The Theory and Measurement Methodology of Interpersonal Communication

Timothy Leary

Editors’ Note: Timothy Leary was a brilliant psychologist who used to teach at Harvard in early 1960s. He and his colleague, Richard Alpert, became involved in research on Psilocybin and LSD. Because of the complication of their project and subsequent entanglement of undergraduate students in recreational use of psychotropic drugs, they were both dismissed from Harvard. Leary was later on arrested on drug charges and spent some time in prison. This paper is based on his dissertation from the University of California, Berkeley in 1950, and appeared in Psychiatry in 1955, Vol. 18, issue 2. The paper reads as though it were just published yesterday. It is an excellent analysis of the dynamic of interpersonal relationships in the spirit of Bion. We thank Taylor & Francis for their permission to reprint this paper electronically in the Psychoanalytic Discourse.

INTERPERSONAL COMMUNICATION, the subject of this paper, is the aspect of personality psychology which is concerned with the social impact that one human being has on another. In the following pages I shall describe some methods that the Kaiser Foundation has developed for isolating and defining human interactions and shall then discuss their implications for a theory of personality.

The phrase interpersonal relations has, in the past decade, won great popularity in psychiatry and personality psychology, and a wide variety of concepts and therapeutic techniques have been based upon this general idea. But considerable vagueness and conceptual looseness characterize many of the references to interpersonal concepts. The need is evident for, first, a systematic theory of interpersonal motivation and, second, an empirical methodology for measuring human interactions.

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In 1949, the Kaiser Foundation research project initiated a series of exploratory investigations with the eventual aim of evolving such a theory and methodology. As a result, an interpersonal system of personality has been developed and applied to various diagnostic and therapeutic situations. The essence of this systematic approach is a multilevel analysis of interpersonal behavior. Five levels of behavior have been defined, ranging in depth from overt behavioral interpersonal expression (Level 1) through conscious and preconscious behavior to the deepest layer of the unexpressed. Discrepancies and conflicts among the levels of personality are objectively measured in terms of variability indices, which are something like the classic defense mechanisms.

The present article is concerned with the measurement of interpersonal behavior in the first of these five levels—the overt, public, interpersonal expressions of the subject—and with some theoretical issues that are pertinent to this area of emotional expression.

DEFINITIONS AND ILLUSTRATIONS

The basic unit involved here is the interpersonal motive as measured by its effect on others. The interpersonal motive of any behavior is determined by asking: "What is this person doing to the other? What kind of relationship is he attempting to establish through this particular behavior?" The answers to these questions define the interpersonal purpose; for example, "He is boasting and attempting to establish superiority," or "He is rejecting and refusing to help."

The concern at this level is with what one person communicates to another. A father, for example, may employ one or one thousand words to refuse his child's request. The mode, style, and content of the two rejecting expressions may be very different, but their interpersonal purpose is the same—rejection.

In studying the interpersonal motives which underlie human behavior, the following hypothesis has developed: In a large percentage of interactions the basic motives are expressed in a reflex manner. They are so automatic that they are often unwitting and often at variance with the subject's own perception of them. The meaning of any interaction is therefore a difficult one to isolate and measure. It is frequently unverbalized and so subtle and reflex as to escape articulate description. Sometimes these interpersonal communications can be implicit in the content of the discussion: Grandfather talks incessantly about the lack of energy and initiative of modern youth in order to impress others with the fact that he is a successful self-made man. Grandmother talks incessantly about sickness, calamity, and death to remind others that the time may be short to repay her for the sacrifices she has made for her children. Grandfather never says openly, "I am better than you young people," and Grandmother never says, "You should feel guilty and devoted to me." Grandfather's remark may be concerned with the issue of the 40-hour week and Grandmother may be quoting

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4 What a person does in any social situation is a function of at least two factors: (1) his multilevel personality structure; and (2) the activities and effect of the other one, the person with whom he is interacting. In order to define and discuss the level of overt communication, it has been necessary at times in this article to talk about interpersonal behavior as though it exists apart from the other aspects of the subject's personality structure or apart from the behavior of others. But the broader contexts, in which it is always imbedded, are implicitly referred to in the subsequent discussions.
from the obituary column of the evening paper. But behind the superficial content of these expressions are the repetitive interpersonal purposes-superiority and reproach. Behind the superficial content of most social exchanges it is possible to determine the naked motive communications: I am wise; I am strong; I am friendly; I am contemptuous. The concomitant message is also there—“you are less wise, less strong, less likeable, contemptible.

The following situation, in which a woman evokes the helpful attitude, exemplifies Level 1 purposive communications: A patient comes to a psychiatrist for an evaluation interview. She reports a long list of symptoms-insomnia, worry, depression- and an equally long list of unfortunate events-divorce, unsympathetic employer, and so on. She cries. Whether her expressions are scored separately and summarized or are judged on the over-all, a clear picture emerges of a dependent approach—“I am weak, unhappy, unlucky, in need of your help.”

In response the psychiatrist is under strong pressure to express sympathetic, nurturant communications. Helpless, trustful behavior tends to call forth assistance. Further, the patient-therapist situation is in essence one that lends itself easily to the “needs help-offers help” relationship. There is a tendency for the psychiatrist to express- either openly or, much more likely, by implication— that he knows how the patient can be assisted. This may be communicated, not in what he says, but in his bearing, attitude, his very quiet competence.

What makes it more complex is the fact that the verbal expression may be quite different from the actual developing relationship. The psychiatrist may interpret the dangers of dependence and the necessity for self-help. The patient may agree. If both of them tend to over-emphasize verbal symbols, there may be an illusion that a collaborative relationship exists. Actually the nurturant-interpreter-trustful-follower situation still exists, not in what the participants are saying, but in what they are doing to each other.

PREVIOUS LITERATURE ON INTERPERSONAL COMMUNICATION

In making interpersonal communication a key concept in its theory of personality, the Kaiser Foundation research group is by no means introducing a new planet into the constellation of personality processes. The importance of reflex interactive behavior has long been recognized by psychiatrists, sociologists, and anthropologists.

The psychologist-philosopher George H. Mead, who has traced in great detail the development of human communication, has made a similar idea the keystone of his "social behaviorism." He places the origin of communication in the "language of gestures," which, as he defines it, is very close to the definition of Level 1 interpersonal expression used in this article: "We are reading the meaning of the conduct of other people when, perhaps, they are not aware of it. There is something that reveals to us what the purpose is—just the glance of an eye, the attitude of the body which leads to the response. The communication is set up in this way between individuals may be very perfect. Conversation in gestures may be carried on which cannot be translated into articulate speech."5

As Mead develops his theory of the "significant symbol," he tends to depreciate the importance of reflex, automatic (nonconscious) communication as compared with vocal, Self-conscious, reflexive language.6 The latter is a high order concept and from the systematic point of view involves three separate levels of personality. Mead’s purpose in developing a social theory of mind led him to employ complex combinations of personality variables. This is quite justifiable from the standpoint of his conceptual intentions, but

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6 Language usage becomes tricky at this point. When Mead uses the term "reflexive," he means something quite different from the term reflex as used in this article. He states: "It is by means of reflexiveness-the turning back of the experience of the individual upon himself—that the whole social process is thus brought into the experience of the individuals involved in it; it is by such means, which enable the individual to take the attitude of the other toward himself, that the individual is able consciously to adjust himself to that process, and to modify the resultant of that process in any given social act in terms of his adjustment to it. Reflexiveness, then, is the essential condition, within the social process, for the development of mind." [Reference footnote 3; p. 134.] This terminology contrasts with that used in this article. The interpersonal behavior at Level 1 is (or at least, can be) nonconscious, involuntary, gestural, which involves an automatic communication with or ‘training of’ the other one; this is here called reflex. The variable by which Level 1 behavior is measured is the interpersonal reflex, or the interpersonal mechanism.
There is one thing that strikes us as interesting about speech; on the one hand, we find it difficult to analyze; on the other hand, we are very much guided by it in our actual experience. That is, perhaps, something of a paradox, yet both the simple mind and the keener of scientists know very well that we do not react to the suggestions of the environment in accordance with our specific knowledge alone. Some of us are more intuitive than others; it is true, but none is entirely lacking in the ability to gather and be guided by speech impressions in the intuitive exploration of personality. We are taught that when a man speaks he says something that he means to communicate. That, of course, is not necessarily so. He intends to say something, as a rule, yet what he actually communicates may be measurably different from what he started out to convey. We often form a judgment of what he is by what he does not say, and we may be very wise to refuse to limit the evidence for judgment to the overt content of speech.7

Later in the same paper Sapir summarizes: "It should be fairly clear from our hasty review that if we make a level-to-level analysis of the speech of an individual and if we carefully see each of these levels in its social perspective, we obtain a valuable lever for psychiatric work. It is possible that the kind of analysis which has here been suggested, if carried far enough, may enable us to arrive at certain very pertinent conclusions regarding personality."8

That these observations, made over a quarter of a century ago, are in conformity with current trends can hardly be considered accidental. Working with Sapir at the time were many theorists who have since become well-known exponents of the culture theory of personality—among them, Harry Stack Sullivan, John Dollard, and W. I. Thomas.

The level of behavior which is operationally defined in this article as the level of public communication possesses, there-fore, a most eminent theoretical heritage. Originating in the concern of Charles Darwin and Wilhelm Wundt with the gestural expression of emotion, taking its philosophic roots in the linguistic concepts of Sapir and Mead, and finding its psychiatric application in the writings of Erich Fromm, Karen Horney, and Sullivan, the basic idea of interpersonal communication has for a century excited the interest of socially oriented theorists.

Clinical and empirical approaches.—The first clinical and empirical approach to interpersonal communication was developed by J. L. Moreno, a pioneering worker who has introduced many ingenious and creative innovations. For over twenty years Moreno has employed sociometric methods in the study of group structure. These techniques indicate the bonds of attraction and repulsion which exist among group members and provide an objective picture of the pattern of interpersonal relationships. Moreno's valuable contributions have not been fully exploited because of the absence of empirical studies. His measurements are not based upon a system of interpersonal variables. Therefore, although his sociometric methods possess considerable functional value, they do not provide an inter-personal diagnosis in terms of a fixed system of variables.

In the past five years, two comprehensive empirical systems for classifying interpersonal behavior have appeared in the literature, in addition to the interpersonal system described in this article. First, a reliable and effective method of categorizing interpersonal processes in terms of positive, negative, or neutral orientation toward a group goal has been presented by Robert F. Bales.9 This has been applied mainly to group decisions and group problem-solving behavior. Second, a method of rating the individual's response to

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8 Reference footnote 5; p. 905.
the group experience has been developed by the English psychiatrist, W. R. Bion and his American follower, Herbert A. Thelen. This has been applied to problems of social structure in psychotherapy groups and to "group dynamics" situations. The aim of these two systems, both of which are major methodological achievements, is to classify behavior that is most crucial to the particular goals of their originators-group problem-solving and group therapy process.

THE INTERPERSONAL SYSTEM OF CLASSIFICATION

The interpersonal system for measuring social interaction that has been developed at the Kaiser Foundation differs in several important respects from the systems developed by Bales and Bion. Unlike them, it is tied to a theory of personality and a system of multilevel measurement. Its aim is to develop a method of measuring interpersonal behavior which will be coordinate with the measures of interpersonal behavior at other levels of personality and which will fit into a multilevel pattern of interpersonal diagnosis. The reflexes of Level 1 are, perhaps, the most crucial aspect of personality, but from the standpoint of functional diagnosis and dynamic theory design they must fit into a multilevel constellation.

In selecting the variables for classifying Level 1 communication, therefore, it is not the purpose or structure or task of the group that has been kept in mind, but the structure of the subject’s total personality. Against this background I shall now consider in detail the empirical methodology that has been developed.

A Listing of Interpersonal Reflexes

To make objective measurements of the reflex phenomena of Level 1, it was necessary to have a finite and defined list of interpersonal behaviors. Through extensive empirical research, a classificatory system for measuring human interaction has been constructed. This variable system is arranged in the form of a 16-point circular continuum which reflects the variety of interpersonal purposes expressed by human beings in their relationships with each other. Because the material dealt with at this level of personality is the communication process-what one person does to another-transitive verbs are used as the verbal descriptive terms for each of the 16 interpersonal variables. Fig. 1 presents the 16 generic interpersonal themes, together with a list of sample activities which illustrate the range of each point around the circle.

For each generic theme there is, of course, an inexhaustible list of verbs. The terms used here are most appropriate for verbal exchanges in therapeutic or diagnostic contexts. Thus, to boast, to claim superiority, to establish autonomy and independence, to act self-confident are all assumed to contain about the same proportion of dominance-hostility as indicated by the point B on the circle. This means that they all express the same qualitative purpose of narcissistic self-approval. The fact that they differ in amount, degree, or extremity of the purpose is handled by an intensity scale.

The kind and not the amount of the purpose is what is concerned here. Other lists are necessary for categorizing nonverbal actions (frowns, gestures, voice tones) and preverbal situations (nursery school interactions, and the like).

Interpersonal Reflexes in a Group Therapy Situation

The following passage, transcribed from a tape-recording of a group psychotherapy situation, illustrates this system of scoring social behavior. The exact words of the participants are given in regular type; and the interpersonal reflexes are scored in bold-faced type. The scoring of each mechanism consists of three

13 Some mechanisms-for example, humor and play behavior-are, of course, much too complex to be captured in essence by a simple rating scheme. When humor and play occur, an attempt is made to score them as follows:
ratings, which are indicated in the following order: the verb considered most closely descriptive of the action, the code letter representing the location of the action along the circular continuum of interpersonal mechanisms, as shown in Fig. 1 and the numerical rating of the intensity of the mechanism along a four-point intensity scale.

In the illustrative situation used here, six male patients file into the therapist’s office and seat themselves expectantly. Patient A glances at a Picasso print on the wall and begins the group therapy process by remarking upon it.

(1) Patient A. Is that supposed to be art on the wall, or is that something somebody drew in the hospital? Ridicules (D-3).

Humor: Most humor seems to have a mildly hostile loading. Some humor is wry, poking fun at self, and is scored H-Self-effacement. Some is mildly bitter, complaining at fate, and so on, and is scored F-Cynicism. Some is sarcastic, biting, poking fun at others; this is scored D-Hostility. Notice that all of these are on the left (hostile) side of the interpersonal circle. Play: It might be conjectured that play can be a derivative of any basic interpersonal orientation, and that any of the 16 interpersonal variables can be expressed in a playful manner. For example, competition can be expressed in play by means of sports and the like, and is scored C. Hostility can be expressed in play-for instance, by teasing-and is scored E or D. Tenderness can be expressed in play and is scored N or O. Collaboration, love, or affiliation can be expressed in a playful way, and are scored L or M. Play seems to be a stylistic variable not necessarily tied to any one interpersonal motive or group of motives.

Each of the 16 interpersonal variables is illustrated by sample behaviors. The inner circle names adaptive reflexes, such as...
(2) Therapist. Now, the purpose of our meeting in general is to help each of you to come to a better understanding of yourself, a deeper understanding of yourself. The meetings will last about an hour and a half, and we'll meet for at least four months, at least 15 or 16 times. [Therapist continues for several minutes to structure the situation.]

Teaches (P-2).

(3) Therapist. . . . I'm going to throw the burden of the conversation now to the group. I'd like to have you tell yourself and tell us, today and for the next few days, who you are, why you see yourself coming here, and what you might want to get from the group. Directs (A-2).

(4) Patient A. What if you don't know? What if you haven't the slightest idea what you want? Passively resists (F-3).

(5) Therapist. Well, that's a good place to start. You have already told us something interesting about yourself. Supports (N-2).

(6) Patient A. How can you talk about something you don't know anything about? Passively resists (F-3).

(7) Patient B. We could have a sympathizers' club here. Ridicules self (H-1) and others (D-1).

(8) Patient C. A friend of mine suggested that, as a matter of fact. Agrees (L-1).

(9) Patient A. Is that it? Are we supposed to cry on each other's shoulders? Is that the object of it? Crocodile tears and sympathetic ears, is that the idea? Passively resists (F-3). (10) Therapist. [Smiles.] I hope we can help each other more than just by groaning together. Ridicules (D-2).

(11) Patient B. Mr. A has said-felt that way too about knowing what I want, but I think that's more of just-or you've just gotten so damn discouraged about things you just don't-well, there's a feeling, I know with myself-feeling that what a lot of people want just aren't worth a candle, that's all-it seems to take too much out of me in the way of effort and emotional drive or something. Takes weak position (I-2).

(12) Therapist. You don't just want the things that any other people want? Summarizes (P-2).

(13) Patient B. Yeah, I seem to have gotten into an attitude of what you might call emotional dumbness where I don't just seem to have the emotional level that some people have. Condemns self (H-3). Some people get enthused about going to a picnic, ball game, or this, that, and the other thing-I mean, speaking for myself, I'll say, "Ah, just let me alone." If somebody's going to a picnic, I don't give a damn whether they go to Milpitas, San Francisco, or what not. I don't expect to enjoy myself at a picnic. I'd rather stay home and sit on my butt and thumb through a magazine or something-keep comfortable and not bother with anything.

(14) Patient D. You're speaking generally now-not just about a picnic? About many things? Because I was going to say, there are a lot of people who take that attitude about certain things. You can never get them to work up enthusiasm, to get them to do anything, and yet they have other outlets, or are enthusiastic about-explains (P-3).

(15) Patient B. Yes, about a lot of things like, for example, a good deal of my problems center about my work. Depreciates self (H-3). I kind of rationalize that by saying, "Oh, to hell with it! Most people do aren't worth doing anyway." I repair air-conditioners for a living, for example. I have a very bad attitude about the sets. Firstly, I can't sympathize with my customers. I don't manage. Proceeding outward, the next ring indicates the type of behavior that this interpersonal reflex tends to 'pull' from the other one; thus the person who uses the reflex A tends to call up in others obedience. These findings involve two-way interpersonal phenomena-what the subject does and what the other does in return-and are therefore less reliable than the other interpersonal categories presented in the inner and outer rings. The next circle illustrates extreme or rigid reflexes, such as dominates. The perimeter of the Circle is divided into eight general categories employed in interpersonal diagnosis. Each of these general categories has a moderate (adaptive) and an extreme (pathological) intensity, such as managerial-autocratic.
see why they want to keep the damn things going. [Laughs.] And they hound me to get the work. Of course, with my attitude, one could make a virtue of it. You could say that I have infinite patience. Pulls for sympathy (1-3). Frankly, I don't care. I'm not anxious to get paid, I'm not anxious to get started and I'm not anxious to finish. In fact, I feel a good deal of anxiety frequently about getting started and I think that's part of Mr. A's—there's something there—a counterforce. It isn't that a person doesn't know what they want to do, really. I mean that there's some counterforce that makes anything that you want to do not worth the price. [He continues at length in this vein.]

(16) Patient B. . . . they feel that I don't have a damn bit of interest in their particular problems and even though my proposition is reasonable—in many cases I've gotten turned down. Accuses others, describes self as exploited (G-3). I had an example of that recently. By the way, am I taking up too much of the time? Mildly criticizes self (H-1).

(17) Therapist. Let's stop a minute because you have raised several interesting themes, the feeling of obligation, the feeling of being pressed in on by forces that—Directs (A-2).

Summarizes (P-2).

(18) Patient B. Like when I rest—like last night when my wife says, "Well, do you want to go out tonight?" I have already complained about being tired and I did feel tired. It was about eight-thirty that I started out. Accuses others (G-3). Passively resists therapist's direction (F-3).

(19) Therapist. Somewhat against your will, but you did go. Reflects (O-2).

(20) Patient B. That's right. Participates (L-1).

(21) Therapist. Now let's stop for a moment. Directs (A-2). Have these themes made anything click as you've listened to Mr. B describe them?

(22) Patient A. The idea of the annoyance of being pressed is common. That's common to everybody, isn't it? When you get somebody on your tail and you know that they are right and they have justification in their claims and that you can't satisfy them or—and then you feel a negative attitude—you would like to take their work and throw it out. Gives opinion (P-2).

(23) Therapist. What do you usually do when you feel that—do you throw their work out? Therapeutic question (O-2).

(24) Patient A. No, you just smile, and say, "Oh, that's too bad." Depreciates self (H-2).


(26) Patient A. Well, sometimes I sort of digress a little bit and I carry on a little campaign trying to impress people that there is a lot more to it—that they are expecting more—Mildly praises self (B-1).

(27) Therapist. But you've never been in that position. Summarizes (P-2).

(28) Patient A. Never been in that position. Sometimes I've wanted things and the next day I got them and it seems as though when I got them it wasn't what I wanted after all. Feels disappointed (G-2).

(29) Therapist. What have your thoughts been as you have listened? Focuses (A-2).

(30) Patient D. Well, first of all, Mr. A's statement of enthusiasm, followed by a period of less enthusiasm or depression, according to my understanding is more or less normal to a certain degree; now if that goes to a greater degree, maybe that's not normal. All of us have periods where we work easily and enjoy our work. Now whether it is during that period you also suffer some of that anxiety, you said you worried
about the periods that
Are coming - Pedantically teaches (P-3).

(31) Therapist. How do you compare with Mr. A or Mr. B as they have presented their situation? Therapeutic question (O-2).

(32) Patient D. Well, it didn't quite fit in exactly. My work is a little different and I don't have to meet the public. Denies problem (B-2). I'm a physicist and as such I work under the directorship of the department head, the group leader, so...that, while we have pressure on us at times to do work, it isn't the idea you're worrying about the business ahead or discouraging customers.

(33) Patient E. Do you worry about your work coming out right? Does that give you anxiety feelings? Therapeutic question (O-2).

(34) Patient D. I think scientific work is very frustrating in one respect and that is it seems like ninety percent of the time or greater your what you do does not come out in a favorable manner. In other words you are only looking for a few successful experiments. That's what makes the money for the company. You have volumes and volumes of papers describing work you did that no one will ever look at again. Describes frustration (G-2).

(35) Patient E. Does that worry you about your relationship with your immediate superiors? Do you feel that maybe you haven't done things right or fast enough or careful enough? Therapeutic question (O-2).

(36) Patient D. Yes, you do have those feelings too, that's true. Accepts (L-2).

(37) Patient B. Well, I think there's a sort of tie-in, that basically it is simply probably you don't meet the general public so much as that your problems center maybe on one or two individuals. Gives opinion (P-2).

(38) Therapist. Have you had this feeling of pressure that Mr. A or Mr. B have described? Therapeutic question (O-2).

(39) Patient D. No, not too much. Denies problem (B-2).

This passage nicely illustrates the development of interpersonal reflex patterns. The opening moments of a psychotherapy group are always most dramatic and important. Six strangers come together, meet for the first time, and begin automatically to train each other. The network of interaction, perception, and misperception begins to weave itself. Consider Patient A in the above passage. In the first five seconds, he has shot a critical and skeptical arrow. He challenges the therapist sarcastically, asking about a picture on the wall. It may be suspected that through these comments he is telling not just the therapist but the group in general, "I'm a negative, uncooperative person; you're going to have trouble with me." The record does not indicate what the five other patients were doing while Patient A was making his opening gambit. A motion picture record might have revealed that they were, in their own ways, beginning to develop their roles. Patient D, who later expresses himself verbally as a self-satisfied, executive person, might very well have been using nonverbal means to communicate his detached competence-crossing his legs briskly and shooting alert glances around the room. Patient B, who is soon to begin building a facade of self-critical weakness, may have been sending sheepish, apprehensive glances towards the others in these opening seconds.

In the subsequent moves of the grumpy Patient A, the same reflex pattern unfolds quite consistently. Interactions (6) and (9) continue to communicate the theme of uncooperative and passive resistance.

As Patient B enters the action, in remarks (11) and (13), a different set of reflexes appears. He begins a sequence of passive self-effacement. His self-deprecatory remarks are continued at length in (15), and by (16) it can be sensed that they have developed into a repetitious circle of pessimistic ruminations. He apologizes for monopolizing the discussion. Interactions (17) and (18) focus on a most interesting transaction. The therapist, in (17), attempts to check the flow of anxiety-driven words, but Patient B in (18) continues his reflex lamentations. In ignoring the therapist's intervention, Patient B provides a nice illustration of the involuntary nature of Level 1 communication. It is safe to guess that this patient did not deliberately or consciously interrupt and disregard the therapist. He has just expressed conscious anxiety about talking too
much, but automatically goes on to provide a rather flagrant example of insensitive, anxiety-driven complaint.

At this point, Patient B has engaged in seven interactions-(7), (11), (13), (15), (16), (18), and (20). What impression has he made on his fellow group members? On the therapist? These seven communications provide the data for a small experiment in interpersonal relations in which the reader may participate. Glance back over Patient B's statements, imagining that you are a member of this therapy group. What feelings do you sense in response to his comments? Some readers have reported a feeling of sympathy, mixed with superiority and irritable impatience. To the extent that these feelings have been aroused, then to that extent Patient B has in seven easy steps taught or trained the reader to respond to him in a typical and consistent way. Patient B had an unusually rigid and in appropriate set of reflexes-apologetic, self-critical, and complaining. He trained the group members and the therapist just as he had trained everyone in his life to respond to him with tolerant and/or irritable superiority.

This set of reflex responses seemed to operate as a defensive maneuver. Occasionally he was able to show other responses. But the more anxious he became the less able he was to respond appropriately and the more driven he was to continue his interpersonal defenses-as illustrated clearly in the sequence (17) and (18).

THE INTERPERSONAL REFLEX

What did this patient do to get five strangers to agree on his social stimulus value? It seems that he trained them to react to him in a very specific way—with rejection and irritation. This question becomes more important—from the diagnostic viewpoint—when it is remembered that, as he reports, he has consistently tended to remain isolated and despised by others over the span of his life. How does he do this?

When his interpersonal actions are traced back to the original recorded protocols, a typical pattern of Level 1 interaction is discovered. The individual units of this behavior—the interpersonal mechanisms or interpersonal reflexes—are defined as functional, purposive units of face-to-face social behavior. These reflexes are automatic and usually involuntary responses to interpersonal situations, often independent of the content of the communication. They are spontaneous, purposive methods of reacting to others.

The exact manner in which these Level 1 communications are expressed is a complex and unsolved problem. This much is clear: they are expressed partially in the content or verbal meaning of the communication and partially in the tone of voice, gesture, carriage, and external appearance. Although the specific method by which human beings express their purposive relationships to each other is unknown, the over-all, molar effect can be reliably rated. Raters—whether trained psychologists or untrained fellow patients can agree with impressive reliability in rating what subjects do to each other in interpersonal situations. Preliminary research by Blanche Sweet suggests that more effective ratings can be arrived at by listening to recordings than by reading typed transcriptions. Sound movies would provide the optimal techniques for preserving the nuances involved in interpersonal reflexes. Future research may determine the specific way in which these spontaneous interpersonal meanings manifest themselves to others. The reflex manner in which human beings react to others and train others to respond to them in selective ways is, I believe, the most important single aspect of personality. The systematic estimates of a patient's repertoire of interpersonal reflexes is a key factor in functional diagnosis. Awareness of crippled reflexes and, if possible, modification of them should be a basic goal of psychotherapy. When more evidence as to the mode of expression—gesture, carriage, content of speech—is accumulated, some additions to therapeutic practice may develop.

Because of their automatic and involuntary nature, interpersonal reflexes are difficult to observe and measure. For the same reason they are most resistant to therapeutic change. The more the members of the psychotherapy group tried to explain to the subject how and why he irritated them, the more he protested his feelings of injury. Later, intellectual insight and voluntary controlled changes to cooperative, self-confident behavior developed. These were, however, quite tentative and unnatural. During many months of

Routine Reflex Patterns

During any one day the average adult runs into a wide range of interpersonal stimuli. He is challenged, pleased, bossed, obeyed, helped, and ignored several times a day. Thus, the person whose entire range of interpersonal reflexes is functioning flexibly can be expected to demonstrate appropriately each of the 16 interpersonal reflexes many times in any day. There are, however, many persons who do not react with consistent appropriateness or flexibility. One person might respond to the pleasant as well as the rude stranger with a disapproving frown. Another might smile in a friendly fashion at both of them. If an extended sample of a subject’s interactions is studied, an interesting fact develops. Each person shows a consistent preference for certain interpersonal reflexes. Other reflexes are very difficult to elicit or are absent entirely. It is possible to predict in probability terms the preferred reflexes for most persons in a specific situation. A small percentage of persons get others to react to them in the widest range of possible behaviors and can utilize a wide range of appropriate reactions. But most persons tend to train others to react to them within a narrower range of behaviors, and in turn show a restricted set of favored reflexes. Some persons show a very limited repertoire of two or three reflexes and reciprocally receive an increasingly narrow set of responses from others.

Definition of Interpersonal Role

Almost everyone manifests certain role pattern which he automatically assumes in the presence of each significant other person in his life. These roles are probability tendencies to express certain interpersonal purposes with significantly higher frequency. The person may be quite unaware of these spontaneous tendencies to complain to his wife, to be stern with his children, to boss his secretary, to depend on the office manager. It must be remembered that the terms used here are statistical probability terms. The subject may have thousands of interactive exchanges each day with each of his significant others, and these may range all over the interpersonal continuum. When evidence is obtained that he consistently and routinely tends to favor certain mechanisms with one person significantly more than can be explained by chance, and tends to pull certain responses from the other to a similar degree, then a role relationship can be said to exist.

This selective process of employing a narrowed range of reflexes with certain others works, as has been seen, in a double reinforcing manner. Most durable relationships tend to be symbiotic. Masochistic women tend to marry sadistic men; and the latter tend to marry women who tend to provoke hostility. Dependent men tend to seek nurturant superiors, who in turn are most secure when they have docile subordinates to protect.

The institutional role relationships—such as boss-secretary, prisoner-guard, student-teacher—tend to be more stereotyped and fixed. Even so, some room for role variability exists. Some secretaries do ‘mother,’ nag, or even boss their nominal superiors. In general, however, it can be surmised that personality factors do enter into the choice of occupation. Those people who are least anxious and most secure when they are submitting to and depending on strong authority tend to seek and hold subordinate jobs. The network of relationships even in the simplest office set-up can be bewildering in its multilevel complexity.

Patients as Diagnostic Instruments

The instrument employed to measure interpersonal reflexes is another human being. Since interpersonal behavior is a functionally important dimension of personality, it is measured directly in terms of the actual social impact that the subject has on others. Some interesting implications develop. By allowing the patient to react with others—say, in a group therapy situation—it is made possible for him to demonstrate directly and openly his repertoire of interpersonal reflexes. It is made possible for him to manifest in the group the pattern of social reactivity which characterizes his dealings with others. He tends to recreate to a mild extent in the group his neurotic adjustment. He accomplishes his own interpersonal diagnosis.

The therapeutic group thus serves as a small subsociety, a miniature world. Many patients tend to arouse in the other group members the reactions which they get from some of the significant others in their
world. The members of a therapy group have a valuable diagnostic function. When they rate each other's interpersonal behavior-on a check list or sociometric blank, covering the range of the 16 generic variables-an estimate of what each patient has done to the others is obtained.

THE PRINCIPLE OF SELF-DETERMINATION

I have consistently employed in the preceding sections a rather cumbersome circumlocution to describe the interaction between the sample subjects and the others with whom they interact. Most statements describing what others did to the sample case have been worded so as to give responsibility to the subject. Thus I say, "He trained or provoked the group members to reject him," rather than "They rejected him." In the listing of illustrative interpersonal reflexes, it may have been noted that both active and passive phrases were used. Thus for the interpersonal reflex G both acts rejected and provokes rejection have been included. The subject is taken as the focus of attention and as the locus of responsibility.

I have tried to stress the surprising ease with which human beings can get others to respond in a uniform and repetitive way. Interpersonal reflexes operate with involuntary routine and amazing power and speed. Many subjects with maladaptive interpersonal patterns can provoke the expected response from a complete stranger in a matter of minutes. The defiant chip-on-the-shoulder attitude; the docile, fawning passivity; the timid, anxious withdrawal-these are some of the interpersonal techniques which can produce the reciprocal reaction from the other person with unfailing regularity. Severe neurotics-defined at this level as persons with limited ranges of reflexes-are incredibly and creatively skilled in drawing rejection, nurturance, and so on, from the people with whom they deal. In many cases the 'sicker' the patient is, the more likely he is to have abandoned all interpersonal techniques except one, which he can handle with magnificent finesse. Most clinicians who have dealt with the so-called catatonic negation will testify that this disorder involves a powerful interpersonal maneuver.

Assigning the causative factor in interpersonal relations to the subject is a standard procedure in dynamic psychiatry. The skillful therapist is usually not inclined to join the abused, unhappy, masochistic patient in lamentation. He is much more inclined to ask himself, and eventually the patient, "What do you do to people with consistent and consummate skill to get them to beat you up?" The principle involved here holds that interpersonal events just do not happen to human beings by accident or external design. The active and executive role is given to the subject.

THE PRINCIPLE OF RECIPROCAL INTERPERSONAL RELATIONS

The principle of self-determination as it operates at Level 1 has several implications. The idea that people must take the credit or blame for their own life situations has had an obvious effect on clinical practice. It assigns to the patient the responsibility for developing and managing his own personality. This is a terrible power, and one which he is often not willing to accept. The key factors in personality seem to be the purposive messages that persons express to others in their Level 1 communications. For many patients these are signals of weakness and blame. "Others must help me; others are myundoing" are familiar and poignant themes expressed by many psychiatric patients. The idea of self-determination removes the protective devices of projection and externalization, giving in return a priceless, but often unwelcome, gift of personal power. If you made yourself and your world, then you can change yourself and your world. Since your own interpersonal communications have woven the unique tapestry of your life, then you are the only one who can create or change the pattern. The responsibility for the past and the endowment for the future are in your hands.

In my development of these themes, a rather curious imbalance may have been noted. For purposes of exposition I have concentrated on the viewpoint of the subject. At times this may have implied a paradoxical situation in which everyone goes around training others to respond to him in specified ways. This is, of course, rather puzzling. If everyone is actively creating his own interpersonal world, no one is left to be passively trained by others. This dilemma is caused by the concentration on one side of the interpersonal exchange-the subject.
Actually, interpersonal relationships can never be understood unless both sides of the interaction are studied. When only one side—the self or subject side—of interpersonal behavior is isolated and studied, there is a risk of distortion. When the various levels and areas are considered in turn, there is a danger of segmental overemphasis—one of the plagues of psychological theory. The principle of self-determination is a probability statement which has reference to the global organization of personality in general and to Level 1 in particular. The over-all counterbalance system of the total personality is, for all predictive purposes, the focal unit. It has special importance in shaping a strategy and tactic of psychotherapy. In the preceding section I have, for expository purposes, stressed the self-response and under-stressed the other, or environmental factors. But in actuality both partners in any relationship share the responsibility for its development—a mutual determining operation is occurring. The mother does not create the child’s personality. The child does not create the maternal reaction. Both mother and child are engaged in a most intricate reciprocal process to which both bring determinative motivations.

**Reinforcement of the Original Reflex through Social Interaction**

In considering both sides of the interpersonal situation—the two-person commerce of communication—the first point worth comment is the reinforcing quality of social interaction. One’s actions toward other people generally effect a mirror duplication or a countermeasure from the others. This in turn tends to strengthen one’s original action. If you walk up and aggressively shove a stranger, the chances are good that he will shove you back. Of course, this rule does not work uniformly. One person out of a hundred might be that Christian soul who would tenderly embrace you. A few might slink away from you. A few might docilely attempt to placate you. But the largest percentage would mirror your aggression and probably shove back. Your counter response would then become the issue. You might apologize, you might retreat, but, assuming you are an aggressive shover to begin with, the statistically probable response would be to shove back, perhaps harder.

You have provoked a response which has reinforced your original action. This reinforcing process is called the principle of reciprocal interpersonal relations. This is a general probability principle which holds that: Interpersonal reflexes tend (with a probability significantly greater than chance) to initiate or invite reciprocal interpersonal responses from the other person in the interaction that lead to a repetition of the original reflex.

**Qualifications and Exceptions**

The reinforcing process I have described is not an all-inclusive principle. It is a probability function. It does not necessarily hold for the individual interaction. Aggression usually breeds counter aggression. Smiles usually win smiles. Tears usually arouse sympathy. In specific cases, however, these general rules break down. Aggression can win tolerant smiles. Tears can provoke curses.

When the thousands of interactions that make up each day of social existence are studied, this principle becomes increasingly useful. Many kinds of variation and inconsistency operate to lower perfect predictability of interpersonal behavior. The meaning of the cultural context, the personality of the other person, and oscillation tendencies in the subject are always complicating factors. Like any other principle which involves human emotions, the principle of reciprocal relations operates in probabilistic terms.

Reciprocal relations are more likely to develop with certain personalities than with others: The principle holds most uniformly with pairs of symbiotically ‘sick’ people. A phobic, dependent wife and a nurturant, strong husband would be such a pair. The more the husband takes care of her, the more the dependence repeats. The more the wife clings, the more pressure there is on the husband to be gentle and protective. Even in a symbiotic marriage of this sort, the reciprocity would tend to break down if other motives entered the behavior of either. If hostile reproach lies behind the wife’s weakness, or if impatient superiority behind the husband’s strength, then new chains of interaction may develop.

There is another aspect of this principle: the sicker a person is, the more power he has to determine
his relationships with others. A maladjusted person with a crippled set of reflexes tends to overdevelop a narrow range of one or two interpersonal responses. These are expressed intensely and often, whether appropriate to the situation or not. Now a normal person has a fairly flexible range of reflexes. He can use any interpersonal response if the situation calls it out. He is less committed and, for that matter, less skillful in the use of any particular reflex. When the two interact, it is the 'sick' person who determines the relationship. The more extreme and rigid the person, the greater his interpersonal 'pull'-the stronger his ability to shape the relationships with others. The withdrawn catatonic, the irretrievable criminal, the compulsively flirtatious charmer can inevitably elicit the expected response from a more balanced other.

The flexible person can draw out a greater variety of responses from others depending on his conscious or unconscious motives at the moment. He can get others to like him, take care of him, obey him, lead him, envy him, and so on. The 'sick' person has a very narrow range of interpersonal tactics, but these are generally quite powerful in their effect. I have seen compulsive, responsible group members after several months of treatment desperately trying to get the other group members to understand and commiserate with their inner feelings of weakness and despair. But they had trained the other members well to look up to them and respect them. Their own managerial reflexes kept firing even at the moment when they were verbally appealing for help and sympathy. Most of the patients seen in the clinic have protected themselves with automatic responses and train others much too easily to follow along the expected lines of interaction.

Another qualification of the principle of reciprocal relations must be emphasized—the effect of variations within the subject. In describing human behavior, the impression is often given that a consistent line of adjustment is exhibited. In most of the illustrations used in this article, the subject's role is made to appear fixed. Actually, inconsistency and changeability are the rule and not the exception in human emotions. The factors of change and stability have been treated elsewhere. They are studied as a separate dimension of personality—the variability dimension. Included under this topic are all the measurable variations which affect human behavior—changes in cultural context, changes over time, changes due to conflict and variety among the levels of personality.

At this point it is sufficient to point out that no interpersonal role is absolutely pure or rigid. The most withdrawn catatonic sends out occasional tendrils of affect. The most hardened criminal occasionally has a moment of congeniality. The most autocratic five-star general occasionally admits he is wrong. Most people show considerable conflict or inconsistency in their actions from time to time. No matter how thick and effective the reflex defenses, underlying inconsistencies eventually manifest themselves.

When this happens, the principle of reciprocal relations tends to break down. The probable accuracy of the predictions drops. For instance, a flirtatious woman evokes seductive responses from a man. His approaches set off stronger flirtatious actions. The man becomes more seductive. But at some point in this process, underlying motives may step in to change the pattern. In some cases, a flirtatious facade may cover deeper feelings of competition or contempt toward men. The woman would then shift to rejecting behavior. The reciprocal pattern of entice versus seduce would shift. The man's reaction would then vary, depending on the nature of his multilevel pattern. He might continue to seduce, he might be hurt, he might become dependent.

The same process of circular interactions leading up to an intense breaking point often occurs between parent and child. Dependence evokes nurturance which evokes further dependence. In some cases the spiraling increase in intensity leads to a temporary crash. At some point the parent's underlying feelings of selfishness or self-protection lead to refusal. Father comes home one night tired and grumpy. Outside events may have set off underlying feelings of deprivation, or self-pity, or sadism. He may snarl at the child. The child then whines. The whining may increase the father's irritation. A new series of reciprocal events may thus be initiated.

Alternations of behavior are, of course, not an unhealthy manifestation. Moods shift; feelings are carried over from one situation into another; past events may set off emotions which are quite irrelevant to the current reality situation. It is safe to suggest that everyone acts inappropriately many times each day. These

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inconsistencies can hardly be considered abnormal. The lines of interpersonal communication are constantly breaking down momentarily, but these breakdowns involve no permanent disasters. A healthy father-child relationship is not paralyzed because one of the two has a bad day or carries over inappropriate feelings.

On the other hand, very rigidly formed relationships can be upset badly by shifts in the pattern of reciprocal relations. Some institutional relationships are very inflexible and demand perfect reciprocity. The army officer expects to evoke consistent obedience. A rent in this kind of interpersonal fabric can be seen as unforgivable. Some kinds of symbiotic marriages are so rigid that deviation in reciprocal roles can cause intense anxiety. When a servile, docile husband shows a flash of rebellion against a dominating wife, the results can be explosive.

Thus many factors tend to qualify the principle of reciprocal relations. Among these I have considered variations in the cultural context, variations in the personality of the other person, and variations due to multilevel ambivalences in the subject's personality.

In this article, which is concerned with interpersonal communication, I have described a measurement methodology and a theoretical context for dealing with certain aspects of behavior. The empirical unit by which social interactions are categorized is called the interpersonal reflex,-- defined as the social impact which the subject's action has on the other person. In discussing this, I have tried to stress the automatic and often involuntary way in which human beings 'train' or provoke others to react in consistent ways.

One of the main theoretical implications of this approach is the principle of self-determination, which focuses on the process by which one tends to create or recreate one's interpersonal world along routinized channels. This assigns to the subject the causative responsibility for the interpersonal relations which he integrates with others. The other theoretical implication which I have stressed-the principle of reciprocal interpersonal relations-refers to the probability tendency for subjects to pull from others interpersonal responses which lead to a repetition of the subjects' own favored interpersonal security operations. Both of these principles are tentative and hypothetical concepts which can be tested by means of the measurement system developed by the Kaiser Foundation research group.

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