than express their positive feelings for them.

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CHAPTER I

INTRODUCTION

Literature Review

Projective identification was first described in 1946 by Melanie Klein as a normative part of early infant development. Other writers (Ogden, 1979; Grotstein 1981; Horowitz, 1983; and Crisp, 1988) assert that projective identification remains a part of interpersonal interaction throughout the life cycle, particularly in intimate relationships. The concept is employed by clinicians to account for some transferance and counter-transference experiences in therapy (Ogden, 1979; and Scharff, 1992), and group phenomena (L. Horowitz, 1983). Other psychoanalytic writers focus on the pathological defensive qualities of projective identification, especially by borderline personalities (O. Kernberg, 1987) and psychotic patients (H. Rosenfeld, 1987). James Grotstein summarized the varied expressions of projective identification stating:

> In its more positive sense, projective identification is responsible for vicarious introspection and, in its more sublimated form, for empathy. It can be seen to operate in such process as anthropomorphism and personification; it is active in romantic experience and from it issues the impact of warnings, advice and persuasion. As a primitive mechanism for communication it exists first between preverbal infants and their mothers, but it is residual in adult life as a form of affective communication. It is of prime importance to authors, educators, ministers, artists, as

well as psychoanalysts (1981, p. 123).

Melanie Klein (1946) initially described projective identification as a phantasied and controlling, (primarily) aggressive onslaught on the mother by the infant. She wrote:

> The phantasied onslaughts on the mother follow two main lines: one is the predominantly oral impulse to suck dry, bite up, scoop out and rob the mother's body of its good contents. . . . The other line of attack derives from the anal and urethral impulses and implies hatred, split off parts of the ego are also projected on to the mother, or, as I would rather call it, <u>into</u> the mother. These excrements and bad parts of the self are meant not only to injure but also to control and take possession of the object. In so far as the mother comes to contain the bad parts of the self, she is not felt to be a separate individual but is felt to be <u>the</u> bad self. Much of the hatred against parts of the self is now directed towards the mother. This leads to a particular form of identification which established the prototype of an aggressive object-relation. I suggest for these processes the term "projective identification" (1946, p. 8).

In Klein's formulation, the child's aggressiveness toward the mother is justified by the child's projected perception of the mother as the persecutor. Since the mother is seen as attacking the him, the child sees the mother as meriting his self-defensive or retaliatory attack.

Klein asserts that an intrapsychic experience by the infant becomes an interpersonal event between the mother and child. The intrapsychic experience is transformed into an interpersonal one through the infant

putting an aspect of himself *into the mother.* Klein insists that the child puts himself into the mother, literally through bodily functions, and ideationally through unconscious fantasy, which she terms "phantasy." Thus, it is both through intrapsychic experience and interpersonal action on the part of the child that he "rids" himself of an unacceptable aspect of himself, and translocates it in the mother. Because the bad aspect of himself is placed in the mother, the child is able to injure and control her *as if she were in fact* the bad part of himself which he cannot accept. The child is able to injure and control the mother by virtue of the way he begins to think about her and to act toward her. He is also able to deny separation between himself and his mother by behaving toward her as if she were merely an extension of himself. The child does not want to loose the bad self-aspect; he wants to externalize his internal conflict, and turn the inner battle into an interpersonal one. In other words, the child seeks to make sense of his inner thoughts and feelings by having them justified in the external world. Klein also acknowledges that good aspects of the self may be projected onto the mother. She writes:

> It is, however, not only the bad parts of the self which are expelled and projected, but also good parts of the self. Excrements then have the signficance of gifts; and parts of the ego which, together with excrements, are expelled and projected into the other person represent the good, i.e., the loving parts of the self. The identification based on this type of projection again vitally influences object relations. The projection of good feelings and good parts of the self into the mother is essential for the infant's ability to develop good object-relations and to integrate his ego.

> However, if this projective process is carried out excessively, good parts of the personality are felt to be lost, and in this way the mother becomes the ego-ideal; this process too results in weakening and impoverishing the ego. Very soon such processes extend to other people, and the result may be over-strong dependence on these external representatives of one's own good parts (1946, pp. 8-9).

Klein does not say if the mother identifies with the projection, or if the mother's thoughts and actions are altered by her identification with the projection so that she begins to aggress against her child. Klein also does not comment on the mother's projections of aggression and idealization onto the child, or to the potential reality aspects of the mother's behavior toward the child which would lead to the child's perception of the mother as aggressive. Rather, Klein's conceptualization portrays projective identification as a primarily intrapsychic process on the part of the infant, motivated by the child's need to defend against awareness and acceptance of his own aggressive impulses toward the mother.

Klein's definition of projective identification raises several questions which psychoanalysts and family therapists still debate. In fact, authors who describe the concept disagree on each component of projective identification. They disagree on the distinction between projection and projective identification; the degree to which it is an intrapsychic and/or interpersonal mechanism; whether or not change occurs in the projector and/or in the recipient of the projection; and whether or not it is a neurotic or psychotic defense. In the preface to her extensive review of the literature on projective identification, Maggie Scharff (1992) asserts that "To check on my purely personal impression

that we are not necessarily speaking at all about the same thing, I turned to the literature to explore the meaning of the term *projective identification.* I was drawn into a quagmire of debates and differing opinions, one more interesting than the next, until I no longer knew what I thought (1992, p. xiii)." Leonard Horowitz, concluded his description of projection identification in marital relations stating, "During several years of studying and teaching the concept, I have found it more elusive and confusing than any other psychodynamic concept I have encountered (1983, p. 261)." Yet, both authors argue against abandoning the term, insisting that it has clinical relevance and communicative power.

The first area of debate concerns the distinction between projection and projective identification. The central issue is whether or not projective identification occurs when the projector identifies with the recipient of his projection, or rather if it is necessary for the recipient of the projection to also identify with the projection. In other words, is projective identification a "one-body or two-body phenomena"? (Scarff, 1992).

As noted earlier, Melanie Klein's definition does not mention changes in the recipient of the projection, therefore Klein's definition promotes a one-body conceptualization of projective identification. Like Klein, James Grotstein promotes a one-body definition of projective identification; however he goes one step further than Klein and argues that there is no distinction between projection and projective identification. Grotstein views projection and projective identification as identical processes. He writes, "projective identification can be thought of in two distinctly separate categories: (a) externalization,

which is projective identification into or onto an object without transformation of the self or the object; and (b) defensive projective identification which invariably results in a transformation of self and of the object" (1981, p. 125).

In contrast, projective identification defined as a two-body experience requires that the recipient identify with the affect or trait which has been projected onto her. Polly Crisp (1988) argues for a two-body definition of projective identification. She states that ". . .in projective identification, blurred boundries are evident, and actual change occurs in the external object. Not merely unconscious fantatsy, but actual interpersonal pressure or behavioral induction toward the recipient is present" (1988, p. 391). In addition, she insists that there is an experiential difference in projection and projective identification. In the case of projection, the individual who is the recipient of a projection feels misunderstood and consequently more distant from the projector. In contrast, in projective identification, the recipient of the projection identifies with the projected perception, and she feels connected to the projector. The recipient demonstrates identification with the projection by behaviorally enacting the affect or trait that was projected in relation to the projector.

Thomas Ogden also defines projective identification as a two-body phenomenon. He asserts that in projective identification both the projector *and* the recipient identify with the projected material; however, the projector identifies with the projected material only after the recipient has contained, and responded to, or "metabolized", the material. Odgen describes projective identification as a three step process:

> In the initial phase, the projector fantasies ridding himself of an aspect of himself and putting that aspect into another person in a controlling way. Secondly, via the interpersonal interaction, the projector exerts pressure upon the recipient of the projection to experience feelings that are congruent with the projection. Finally, the recipient psychologically processes the projection and makes a modified version of it available for re-internalization by the projector (1979, p. 371).

Melanie Klein insists that projective identification functions as an object relationship and a defense. She described it as a primitive defense i.e., normally occuring early in development, which serves the function of enabling the child to rid himself of unacceptable impulses. She described projective identification as a primarily aggressive object relation. Klein acknowledged that positive self-aspects could be projected, but she asserted that even positive projective identification could be impoverishing to the ego. Thomas Ogden attributes four functions to projective identification, ". . . [it] is a psychological process that is simultaneously a type of defence, a mode of communication, a primitive form of object relationship, and a pathway for psychological change" (1979, p. 362).

The relationship which is formed by projective identification is designed to deny separation and to enhance connection. Ogden states that in projective identification "The projector subjectively experiences a feeling of oneness with the recipient with regard to the expelling feeling, idea, or self-representation (1982, p. 34)." The denial of separation and enhanced connection are achieved in two ways: either the

individuals join together in a shared affect state and both behave in a manner congruent with the projected material with the resulting sensation of being in union as one, or they share complementary affect states in which one person's subjective experience does not make sense without the validation of the other's complementary response. In both cases of projective identification separation is minimized and the two individuals feel strongly bound together. Polly Crisp (1986) terms these two types of relationships "similarity" and "complementary" projective identification.

The relationship formed by sharing an affect state leads to increased empathy and understanding for the other person due to the feeling of sameness or oneness between them. In contrast, the relationship formed by the adoption of complementary affect states, the type Klein emphasized, results in the subjective experience of conflicted dependence. Rather than being one by virtue of being the same, the two individuals are one because they are two different halves of one whole. The two individuals fit together like a lock and key; each needs the other to be different from themself in a particular and complementary way. Polly Crisp cites an example of a marital relationship characterized by conflictual dependence maintained by complementary projective identification:

> For example, it may be said that the passive clinging wife projects her anger into her abusive husband or that the abusive husband projects his dependency into her. Thus each partner ends up carrying that which has been disowned by the other to the extent that the interpersonal fields of each combine to complete the whole.

> The abusive husband may deny his own dependency, but behave in such ways in relation to his wife that she assumes a dependent position. He does not have to be conscious of his own dependency needs, and she does not have to be conscious of her need to abuse others. The complementary abusive and dependent positions of each create a balance in the marital system, and each portrays antithetical aspects of the other (1988, p. 389).

Projective identification also serves a communicative function (Ogden, 1982; Scarff, 1992). Through the inducement of affective states and interpersonal responses, one individual makes it possible for another to *experience* what she experiences. Projective identification does not initally bring cognitive understanding, in fact it often interferes with cognitive understanding. Rather, projective identification provides the individual with first hand experience of the other's inner affective state.

The opportunity for psychological change, which Ogden (1982) asserts is a function of projective identification, is dependent upon the response of the recipient of the projection. The recipient of the projection has two options; either he may identify with the projection and play the role or he may read the communication from the projector and choose to respond differently. Choosing the second option opens the door to a new type of relationship between the two individuals.

The communicative aspect of projective identification is used by clinicians to gain information about the patient's emotional experience with others. The therapist is able to identify emotions aroused in herself through projective identification as countertransference responses

to the patient. The therapist may intervene more effectively if she can use the information gained from projective identification to create a new experience for the patient, rather than reifying the patient's past experience with others.

Finally, projective identification is used as a defense. It is used to deny and externalize awareness of unacceptable affects, impulses and traits in the self. Klein attributed the need to deny unpleasant experiences to the infant, but anxiety is aroused by the experience of some affects throughout the lifespan. Klein stated that the child utilizes projective identification in the paranoid-schizoid position, a developmental period when the predominate anxiety the child experiences is fear of annihilation. The child in the paranoid-schizoid position projects hostility in order to make sense of his phantasy of a hostile environment (primarily mother), and to save himself from internal destruction. In contrast, the predominate anxiety for the slightly older child in the depressive position is fear of abandonment. Consequently, the child in the depressive position is concerned that his hostility will injure the mother, or drive her away.

Children in the depressive position, and individuals at all subsequent stages of development, learn through interaction with others that their actions have consequences. Children learn that some responses may be harmful to others, and that some may bring harm to them through the hostility, rejection, or neglectful response they evoke in others. Thus, the individual learns through interaction with others that some affects or traits are unacceptable or dangerous to express. In order to avoid the anxiety which results from acknowledging the dangerous characteristics in

himself, the individual disowns and externalizes ownership of the qualities; the individual projects the affects and traits and perceives them as an attributes of someone else.

According to Object Relations theory, development proceeds through an on-going process of introjection, projection and re-introjection. A constant flow is maintained between what is outside becoming inside and what is inside becoming outside, especially when the self-other boundries are not yet clearly developed. Due to the cyclical nature of the process, the material that is projected is also re-introjected, so the child is never quite able to rid himself of the bad self-aspect. Throughout the lifespan establishment of relationships through projective identification allows individuals to make sense of their intrapsychic perceptions, affects and experiences. Projective identification allows individuals to transfer their experiences back and forth from the internal world into the interpersonal arena through projection, re-introjection and identification. In other words, projective identification allows conflicts to remain relational, rather than being internalized in the individual as intrapsychic conflict.

Timothy Leary writes that "Interpersonal reflexes tend to initiate or invite reciprocal interpersonal responses from 'others' that lead to a repetition of the original reflex" (1982, p. 23). In other words, aggression usually begets aggression, kindness generally invokes a kind response, and sadness stirs the other to respond sympathetically. Humans are socially conditioned to respond either in kind or with the appropriate complementary response. Individuals are often induced to experience a range of affects, and display a range of behaviors, in response to the

displayed affects and behaviors of others.

Leary defines personality as "the pattern of interpersonal responses employed to reduce anxiety, ward off disapproval, and maintain self-esteem" (1982, p. 23). Familiar situations, even if consciously disliked by the individual, are less anxiety provoking than novel ones. An anxious person who is fearful of disapproval is more likely to adopt a narrow range of behaviors, to be comfortable with a narrow range of affects, and to restrict his interpersonal relations by sticking to a few automatic interpersonal "reflexes." Leary asserts that the reflexes are automatic responses, so the subject is often unaware of them. Ironically, the responses from others that the reflexes elicit are often at odds with what the person says he wants. Projective identification is the process whereby one individual creates a relationship with another which pulls for a familiar response, often despite conscious wishes to the contrary.

A third question raised by projective identification is object choice: who is selected to be the recipient of a projection, and how is that person persuaded to play out the role? The projector must find someone who either obviously fits the criteria, or else he must induce someone in his interpersonal world to play the part.

Individuals who are in intimate relationships with the projector are most often chosen as recipients of projective identification because they desire connection with the projector. Horowitz asserts that "Projective identification grows only in the soil of intimacy and intense involvement (1983, p. 266)." The necessary pre-requesits for projective identification are all customary aspects of intimate relationships; affective involvement with the other, heightened sensitivity to the

others' perception of oneself, and relatively permeable self/other boundries. Similarly, the four functions of projective identification: defense, communication of affect, establishment of a relationship, and desire for familiarity or for a corrective experience in relationship with another, all come into play in the choice of a mate.

Projective identification comes into play in the selection of a mate when individuals select someone to marry with whom they believe they can have a different experience than they did in their family of origin. Paradoxically, the individual who says that she wants something different often continues to expect, and to reflexively push the other, to respond in the previously experienced and expected way via projective identification. The secret hope, despite her resistance to it, is that the other will respond differently. By re-enacting the old conflict, the opportunity is created for the other to respond differently. However, if a corrective experience does not occur, and projective identification leads simply to resumption of the family of origin conflict in the couple without resolution, then the conflict poses a threat to the stability of the relationship.

When a conflict becomes destabilizing to the marital relationship often the pair seeks someone else outside of their relationship to become the bad object. Parents often choose one of their children to become the focus of their attention. The shift in focus to the child as "the problem" allows the parent's to join together in a shared view of the third individual as the source of conflict, which brings stability to the marital relationship. The process of shifting the focus to a third individual is called triangulation. When a child is chosen to be the

third person in the triangle, and in the process the child is identified as the problem, the process is referred to as scapegoating. Broderick & Pulliam-Krager state:

> . . .when a family feels that its basic stability is threatened by a growing rift between the parents, one alternative is to divert attention from the threatening parental split to a relatively safe scapegoat from among the children. Some have argued that the weakest and most vulnerable child is chosen. . . .Others find it more credible to believe that the child who is most disruptive is chosen (1979).

The concept of "family homeostasis" (Jackson & Yalom, 1954) is used to describe the systemic aim of a family to regulate itself in order to maintain stability and balance. Levang (1989) asserts that family coalitions may shift among dyads, e.g., from a two parent coalition against a child, to a child and parent allied against the other parent, but the "we against you" dynamic remains the constant element in the flux of shifting alliances.

Vogel and Bell (1968) suggest several reasons why a child is scapegoated by the parents. First, the child is relatively powerless and in a dependent position in relation to the parents -- the child cannot easily leave the parents. Second, the child has relatively few essential tasks to perform in the family. Handicapping the child has less costly consequences to the family, at least initially, than handicapping one or both of the parents. Third, children are malleable, and very responsive to their parents' consciously and unconsciously expressed needs for them. Vogel and Bell write:

> Because the child's personality is still very flexible, he can be molded to adopt the particular role which the family assigns him. When the child does take on many of the characteristics which the parent's dislike in themselves and each other, he becomes a symbolically appropriate object on which to focus their anxieties (1968, p. 416).

The same possibilites exist in selecting a child to play the role of the scapegoat as they do in selecting any individual to be the recipient of a projective identification: either children fit the characteristic and pull for the parent's response, or they must be induced to accept the role. If the parents have a strong need to see the child in a certain way which has little to do with an accurate appraisal of the child, then they will selectively respond to the child in order to elicit the affect and behavior they need to see. In behavioral terms this process is called selective reinforcement or shaping.

Zinner and Shapiro (1972, 1974), and other family therapists with an Object Relations theoretical view (Sally Box, 1986, Jill Scharff, 1992), describe projective identification as a central mechanism operative in families in which adolescents are acting out disavowed aspects of their parents. In such cases the child is not acting out an internal conflict, but rather, through projective identification, is acting *for* the parent, while the parent retains the role of disapproving the activity of their child.

Zinner and Shapiro define projective identification as ". . .an activity of the ego which, among its effects, modifies perception of the object, and, in reciprocal fashion, alters the image of the self. These

conjoined changes in perception influence and may, in fact, govern behavior of the self toward the object" (1972, p. 523). Zinner and Shapiro employ the term "defensive delineations" to describe this process whereby parents perceptions of their children are more strongly influenced by how the parents *need* to see their children, rather than by a realistic appraisal of the characteristics of the child:

> Among parental delineations are those which are more determined by their service on behalf of parental defensive needs than by their capacity to appraise or perceive the realistic attributes of the adolescent. These "defensive delineations" are an expression of parental defensive organization and, as such, the parent is strongly motivated to sustain these perceptions of the adolescent regardless of the adolescent's behavior which might otherwise alter the parental image. . .The adolescent does identify with defensively distorted parental images of him, and in this fashion, his own subjective self-experience is likely to be affected by his parent's efforts to diminish their own anxiety (1972, p. 524).

Zinner and Shapiro further assert that projective identification has an impact on the developing child which extends beyond the immediate interaction. They state, "Projective identification leads to authentic and lasting structural change in the *recipient* of the projections. A prime example of this is the effect of family interaction on the developing personality of the child (1972, p. 110)."

Zinner and Shapiro (1974) assert two interrelated reasons why

parents scapegoat their children via projective identification. The first is that when the parents were adolescents they were unable to integrate and internalize the conflicting drives to obtain gratification of id impulses and the super-ego prohibitions against gratification. Consequently, the two functions remain split, and one or the other is perceived to be expressed externally. In order for a balance to be achieved between expression of the impulse and its inhibition, one member of the dyad must take the role of acting impulsively and the other the role of the super-ego-critic.

In the relationship established with their child through projective identification, the parent has two options. First, the parent may establish a relationship with the child in which the parent acts out the same role he did as a child in his family of origin, but now enacting the role in relation to his child instead of his parent. Second, the parent may adopt the role previously taken by one or both of his parents. In the second case he is able to turn his passive experience into active experience, and to gain a sense of mastery through identification with the aggressor. The roles adopted by parent and child are rigid, but they may oscillate in their enactment of the roles. The critical point is that at any given point each is expressing one of the complementarily opposite positions.

Zinner and Shapiro (1974) suggest that a family dynamic of externalizing conflict creates a situation where the family members function as parts of a single, psychic whole, rather than each functioning as separate, whole individuals. This type of family functioning proves particularly problematic when the child reaches adolescence. In

adolescence the teen must navigate the developmental task of consolidating an individual identity, and begin to separate from the family. When a family system depends upon the function a child serves to maintain its homeostatic balance, then the level of conflict is likely to increase in the home when the child attempts to separate from the family. If the child has been assigned the role of acting out the impulses of the parents, or is assigned the role with the onset of puberty, then it is probable that his level of acting out will increase. Zinner and Shapiro state that:

> The variables relevant to the development of psychopathology in the offspring seem to involve the content of the projected material, the capacity of the parent to differentiate himself from the child, and the intensity of the parental defensive requirements (1972, p. 526).

Objectives of the Study

The present study will examine empirically the role of projective identification from the perspective of object relations oriented family therapists Sally Box (1986), Scharff & Scharff, (1987), and Zinner & Shapiro (1972, 1974). These therapists suggest that some parents manage their anxiety through the symptomatic behavior of their children. Impulses that parents are conflicted about directly expressing themselves may be expressed through their children. Thus, the study will examine families in which one of the children is identified as a psychiatric patient.

The present study accepts Ogden's (1979) defintion of projective identification, and assumes that projective identification is a two-body phenomenon which leads to an alteration in the self concept of each

participant, and to a change in the relationship between them. However, the present method of assessing projective identification cannot measure change as it occurs in the projector and recipient, nor can it demonstrate that projective identification is the causal factor of change in the individual family members or in their relationships. Rather, the method is an initial attempt to measure lasting structural change in the child as a consequence of repetitive engagement in projective identification with the parent. This will be accomplished through comparing the content of the parent's projections, and the child's description of himself as embodying those traits which the parent's project, to see if they match.

The study endeavors to operationalize Ogden's (1979) definition of projective identification as a three step intrapsychic and interpersonal process, and proposes a method to assess projective identification in parent-child dyads. The interpersonal aspect of projective identification is assessed through use of a questionnaire designed to measure interpersonal behavior, and by obtaining data within the interpersonal context of the family. The method is limited in its ability to assess the intrapsychic aspects of projective identification due to the difficulty of measuring unconscious functioning. The study proposes a method to attempt to measure unconcious activity using conscious self-description, yet utilizing the information from the description which is disowned by the individual, thus material that is not an acknowledged part of the person's conscious self-description. An additional check is used in order to differentiate the traits which might be unconsciously disowned and projected, from the traits which are simply not an aspect of the person; only those traits which one individual disowns, yet an observer familiar

with the individual says describe that individual, will be considered projected traits.

Due to her focus on intrapsychic and instinctual processes, Klein ignored the issue of environmental characteristics pre-existing in the parents or the child which might causally contribute to the content of projective identification between parent and child. Klein also focused on projections which originated in the child and were directed toward the parents. In contrast, the present study examines projections which originate from the parent and that target a particular child. In addition, the present study acknowledges that both parent and child may exhibit qualities which pull for a particular type of response from the other, but the empirical design does not make it possible to identify and differentiate those contributing factors. The one time data collection method will present an initial, exploratory snapshot of families to see if there is a match between the traits that parents project, and the traits which the identified patients in a family describe as descriptive of themselves.

The study follows Klein's lead in focusing on the projection of bad self aspects more so than the projection of desirable traits. It is assumed that parents project both desirable and undesirable traits onto their children, and that they experience both shared and complementary affect states. However, it is expected that the majority of the traits projected onto the identified patients will be undesirable, leading to a complementary style of projective identification.

The study will not examine the role of bio-genetic factors. In recent years scientists have identified bio-genetic factors which

contribute to the familial transmission of many psychiatric disorders including alcoholism, antisocial tendencies, hyperactivity, affective disorders and schizophrenia, but it is beyond the scope of this study to examine the role of genetics. I acknowledge that an interaction effect between genetic and environment factors is necessary for the development of behaviorally expressed symptomatic behaviors. However, this study will focus solely on the elucidation of a single psychological process, projective identification, and the role this process plays in the interactions between parents and children.

Significance of the Study

Despite frequent use of the construct "projective identification" in clinical theory and vignettes to explain certain types of experiences and relationships, the concept has received minimal empirical study. A thorough review of the literature revealed only two attempted measures of projective identification. The first measure, presented by Irene Paulson (1978 unpublished dissertation), is composed of six statements designed to determine whether the individual functions primarily in the paranoid-schizoid position or the depressive position as defined by Klein. Thus, it is an assessment of a developmental position rather than a measure of projective identification. The second measure of projective identification (Sugarman, 1980) is a single Rorschach test indicator which is composed of a combination of Rorschach determinants. The indicator is proposed to assess projective identification when it is used as a defense by individuals with Borderline Personality Disorder, thus it has limited applicability as a measure of the construct.

In contrast to Paulson (1978) and Sugarman's (1980) studies, the

the present study offers an empirical method of assessing projective identification which is designed solely to measure projective identification. The method is designed to correspond as closely as possible to the theoretical definition of projective identification as a series of intrapsychic and interpersonal events.

The rarity of research on projective identification is due in part to the difficulty of assessing a phenomenon which is temporally transitory, and occurs in subtle sequences across interpersonal exchanges. The present study addresses this issue by measuring projective identification as it is embodied in the internalized self and other descriptions of family members.

Hypotheses of the Study

The specific aim of this study is to differentiate the patient-child from their siblings in terms of projective identification. The two hypotheses of the study are as follows:

(1) (a) The identified patients will be the recipients of a greater number of projected traits from both parents than the siblings;

(b) The identified patients will more often identify with the projected traits than the siblings;

(c) The content of the traits projected onto the identified patient will be less socially desirable than the content of the traits projected onto the siblings.

(2) The parents will show greater agreement in their descriptions of the identified patients than they will in their descriptions of the siblings.

The first hypothesis is derived from Zinner and Shapiro's (1972,

1974) assertion that parental distortions are projections of the parent's disowned affects and traits which they attribute to their child. The parents see their problem child in a distorted way, i.e., project disowned affects onto their child, due to their need to diminish their anxiety. The child internalizes and identifies with the parent's perception of him, and alters his self-concept to meet his parent's unconscious needs for him to embody and express their disowned qualities. Thus, it is expected that the child who is the identified patient will be the recipient of a greater number of projections from the parents than his or her sibling; that the identified patient child will identify with more of the projections from their parents than the non-patient sibling; and that the content of the traits projected onto the identified patients will be more socially undesirable than those projected onto the siblings.

The second hypothesis, that the parents will more often agree in their description of the identified patients than siblings, stems from Vogel and Bell's concept of scapegoating (1968). Scapegoating the child enables the parents to join together in shared identification of a third individual as "the problem." Identifing the child as the problem shifts the focus from conflicts in the marital dyad, and provides a way for the parents to unite. Due to the assumed parents' shared view, it is hypothesized that the parents will more often agree in their description of the identified patients than they will need to do in their description of the siblings.

CHAPTER II

METHODOLOGY

Subjects

Subjects were 11 two-parent families with one child involved in individual, psychiatric treatment, and a sibling who was not involved in individual psychiatric treatment. All families participated in some form of family therapy in conjunction with the identified patient's individual treatment. The experimental group is composed of the identified patients, and the control group is the siblings.

The identified patients ranged in age from 12 to 17 years old (mean age = 15 years), and the siblings ranged in age from 11 to 22 years of age (mean age = 16 years). The fathers ranged from 35 to 53 years old (mean age = 43 years), and the mothers' ranged from 37 to 52 years old (mean age = 44 years). The participating families reported a range of income from $5,000 - $10,000 to $50,000 and above. The mean family income was $35,000, but the median income was $50,000 and above.

Of the 10 families, 8 were intact families, 2 were step families (in both cases the father was a step father and the siblings were whole siblings), and in 1 of the families the two children were adopted in infancy. The identified patients were predominately female: 9 of the identified patients were female and 2 were male. The siblings were more evenly distributed by sex: six of the siblings were female and five were male. The subjects were also evenly distributed in terms of same sex and different sex dyads: in six of the families the identified patient and

sibling were the same sex, and in five of the families they were the opposite sex. The sample consisted entirely of white families because none of the families referred by the participating agencies were minority families.

Subjects were recruited from six psychiatric facilities: The Children's Hospital, Denver, Colorado, the Adolescent Psychiatric Unit; Arapahoe House, Denver, Colorado, a 30 day residential facility for substance abusers; The Oaks of Saint Mary's, Knoxville, Tennessee, both the Residential and Partial Hospitalization programs; Ridgeview Psychiatric Hospital and Center, Oak Ridge, Tennessee, both the Adolescent Psychiatric Unit, and the out-patient therapy department; DRI Adolescent Center, Knoxville, Tennessee a 30 day alcohol and drug residential treatment facility; and McNabb Mental Health Center, Knoxville, Tennessee, the Children and Youth Center.

A total of 12 psychiatric treatment facilities were asked to participate in the study, including agencies in Knoxville, Tennessee; Atlanta, Georgia; and Denver, Colorado. Six of the agencies agreed to participate in the research project, four agencies refused to participate, and two of the agencies never completed their review process. Finally, seven private, out-patient therapists were approached to participate in the study. Six of the therapists agreed to assist with data collection for the study, but only one of them could identify families in their caseload which met the research design criteria.

In the first four months of data collection subjects were approached to participate in the study only if they were diagnosed as substance abusers. Only one family fully completed all the questionnaires, and the

substance abuse screening criteria was dropped. Adolescents treated for substance abuse rarely had two-parent families, and most of them were in the temporary custody of the Colorado Department of Social Service or the Tennessee Department of Human Services. The fact that the children were in protective custody made it impossible to obtain parental consent and to obtain parental and sibling participation in the study. Subject selection criteria were widened to include any child in psychiatric treatment, regardless of diagnosis; the subject age range was broadened from 13 to 18 years to 10 to 22 years of age.

The family therapists at each facility screened the families to participate in the study. The family therapists were instructed to ask all families in their caseload which met the reasearch design criteria to participate in the research project. Confidentiality was maintained by having the family therapists ask the families if they were willing to talk with the researcher; if the family members consented, then the researcher contacted the family and made arrangements to collect the data. Seven of the families completed the questionnaries on site in the researcher's presence; the other four families elected to take the questionnaires home and return them. Questionnaires from five families could not be used in the data analysis because either data could not be obtained from all four family members, or the family did not meet the research design criteria.

Measurement Procedures

Interpersonal checklist (ICL), (Leary, 1956). The ICL is a part of the Leary System of Interpersonal Assessment. The Leary system is designed to measure interpersonal behavior along a continuum of two dimensions: dominance/submission and hostility/affiliation. Depicting the

two dimensions graphically as intersecting axes, Leary created a circular model, the "Circumplex," a pie chart with eight equal areas called "octants." Each octant represents an interpersonal style. The eight octants and interpersonal styles are depicted in Figure 1.

The ICL is a list of 128 adjectives and phrases used to assess interpersonal attributes. Leary and his associates developed the 128 item list by selecting four attributes to characterize each of the eight interpersonal styles. They further described each of the four attributes with four phrases which express subtley different degrees of social desirability. For example, for the octant (BC) Competitive - Narcissistic, the four traits are most benignly described as: "self-respect," "independence," "capacity for self care," and "indifference to others." The four degrees of social desirability for the characteristic "self-respect" are: "self-respecting," "self-confident," "boastful," and "somewhat snobbish." Thus, a pool of 16 items ranging from socially desirable expressions of a trait, to socially undesirable expressions of the same trait are used to define each interpersonal style. For further information regarding the development of the ICL see Leary, 1956. A copy of the ICL is presented in Appendix A.

The ICL is used in the present study to obtain each family member's description of him or herself, and their descriptions of the other three family members. The subjects completed the checklist of 128 items five times to check off those items which: 1) describe himself/herself; 2) describe the other three family members; and 3) the person he or she is NOT. Subjects who completed the questionnaire on site required an average time of 30 to 40 minutes to complete the ICL.

The Eight Octants of the Leary System of Interpersonal Assessment

Octant #	Octant Label	Interpersonal Style
I	AP	Managerial - Autocratic
II	BC	Competitive - Narcissistic
III	DE	Aggressive - Sadistic
IV	FG	Rebellious - Distrustful
V	HI	Self-effacing - Masochistic
VI	JK	Docile - Dependent
VII	LM	Cooperative - Over-emotional
VIII	NO	Managerial - Autocratic

The Four Socially Desirable Octants

VII	LM	Cooperative - Over-emotional
VIII	NO	Managerial - Autocratic
I	AP	Managerial - Autocratic
II	BC	Competitive - Narcissistic

The Four Socially Undesirable Octants

III	DE	Aggressive - Sadistic
IV	FG	Rebellious - Distrustful
V	HI	Self-effacing - Masochistic
VI	JK	Docile - Dependent

Figure 1

Octants from the Leary System of Interpersonal Assessment

Family history questionnaire, (FHQ). The FHQ was developed for the present study in order to gain four types of information from the parents, but only the demographic information was utilized. Two of the sections included questions about substance abuse which were no longer relevant to the study. The final section asked parents to rate each of their children in infancy and at the present on ten dimensions to assess temperament, which was also irrelevant to the present study. Completion of the FHQ took parents an average of ten minutes. A copy of the FHQ is presented in Appendix B.

A generic version of the informed consent form appears in Appendix C. The informed consent form was individualized for each data collection site in order to include the name of that agency, and to specify the name of the individual to contact at that site for further information.

Data Analysis

The experimental variables are the parent's descriptions of themselves and their children, and the children's descriptions of themselves on the ICL. The dependent variable is the child's status as the identified patient or the sibling not in treatment. The investigator did not introduce any interventions; the subjects simply described themselves and their family members.

Data from the Interpersonal Checklist were scored in two ways to test the two hypotheses. First, the data from the ICL were scored according to the researcher's operational definition of projective identification. The three step operational definition of projective identification, and the three step method of assessing it appear in Figure 2. The empirical definition of projective identification is based upon

3 Steps of Projective Identification	3 Step Operational Index
1. *Possible Projected Traits*: traits which one parent denies, but the spouse says apply.	1.a) Traits one parent endorses on the ICL as "not me," AND b) Traits the spouse endorses on the ICL to describe that parent.
2. *Recipient of the Projection:* child who is described by the parent as embodying the "possible projected traits."	2.a) Items from step 1, AND b) Traits the parent endorses on the ICL to describe that child.
3. *Identification with the Projection*: child who is "recipient of the projection," and describes self as embodying the "possible projected traits."	3.a) Items from step 2, AND b) Traits the child endorses on the ICL as "me."

Figure 2
Operational Definition of Projective Identification

Thomas Ogden's (1979) theoretical definition of projective identification as a three step process. Ogden suggests that in the first step the projector "fantasies ridding himself of an aspect of himself and putting that into another person in a controlling way." In the second step "via the interpersonal interaction, the projector exerts pressure upon the recipient of the projection to experience feelings that are congruent with the projection." Finally, in the third step "the recipient psychologically processes the projection and makes a modified version of it available for re-internalization by the projector (1979, p. 371)."

In the present study, Ogden's first step in the projective identification sequence was assessed by identifying those traits which the parents might project onto their children. The traits which a parent disowned as "not me" on the ICL were compared with their spouses' endorsement of traits to describe them. Those traits which a parent denied, and which overlapped with the traits the other parent said applied, are labeled "possible projected traits."

The second step involves identifying the recipient of the projection. The present study presumed that parents and children have developed a stable relationship; therefore, traits which are attributed to the children are relatively stable across time. Consequently, in the present study, Ogden's "interpersonal pressure to experience feelings that are congruent with the projection" was assessed by determining which child is the recipient of the parents' projections. The "possible projected traits" from each parent were matched with the parents' endorsements of their children on the ICL. The "possible projected traits" which were projected onto a child marked that child as the "recipient of the

projection."

The final step in the projective identification sequence requires the recipient of the projection to process the projection and make it available for the projector to re-internalize. Projective identification is successful only when the recipient's behavior and self-concept are altered by taking on the projection. Thus, the final step is assessed by examining the children's self-descriptions. If the children endorsed items to describe themselves which were "possible projected traits," projected onto them by a parent as the "recipient of the projection," then the child "identified with the projection."

The projective identification scoring system is based on a series of AND statements. AND is used in the present study to denote matches between two items. The process of comparing items on the checklist in the three steps by using AND is depicted in Figure 3.

Testing all three parts of the first hypothesis was accomplished by counting the number of traits, and testing the differences in the means with Student's t test. The Mann-Whitney U-test, a distribution-free alternative to the t test, was initially considered to test significance. However, due to the large number of ties in the data sample, the Mann-Whitney was rejected as an inappropriate method of assessment.

Data analysis for the first hypothesis consisted of counting the number of traits identified in each of the three steps of the projective identification scoring system, then testing the significance of the difference in the means with Student's t test. First, the number of "possible projected traits" the fathers and mothers projected onto the identified patients and siblings as the "recipients of the projection"

Measuring Projective Identification with "AND:"

If a trait is endorsed on the ICL it is scored a 1.
If a trait is not endorsed on the ICL it is scored a 0.

For each of the three steps in the operational definition of projective identification, the traits that are endorsed by one individual are compared with the traits that are endorsed by another individual. Only when both individuals endorse a trait does it meet the criteria of "AND."

Rules for AND: If 1 and 1 = 1
1 and 0 = 0
0 and 1 = 0
0 and 0 = 0

Example of AND from step 1 with Family #1:

A: FANoMe = 00110011001000110011000100110100110011
B: MAFath = 10001000000000010000001000000000010001

A AND B = 00000000000000010000000000000000010001

Sum (A AND B) = 3

Note:
[a]FANoME = Father's description on the ICL of "not me."
[b]MAFath = Mother's description on the ICL of Father.

Figure 3

Operational Definition of "AND"

were counted. Student's t test was used to test for significant differences between the mean number of traits projected onto each child by each parent.

Second, the number of times the identified patients and siblings "identified with the projection" from the fathers and mothers were counted. Student's t test was used to test for a significant difference in the mean number of traits the children identified with from their parents.

Third, the traits projected onto the two child groups by the fathers and mothers, and the projected traits the children identified with, were identified as socially desirable or undesirable using the Leary system of octants. According to the Leary system, octant numbers 1, 2, 7 and 8 are socially desirable styles of interpersonal behavior, whereas octants 3, 4, 5 and 6 are socially undesirable styles of interpersonal behavior. The number of socially desirable and undesirable traits projected onto the two groups of children by the mothers and fathers were counted. The number of socially desirable and undesirable projected traits the children identified with were also counted. Student's t test was used to test for significant differences.

In order to test the second hypothesis, the checklist endorsements of the 128 items were scored accorded to Leary's system in the customary manner (Leary, 1956). Using Leary's transformation scores, the self and "not me" descriptions by each individual, and their descriptions of the other three members of their family, were categorized into interpersonal styles of behavior represented by the eight octants. This transformation of the data resulted in the formulation of twenty summary points which

were plotted in the octants on the Circumplex. The twenty points are composed of the five ratings produced by each of the four subjects in a family.

Parental agreement was assessed by counting the number of times both parents in a dyad described the identified patients in the same octant, and the number of times parent dyads described the siblings in the same octant. A Pearson Chi Square was used to determine the signficance of the association between parental agreement (yes, no) and status of the child (identified patient, sibling).

CHAPTER III

RESULTS

The results are computed from endorsements on the Interpersonal Checklist (ICL) by 11 families. The four members in each family completed the ICL five times: once to endorse traits which describe him or herself, three times to endorse traits which describe the other three family members, and once to endorse traits which describe what the person is not like; the "not me." The data were analyzed in two ways to test two hypotheses. First, a subset of the 128 items on the ICL was created and analyzed using the present study's operational definition of projective identification to assess projective identification. Second, the full set of 128 items from the ICL was used to determine each family member's overall description of the other three family members. The family members' descriptions were used to assess parental and child agreement. The scoring system from the Leary System of Interpersonal Assessment was used to transform the endorsments into octant numbers which identify specific interpersonal styles of relating to others.

Among the identified patients there were more females than males, but the association between gender and status as the identified patient or sibling was not significant ($X^2(1) = 3.14$, $p > .05$).

Projective Identification

Recipients of the projection

The Interpersonal Checklist (ICL) endorsements for each member of the 11 families were scored according to the present study's operational

definition of projective identification. Using the scoring system, a subset of ICL traits were identified which parents disowned in themselves. These disowned traits were termed "Possible Projected Traits." Those "Possible Projected Traits" which the parents endorse on the ICL as characteristics of their children mark that child as the "Recipient of the Projection." The first hypothesis asserted that the identified patients would receive a greater number of "Possible Projected Traits" from both parents as the "Recipient of the Projection" than the siblings.

The numbers of traits from the ICL which the 11 fathers projected onto their two children as the "Recipient of the Projection" appear in Table 1. The 11 fathers projected an average of 2.7 "Possible Projected Traits" onto the identified patients as the "Recipient of the Projection," compared to an average of 1.7 traits projected onto the siblings as the "Recipient of the Projection." The difference between the means for the number of traits projected onto the identified patients and siblings was not significant, ($t(10) = 1.29$, $p > .05$).

The numbers of traits from the ICL which the mothers projected onto their children as the "Recipient of the Projection" appear in Table 2. The 11 mothers projected an average of 1.4 "Possible Projected Traits" onto the identified patients as the "Recipient of the Projection," compared to an average of 0.6 traits they projected onto the siblings as the "Recipient of the Projection." As with the fathers, the difference was not significant, ($t(10) = 2.20$, $p > .05$).

There was a significant difference between mothers and fathers in the number of traits they projected onto their children, ($t(10 = 3.46$, $p < .05$). The 11 fathers projected a total of 49 "Possible Projected

Table 1: Measure of Projective Identification from Fathers to Children

Family #	IP Recipient[a] of the Projection	SIB Recipient of the Projection	IP Identified[b] with the Projection	SIB Identified with the Projection
1	3	2	3	0
2	3	2	2	0
3	5	4	3	0
4	5	0	0	0
5	0	1	0	0
6	3	7	2	6
7	2	0	2	0
8	6	1	2	1
9	0	1	0	0
10	1	0	0	0
11	2	1	1	0
Sums	30	19	15	7
Means	2.7	1.7	1.4	0.6

Note.

[a]The number of traits from the ICL which the fathers projected onto the identified patients (IP) and to the siblings (SIB) as the "Recipient of the Projection;"

[b]The number of times when the identified patients (IP) and siblings (SIB) "Identify with the Projection."

IP, SIB Recipient ($t(10) = 1.29$, $p > .05$)
IP, SIB Identified ($t(10) = 1.23$, $p > .05$)

IP Recipient, Identified ($t(10) = 2.68$, $p > .05$)*
SIB Recipient, Identified ($t(10) = 2.96$, $p < .05$)*

Table 2: Measure of Projective Identification from Mothers to Children

Family #	IP Recipient[a] of the Projection	SIB Recipient of the Projection	IP Identified[b] with the Projection	SIB Identified with the Projection
1	0	1	0	0
2	5	0	5	0
3	3	2	0	1
4	1	0	0	0
5	1	0	1	0
6	5	2	2	0
7	2	0	0	0
8	0	1	0	1
9	0	0	0	0
10	0	0	0	0
11	2	0	0	0
Sums	19	6	8	2
Means	1.73	0.55	0.73	0.18

Note.

[a]The number of traits from the ICL which the mothers projected onto the identified patients (IP) and to the siblings (SIB) as the "Recipient of the Projection;"

[b]The number of times when the identified patients (IP) and siblings (SIB) "Identify with the Projection."

IP, SIB Recipient ($t(10) = 2.20$, $p > .05$)
IP, SIB Identified ($t(10) = 1.07$, $p > .05$)

IP Recipient, Identified ($t(10) = 2.62$, $p < .05$)*
SIB Recipient, Identified ($t(10) = 1.78$, $p > .05$)

Traits" onto their children. In contrast, the 11 mothers projected 25 "Possible Projected Traits" onto their children. Thus, the fathers projected almost double the number of traits that the mothers projected onto their children. The difference in parental rate of projection remained constant across both child groups; the fathers projected a larger total number of traits than the mothers did onto both the identified patients and the siblings.

Content of the projection

The first hypothesis further stated that the content of the traits projected onto the identified patients would differ from the content of the traits projected onto the siblings. It was hypothesized that the traits the parents project onto the identified patients would be socially undesirable, and that the content of the traits projected onto the siblings would be socially desirable.

The content of the projected traits was assessed by using the item numbers from the Interpersonal Checklist (ICL). Each of the 128 traits on the ICL describes an octant on the Circumplex, so the item numbers could be used to identify the octant numbers of the traits projected onto the children. The item numbers and octant numbers of the traits projected onto the identified patients appear in Appendix D. The item numbers and octant numbers of the traits projected onto the siblings appear in Appendix E.

Using Leary's system, octants 1, 2, 7 and 8 are socially desirable styles of interpersonal relating, whereas octants 3, 4, 5 and 6 are socially undesirable styles of interpersonal relating. The numbers of socially desirable and undesirable traits the 11 fathers projected onto

the identified patients and siblings as the "Recipient of the Projection" appear in Table 3. The numbers of socially desirable and undesirable traits the 11 mothers projected onto the identified patients and siblings as the "Recipient of the Projection" are presented in Table 4.

The hypothesis that the content of the traits projected onto the identified patients would be socially undesirable was not supported; the preponderance of the traits projected onto the identified patients by both parents were socially desirable. The 11 fathers projected an average of 2.1 socially desirable traits onto the identified patients, compared to an average of 0.6 socially undesirable traits. The difference of the means was significant ($\underline{t}(10) = 2.95$, $\underline{p} < .05$).

The mothers projected fewer traits onto their children than the fathers did, but they followed the same pattern of projecting more socially desirable than undesirable traits onto the identified patients. The 11 mothers projected a mean number of 1.2 socially desirable traits and a mean number of 0.5 socially undesirable traits onto the identified patients. The difference was significant, ($\underline{t}(10) = 2.28$, $\underline{p} < .05$).

The 11 fathers projected an average of 0.8 socially desirable traits onto the siblings, compared to an average of 0.9 socially undesirable traits. Thus, the fathers projected slightly more socially undesirable traits than desirable traits onto the siblings, but the difference in the two groups was not significant, ($\underline{t}(10) = -0.23$, $\underline{p} > .05$).

The 11 mothers projected an equal number of socially desirable and undesirable traits onto the siblings. The mothers projected a mean number of 0.3 socially desirable traits and a mean number of 0.3 socially undesirable traits onto the siblings. The difference in the two groups

Table 3: Number of Socially Desirable and Undesirable Traits Projected by the 11 Fathers onto their Children

	IP	SIB	IP	SIB
Family #	Socially[a] Desirable Traits	Socially Desirable Traits	Socially[b] Undesirable Traits	Socially Undesirable Traits
1	3	1	0	1
2	2	0	1	2
3	2	2	3	2
4	5	0	0	0
5	0	0	0	1
6	2	5	1	2
7	2	0	0	0
8	4	0	2	1
9	0	0	0	1
10	1	0	0	0
11	2	1	0	0
Sums	23	9	7	10
Means	2.1	0.8	0.6	0.9

Note.

[a]The number of socially desirable traits from the ICL which the fathers projected onto the identified patients (IP) and to the siblings (SIB) as the "Recipient of the Projection;"

[b]The number of socially undesirable traits from the ICL which the fathers projected onto the identified patients (IP) and siblings (SIB) as "Recipient of the Projection."

IP, SIB Desirable ($t(10) = 1.96$, $p > .05$)
IP, SIB Undesirable ($t(10) = -1.15$, $p > .05$)

IP Desirable, Undesirable ($t(10) = 2.95$, $p < .05$)*
SIB Desirable, Undesirable ($t(10) = -0.23$, $p > .05$)

Table 4: Number of Socially Desirable and Undesirable Traits Projected by the 11 Mothers onto their Children

	IP	SIB	IP	SIB
Family #	Socially[a] Desirable Traits	Socially Desirable Traits	Socially[b] Undesirable Traits	Socially Undesirable Traits
1	0	1	0	0
2	4	0	1	0
3	2	2	1	0
4	1	0	0	0
5	1	0	0	0
6	3	0	2	2
7	1	0	1	0
8	0	0	0	1
9	0	0	0	0
10	0	0	0	0
11	1	0	1	0
Sums	13	3	6	3
Means	1.2	0.3	0.5	0.3

Note.

[a]The number of socially desirable traits from the ICL which the mothers projected onto the identified patients (IP) and to the siblings (SIB) as the "Recipient of the Projection;"

[b]The number of socially undesirable traits from the ICL which the mothers projected onto the identified patients (IP) and siblings (SIB) as "Recipient of the Projection."

IP, SIB Desirable ($t(10) = 2.09$, $p > .05$)
IP, SIB Undesirable ($t(10) = 1.40$, $p < .05$)

IP Desirable, Undesirable ($t(10) = 2.28$, $p < .05$)*
SIB Desirable, Undesirable ($t(10) = 0.00$, $p > .05$)

was not significant, ($t(10) = 0.00$, $p > .05$).

Comparing the two child groups, the fathers projected an average of 2.1 socially desirable traits onto the identified patients versus an average of 0.8 socially desirable traits projected onto the siblings. The difference was not significant ($t(10) = 1.96$, $p > .05$). In terms of socially undesirable traits, the fathers projected an average of 0.6 traits onto the identified patients and an average of 0.9 traits onto the siblings. This difference was also not significant ($t(10) = -1.15$, $p > .05$).

Comparing the two child groups for the 11 mothers' projections reveals the same pattern. The mothers projected an average of 1.2 socially desirable traits onto the identified patients versus an average of 0.3 socially desirable traits projected onto the siblings. The difference between the two groups was not significant ($t(10) = 2.09$, $p > 0.5$). In terms of socially undesirable traits, the mothers projected an average of 0.5 traits onto the identified patients and an average of 0.3 traits onto the siblings. The difference in the means was not significant ($t(10) = 1.40$, $p > .05$).

Projective identification

Only when the "Recipient of the Projection" identifies with the projection does projective identification occur. The first hypothesis additionally stated that the identified patients would "Identify with the Projection" more often than the siblings. The numbers of times the identified patients and siblings identified with the traits the fathers projected onto them appear in Table 1. The numbers of times the children identified with traits the mothers projected onto them are presented in

Table 2.

The identified patients identified with 50% of the traits projected onto them by the fathers. The difference between the mean number of traits projected onto them, and the mean number of traits with which they identified, was significant ($t(10) = 2.68$, $p < .05$). The identified patients also identified with a significant number of the traits their mothers projected onto them. The patient group identified with 42% of the traits projected onto them by their mothers, ($t(10 = 2.62$, $p < .05$).

The siblings identified with 37% of the traits projected onto them by the fathers. The difference in the number of traits the fathers projected, and the number the siblings identified with, was significant, ($t(10) = 2.96$, $p < .05$). The siblings identified with 33% of the traits projected onto them by the mothers. This difference was not significant, ($t(10) = 1.78$, $p > .05$).

Comparing between the two child groups, the identified patients identified with a mean of 1.4 traits projected onto them by the fathers, whereas the siblings identified with a mean of 0.6 traits projected onto them by the fathers. The difference between the means was not significant, ($t(10) = 1.23$, $p > .05$). The identified patients identified with a mean of 0.7 traits the mothers projected onto them, whereas the siblings identifed with a mean of 0.2 traits the mothers projected onto them. This difference was also not significant, ($t(10) = 1.07$, $p > .05$).

Content of projective identification

The traits the children identified with were examined in terms of social desirability and social undesirability in the same way that the traits the parents projected onto the children were examined for these

qualities. Table 5 presents the numbers of times when the identified patients and siblings identified with socially desirable and undesirable traits the fathers projected onto them. Table 6 presents the numbers of times when the identified patients and siblings identified with socially desirable and undesirable traits the mothers projected onto them. The 11 identified patients identified with a mean of 0.8 socially desirable traits, and a mean of 0.5 socially undesirable traits projected onto them by their fathers. This difference was not significant, ($t(10) = 0.52$, $p > .05$). The identified patients identified with a mean of 0.5 socially desirable traits, and a mean of 0.3 socially undesirable traits projected onto them by their mothers. This difference was also not significant, ($t(10) = 0.52$, $p > .05$).

The 11 siblings identified with a mean of 0.4 socially desirable traits, and a mean of 0.3 socially undesirable traits projected onto them by their fathers. This difference was not significant ($t(10) = 0.43$, $p > .05$). The siblings identified with a mean of 0.09 socially desirable traits, and a mean of 0.09 socially undesirable traits projected onto them by their mothers. This difference was also not significant ($t(10) = -0.56$, $p > .05$).

Comparing the two child groups, the identified patients identified with 0.8 socially desirable traits projected onto them by their fathers, whereas the siblings identified with 0.4 socially desirable traits projected onto them by their fathers. The difference of the means was not significant ($t(10) = 0.96$, $p > .05$). In terms of socially undesirable traits, the identified patients identified with mean of 0.5 undesirable traits, and the siblings identified with a mean of 0.3 undesirable traits

Table 5: Number of Socially Desirable and Undesirable Traits Projected by the Fathers and Identified with by the Identified Patients and Siblings

	Identified Patients[a]		Siblings[b]	
Family #	Socially Desirable	Socially Undesirable	Socially Desirable	Socially Undesirable
1	3	0	0	0
2	2	0	0	0
3	0	3	0	0
4	0	0	0	0
5	0	0	0	0
6	1	1	4	2
7	2	0	0	0
8	0	2	0	1
9	0	0	0	0
10	0	0	0	0
11	1	0	0	0
Sums	9	6	4	3
Means	0.8	0.5	0.4	0.3

Note.

[a]The number of socially desirable and undesirable traits which the fathers projected onto the identified patients and with which the IP's identified;

[b]The number of socially desirable and undesirable traits which the fathers projected onto the siblings and with which the SIB's identified.

IP, SIB Socially Desirable ($t(10) = 0.96$, $p > .05$)
IP, SIB Socially Undesirable ($t(10) = 0.90$, $p > .05$)

IP Desirable, Undesirable ($t(10) = 0.52$, $p > .05$)
SIB Desirable, Undesirable ($t(10) = 0.43$, $p > .05$)

Table 6: Number of Socially Desirable and Undesirable Traits Projected by the Mothers and Identified with by the Identified Patients and Siblings

	Identified Patients[a]		Siblings[b]	
Family #	Socially Desirable	Socially Undesirable	Socially Desirable	Socially Undesirable
1	0	0	0	0
2	4	1	0	0
3	0	0	1	0
4	0	0	0	0
5	1	0	0	0
6	0	2	0	0
7	0	0	0	0
8	0	0	0	1
9	0	0	0	0
10	0	0	0	0
11	0	0	0	0
Sums	5	3	1	1
Means	0.5	0.3	0.09	0.09

Note.

[a]The number of socially desirable and undesirable traits which the mothers projected onto the identified patients and with which the IP's identified;

[b]The number of socially desirable and undesirable traits which the mothers projected onto the siblings and with which the SIB's identified.

IP, SIB Socially Desirable ($\underline{t}(10) = 0.94$, $\underline{p} > .05$)
IP, SIB Socially Undesirable ($t(10) = 0.80$, $\underline{p} > .05$)

IP Desirable, Undesirable ($\underline{t}(10) = 0.52$, $\underline{p} > .05$)
SIB Desirable, Undesirable ($\underline{t}(10) = -0.56$, $\underline{p} > .05$)

projected onto them by their fathers. The difference was not significant ($t(10) = 0.90$, $p > .05$).

Comparing the two child groups for identification with projections from their mothers, the identified patients identified with a mean of 0.5 socially desirable traits, compared to the siblings who identified with 0.09 socially desirable traits. This difference was not significant ($t(10) = 0.94$, $p > .05$). In terms of socially undesirable traits, the identified patients identified with a mean of 0.3 undesirable traits, versus the siblings who identified with a mean of 0.09 undesirable traits projected onto them by their mothers. The difference of the means was not significant ($t(10) = 0.80$, $p > .05$).

Parental Agreement

The second hypothesis stated that the parents would show greater agreement in their description of the identified patients than they would in their description of the siblings. Parental agreement was assessed using the total pool of 128 items from the ICL, rather than the subset of "Possible Projected Traits." Using the Leary scoring system, the parents' endorsements of traits on the ICL to describe their children were transformed into octant numbers. When the two parents' descriptions of their children are in the same octant they agree or "match" in their description of that child. The parents' descriptions of their children by octant numbers appear in Appendix F. Circumplex graphs for the 11 families appear in Appendix G.

Six of the 11 parental dyads agreed in their descriptions of the identified patients, compared to 3 of the 11 dyads who agreed in their description of the siblings. However, a test of the association between

parental agreement (yes, no) and child status (identified patient, sibling) was not significant ($X^2(1) = 1.69$, $p > .05$).

Content of parental agreement

The octant numbers for each family members' self and other endorsments on the ICL appear in Appendices H - K. Appendices H - K also present the numbers of times the 22 parents and 22 children describe themselves and their three family members in socially desirable and undesirable octants.

Ninety percent of the mothers described themselves in socially desirable octants. The mothers described their husbands in socially desirable octants in 73% of the cases. Consistent with their wives ratings of them, 73% of the fathers described themselves in socially desirable octants. The fathers described their wives in socially desirable octants in 73% of the cases. Thus, the majority of the parents agreed that they each interact with others in a socially desirable manner.

In contrast, the 11 fathers described the identified patients in socially desirable octants in only 27% of the cases, whereas the mothers described 55% of the identified patients in socially desirable octants. The association between the two groups was not significant ($X^2(1) = 1.69$, $p > .05$).

The fathers described the siblings in socially desirable octants in 64% of the cases, versus the mothers' description of 90% of the siblings in socially desirable octants. The association between groups was also not significant ($X^2(1) = 2.32$, $p > .05$).

The 11 identified patients and 11 mothers described the siblings in socially desirable octants in 90% of the cases. In contrast, the 11

fathers described the siblings in socially desirable octants in 64% of the cases. The siblings described themselves in socially desirable octants in 73% of the cases. The numbers of times family members and siblings described the siblings in socially desirable and undesirable octants appear in Table 7. The association between the siblings' endorsement of themselves as socially desirable, and the other three family members' endorsements of the siblings as socially desirable, was not significant ($X^2(3) = 3.77$, $p > .05$).

The 11 mothers and 11 siblings described the identified patients in socially desirable octants in 55% of the cases. Comparatively, the fathers described the identified patients in socially desirable octants in only 27% of the cases. The identified patients described themselves in socially desirable octants in 64% of the cases. The numbers of times the family members and identified patients described the identified patients in socially desirable and undesirable octants appears in Table 8. The contingency between the identified patients' endorsements of themselves as socially desirable, and the other three family members' endorsements of them as socially desirable was not significant, ($X^2(3) = 3.27$, $p > .05$).

Gender differences of the identified patients and siblings were not signficantly associated with the fathers' ratings of social desirability and undesirability. The numbers of times the 11 fathers and 11 mothers described the male and female children as socially desirable and undesirable are presented in Tables 9 and 10. The association between gender (male, female) and social desirability (desirable, undesirable) was not significant for the identified patients ($X^2(1) = 0.92$, $p > .05$); or for

Table 7: The Number of Times Family Members and Siblings Describe the Siblings in Desirable and Undesirable Octants.

	Socially Desirable	Socially Undesirable
Fathers of SIB	7	4
Mothers of SIB	10	1
Siblings of SIB	8	3
IP's of SIB	10	1

Fathers, Mothers of SIB $X^2(1) = 2.32$, $p > .05$

$X^2(3) = 3.77$, $p > .05$

Table 8: The Number of Times Family Members and Identified Patients describe the Identified Patients in Desirable and Undesirable Octants.

	Socially Desirable	Socially Undesirable
Fathers of IP	3	8
Mothers of IP	6	5
Siblings of IP	6	5
IP's of IP's	6	5

Fathers, Mothers of IP $X^2(1) = 1.69$, $p > .05$

$X^2(3) = 3.27$, $p > .05$

Table 9: The Number of Times Fathers Described the Male and Female Children in Desirable and Undesirable Octants.

	Socially Desirable	Socially Undesirable
Male IP	0	2
Female IP	3	6
Male SIB	2	3
Female SIB	5	1

Note.
Male IP, Female IP $X^2(1) = 0.92$, $p > .05$
Male SIB, Female SIB $X^2(1) = 2.21$, $p > .05$

Male IP, SIB; Female IP, SIB $X^2(3) = 5.73$, $p > .05$

Table 10: The Number of Times Mothers Described the Male and Female Children in Desirable and Undesirable Octants.

	Socially Desirable	Socially Undesirable
Male IP	0	2
Female IP	6	3
Male SIB	4	1
Female SIB	6	0

Note.
Male IP, Female IP $X^2(1) = 2.93$, $p > .05$
Male SIB, Female SIB $X^2(1) = 1.32$, $p > .05$

Male IP, SIB; Female IP, SIB $X^2(3) = 7.88$, $p > .05$

the siblings, ($X^2(1)= 2.21$, $p > .05$). The association between gender and child status was also not significant when both child groups (identified patients, siblings) were compared ($X^2(3) = 5.73$, $p > .05$). The association between gender of the child and social desirability and undesirability for the mothers' descriptions was not significant for the identified patients ($X^2(1) = 2.93$, $p > .05$), or for the siblings, ($X^2(1) = 1.32$, $p > .05$). However, the association between gender and child status when both child groups are included is significant ($X^2(3) = 7.88$, $p > .05$).

CHAPTER IV

DISCUSSION

Summary of Findings

The first hypothesis was tested using the study's method of assessing projective identification. The hypothesis that the identified patients would be the recipients of a greater number of projected traits from their parents than the siblings was not supported. The identified patients were the recipients of a greater number of projected traits than the siblings from both parents, but the difference was not statistically significant. The 11 fathers projected significantly more traits than the 11 mothers onto both groups of children.

The first hypothesis further stated that the identified patients would more often identify with the projected traits from their parents than would the siblings. This hypothesis received mixed support; the patients did identify with a significant number of the traits projected onto them by both their fathers and mothers, but the siblings also identified with a significant number of the traits projected onto them by their fathers.

The third part of the first hypothesis stated that the content of the traits projected by the two parents onto the identified patients would be more socially undesirable then the content of the traits projected by the two parents onto the siblings. This hypothesis was not supported, and in fact, the opposite finding was obtained; the 11 fathers and 11 mothers projected a significantly greater number of socially desirable traits onto

the identified patients than the siblings.

The second hypothesis was tested using the total pool of 128 ICL traits that the parents endorsed to describe themselves and their children. The hypothesis that the parents would show greater agreement in their description of the identified patients than the siblings was not supported. The parents agreed more often in their descriptions of the identified patients than the siblings, but the difference was not statistically significant.

The results do not support the possibility that the sex of the children influenced the fathers' projection of socially undesirable traits. However, gender may have played some role in the mothers' perception of some traits as socially undesirable when expressed by their children.

Implications of Findings

The method of determining projected traits required that the traits which one parent disowned must be attributed to that parent by his or her spouse. Therefore, the fathers disowned more qualities which their spouses said applied to them than the mothers did. This finding may indicate that the fathers are less accurate appraisers of themselves than the mothers. In any case, it demonstrates that the mothers describe themselves more like their spouses also describe them, and the fathers descibe themselves less like their spouses also describe them. In addition, the fathers describe their children as embodying those same traits that they and their spouses disagree on as aspects of the fathers.

The interpretation of this finding must take into consideration the questionable accuracy with which parents describe themselves, each other

and their children, and their children describe themselves. Since the family members were not rated by an observer outside of the family system, the findings must be interpreted with the proviso that whether or not the ratings are "accurate," they do reflect the parents' and childrens' descriptions of themselves and each other, thus they are meaningful within the context of the family system. Watzlawick et al, in their study of scapegoating in families with an identified patient, addressed this issue and concluded that, ". . .it seems we are stuck with measuring both interpersonal perception and intentional distortion as one. Further reflection makes it clear that the two are not really ever conceptually distinct usual clinical discussions of 'scapegoating' or 'defense' (1970, p. 38)."

Given this proviso, the fact that the fathers describe their children as embodying a greater number of their disowned traits suggests that the father's descriptions of their children are determined more by how they need to see the children, i.e., viewed through the lens of what they project onto their children, rather than being based upon a realistic assessment of the children. This conclusion is in line with Zinner and Shapiro (1972, 1974) assertions that parents' distorted images of their children, i.e., perceptions influenced by projection, serve defensive purposes, ". . .and, as such, the parent is strongly motivated to sustain these perceptions of the adolescent regardless of the adolescent's behavior which might otherwise alter the parental image (1972, p. 524)."

The patient-children identified with a significant number of the traits that both of their parents projected onto them. The siblings also identified with a significant number of the traits their fathers projected

onto them, but not their mothers. Thus, the hypothesis was not supported that the patients would identify with a greater number of the traits their parents projected onto them than the siblings. The results of the present study indicate that both children identify with the projections from their parents, particularly from their fathers. This finding affirms that the identified patient is not the only child who identifies with the parents' projections onto him or her.

The surprising finding is that both parents projected significantly more socially desirable than undesirable traits onto the identified patients. Based upon the theories of Zinner & Shapiro (1972,1974) and Vogel & Bell (1968), it was hypothesized that the parents would project primarily socially undesirable traits onto the identified patients. Zinner & Shapiro and Vogel & Bell describe conflictual parent-child relationships in which one of the children is identified as a problem child. These authors focus on the parents' role in the relationship with their child. They state that the parents need to see their child in a certain way to fit their needs, which may or may not lead to an accurate appraisal of their child. Specifically, the parents project their disowned traits onto the child. The child identifies with the projection; then, he begins to act in a manner which conforms to the parents' projection. This theory predicts that parents project onto their children undesirable qualities which they cannot acknowledge in themselves and which they will be critical of in their children. Thus, the results indicate a significant finding which is the opposite of what was expected.

There are two possible explanations for these findings. First, it is possible that the parents do not view the traits they projected onto

their children as positive, even if they are generally considered socially desirable by others. Individuals have idiosyncratic values which may not correspond with the values of the culture at large, and it may be that the fathers do not share the view that the projected traits are desirable. In this case, the children become who their parents unconsciously need them to be, even if it is not what they consciously want their children to be. If this is true, these results may support the theories proposed by Zinner & Shapiro and Vogel & Bell; the fathers, and to a lesser degree the mothers, are projecting what they consider to be undesirable traits onto the child, despite the cultural view that these traits are desirable.

An alternative explanation of the findings does not conform to the theoretical expectations of scapegoating (Vogel and Bell, 1968) and parental defensive deliniations (Zinner & Shapiro, 1972, 1974). It is possible that the present method of assessing projective identification revealed a component of parent-child relations which has been under-appreciated in the clinical literature to date, e.g., that parents project desirable traits onto their children as well as undesirable ones. Parent-child relationships, and other intimate dyadic relationships, involve a complex interplay of affective responses between two individuals. These findings indicate that parents unconsciously communicate their positive regard for their children, as well as their negative feelings toward their children. It seems that affects which cannot be expressed directly to their children are communicated unconsciously through projection, whether they are desirable or undesirable. It may be that the fathers in this study have difficulty directly expressing their positive emotions for the identified patients, and that they are more able to directly express their

criticism of them.

In contrast to the father's projection of socially desirable traits onto the identified patients, the data suggest that the father's overall description of the patients is socially undesirable. Using all 128 items from the ICL, instead of the subset of projected traits, the fathers described the identified patients in socially undesirable octants in a majority of cases (73%). In addition, in contrast to the father's slightly greater projection of socially undesirable traits onto the siblings, the data suggest that the fathers overall description of the siblings was socially desirable. The fathers described the majority of the siblings in socially desirable octants (64%). Thus, the father's described the identified patients as behaving in a socially undesirable manner, yet projected socially desirable traits onto them. Conversely, the fathers described the siblings as behaving in a socially desirable manner, yet they projected slightly more undesirable than desirable traits onto them. This paradox can also be explained by the same interpretations suggested to account for the father's projection of socially desirable traits onto the children.

Using the first interpretation, the fathers induce the identified patients to enact traits which they cannot acknowledge in themselves, then they are critical of their children for expressing them, i.e., the children become what the parents need them to be, but not what the parents want them to be. The fathers do not think the projected traits are positive, and that view is consistent with their overall description of the identified patients. The alternative explanation suggests that the fathers, and to a lesser extent, the mothers, project what they cannot

speak directly. The parents experience both positive and negative feelings toward their children, but it seems they have difficulty communicating both emotions. These findings suggest that whichever emotion the fathers express directly, they express its complement indirectly through projection. Therefore, the fathers project positive traits onto the identified patients whom they describe overall in socially undesirable terms, and they project slightly more undesirable than desirable traits onto the siblings whom they describe overall in socially desirable terms.

Contributions of the Study

Projective identification is a useful and often-used psychoanalytic construct which has not been previously subjected to empirical investigation. A thorough review of the literature revealed that no other viable method of measuring projective identification exists. The present study is an exploratory attempt to develop a method to assess projective identification.

The method of assessing of projective identification proposed by the present study attempts to operationalize Ogden's (1979) theoretical definition of the construct. Ogden's three steps of intrapsychic and interpersonal exchange are translated into the three operational steps: define the projected traits; identify the recipient of the projection; determine if the recipient identifies with the projected traits. As noted earlier, two aspects of Ogden's definition cannot be directly assessed by this method: (1) unconscious functioning resulting in projection and (2) change in the recipient as a consequence of the projection. Thus, an attempt is made to render a valuable psychoanalytic concept empirically

assessible, but the complexity of the construct makes it difficult to do complete justice to the concept at this exploratory stage in the research process.

The proposed method measures the intrapsychic and interpersonal aspects of projective identification in the context of the relationship in which it operates. Consequently, both members of the dyad involved in the projection identification complete the assessment instrument. The measure is applicable for use with any combination of dyads, including parent-child, husband-wife, even therapist-client.

The proposed method of assessing projective identification utilizes a previously developed questionnaire, the Interpersonal Checklist, which is normed for use with a clinical population, and already familiar to many clinicians. The body of literature describing the ICL and the Leary System provides an accessible method to interprete the clinical significance of the traits identified with the projective identification scoring system.

The method of assessing projective identification relies upon a simple sequence of "AND" statements. The logic rules for using AND statements appear in Figure 3 in the Methods section of the present study. The AND statements may be readily translated into any computer programing language as "If, then. . ." statements. Consequently, this method of assessing projective identification is replicable for other researchers.

Limitations of the Study

The sample size of 11 families was too small to find statistical significance where slight differences existed. The method of assessing projective identification proposed by the study narrows the subset of

endorsed items. Only a small number of items make it all the way through the three-step analysis. With this shrinking number of items, floor effects may be encountered in some samples, i.e., the numbers are so low that differences cannot be detected. In the present study, a floor effect was obtained due to a low endorsement rate of items by some families.

The sample for the present study was heterogenous in terms of treatment setting, psychiatric diagnosis, and stage in treatment. Sample heterogeneity usually increases the generalizability of the results to a wider segment of the population. However, the method of assessing projective identification proposed by this study is a new measure. The method may need to be tested on a more homogenous sample before being considered a robust test of projective identification for use with a heterogenous sample.

The method is proposed as an exploratory attempt to operationalize the construct of projective identification with acknowlegment of its limitations. The present method is limited in its ability to measure intrapsychic functioning, in particular the unconscious mental activity of projection. The method is also not able to measure change as it occurs in the projector or recipient as a result of projective identification. Thus, the method cannot show that projective identification is the causitive factor in the child's endorsement of traits which correspond to traits which the parent's might project onto that child.

Suggestions for Future Research

The proposed method of assessing projective identification needs further validation. The findings of the present study, while in the proposed direction, were not statistically significant. This finding

raises two questions which could be further investigated through future research. First, it is possible that the operational defintion is not an accurate method to assess projective identification in all its complexity. Second, it is possible that the construct does not exist as defined and that some other factor, or factors, in the parent-child relationship are responsible for the findings.

The data collection difficulties of the present study could be surmounted by a long-term data collection policy and by a closer affiliation with a treatment agency, or some other human service organization. A clinician who has direct access to a patient population would not encounter the difficulty posed to the present study in getting other therapists to screen families for participation.

In addition, a clinician involved in data collection could provide a more objective view of the family. In the first step of the three step operational definition of projective identification the spouses serve as a "validity check" for each other. In other words, the subset of "possible projected traits" consists of those traits which one parent disowns, and the other parent says applies to their spouse. This step assumes that the spouse is a valid judge of the other parent. A clinician doing research with families being seen in treatment would be able to provide an additional validity check based on her knowledge of the family members. This could be accomplished by the clinician also completing the ICL to describe each of the family members, or each member of the dyad.

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APPENDIXES

APPENDIX A: INTERPERSONAL CHECKLIST

Family #: _____
Circle 1 of the following descriptors to identify your family position: father (step-father); mother (step-mother); adolescent in treatment; sibling not in treatment
Your age: _____

THE INTERPERSONAL CHECKLIST - REVISED FORM

In SECTION ONE, please check all the adjectives/phrases which describe YOU. Leave blank those adjectives/phrases which do not describe you.

SECTION ONE:

I.

[ ]	well thought of	[ ]	often admired
[ ]	always giving advice	[ ]	tries to be too successful
[ ]	makes a good impression	[ ]	respected by others
[ ]	expects everyone to admire him/her	[ ]	acts important
[ ]	able to give orders	[ ]	good leader
[ ]	bossy	[ ]	manages others
[ ]	forceful	[ ]	likes responsibility
[ ]	dominating	[ ]	dictatorial

II.

[ ]	self-respecting	[ ]	self-confident
[ ]	boastful	[ ]	somewhat snobbish
[ ]	independent	[ ]	self-reliant & assertive
[ ]	proud & self-satisfied	[ ]	egotistical & conceited
[ ]	able to take care of self	[ ]	businesslike
[ ]	thinks only of self	[ ]	selfish
[ ]	can be indifferent to others	[ ]	likes to compete with others
[ ]	shrewd & calculating	[ ]	cold & unfeeling

SELF - Page 2

III.

[ ]	can be strict if necessary	[ ]	hard-boiled when necessary
[ ]	impatient with others' mistakes	[ ]	sarcastic
[ ]	firm but just	[ ]	stern but fair
[ ]	self-seeking	[ ]	cruel & unkind
[ ]	can be frank & honest	[ ]	irritable
[ ]	outspoken	[ ]	frequently angry
[ ]	critical of others	[ ]	straightforward & direct
[ ]	often unfriendly	[ ]	hard-hearted

IV.

[ ]	can complain if necessary	[ ]	resents being bossed
[ ]	bitter	[ ]	resentful
[ ]	often gloomy	[ ]	skeptical
[ ]	complaining	[ ]	rebels against everything
[ ]	able to doubt others	[ ]	hard to impress
[ ]	jealous	[ ]	stubborn
[ ]	frequently disappointed	[ ]	touchy & easily hurt
[ ]	slow to forgive wrong	[ ]	distrusts everybody

V.

[ ]	able to criticize self	[ ]	easily embarrassed
[ ]	self-punishing	[ ]	timid
[ ]	apologetic	[ ]	lacks self-confidence
[ ]	shy	[ ]	always ashamed of self
[ ]	can be obedient	[ ]	easily led
[ ]	passive & unaggressive	[ ]	obeys too willingly
[ ]	usually gives in	[ ]	modest
[ ]	meek	[ ]	spineless

SELF - Page 3

VI.

[ ]	grateful	[ ]	often helped by others
[ ]	dependent	[ ]	hardly ever talks back
[ ]	admires & imitates others	[ ]	very respectful to authority
[ ]	wants to be led	[ ]	clinging vine
[ ]	appreciative	[ ]	accepts advice readily
[ ]	lets others make decisions	[ ]	likes to be taken care of
[ ]	easily fooled	[ ]	trusting & eager to please
[ ]	anxious to be approved of	[ ]	will believe anyone

VII.

[ ]	cooperative	[ ]	always pleasant & agreeable
[ ]	too easily influenced by others	[ ]	wants everyone's love
[ ]	will confide in anyone	[ ]	eager to get along with others
[ ]	agrees with everyone	[ ]	wants everyone to like him/her
[ ]	fond of everyone	[ ]	friendly all the time
[ ]	friendly	[ ]	sociable & neighborly
[ ]	likes everyone	[ ]	loves everyone
[ ]	affectionate and understanding	[ ]	warm

VIII.

[ ]	considerate	[ ]	kind & reassuring
[ ]	forgives anything	[ ]	too lenient with others
[ ]	encourages others	[ ]	tender & soft-hearted
[ ]	over-sympathetic	[ ]	tries to comfort everyone
[ ]	helpful	[ ]	enjoys taking care of others
[ ]	generous to a fault	[ ]	too willing to give to others
[ ]	big-hearted & unselfish	[ ]	gives freely of self
[ ]	over-protective of others	[ ]	spoils people with kindness

Family #: _____
Circle 1 of the following descriptors to identify your family position: father (step-father); mother (step-mother); adolescent in treatment; sibling not in treatment
Your age: ____

THE INTERPERSONAL CHECKLIST - REVISED FORM

In SECTION TWO, please check all the adjectives/phrases which describe YOUR SPOUSE if you are a parent, OR YOUR FATHER if you are a child. Leave blank those adjectives/phrases which do not describe your spouse (or father).

SECTION TWO:

I.

[ ]	well thought of	[ ]	often admired
[ ]	always giving advice	[ ]	tries to be too successful
[ ]	makes a good impression	[ ]	respected by others
[ ]	expects everyone to admire him/her	[ ]	acts important
[ ]	able to give orders	[ ]	good leader
[ ]	bossy	[ ]	manages others
[ ]	forceful	[ ]	likes responsibility
[ ]	dominating	[ ]	dictatorial

II.

[ ]	self-respecting	[ ]	self-confident
[ ]	boastful	[ ]	somewhat snobbish
[ ]	independent	[ ]	self-reliant & assertive
[ ]	proud & self-satisfied	[ ]	egotistical & conceited
[ ]	able to take care of self	[ ]	businesslike
[ ]	thinks only of self	[ ]	selfish
[ ]	can be indifferent to others	[ ]	likes to compete with others
[ ]	shrewd & calculating	[ ]	cold & unfeeling

SPOUSE or FATHER - Page 2

III.

[ ]	can be strict if necessary	[ ]	hard-boiled when necessary
[ ]	impatient with others' mistakes	[ ]	sarcastic
[ ]	firm but just	[ ]	stern but fair
[ ]	self-seeking	[ ]	cruel & unkind
[ ]	can be frank & honest	[ ]	irritable
[ ]	outspoken	[ ]	frequently angry
[ ]	critical of others	[ ]	straightforward & direct
[ ]	often unfriendly	[ ]	hard-hearted

IV.

[ ]	can complain if necessary	[ ]	resents being bossed
[ ]	bitter	[ ]	resentful
[ ]	often gloomy	[ ]	skeptical
[ ]	complaining	[ ]	rebels against everything
[ ]	able to doubt others	[ ]	hard to impress
[ ]	jealous	[ ]	stubborn
[ ]	frequently disappointed	[ ]	touchy & easily hurt
[ ]	slow to forgive wrong	[ ]	distrusts everybody

V.

[ ]	able to criticize self	[ ]	easily embarrassed
[ ]	self-punishing	[ ]	timid
[ ]	apologetic	[ ]	lacks self-confidence
[ ]	shy	[ ]	always ashamed of self
[ ]	can be obedient	[ ]	easily led
[ ]	passive & unaggressive	[ ]	obeys too willingly
[ ]	usually gives in	[ ]	modest
[ ]	meek	[ ]	spineless

SPOUSE or FATHER - Page 3

VI.

[ ]	grateful	[ ]	often helped by others
[ ]	dependent	[ ]	hardly ever talks back
[ ]	admires & imitates others	[ ]	very respectful to authority
[ ]	wants to be led	[ ]	clinging vine
[ ]	appreciative	[ ]	accepts advice readily
[ ]	lets others make decisions	[ ]	likes to be taken care of
[ ]	easily fooled	[ ]	trusting & eager to please
[ ]	anxious to be approved of	[ ]	will believe anyone

VII.

[ ]	cooperative	[ ]	always pleasant & agreeable
[ ]	too easily influenced by others	[ ]	wants everyone's love
[ ]	will confide in anyone	[ ]	eager to get along with others
[ ]	agrees with everyone	[ ]	wants everyone to like him/her
[ ]	fond of everyone	[ ]	friendly all the time
[ ]	friendly	[ ]	sociable & neighborly
[ ]	likes everyone	[ ]	loves everyone
[ ]	affectionate and understanding	[ ]	warm

VIII.

[ ]	considerate	[ ]	kind & reassuring
[ ]	forgives anything	[ ]	too lenient with others
[ ]	encourages others	[ ]	tender & soft-hearted
[ ]	over-sympathetic	[ ]	tries to comfort everyone
[ ]	helpful	[ ]	enjoys taking care of others
[ ]	generous to a fault	[ ]	too willing to give to others
[ ]	big-hearted & unselfish	[ ]	gives freely of self
[ ]	over-protective of others	[ ]	spoils people with kindness

Family #: _____
Circle 1 of the following descriptors to identify your family position: father (step-father); mother (step-mother); adolescent in treatment; sibling not in treatment

THE INTERPERSONAL CHECKLIST - REVISED FORM

In SECTION THREE, please check all the adjectives/phrases which describe the ADOLESCENT IN TREATMENT -OR- if that is you, please describe YOUR MOTHER. Leave blank those adjectives/phrases which do not describe the adolescent in treatment (or your mother).

SECTION THREE:

I.

[ ]	well thought of	[ ]	often admired
[ ]	always giving advice	[ ]	tries to be too successful
[ ]	makes a good impression	[ ]	respected by others
[ ]	expects everyone to admire him/her	[ ]	acts important
[ ]	able to give orders	[ ]	good leader
[ ]	bossy	[ ]	manages others
[ ]	forceful	[ ]	likes responsibility
[ ]	dominating	[ ]	dictatorial

II.

[ ]	self-respecting	[ ]	self-confident
[ ]	boastful	[ ]	somewhat snobbish
[ ]	independent	[ ]	self-reliant & assertive
[ ]	proud & self-satisfied	[ ]	egotistical & conceited
[ ]	able to take care of self	[ ]	businesslike
[ ]	thinks only of self	[ ]	selfish
[ ]	can be indifferent to others	[ ]	likes to compete with others
[ ]	shrewd & calculating	[ ]	cold & unfeeling

ADOLESCENT IN TREATMENT or MOTHER - Page 2

III.

[ ]	can be strict if necessary	[ ]	hard-boiled when necessary
[ ]	impatient with others' mistakes	[ ]	sarcastic
[ ]	firm but just	[ ]	stern but fair
[ ]	self-seeking	[ ]	cruel & unkind
[ ]	can be frank & honest	[ ]	irritable
[ ]	outspoken	[ ]	frequently angry
[ ]	critical of others	[ ]	straightforward & direct
[ ]	often unfriendly	[ ]	hard-hearted

IV.

[ ]	can complain if necessary	[ ]	resents being bossed
[ ]	bitter	[ ]	resentful
[ ]	often gloomy	[ ]	skeptical
[ ]	complaining	[ ]	rebels against everything
[ ]	able to doubt others	[ ]	hard to impress
[ ]	jealous	[ ]	stubborn
[ ]	frequently disappointed	[ ]	touchy & easily hurt
[ ]	slow to forgive wrong	[ ]	distrusts everybody

V.

[ ]	able to criticize self	[ ]	easily embarrassed
[ ]	self-punishing	[ ]	timid
[ ]	apologetic	[ ]	lacks self-confidence
[ ]	shy	[ ]	always ashamed of self
[ ]	can be obedient	[ ]	easily led
[ ]	passive & unaggressive	[ ]	obeys too willingly
[ ]	usually gives in	[ ]	modest
[ ]	meek	[ ]	spineless

ADOLESCENT IN TREATMENT or MOTHER - Page 3

VI.

[ ]	grateful	[ ]	often helped by others
[ ]	dependent	[ ]	hardly ever talks back
[ ]	admires & imitates others	[ ]	very respectful to authority
[ ]	wants to be led	[ ]	clinging vine
[ ]	appreciative	[ ]	accepts advice readily
[ ]	lets others make decisions	[ ]	likes to be taken care of
[ ]	easily fooled	[ ]	trusting & eager to please
[ ]	anxious to be approved of	[ ]	will believe anyone

VII.

[ ]	cooperative	[ ]	always pleasant & agreeable
[ ]	too easily influenced by others	[ ]	wants everyone's love
[ ]	will confide in anyone	[ ]	eager to get along with others
[ ]	agrees with everyone	[ ]	wants everyone to like him/her
[ ]	fond of everyone	[ ]	friendly all the time
[ ]	friendly	[ ]	sociable & neighborly
[ ]	likes everyone	[ ]	loves everyone
[ ]	affectionate and understanding	[ ]	warm

VIII.

[ ]	considerate	[ ]	kind & reassuring
[ ]	forgives anything	[ ]	too lenient with others
[ ]	encourages others	[ ]	tender & soft-hearted
[ ]	over-sympathetic	[ ]	tries to comfort everyone
[ ]	helpful	[ ]	enjoys taking care of others
[ ]	generous to a fault	[ ]	too willing to give to others
[ ]	big-hearted & unselfish	[ ]	gives freely of self
[ ]	over-protective of others	[ ]	spoils people with kindness

Family #: _____
Circle 1 of the following descriptors to identify your family position: father (step-father); mother (step-mother); adolescent in treatment; sibling not in treatment

THE INTERPERSONAL CHECKLIST - REVISED FORM

In SECTION FOUR, please check the adjectives/phrases which describe the SIBLING NOT IN TREATMENT -OR- if that is YOU, please describe YOUR MOTHER. Leave blank the adjectives/phrases which do not describe the sibling not in treatment (or your mother).

SECTION FOUR:

I.

[ ]	well thought of	[ ]	often admired
[ ]	always giving advice	[ ]	tries to be too successful
[ ]	makes a good impression	[ ]	respected by others
[ ]	expects everyone to admire him/her	[ ]	acts important
[ ]	able to give orders	[ ]	good leader
[ ]	bossy	[ ]	manages others
[ ]	forceful	[ ]	likes responsibility
[ ]	dominating	[ ]	dictatorial

II.

[ ]	self-respecting	[ ]	self-confident
[ ]	boastful	[ ]	somewhat snobbish
[ ]	independent	[ ]	self-reliant & assertive
[ ]	proud & self-satisfied	[ ]	egotistical & conceited
[ ]	able to take care of self	[ ]	businesslike
[ ]	thinks only of self	[ ]	selfish
[ ]	can be indifferent to others	[ ]	likes to compete with others
[ ]	shrewd & calculating	[ ]	cold & unfeeling

SIBLING NOT IN TREATMENT or MOTHER - Page 2

III.

[ ]	can be strict if necessary	[ ]	hard-boiled when necessary
[ ]	impatient with others' mistakes	[ ]	sarcastic
[ ]	firm but just	[ ]	stern but fair
[ ]	self-seeking	[ ]	cruel & unkind
[ ]	can be frank & honest	[ ]	irritable
[ ]	outspoken	[ ]	frequently angry
[ ]	critical of others	[ ]	straightforward & direct
[ ]	often unfriendly	[ ]	hard-hearted

IV.

[ ]	can complain if necessary	[ ]	resents being bossed
[ ]	bitter	[ ]	resentful
[ ]	often gloomy	[ ]	skeptical
[ ]	complaining	[ ]	rebels against everything
[ ]	able to doubt others	[ ]	hard to impress
[ ]	jealous	[ ]	stubborn
[ ]	frequently disappointed	[ ]	touchy & easily hurt
[ ]	slow to forgive wrong	[ ]	distrusts everybody

V.

[ ]	able to criticize self	[ ]	easily embarrassed
[ ]	self-punishing	[ ]	timid
[ ]	apologetic	[ ]	lacks self-confidence
[ ]	shy	[ ]	always ashamed of self
[ ]	can be obedient	[ ]	easily led
[ ]	passive & unaggressive	[ ]	obeys too willingly
[ ]	usually gives in	[ ]	modest
[ ]	meek	[ ]	spineless

SIBLING NOT IN TREATMENT or MOTHER - Page 3

VI.

[ ]	grateful	[ ]	often helped by others
[ ]	dependent	[ ]	hardly ever talks back
[ ]	admires & imitates others	[ ]	very respectful to authority
[ ]	wants to be led	[ ]	clinging vine
[ ]	appreciative	[ ]	accepts advice readily
[ ]	lets others make decisions	[ ]	likes to be taken care of
[ ]	easily fooled	[ ]	trusting & eager to please
[ ]	anxious to be approved of	[ ]	will believe anyone

VII.

[ ]	cooperative	[ ]	always pleasant & agreeable
[ ]	too easily influenced by others	[ ]	wants everyone's love
[ ]	will confide in anyone	[ ]	eager to get along with others
[ ]	agrees with everyone	[ ]	wants everyone to like him/her
[ ]	fond of everyone	[ ]	friendly all the time
[ ]	friendly	[ ]	sociable & neighborly
[ ]	likes everyone	[ ]	loves everyone
[ ]	affectionate and understanding	[ ]	warm

VIII.

[ ]	considerate	[ ]	kind & reassuring
[ ]	forgives anything	[ ]	too lenient with others
[ ]	encourages others	[ ]	tender & soft-hearted
[ ]	over-sympathetic	[ ]	tries to comfort everyone
[ ]	helpful	[ ]	enjoys taking care of others
[ ]	generous to a fault	[ ]	too willing to give to others
[ ]	big-hearted & unselfish	[ ]	gives freely of self
[ ]	over-protective of others	[ ]	spoils people with kindness

Family #: _____
Circle 1 of the following descriptors to identify your family position: father (step-father); mother (step-mother); adolescent in treatment; sibling not in treatment

THE INTERPERSONAL CHECKLIST - REVISED FORM

In SECTION FIVE, please check the adjectives/phrases which describe the WHO YOU ARE NOT (what you think you are not like). Leave blank the adjectives/phrases which describe you as you think you are.

SECTION FIVE:

I.

[ ]	well thought of	[ ]	often admired
[ ]	always giving advice	[ ]	tries to be too successful
[ ]	makes a good impression	[ ]	respected by others
[ ]	expects everyone to admire him/her	[ ]	acts important
[ ]	able to give orders	[ ]	good leader
[ ]	bossy	[ ]	manages others
[ ]	forceful	[ ]	likes responsibility
[ ]	dominating	[ ]	dictatorial

II.

[ ]	self-respecting	[ ]	self-confident
[ ]	boastful	[ ]	somewhat snobbish
[ ]	independent	[ ]	self-reliant & assertive
[ ]	proud & self-satisfied	[ ]	egotistical & conceited
[ ]	able to take care of self	[ ]	businesslike
[ ]	thinks only of self	[ ]	selfish
[ ]	can be indifferent to others	[ ]	likes to compete with others
[ ]	shrewd & calculating	[ ]	cold & unfeeling

WHO YOU ARE NOT - Page 2

III.

[ ]	can be strict if necessary	[ ]	hard-boiled when necessary
[ ]	impatient with others' mistakes	[ ]	sarcastic
[ ]	firm but just	[ ]	stern but fair
[ ]	self-seeking	[ ]	cruel & unkind
[ ]	can be frank & honest	[ ]	irritable
[ ]	outspoken	[ ]	frequently angry
[ ]	critical of others	[ ]	straightforward & direct
[ ]	often unfriendly	[ ]	hard-hearted

IV.

[ ]	can complain if necessary	[ ]	resents being bossed
[ ]	bitter	[ ]	resentful
[ ]	often gloomy	[ ]	skeptical
[ ]	complaining	[ ]	rebels against everything
[ ]	able to doubt others	[ ]	hard to impress
[ ]	jealous	[ ]	stubborn
[ ]	frequently disappointed	[ ]	touchy & easily hurt
[ ]	slow to forgive wrong	[ ]	distrusts everybody

V.

[ ]	able to criticize self	[ ]	easily embarrassed
[ ]	self-punishing	[ ]	timid
[ ]	apologetic	[ ]	lacks self-confidence
[ ]	shy	[ ]	always ashamed of self
[ ]	can be obedient	[ ]	easily led
[ ]	passive & unaggressive	[ ]	obeys too willingly
[ ]	usually gives in	[ ]	modest
[ ]	meek	[ ]	spineless

WHO YOU ARE NOT - Page 3

VI.

[ ] grateful
[ ] dependent
[ ] admires & imitates others
[ ] wants to be led
[ ] appreciative
[ ] lets others make decisions
[ ] easily fooled
[ ] anxious to be approved of

[ ] often helped by others
[ ] hardly ever talks back
[ ] very respectful to authority
[ ] clinging vine
[ ] accepts advice readily
[ ] likes to be taken care of
[ ] trusting & eager to please
[ ] will believe anyone

VII.

[ ] cooperative
[ ] too easily influenced by others
[ ] will confide in anyone
[ ] agrees with everyone
[ ] fond of everyone
[ ] friendly
[ ] likes everyone
[ ] affectionate and understanding

[ ] always pleasant & agreeable
[ ] wants everyone's love
[ ] eager to get along with others
[ ] wants everyone to like him/her
[ ] friendly all the time
[ ] sociable & neighborly
[ ] loves everyone
[ ] warm

VIII.

[ ] considerate
[ ] forgives anything
[ ] encourages others
[ ] over-sympathetic
[ ] helpful
[ ] generous to a fault
[ ] big-hearted & unselfish
[ ] over-protective of others

[ ] kind & reassuring
[ ] too lenient with others
[ ] tender & soft-hearted
[ ] tries to comfort everyone
[ ] enjoys taking care of others
[ ] too willing to give to others
[ ] gives freely of self
[ ] spoils people with kindness

APPENDIX B: FAMILY HISTORY QUESTIONNAIRE

Family #:_____
Circle 1 of the following descriptors to identify your family position: Father (Step-Father); Mother (Step-Mother)

FAMILY HISTORY QUESTIONNAIRE

Part A

Please answer the following questions to describe your son or daughter who is currently in treatment.

The first section of questions asks you to describe your child as an infant and young child. The second set of questions asks you to describe your child currently.

Please circle the one adjective/phrase which best describes your child at the specified ages.

1. When my son/daughter was an infant he/she:
   a. cried alot and was difficult to comfort
   b. cried very little but was difficult to comfort when he/she did cry
   c. cried alot but was easy to comfort
   d. cried very little and was easy to comfort when he/she did cry

2. When my son/daughter was a young child he/she:
   a. was frequently ill
   b. was frequently ill and required medical treatment or medical hospitalization
   c. was rarely ill
   d. was rarely ill but once or twice required medical treatment or medical hospitalization

3. When my son/daughter was a young child he/she:
   a. often was hurt from accidents
   b. rarely was hurt from accidents

Part B

1. My son/daughter currently:
   a. does not argue with me, and does what I say to do
   b. argues with me, but eventually does what I say to do
   c. does not argue with me, yet does not do what I say to do
   d. argues with me, and does not do what I say to do

2. My son/daughter currently:
   a. is well behaved, and does not get into trouble outside of the home
   b. is well behaved, yet still gets into trouble outside of the home
   c. misbehaves, yet does not get into trouble outside of the

home
d. misbehaves, and gets into trouble outside of the home

3. My son/daughter's school performance:
   a. is about the same as it ever was
   b. has improved in the last year
   c. has gotten worse in the past year

4. My spouse and I get into fights over my son/daughter:
   a. yes
   b. no

5. My son/daughter and I have:
   a. never gotten along together
   b. gotten along fine until the past year or so
   c. get along fine together

6. My son/daughter and I talk about things that are happening in his/her personal life:
   a. yes
   b. no

7. My son/daughter and I talk about things that are happening in my personal life:
   a. yes
   b. no

Part C

Please answer the following questions to describe your son or daughter who is also participating in this study, and who is not currently in treatment.

The first section of questions asks you to describe your child as an infant and young child. The second set of questions asks you to describe your child currently.

Please circle the one adjective/phrase which best describes your child at the specified ages.

1. When my son/daughter was an infant he/she:
   a. cried alot and was difficult to comfort
   b. cried very little but was difficult to comfort when he/she did cry
   c. cried alot but was easy to comfort
   d. cried very little and was easy to comfort when he/she did cry

2. When my son/daughter was a young child he/she:
   a. was frequently ill
   b. was frequently ill and required medical treatment or medical hospitalization
   c. was rarely ill
   d. was rarely ill but once or twice required medical treatment

or medical hospitalization

3. When my son/daughter was a young child he/she:
   a. often was hurt from accidents
   b. rarely was hurt from accidents

Part D

1. My son/daughter currently:
   a. does not argue with me, and does what I say to do
   b. argues with me, but eventually does what I say to do
   c. does not argue with me, yet does not do what I say to do
   d. argues with me, and does not do what I say to do

2. My son/daughter currently:
   a. is well behaved, and does not get into trouble outside of the home
   b. is well behaved, yet still gets into trouble outside of the home
   c. misbehaves, yet does not get into trouble outside of the home
   d. misbehaves, and gets into trouble outside of the home

3. My son/daughter's school performance:
   a. is about the same as it ever was
   b. has improved in the last year
   c. has gotten worse in the past year

4. My spouse and I get into fights over my son/daughter:
   a. yes
   b. no

5. My son/daughter and I have:
   a. never gotten along together
   b. gotten along fine until the past year or so
   c. get along fine together

6. My son/daughter and I talk about things that are happening in his/her personal life:
   a. yes
   b. no

7. My son/daughter and I talk about things that are happening in my personal life:
   a. yes
   b. no

INDIVIDUAL AND FAMILY INFORMATION QUESTIONNAIRE

Part A

Please circle the one answer, or fill in the blank, with the information which best describes yourself, and when indicated, your family.

1. Your sex:
   a. male
   b. female

2. Your age:
   a. currently _____
   b. when you first married _____
   c. when your first child was born _____
   d. when your second child was born _____
   e. when your third child was born _____
   f. when your fourth child was born _____

3. What is your position in the birth order of your family of origin, e.g., first born and first female etc. _____

4. Marital status:
   a. First marriage
   b. Re-marriage #_____

5. What is your current approximate annual income (combined for both spouses):
   a. Not employed
   b. Less than $5,000
   c. $5,000 to $9,999
   d. $10,000 to $14,999
   e. $15,000 to $19,999
   f. $20,000 to $29,999
   g. $30,000 to $39,999
   h. $40,000 to $49,999
   i. $50,000 and over

6. What is the highest level of education you have completed?
   a. some grade school
   b. completed grade school
   c. some high school
   d. completed high school
   e. some training other than college (i.e., vocational)
   f. some college
   g. graduated from college
   h. some graduate work
   i. attained graduate or professional degree

Part B

7. At what age did you first drink an alcoholic drink? _____

8. At what age did you first take a non-prescription or recreational drug? _____

9. Do you think that you have a problem with drinking or drug use?
   a. yes
   b. no

10. If yes to #9, at what age did you first think you might have a problem with alcohol/drugs? _____

11. If yes to #9, at what age did your spouse first tell you he/she thought you had a problem with drinking/drugs? _____

12. Did your drinking/drug use <u>increase</u> after any of the following events?:
   a. birth of first child
   b. birth of second child
   c. birth of third or other later born children
   d. marital separation or divorce
   e. loss of a job
   f. development of a serious medical illness
   g. development of a physical injury or disability

13. Did your drinking/drug use <u>decrease</u> after any of the following events?:
   a. birth of first child
   b. birth of second child
   c. birth of third or other later born children
   d. marital separation or divorce
   e. loss of a job
   f. development of a serious medical illness
   g. development of a physical injury or disability

14. Did your spouse's drinking/drug use <u>increase</u> after any of the following events?:
   a. birth of first child
   b. birth of second child
   c. birth of third or other later born children
   d. marital separation or divorce
   e. loss of a job
   f. development of a serious medical illness
   g. development of a physical injury or disability

15. Did your spouse's drinking/drug use <u>decrease</u> after any of the following/events?:
   a. birth of first child
   b. birth of second child

c. birth of third or other later born children
d. marital separation or divorce
e. loss of a job
f. development of a serious medical illness
g. development of a physical injury or disability

16. Have you ever confronted your spouse about his/her drinking/drug use?
a. yes
b. no

17. Has your spouse ever confronted you about your drinking/drug use?
a. yes
b. no

18. Do/did any of the members of your family of origin (family you grew up in) have a problem with drinking/drug use?
a. yes
b. no

19. If yes to #18, list the individuals by kinship title (i.e., mother, father, uncle, older brother, younger sister, etc.)

a. _____ e. _____
b. _____ f. _____
c. _____ g. _____
d. _____ h. _____

20. Does your spouse remind you of any of the above listed individuals in your family or origin?
a. yes
b. no

21. If yes to #20, list that individual whom your spouse most reminds you of _____

Part C

22. Does your child who is currently in treatment remind you of any of the individuals listed in #19, or anyone else in your present nuclear family?
a. yes
b. no

23. If yes to #22, list that individual whom your chemically dependent child most reminds you of _____

24. Have you ever told your child that he/she reminds you of/is like this particular individual?
a. yes
b. no

25. Does your other child who will be participating in this study remind you of any of the individuals listed in #19, or anyone else in your present nuclear family?
    a. yes
    b. no

26. If yes to #25, list the individual whom your other child most reminds you of _____

27. Does your other child who will be participating in this study remind you of any members of your family other than the ones listed in #19?
    a. yes
    b. no

28. If yes to #27, list whom this child reminds you of (by kinship title) _____

29. Have you ever told this child that he/she reminds you of/is like this particular individual?
    a. yes
    b. no

APPENDIX C: INFORMED CONSENT FORM

INFORMED CONSENT FORM
PERMISSION FOR CLINICAL RESEARCH INVESTIGATION

TITLE: Projective Identification: The Tie that Binds

INTRODUCTION: We are asking you to decide whether you want to be a part of this study. We will describe the study below. We will also tell you the advantages of being in the study, as well as problems that might happen. If you sign this paper you are telling us that you know enough about the study to agree that you can take part in it.

1. **PURPOSE OF THE STUDY:** This study is to find out about the way family members are alike and different from each other, and what role, if any, drug and alcohol use/non-use plays in how family members see themselves as the same or different from other family members.

2. **DESCRIPTION OF THE STUDY:** Lisa C. Kaley will distribute questionnaires to four members of your family; both parents and two siblings, one of whom is currently in therapy, and one sibling who lives at home. In order to participate you will simply need to complete the questionnaires and return them. If possible, a time will be set aside for all four family members to complete the questionnaires at the same time at the therapists' office, perhaps after your family session. If it is not possible to complete the questionnaires at the office, you may take them home, but you will each need to complete them when you are alone.

For parents there are four questionnaires which ask for the following information: (1) check off adjectives from a list to describe yourself and the other three family members in the study; (2) and (3) check yes or no questions about your alcohol and drug use; (4) a combination of circle and fill in the blank questions about yourself, your spouse, your children and your family of origin. Some questions ask about substance abuse and others are more general information questions.

For adolescents only the first three questionnaires described above will be used.

3. **RISKS AND DISCOMFORTS:** The Federal Government says that you must be told of any problems that may happen because of this study. You need to understand the risks, possible problems, and discomforts that may be part of this study.

In this study the principle risk is that you are asked to think about and be willing to describe your family members, and you and your family members' use of alcohol and drugs. For some individuals this may raise uncomfortable or unpleasant feelings. Participating in the study will also require about 35 to 45 minutes of your time.

4. **BENEFITS:** No promises can be made about what may happen if you are part of this study. It is possible that this study will be of no direct benefit to you. The good that may happen is that while completing the questionnaires you may realize some things about yourself and your family which may be helpful to discuss during your/your adolescent's treatment.

5. **QUESTIONS ABOUT STUDY:** You may ask any questions you want about this study. You may address your questions to the principal investigator,

Lisa C. Kaley at The University of Tennessee Student Counseling Center, phone number 974-2196, or the Project Director at U.T., Bob Wahler, Ph.D. at 974-2161. You may also speak to your therapist about the study.

6. **CONFIDENTIALITY:** The people doing this study will keep facts about you private. Your questionnaires will be identified by a number which each family member will use, and your position in the family, i.e., mother, father, adolescent in treatment and sibling not in treatment. Your name will not be written on any of the documents, and your therapist will not see your answers. Family members will also not be allowed to see each others responses.

7. **VOLUNTARY PARTICIPATION AND OPTION TO WITHDRAW:** You are part of this study because you want to be. You may choose not to be in this study. If you do not want to be in the study, simply do not sign this consent form. You may also decide to stop participating at any time by simply not completing the questionnaires. If you do not participate in the study it will not affect your treatment.

8. **FUNDING AND COMPENSATION:** If you or your child feel you are harmed by participating in this study, your therapist can provide or refer you for psychological treatment. You will have to pay for that treatment. While you and your child are in this study you continue to have to pay for treatment.

9. **AUTHORIZATION:** I have read this paper about the study. I know what will happen, both the possible good and bad (benefits and risks). I agree to be in this study. I know I can stop being in the study and it will not affect my treatment.

I consent to be in this study. I have received a copy of this consent form.

Child Assent_____ Date:_____

I consent to be in this study, and I consent to my child being in this study.

Parent Consent_____Date:_____
/Guardian

Consent form explained by:_____Date:_____
investigator

Witness, if appropriate_____

Appendix D: Item Numbers and Octant Numbers of Traits Parents projected onto Identified Patients

Family #	Father	Mother
1	36[a]b,(I)[c], 67,(I), 95, (VIII)	None
2	29,(VIII), 45,(IV), 71, (II)	42,(III), 62,(VIII), 70,(II), 91,(VII), 95,(VIII)
3	3,(I), 44,(III), 53, (VI) 55,(VI), 62, (VIII)	83,(V), 95, (VIII), 97,(I)
4	27,(VII), 28,(VII), 29,(VIII) 31,(VIII), 63,(VIII), 67,(I)	
5	None	60,(VII)
6	1,(I) 23,(VI), 95, (VIII)	4,(I), 11,(III), 29,(VIII), 50,(V), 99,(I)
7	69,(II), 125,(VIII)	35,(I), 116,(V)
8	35,(I), 50,(V), 53,(VI) 58,(VII), 61,(VIII), 95,(VIII)	None
9	None	None
10	35, (I)	None
11	28, (VII), 60, (VII)	120, (VI), 122, (VII)

Note.

[a]Item numbers from the ICL for traits parents' projected onto the identified patients.

[b]Identified patients identified with the underlined items.

[c]The octant numbers for the traits are in (parenthesis).

Appendix E: Item Numbers and Octant Numbers of Traits Parents projected onto the Siblings

Family #	Father	Mother
1	104[a],(II)[c], 120,(VI)	35,(I)
2	45,(IV), 76,(III)	None
3	3, (I), 7,(II), 44,(III), 55,(VI)	95,(VIII), <u>97</u>[b],(I)
4	None	None
5	118,(VI)	None
6	<u>1</u>,(I), <u>5</u>,(II), <u>69</u>,(II), <u>111</u>,(IV), <u>114</u>,(V), <u>123</u>,(VII), 126,(VIII)	11,(III), 50,(V)
7	None	None
8	<u>22</u>,(VI)	<u>23</u>,(VI)
9	46,(IV)	None
10	None	None
11	60, (VII)	None

<u>Note</u>.
[a]Item numbers for traits the parents' projected onto the siblings.
[b]The siblings identified with the <u>underlined</u> traits.
[c]The octant numbers for the traits are in (parenthesis).

Table F: Parental Description of their Children by Octant Numbers

	Identified Patients		Siblings	
Family #	Mother	Father	Mother	Father
1	I	III	II	III
2	IV	IV	I	I
3	II	III	VIII	VIII
4	II	II	VII	II
5	I	III	I	I
6	VII	IV	VIII	I
7	II	IV	II	III
8	III	III	II	I
9	II	II	II	III
10	III	III	VII	VIII
11	II	II	I	III
	Total matches = 6		Total matches = 3	

Parental agreement IP, SIB $X^2(1) = 1.69$, $p > .05$

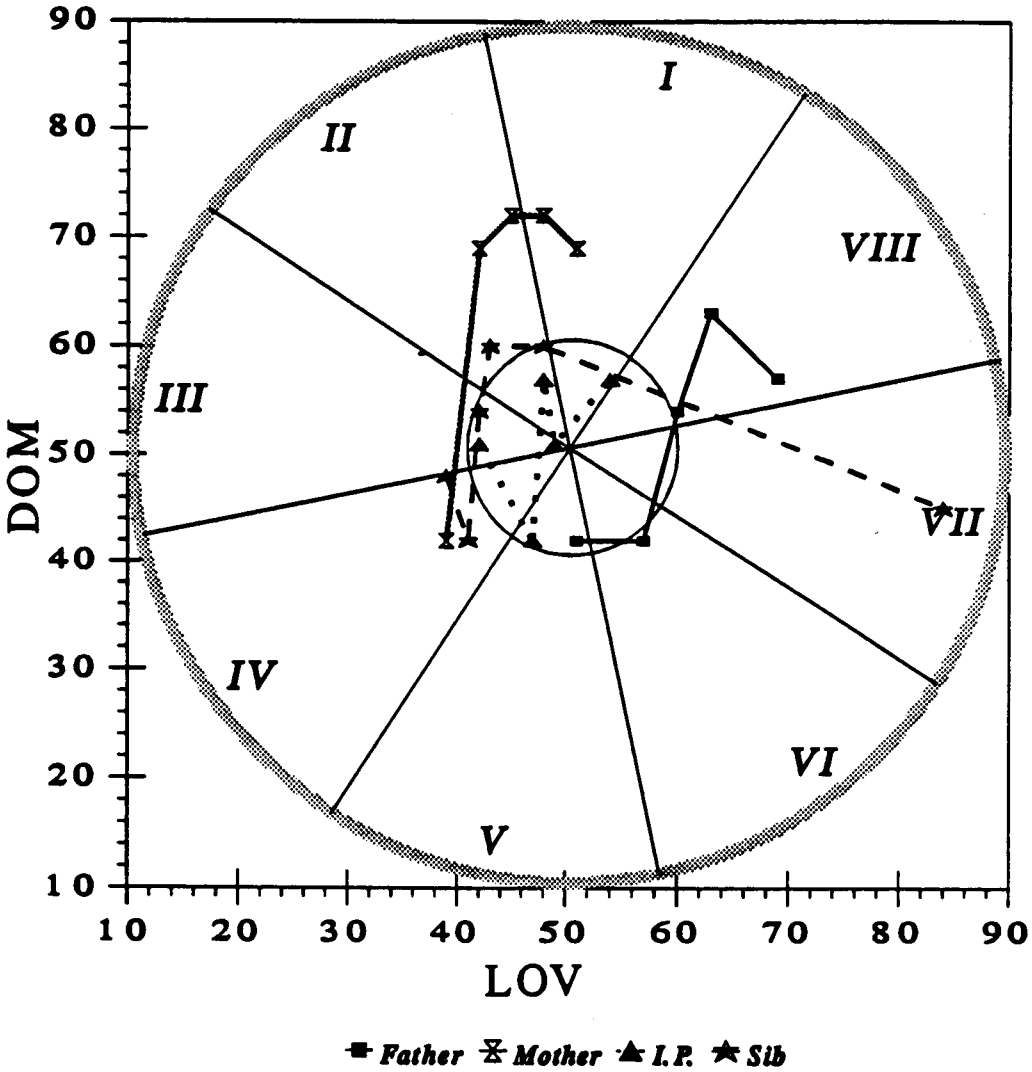
Note.

The eight octants and interpersonal styles are:

Octant #	Octant Label	Interpersonal Style
I	AP	Managerial - Autocratic
II	BC	Competitive - Narcissistic
III	DE	Aggressive - Sadistic
IV	FG	Rebellious - Distrustful
V	HI	Self-effacing - Masochistic
VI	JK	Docile - Dependent
VII	LM	Cooperative - Overemotional
VIII	NO	Responsible - Overgenerous

APPENDIX G: LEARY CIRCUMPLEX GRAPHS OF THE 11 FAMILIES

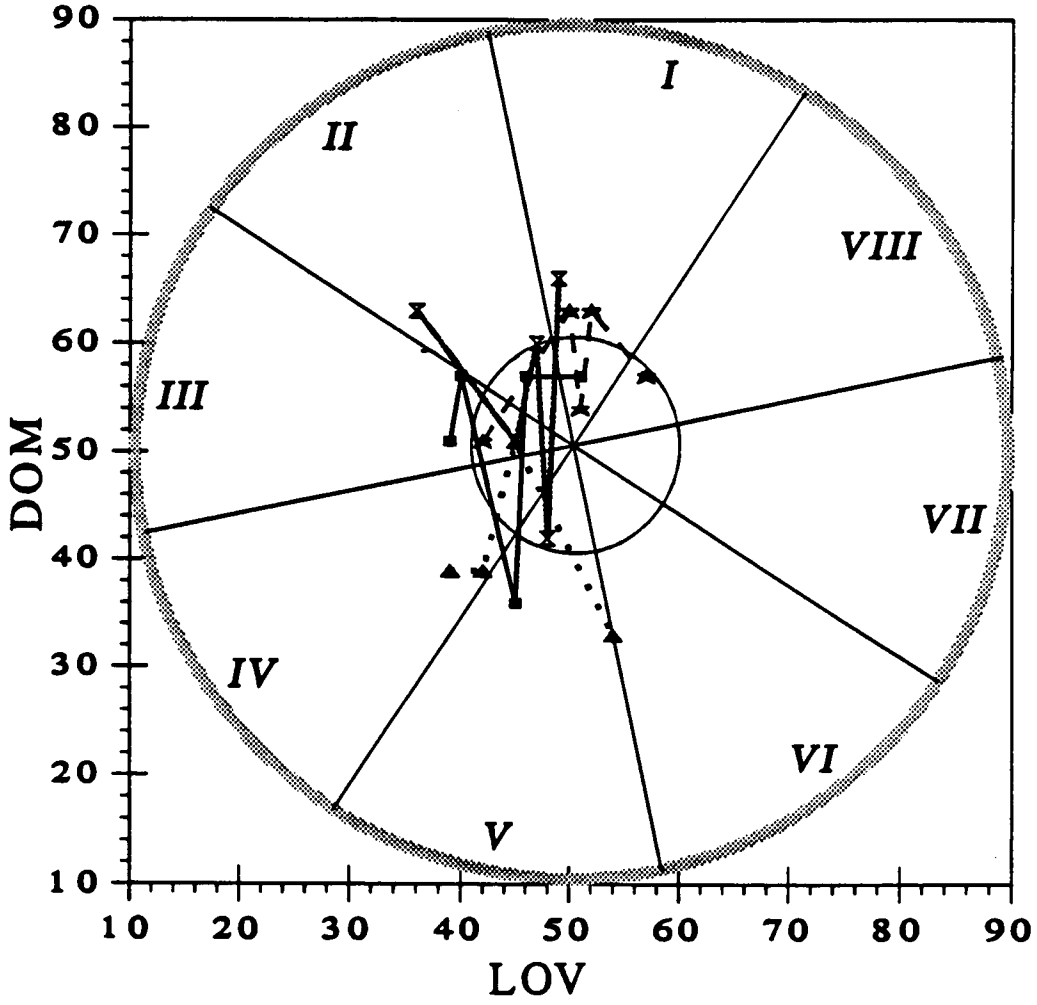
Circumplex Model of Interpersonal Assessment



I. Managerial-Autocratic
II. Competitive-Exploitive
III. Blunt-Aggressive
IV. Sceptical-Distrustful
V. Modest-Self-effacing
VI. Docile-Dependent
VII. Cooperative-Overconventional
VIII. Responsible-Overgenerous

Leary Scores for Family #1

Circumplex Model of Interpersonal Assessment

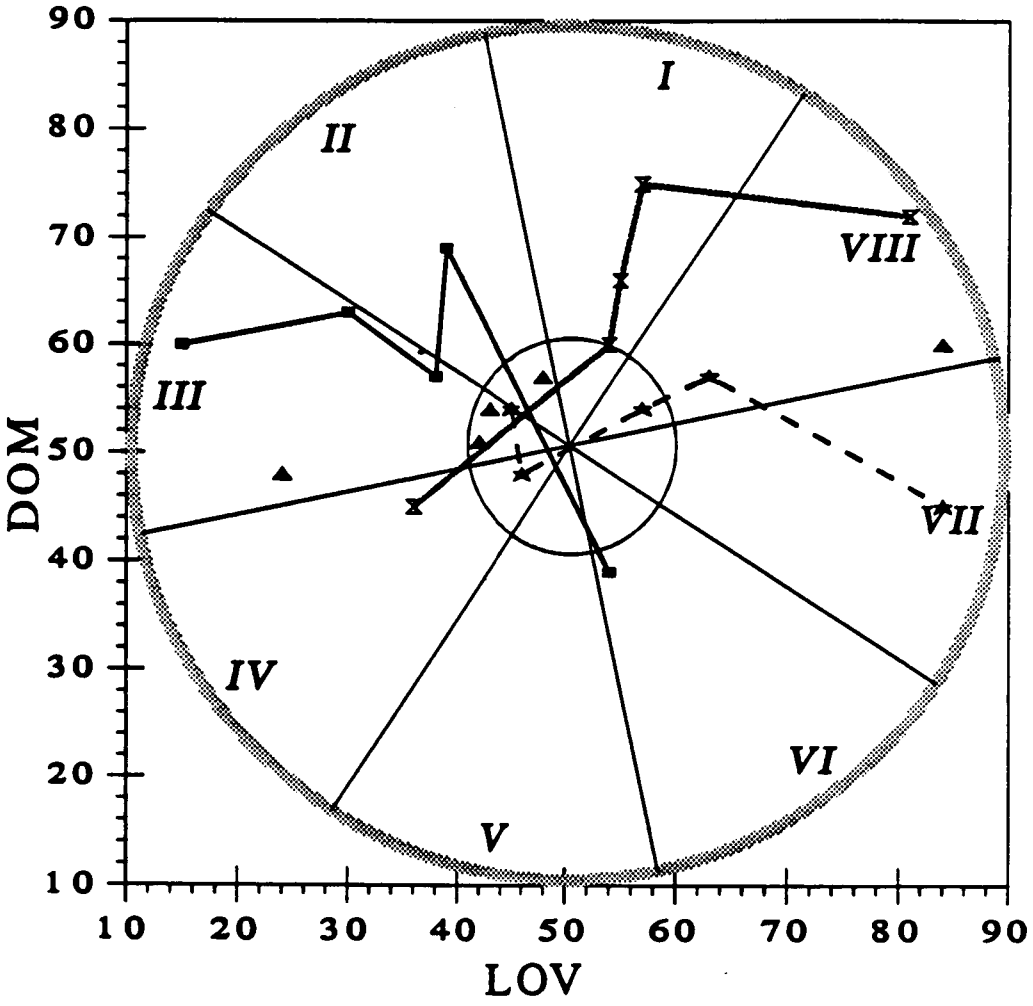


■ *Father* ⧖ *Mother* ▲ *I.P.* ★ *Sib*

I. Managerial-Autocratic	V. Modest-Self-effacing
II. Competitive-Exploitive	VI. Docile-Dependent
III. Blunt-Aggressive	VII. Cooperative-Overconventional
IV. Sceptical-Distrustful	VIII. Responsible-Overgenerous

Leary Scores for Family #2

Circumplex Model of Interpersonal Assessment

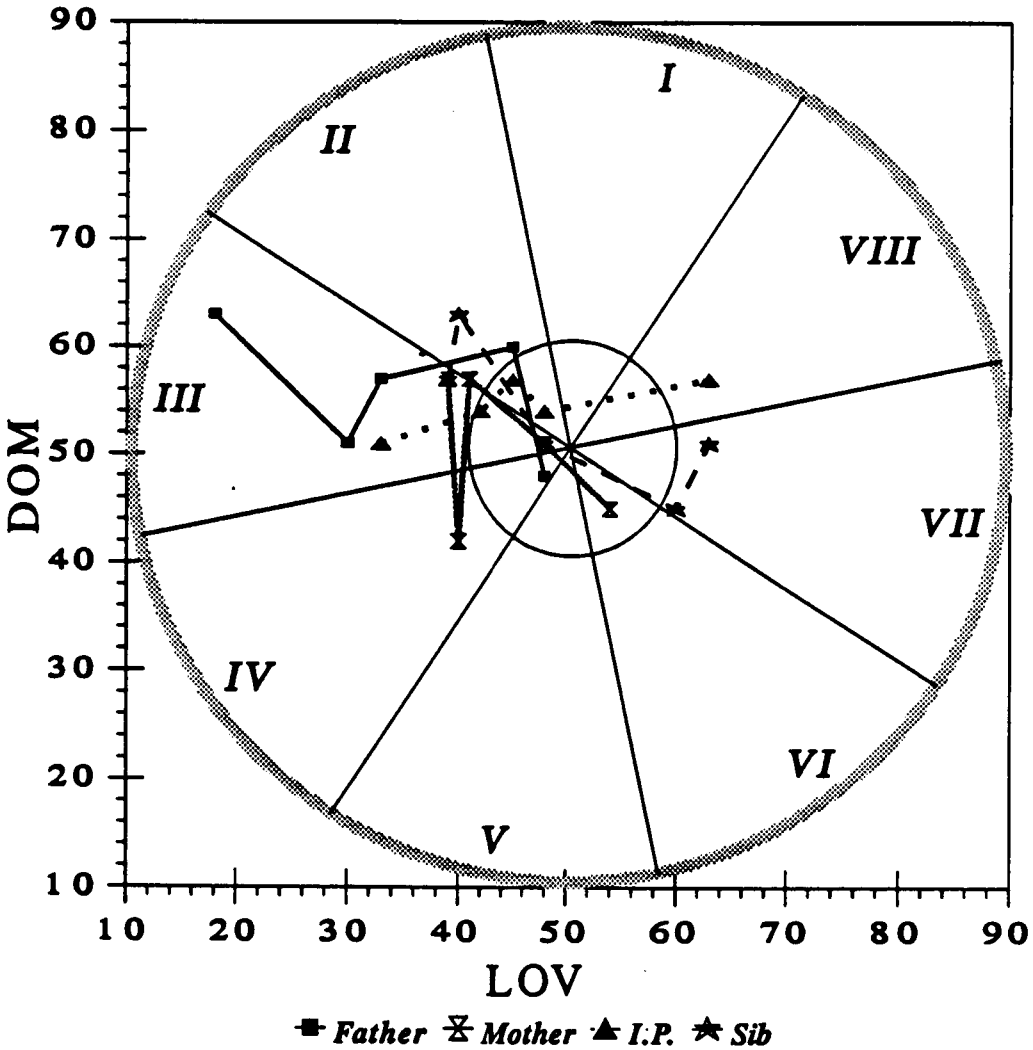


■ *Father* ⧖ *Mother* ▲ *I.P.* ★ *Sib*

I. Managerial-Autocratic	V. Modest-Self-effacing
II. Competitive-Exploitive	VI. Docile-Dependent
III. Blunt-Aggressive	VII. Cooperative-Overconventional
IV. Sceptical-Distrustful	VIII. Responsible-Overgenerous

Leary Scores for Family #3

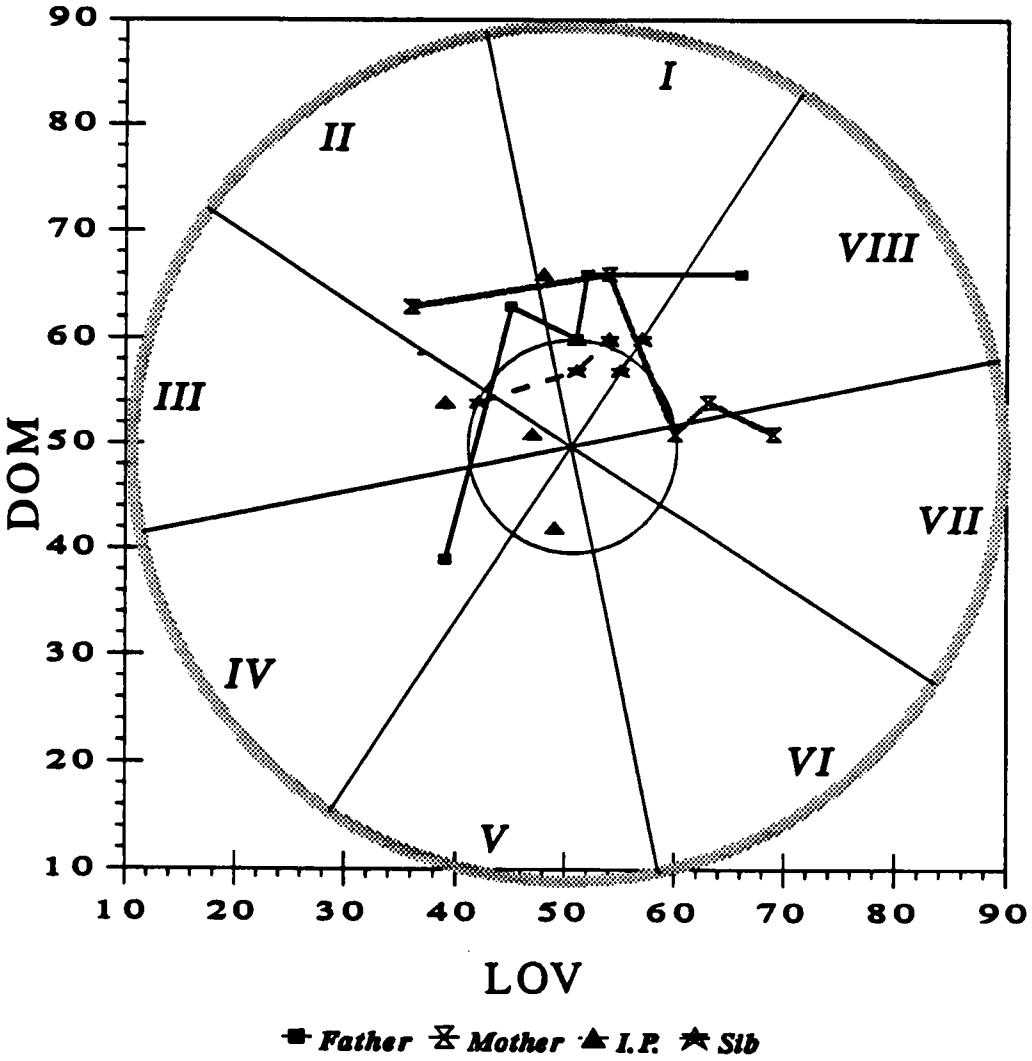
Circumplex Model of Interpersonal Assessment



I. Managerial-Autocratic
II. Competitive-Exploitive
III. Blunt-Aggressive
IV. Sceptical-Distrustful
V. Modest-Self-effacing
VI. Docile-Dependent
VII. Cooperative-Overconventional
VIII. Responsible-Overgenerous

Leary Scores for Family #4

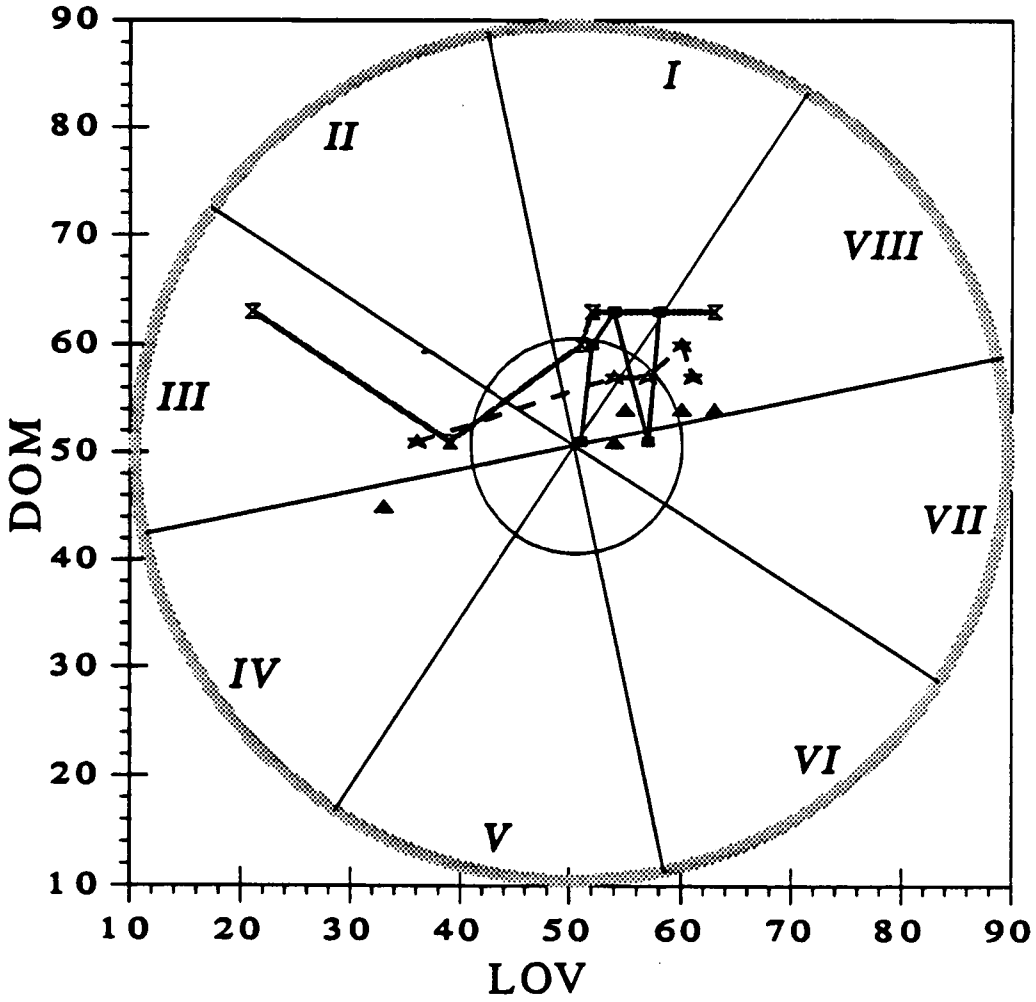
Circumplex Model of Interpersonal Assessment



I. Managerial-Autocratic
II. Competitive-Exploitive
III. Blunt-Aggressive
IV. Sceptical-Distrustful
V. Modest-Self-effacing
VI. Docile-Dependent
VII. Cooperative-Overconventional
VIII. Responsible-Overgenerous

Leary Scores for Family #5

Circumplex Model of Interpersonal Assessment

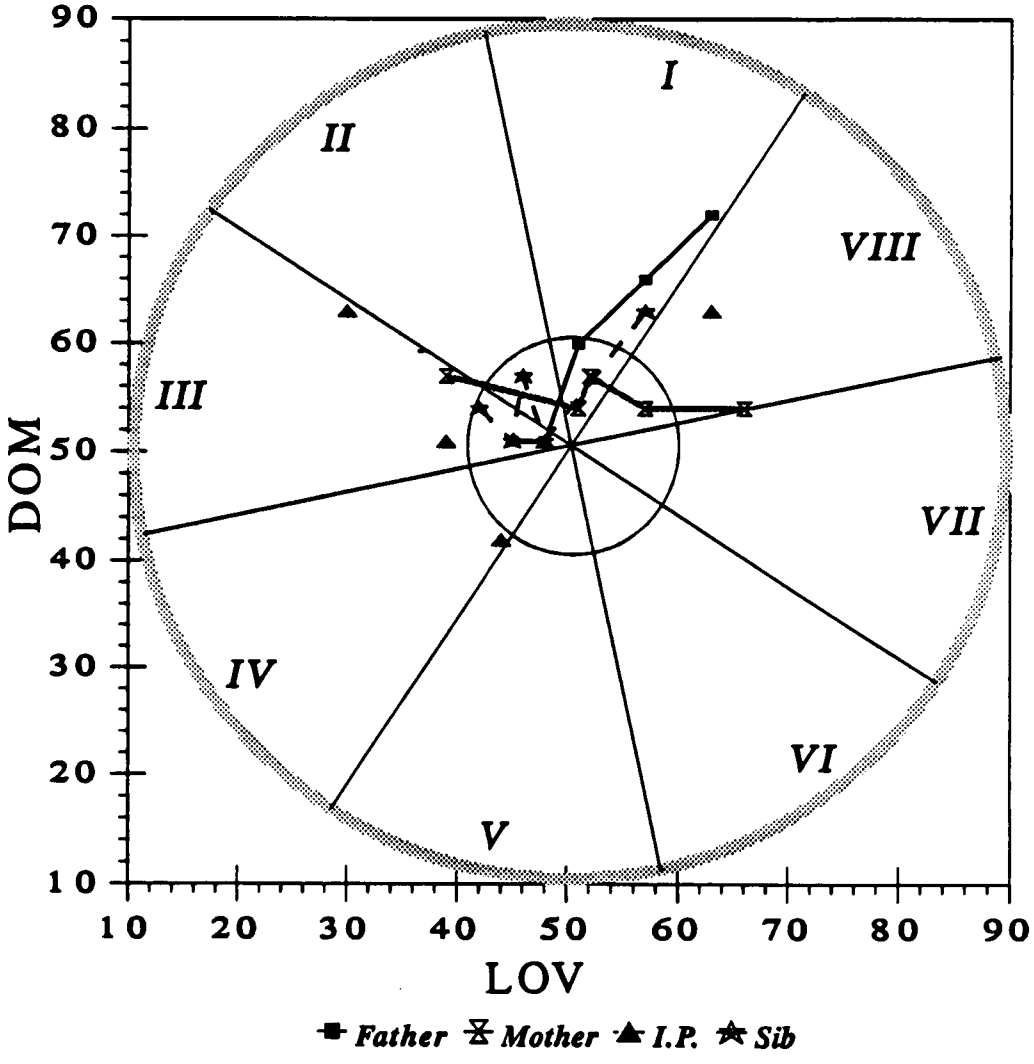


■ *Father* ⧖ *Mother* ▲ *I.P.* ★ *Sib*

I. Managerial-Autocratic	V. Modest-Self-effacing
II. Competitive-Exploitive	VI. Docile-Dependent
III. Blunt-Aggressive	VII. Cooperative-Overconventional
IV. Sceptical-Distrustful	VIII. Responsible-Overgenerous

Leary Scores for Family #6

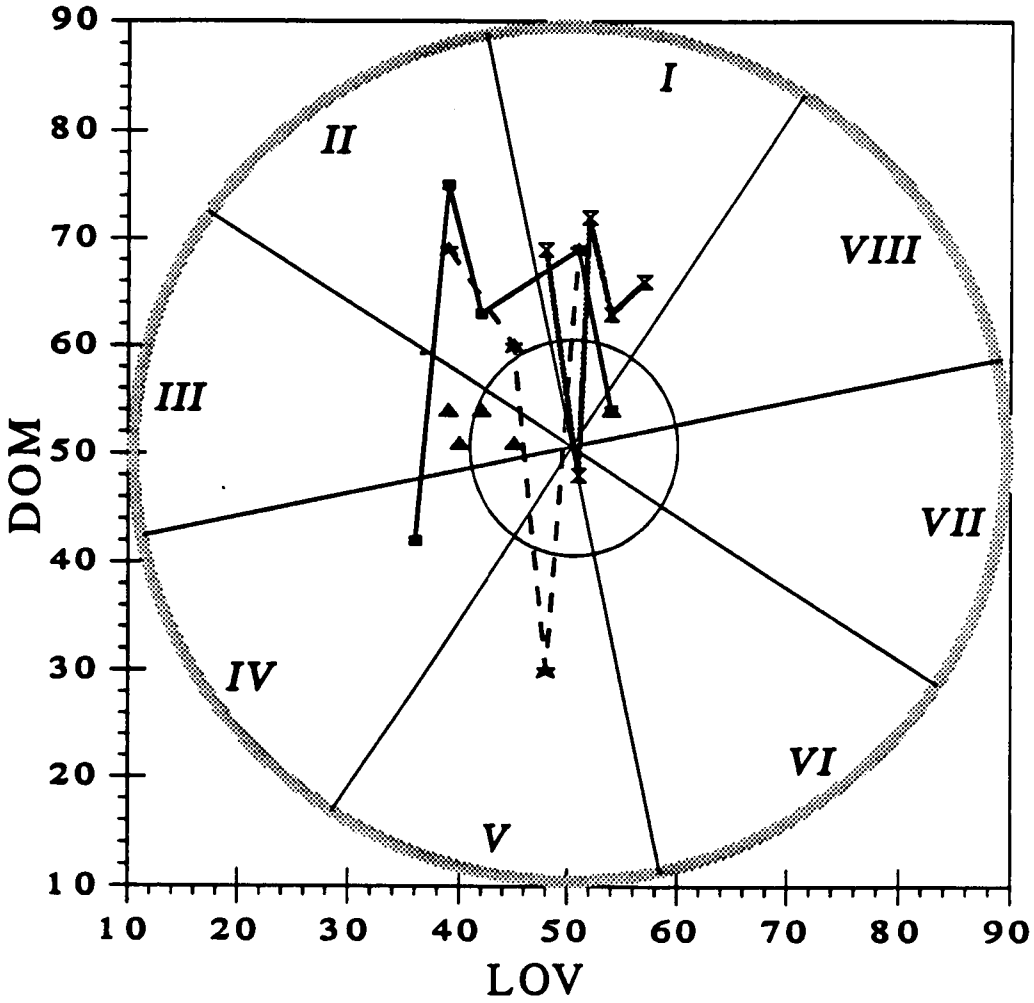
Circumplex Model of Interpersonal Assessment



I. Managerial-Autocratic
II. Competitive-Exploitive
III. Blunt-Aggressive
IV. Sceptical-Distrustful
V. Modest-Self-effacing
VI. Docile-Dependent
VII. Cooperative-Overconventional
VIII. Responsible-Overgenerous

Leary Scores for Family #7

Circumplex Model of Interpersonal Assessment

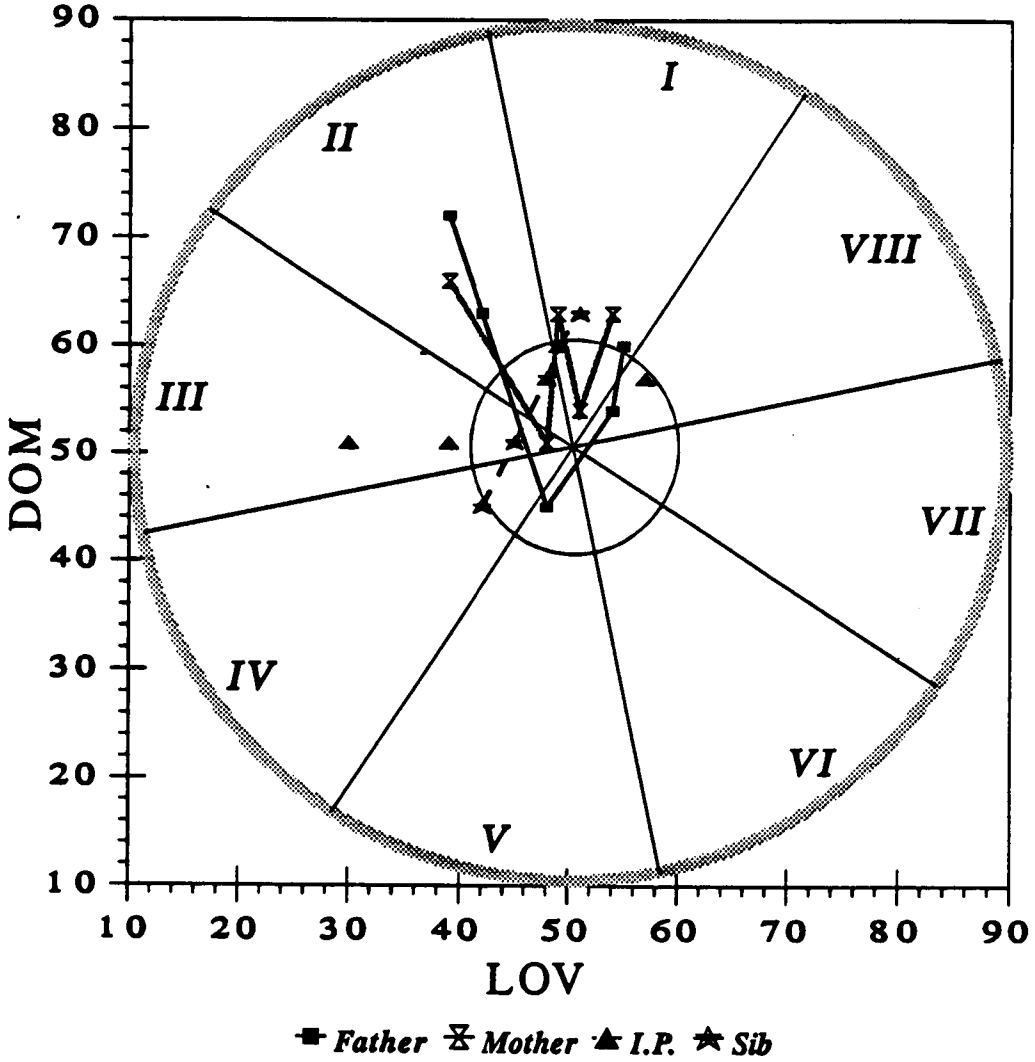


Father *Mother* *I.P.* *Sib*

I. Managerial-Autocratic	V. Modest-Self-effacing
II. Competitive-Exploitive	VI. Docile-Dependent
III. Blunt-Aggressive	VII. Cooperative-Overconventional
IV. Sceptical-Distrustful	VIII. Responsible-Overgenerous

Leary Scores for Family #8

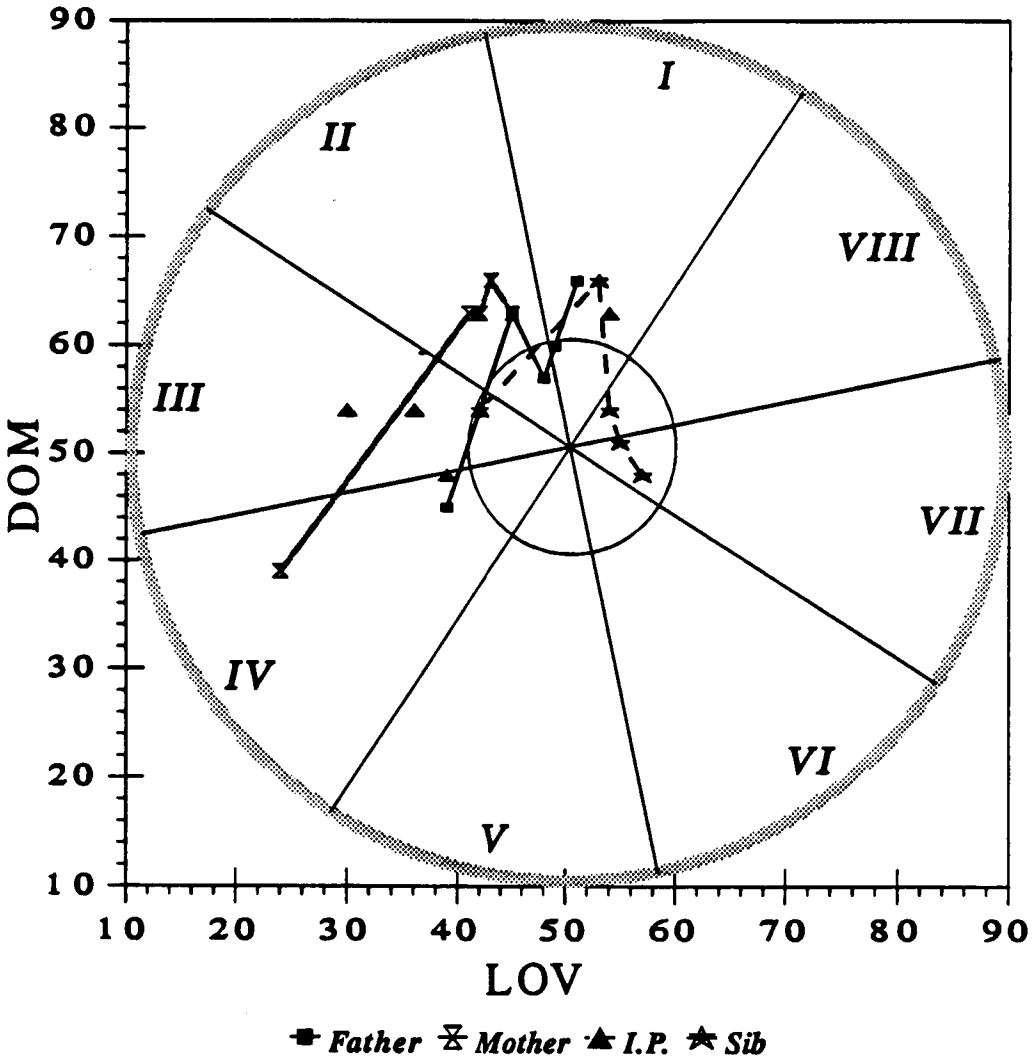
Circumplex Model of Interpersonal Assessment



I. Managerial-Autocratic
II. Competitive-Exploitive
III. Blunt-Aggressive
IV. Sceptical-Distrustful
V. Modest-Self-effacing
VI. Docile-Dependent
VII. Cooperative-Overconventional
VIII. Responsible-Overgenerous

Leary Scores for Family #9

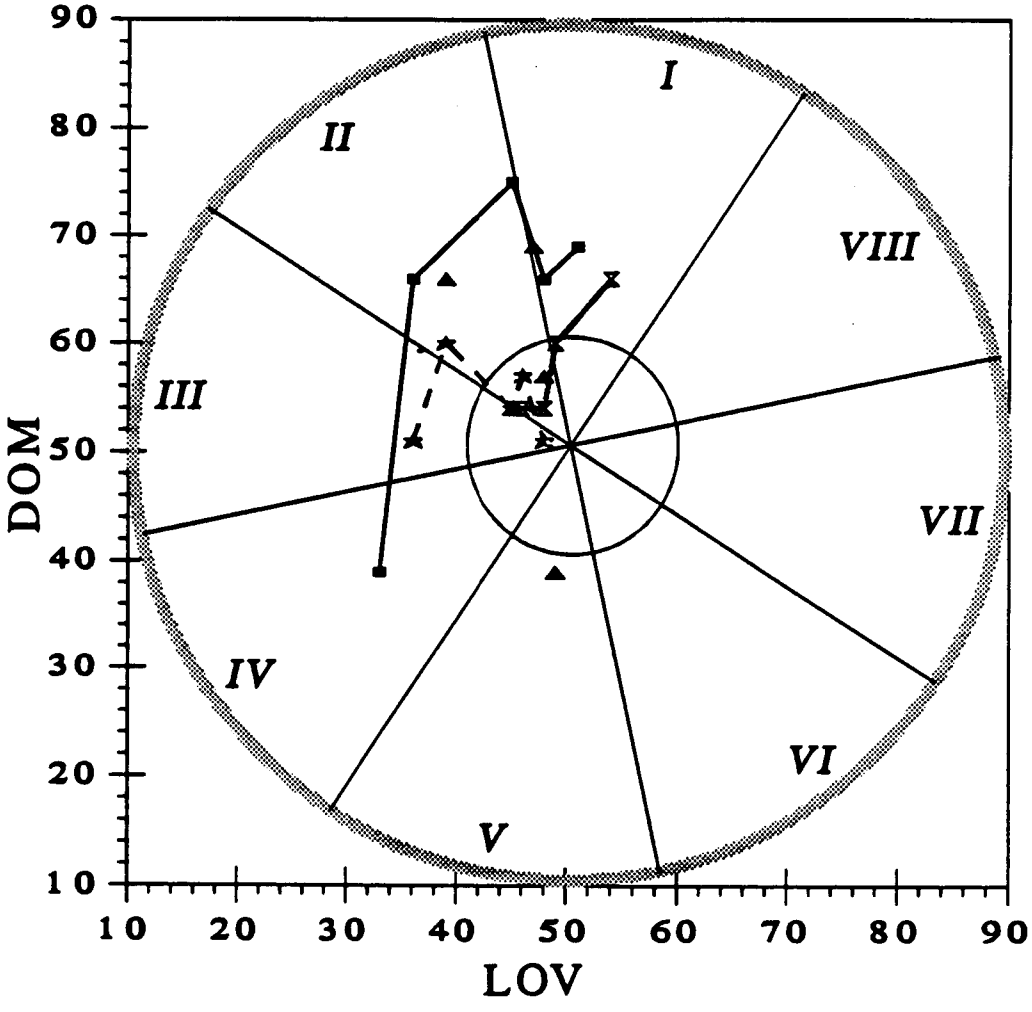
Circumplex Model of Interpersonal Assessment



I. Managerial-Autocratic
II. Competitive-Exploitive
III. Blunt-Aggressive
IV. Sceptical-Distrustful
V. Modest-Self-effacing
VI. Docile-Dependent
VII. Cooperative-Overconventional
VIII. Responsible-Overgenerous

Leary Scores for Family #10

Circumplex Model of Interpersonal Assessment



I. Managerial-Autocratic
II. Competitive-Exploitive
III. Blunt-Aggressive
IV. Sceptical-Distrustful
V. Modest-Self-effacing
VI. Docile-Dependent
VII. Cooperative-Overconventional
VIII. Responsible-Overgenerous

Leary Scores for Family #11

Appendix H: Octant Numbers for the 11 Fathers' Endorsements on the ICL

Fathers

Family #	Self	Mother	IP	Sib	Not me
1	8	2	3 F[a]	3 M	6
2	3	3	4 F	1 F	5
3	2	1	3 F	8 F	6
4	2	2	2 F	2 F	4
5	8	7	3 F	1 F	4
6	8	3	4 F	1 M	7
7	3	1	4 F	3 M	3
8	1	1	3 M	1 M	4
9	5	3	2 F	3 F	2
10	1	2	3 M	8 F	4
11	1	1	2 F	3 M	4

[a]Sex of the children

Fathers[a]

	Social Desirability	Social Undesirability
Self	8	3
Wife	8	3
IP	3	8
SIB	7	4

Note.

[a]The number cases when fathers describe themselves and their family members in socially desirable and undesirable octants

Appendix I: Octant Numbers for the 11 Mothers' Endorsements on the ICL

Mothers

Family #	Self	Father	IP	Sib	Not me
1	1	1	1 F[a]	2 M	4
2	2	3	4 F	1 F	5
3	1	3	3 F	8 F	4
4	6	3	2 F	7 F	3
5	8	2	1 F	1 F	2
6	1	1	7 F	8 M	3
7	8	1	3 F	3 M	3
8	1	2	3 M	2 M	5
9	2	8	2 F	1 F	1
10	2	2	4 M	7 F	4
11	2	2	2 F	2 M	2

[a]Sex of the children

Mothers[a]

	Social Desirability	Social Undesirability
Self	10	1
Husband	8	3
IP	6	5
SIB	10	1

Note.

[a]The number of cases when mothers describe themselves and their family members in socially desirable and undesirable octants

Appendix J: Octant Numbers for the 11 Siblings' Endoresments on the ICL

Siblings

Family #	Self	IP	Not me	Father	Mother
1	4 M[a]	1 F	4	6	1
2	8 F	3 F	3	1	2
3	2 F	2 F	4	3	1
4	7 F	2 F	2	3	2
5	1 F	2 F	3	1	1
6	1 M	8 F	3	1	8
7	3 M	3 F	2	1	1
8	1 M	4 M	5	2	1
9	4 F	3 F	1	1	1
10	7 F	3 M	3	2	2
11	2 M	2 F	3	1	2

[a]Sex of the children

Siblings[a]

	Social Desirability	Social Undesirability
Self	8	3
Father	8	3
Mother	11	0
IP	6	5

Note.

[a]The number of cases when the siblings describe themselves and their family members in socially desirable and undesirable octants

Appendix K: Octant Numbers for the 11 Identified Patients' Endoresments on the ICL

Identified Patients

Family #	Self	Sib	Not me	Fathers	Mothers
1	2 F[a]	1 M	5	1	1
2	6 F	1 F	5	2	1
3	3 F	7 F	8	3	8
4	3 F	3 F	8	3	4
5	2 F	1 F	5	1	7
6	8 F	1 M	1	1	1
7	8 F	1 F	3	1	8
8	3 M	2 M	8	8	1
9	8 F	2 F	3	2	2
10	3 M	1 F	1	2	2
11	5 F	2 M	1	2	1

[a]Sex of the children

Identified Patients[a]

	Social Desirability	Social Undesirability
Self	7	4
Father	9	2
Mother	10	1
SIB	10	1

Note.

[a]The number of cases when the identified patients describe themselves and their family members in socially desirable and undesirable octants

VITA

Lisa Carlyn Kaley was born in Atlanta, Georgia on December 27, 1961. She is the oldest of three children born to Max and Jane Kaley. Lisa graduated from Sprayberry High School in Marietta, Georgia in 1979.

Lisa attended Emory University in Atlanta, Georgia. She graduated magna cum laude in 1983 with a Bachelor of Arts degree in Psychology. Following graduation Lisa worked as a staff member at Ridgeview Institute in Smyrna, Georgia on the adolescent chemical dependency unit.

Lisa entered the Ph.D. program in Clinical Psychology at the University of Tennessee in 1985. She was a member of the Child Behavior Institute research team. Lisa received her clinical training at the University of Tennessee Psychology Clinic from 1986 through 1989 and at Ridgeview Psychiatric Hospital and Center in Oak Ridge, Tennessee from 1987 through 1989. During graduate school Lisa also worked as a staff member at Peninsula Psychiatric Hospital on the adolescent psychiatric unit in 1986; a test administrator in the Campbell County school system in 1988; a group therapist at Cooper House group home and Haslam Residential Center in 1989; and as an individual therapist on the Adolescent Psychiatric Unit of Ridgeview Psychiatric Hospital and Center in 1990.

Lisa completed her clinical internship at The Children's Hospital in Denver, Colorado, an A.P.A. approved internship, in 1990 to 1991. Lisa worked at the University of Tennessee Counseling Center as an individual therapist in 1991 to 1992. She graduated from The University of Tennessee with a Ph.D. in Clinical Psychology in August, 1992.