THERAPEUTIC USE OF THE SELF
A Concept for Teaching Patient Care

Formulated by the
Committee on Psychiatric Nursing of the Group for Advancement of Psychiatry*

Report No. 33
419 Park Avenue South, New York, N.Y. 10016
June 1955

CONTENTS

I. Introduction
II. General Comments
III. Specific Considerations
1. Regression with Symptoms of Dependence
2. Areas of Dysfunction
3. Decreased Capacity for Mature Object Relationships
IV. Conclusion

I. INTRODUCTION

An understanding of the behavior of the mentally ill patient, and an appropriate response to it by nursing personnel(a) is necessary for therapeutic effectiveness in the day by day care of the patient.

This communication deals primarily with psychiatrically oriented concepts which will assist in the better interpretation of the patient's manifest behavior. As a consequence we should have better recognition of the patient's emotional needs, awareness and use by nursing personnel of supporting and corrective responses to his emotional needs, appreciation of some aspects of interaction between patient and nurse, and its meaning and application in the therapeutic effort.

We wish to discuss these concepts as current working formulations and to offer a dynamic orientation for persons, by whatever title designated, who participate in the daily 24-hour care of the mentally ill.

We hope that these concepts will be transmitted into daily action and thus help the leader, supervisor, teacher, or administrator to make his job assignments and conferences and classes more meaningful, so that personnel may become more aware of the patient's needs, and therefore more successful in treating him.

In particular, we direct this communication to those concerned with instruction of psychiatric aides, professional nurses, orderlies, practical nurses, attendants, psychiatric technicians, and others who perform similar duties.

A hierarchy of personal relationships exists in every mental hospital, private or public, large or small, well-staffed or not. It is not our task, and it would be presumptuous, to prescribe for each institution how the director and the directed, teacher and student, supervisor and supervisee, nurse and patient should put these concepts into operation. We prefer to call attention to this ubiquitous and complex problem, and offer some suggestions toward assessing it. We hope thus to define the meaning of personal relationships and of the forces involved. These relationships are sensed by all. Too often they are left anxiously unscrutinized or are defensively assigned to "roles" that nurses "should" assume.

The earlier survey(b) of training programs for psychiatric nursing personnel suggested only limited awareness of the problem of nurse-patient relationships. We do not believe that this indicates an absence of concern regarding this complex problem but rather that it indicates a lack of clarity about conceptual goals, an imperfect focus on which area of patient behavior to scrutinize, an inadequate comprehension of emotional processes, and an incomplete understanding of the anxiety-provoking nature of the behavior of the mentally ill.

A patient enters a psychiatric hospital because he has experienced difficulties in living in the outside world. Whatever the nature and expression of these difficulties, they invariably include a breakdown in relationships with other people. The hospital must serve as a smaller, limited world wherein new experiences in living, and new personal relationships, produce minimal anxiety and maximal support. Thus, the patient gradually may be helped to feel that living with others is less threatening and a less forbidding experience.

We assume that the behavior of the patient has meaning; that his behavior affects the behavior of those who care for him; and that the behavior of those who care for him affects the patient.

The patient's hospitalization should enable him to learn to live more effectively with other people. Every mental illness includes the problem of the patient's

*This report was developed by the Committee on Psychiatric Nursing of the Group for the Advancement of Psychiatry with the collaboration of Mrs. Gwen Will, R.N., (representing The American Nurses Association), Miss Kathleen Black, R.N., (representing the National League for Nursing), Mrs. Frances Thompson Lenahan, R.N., and Mr. Gordon Sawatsky, a psychiatric aide. We gratefully acknowledge their help.

This report was prepared under the chairmanship of Elvin V. Semrad, M.D.

(a) The term nursing personnel or nurse will be used throughout the text to include all persons, by whatever title, who are involved in the 24-hour care of the mentally sick patient.

(b) G.A.P. Report No. 22, "The Psychiatric Nurse in the Mental Hospital".
particular way of relating himself to others and participating with others in activities. When a patient enters a mental hospital he has already established patterns of behavior intended to facilitate his withdrawal from anxiety-provoking relationships. Withdrawal may be variously expressed. In the attempt to cope with his anxiety, the patient chooses that form of expression which, in his past experience, has been most effective in maintaining distance from others for his subjective comfort.

In the hospital new personal relationships must gratify the patient's needs, facilitate his communication with others, and enhance his social participation. It follows that the nursing personnel, which has the longest and most intimate contact with the patient, is deeply involved in these processes. Every contact with the patient, whether in the performance of "official nursing care" or in a less directed capacity, involves patient-nurse relationships. The relationship can be therapeutic or harmful. If these relationships remain essentially therapeutic, the patient-nurse relationship can become an integral part of the patient's whole therapeutic regimen. It is important for nursing personnel to understand and to be aware of the feelings, thoughts, and actions of the patients. They should have a similar understanding of their own thoughts and actions in any situation. Such awareness is acquired gradually and depends upon collaboration with the psychiatrist, conferences with supervisors and coworkers, and repeated experiences with patients.

II. GENERAL COMMENTS

To extend the common awareness of anxiety, and of reactions and defenses to anxiety, we should like to elaborate, first on the theme of regression with symptoms of dependence which is part of every illness, mental and physical. Next, we wish to re-examine the changes in object-relationship that invariably ensue when chronic and intense dependency are expressed.

To illustrate these two main inter-dependent dynamic concepts of every mental illness we have chosen to discuss the following dysfunctions: 1) Disturbance of Productive Activity; 2) Inability to Control Basic Impulses; 3) Changed Moral Standards and Conventional Attitudes; 4) Diminished Integrative Capacities; and 5) Disturbances of the Function of Reality-testing.

These phenomena are readily available for continued observation in daily behavior. They are manifestations about which society has ideas of "normality," concepts of good and bad, and of morality and immorality. They deal with problems whose mastery is the concern of patient as well as nurse.

This report will not allude to structure, etiology, and genesis of the basic conflicts. The understanding and resolution of these conflicts in the patient are essentially the task of the psychiatrist. This demands orientation and techniques which are not available to the nurse. Although nursing personnel and psychiatrist may well have different goals and techniques, it cannot be sufficiently emphasized that whoever works with the mentally ill must face and react constructively to the phenomena of regression and altered, decreased capacity for object relations.

The recognition of these processes and the understanding of their dynamic significance can become the common denominator of all the different "therapies" to which the patient is invariably and unavoidably exposed. The understanding of these concepts should offer a basis for communication among the various participants in patient care. It is only through such communication in the hierarchy of personnel that consistency and direction can be brought to the total therapeutic regimen. The understanding of these concepts should further facilitate the definition of different roles for personnel, and of the various levels and areas wherein each person can make his contribution toward a plan of treatment.

III. SPECIFIC CONSIDERATIONS

1. Regression with Symptoms of Dependence. Regression is a return to earlier (childhood) methods of solving personal conflicts. It occurs when physical or emotional stress is too severe to be integrated in the usual (adult) manner. Each individual, in his ordinary relationships with people, at one time or another finds the need to return to earlier modes of behavior. For instance, sleep is the universal form of regression following the tiring activities of the day. Often, under the influence of group situations, an individual may allow himself activities which are regressive in nature; for example, the mischievous, childlike behavior frequently observed as part of activity at a class reunion of the old alumni, or at a business convention.

To understand the process of pathological regression, it is necessary first to understand the effects of progression, as manifested in the growth toward maturity in the formative years. The infant is endowed with capacities, instincts, and drives that propel it steadily toward growth, development, and maturity—physical and emotional. The normal development of this process can be envisioned as a complex progression. Various stages of development are clearly recognizable in the maturation of the organism.

However, at any time during the course of that maturation, the individual may find himself faced with insurmountable conflicts. To cope with the anxiety produced by these conflicts, and despite his propensity for growth, the individual may be forced to return to an earlier level of development in which he felt more protected, and therefore safe. This return to earlier modes of behavior is the characteristic of regression.

The regression will take on the features of the developmental stage to which the individual returns. The more profound the regression, the more childish and infantile will be the behavior of the patient. The depth to which he regresses will depend on a number of variables such as the intensity, duration, and severity of the conflict which he has had to face in the present situation; the nature of the conflicts which he has faced during his maturation process; and the
similarity between the conflicts experienced by him as an adult and those conflicts experienced by him as a growing child. Following are examples of the operation of each of these variables:

a. The soldier in combat, overwhelmed by fear, fatigue, hunger and low morale, may regress to very primitive modes of behavior. These may be characterized by inattention to basic physical needs. He may lie mute and disinterested in his surroundings.

b. An individual in childhood had had repeated demands for performance, which have been a source of intense, chronic anxiety. He enters into a relatively benign work situation. Intellectually he has the capacity to perform this job successfully. Because of his chronic anxiety and his fear of failure, he constantly seeks reassurance from his employer. At home he demands special attention and sleeps a great deal.

c. A child may have felt unloved and deprived of essential emotional relationships. As a man he may react to a minor loss of love, such as a girl friend's refusal of a date, by behavior including temper tantrums, crying or petulance.

When regressive behavior appears, the individual, though an adult, will seem more childlike in his behavior. His usual mature ways of handling problems will be changed. Instead, he will opt to depend increasingly on others. He will become indecisive. He will expect more care and attention both physically and emotionally. If he attempts to deal with problems he will do so in an inadequate and childlike manner. Following are two examples of such behavior:

a. The patient hospitalized for a minor surgical procedure has an uneventful post-operative course. However, on the day he is able to be ambulatory, he says he cannot get up, and rejects the nurses' attempts to help him. During the next several days, he repeatedly rings his bell and refuses to help himself in any way. It is important to understand this behavior (regression) as a response to the patient's anxiety. If this situation is to be handled in a therapeutic way, the nurse should avoid labeling him as uncooperative and demanding.

b. On the ward one observes a carelessly dressed, unshaven patient. He never washes, shaves, or changes his clothing unless the nurse reminds him to do so and assists him. He seems unable to make the most minor decisions for himself. He repeatedly asks the nurse for favors. Yet before his illness this patient was a fastidious, self-sufficient business executive.

The degree of regression with resultant dependence may vary from the simple increase of demands for physical care in a person with an organic illness, to that of a completely dependent individual who no longer assumes responsibility for the most basic functions of the organism, such as eating or control of bowel and bladder function. Thus, his dependence is an attempt to cope with the threats from the physical and emotional environment (defense).

Thus far we have discussed regression and resulting dependence as if they occurred in pure form. However, as in any disease, the organism attempts in some way to overcome or deny the occurrence of the process. As a result other responses are set in motion. These are in the form of mechanisms that attempt to hide from others and from himself the severity and type of disturbance taking place in the personality. We may have, then, the type of reaction in which the individual simply seeks oblivion from the presence of the process. This is an example of simple Denial. On the other hand, the person may go one step further than simple Denial and impute the dependence to someone else. This is Projection. Or, again, he may attempt to cope with the conflict by using actions and expressions that are contradictory and thus ineffective in solving the problem. This is an example of Reaction Formation. In some instances, the organism is able to function fairly well by becoming aggressive in helping others or in caring for others as he would like to be cared for. In this way he may overcome somewhat successfully the anxiety provoking process. This is an example of Overcompensation.

It is useful for nurses to understand the patient's need which is expressed by the defense and that against which he defends. It is important to point out here that attitudes, reactions, and roles cannot always be prescribed for the patient's needs as they are understood in the framework of his whole personality. It is frequently necessary to respect and support the defense and to make it operable as such. At other times, it is more helpful to support that which is defended against, than to implement the mechanism used by the patient. The following are examples:

a. A group of patients is going out for a scheduled activity. At the last minute Mrs. Smith, a new patient, complains she has cold feet, feels cold all over, and returns to her bed. The nurse, though aware that this is a defense against the patient's anxiety, responds directly to this expression by covering the patient, getting a hot water bottle and staying with her. In this instance, the defense is respected and supported.

b. At a later time in Mrs. Smith's hospitalization, it may be more therapeutic to anticipate anxiety-provoking situations and to give support and help in these, thereby decreasing the necessity for Mrs. Smith to develop the previously mentioned type of defense. In other words, the nurse may discuss the activity with Mrs. Smith and help her to identify her feelings and fears about them.

In addition to the decision to support the defense, or that which is defended against (never a complete either-or proposition) an estimation of the degree of support and timing of support is necessary. Furthermore, there must be a readiness to modify degree and timing of support. We may categorize these concepts as follows:

A patient with a mild degree of dependence may require support of his dependence until he is able to accept more responsibility.

A patient with a moderately severe problem of dependence may need gratification of the dependence by the nurse. At the same time, other members of the team may help the patient toward insight that would
enable him to assume more responsibility.

A patient with severe problems of dependence may require the nurse’s tolerance of complete regression. The nurse must offer kind, understanding support and love over a long period of time before the patient can accept some responsibility.

The most common nursing problems demand insight and therapy to some degree, but deal chiefly with supportive attitudes and activities.

Nurses not infrequently display overindulgence, rejection, or punitive control of the patient. With awareness, however, the nurse can be sympathetic, supporting, accepting, permissive and firm in her guidance of the patient.

It is quite obvious that the nurse by herself cannot make the decision for the most effective plan of treatment. Communication through conferences and discussions should formulate the general therapeutic attempt. Further supervision should be available to help each nurse to assess her part in the accepted therapeutic effort.

The patient may withdraw from participation in living by regression and symptoms of dependence. This prevents his having many experiences that would contribute to strengthening relationships with people. For example, the patient may refuse to eat by himself, bathe and dress, and may become completely dependent on nursing staff for physical survival. The nurse may easily assume the role of a person upon whom the patient is dependent. The patient may come to feel comfortable when fed, bathed, and dressed. The nurse needs to understand why this kind of participation is a comfortable one for the patient, and also must be aware of her own feelings about having someone dependent upon her. Otherwise, the nurse may be uncomfortable about giving the sort of care which may be helpful to the patient at this point in his illness. This involves some understanding of the patient’s past experiences which have necessitated his dependence, and also some understanding of the nurse’s feelings about dependence.

A serious problem may arise when the nurse actually receives a great deal of satisfaction from working in a situation in which the patient is dependent on her. In such instances, the behavior of both may become fixed at this point, the nurse actually fostering continued dependent behavior on the part of the patient. Such fixation on dependence is contrary to goals in nursing. When present many cues are missed that might lead to experiences that would lead away from dependent or regressed behavior. The patient may reach for the spoon to feed himself, but this cue is not observed or used. The necessity to maintain the patient’s dependence reflects, then, the nurse’s need for satisfaction and security, and discourages the patient’s first timid attempt away from dependence.

2. Areas of Dysfunction. The following five sections illustrate various mechanisms involved in personality change. These sections focus on essential areas of dysfunction of the personality that are associated with the ever-present regression and dependence and concomitant disturbed relationship to other persons.

a. Disturbance of Productive Activity. Every mature individual has at his disposal sufficient amounts of energy in his usual daily activity. The energy is used for physical activities which include his work and recreation. Additional amounts of energy are drawn upon in the solution of the emotional or intellectual problems which arise as part of the daily routine. The individual can also draw upon reservoirs of energy if emergency situations arise. In the integrated individual there is, then, an availability of energy to be used in productivity.

The growing and adult individual constantly exchanges energy with his environment. In infancy there are great demands for energy made on the environment, since the organism must use energy for growth. As growth progresses and becomes slower, there is increasingly more energy available for the use of the individual in productive activities. In the adult there is enough available energy so that some can be transmitted to others in the form of physical, emotional, or intellectual support. Energy is also available for productive and creative activity. Finally, energy will be used in procreation and in the rearing of children.

Wherever conflicts are met in life-situations, a certain amount of energy is used in an attempt to solve the problems inherent in the conflicts. This energy must be drawn from that which normally would be used for productive activity. A patient who is in constant conflict uses large amounts of energy in attempting to solve his problems. It follows, then, that there will be very little, if any, energy available for productive activity.

As a result, the patient may display a general decrease of activity, both physical and mental. He may, in extreme situations, appear stuporous, and therefore, unable to use any energy in productive activity related to his environment. The regressed schizophrenic is using much energy attempting to solve problems in an unrealistic (autistic) manner. In the less severe stages, we may see a patient who to some degree can participate in ward activities, but who soon tires and must be excused. This is quite apparent in the depressed patient who spends much time in self-contemplation, and in whom expenditure of effort is followed by almost complete exhaustion. Again, a patient may be using large amounts of energy in what seems to be productive activity, but on closer examination it becomes apparent that this is being used to deny the presence of internal conflicts. This activity is only a facade which is easily discernible. This type is most commonly seen in the manic patient who is overactive in an attempt to deny an underlying depression. His overt behavior shows that he is expending great amounts of energy, but examination of his productivity indicates that a host of projects is started enthusiastically but the work does not go beyond that stage.

The problems posed for the nurse who is in relationship with these patients are ones which center
on the expenditure of energy. The recognition that the patient is using energy in attempts to solve internal conflicts will direct the nurse to keep the patient’s activities within the limitations of his available energy. She will then be able to accept the patient’s fatigue as real and not react to what is an apparent but not actual laziness. On the other hand, these patients tend to demand a great deal of energy from the nurse. This becomes a source of irritation and resentment if the nurse allows herself to go beyond her available energy.

b. Inability to Control Basic Impulses. Before considering this aspect, there must be some understanding about what the basic impulses are, how they function, and how they are normally controlled.

At the time of birth the child’s energy is released by a constant discharge of varied and random impulses. This can be seen in the apparently purposeless movements of the muscles of the body. Any minor frustration is reacted to with massive impulsive responses; the crying of the baby involves his entire musculature. Again, when the bowels are filled, the baby responds immediately by evacuation. Hunger is responded to with desire for immediate gratification associated with a crescendo of crying.

In the process of growing from a baby to an adult, the individual learns different patterns for controlling his basic impulses through the relationships with his parents and other people. To gain love and approval he learns to postpone immediate gratification of such impulses as eating, evacuation of bowels and bladder. He learns that responses to minor frustrations by violent temper outbursts bring loss of love and approval, and therefore, he institutes controls. Later, when the sexual impulse becomes more manifest, the child shows early lack of control, just as with other impulses, but gradually and for the same reasons, he learns to control these impulses. By these experiences he learns to delay gratifications in accordance with the wishes of people with whom he lives and in keeping with the demands of society.

When a patient comes to a mental hospital, because of the regression inherent in his illness, we see the re-emergence of these basic impulses with the learned patterns of control removed in varying degrees. The patient immediately responds to his impulses. If he is hungry, he demands food, and if he is frustrated, he may respond with violent temper tantrums. He may no longer be able to control his bladder and bowels. He may void, soil, and smear on the ward, when and where the impulse emerges. In the sexual sphere the same response is apparent. The patient attempts to obtain immediate gratification.

The patient may respond to this loss of control by attempting to set up a variety of defenses. One example is seen in the patient who, constantly faced with sexual impulses which he cannot control, finds a solution by saying that those around him are making sexual approaches to him, or that voices tell him to masturbate (projection).

Another more direct solution for the patient is to participate on the ward in such a manner that he forces the nursing staff to place controls on him. For example, he may constantly tear off his clothing, and as a result of his nudity gets himself confined to his room. He may become so combative during his rages that those in the situation must use physical control of his behavior. His lack of bladder and bowel control may lead to his being dealt with as one would deal with the young child during toilet training. The patient thereby gets the nurse to help him control his impulses.

Another method of handling this problem can be observed when the patient deals with these impulses by incessant and vigorous denial. By this emphasis on the denial, he actually is giving the clue to his concern about his impulses.

When through illness there is a loosening of the inhibitions, and an inability to control the basic impulses as described above, the patient naturally experiences certain emotional disturbances. The whole process impairs the individual’s confidence in himself and his security. We see here the emergence of anxiety. The very anxious patient often has a fear of some impending disaster such as death or loss of control. He usually hides these extreme fears, but gives clues to them in his actions. He may attach anxiety to things or situations that, in the immediate surroundings, can justify such emotion. The demand for frequent contact with the doctor or nurse may amount to the same thing. Anxiety arising from fear of loss of control may lead to a frenzied, or even panic state.

The threat of loss of control of basic impulses, especially those that might call for aggressive action toward others, may lead to anger. Anger, also, may come as a result of disappointment in the self. It is often closely related to, or intertwined with, anxiety because the patient fears his aggressiveness. Hostility is readily recognized when it is directed toward others, but not infrequently, in a more disguised manner, it may be directed inwardly, and the patient may come to hate himself. For example, the loss of a loved one may be accompanied by anxiety and hostility. The patient may show his feelings by denying virtues to and by criticizing the loved one, or by condemnation of himself as an unworthy individual.

Depression may be foremost as a reaction to the inability to control impulses, but usually it is co-existent with anxiety and hostility; sometimes it is less manifest. Occasionally the depression is so profound that all other emotions are blanketed or “snowed under.” More often, anxiety and hostility will break through and show themselves in agitation and rebellion against those near the patient, against rules, regulations and reason.

This type of dysfunction may present a difficult nursing problem. The patient’s own discomfort about this behavior and the anxiety about it may incite many negative responses. The patient may refuse to dress in what is considered appropriate clothing. She may allow her blouse to fall in such a way as to expose her breasts, or she may wear a skirt in such a way as to exhibit her genitals. In addition, she may act toward
the nurse in a very seductive manner, or may withdraw to a corner of the ward and indulge in open masturbation. Such behavior on the part of the patient may make relationships very difficult with others on the ward. Even though it may be looked upon as the patient’s attempt to gain some love and attention from others, nurses may experience great difficulty in maintaining any sort of relationship with the patient as this behavior is not acceptable to them. Here the understanding and awareness of their feelings toward their own basic impulses is significant. When nurses are able to discuss freely how they feel about this sort of behavior, rather than merely to focus on the “right and wrong” aspects of the behavior (people should not masturbate, people should wear clothing, etc.), they are much better able to handle the problem. Their anxiety and discomfort in such a situation does much to sustain this behavior in the patient. When expressed openly, their discomfort decreases, and the patient may be helped to handle his problem in a more useful and mature way.

c. Changed Moral Standards and Changed Conventional Attitudes. In our culture, one way of securing approval and love is by being good. Patients often find such a pattern of behavior in their relationships with others successful when nothing else seems effective. However, the price of this is high. Self-expression, creativity and growth of the individual suffer. The person who pays this price often comes to harbor intense resentment against those who respond to his conventional “good” patterns. He may rebel against convention itself. Direct expression of resentment is not possible for this person as it may bring disapproval and loss of love. These resentments and fears find expression in behavior which deviates markedly from what is usually considered “proper” or acceptable in domestic or social situations. It is behavior that is usually expressed at the expense of some other person, has a retaliative quality, and very often is an implicit bid by the patient for punishment.

Respect for moral standards and conventional attitudes expresses itself in conformity. Social conformity is the result of a compromise between a person’s need for affection and an inherent urge for independence. The need for parental affection is the young child’s most fundamental incentive toward domestication and social conformity. In later childhood, incentive to social conformity comes from the desire for the respect of one’s fellows. Opposing this need for the parent’s affection is a strong human desire for independence and a resentment of control. This struggle ordinarily reaches its peak in adolescence. A conflict occurs when there is inadequate affectionate response from the loved ones, parents or others. Anxiety and insecurity which are part of this conflict may lead to attention-gaining behavior. This behavior defies the moral standards and conventional attitudes of the loved ones. Society commonly calls this bid for attention “misbehavior.” Attention-getting tendencies are common means of fulfilling a common childhood need, yet evoke punishment and threats. These, in turn, lead to resentment. A conflict ensues, namely, resentment versus a desire for affection.

Some handle the conflict (resentment versus desire for affection) by an attitude of filial devotion (maintaining the moral standards and conventional attitudes of the parents) which, in turn, assures affection and security. Such a happy solution may not always be present. There are often periods of open resentment and a flaunting of conventional and moral standards. The same series of events may result when a conflict is set up by frustrations of the natural propensities of a child.

Symptoms reflecting changes in moral standards and conventional attitudes deal essentially with the mechanisms of distortion and denial. These are generally ineffective defenses that try to reduce dissatisfaction experienced in being inadequate, and resentments associated with feelings of lack of affection. The distortions may vary in degree, harbor elements of “make-believe,” and in their severest form, may appear as symptoms of delusions and hallucinations. The resentments translate themselves into a “don’t mind,” “don’t care” attitude which then gives permission to ignore or defy standards and conventions. These mechanisms expressed in asocial, amoral, anticonventional behavior becomes a difficult problem to the patient, as his already handicapped ability to relate effectively with others will now be additionally threatened by disapproval, contempt, or open retaliation on the part of other patients and nurses. The nurse, however, has the opportunity to assess this behavior for what it implies, and can avoid adding fuel to the fire.

Such conflict and anxiety is often demonstrated on the hospital ward by a change in the patient’s moral standards and conventional attitudes; for example, a complete disregard of conventions, or rebelling against them. The patient may refuse to conform to any routine or control. He may be insulting, disrespectful of others, distort the truth, become boastful and tell long tales. This disregard of conventions and acting out behavior are often focused on the nurses, as they may assume the familiar roles of the patient’s past, which seemed to the patient so unloving and ungracious except in response to “good” conventional behavior. Now all the resentment and anxiety are directed toward those caring for him.

In the setting of symptoms of outspoken resentment, acted-out resentment, distortion or denial, the patient usually finds himself in a recurrent state of helplessness. In spite of feeling helpless, the patient is compelled to use the very same or similar defenses which in the first place made him feel inadequate and ineffective. He may be chagrined or embarrassed about it and strives to minimize his helplessness by brazenly flaunting appeals made to him for moral and conventional conformity. He may welcome the invalid state with varying degrees of regression, such as not-minding, denying, avoiding issues involving moral standards and conventional attitudes in order to achieve what is more important, namely, self-consolation. This invalid role may be very difficult for some.
patients to accept. In others an aptitude for invalidism is great and is the nurse’s main problem. In these the tendency to welcome invalidism represents only the need to escape from a temporary but unusually harrowing set of anxieties. In either case, it is useful for her to evaluate the patient’s sense of responsibility and his capacity to tolerate it, as well as his capacity to tolerate anxiety. Here, again, is the need to understand the psychological and physiological functions of anxiety and various human reactions to it.

There are clinical syndromes in which the etiological factors are impersonal (e.g. organic brain disease). It is clear that some organic dementias may be more determined by brain disease, but nevertheless, the problems of care entail the same considerations and implications as found in regressed patients.

The recognition that the symptoms of changed moral standards and changed conventional attitudes are (reaction to a need) namely, a need for human affection, can serve as an incentive to make bodily and social control worthwhile. The patient in his development has already experienced interference with carrying out skillful functions. In the past, such failure caused great resentment against the interferers (parental figures) who also were the persons upon whom the patient was dependent. It is the person upon whom he now is dependent who is involved in the struggle and becomes the object of revenge. It is from this person that the patient seeks punishment for flaunting the rules of the game.

The problem of the nurse’s feeling which arises as a reaction to the patient’s feelings (countertransference) can very seriously impede the patient’s care. For example, he may become so uncomfortable that he may withdraw from the patient by involving himself busily in administrative or housekeeping tasks. On the other hand, this sort of acting-out by the patient may call forth punitive behavior on the part of the nurse. Overt forms of counter-aggression may be acted out by putting patients unnecessarily into packs, or confining them to isolation. Somewhat more subtle forms of aggression are conveyed through disapproving gestures, facial expressions, and the spoken word. All of this may tend to perpetuate the patient’s pattern of acting-out against conventional attitudes and the usual moral standards.

It is important to help nurses develop awareness and understanding that they may be unwittingly aiding the patient to break all the rules. This understanding will be greatly facilitated by group experience wherein the nurse has an opportunity to compare her own experience with that of others and thus become aware of the deviants in her feeling toward conventions. She may thus learn what resentments he harbors and what the rewards of “being a good child” are.

d. Diminished integrative Capacity. Every person has some ability to act in life with a sense of control within himself. This sense of control arises from the maintenance of a harmonious equilibrium between the basic impulses and controlling forces. The process involved in this effort toward harmony we shall call integration. Some of the primitive forces within the individual are of a vehement and ruthless nature. They seek gratification in a selfish manner. If the forces were left unleashed, the person would tend toward disintegration. Such threats imposed upon others would arouse retaliation.

These forces are restrained early in a person’s life. Prohibitions and limitations, primarily through parental attitudes, impinge upon the wishes for primitive gratification. It is the struggle between the inner desires and the prohibitions (other person, or later, self-imposed) that is sensed as conflict. Integration deals with the factors that implement mastery of the ensuing tensions.

The development of mastery begins in early life. It demands a gradual and appropriate weaning from the early feeling of power (omnipotence). This feeling of power is gradually relinquished under the supporting experience of obtaining satisfaction, of being loved and approved. Guidance that sets up pertinent limitations is essential. This helps the child to survive the ensuing struggle-for-power period of the first years of life. Gradually, a feeling of personal self-strength (ego-strength) is developed. This is implemented as the child is helped to delay immediate gratification in favor of long-term pleasurable experiences; to learn to make decisions; to accept disappointment and frustration; to tolerate varying degrees of anxiety; to engage in re-evaluation of standards arbitrarily imposed upon him; and to refine reality-testing. Furthermore, reactions and defenses are developed to serve as buffers and to reduce the tensions if a more complete mastery is not immediately possible.

The development of ego-strength brings with it an ability on the part of the individual to meet stresses and strains in such a way that they are integrated (incorporated) into the fabric of his personality. However, integration is never complete, nor is it ever static.

In the course of life experiences, the individual may meet situations sufficiently traumatic to tax his capacity for re-establishing the harmonious balance. This occurs either because of the intensity, or of the duration of the stresses. Repeated experiences of trial and error, of satisfaction and disappointment, leave traces or residues of old conflicts. New situations that cannot be mastered may thereby recall feelings of anxiety attached to these residues. The new situations reinstate the earlier conflict. This will be apparent in a decreased ability to relate to others.

The individual whose capacity for integration is currently intact, can meet the ordinary stresses of the day to day experience without undue anxiety or loss of equilibrium. A friend’s sarcastic or angry remark, for instance, will be resented briefly, but before long will be recognized as a sign of irritability or of momentary jealousy, and will be replied to either in kind or with friendly tolerance, and soon will be forgotten.

Often a patient who is ill is not able to integrate experiences or feelings which occur in accordance with learned patterns of behavior. He will participate
on the ward in a less adequately integrated manner. For example, he may come to feel confused, doubtful, hesitant and afraid, and may be unable to resolve these feelings. These unintegrated feelings are often transferred to members of the nursing personnel with whom he associates in his daily living. These transferred feelings and behavior toward the staff may effectively create fear, doubt, hesitation, and hostility in return. This reciprocal response makes the nurse uncomfortable and anxious with the patient. In extreme situations, the nurse may withdraw from the patient, or almost completely isolate him.

The understanding of the nurse’s feelings about problems of impaired integration needs to be explored and clarified. Nursing skills are often enhanced by participation in patient-oriented conferences and informal discussions.

e. Disturbance of the Function of Reality Testing. One of the most important examples of personality dysfunction is the impairment of reality-testing. In the child there is little ability to recognize what sensations are coming from outside himself and what sensations originate from within. He is unable to recognize the boundaries of his own body. The environment is conceived of as continuous with himself. As the child grows, he learns to delineate himself from his environment. As a result, he is able to recognize what sensations are coming from within himself and what sensations are coming from without.

We may recognize varying degrees of impairment. These may include the complete breakdown of a psychosis in which impaired reality testing may be expressed by the patient’s conviction that he is influenced by magic or electrical forces, or psychoneurotic disorders in which the patient may deny that physical complaints can be caused by emotional problems. He may be unable to rid his mind of disturbing fears or obsessive thoughts. The presumably normal person under stress may misinterpret other people’s attitudes and intentions.

This impairment of reality-testing may be maintained by the use of a variety of defenses. The use of these prevents the patient from seeing things and people as they really are. His feelings do not correspond with the external reality. These defenses may include denial, when the patient maintains that a dead person is not dead; or distortion of reality, when the patient regards friendly persons as hostile; or evasion, when the patient seems quite unaware of a disturbing reality. This impairment of reality-testing follows the inability of a person to tolerate, without serious loss of self-esteem, a reality which is threatening or unsatisfying.

Mentally ill patients often experience difficulties in recognizing the origins of sensations as a result of the inevitable regression accompanying their illness. The patient may, as a result, appear unable to care for himself, while another patient may be unrealistically confident that he needs no help. Still another may create in fantasy a situation which does not exist, as in delusions and hallucinations.

The effort of the patient to create his own world, frequently without consideration of his family and community, provokes hostile, anxious retaliation from family and community, which may lead to his being forcibly removed from the community and placed in a mental hospital.

It is useful that the hospital provide a more tolerant, protective environment, compared with the disturbing, anxiety-provoking situation from which the patient came. It is to a large extent the nurse’s attitude which provides a “world reality in miniature” that the patient can accept without anxiety. To be more specific, when a patient is extremely uncomfortable or anxious in his relationships with people around him, he may see or perceive ward situations and people on the ward quite differently from what they are in reality. This type of protective or defensive reaction on the part of the patient serves to create a safe distance between him and people around him, and thus decreases his discomfort and anxiety. At the same time, this distance or temporary loss of relationship leads to a peculiar effort to have some relationship with the people about him. For example, if the patient can distort the ward situation to the point that he believes all people to be against him, and can hear them talking about him, he may then become involved listening to these people, protecting himself against them, and thus withdraw to a marked degree from contact with people in his daily living on the ward.

The nurses, who are in reality the “people around him,” may become uncomfortable through repeated expressions on the part of the patient regarding nurses’ plans to do away with him. They may be so disturbed by their own discomfort that they may stay farther and farther away, and thus reinforce the patient’s anxiety. Such a situation makes it difficult to focus on the real problem of how to provide experiences in which the patient does not feel so uncomfortable, and through which reality can, little by little, come within range for him.

3. Decreased Capacity for Mature Object Relationships. Some form of emotional interchange with others is characteristic of people. This interchange, which is not exclusively verbal, depends also on gestures, facial expressions, tears, laughter and more subtle physical signs such as turpitude of skin, tone of voice, brightness of eyes, blushing, sweating and posture. These compositely reflect the individual’s emotions. Feelings of anxiety, fear, anger, contentment, gaiety, calmness, puzzlement, to name only a few, can be discerned. The recognition of some of these emotions is easy; others take more sensitivity to grasp. It is of utmost importance to those working with the emotionally disturbed to learn to recognize unusual, peculiar, conflicting, often ineffective, seemingly purposeless ways of expression.

Emotional interchange between people is motivated by a need to express oneself, to reduce inner tensions, and to obtain a response from the other person. This response is important, since it leads either to gratification or frustration. When an anticipated gratifying
response does not occur, the relatively healthy person can decide whether he has not made himself understood, or whether the other person could not respond appropriately. After making such an evaluation, he may try a different approach. The results of trial and error gradually develop the ability to grasp relatively accurately the effect of one's own emotions on others.

The process is complicated as conscious and irrational feelings occur simultaneously with unconscious irrational feelings and expressions of these feelings.

It becomes clear that this complex interplay between individuals requires personal integration, and leans heavily on intact ability for reality-testing. It demands control of basic impulses. Evaluation of moral standards and conventional attitudes of the given cultural and social milieu are reflected in this process.

The essentially "normal" development of the capacity for emotional interchanges with other people is a complex, uneven, hazardous progression. This progression can be assigned arbitrarily to three periods in the individual's development.

First comes the early, completely dependent (biological and emotional) infant period when the necessity to receive appropriate recognition and gratification of needs is very high. The means of denoting satisfaction or countering frustrations are diffuse and undifferentiated.

Later, a semi-cooperative period evolves in which receiving gratification, guidance, tolerance, and support are essential. The response in this period can be expressed as active aggression, attack, non-conformity, refusal, withdrawal, or opposition. Satisfaction can be registered in words, compliance in behavior, outbursts of loving affection, and a host of other ways. This is a period of tentativeness wherein the strength of needs can quickly dispel the cooperative participating efforts.

A still later period eventuates in which the individual gradually embarks on a more reciprocal emotional level. Perceptions and feeling-into (empathy) the needs and feelings of others modify to some extent the demands made on others. Expectations and expectations become more accurate. The subtle balance of obtaining gratification and of satisfactorily giving becomes refined. This period deals repetitively in testing out the internal and external appropriateness of expression of feelings and the response obtained. The relatively objective assessment of this interplay is an expression of maturity. At best, there is unevenness, success and failure, for every person. To the most mature come experiences of stress and anxiety, both from within and without. The way equilibrium can be sought and obtained, the time in which this can be accomplished, and the maintenance of relative intactness of the person while he meets these stresses denote the state of mental health.

Certain life stresses can impair the individual's capacity to relate with other people. Such experiences include severe organic changes resulting from toxic or mutilating agents; severe and continued deprivations such as starvation, exposure to extreme temperatures; disorganization of familiar personal relationships because of death or separation; unconscious revival of unmastered inner conflicts, such as feelings of guilt about unrecognized destructive wishes, or anxiety over unconscious temptations of a sexual nature. Every illness, physical or emotional, decreases the individual's capacity for mature (object) relationships. The sick person makes bids for relationships with others, but his approaches may be clumsy, bizarre and inappropriate.

A patient's conflicts may be such that he no longer can repress thoughts of attacking or killing another person. In coping with the resulting anxiety, he may ascribe these feelings to another person and accuse the other person of his own wishes (projection). Irrational as this is, anxiety is thereby partially reduced and a relationship with another person is attempted. The response of the nurse to this behavior is of utmost importance. If the nurse responds with hostility or withdrawal, she may reinforce the behavior. If the nurse, however, can understand this behavior as a defense, achieve clarity about her (the nurse's) own feelings toward aggressive feelings and actions, the first step has been taken toward helping the patient to become less anxious and to facilitate a change in his behavior.

A retarded and withdrawn patient may give the impression that he is unaware of his surroundings, and does not care to relate to others. Such an assumption is erroneous. His extreme passivity is a form of human contact at the level on which he can participate in relationships at this time in his life. Passive participation on the part of the nurse is the first step in breaking the wall of non-communication. Nurses may be hampered by their feelings that one has to be actively doing something in order to help a patient. Sitting with the patient, saying nothing, may be the only sort of relationship in which the patient can be comfortable at this time.

A patient who has regressed to very infantile levels may use his need to be fed, or to be cleansed after soiling as a bid for help, for physical closeness to another, for love and affection, for encouragement. He may desire such responses to offset deep feelings of inadequacy, fear of loss of control of his emotions, possibly feelings of shame and humiliation. He is frightened and wants reassurance that he will not be abandoned. If, in addition to meeting these expressed needs in an understanding manner, the nurse through repeated experiences with the patient becomes alert to cues that indicate his readiness for a more mature relationship, the patient's anxiety may be greatly diminished. The sick person's emotional reactions give evidence that the "healthy" part of himself is trying to relate to others. Repeated failures may overwhelm the threatened person so that he will reach a "point of no return."

The nurse may tend to treat the patient as essentially a rational person. In common social intercourse, attack can be averted or met with attack, argument with argument. Withdrawal, annoyance, unresponsive-
ness may well be met with indifference or counterwithdrawal. The essentially healthy person soon will erect defenses that will bring a tolerable equilibrium to the tense situation. Anxieties, fears, hostile or erotic feelings can be managed in appropriate time.

When the nurse comes into contact with human behavior that is unfamiliar to her, she is tempted to take the expressions literally, using familiar values. The sick person's attempt to relate to the nurse may arouse anxiety, hostility, fear or contempt. These emotions then demand defensive attitudes and actions on the part of the nurse. The nurse who becomes overwhelmed by the patient's primitive and crude expressions may be unable to hide her feelings and may retaliate physically. In other instances, she may become oversolicitous. The patient's sexual behavior may become provocative and arouse in the nurse responses similar in kind and intensity. The nurse may become terrorized as she becomes aware that she, too, may harbor feelings and impulses not dissimilar to those of the patient.

Conflicts, once well buried, may be revived under the impact of dealing with psychotic patients. The more the nurse defends herself against anxiety aroused by these conflicts, the less chance she has of helping the patient, and the less chance she has of using the relationship effectively. She may abandon the patient by overemphasizing her so-called administrative responsibilities. She may become overly interested in impersonal treatments, as diets and laxatives, or in time-consuming linen counts. She may argue with the physicians that the patient should have shock therapy and maintain that the physicians do not know what they are doing. She may become angry when the patient does not show his appreciation by getting well quickly. She may prevent the patient's discussing what is important to him. The nurse may act passively through failure to carry out working arrangements for the patients. She may not insist on regular schedules or may fail to remind patients of appointments. By such methods the nurse diminishes the likelihood that a therapeutic relationship can be developed with the patient.

Cogently directed patient-nurse relationships are therapeutically effective. The nurse's awareness of the patient's needs, and the nurse's increased conviction of her own adequacy in meeting these needs, will be reflected in her relationships with patients. Excellent opportunities for the development of these relationships are offered by necessary nursing care. The nurse can become aware of the meaning and significance of her very presence in relationship to the patient. The nurse will become increasingly able to carry the responsibility of being the person who conveys strengthening, supporting attitudes to the patient.

IV. CONCLUSION

We recognize that there is no easy answer to the problem involved in the selection and adequate training of specific individuals to provide the relationships needed by emotionally ill patients. Ideally, the curriculum should offer planned, supervised clinical experience which makes it possible for the nurse to increase her understanding of patients.

The instructor of nursing personnel has, in her relationship with her students, a royal opportunity to help students in their relationships with patients. The instructor, too, has to evaluate her own use of defenses against anxiety. One of the most common defenses observed is the zeal with which the various "ologies" are taught. Knowledge and memory are emphasized. Nursing routines are laboriously checked. Close relationships, living relationships are avoided.

We probably can teach didactically very little of value to the nurse in terms of dealing with patients. We can, however, provide situations in which she herself can learn with a minimum of anxiety. The nurse may gradually reach a high point of tolerance of anxiety because of her own self-knowledge. With experience she may learn not only to appreciate the dilemmas of her patients but also to help them through their disparate efforts to cope with them.

SELECTED READING

4. Behymer, Alice F., Interaction Patterns and Attitudes of Affiliate Students in a Psychiatric Hospital, Nursing Outlook, 1: No. 4, 205-207, April, 1953.
22. GAP Report No. 22, The Psychiatric Nurse in the Mental Hospital, Group for the Advancement of Psychiatry, 3617 W. Sixth Ave., Topeka, Kansas, May, 1952.
32. Henry, J., quoted in Reference 15 as a personal communication.
57. Morimoto, F. R., Favoritism in Personnel-Patient Interaction, accepted for publication by Nursing
Research.


59. Morimoto, F. R. and Kandler, H. M., A Comparison of Skills and Interests of Patients and Nursing Personnel in a Psychiatric Hospital, accepted for publication by Nursing World.


DISTRIBUTION OF THIS REPORT

American Psychiatric Association (Request List from Members)
Request List from Psychiatrists, Psychiatric Nurses, Psychiatric Social Workers, Psychologists, Medical Libraries, etc., United States and Foreign Countries
State Mental Hygiene Organizations
State Mental Health Authorities of United States
Provincial Directors of Mental Health Services in Canada
Member Organizations of the World Federation for Mental Health
GAP
Group for the Advancement of Psychiatry

The Group for the Advancement of Psychiatry has a membership of approximately 150 psychiatrists, organized in the form of a working committee of about 10 members each, which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1948 its membership has included related disciplines, such as sociologists, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

COMMITTEES

Committee on Aging
D. C. McKerracher, Saskatoon, Can.
Marvin L. Adland, Rockville, Md.
Alvin L. Goldfarb, New York
Lawrence Greenleesh, Beverly Hills
Michael H. Halsted, Chicago
Maurice Linden, Philadelphia
David Rothchild, Worcester

Committee on Child Psychiatry
Othild Krug, Cincinnati, Ohio
Frederick H. Allen, Philadelphia
Anna R. Allman, Chicago
Georg E. Gardner, Boston
J. Cotter Hirschberg, Topeka
William S. Langford, New York
Osewelt Rexford, Boston
Helen O. Wellman, New Haven
Bernard H. Hall, Topeka
Jay L. Stoll, Washington
Robert W. Hyde, Boston
Fred W. Roberts, Chicago
Elwin V. Semrad, Boston
Benjamin Simon, Arlington, Mass.

Committee on College Student
William M. Shansan, Denver, Colo.
Leo Bernau, Chestnut Hill, Mass.
Harold E. Eddy, New York
Dana L. Farmsworth, Cambridge
Edward J. Harnack, New York
William Felts, Philadelphia
Bruce Robinson, Newark, N. J.
Benson R. Snyder, Wilkes-Barre
John A. Rose, Philadelphia
Mabel Rosenthal, New York
Robert L. Rubblefield, Denver
Ernest E. Walmsley, New York

Committee on the College Student
Sidney Berman, Washington
Willard Bloomer, Boston
George S. Stevenson, New York
Jack Weinberg, Chicago

Committee on Hospitals
Walter H. Baer, Peoria, Ill.
Kenneth E. Angel, Atlanta, Ga.
Alfred E. Ray, Topeka
Robert E. Bennett, Trenton
Wm. D. Davy, Jr., Philadelphia
Robert S. Garber, Princeton
Paul Hersch, New Haven-Salem
George W. Jackson, Topeka
Robert N. Isenstam, Indianapolis
Harry P. Osmund, Weyburn, Sask.
Lee G. Pollow, Boynton, Fla.
Herbert J. Tampkins, New York
Gal H. Walker, Folke, Pa.

Committee on International Relations
Bertram Schaffer, New York, N.Y.
Royder Aitken, Haventown, Pa.
Frank Freudenthal, New York
Florence Powdermaker, New York
Boyd F. Steele, Philadelphia
Mottram Torre, Washington

Committee on Medical Education
Maurice H. Greensh, Baltimore, Md.
C. Hardin Branch, Salt Lake City
Jerome H. Barnes, Baltimore
George C. Hert, Chapel Hill
Robert G. Hoelt, New Orleans
Henry D. Loeb, Cincinnati
Herbert C. Morishita, Topeka
Russell Monroe, New Orleans
George S. Saalow, Boston

Committee on Preventive Psychiatry
Ivar Berliem, Detroit, Mich.
Julian C. Caplan, Boston
Stephen Charles, New Haven
Jacques G. Cottrell, Detroit
Ernest M. Groomer, Syracuse
Roger W. Howe, Chapel Hill
Benjamin Jeffries, Detroit
Erich W. Bimlunsky, Boston
Leon S. Sall, Media, Pa.
Benjamin Simon, Pittsburgh
Lloyd J. Thompson, Winston-Salem
Warren T. Vaughan, Jr., Weston, Mass.

Committee on Psychiatric Nursing
David A. Young, Raleigh, N. C.
Herbert G. Bailey, New Haven
Edward C. Frank, Louisville, Ky.
Arnow L. Itken, St. Paul
Peter Neubauer, New York

Committee on Psychiatry and Social Work
Jesse Josselyn, Chicago, Ill.
C. Knick, Atlanta, Ga.
Edward C. Frank, Louisville, Ky.
S. L. Slade, St. Paul
Peter Neubauer, New York

Committee on Psychiatry in Industry
Walter D. Woodward, New York, N. Y.
Matthew Brody, Brooklyn
Robert T. Coll, Rochester, N. Y.
Frederick H. Hanson, New York
Leonard K. Himcher, Ann Arbor
Alan McLean, Ill.
Graham R. Mall, Oakmont, Pa.
Louis L. Turenu, St. Louis

Committee on Psychiatry and Law
Lawrence Z. Freedman, New Haven, Conn.
Edward A. Phillip, Philadelphia
Frank C. Bezmen, Charlotteville
Bernice Cheadell, Minneapolis
Manfred S. Guttman, Chicago
Philip O. Roche, Philadelphia
Gregory Zilberg, New York

Committee on Psychopathology
James C. Miller, Chicago, Ill.
Daniel W. Badal, Cleveland
Eugene Brody, New Haven
Norman Camner, New Haven
Paul Huston, Iowa City
William Llano, Philadelphia
Marvin Stein, Philadelphia

Committee on Public Education
John L. Farn, Katrina, N. Y.
Leo H. Bardeen, Baltimore
Jack E. Wall, Boston
Alan Gregor, Big Sur, Calif.
Morris Kenworthy, New York
Paul L. Moring, Sidney
Margolin, New York
Peter A. Deters, Detroit
William C. Memminger, Topeka
Robert T. Morse, Washington
Julius Schreiber, Washington
Kent A. Zimmerman, Berkeley, Calif.

Committee on Research
Alfred H. Staats, Boston, Mass.
Jacob E. Finsinger, Baltimore
Edwin F. Gildes, St. Louis
David Hamburger, Chicago
Lucie Nessser, Chapel Hill
Gilbert Nottman, Boston
Eleanor F. Nett, Boston
Franklin M. Feiner, Washington
Richard E. Renner, Chicago
James S. Tyhurst, Montreal

Committee on Social Sciences
Viola W. Bernard, New York, N. Y.
Nathan W. Ackerman, New York
Charles Baker, New York
Mabel B. Cohen, Chevy Chase
Harold G. Chute, New York
Helen V. McLean, Chicago
Angel N. Miranda, New York
Edward Stainbrook, Mass.
Rutherford B. Stevens, New York
Ian Stevenson, New Orleans

Committee on Therapy
Bernard Bandler, Boston, Mass.
Henry W. Brown, Pittsburgh
Hugh T. Gambke, New York
O. Spurgeon, Dean, Philadelphia
M. M. Frolich, Ann Arbor
Walter W. Hamb, Rochester, N. Y.
Milton Rosenbaum, New York

Committee on Finance
Leo H. Bartemeier, Baltimore, Md.
Malcolm F. Farrell, Waverly

Consultants Committee
Walter E. Barton, Boston, Mass.
Henry W. Brins, Pittsburgh
Jack E. Wall, Boston
William C. Memminger, Topeka

Contributing Members
Spalding Ackerly, Louisville
Franz Alexander, Chicago
Grace Baken, New York
A. E. Bennett, Berkeley
Edward G. Billings, Denver
Carl Bing, Cambridge
Walter Bromberg, Westmont
Dale Cameron, St. Paul
Jules V. Coleman, New Haven
Franklin D. Elia, Detroit
Thomas M. French, Chicago
Clement F. Fray, New York
Herbert S. Suckin, Denver
Maxwell Goetzman, New York
John H. Greit, Indianapolis
J. F. M. Grinn, Toronto
Roy K. Grinker, Chicago
Herbert I. Harris, Cambridge
Joseph Hughes, Philadelphia
Lawrence S. Kibbee, New York
Zigmond M. Lebovich, Waukegan, D. C.
Alexander H. Leighton, Ithaca
Maurice Levine, Cincinnati
William Malamud, Boston
Mack Lipkin, New York
Alfred O. Ludwig, Boston
LeRoy Maeder, Philadelphia
William Malamud, Boston
Lindley H. Pennington, Topeka
John A. F. Mill, New York
D. T. Morris, Dallas
John H. Murray, Boston
Rudolph G. Novick, Chicago
Douglas W. Orr, Seattle
Herbert P. Plate, Chicago
Norman Rodger, San Francisco
Lewis D. Robbins, Topeka
Frank H. Sperber, Augusta
Harry C. Solomon, Boston
Edward S. Staelin, Philadelphia
Emmy Sylvestre, San Francisco
M. A. Tanzman, Farming
Charles W. Tidd, Los Angeles
Adrian H. Vander Veer, Chicago
David G. Wright, Providence

July, 1955