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SOME COMMUNICATION PATTERNS OBSERVED IN FAMILIES USING AN IDENTIFIED PATIENT AS A SCAPEGOAT

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Some Communication Patterns Observed in Families Using an Identified Patient as a Scapegoat

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According to Vogel and Bell (1960), scapegoating is a social process in which tensions between or among group members are projected either onto a member of the group or onto an outsider. They suggest that the scapegoat serves the function of alleviating or channeling group tensions by "taking the blame." On the basis of the intensive study of a small group of families, each with an emotionally disturbed child, and a matched sample of "well" families, none of which manifested any disturbance, Vogel and Bell (1960) suggest that scapegoating within their sample of families is characterized by the following features: the scapegoat is an identified patient (usually a child) who is in some way "different" or exceptional, discipline is inconsistent (especially with reference to the patient's presenting problem), tension and value-conflict exist between the parents, and affect-expression is minimal between the parents.

Parenthetically, it should be noted that projection is, by definition, the primary feature of both scapegoating and paranoia. The difference between the two lies in the fact that the former is a group phenomenon whereas the latter is an intrapsychic phenomenon.

Theoretically, scapegoating should have three kinds of effects: 1. Scapegoating should retard the progress of family

therapy and reduce its effectiveness. 2. Scapegoating should encourage the development of pathology within the scapegoat. 3. Scapegoating should affect the pattern of family communications. The present study is primarily concerned with the behavior and communication patterns in scapegoating families and with the differences in these patterns between scapegoating and non-scapegoating families.

In order to understand the way in which scapegoating affects the course of family therapy, it is first necessary to understand the nature of family therapy. Whereas psychoanalysis focuses on internal psychological disorders, family therapy deals with disorders of a system of interacting personalities (Ackerman, 1962). The family therapist's job, then, is to reinforce the expression of valid, genuine emotion, to encourage mutual trust, and to realign roles within the family. In short, the family therapist deals explicitly with disturbed patterns of communication. In all of this, it should be noted that family therapy and psychoanalysis, or, for that matter, any other form of psychotherapy are in no sense mutually exclusive; they may be used in a complimentary fashion in the clinical setting. The point to be made is that the unique value of family therapy lies in the fact that by focusing on the disorders of a system of interacting personalities, the family therapist can attempt to relieve the pressure on the scapegoat and encourage the constructive expression of emotion by penetrating the mutually augmentative relationship between the pathology of a given family

member and the disturbed pattern of communication in the family.

Scapegoating may be expected to retard the process of family therapy outlined above since it causes one individual's behavior to become the focus of discussion rather than the disturbed patterns of family interaction. For example, it often happens that one result of scapegoating is that once the original presenting problem has been dealt with, the family conflict is expressed anew in terms of different symptoms presented by the original scapegoat or in terms of symptoms presented by a new scapegoat (Ackerman, 1962; Ackerman, et al. 1967). This process seems to operate in a way which is analogous to symptoms substitution.

Scapegoating may be said to be conducive to the development of disturbed behavior in the sense that the scapegoat may eventually become socialized into the role of the disturbed or mentally ill person. In Goffman's (1961) terms, the scapegoat may be said to be in the "pre-patient" phase of mental illness. That is, the scapegoat has not actually been labelled mentally ill (although this may take place in time), but his behavior has become an appropriate object for scrutiny and comment by professional persons as well as by family members. Social pressure is usually brought to bear during the pre-patient phase of mental illness for the patient to play the role of the sick person whether he is sick or not, thus validating the diagnosis of mental illness (Goffman, 1961, 1963; Sarbin, 1967; Scheff, 1966). Family therapy should tend to discourage the socialization of any one person into the role of the mental patient since the

focus of attention is on the interactions of a group of people rather than on the behavior of any one person.

Unfortunately, apart from the work of Vogel and Bell (1960), there seems to be very little literature concerned with the peculiar behavioral and communicative characteristics which scapegoaters are presumed to exhibit. The purpose of the present study is to investigate the following hypotheses about the behavioral and communicative characteristics of scapegoaters:

Hypothesis 1: The group of high scapegoating families should be found to have more identified patients who are different or exceptional in some way than the families in the low scapegoating group (Vogel and Bell, 1960). Also, it follows from the notion that the patient is forced to play a social role whether he is sick or not (Goffman, 1961; Scheff, 1966) that there should be no more evidence that the identified patients in the high scapegoating group are in fact different or exceptional than there is evidence that the identified patients in the low scapegoating group are in fact exceptional. In other words, the hypothesis is that patients in the high scapegoating group will be perceived by their families as being more disturbed than will the patients in the low scapegoating group.

Hypothesis 2: The families in the high scapegoating group should show less affect than the families in the low scapegoating group since one purpose of scapegoating is to allow family members to conceal tensions which they are afraid to deal with openly. Specifically, the parents in the high scapegoating group

should be found to express less affect between one another than than parents in the low scapegoating group (Vogel and Bell, 1960).

Hypothesis 3: The parents within the high scapegoating group should be more inconsistent about discipline of the identified patient than parents in the low scapegoating group (Vogel and Bell, 1960).

Hypothesis 4: Parents in the high scapegoating group should show more evidence of disagreements between themselves with respect to expressed values than parents in the low scapegoating group (Vogel and Bell, 1960).

Hypothesis 5: Families as a whole in the high scapegoating group should make more declarative statements than families in the low scapegoating group. Hypothesis 6: Families in the high scapegoating group should make more imperative statements than families in the low scapegoating group. Hypothesis 7: Families in the high scapegoating group should make more interrogative statements than families in the low scapegoating group.

Hypothesis 8: Families in the high scapegoating group should make fewer statements in which affect is expressed than families in the low scapegoating group since Vogel and Bell (1960) suggest that one of the characteristics of the scapegoating situation is that affect-expression between the parents tends to be suppressed.

Hypothesis 9: Families in the high scapegoating group should make more evaluative statements than families in the low scapegoating group. Hypothesis 10: Families in the high

scapegoating group should make more prescriptive statements than families in the low scapegoating group. It is predicted that families in the high scapegoating group will make more evaluative and prescriptive statements about the behavior of the patient than will low scapegoating families since one aspect of the scapegoating situation (pre-patient phase of mental illness) is the fact that the scapegoat is in some way stigmatized with the result that the expectations of others concerning his behavior are stereotyped (Goffman, 1961).

Method

Subjects: The sample consisted of ten families, each with a child as an identified patient, which came to the Psychological Services Center at the University of Massachusetts at Amherst for evaluation. The requirements for inclusion in this study were that there be a clinical file and a taped interview in which at least two family members were present for each family. Table 1 lists some of the characteristics of the families studied

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Insert Table 1 about here

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including the marital and educational status of the parents, the number of children in the family, whether the identified patient was adopted or natural, the sex of the patient, and which family members were present for the taped interview. Note that only one set of parents was divorced and that only one of the patients was a female.

Table 1

Characteristics of the Families Studied

Family number	Marital status of parents	Educational status of father	Educational status of mother	Number of children (including patient)	Patient adopted or natural	Sex of patient	Family members in interview
1**	Married	H. S.	B.A.	4	Natural	Male	Mother, patient.
2*	Married	Ph.D.	H. S.	2	Natural	Male	Father, mother.
3*	Married	H. S.	H. S.	5	Natural	Male	Father, mother, patient, 1 sib.
4**	Divorced	H. S.	H. S.	5	Natural	Male	Father, mother, patient.
5**	Married	B.S.	B.A.	2	Natural	Female	Father, mother, patient.
6*	Married	Ph.D.	H. S.	2	Natural	Male	Father, mother patient.
7*	Married	M.A.	B.A.	2	Adopted	Male	
8**	Married	Ph.D.	H. S.	2	Natural	Male	Father, mother, patient, 1 sib.
9**	Married	1 yr. coll.	Ninth grade	2	Adopted	Male	Father, mother, patient.
10*	Married	H. S.	R. N.	3	Natural	Male	Father, mother, patient.

*High scapegoating group
**Low scapegoating group

Raters: There were 12 raters in this study aside from the experimenter. All the raters were volunteers. Nine of the raters were graduate students in the Department of Psychology at the University of Massachusetts, one rater was an undergraduate in the department, one was a faculty member in the department, and one was the wife of a graduate student.

Design and Procedure: Each of the ten families chosen for this study was rated on the extent to which the identified patient was scapegoated by his family, the extent to which the family exhibited the associated characteristics suggested by Vogel and Bell (1960), and the extent to which each family used declarative, interrogative, imperative, affective, evaluative and prescriptive sentences in discussing the presenting problem.

The instructions for the scapegoating rating were:

> Scapegoating is defined as occurring when a group (a family in this case) blames a member of the group for the existence of tensions within the group. You are to rate the extent to which a family blames a family member for its problems as well as the extent to which the family denies its blaming behavior on the following continum: much, some, a little, none. An example might help to clarify this: If a family indicates that its only problems are caused by the patient's behavior, then at least some blaming behavior is occurring. If that same family indicates that its problems antedated the patient's maladaptive behavior, then no blaming is occurring. If this family indicates that it has other problems besides the patient's behavior, then denial is not occurring. Look for concrete examples of other problems such as arguments between the parents, problems at work, problems with other sibs, etc. If the family indicates that it has other problems, but doesn't indicate what they are, then some amount of denial is occurring.

The instructions for the associated characteristics ratings were:

> On the basis of the clinical record, you are to make the following ratings:

1. Is there any evidence that the identified patient is perceived by his family as being different or exceptional in some way from other children his age? For example, do they think that he is retarded or that he has some physical handicap? Much, some, a little, none. Is there any clinical or medical evidence that the patient is exceptional or different? Much, some, a little, none.
a. Is any other child in the family perceived as being different or exceptional? Much, some, a little, not exceptional. Is there any clinical or medical evidence to support this perception? Much, some, a little, none.
2. Is there any evidence of affect suppression between the parents? For example, is any mention made of frigidity, coldness, or indifference between the parents? Much, some, a little, none.
a. Is there any evidence of affect suppression in any other dyad in the family? Much, some, a little, none.
3. Is there any evidence that one parent treats or disciplines the patient differently than the other parent treats or disciplines him? For example, does one parent do all the punishing? Much, some, a little, none.
a. Is there any evidence that one parent treats or disciplines any other child in the family differently than the other parent treats that same child? Much, some, a little, none.
4. Have the parents ever disagreed with respect to expressed values? For example, does one parent value education more highly than the other parent? Much, some, a little, none.

The instructions for the verbalization ratings were:

Each tape will be approximately one hour in length. Rate only the first half hour. Break this half hour into six five-minute sequences. You can time the five minute sequences by using the counter on the tape recorder to measure the length of tape played in five minutes and using the counter as a timer thereafter. Use one rating sheet for each dyad present. Each time someone speaks, use the sheet which has been coded for the appropriate dyad (e.g., the sheet coded "6" if the patient is speaking to the father) and count the number of intelligible statements which fall into each category. For example, in the third five minute sequence, if the patient speaks to the father, find the sheet coded "6", find the column marked "3", and make a tally mark for each declarative sentence, each interrogative sentence, and so on. A statement is defined as a verbalization containing a subject and a verb. Definitions and examples of the various categories are:

1. Declarative sentence: a simple statement of fact. This category also includes sentences of the form: If . . . , then . . . . Examples: John ran away from home twice last week. If you don't behave, (then) I'm going to have to spank you.

2. Interrogative sentence: information is sought. Such sentences are usually distinguished by a lifting of the voice (inflection) toward the end. Examples: When are we leaving? Where were you?
3. Imperative sentences are used to express commands. Examples: Sit down! Don't climb out the window!
4. Affect: this can be broadly defined as emotion. Examples of affect-expression are laughing, crying, shouting, and saying such things as "I love you" or "I hate you." Note that a sentence may fall into more than one category. For example, the sentence "I love you" is a declarative sentence which expresses affect. In such a case, make one tally mark for each appropriate category (in this case, mark "declarative sentence" and "affect expressed").
6. An evaluative statement is a statement in which some sort of comparison is made. Examples: Johnny just isn't learning to read as well as other children his age. (N. B.: this is also a declarative sentence.) Bobby doesn't behave as well as our other children. (This is also a declarative sentence.)
7. A prescriptive statement is a statement which contains the words "should" or "ought." Examples: Johnny should know how to read better than he does. (This is also a declarative sentence.) Shouldn't Bobby go to bed earlier? (This is a prescriptive statement in the form of an interrogative sentence.)

The definitions of the various categories and ratings are contained in the instructions. For sample rating forms, see appendices 1-3. The scapegoating and associated characteristics ratings were made on the basis of the information contained in the clinical files and the verbalization ratings were made on the basis of the first half hour segment of a taped interview made either during the initial intake procedure or during the early stages of therapy. Each case file contained reports on the intake interview, school and doctors' reports, the family social history, a record of the patient's diagnostic testing (if any), and a diagnostic summary and list of recommendations made by the case workers.

The verbalization categories used were those of Lennard and Berstein (1960). Lennard and Berstein (1960) define a proposition

as a "verbalization containing a subject and a predicate either expressed or implied." A statement is defined as an uninterrupted series of propositions. The assumption is that by analyzing the grammatical mood, affective content, and form of a subject's speech, one can infer what the speaker's attitude toward the thing spoken of is. The verbalization ratings were made in an effort to ascertain whether or not there were significant differences between the high and low scapegoating groups in the way they talked about the identified patient and his presenting problems.

Each type of rating for each family was done by a different rater so as to insure that the ratings for each family would be independent of one another. Half the ratings in each of the three bodies of data were rated by a second rater so that an estimate of the inter-rater reliability could be made.

To insure that no rater would rate the same family twice, a record was kept by the experimenter of who had made the various ratings for each family. Raters were given clinical files and tapes to rate after consultation of the record kept by the experimenter.

Reliability: The Pearson product-moment correlation coefficient was used to determine the degree of reliability between the initial ratings and the check ratings. Only those associated characteristics and verbalization categories which were found to have inter-rater correlation coefficients which approached significance ($p<.10$) were investigated further. The Pearson product-moment correlation coefficients presented in Table 2

are for the individual items in each rating scale. The correlation coefficients presented opposite the titles of the three scales in Table 2 represent the total inter-rater reliability for

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each of the three independent bodies of data.

The reliability findings were sufficient to permit the following hypotheses to be tested: Parents within the high scapegoating group should be more inconsistent with respect to disciplining the patient than parents in the low scapegoating group (hypothesis 3). Families in the high scapegoating group should make more declarative statements than families in the low scapegoating group (hypothesis 5). Families in the high scapegoating group should make more imperative statements than families in the low scapegoating group (hypothesis 6). Families in the high scapegoating group should make more interrogative statements than families in the low scapegoating group (hypothesis 7). Families in the high scapegoating group should make fewer statements in which affect is expressed than families in the low scapegoating group (hypothesis 8). Families in the high scapegoating group should make more evaluative statements than families in the low scapegoating group (hypothesis 9).

Table 2

Inter-rater correlation coefficients for individual items in the rating scales and inter-rater correlation coefficients for the total scales

Item	r	df
Scapegoating (total)	.8715*	3
Blaming	.6910	3
Denial	.8128*	3
Associated characteristics (total)	.5933*****	43
Perception of patient as exceptional	.6324	3
Evidence for perception of patient as exceptional	.2721	3
Perception of other family member as exceptional	.7717	3
Evidence for perception of other family member as exceptional	.9490***	3
Affect suppression between parents	.5976	3
Affect suppression in other dyads	.2886	3
Inconsistent discipline of patient	.9185**	3
Inconsistent discipline of other child in family	.4082	3
Disagreement with respect to expressed values	.0000	3
Verbalizations (total	.9203*****	208
Declarative sentences	.8990*****	33
Interrogative sentences	.4369****	33
Imperative sentences	.9067*****	33
Statements with affect expressed	.8329*****	33
Evaluative sentences	.8286*****	33
Prescriptive sentences	-.3213*	33

*p<.10
**p<.05
***p<.02
****p<.01
*****p<.001

The ten families in this study were divided into two groups (five families were in each group) on the basis of the amount of scapegoating in each family. The scapegoating scale ran from a low of zero to a high of six. This scale was arbitrarily divided in the middle so that families with a scapegoating score of three or less were considered to be in the low scapegoating group while families with a scapegoating score of four or more were considered to be in the high scapegoating group. It is interesting to note that of the ten families studied, only one family showed no evidence of scapegoating. The high and low scapegoating groups were then compared by means of the Mann-Whitney U test for small samples (Siegel, 1956) on those associated characteristics and verbalization categories which were found to have inter-rater correlation coefficients which approached significance ($p<.10$).

The raw data used for these comparisons are summarized in Table 3. The names of the categories on which the two groups are being compared appear on the left, and the group means, standard deviations, and the U's are listed across the page.

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Insert Table 3 about here

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The Mann-Whitney U test was used to make the comparisons between high and low scapegoaters because it is one of the most powerful and efficient nonparametric alternatives to the parametric t test (Siegel, 1956; Hays, 1963). The t test is not

Table 3

Results of the comparison of high and low scapegoating groups by means of the Mann-Whitney U test on those items which had sufficient inter-rater reliability to permit testing of the predicted differences between high and low scapegoating groups.

Item	Mean of high scapegoating group	SD of high scapegoating group	Mean of low scapegoating group	SD of low scapegoating group	U
Associated characteristics total	11.40	2.06	8.60	4.08	8
Inconsistent discipline of identified patient by parents	1.60	1.20	1.40	1.20	13
Verbalizations (total)	216.25	15.16	174.20	50.79	3*
Declarative sentences	175.00	16.84	149.00	50.80	8
Interrogative sentences	20.50	11.72	3.80	2.99	0**
Imperative sentences	3.75	2.68	2.00	2.00	6
Statements with affect expressed	4.75	1.92	8.20	3.97	3*
Evaluative sentences	10.50	7.40	10.60	7.31	10

*p $<.06$
**p $<.01$

appropriate for comparisons involving associated characteristics because the associated characteristics were measured on an ordinal rather than an interval scale.

Discussion

The findings presented in this paper should be regarded as being merely suggestive rather than definitive since there were many hypotheses to be tested. Given many hypotheses to be tested, one would expect that some of them would reach statistical significance merely by chance.

Unfortunately, many of the predicted differences between the high and low scapegoating groups could not be tested due to the lack of sufficient inter-rater reliability. Note, however, that all of the individual items for which the inter-rater r is not significant have only three degrees of freedom associated with them. The implication here is that some of the inter-rater r's were statistically insignificant not so much because of a lack of inter-rater agreement as because of an insufficient number of data points. It may be, therefore, that if more families could have been included in the sample, more of the inter-rater r's would have been statistically significant.

Of those items for which the inter-rater r's were statistically significant, no test of the hypothesis that scapegoaters use more prescriptive statements in discussing the presenting problems was possible due to the fact that the inter-rater correlation coefficient was negative and statistically significant, thus indicating a substantial amount of inter-rater disagreement. One possible explanation for this apparent disagreement is that

very few prescriptive statements were made by any of the subjects in this study with the result that any inter-rater disagreement would tend to distort the value of the r, given the restricted range of scores.

The inter-rater reliability coefficient for the scapegoating scale approached significance and the inter-rater reliability coefficient for the associated characteristics scale was significant. Thus, a rough test of hypotheses one and four was made using the total of the associated characteristics scores even though an item-by-item comparison could not be made in order to test these hypotheses. Briefly, hypotheses one and four state that the high scapegoating group should show more perception of the identified patient as being exceptional (hypothesis 1) and more value disagreement between the parents (hypothesis 4), than the low scapegoating group. However, since there was no significant difference between the high and low scapegoating groups with respect to the total associated characteristics exhibited, no confirmation of hypotheses one and four was possible.

It is apparent that, within the limits of the sample studied, the high scapegoating group tended to make more statements of all kinds than did the low scapegoating group, the high scapegoating group tended to make more interrogative statements than did the low scapegoating group, and the high scapegoating group tended to make fewer statements in which affect was expressed than did the low scapegoating group. Thus, the hypothesis that the high scapegoating group should make more interrogative statements than the low scapegoating group (hypothesis 7) and the hypothesis that the

high scapegoating group should make fewer statements in which affect is expressed than the low scapegoating group (hypothesis 8) were confirmed. Also, the confirmation of hypothesis eight lends considerable support to the hypothesis that the high scapegoating group should show less affect than the low scapegoating group (hypothesis 2).

The fact that the high scapegoating group tended to talk more in the taped interviews than the low scapegoating group was an unexpected result in that there was little theoretical reason to predict that a difference would exist between the high and low scapegoating groups with respect to the total number of verbalizations. This fact is, therefore, presented as an empirical finding of this study. This result, however, is in line with the original predictions that the high scapegoating group would make more declarative, interrogative, imperative, evaluative, and prescriptive statements than would the low scapegoating group (hypotheses 5, 6, 7, 9, and 10), although it cannot be considered as being in any way a test of any of these individual hypotheses.

It should be noted that, in the sample under discussion, the high scapegoating group was not significantly different from the low scapegoating group with respect to the total associated characteristics exhibited. While this result cannot be considered as a test of the predicted differences between the high and low scapegoating groups with respect to any of the individual associated characteristics, it does suggest that the effects of scapegoating were not as strong in the sample studied as might have been supposed on the basis of the theoretical considerations presented earlier

in this paper (Vogel and Bell, 1960). It may be, however, that the distinctions between the two groups were blurred by the fact that nine out of the ten families studied showed at least some evidence of scapegoating, and hence they might be expected to show at least some evidence of the associated characteristics thought to be associated with scapegoating.

The high scapegoating group tended to make significantly more interrogative statements than did the low scapegoating group. Since the reasons why this might be the case are not clear because no dyadic or content analyses of the verbalizations were possible, this fact is presented as an empirical finding of this study.

The fact that the high scapegoating group tended to make significantly fewer statements in which affect was expressed than did the low scapegoating group is consistent with the finding of Vogel and Bell (1960) that one of the characteristics of the scapegoating situation is that there tends to be affect-suppression between the parents. This result is to be expected in light of the fact that the definition of scapegoating given earlier in this paper suggests that scapegoating is one way of covering up tensions within a family. That is, in a family in which the members have difficulty in dealing with emotions such as anger, hostility, and guilt, one way of dealing with them which would substantially lessen their impact would be to "sweep them under the rug" or to channel them via the mechanism of scapegoating. In essence, then, scapegoating may usefully be seen as a kind of escape which is sometimes resorted to when the family finds itself unable to deal with tensions in more constructive ways. In light of the above

considerations, it seems that it might be useful to incorporate affect-suppression as part of the definition of scapegoating in that it can be seen not only as a characteristic of scapegoaters' communications, but also as a kind of motivation in that it aids in the avoidance of dangerous or potentially dangerous conflicts.

One of the central notions behind the idea that a disturbed child is often the family scapegoat (Vogel and Bell, 1960) is that the patient's disturbed behavior is due to the fact that the parents react to the disturbed child in a different way from the way in which they react to the patient's siblings. It might be, however, that the disturbance is due to the fact that the patient perceives the nature of the parental relationship more accurately than his siblings. For example, DuHamel and Jarmon (1970) suggest that "the parental dyad is conceptualized as a more distant relationship by emotionally disturbed children than it is by their siblings or a matched control group" (p. 7).

It would be theoretically useful at this point to explore the relationship between scapegoating, affect suppression, and the child's conception of the parental dyad. For example, if it could be shown that disturbed children in a high scapegoating group conceptualize the parental relationship as being more distant than do their siblings or disturbed children in a low scapegoating group, it would lend further support to the notion that one of the characteristics of scapegoating is affect suppression between the parents. On the other hand, if it were to be shown that disturbed children in both the high and low scapegoating groups conceptualize the parental relationships as being equally distant and more distant

than do siblings or normal controls, it would call into question the hypothesis that affect suppression is specifically a characteristic of the scapegoating situation and it would lend support to the hypothesis that the behavior of disturbed children is at least partly a function of the fact that they perceive the parental relationship as a distant one.

One possible reason why many of the predicted differences did not reach significance is that most (i.e., 90%) of the families studied showed at least a little evidence of scapegoating. That is, since pure cases of either scapegoating or non-scapegoating were difficult to find, many of the predicted differences may have been somewhat blurred by the similarity between the two groups tested.

It might also be, however, that scapegoating is not a very useful construct in differentiating clinical groups, even though it may have the effects mentioned by Vogel and Bell (1960). It may be that scapegoating can only differentiate in the grossest way, disturbed from non-disturbed families.

Another problem with the present study was that the inter-rater reliability was rather low for some of the individual items. This problem might be solved by using a group of raters with somewhat more similar experiences in making clinical judgements and by increasing the number of check ratings.

A third weakness of this study is that the sample size was severely limited, thus further obscuring any differences which may have existed between the high and low scapegoating groups and limiting the generalizability of the results.

A fourth limitation of the present study is that it was impossible to do any meaningful analysis of the taped interviews in terms of dyadic interactions in view of the fact that the same dyads did not always appear in the taped interviews (e.g., the father was absent in one interview, the patient was absent in another interview, etc.).

A fifth weakness of this study is that the sample may have been biased to begin with. That is, since the sample used in this study was so small, the chances of getting sample biased toward scapegoating were much greater than they would have been if a larger sample had been used. That the sample may have been biased seems likely in view of the fact it was somewhat more homogeneous with respect to the dimension of scapegoating than might have been expected on the basis of a truly random sampling of a clinical population.

Finally, in any replications of this study which may be done, it would be adivsable to use an interval rather than an ordinal scale to measure scapegoating and the various associated characteristics. Use of an interval scale would permit the use of parametric *t* tests, thus rendering both results and interpretations somewhat more clear-cut.

Summary of the findings:

Regardless of the dynamics of scapegoating, the data indicates that the high scapegoating group differed from the low scapegoating group in the following ways: the high scapegoating group talked more in the taped interviews, asked more questions, and expressed less affect in their speech than did the low scapegoating group.

On the basis of both past and present evidence, it is suggested that affect suppression is probably one of the most salient characteristics of the scapegoating situation. It is further suggested on theoretical grounds that affect suppression (avoidance of emotion) is, in a sense, an unconscious goal of scapegoaters.

In the light of the methodological problems encountered in this study, however, the findings cannot be considered to be at all conclusive. It is suggested that in any replications of this study which may be done that a much larger sample be used and that the groups to be compared should consist of a group of families, each with a disturbed child, all of which show evidence of scapegoating behavior and a group of normal control families, none of which show any evidence of scapegoating behavior. Further, it would be useful to use an interval rather than an ordinal scale to measure scapegoating and the associated characteristics. An interval scale or a fair approximation thereof might be obtained in this instance by using scale with a larger number of intervals, check rating all of the data, and using the average of the original and check ratings to compare the two groups. Finally, inter-rater reliability might be improved by using a more homogeneous group of raters than was used in this study.

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Appendix 1

Rating Form I (Scapegoating)

Rater Name:

Number of family being rated:

Amount of blaming behavior: Much_____Some____A little____None____

Amount of denial: Much____Some____A little_____None_____

Total: _____. To get a total, count "much" as 3, "some" as 2, "a little" as 1, and "none" as 0.

Appendix 2

Rating Form II (Associated Characteristics)

Rater name:

Number of family being rated:

1. Is there any evidence that the patient is perceived by his family as being exceptional in some way? Much____Some____A little____ None____. Basis for rating_____.
   a. Is there any medical or clinical evidence that the patient is exceptional in some way? Much____Some____A little____ None_____. Basis for rating_____.
   b. Is there any evidence that any other child in the family is perceived by the family as being exceptional in some way? Much_____Some____A little____None_____. Basis for rating_____.
   c. Is there any medical or clinical evidence to support the perception in (b)? Much____Some_____A little_____None____. Basis for rating_____.

2. Is there any evidence of affect suppression between the parents? Much____Some____A little_____None_____. Basis for rating_____.
   a. Is there any evidence of affect suppression in any other dyad in the family? Much_____Some____A little_____None_____ Basis for rating_____.

3. Is there any evidence that one parent treats or disciplines the patient differently than the other parent treates or disciplines him? Much_____Some_____A little_____None_____. Basis for rating_____.
   a. Is there any evidence that one parent treats any other child in the family differently than the other parent treats him? Much_____Some_____A little_____None_____. Basis for rating_____.

4. Is there any evidence that the parents have ever disagreed with respect to expressed values? Much____Some____A little_____ None_____. Basis for rating_____.

Appendix 3

Rating Form III (Verbalizations)

Rater name"

Number of family being rated:

Dyad code number:

	Time Sample Number					
Categories	1	2	3	4	5	6
Declarative sentences						
Interrogative sentences						
Imperative sentences						
Affect expressed						
Evaluative statements						
Prescriptive statements						