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PERSPECTIVES OF THE RESEARCH DEPARTMENT OF THE MENNINGER FOUNDATION

By GARDNER MURPHY, Ph.D.* and ROBERT WALLERSTEIN, M.D.†

Rather than simply marking off a corner of the intellectual terrain for the specialized activities of a research department, the thought of The Menninger Foundation has been crystallizing increasingly in the direction of a research attitude as a pervading facet of every therapeutic, educational, or service function. Research then properly becomes a way of conceptualizing the regular working data of clinical operations in order to find common ground, to allow the emergence of broad hypotheses suggested tentatively by these clusters, and then to arrange and systematize the data so as to throw continuing light on the validity of these hypotheses and the direction their revision should take. Within this context, a review of the spectrum and the perspectives of the Research Department becomes the conveying of a feeling tone about the clinical atmosphere and the frame of reference within which clinical and educational functions are carried on, as much as a consecutive listing of specific research projects in progress under the auspices of the Research Department.

In many respects, the operating set-up at The Menninger Foundation is specifically suited to the kind of research spirit and the special research activities that it is trying to develop. It is in essence a multidisciplinary group practice, providing facilities for a wide gamut of psychiatric therapeutic methods applied to the entire range of mental illnesses. It has hospital, day hospital, and out-patient settings. It has a comprehensive hospital management and activities program, as well as a large-scale program of individual psychotherapeutic activity within a consistent and unifying matrix of dynamic psychiatric concepts. In view of the volume of clinical material, opportunities are available for the pursuit of promising clinical problems that stir the interests of groups of colleagues. The multidisciplinary and group nature of the clinical psychiatric practice make for fruit-

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ful testing and interchanges of ideas as well as for collaboration in the attack on problems where different kinds of specialized training—psychiatry, clinical psychology, social work, nursing, adjunctive therapy—can be brought to bear as required by the clinical problem.

Within the framework of these advantages and possibilities, the current and projected research program of The Menninger Foundation can be presented both for purposes of periodic stock-taking, necessitated by its rapid and variegated growth, and for possible assessment of currently neglected avenues of approach, either additional to, or perhaps broadly integrative of, current work in progress. It is perhaps best to begin such a review with those research activities most intimately integrated into the matrix of ongoing clinical work and patient care, and then go on to those less organically related to immediate therapeutic activities and less immediately relevant to clinical problems.

II

The Psychotherapy Research Project began as a pioneering interest on the part of Dr. Paul Bergman and became some two years ago an official activity of the Department of Adult Psychiatry. Its present co-chairmen are Dr. Donald Watterson and Dr. Lewis L. Robbins, the Director of the Department of Adult Psychiatry. It was conceived as a broad attack on the many problems of the nature and the effectiveness of psychotherapy and as a systematic testing of hypotheses relating to the psychotherapeutic process.

This project has had a number of vicissitudes, as it has grappled with the many problems of research design and method involved in the attempt to derive insights from the bewilderingly complex data of therapeutic interactions, in which relevant variables cannot be consistently eliminated or held constant in the interests of neatness of design; and in which the most significant observer (the therapist) is inevitably—and deliberately—the single most potent force for altering the very data being observed. The difficulties so universally met (GAP Committee on Psychotherapy, successive Round Tables on the problems of research and psychotherapy at the American Orthopsychiatric Association conventions in 1946,–47,–48) in definition of the units of behavior being measured, the units of observed change, and the meaning of the observed changes, once determined, attest the complexity of the problems being tackled.

At present, the working of the Psychotherapy Research Project consists chiefly of three subcommittees each working from a particular vantage point, and pointing toward a diffusion outward to meet each other with interlocking data, illuminating each other's field of inquiry. The cross-sectional vantage points chosen thus far are (1) Psychotherapy Initial Study, a predictive study done at the time of initial clinical evaluation, under the direction of Drs. Robbins and Robert Wallerstein, (2) Psychotherapy Termination Study, a retrospective critical study done at the time of termination of psychotherapy, under the direction of Dr. Watterson, and (3) Psychotherapy Follow-Up Study, done mainly by personal visits at varying time intervals after the return of the patient to his home community, under the direction of Mrs. Helvi Boothe, the head of the social work staff.

The entire Psychotherapy Research Project is the subject of a separate article for this issue of the *Bulletin* by Dr. Watterson, and therefore the salient features of its component parts will not be further delineated here. The whole project can develop, it is hoped, into a consistent and sustained inquiry into the ongoing therapeutic process, using continuing observation of therapy currently being done and supervised; and into the outcome of prediction, the nature of therapeutic interaction, and its adherence to or departure from the predicted course. Ultimately, through such a process-centered approach from the vantage point of observation and supervision of therapeutic interaction, insights will accrue as to the "what" and the "how" of the therapeutic process—the factors that make for change, and the areas of predictability.

Somewhat related to the over-all Psychotherapy Research Project, particularly in giving impetus to the institution of the Follow-Up Study as part of the design of the larger project, has been another smaller follow-up study, more circumscribed in its objectives. This study, which is the subject of a separate contribution to this issue of the *Bulletin* by Mrs. Mildred Faris and Dr. Herbert Modlin is a review of 38 patients who came to The Menninger Foundation for work-ups and evaluations, most of whom did not remain for psychiatric care here, but returned to their homes with specific recommendations. The study investigates the effectiveness of the proffered recommendations as measured by the degree to which they were accepted and subsequently followed.

III

Side by side with the research activity into the nature of the psychotherapeutic process, are a number of projects geared to problems of hospital management, the milieu program, and the over-all effort to systematize methods of collecting and organizing data in the field of observation and control of the total life setting of the hospitalized patient. Such, for example, is a proposed study under the direction of Mr. Gerald Ehrenreich of the problem of prediction from the verbal material of clinical psychological tests to actual behavior processes in the hospital milieu. The design of the project is to study the battery of available psychological test data

obtained at the time of initial appraisal of the patient from the viewpoint of predicting not only the configurations of traits, impulses, and defenses which will emerge as the characteristic patterns and reactions of that individual in psychotherapy (also a primarily "verbal" interaction) but also to carry predictions over to manifestations in concrete social situations. Direct observation of the patient's actual behavior will thus be cross correlated with the predictions made from the verbal productions of the clinical testing situation. This entails the translation of knowledge of intrapsychic impulse-defense systems into predictions of overt manifestations in specified situations, which can be carefully delineated and readily studied in this controlled environment.

Another study of the hospital milieu, geared to the complex of countertransference attitudes evoked in the hospital physicians by their patients, is the Sedation Study of Drs. Irving Kartus and Herbert Schlesinger, in operation already well over a year. The study was built around the patterns of administration of sedative drugs to hospital patients as a readily identifiable and quantifiable piece of interaction between physician and patient. This interaction can be studied as a reflection of the pattern of relationship between the two, *e.g.*, the nature and meaning of the behavior of physician to patient as revealed in his manner of handling the problem of sedation, and even longitudinally, of the evolving pattern of the relationship. Another ongoing study is one by Drs. Derek Miller and Keith Bryant into the meaning of management prescriptions for the handling of in-patients by hospital personnel, and the ways in which such prescriptions are varyingly or consistently interpreted and the consequent impact on the patients of these interpretations.

A study proposed by Drs. Joseph Satten and Wallerstein deals with the problems of the psychological treatment of alcoholism, of "motivation" for treatment, and the meaning and consequences of the offer of Antabuse to the alcoholic patient, particularly as it casts light on these wider problems of treatment, motivation, and "acting out." Antabuse is chosen as the anchor of this study because it provides a well-structured, discrete situation around which this whole complex of psychological factors can be both discerned and studied in their interrelatedness. The study of this manageable microcosm of behavior can be used then both to cast more light on the role of Antabuse in the therapy of the alcoholic patient and also on the wider problems of alcoholism itself. Such questions come to mind as these: How willing is the alcoholic patient to take this internal chemical barrier into himself? What is his underlying fantasy about the role this will play in his life and about the meaning of this willingness? How does this willingness correlate with his "motivation" for treatment? To what extent is it a reliable correlate, and hence a reliable prognostic indicator of, say, capacity to enter into a sustained psychotherapeutic relationship, or even of ultimate favorable or unfavorable outcome of the psychotherapeutic endeavor? Can we even try to correlate discernible differences in physiological Antabuse-alcohol test reactions to psychological variables?

IV

In the study of psychophysiologic phenomena that comprise the frontier between general medicine and psychiatry, so-called psychosomatic medicine, The Menninger Foundation is less well equipped for independent investigative work, as it does not have the laboratory facilities—routine and experimental—that are part of the essential clinical functioning of a teaching general hospital. A research project is being planned, however, in conjunction with available local resources for physiological study, centering on clinical problems of thyroid-gland dysfunction. Dr. Homer Hiebert, roentgenologist at Stormont-Vail Hospital in Topeka, and Dr. Frank Hoecker, of the Biophysics Department of Kansas University in Lawrence, have been using radioactive isotope techniques with a group of individuals, manifesting clusters of "psychoneurotic" complaints, and who show with radio-iodine tracer studies localizable "hot nodules" of over-active thyroid tissue without any other demonstrable evidence of thyroid or other physiologic disturbance.

Before the advent of the newer radioactive techniques, these patients could not be distinguished physiologically in any manner. For the most part after either surgical ablation of the "nodule" or radio-iodine treatment of the gland, the presenting cluster of "psychoneurotic" complaints is reported to remit completely. Drs. Wallerstein, Watterson, and Philip Holzman are working up plans for a joint psychiatric-psychological study of this series of events, in conjunction with simultaneous physiological, pathological, and radioactive studies. Patients will group themselves into three follow-up categories: hemithyroidectomy, radio-iodine treatment, and those subjected to neither procedure. If these patients fall into groupings that relate to some of the usual psychiatric nosologic categories, the physiological studies of the thyroid can perhaps be brought into relation to the psychiatric evaluation process, and the over-all incidence and nature of the dysfunction further illuminated.

V

In the field of education, The Menninger Foundation undertook in 1946 a pioneering effort in conjunction with the Winter VA Hospital—and later extended it to Topeka State Hospital—to train as many as 100 psychiatric residents at one time. This ambitious program, called the Menninger School of Psychiatry, plunging into complex and relatively unexplored

fields, opened up a wide area of possible research into the problems of professional education in general and psychiatric education in particular. One aspect of this field selected out for careful research study is that of the criteria for selection of likely candidates for psychiatric training. The Selection Project, now completed after seven years of intensive labor and being written up by Drs. Robert Holt and Lester Luborsky, will serve to help those everywhere who teach young psychiatrists to understand something about the selection of the best candidates and also about changes which occur in the personalities and skills of such candidates during the course of their training. A progress report by Dr. Luborsky on the current state of this project is included in this issue of this *Bulletin*.

Another, differently focussed, project into an aspect of the educational process was the Psychotherapy Supervision Project carried out over a number of years by Dr. Rudolf Ekstein and a group of collaborators. The project was primarily a clinical and educational one; to improve levels of psychotherapeutic skill on the part of young therapists in training—psychiatric residents and psychological internes—by providing structured individual psychotherapy supervision. Simultaneously the supervisors themselves met in a group seminar and in individual sessions with the training consultant, to learn supervisory skills and to derive new insights into the nature of the supervisory process itself. The fruits of that collaborative endeavor are likewise currently being written up and a successor to the original project is again in operation, under Dr. Ekstein's leadership, at the Topeka State Hospital.

VI

More and more today we tend to think of problems developmentally. In a world where static modes of thinking have become more and more outmoded, nothing could be more crucial to a long-range view of research in a psychiatric center than study concerned with the problems of children. Some of these problems relate to hereditary tendencies, constitutional factors, nutritional, epidemiological, climatic and other factors viewed in terms of the physical and biological sciences; these studies require a type of facilities which can be more readily established in a great urban center or as part of a long-range plan of the National Institutes of Health or a group of cooperating universities. But other phases of our understanding of the development of healthy and unhealthy childhood can be better studied in a small center with intimate personal contact and a daily sharing of research ideas by a group of like-minded people. The Southard School, partly by virtue of its intimate organic relation to other phases of a larger psychiatric endeavor, partly because of its small inpatient group in relation to a relatively large staff—with resulting intimacy of study and continuous

exchange of professional skills and ideas in the service of the child—is almost ideally fitted for certain types of research.

The current research program of the Southard School includes an intensive study under Dr. Ekstein's leadership, through group seminar, and through supervision and study of individual case records, of the psychology and the psychotherapy of the borderline and psychotic child. Taking as the vantage point for observation of the psychological world of these severely disturbed children the mutually interacting psychotherapeutic process, implications for modifications of psychotherapeutic techniques derive organically from the psychological insights obtained. Several publications have already resulted from this study, which is now entering a broadened, more comprehensive phase of more systematic inquiry.

Concomitantly, in the realm of normal childhood and development, some of the children studied here by Dr. Sibylle Escalona in the Infancy Project are being intensively followed up to observe continuities in personality year by year, especially in terms of the individual differences observed in the infants and the postulated differences in trait configurations and temperament predicted therefrom. Likewise, using some of the same children, Drs. L. B. Murphy and Nelly Tibout and their collaborators have embarked on a Coping Project, a study of the ways in which normal children meet, master, and cope with the frustrations and difficulties which they confront; a study of the adequacies and resources of children's personalities to complement the more usual studies into weaknesses and psychopathological mechanisms. A fuller account of work at the Southard School has recently appeared in this *Bulletin*.

VII

In connection with the Rehabilitation Center for the Blind in Topeka, Dr. Helen Sargent has been carrying on a series of researches aimed at working out the applications and the limitations of her "Insight Test" as a projective psychological testing technique, perhaps uniquely suited to the special situation of the blind individual. In connection with this study, a Behavior Description Scale, and special adolescent forms of the Insight Test, were developed for clinical applicability to the problems of the blind. The Insight Test has been studied comparatively in both oral and braille forms, as well as in juxtaposition with matched control subjects with normal vision.

VIII

To turn now to the specific projects of the Research Department which are less closely related to the ongoing clinical therapeutic work, we wish to say a few words about the Perception Project. Six years ago, Dr. George

S. Klein developed a basic project on individuality in the processes of perceiving, very rich in implications for general personality study and for the understanding of specific weaknesses or predispositions to individual difficulty. Interpretation of external sensory phenomena has proven to be highly individualized along several axes of inquiry, in terms of the differently organized ways of viewing the world—"cognitive systems"—of the perceivers. Drs. Klein, Riley Gardner, Holzman, and Schlesinger, with the assistance of Miss Diana Laskin, are now carrying forward a new Integration Study. This is an eight-hour laboratory study of each of 60 subjects to each of whom the experimental procedures developed in the last few years is being applied in an integrated fashion. Thus the interrelationships between the different perceptual dimensions and their unifying relationship to the basic personality organization can be tested out and light thrown on the extent to which the personality configurations molds the manner of perceiving, along whichever axis it is measured. The current status of this attempt to see, in their interrelations, many attributes of personal individuality which have been separately studied in earlier investigations, is separately reported by Drs. Klein and Holzman in this issue of this *Bulletin*.

The word "appraisal" has often been used in psychiatry. Here we have appraisal, also, in experimental psychology, and the two are growing close together. The Perception Project, like many other activities here, is a form of appraisal of the individual, and we are thus coming to a point where appraisal of the person through laboratory studies, through projective tests, through psychiatric procedures, through social contacts and follow-ups, represents a complex and ultimately integrated view of the strengths and weaknesses of the individual person. Such studies, when further advanced, should not only help to make clear whether the person needs special help, but also to define the special strengths from which his greatest happiness and social usefulness may stem. The Coping Study at the Southard School and the studies of perception are examples of attempts to tap and define resources as well as vulnerabilities of various kinds of people. This suggests a long-range view of personality study in and for itself as a major phase of our research.

Supplementing the Perception Project, Dr. Gardner Murphy's recently organized Perceptual Learning Project, has been specially concerned with the problem of bias, distortion or self-deception as it enters into processes of interpreting the world and, in particular, to ways in which the individual may *outgrow or unlearn* these biases. The basic problem is the way in which the person may come to re-learn or reorganize his way of perceiving so as to have less of illusion and self-deception in it. Insofar as positive findings can be secured in the laboratory and can then be closely articulated with

observations of what goes on in the course of treatment, we may perhaps ultimately help to understand in one more dimension the ways in which the patient misinterprets his world, and perhaps also the ways in which the psychologist and psychiatrist—being human—show their own individuality in perceiving.

There is enough damage done in the world by perceptual bias, by self-deception, by inability or unwillingness to see, hear, remember and think objectively, to warrant our making the understanding and control of these processes one of our major concerns. The Menninger Foundation is a place well suited for the prosecution of such a program in an atmosphere in which psychiatric and other dimensions of understanding can be combined with such an experimental program.

IX

In summary, we have tried to delineate the extent of our clinical research program, our educational research program, and our laboratory research program. We hope they will coalesce into an effective unified program, contributing to the world's psychiatric development, capable from year to year of throwing more and more light upon basic problems of human psychology and psychopathology, and upon the circumstances from which more effective psychotherapeutic help can effect restoration of healthier living.

PROBLEMS IN THE EVALUATION OF PSYCHOTHERAPY*

By DONALD J. WATTERSON, M.D.†

The obligation to determine the effectiveness of our methods of psychological treatment has been acknowledged ever since the development of psychoanalytic treatment by Freud. This was never Freud's central interest, but some of his most significant thrusts in the development of psychoanalytic theory were made necessary by his realization, with experience, that this or that element of the treatment was effective or ineffective. Moreover, one of Freud's last pieces of writing, "Analysis Terminable and Interminable," was concerned with crucial questions of limitations to the scope and effectiveness of psychoanalytic treatment.

General Considerations

Space limitations prohibit any review of pertinent literature concerning reports of results in psychoanalytic treatment and psychotherapy, and the several symposia which have been held on this subject.[1-3] However, the crucial question of controls, though first broached in 1933,[10] has received relatively scant consideration since,[11, 16] and attempts to bypass this problem or to devise short cuts have been as misleading as they have been stimulating.[5, 6, 12, 17]

Nor is it possible to devote more than a brief paragraph to a discussion of the hypotheses which energize this present study though a large proportion of the time devoted to this work has been taken up in such discussion. Our starting point is the hypothesis that psychotherapy brings about, or aids in bringing about, an improved state of mental health. Our next general hypothesis is that the essential medium of effective psychotherapy is an attitude of genuine human interest on the part of the therapist toward the patient. Our more detailed hypotheses are derived from psychoanalytic theory. Inevitably we are in sympathy with attempts to extend analytic theory into a general theory of psychological treatment, and in particular, with attempts to provide greater theoretical accomodation for the subtleties of the relationship between patient and therapist.[4, 14]

* The work described in this paper began in 1948 when the first proposal was drawn up by Dr. Paul Bergman. Other colleagues who have actively shared in the thinking and the work are Gerald Aronson, M.D., Michalina Fabian, M.D., Robert Holt, Ph.D., Hellmuth Kaiser, Ph.D., Lester Luborsky, Ph.D., Herbert Modlin, M.D., Gardner Murphy, Ph.D., Lewis L. Robbins, M.D., Robert S. Wallerstein, M.D., Benjamin Rubinstein, M.D., and Mrs. Helvi Boothe. Karl Menninger, M.D., is consultant to the project.

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There is some confusion about the nature of the problems, calling for clarification and investigation in the field of psychoanalytic treatment or psychotherapy. Some workers see the urgent task to be a direct and straightforward evaluation of the effectiveness of the various elements (or the various kinds) of psychotherapy. Other workers despair of such an approach and think that the proper focus (proper in the sense of being feasible and economical, having in view the present state of knowledge) is the minute study of the processes of psychological treatment. The decision as to what constitutes an appropriate problem for research is largely a matter of taste. In the case of research into psychological treatment, there is plenty of room for the psychological naturalist, always on the qui vive for the novel or interesting phenomenon that suddenly raises a new question or immediately solves some unsettled problem, and for the research worker who enjoys making his hypotheses more explicit and testing them out more rigorously. The research worker whose preoccupation is process tends to look at psychotherapy under the high power of his microscope and is content to view one minute fragment of the field at a time, whereas the researcher whose primary preoccupation is the evaluation of the effectiveness of psychological treatment uses his lowest-power objective since it suits his purposes better to be able to view the whole field even if he misses the detail in doing so.

Many attempts have been made to plan a laboratory where research into psychotherapy can be carried out, some of the plans and sketches being quite elaborate.[3] But it has been simpler to plan the mechanics of observation than to think through the complicated question of what it is we want to observe. Kubie[3] and others have, of course, given immense thought to the latter problem too, but everyone who has applied himself to this task has had great difficulty in translating rather nebulous theory into exactly-stated operational concepts and working hypotheses.

It is surely only realistic to undertake research into psychotherapy in the setting where the latter occurs and is accessible to investigation. One often hears it deplored that a great deal of psychoanalytic and psychotherapeutic treatment has been and still is carried out in private practice. The research worker has to adapt himself to this situation, to interpolate himself in some way into the private practices and the busy hospitals and outpatient clinics.

Psychotherapy Research Setting at the Menninger Clinic

Certain settings are probably more favorable than others, having in mind both the degree of acceptance of the need for such research and the number of observation points already extant. For instance, we regard the Menninger Clinic as an appropriate setting for research of this kind. It includes all

those various departments whose collaboration would be helpful, namely, Departments of Adult Psychiatry, Child Psychiatry, Neurology and Neurosurgery, Education, Research, and Social Applications. Psychotherapy of different kinds is provided as one method among the usual modern methods of psychiatric treatment and the amount of such psychotherapy carried out is considerable. At any one time between two hundred and two hundred fifty patients (including both inpatients and outpatients) are receiving one or another form of psychological treatment. Approximately a quarter of this is psychoanalytic treatment and the other three-quarters are analytically oriented psychotherapy of different kinds distinguished as expressive, supportive, and so forth. The medical records, including regular progress notes of psychotherapy and, in many cases, detailed process notes hour by hour, while perhaps inadequate in some respects from the point of view of research requirements, are comprehensive and even elaborate in comparison with the records of much clinical practice.

Since the work is carried out in a group setting, there already are a number of additional observation windows which may be expected to be useful to the researcher. For example, it is usual for one psychotherapist to meet with another regularly in order to get supervision of his work, and this opens up an additional window through which both the patient and the therapist can be seen and upon which observations, records and reports can be based. In many cases this periodic scrutiny is even more intense and prolonged, namely where the treatment occurs in the setting of training in psychoanalysis. In fact the work already done in connection with the program of psychotherapy research at the Menninger Clinic can be looked on essentially as the opening up of one or two additional windows at different points during the treatment and after the end of treatment, and the development of devices by which to describe and measure what we see.

Psychotherapy Research Aims

Before considering these windows and instruments of description and measurement, a word should be said about the aims of this psychotherapy research program. The ultimate aim is, of course, to develop further understanding of the processes of psychotherapy, of the ways in which psychotherapy brings about changes in people, and of the effectiveness of the various elements in psychotherapy in relieving suffering and promoting human growth. The more immediate aim is the development of methods by which relevant variables in the patient, therapist, and environment may be detected, described and measured. No apology need be made for the fact that these ultimate and immediate aims are expressed in a rather general way. In the nature of the situation it could hardly be otherwise at present.

The major preoccupations in the foreseeable future will continue to be

the opening up of windows, the development of rating scales of one sort or another, and a continual search for some solution to the enigmatic problem of controls. A fruitful by-product has been and will continue to be the awakening and sharpening of research interests and skills in those of us taking part in psychotherapy, and ultimately the other psychiatric treatments too.

Work Under Way or Projected

One of the windows (into therapy) which has been opened up somewhat is known as the Termination Study since it is an inquiry carried out either at the point of termination of treatment or at the point of some significant shift in the treatment plan. This study aims primarily at discovering just what went on during the course of treatment and secondarily at describing and evaluating the status of the patient at the end of treatment.

Each termination study is carried out jointly by two observers, both of them psychotherapists of some experience. The observers first of all study all the available written material in the medical record of the patient; this includes the rather extensive case study made before treatment began, the monthly progress notes, the discharge summary, correspondence, etc. They also study samples of the hour-by-hour process notes kept by the therapist or the transcriptions of electrical recordings if these are available (which so far applies to a very few cases only).

We have been unable completely to follow Shakow's ideal[3] of not burdening the therapist with some of the onus of the research. After reading what has been written about the patient and the treatment, the observers meet with the therapist for one or two sessions of an hour each. They interview the therapist in a relatively free manner, nevertheless following a prearranged scheme for the collection of data. The three main areas of the interview are the technical procedures and emotional atmosphere of the treatment, the course of the patient's status during the treatment, and his condition at the end of treatment. When this interview with the therapist is completed, the observers may supplement their information by interviewing the therapy supervisor. They then record their findings independently in a long and rather elaborate questionnaire which attempts as far as possible to codify the material but also encourages free description. The observers then meet to compare and discuss their completed questionnaires, and to discover the cause (and if possible to resolve) such differences as appear in their reports.

This undertaking of the termination studies has so far gone through three phases or steps of refinement but it is expected that further such steps will be needed in order to simplify and also increase the reliability of data gathering and reporting. A simple measure which may add to them considerably

and which we plan to embark upon shortly is having one or both the observers interview the patient at the end of treatment. There are some cases in which this cannot be done because the patient would be unwilling or might be disturbed by such an interview, but there must be a number of cases where an interview of this kind would be harmless and where the patient would be an interested participant.

When the patient terminates treatment a wall of darkness often descends between him and the Clinic. A second window is in the process of being cut in this wall, namely the follow-up studies. This is also still at the point of pilot studies, but it is expected that within a fairly short time methods will have been evolved which can then be applied routinely. At the moment, a pilot study is being completed in which approximately 120 patients who ended treatment in January and February, 1952 are being followed up. In something over half these cases, preparation for the follow-up study has been made by correspondence and the inquiry itself then carried out personally by a visit to the patient and the patient's family by one of the psychiatric social workers*; this has been possible where the patient's home has been within a radius of about 600 miles from Topeka. Patients who live more distantly have been followed up by letter and questionnaire only. One fact which emerges already (many other workers have reached the same conclusion) is that follow-up correspondence yields extraordinarily meager data of dubious reliability in comparison with follow-up by a personal visit.

Our first glimpse of a patient is at the time of the initial evaluation studies. In the course of ordinary clinic practice a rather large window onto the patient's life and psychiatric status has already been opened up at this point. Perhaps for this reason we gave this channel of observation little additional attention in the early days of this research. During the past few months, however, a subproject known as the Initial Study has been brought into being. One of its purposes is to devise an instrument whereby data which are needed in order to evaluate adequately the initial status of the patient can be collected, recorded, and coded. Thus the obvious step can now be taken of bringing into line the kinds of data which are being collected at the time of initial evaluation, of termination of treatment, and of follow-up, and of recording these data and the inferences drawn from them

* Mrs. Helvi Boothe, Chief Psychiatric Social Worker, has taken the major responsibility for the development and guidance of this aspect of the work, actively assisted by many of her psychiatric social worker colleagues, notably Mrs. Mildred Faris and Miss Marjorie Scott. It should also be mentioned that follow-up work was partly instigated and certainly stimulated by the project undertaken principally by Dr. Herbert Modlin and Mrs. Mildred Faris in connection with evaluation studies of outpatients (and reported on separately in this issue).

in a uniform and systematic manner. In this way, procedures in relation to the patient which may be separated from each other by many months or even several years are brought into gear together.

Mention has been made of the development of *rating scales*, instruments by which we can measure what we see through the various windows. Scales can of course vary in complexity from the simplest kind of three- or five-point scales, which we bring into being without difficulty and use in the course of systematically recording and coding some of the accumulating data, to rather complex instruments requiring perhaps many months of work to devise and validate.

Fairly early in the psychotherapy research program we brought into being an instrument known as the *Health-Sickness Rating Scale*. The purpose of this was to devise some measure of the patient's over-all state of mental health. We felt that the usual improvement scales were not sufficiently informative of the amount of change occurring in the patient: a very slightly sick patient recovers completely and leaps up to the top of an improvement scale, whereas a more sick individual makes a substantial gain in his mental health but moves up perhaps only one step. The continuum of the Health-Sickness Rating Scale ranges from a state of ideally good mental health at one end to a state of total personality disintegration at the other. The latter point was designated zero and the point of perfect mental health one hundred; the hundred-point scale was used not because we thought it possible to make the fine differentiations that this might seem to imply, but simply because a hundred-point scale is a standard one. We left it to the person using it to decide what degree of refinement of rating suited his own whim or temperament.

The Scale provides three kinds of guides: first, a definition of those criteria which we thought are important in assessing mental health and sickness, second, a definition of a number of anchor points on the Scale, and third, thirty-four sample case descriptions ranging over the entire reach of the Scale. We recognize that (as in the case of any such rating device) observers can use the Health-Sickness Rating Scale in a uniform way only if they practice together over a number of weeks. In this way individual idiosyncrasies of raters gradually become smoothed out.

Space will not allow further description of this Scale nor of the tests to which we have put it, but mention should be made of the criteria that we formulated as a guide to its use. These criteria are for the most part the usual ones employed by psychiatrists in assessing mental health. They are not tied to any particular theoretical system, so that therapists of different theoretical persuasions would, we hope, not be hampered or inhibited in using them. They are largely descriptive in nature with the exception of the second, which is admittedly inferential. They are (1) the

patient's need to be protected and/or supported by the therapist or hospital versus the ability to function autonomously. (2) The seriousness of the symptoms (*e.g.* the degree to which they reflect personality disorganization). (3) The degree of the patient's subjective discomfort and distress. (4) The patient's effect on his environment: danger, discomfort. (5) The degree to which he can utilize his abilities, especially in work. (6) The quality of his interpersonal relationships. (7) The breadth and depth of his interests.

Several other areas have featured in our weekly discussions but actual work has not yet grown from them. The area of psychiatric nosology has engaged our attention, especially the possibility of utilizing Dr. Karl Menninger's schema of hierarchically ordered *tension regulating devices* in our evaluative descriptions of the patient at various points during the treatment.[13] Certainly evaluative studies urgently need a reliable instrument with which the psychiatric status of the patient may be described and rated in various ways.

Preliminary work has also been undertaken in developing methods for describing the relevant aspects of the personality of the therapist. One such method which we have evolved uses twenty-seven adjectival descriptions of those personality characteristics thought to be important in therapists, and requires a rating of each on a five-point scale. Therapists could use this to provide descriptions and ratings of each other. It has not yet been put into practice.

The Problem of Controls

The thorniest problem still remains to be effectively tackled, however, namely, setting up controls, and by their adequacy the whole project will ultimately stand or fall. As yet we have not found a clear-cut solution, but there are three possibilities. One possibility is to study a control group of those patients who have applied for treatment, have undergone evaluation, but for one reason or another are unable to avail themselves of treatment facilities. For instance, many young men are pulled into the Army before they can start treatment, or people move according to the fluctuations and vagaries of their employment. It must be confessed, however, that the number of persons who seriously seek but fail to get treatment today is rather small: it would not be easy to gather such a control group together.

Another possibility is the use of so-called self-controls, a method which has been employed with some success by Rogers and his associates.[15] The patient applies for treatment, is given whatever psychiatric evaluation is needed, and is then asked to wait some months before treatment can be started. At the end of this waiting period, the patient's status is again evaluated in various ways. He then embarks on treatment and is once again

evaluated as to his mental health at the end of treatment. Thus the kind and extent of changes occurring during treatment can be compared with those occuring during the period of self-control. Patients often have to wait a number of months before treatment is available, hence this method need impose no additional hardship on them. However, the method has several serious drawbacks. In the first place, the control period is inevitably rather short compared with the duration of treatment itself and subsequent follow-up studies. In the second place, the promise of treatment just around the corner must itself influence the patient's well-being (though perhaps not always in the same direction).

A third possible solution to the question of controls may come from a different perspective of the problem. When we test the efficacy of a given drug, we give tablets of the actual drug to the experimental group and dummy tablets, identical in outward appearance, to the members of the control group. Neither the therapist who hands the pills to the patient, nor the patients themselves, know which are the real and which the dummy pills. It is possible and logical to think about psychotherapy in a parallel way; the patient receives a unit of supposed treatment, but this unit may contain the necessary ingredients or it may not. There is nothing fanciful or unusual about such a point of view. We are quite used to judging a kind of psychotherapy as being likely to succeed or to fail because it contains or fails to contain this or that ingredient.

However, before this third possible solution could be put to a test, it would be necessary to have precisely stated hypotheses concerning the association between the presence or absence of various elements in the treatment (thought of as essential ingredients or as "impurities" as the case may be) and ensuing changes in the patient. We might, for instance, develop working hypotheses relating the occurrence of characterological change to the amount or kind of insight or to the recovery of the infantile amnesia, or relating certain attitudes on the part of the therapist to changes of a favorable or unfavorable kind in the patient. But it must be clear to anyone who has thought about such work that much time and vast labor will be needed before our hypotheses can be stated in operational terms with precision and clarity.

When that point is reached, it should be possible to make testable predictions that a certain technical maneuver or a particular therapist will be associated with a given change in the patient owing to the presence or absence of some specific element of technique or personality factor respectively. Experimental and control groups could be brought into being to test out such specific hypotheses. Neither patient nor therapist would know what hypotheses were actually being tested, that is which therapy or therapist was deemed by the investigators to promote (or to fail to promote)

this or that change in the patient. There is reason to believe that ultimately this method of carrying out control studies would be perfectly feasible. In many ways it is the method of choice.

Summary

The emphasis of this research is on the gross changes in the patient which are seen during and after psychological treatment. But it is our contention that studies of these broad aspects of the treatment situation, and, on the other hand, of the minutiae of the processes of treatment are inescapably interdependent. Research into psychotherapy is comparable in this respect to psychotherapy itself—part of the time the psychotherapist gazes at the patient through a wide angle lens, observing only the most pervasive features of the behavior and development of the patient, while at other times he focuses with concentrated attention on a single point of the treatment process. The observations and inferences coming from the wide-angle focus feed back to the situation of narrowed attention, and vice versa.

This paper has briefly described three observation windows which are in process of being opened up into the stream of psychological treatment carried out at the Menninger Clinic, and has mentioned one of the devices which has been developed to assist in the charting of what is observed through these windows (the Health-Sickness Rating Scale). The theoretical framework which guides, limits, and orders the data collection is that part of psychoanalytic theory which is most relevant in the treatment situation. Three general problems of such research into psychotherapy are considered —the need for an extension of theoretical concepts which will do justice to the prominent and refined attention we give to object relations, the perplexing problem of controls, and the need for research methods which allow the therapist to proceed with his work unburdened and unembarrassed by the research inquiries.

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FOLLOW-UP STUDY OF PSYCHIATRIC TEAM FUNCTIONING

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The follow-up study which this paper will report was undertaken to assess the effectiveness of a psychiatric team engaged in outpatient evaluation. Our aim was not primarily to follow up patients to ascertain whether their symptoms had become more or less severe, but rather to appraise the work and effectiveness of our outpatient evaluation service. The study sought to answer, "What happened to our recommendations?" Corollaries to the main question were: What service did the patient and his family receive? Was it the service needed? How could the service be improved, or additional service be offered? What factors most influenced the patient toward or against successfully following our recommendations?

Outpatient evaluation at the Menninger Clinic consists of a thorough diagnostic study of a patient for one to two weeks culminating in recommendations for his treatment. The term "evaluation" is more appropriate to our work than "diagnosis" because the latter connotes, in the medical sense, ferreting out and labeling a pathological process within the patient. Since psychiatry is properly concerned with the whole person, his physical, intrapsychic, interpersonal, and cultural areas of adaptation, we must evaluate as inclusively as possible the internal and external environment of the patient in formulating recommendations pertinent to his particular adjustment problems.

Acceptance, during the last decade, of this encompassing approach to maladaptation has led to the development of the psychiatric team. As distinguished from teams practicing hospital psychiatry, child psychiatry, guidance clinic psychiatry, or psychosomatic medicine, an outpatient team minimally consists of psychiatrist, clinical psychologist, and psychiatric social case worker; although teams may include more than one representative from each of these three categories plus professional workers from such fields as neurology, internal medicine, occupational therapy, and vocational guidance.

The psychiatric team (called section at the Menninger Clinic) observed during this study was one of several teams engaged simultaneously in the normal routine of hospital treatment and outpatient evaluations. In addition, individual section members did consultations, special psychotherapy, research, and teaching in various educational programs. The section consisted of a senior psychiatrist (section chief), two staff psychiatrists, clinical psychologist, social worker, activities therapist, and nurse. One new out-

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patient was assigned to the section weekly for evaluation so that each of the two staff psychiatrists received a new patient every two weeks.

In the initial planning by the admissions office with the patient, or referring doctor, it was strongly requested that a close relative accompany the patient to Topeka. Daily interviews proceeded for one to two weeks, providing opportunity for clinical study of the patient and case work with the relatives. Continued interchange among the section members of historical and examinational information clarified the maladjustment picture and indicated the treatment recommendations to be made. When evaluation ended, a final section conference reviewed all data, summarized the work with patient and relative, decided upon a diagnosis, and completed the recommendations. Usually the recommendations became clear after a few interviews, and the psychiatrist and case worker had begun presenting them to patient and relatives and working for their acceptance even prior to the final conference. Occasionally, the recommendations could not be spelled out before the final conference and were then presented to patient and relative, either separately or together, in one or more postconference interviews.

Recommendations varied from immediate hospitalization to minor environmental changes. Patients were mostly non-Topekans, and only a few remained for treatment. The rest left with our recommendations, severing our connection with them. The section was thus unable to check the accuracy and value of its work, and as patient after patient disappeared following evaluation, we felt more need to evaluate ourselves. We, therefore, devised a follow-up study of the 38 outpatients seen by this team during the 18-month period of January 1, 1951, to July 1, 1952.

Method of Study

Our investigation was in three parts: (1) preparation of a large summary data sheet containing routine facts such as age and marital status, together with information on all factors which might conceivably influence the patient and his family to accept or reject our counsel. In particular, we defined attitudes—at the beginning and end of evaluation—expressed by patient, relatives, and ourselves toward his illness and the examination; (2) a follow-up inquiry of each patient approximately one year after his evaluation (the majority of patients have been followed for two or three years); and (3) analysis of the data finally collected, to learn what had happened to our recommendations and what were probably determinant factors in the patient's following our professional advice or failing to do so.

Since 38 patients came from 16 states, the only feasible method of inquiry initially was correspondence. A letter was sent to 31 patients. The other seven patients had been heard from (three were hospitalized here, one returned after leaving, the relatives of one visited us, one sent spontaneous reports, one was visited by a section member). The letter was sent to the

person (patient or relative) deemed most likely to reply, with the signature of the section member who had had the most effective relationship with the addressee. Fourteen replies were received. One letter was returned with the stamp "Addressee Unknown"; this patient was lost to the study. Meanwhile, information on six patients had been obtained by other means. A second letter was sent, approximately three months after the first, to the ten patients about whom we still had no follow-up information. It was a simple, friendly note signed by the General Secretary of The Menninger Foundation to demonstrate that this was a serious project rather than a routine inquiry. The second letter evoked three additional responses. Thus, our attempt through the two letters to re-establish contact with 31 patients was 55 per cent successful.

Two patients responded to neither letter and could be reached by no other available means. Follow-up information was successfully obtained for 35 patients as follows:

17 responded to letters
5 hospitalized in Topeka
4 visited in their homes by a team member
6 report received from doctor outside Topeka
1 spontaneous report from patient
2 spontaneous report from relative

35 Total

In several instances, information came from more than one source. Most of the respondents to our first letter were professional workers or business executives from urban centers. Five of the seven who answered neither letter were from rural areas. Two patients who answered neither letter were visited by a team member in their homes, and each stated in effect that he seldom wrote letters to anyone and was nonplused by trying to express himself on paper. Both patients were cordial and cooperative in oral interrogation. Another rural patient delayed replying to our letters for three months. This experience suggests that the patient's level of sophistication should be assessed in attempts to gather follow-up information by correspondence.

We estimate that six patients left Topeka dissatisfied with the examination and recommendations; and we consider that possibly others also were displeased or dismayed without our becoming aware of it. One of these six patients wrote us his criticisms frankly, one answered obliquely, and the other four were among the 13 who ignored our correspondence. These figures neither clearly substantiate nor disprove our supposition that dissatisfied patients would be unresponsive to our request for information.

A simple statistical analysis of these patients revealed no significant

deviation from a cross section of patients at the Clinic. The following brief summary of our tables and charts gives a gross description of the 38 patients:

Age: 60 % in the 25–45 years of age range (extremes were 20 and 66)
Sex: 60 % male
Marital status: 61 % married; 8 % divorced; 29 % single
Annual income: 90 %, $15,000 or less
Occupation: 54 % business or professional men; 30 % housewives; 16 % students, unemployed, others
Referrer: 7 % teachers, ministers, others; 19 % psychiatrists; 45 % other M.D.'s; 29 % self
Length of illness: 32 % had overt symptoms for two years or less; 45 % had been ill five years or more
Psychiatric treatment: 44 % had had extensive treatment; 35 % were seeing a psychiatrist for the first time
Diagnostic categories: 29 % psychotic reaction; 31 % neurotic reaction; 31 % personality disorder; 9 % organic brain disease

Recommendations

Our recommendations to the 38 patients are summarized in the following table which indicates what happened, *i.e.*, whether the patients were able to comply with them. Of the 35 patients about whom we have data, all but three acted on our professional advice, at least in part. This was a surprise to us. Patients who did not follow recommendations closely were placed in the "Partly Followed" column. Two of the four patients for whom psychoanalysis was prescribed went to nonanalysts for psychotherapy, and we classified them, "Partly Followed." In another "Partly Followed" case, we recommended immediate hospitalization for a schizophrenic girl, but her parents procrastinated for three months before acceding.

Recommendations	Result			
	Followed	Partly Followed	Not Followed	Result Unknown
Hospitalization here	3	2		
Hospitalization elsewhere	1			1
Outpatient treatment here	2		1	
Outpatient treatment elsewhere.	5	5	1	1
Psychotherapy (8)	(3)	(3)	(1)	(1)
Psychoanalysis (4)	(2)	(2)		
Milieu program at home	2	3	1	1
Specific environmental or personal change	6	3		
Total	19	13	3	3

The first four categories of recommendations in the table are self explanatory. The fifth, "Milieu program at home," includes such cases as the following:

Case 3. A 60 year old business man was having difficulty adjusting to mild heart pathology and imminent retirement from business in favor of his son. Somatic preoccupations, tension, and depression were prominent symptoms. The patient's assets included compulsivity, energy, respect for medical opinion, and a devoted 40 year old wife. Capitalizing on these we prescribed (1) a maximum of three hours a day at work limited to public relations and community contacts, the actual business operations to be handled by his son; (2) development of a specific gardening project and a metalworking shop at home to occupy him for several hours daily with his wife acting as "boss."

Case 1. We found the illness of a 38 year old rancher to be a nonspecific chronic brain syndrome. After implications of this diagnosis had been explained and worked through with the patient's father, a program of scheduled, regulated activities was planned which could be implemented in the patient's home and which would provide (1) a consistent, structured, supportive environment to reduce his confusion, (2) reactivation of his compulsive traits, (3) an outlet for his restlessness, (4) activity contributive to his self-esteem.

The sixth category of advice, "specific environmental change," included the following:

Case 22. A 59 year old widow consulted us because of anxiety, depression, and feelings of unreality. She had suffered paranoid delusions for at least eight years, the current version of which was suspicion that her brother-in-law was poisoning her food. We considered but rejected lobotomy, and the patient was advised to (1) move from her brother-in-law's house into her own and (2) to renew some of her previously gratifying social activities.

Case 2. A 37 year old married farmer complained of tension, discouragement, periods of mild confusion, and indecisiveness. A business partnership with his father was complicated by his inner conflicts of dependence on and hostility toward his father. Our recommendations to him and his wife were (1) to eliminate certain business entanglements and limit his farming activities to a one-man operation, (2) to spend part of his time trading in stock, at which he was competent and felt secure, (3) to relax his grim competition with his father and to find more time for enjoyment of his relationship with his wife.

Discussion of Results

A careful study of our data sheets, process notes of the interviews with the patients and relatives, and the responses to our follow-up inquiries, revealed that our evaluative process usually included four steps: (1) defining the problem, (2) getting our view across, (3) inciting the patient and/or relative to do something, (4) helping him or them to do it.

Successful application of this plan demands a highly integrated, smoothly functioning, multidisciplined team. Much current literature concerning the psychiatric team advocates each member's representing his own discipline

and faithfully fulfilling the functions of his professional specialization. This is not our total concept of a team. In our lexicon, adaptability is the key word; and this necessary adaptability can be achieved only by a group of separate professional persons who have in a sense ceased to be separate and have become through growth, a unit. Thus the whole group together, in resources of pliability it possesses, is greater than the sum of its parts, and far exceeds the capability of its most brilliant single member.

Step 1. In helping the patient and relatives define the problems that brought them to us, we perforce give first attention to the patient's presenting symptoms. However, since symptoms are the ego's defensive reaction to stress, observing and describing the symptoms is usually an insufficient basis for planning a treatment regime. It is important also to define the primary stress to which the patient is reacting and to establish a dynamic explanation of why a certain situation is stressful for this particular patient. Of related importance are secondary stress and secondary gains created by symptoms and inevitably involving persons in the patient's immediate environment. Since 68 per cent of our patients had been overtly ill for two years or longer, the ramifications of their mental illness, intrapsychically and interpersonally, were extensive and tangled. We believe that our relative success in translating our recommendations understandably and acceptably to the patient was in nearly direct ratio to the degree of our success in comprehending the patient's total life situation.

The trend of modern psychiatric thinking is toward emphasizing the whole organism, the total personality, the psycho-socio-somatic unit. This inclusive viewing of the organism in its immediate and remote environments is strongly reflected in current psychiatric literature.

The need to assess as many interacting elements of personality as possible engendered the multidisciplined psychiatric team. In outpatient evaluations, team approach is especially significant since the patient remains enmeshed in environmental and personal entanglements. Our procedure invites maximum participation of patient and relatives in defining the medical, psychological, familial, sociological and cultural components of their problem and in mobilizing their resources to meet it. In this comprehensive assessment of the patient's internal and external environment, work with relatives is frequently crucial. In addition to the example in Case 21, above, the following also illustrates this point:

Case 17. A middle aged businessman came to the Clinic, pronounced by his wife, his physician and himself, an alcoholic. His wife, particularly, blamed the drinking for his business reverses, her ill health, and their marital discord. The referring doctor sent along his long medical record of the wife; and armed with this foreknowledge, the social worker and psychiatrist approached the marital problem. Her initial indignation and defensiveness gradually gave way to interest

in her own attitudes and their effect upon the marriage. As she relinquished emphasis on her husband's alcoholism, he was enabled to feel less guilty and resentful and to see how his drinking affected their relationship. Follow-up reports two years later from the physician as well as the patient and his wife reveal that he is not drinking, she has not consulted a doctor for over a year, and they are participants together in community activities and home projects.

Step 2. As our view of the patient's problem clarifies, the major technical problem we face is getting our understanding across to the patient and relatives. In a few cases we have failed. We find the following techniques useful: enlisting, when indicated, the services of internist, neurologist, other medical specialists, medical laboratory, and day hospital activities program as well as all the resources of the psychiatric team, to establish the undeniable authority of a thorough examination; psychological testing, both for its important contribution to diagnosis and treatment planning and for the impressive psychological effect it usually has upon the patient; inaugurating a "therapeutic" process in the doctor-patient and, occasionally, in the case worker-relative interviews. Early in our work we abandoned the idea of purely diagnostic interviews.

Step 3. The third step in our evaluations is helping the patient capitalize on his motivation to seek help. No one "gives" a patient motivation, but often it can be fostered by various means. Many of our patients arrive with full determination to get assistance. Many do not. Six of the patients were negativistic regarding the examination or severely lacking in insight; and at least six others were indifferent. However, all but one of these twelve followed our recommendations.

We gave much thought to the expressed and implied attitudes of all persons involved, at the beginning and end of evaluation. In 22 cases there were no significant alterations in attitudes of patient or relative toward the illness examination. In most of these 22 instances, no change was particularly desirable. In five instances, we think our help was instrumental in improving the attitude and understanding of the relatives, and in four other cases, that of the patients. On the other hand, six patients and the relatives of two other patients were disappointed in the procedure, largely because a quick cure or foolproof answer had not been offered. In spite of their disappointment, four of these eight answered our letters, and a fifth returned for treatment a year after his initial visit.

We sought in each case the strength or the lever which would prove most usable. The helping techniques we employed were individualized for each of the 38 situations but they can be summarized in five groups. In a few cases two of the five approaches were combined. We emphasized the following:

a. The seriousness of the illness—four cases. With medical authority,

in the best sense, we said, "Your daughter is seriously ill and needs immediate hospitalization," or "Your wife is a narcotics addict and must be weaned from the drug." In these four cases our recommendations were followed.

b. The incapacitating nature of the illness—11 cases. In contrast to our attitude in a., above, we emphasized the probable value of treatment but left the decision entirely to the patient: "These symptoms which have handicapped you for six years will probably continue unless you obtain psychiatric help." The two patients who did not follow our recommendations were in this group.

c. The patient's defenses and strengths—11 cases. The focus was not on the psychopathology, as in a., and b., but on reconstituting compulsive defenses or redeveloping previously exercised strengths.

d. The relatives' concern or distress—seven cases. Since a third of our patients were either neutral or resistive in their attitudes about examination, we found it essential to enlist the relatives' collaboration.

Case 32. The husband of a severely phobic woman was hampered and harassed by her symptoms. We utilized the motivation springing from his distress when we recommended psychoanalysis, even though this form of treatment was not available in their community. We hoped that his need to be free of his wife's pathological demands would supply the extra impetus necessary to her entering treatment. It did.

e. The relatives' ability to learn and change—eight cases.

Case 24. The patient, a 35 year old married man with a passive, ineffectual personality pattern and an I. Q. of 96 complained of intermittent headaches and unhappiness with his nagging, demanding wife. She impressed us as a pleasant but determined woman of compulsive, energetic make-up with definite ideas about how a husband should perform. Since her husband's inadequacies were deeply rooted and not amenable to brief psychiatric help, we spent several hours counseling with her in an effort to explain her husband's limitations, to underline her exacting and inflexible standards, and to suggest that improvement in their marriage would be determined largely by her ability to modify some of her attitudes.

In several instances we readily agreed that had circumstances of the patient's life been different, our recommendations would have been different. We attempted to accommodate our concept of an ideal treatment program to the reality situation in each case. We sent two frankly psychotic and five borderline patients home without psychiatric referral. In other severe cases no compromise could be made and immediate treatment was urged. Representative recommendations which were tailored to fit the patient's total needs included retirement from business, change of residence, antabuse therapy, hospitalization, extended travel, psychoanalysis, brief

psychotherapy, speech retraining, foster home, pentothal interviews, separation from in-laws.

Step 4. In many instances we assisted the patient or relatives in carrying out our recommendations by suggesting hospitals, therapists, specific plans, or daily schedules to follow at home. The evaluation period was of primary importance in our "helping" with the recommendations because the interviews were continued until we sensed that the patient and relative understood the recommendations and accepted or rejected them.

Assessment of Errors

At the time each patient left evaluation, we recorded our opinion of how well we had managed the case. In seven instances we were dissatisfied with the way we had worked, and we concluded that these seven cases had been poorly handled. Five of these patients did not answer our correspondence, and two of the three about whom we lack information are in this group.

Case 2. We were unaware of community resources (a local psychiatrist) and advised the patient to emancipate himself from his father on his own initiative. He tried, became obsessed with guilt feelings and attempted suicide. After that, he consulted the local psychiatrist and received considerable help which enabled him ultimately to carry through our original suggestions.

Cases 15, 20, 23. In these instances, we should have been more flexible. We made the "proper" recommendations for each patient and insisted that he accept it. All three, in a rebellious turmoil, left Topeka. Two eventually followed our advice in modified form.

Case 8. We did not insist on the father's participation; and only after the patient had left Topeka, we learned that the father, distressed regarding his son's illness, would have been cooperative and helpful.

Case 5. The severely alcoholic patient was the wife of a military officer. We suggested antabuse treatment on an outpatient basis, as a compromise between the patient's difficult circumstances and what we preferred to recommend. The antabuse attempt failed, however, and hospitalization was the last resort after all.

Case 37. We underestimated the interfamily influence of a hysterical adolescent daughter. We had hoped that the patient and her husband, through increased understanding of each other's needs and limitations, would lessen the stresses between them, but their daughter's problems nourished the family neurosis for some time. The couple did finally carry out our advice to spend more time together apart from their daughter.

Conclusions

At the beginning of this study we estimated that half to two-thirds of the patients would follow our recommendations, that the rest would not. We intended then to compare the two groups of patients and search for those factors which influenced them one way or the other. Since 90 per cent of the patients had followed our advice, at least in part, we abandoned our original plan and instead set about analyzing our follow-up data, seeking explanation for the unexpectedly successful outcome of our evaluation service. We wish it understood that we apply "successful" to only one aspect of our endeavor. We asked ourselves, "Did the patients successfully follow our recommendations?" The answer was "Yes" in 90 per cent of the cases. From this study we cannot judge the ultimate correctness or value of our professional advice in all cases. For example, the bulk of patients referred for psychotherapy dutifully began treatment, but we do not have complete data to show whether all the patients stayed in treatment, whether the treatment was remedial, or whether psychotherapy should have been the prescription of choice.

In this paper we have confined our attention to the question of what happened to specific recommendations which we worked out with our patients and their relatives. In a paper yet to be published, we intend to present data on the therapeutic effect of the evaluation experience quite apart from the matter of the recommendations. In one sense, separating these two aspects of our work is artificial since in many cases the therapeutic impact of the evaluation period was responsible for the patient's understanding and accepting our recommendations. In some instances, changes in his view of himself and of his immediate situation obviously made the evaluation study an important experience to the patient whether or not he subsequently followed specific advice.

Case 21. An intelligent, unmarried minister consulted us because of handicapping neurotic symptoms. He felt the need for prolonged psychiatric treatment but had been unable to present a convincing case to his impatient father and his unheeding mother. A series of psychiatric interviews with the patient revealed the ineffectualness in his approach to his parents. At the same time, case work with the mother helped her to realize her son's psychological suffering and to understand psychiatric treatment. Influenced by her attitude, as well as by the patient's increased determination, the father consented to the inauguration of our treatment program. The patient eventually began a psychoanalysis; but even if he had not found it possible to obtain specific treatment, the improved relationship of these three would have made the evaluation procedure worth while.

We consider the project a pilot study only, since 38 patients constitute insufficient bulk to validate results statistically.

SELECTING PSYCHIATRIC RESIDENTS: SURVEY OF THE TOPEKA RESEARCH*

By LESTER LUBORSKY, Ph.D.†

Psychiatric training institutions have progressively put more effort into selection of residents and are asking for evidence that they are getting the best qualified men. Generally, selection procedures became important because of the flood of applicants after World War II and because personality assessment techniques had proved useful in selection for many types of work[1,7] and in the clinical evaluation of patients.

A recent study conducted for the Group for Advancement of Psychiatry[4] showed that few psychiatric residency centers were satisfied with their selection methods, but they lacked any systematic research to support this judgment. Among the institutions now studying the results of their own selection are the Langley-Porter Clinic, Hillside Hospital, Yale Medical School Department of Psychiatry, the Associated Psychiatric Faculties of Chicago, and Bellevue-New York University Training Center.

The present survey summarizes a seven-year project in terms of the immediate and far-reaching implications for schools of psychiatry.

Many details are given in two previous reports in this journal.[5, 12] The project is now essentially completed and the principal investigators are working on a book on the selection of psychiatric residents and consideration of the applications of results to other fields, *e.g.*, the selection of candidates for psychoanalytic training.[6, 13]

In our research, all candidates were interviewed by experienced psychiatrists and given a battery of tests by a clinical psychologist. Interviewers and psychologists independently predicted the level of competence in psychiatry. The choice of a criterion of competence is as crucial in such a research as are good predictions. Our principal criterion was the average of the supervisors' ratings during the last two years of residency, of "over-all performance as a psychiatric resident." Several other criteria have been tried, *e.g.*, ratings by residents' colleagues (which correlated quite highly with supervisors' ratings) and academic examinations (which correlated

* While the writer takes responsibility for this summary, he is acting as a reporter of a project jointly executed with Dr. Robert R. Holt (now Director, Research Center for Mental Health, New York University), and in its first years, also with Dr. William R. Morrow. We gratefully acknowledge the financial support of the Veterans Administration for the first five years, and of the New York Foundation for the last two years. The funds were administered by The Menninger Foundation Research Department headed successively by Dr. David Rapaport, Dr. Sibylle Escalona, and Dr. Gardner Murphy.

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only slightly with our main criteria). Then all who had been assessed (457 physicians in all) were followed up by mail.

These are the principal findings and their implications:

1. *A selection system of the type used is better than to make no selection.* In our procedure, each member of the Admissions Committee surveyed individual reports of three interviewers and a battery of psychological tests, letters of recommendation, academic records, the applicant's letters to the school, and a photograph. The method was worth the labor. The test and the average of the interview predictions by themselves had low but not negligible validity. (The correlations were mainly between .2 and .4.) Furthermore, these correlations were based only on residents who were trained by the Menninger School of Psychiatry and therefore cover only part of the group and part of the information considered by the Admissions Committee. The quality of the work of most "rejectees" could not be found out, but most of those who dropped out of psychiatry were among the rejectees and we assume they were the least fitted for the field. The Admissions Committee did not use the test and interview predictions mechanically, but considered *all* the information at hand in reaching a decision. Our belief, shared by the Admissions Committee and those who work for the Committee, is that many of the poorest applicants were not accepted by the school. Further support is lent to this view by the descriptions of the rejectees given in the psychological tests (although, of course, the complete accuracy of these descriptions cannot be taken for granted). Through the follow-up questionnaires sent to the rejectees and acceptees, we established that such criteria as obtaining a residency, staying in the field of psychiatry, and obtaining diplomate status from the American Boards of Psychiatry and Neurology were related to the decisions of the School. Roughly then, the Admissions Committee's decisions have had a useful level of validity. Most candidates who were not interested enough in psychiatry or not well enough suited to continue in the field were rejected, although others who were rejected probably could have become adequate residents and psychiatrists.

2. *Single interviewers as selectors do a poor job.* Rarely do they do much better than would be expected on the basis of chance alone. Only one out of nine of the school's interviewers who had seen a large number of applicants made predictions significantly better than chance on the accepted residents. Although individually these experienced psychiatric interviewers could not predict how competent a resident would be after three years of training, the *average* of the ratings given by the three interviewers was significantly better than chance. Two interviewers were better than one, and three better than two. Apparently they tended to cancel out and compensate for each others' errors.

The accuracy of prediction had no marked relationship (within the *accepted* group) to the age or experience of the interviewer, although the most successful interviewer was generally considered a good psychiatrist and analyst.* The obvious implication is that interviewers should be used who have demonstrated their ability in the job of selecting. This means trying them out, since one cannot tell who will do well until his batting average has been established. It is important, therefore, to retain the same interviewers from year to year. In this way they can gain experience while building up a large enough number of cases on which to determine their level of success. Predictions on those an interviewer has rejected should be considered, when possible, to see if he is weeding out the poorest candidates.

Whether skillful interviewers can teach their skills to others is questionable because the level of their achievement is not high enough to make its bases easily communicable. It seems worth while to inform each interviewer of his typical errors and successes. We do not know how helpful it is to provide interviewers with a list of candidates' qualities on which they, *as a group*, typically err (for example, the qualities listed by us in our study of interviewers' over- and under-estimations and by Dr. Henriette Klein in her report at the 1953 American Psychoanalytic midwinter meetings[9]: interviewers typically underestimate people showing strong anxiety or much aggressiveness toward the interviewer and they typically overestimate those showing evidence of a wealth of cultural attainments).

3. *A battery of psychological tests rated by psychologists is at least as good a means of selection as the average of three interviewers' ratings*, though each technique may have its special advantage. On all accepted residents, the correlation between test predictions and the criterion was .27, while between interview predictions and criterion, it was .24—an insignificant difference. The slight advantage for the tests used in this study may only be due to local circumstances. Psychiatrists have an hour for each interview plus a few minutes for filling out a report, while the psychologists have three hours for administering a wide variety of tests plus several hours for their analysis. Yet the level of correct prediction still depends upon the particular psychologist, for they vary in their success, though somewhat less than the interviewers do. Excluding either of these techniques would result, we believe, in less efficient selection, even though relative superiorities are not marked.

4. *No single procedure was discovered by our method which could supplant or consistently improve on the tester's and interviewer's clinical judgments.* However, putting together all the material—the tests, interviews, background data—in the hands of single persons, brought better predictions

* See further qualification of this finding under point number five.

than any single test or interview. While time consuming, this method points up the advantage of each evaluator's seeing the widest possible amount of information on the applicant. For example, if an autobiography is available, each evaluator should be allowed to read it rather than relying on one judge's evaluation of it.*

5. *Interviewers for selection should represent a cross section of what one wants the school to be and the kind of psychiatrists one wants to develop.* Two findings are consistent with this point, although neither one provides direct backing for it.

a. Supervisors' personal liking of the resident is highly related to their judgment of his competence, though there is a considerable residue of judgment about work that is independent of liking. Furthermore, we fell into the correlation and to an even greater extent, when rating our personal liking on the basis of the initial tests and interviews without knowing anything else of the applicant. That is, those we believed competent, we liked. A curious finding was that the ratings showing how well the persons making the predictions *liked* each candidate actually predicted good psychiatric work better than did the explicit predictions of competence in work functions. We do not have sufficient substantiation for one possible conclusion: that by focussing on whether a given candidate has specific appropriate abilities the interviewer *hinders* his own prediction. Interviewers should assess the candidate's abilities, but in their final judgment, interviewers should not *ignore* their own personal reactions. Furthermore, it is a plausible hypothesis that people like those who are like themselves. If this is true, then the school should consider whether it is well represented by the interviewers.

b. Having interviewers represent a good sample of the institution is strongly supported from another source. Originally, we believed there was no marked relationship between any characteristic of the interviewer and his proficiency at his task. We were then basing our conclusions on the correlations within the group of accepted residents (where the top correlation was .31). A different conclusion resulted from the answers to how successful individual interviewers were in making the gross distinction between the acceptable residents (adequate or better) and unacceptable residents. The 233 residents who were accepted and trained by the school and 47 others who dropped out of psychiatry after being rejected were considered in answering the question. Seven psychiatrists interviewed enough candidates to permit analyzing their ratings and recommendations in this second way and only two of them failed to make the basic distinction cor-

* Other projects show that the accuracy of prediction did not continue to increase beyond a certain point as more material was made available to the assessors.[5,15,17]

rectly to a degree significantly greater than chance. Although not firmly based, it is our impression that those who select poorly are also the least talented and competent in psychiatry, especially in the typical work functions of Topeka psychiatrists.

6. *Just as no simple single selection technique was found, neither could a single type of person who will make an adequate practitioner of psychiatry be delineated.* Probably if there were such, we should have been able to develop or discover a simple technique of selecting him. Among the successful residents there were wide differences in personality structure and socio-cultural background.

But there are strong consistencies in many of the qualities that experts (mainly training analysts) say a psychoanalytic psychiatrist should have and in the qualities that supervisors of psychiatric residents say they do have. For the latter, we made a summary of the free verbal descriptions by supervisors of 33 of the best and 33 of the poorest psychiatric residents.[10, 11] We found considerable overlap in the areas mentioned by the supervisors and those mentioned by the training analysts. These are briefly summarized under five headings: (1) work capacities and endowment (*e.g.*, sensitivity, intelligence); (2) quality of relationships with patients, ward personnel and supervisors; (3) the manner of regulation of impulses and affects; (4) the mental health of the resident and (5) his capacity for change. Educators of psychiatric residents may find in this comprehensive survey some implications for training.

There are such great differences between the better and poorer residents in some qualities that it is hard to understand why we had such difficulty in prediction. Apparently after working with a man awhile, it is easier to agree on his qualities than when one first meets him.* Two of the principal investigators agreed frequently on many qualities (*e.g.*, ethnocentric prejudice, consciousness of social injustice, clarity of thought), but disagreed on some crucial ones (*e.g.*, empathy, self-confidence, adequate emotional control). Reviewing some predictions on which we erred, we were impressed with our correct assessment of many specific qualities and our inability to cast these up into proper balance so as to judge ability to develop skill as a psychiatrist.

7. *The findings warrant special consideration of the age of an applicant.* For example, out of 230 residents, not one who was aged 38 or over when he applied received a performance rating above average. There were 22 such residents; 18 were rated in the inadequate range, the remaining four were rated average. In this result, perhaps age itself is not as important as the significance of a person's changing specialties in middle age—perhaps he had not done well in his previous profession or he had suffered an unsettling personal shock. Such a person *could* also be a "late bloomer,"[8] although this was not true of any in our group.

* Similarly it is commonly found that the reliability of personality ratings is increased with longer contact between subjects and observers.

8. *One should learn details of an applicant's previous work as a psychiatric resident (or similar work) if he has had such experience.* While it is hard at the initial selection to make predictions that are highly related to later performance, early performance in a psychiatric residency is considerably related to later performance. A man's supervisors (as well as colleagues) tend to agree considerably on his competence and these judgments remain comparatively constant throughout training. More accurate predictions were obtained on applicants with previous psychiatric experience than on those having none.

9. *The resident's capacity for growth, and the success of the school in fostering this, will affect initial predictions enormously.* Most residents develop evenly, but some show surprising improvement during training. Predominantly, these late developers are serious, inhibited, and shy. Some are neurotically hampered and seek psychiatric help. (About a fourth of all residents studied got some psychiatric treatment during the residency period and many more thereafter.)

"Natural" growth-inducing factors influence the resident's development. In Topeka, many residents have, for the first time, married, bought a house, and become parents. Also, perhaps even more than by the school's didactic program are they benefited by their association with staff members who may serve as models of the competences the residents are trying to attain.

A capacity for growth is not only evidenced by startling changes, but it is one of the most distinguishing qualities between the better and poorer residents. The supervisors emphasize that the more competent residents do not so often make the same mistakes; they are not so defensive that they cannot learn. The supervisors have more faith in their continued development and refer to them as having "good potentialities." The question in the selection process then should be: what kinds of residents develop best?

Discussion

Our finding that some who do not look good early in training turn out well later on, does not necessarily imply that one should accept more borderline applicants. Some borderline residents do not improve; others get worse. Giving more people a chance to enter the school, and evaluating their work at the end of a year might be justified. We agree that selection does not stop at entrance into the school—that it has to be a continuous process of the resident's judging his own interest and fitness, along with a similar judgment by the school. But, carried too far, this policy would

lose the gains of the initial selection and add unduly to the burdens of the supervisors—they would be taken up more with "weeding out" rather than "nurturing growth."

The great improvement in some originally unpromising residents suggests that a major research effort of the school should go into finding the best ways to accelerate the growth of the residents' potentialities. One such investigation of ways of supervising residents' psychotherapy[2] had a positive effect on the skill of the supervisors who participated.

Just because the predictive instruments, the tests and interviews, were a good deal less than perfect, one should not conclude that they are no good. It should be considered rather that the procedures are less useful in predicting later clinical skills than in their typical applications to clinical evaluation of patients. Selection studies have been much more successful in predicting other than clinical skills, for example, those involving intelligence in a narrower sense, and those involving motor skills. Much of our personality description is probably correct, but we fell short in converting what we knew about the person into a prediction of his competence. It was easy enough, in many failures in prediction, to review the assessment data and find the responsible errors.

Difficulty in predicting was not only that of casting the qualities into a correct synthesis. In rating residents, we disagreed sometimes on some crucial qualities, even though their definitions and the way they were to be recognized in our procedures had been agreed on before-hand. Empathy, for example, was a quality described as a requisite by the experts and imputed to the better psychiatric residents by the supervisors. Unfortunately, such concepts are difficult to define so that people will agree on what they mean *in the individual case*. The important question then is this: will the individual interviewers agree that one particular applicant is empathic and another not? Our evidence suggests that they will agree regularly on some qualities and seldom agree on others in rating specific individuals. On the majority of the qualities judged, we agreed more often than we did on the judgment of how good a psychiatrist a man would make, thus emphasizing a common finding in this type of assessment work, that it is harder to assemble qualities into predictions than it is to judge whether they are present.

We suggest that each school of psychiatry arrange a simple method of checking up on the value of its own special predictions. We have not come up with any simple answer to the problem. Some readers may even take solace in our difficulty, for it points not only to weaknesses in our best predictive instruments for the task of choosing clinicians, but it shows how stubbornly a person defies our best efforts to foretell his development. At least, he does not defy us completely, for a modest level of service has been obtained, and we have demonstrated that research in this area is feasible.

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THE PERCEPTION PROJECT: PROGRESS REPORT FOR 1953–54

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Over the years, an objective of our laboratory studies of perception has been the formulation of regulative principles of personality as they appear in cognitive behavior. It is our working assumption that such principles—*cognitive attitudes*, as we have come to call them—produce the consistencies in various aspects of a person's thought organization and in his manner of perceiving his environment. If such perceptual controls are indeed basic personality dispositions, they should allow us to predict from a person's perceptual behaviors to his adaptive as well as expressive behavior in a wide variety of situations. The assumptions in this point of view and the directions in research that they have generated have been reviewed in several publications.[7, 8, 10]

During the past year, our experimental activities centered upon several problems arising out of previous studies: (1) We have planned an intensive study of 60–75 subjects all to be tested on a battery of cognitive tasks that have been crucial in previous attempts in this laboratory to define several cognitive attitudes. (2) We completed a study of the effects of a need (thirst) on persons who differ in their manner of dealing with intruding and distracting stimuli. This problem developed from the more general question concerning the role of cognitive attitudes in the regulation of need-states in behavior. (3) We undertook further studies of the tendencies in individuals either to be tolerant or intolerant to unstable stimulus contexts. For instance, tolerance for instability was studied in the recall of stories containing incongruent, illogical, and nonsequential elements. (4) An early study from this laboratory suggested that the extent to which percepts are colored by an affect or expressive (physiognomic) quality may reflect basic personality dispositions, with important consequences in a variety of situations. During the past year, we completed a study which explored the possibility of a generalized physiognomic disposition in cognitive organization. (5) Recent pilot studies have been investigating techniques for exploring the significance of variations in sensory thresholds in personality organization. (6) We have taken an increasing interest in more direct observations of the everyday social behavior of hospital patients,

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who have been our laboratory subjects, as a way of enlarging our understanding of the general personality dispositions that are implied in the cognitive attitudes seen in the laboratory. Plans are being developed now to investigate the generality of cognitive attitudes through direct observational studies of social behaviors in well-defined social situations.

We shall describe a few of these developments in somewhat greater detail.

Relations among previously defined cognitive attitudes: the Integration Study. Previous studies have resulted in several tentatively defined cognitive attitudes. For example, in one of our laboratory situations, subjects were required to judge the sizes of successively presented squares that gradually increased in size (the schematizing test). From subjects' performance on this test we were able to infer two relatively stable, preferred ways of organizing sense data: *leveling* and *sharpening*. Sharpening refers to a person's tendency to be particularly attuned to changes and differences in stimuli. Sharpeners prefer complex organizations to more simple ones; indeed they seem to search for and maintain highly differentiated patterns; in looking at a forest they continue to see each tree.

Leveling, on the other hand, results in minimizing differences and in preferring the experience of "sameness" to change. Thus, levelers organize fields in either a simple or diffuse way. The trees of the forest lose their individuality and blend into each other. These general tendencies either to level or sharpen differences were then explored in tasks other than the schematizing test—tasks which had as their principal requirement the distinction of differences in auditory and kinesthetic as well as visual sensations. Here again we found that sharpeners were able to maintain the distinctiveness of each stimulus.[5, 6]

Another set of cognitive attitudes has been a preference of some people for narrowed concentration, making them exceedingly well able to shut out distractions and irrelevancies from a task at hand (*focussing*) while others seem to prefer to experience more globally, tend more to be influenced by distractions and intrusive irrelevancies in certain tasks, but also better able to respond emotionally when it is quite appropriate to do so (*nonfocussing*).[13] Still another cognitive attitude we have studied in our laboratory concerns the "fineness or coarseness with which people categorize the objects of their experience."[3] These are but three of the cognitive controls we have dealt with.

It is possible that these definitions overlap, and that they may reflect particular aspects of more generic regulative principles. We have designed the integration study so that all procedures relevant to each of the cognitive attitudes are administered to a single large group. We plan to test 60–75 subjects on 15 procedures, all of which have been crucial in finding the sets of cognitive attitudes. Testing the same subjects on all our procedures will

for the first time permit us to re-evaluate our previous conceptions of cognitive attitudes and the relations among them. Thus each subject in this study performs in a variety of tasks such as the schematizing test, judging the size of discs on which extraneous content has been superimposed, sorting into groups a large number of diverse articles, naming colors that are printed in disparate color-words (thus the word "red" is printed in yellow ink, and the subject is required to name the color of the ink and not to read the word), and others. Another source of data is being tapped through an extensive questionnaire given to all subjects. The questionnaire, consisting of 232 items, attempts a survey of social behaviors thought to be associated with the various forms of cognitive control.

Our studies have implicitly assumed that cognitive attitudes are relatively stable personality dispositions, a supposition never directly tested. We plan to test a number of people who served as subjects in many of these tasks as long ago as four years. Such retesting will permit us to evaluate the reliability of our tests and possibly the durability of these cognitive controls and may provide an opening into the problem of the continuity of personality over long periods of time. In addition to the retesting of old subjects we plan to study the extensive clinical case material on a few selected subjects, in order to enrich our understanding of their perceptive and cognitive tendencies in the laboratory performance situations.

We are also attempting to link our definitions of cognitive attitudes to those developed by H. A. Witkin and his collaborators.[15] One of their key test situations directs subjects, sitting in a darkened room, to adjust a luminous rod to the upright position when the surroundings and the subjects' chair are tilted various degrees from the vertical. Witkin and his coworkers distinguished those who depended primarily upon visual cues ("field dependence"), and those who depended upon bodily kinesthetic cues ("field independence") in adjusting the luminous rod. Their data suggest that these preferred tendencies may reflect fundamental personality dispositions. These definitions and the test situations used by Witkin have much in common with those developed in our laboratory and with the regulatory styles described in our work. It seems worth while to explore the link more systematically. We have included in our integration test battery Witkin's tilted rod-frame-chair test and two other tests which he found to correlate highly with it: the Rorschach, and Witkin's adaptation of the Gottschaldt figures.

Similar coordination is planned with the perceptual studies of Dr. Gardner Murphy's group aimed at the effects of experiences of reward and punishment and success and failure on perceptual behavior. Subjects of our Integration Study will comprise part of the population they will test.

Our first steps in analyzing these data will be to check on the reliability

of the measures used in our earlier studies. The major question of this study concerns the parsimony of definitions of attitudes which can most efficiently account for the obtained correlations. Having tested all of our subjects on all of our tests should make it possible to think afresh about the assumptions we have made in establishing even tentatively a number of independent "dimensions" of personality.

Our plans also include pilot studies of direct observations of subjects in selected social situations. Several studies in this laboratory have suggested that the generalized modes of cognitive control observed in our cognitive tasks may be useful for understanding behaviors in other areas of response (emotional sensitivity and control) and in social situations. This has raised the possibility that more general "system-principles" of personality organization may determine both the regulative consistencies in such interpersonal situations and the consistencies observed in our laboratory studies. Up to now, our efforts to extend predictions to situations outside the laboratory have been confined to self ratings on questionnaires, a notoriously limited technique. The hospital milieu in which many structural characteristics of various patient activities remain relatively constant would seem to be ideal for such more direct observational studies. In addition, the exhaustive personal inventory administered to each subject for self ratings establishes a logical bridge to field studies of behavior. The relating of cognitive consistencies in the laboratory, *self* appraisals of performance in the social situations via the questionnaire, as well as actual *observational* data by experienced observers in the hospital setting would mark a significant advance in our method.

Studies of individual differences in the effects of a need state (thirst) upon cognitive behavior. An important theoretical extension concerns the adaptive significance of cognitive attitudes in the "delay" and control of need gratification. Our conception of cognitive attitudes was developed within the framework of a larger conception of ego organization. For instance, much of our work assumes that ego organization is in part a network of controls organized to modulate claims of drive and reality. In psychoanalytic theory, impulse control has been discussed mainly in terms of defense. It seemed important to investigate the possible function of cognitive controls observed in our laboratory situation for the delay and discharge of need-tension. The question is relevant also to the general issue of structural constraints upon the directive influence of needs. Thus a series of experiments demonstrate that the effects exerted by a need in perceptual-associative behavior are distinctly different where the cognitive attitudes and adaptive problems vary.[9]

These studies and others seem to suggest that a wide variety of controls, of which defense may only be one form, condition the working of need and

drive and behavior. In general, these studies have contributed to our attempts to establish more explicit links to the psychoanalytic framework. For instance, it does not seem likely that the concept of defense, even "autonomous defense," in the psychoanalytic literature is wholly adequate to describe the regulative strategies that subjects have shown in our perceptual tasks. Our data seem increasingly relevant to formulations by Hartmann,[4] Rapaport,[12] and Kris[11] regarding "autonomous" "conflict free" functions in ego organizations, *i.e.*, functions not exclusively or even necessarily developed from or in the service of drive-conflicts. These are by no means firmly held propositions in our work, but it seems a worthwhile working assumption that those aspects of perceptual processes which psychoanalytic theorists currently view as "autonomous" are themselves idiosyncratically organized within people into "styles" or regulative principles. The conception of cognitive attitudes may be relevant to this possibility. It seems also valuable to distinguish between functions specifically organized in relation to drive conflict from those which promote delays and detours in drive gratification in keeping with reality requirements.

Individual differences in sensory thresholds. During the past year, a renewed interest has developed in the significance of sensory thresholds in personality organization. Early formulations of this problem in this laboratory assumed that cognitive controls manifest themselves through particular structures and functions termed *adaptive properties*, of which sensory thresholds were considered one.[7]

Freud's concept of the "protective barrier,"[2] early raised the possibility of adaptive selectivity at the receptor level, in contrast with the wholly peripheral conception of modality sensitivity and with this the possibility that adjustive requirements of the organism may be reflected in changes in threshold sensitivity. Early pilot studies in this laboratory on threshold variations in hypnosis seemed to encourage this supposition, as have more recent clinical reports. For instance, Brenman, Gill, and Knight[1] have reported fluctuations of sensitivity which seem closely to parallel altered ego states.

The first studies planned are concerned largely with the issue of the adaptive importance of changes in threshold level. How does sensitivity vary where strong affect is present? How does threshold sensitivity vary in situations that require directed attention and in those that do not? For example, the instructions in typical psychophysical studies of threshold sensitivity require directed attention. Is the sensitivity displayed under such circumstances typical for a subject or is it unique to the circumstances? We plan a series of experiments of threshold variations in several sensory modalities, when directed attention is explicitly called for, and when it is not. For instance, it may be possible to tap incidental sensitivity through

a sorting test which requires subjects to place cards into particular bins in response to signal letters appearing on a screen. The signal letters would be clearly supraliminal. Interposed between these easily seen letters would be others below threshold; the latter would be gradually increased in clarity until seen as measured by the subjects' response. We plan also to test threshold "drift" under situations that induce unique affective experience, such as photic driving, the total homogeneous field (*Ganzfeld*), and perhaps the use of certain drugs.

In a pilot study already undertaken, a mechanical vibrator applied to the ankle bone was used to induce vibratory sensations. Vibration thresholds were obtained on a small group of subjects under two conditions: (1) with the subject's eyes *open*, and (2) with the eyes *closed*. Readings were taken on three successive days. There were striking individual differences not only in threshold level and in diurnal variation, but also, for certain individuals, between the two conditions. With some subjects, thresholds were lower when their eyes were closed, and variability also less. Others showed a reverse tendency or no difference at all between the two conditions. Subjects' reports disclosed that when the vibration approached threshold level, those subjects who with their eyes closed were particularly sensitive, experienced the vibration from *within* the bone. (This called to mind Werner's distinction between "vital" and "externally localized" sensations.[14]) Those who showed no difference between conditions, or a higher threshold with eyes closed, maintained that they experienced the sensation as imposed upon them. Thus, quantitative differences seemed to parallel differences in sensation quality at or near threshold.

We are planning to investigate under many stimulus conditions the adaptive importance of differences in sensation quality that appeared in this study, particularly differences among those whose sensory experience depends on localizability of sensation externally or on the surface of the body, or internally.

The work we have thus far completed, embracing theoretical developments and our major findings on the problem of cognition personality relationships, will be systematically described in a comprehensive monograph now in preparation. This book, dealing with the general problem of how forms of cognitive behavior express the adjustive economy of the ego system, is a collaborative effort of those who have been identified with the project from its inception: George S. Klein, Riley W. Gardner, Philip S. Holzman, and Herbert J. Schlesinger.

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BOOK NOTICES

A Way to the Soul of the Mentally Ill. By GERTRUD SCHWING. Translation tion by Rudolf Ekstein, Ph.D.* and Bernard H. Hall, M.D.* $3. Pp. 158. New York, International Universities, 1954.

This book by Gertrud Schwing belongs to a great tradition so well exemplified in the writings of Fromm-Reichmann and Sechehaye. While there are important differences in therapeutic approach and theoretical understanding among these three women, there is common to all a tenderness, intuition, and devotion which easily fits Federn's definition of "motherliness."

One must read this contribution with the heart as well as the mind, and with an eye on historical perspectives. At the time Schwing initiated her psychotherapeutic work with regressed schizophrenics, few European psychoanalysts were interested in this problem. What evolved from her dedicated efforts was first and foremost a striking confirmation of the hope offered such patients by the work and observations of Federn, Hollos, and Bleuler. In addition there came a series of technical recommendations and theoretical constructions of considerable importance. These range from a focus on the problems of identification in relation to mental equilibrium to observations concerning redistribution of the psychic economy in response to intercurrent illness, physical force, or insulin coma.

The book is written with a gentle modesty yet an earnest conviction, both characteristics which must have played an important role in Schwing's ability to make contact with the most withdrawn patients.

MILTON WEXLER, PH.D.
Beverly Hills, California

Ego Development and the Personality Disorders. By DAVID P. AUSUBEL. $10. Pp. 564. New York, Grune & Stratton, 1952.

Ausubel's thesis is comparatively simple. There are two main crises in ego development. On their outcome depends on the one hand personality development and on the other hand proneness to mental illness in general and to specific types of mental illness in particular. The first crisis is at the transition from infancy to childhood, the second begins at puberty though it continues for many years.

His hypothesis revolves around what he calls *satellization*, evidently a new name for an older concept, *identification*. But it is not clear why Ausubel utilizes one concept of dynamic psychology and summarily rejects or attempts to discredit the rest. His theoretical flimsiness shows up sharply, for example, in the fact that the sections of the book on the classification of mental disorders, and on psychotherapy, are not only brief and unconvincing but also are tied to the author's theoretical position merely by one or two slender threads. (Donald J. Watterson, M.D.)

Three Men. By JEAN EVANS. $3.75. Pp. 297. New York, Alfred A. Knopf, 1954.

* Members of the staff of the Menninger Clinic, Topeka, Kansas.

In this book a science writer has carefully collected biographical material on three psychiatric cases. From a sociological and descriptive psychological standpoint, this is well done. The psychiatric point of view is rather pointedly omitted. An introduction by Professor Gordon Allport professes considerable enthusiasm about the value of the material for teaching purposes for the very reason that the author imposes a minimum of interpretation. One of these cases is the extraordinary optic atrophy case in which vision was restored for reasons totally unknown and unexplained. (K.A.M.)

Frontal Lobes and Schizophrenia. By MILTON GREENBLATT and HARRY C. SOLOMON. $12.50. New York, Springer, 1953.

The second lobotomy project of the Boston Psychopathic Hospital reports a detailed research study of 116 patients with chronic mental illness both before and after various types of frontal lobe surgery. After careful psychiatric, psychologic, sociologic, sociometric, physiologic, and pathologic studies, it is concluded that the bimedial lobotomy is the superior operation. A theory of frontal lobe functioning and an explanation of the beneficial effect of lobotomy is presented. Frequent summaries of data with conclusions assist the reader to understand the studies. The report makes a significant contribution to our knowledge of frontal lobe functioning and the lobotomy procedure. (Kenneth G. Rew, M.D.)

Psychological Reflections. JOLANDE JACOBI, ed. $4.50. Pp. 342. New York, Pantheon, 1953.

Of all the books by and about Jung, this is perhaps the most readable to those individuals outside of his personal and professional circles. It is a collection of excerpts from his writings organized about such topics as consciousness, dreams, doctor and patient, development of the personality, and the way to God. Particularly valuable are the one line synopses cleverly drawn from the text by the editor and used as a kind of table of contents. (K.A.M.)

Problems of Infancy and Childhood. MILTON J. E. SENN, ed. $2.50. Pp. 160. New York, Josiah Macy, 1953.

The sixth conference on problems of infancy and childhood, for which the Josiah Macy, Jr. Foundation brought together a group of distinguished pediatricians, psychiatrists and obstetricians, including Marian Putnam, Benjamin Spock, Katherine Wolf, and Erik Erikson, reports three main papers each of which is followed by discussion. The reports are: "Emotional Development in the First Year of Life," by Sibylle Escalona, "Observation on Individual Tendencies in the First Year of Life," by Katherine M. Wolf, and "Excessive Crying in Infants—A Family Disease," by Ann Stewart. The report by Sibylle Escalona consists of some fifty-five pages of general summary of her pithy and vivid findings on the infant study which was conducted at The Menninger Foundation and twenty-five more pages of illustration of two cases with discussion by the group. For anyone who wants to know about the beginnings of emotional development, this book is a must. (Lois Murphy, Ph.D.)

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