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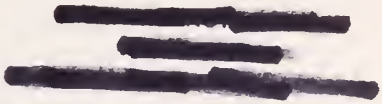

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SUMMER 1967

The Journal of the Fort Logan Mental Health Center is a scientific quarterly which publishes original articles describing individual or collective modes of prevention, treatment, and related aspects of care for those persons with emotional disturbances. Emphasis is placed upon recording the investigation and description of those modalities broadly subsummed within the concepts of social and community psychiatry.

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Fort Logan Mental Health Center
Alan Kraft, M.D., Director

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JOHN A. LOVE
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DEPARTMENT OF INSTITUTIONS
STATE SERVICES BUILDING
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DAVID A. HAMIL
DIRECTOR

July 5, 1967

Alan M. Kraft, M. D.
Director
Fort Logan Mental Health Center
Fort Logan, Colorado

Dear Doctor Kraft:

It is with mixed emotions that I accept your resignation as Director of the Fort Logan Mental Health Center effective September 1, 1967.

I am, of course, pleased you have been selected for the challenging position as head of the Department of Psychiatry at Albany Medical College. Your description of the opportunities for service and advancement in this new location calls for an additional tax upon your recognized abilities.

Your leaving also puts to task those of us responsible for your replacement. Under your able guidance the Fort Logan Mental Health Center has established an international reputation for both the novelty and excellence of its treatment. It will be our intention that your successor not only maintain what has been established, but to enhance it at every opportunity.

Working with you for the past 4½ years has been a personal pleasure as well as an educational experience. We have shared many commendations and, of course, a limited number of castigations.

I commend you for your excellent contribution to the people of Colorado and I wish you well in your association with the citizens of Albany, New York.

Sincerely,

David A. Hamil

DAH:de

On June 27, 1967, Alan M. Kraft, M.D., Director of Fort Logan Mental Health Center since 1962, announced his resignation from the Center. Through Mr. David Hamil, Director of the Department of Institutions, we wish to express our appreciation to Dr. Kraft for his dedicated service to the hospital and to the community.

The Staff of the Fort Logan Mental Health Center

NOTICE TO CONTRIBUTORS

Manuscripts should be submitted in triplicate in the form in which the author wishes the paper to appear. Copy should be double-spaced, with margins of at least one and one-fourth inches. Each article should be concluded with a brief one-or two-paragraph summary.

References should be indicated by numbers in parentheses. The list of references at the end of the article should be alphabetical, and the names of journals should not be abbreviated. The following format is to be observed.

JAHODA, MARIE, Current Concepts of Positive Mental Health, New York, Basic Books, 1958.

RIESMAN, D., "Some Observations on Interviewing in a State Mental Hospital," Bulletin of the Menninger Clinic, Vol. 23, pp. 7-19, 1959.

The author should include an address to which inquiries regarding the article should be sent, in the form of a footnote indicated by an asterisk on the first page of the article. Reprints will be furnished at the author's expense.

Manuscripts and all correspondence should be addressed to the Managing Editor, Journal of the Fort Logan Mental Health Center, 3520 West Oxford Avenue, Denver, Colorado 80236.

SUMMER CONTENTS 1967

ATTITUDE THERAPY*

JAMES C. FOLSOM, M.D.,** *Hospital Director, and*
EARL S. TAUBEE, PH.D., *Chief, Psychology Service*
Veterans Administration Hospital, Tuscaloosa, Alabama

Many people seem to be of the opinion that attitude therapy is new on the psychiatric scene, but this is not really true. In describing the use of specific attitudes in the treatment of the psychiatric patient, the oft-quoted first aphorism of Hippocrates (2) adequately defines the role of the physician and the treatment team in this approach: "Life is short, and the art long; the occasion fleeting; experience fallacious, and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate." The writings of Hippocrates, who lived in the golden age of Greek culture, represent the empirical, or "common sense," approach in those ancient times.

There is nothing magic about attitude therapy itself. The concepts are actually quite old. Its earlier model is best exemplified by what was called moral treatment in the first half of the nineteenth century, as described in *Moral Treatment in American Psychiatry* by J. S. Bockoven, M.D. (1). Another contemporary author, Dr. Karl Augustus Menninger (4), in a revision of his *A Manual for Psychiatric Case Study*, stated in the section defining milieu therapy:

> The expression "milieu therapy" is so loosely applied that perhaps we ought to define it. Milieu therapy does not mean a cheerful and encouraging attitude on the part of the personnel, as some doctors sometimes seem to think. The essence of

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*Adapted from a speech given by Dr. Folsom at the Eleventh Annual Conference, VA Cooperative Studies in Psychiatry in New Orleans, Louisiana on March 17, 1966. The speech was one of four parts of a Symposium on Behavior Therapy.

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> milieu therapy lies in the definite therapeutic structuring of the special environment provided. We have spoken as if this were always a hospital; of course it can be a school, a colony, or even a prison. But the important aspect is not the confinement or restraint, but the structure. This structure does involve certain regulations, certain directions, certain control, and in this sense there are certain limitations of freedom with the very purpose of giving a greater freedom in certain other directions. It is characteristic of many patients that they first see the structure as restraining, and later see that same structure as affording a greater freedom.

In a paper presented at the Central Office Conference of VA Psychologists, May 1965, in Chicago, Illinois (5), one of the authors said:

> Basic to attitude therapy is the philosophy that there is no such thing as a hopelessly ill mental patient. Also, that regardless of age, intelligence, chronicity, diagnosis (functional or organic), level of anxiety, etc., there are maladaptive or troublesome behavior patterns for a particular patient which can be identified and modified, at least to some extent, in order to effect a better adjustment—providing the proper therapeutic situation is established. The first step in doing this is to identify such a *behavior pattern*, not an isolated symptom, note how it works and then select the treatment attitude which is appropriate (e.g., Active Friendliness, Passive Friendliness, Kind Firmness, Matter-of-Fact, or No Demand). After an attitude is prescribed, it must be applied consistently around the clock by all personnel having contact with the patient. Often the particularly disturbing pattern of behavior is pointed out to the patient and it is explained to him how we will help him modify it. Through this rather direct and structured manner the patient gets the feeling that the team knows what it is doing and that he can be helped. Anxiety is reduced, the interfering behavior pattern is modified and new responses acquired. The patient is able to regain some thoughtful, conscious, self-direction.

It was also in that paper (5) that the following statement was made: "Most of the behavior therapists have been primarily interested and concerned with modifying a particular symptom." For example, if the patient comes in with a major symptom of fear of automobiles, then the behavior therapist will work to modify or eliminate that fear. If the fear is of high places, the therapist would proceed to modify that behavior, or eliminate that fear. With geriatric

patients, the attempt is to modify their behavior of soiling themselves, crying constantly, etc.

It has been our experience that most of our patients have many symptoms, and it is impossible to isolate one symptom from the others. Attempts are being made to identify patterns of behavior. For example, one pattern of behavior has been identified by its aggressiveness, demandingness, and combativeness. Another pattern of behavior is seen in the socially withdrawn individual who has seemingly lost all interest in what is going on around him. A third is that of overwhelming seductiveness and manipulative behavior. Another pattern is that of depression with a goal direction of self-destruction, and last is one of multiple physical symptoms.

With most of our patients emphasis on a particular symptom will not do the job, so attempts are made to identify the major patterns. Attitude therapy can then be prescribed by means of the specific attitude that works with each of these patterns. For example, in the socially withdrawn individual, it has been found that the attitude of active friendliness helps to get the patient to move out a little from his state of withdrawal. We reward this "moving out from isolation" on the part of the patient by continuing to be actively friendly, but do not deal with the individual symptoms of drooling saliva, uncombed hair, sloppy eating habits, unzipped pants, untied shoelaces, incontinence of urine, refusal to speak to others, etc. It is our belief that more of his symptoms can be covered by trying to determine a pattern that needs to be changed. If we can modify this pattern, then the individual symptoms will disappear, because all of the symptoms are part of his pattern of withdrawal. Each symptom creates more distance between himself and other people.

Of basic importance to modifying the behavior pattern of the individual is the concept that treatment personality of the entire hospital staff must exist in an almost tangible way. The term "reinforcing system" may be preferred to the term "treatment personality." The treatment personality can be defined, and its techniques can be taught. Its use can be prescribed by the treatment team which is intimately involved with the total process, and this treatment personality must pervade every aspect of the patient's

existence. It must involve the entire paid personnel of the hospital as well as the entire patient personnel of the hospital. These concepts can further include the family of the patient in all of their contacts with the patient, both through visits in person, contacts by telephone, contacts by mail, negative contacts by neglect, etc. Also involved will be volunteer workers to the hospital. The *patient* becomes a part of his own treatment process and through such involvement becomes a member of his own treatment team. Other patients are important members of the total treatment team also.

Attitude therapy is a communication device and a way of life. It allows for the use of a type of treatment shorthand that conveys a great deal of information through the use of a few words which have taken on additional meaning.

Through attitude therapy techniques, we reinforce desirable behavior and extinguish undesirable behavior. Through these techniques the patient's anxiety is reduced, the interfering pattern of behavior is modified, and a new, more desirable behavior pattern is acquired or established. The most important thing in this, as in all efforts toward behavior modification, is the consistency of reward. Therefore, all employees must be consistent in their approaches to the patient.

An introduction to attitude therapy can be found in the Menninger Foundation's *Guide to the Order Sheet* (3):

> These (the general attitudes) are extremely important since, if we are to accomplish the therapeutic aim, it is essential that all persons who come in contact with the patient should maintain a uniform attitude insofar as possible; in other words, one nurse must not be "indulgent" and another "severe" or one therapist must not be "solicitous" and another "indifferent." Since the system of treatment for the patient is based on contact with many different members of the professional staff, it can function well only when everyone with whom the patient may come into contact maintains the same general attitude toward him. Furthermore, the attitude assumed toward a patient is probably more important than any particular activity. There is reason to believe that the manner in which we say things and the atmosphere created through our attitudes are actually more important than what we say and what we do. Many patients react to our feelings and manners much more than they do to our words.

In our experience, the best way to introduce an attitude therapy program to a hospital staff is to begin teaching the attitude of "kind firmness." In the fall of 1962 we began treating a patient who had been considered hopeless during several previous hospitalizations. He had shown signs of marked improvement at times, and then would become so sick as to be dangerous not only to himself but to other people. The diagnosis in this case was schizophrenic reaction. At the time we began treating him, the patient was making repeated attempts to kill himself. These were serious attempts and he required around-the-clock, one-to-one supervision to prevent his committing suicide. At times he would become physically assaultive to other patients and personnel, trying to kill individuals so that they could "go be with his sister in heaven."

After a lengthy staff evaluation of this case, it was decided that we would treat the depression first. The treatment prescribed was the attitude of "kind firmness."

"Kind firmness" is that treatment attitude of taking over completely for the patient, allowing him to make no decisions, and forcing him to work during all of his waking hours. This is based on the understanding that the depressed individual has turned in on himself anger that normally is expressed toward objects and individuals in the world. The depressed patient, for various reasons, is unable to express these feelings outwardly and turns the anger in on himself. He will then have to kill himself to get rid of the hated object, which has become his own person. The treatment aim is to get him to express anger toward the outside world—first at the blocks of wood he is sanding—later toward the therapists (usually nursing assistants) who are directing his labors. The patient learns that he not only can, but should, express negative feelings. He learns it is appropriate to express hostility or negative feelings, and that he will not be rejected for doing so. He learns that in certain settings the expression of anger is desirable and worthy of positive reinforcements.

At the treatment planning conference the patient being considered was begging for electroshock, saying that he needed to be punished and that God was going to see that he died. He was told that we were not going to use electroshock, that work was the

treatment for depression, and that he was now on an entirely new treatment program. He was put to work sanding small blocks of wood and kept on this menial, ungratifying task all day long except for toileting, eating, and sleeping. Some days he worked as much as sixteen hours.

This patient then began a series of rapid changes from extreme depression to extreme aggressions. He would very quickly change from his expression of suicidal thoughts, his look of total dejection, and his easy compliance with instructions to continue sanding the block of wood, to attempts to destroy everything in his environment. It became the treatment team's very difficult problem of knowing just when to switch from the attitude of "kind firmness" for the depression to a "no demand" attitude when the patient was trying to kill and destroy everything in his enviroment. After several days the treatment team was able to anticipate his mood changes. They were able to remove him from the anti-depressive room to the day room before he would lose control. They were able, also, to take him quickly back into the anti-depressive room when the depression reappeared. This treatment program lasted several weeks, and he ultimately became well enough to leave the hospital. He has subsequently terminated a very traumatic marriage and has been working full time for the past year.

This same case also illustrates the "no demand" attitude. "No demand" attitude means that no demands whatsoever are placed upon the patient. This treatment approach is used with those individuals who are in a panic state. They are seriously trying to destroy everything around them. We look on this as a sort of global suicide with the patient wanting to be the last to go. He is the person who is always picking a fight with you—and the world.

The panicked individual is in a state of fear, which he tries to overcome by frightening the world away by threatening it with destruction. The patient is told that we have four rules for him. First, he may not leave the treatment program without permission. Second, he may not hurt himself. Third, he may not hurt anyone else. Fourth, he must take prescribed medications. With the exception of these four rules, the patient may do anything. We have observed that no matter how destructive the patient's behavior is,

if he does not get positive feedback of counter-aggression, he will rapidly settle down. We rarely see rage episodes last longer than a few minutes. It seems much longer, but when the staff can stand calmly by and see that the four rules are maintained, we see the behavior quickly modified and the patient able to become calm.

The "no demand" attitude is not, however, the second one that is taught to the staff. The anti-depressive program with the attitude of "kind firmness" causes much resentment on the part of some staff members. They believe this to be abusive toward the patient, and some staff members actually have had to leave the treatment area because they would cry while trying to enforce a work program on a depressed patient. In order to give some relief and to show that attitude therapy is not all force of our will over the patient's, we turn to the treatment attitude of "active friendliness."

"Active friendliness" means doing everything within our power to give the patient pleasure. Other descriptive terms for this approach are "tender loving care" and "giving love unsolicited." The attitude of "active friendliness" is used to treat the apathetic, withdrawn individual who has seemingly lost all interest in life. A typical case is that of a young sailor who came to us following many months of hospitalization in various Navy hospitals. He had received good treatment, which was well documented in his records. He believed that electricity had jumped into his body when he had touched a large coffee urn many months before. This electricity affected his entire body—particularly his sexual organs. The patient had become incontinent of urine during the day, and he was enuretic. He was unkempt in his personal appearance, had no interest in anything, and had been mute for many months.

On the second day of hospitalization he was presented to the treatment planning conference, during which time he was called in for an interview before the staff. He had to be led into the room, then sat with his head down and his eyes closed, his arms hanging limply by his side. "Active friendliness" was started by the interviewer with the opening statement that we were glad that he had come to our hospital. He was told further that we believed we understood how much he was suffering, and we understood why he could

not communicate with other people. We told him we believed he was afraid, that we understood this fear and respected it. We told him we were going to be his friends and that there was nothing he could ask that we would not attempt to grant.

The patient made very few moves during this conversation. He made no verbal replies to anything. He was told that we were going to get him cleaned up from head to foot, comb his hair, zip his pants, tie his shoes, help him buy new clothes, etc. He was asked to raise his head and open his eyes so he could look at the people who were going to help him. He slowly raised his head and smiled at the group. He was thanked for raising his head and looking at the people and was praised for smiling so nicely at them. He was told that everyone was going to be friendly, and that we were so delighted he was going to be with us so we could treat him.

The patient was then told that he could go on back to the ward, but he made no move to leave. Since he was on "active friendliness," he could not, of course, be forced to go. Finally, he was asked if he wanted to say something to the group. He sat up straighter in the chair, raised his head, looked out at the group and said, "I feel like I am coming out of a long dream."

The patient ceased being incontinent of urine. He began talking and within 24 hours he asked if he could walk out on the grounds. This was, of course, granted. Within five days he was on open ward, on total self-care, and within six weeks had left the hospital to join his family and enter a trade school.

"Passive friendliness" is similar to "active friendliness," the only difference being that staff attentions are not forced on the patient. We say to the individual on "passive friendliness," "We are here to help you. We know you are frightened of other people. You are suspicious. You find it difficult to relate yourself to other people. Therefore, we will not move in too close. We will be here to help you. You may ask us anything you want. We will not offer things to you because you might misinterpret our intentions."

This program is used for the suspicious paranoid individual, many of these patients having problems of a sexual nature. One 35-year-old man came to the hospital voluntarily. His marriage was deteriorating, he had lost his job, his boss had told him he needed

psychiatric help. He had become so suspicious of his fellow workers that life in the office was becoming unbearable for all of them. Counseling by the family minister, the boss, his parents and his wife's parents had been to no avail.

The patient made it clear in a treatment planning conference interview that he felt pressured by other people and wanted to be left alone. He admitted being suspicious of his wife if she stayed at the grocery store five minutes longer than he thought was necessary. He thought she was having sexual relations with the butcher, and he accused her of flirting with the filling station attendant. The treatment prescribed was the attitude of "passive friendliness." He was told we would be available to respond to any requests, but would not force ourselves on him. In carrying this out we did not ask him if he wanted a second cup of coffee, as we do the person on "active friendliness," because this patient would wonder why we were so attentive. He would wonder what designs we had on him that we were being so nice. We did not offer to take him for a walk or to the canteen, since he would wonder if we were trying to get his money or use him to our own ends. We did not offer to comb his hair, tie his shoes, or zip his pants for him, as such approaches would have made him more suspicious.

Suspicious patients have said to us when told they were to be left alone, "That's what I have been trying to tell everybody I need to have time to find myself." Many of these patients never ask us for favors, and make no requests. They do, however, make rather dramatic changes. When the pressure is off, they can begin to function in society with other people, begin to communicate again on a realistic basis, and within four to six weeks be able to return to their communities and function again as productive members of their families.

A "matter-of-fact" attitude is the fifth. This is best described as being essentially the way we all deal with each other in day-to-day relationships. We use this for midrange cases, character disorders, criminal psychopaths, alcoholics, midrange schizophrenics, anxiety reactions, and cases with psychosomatic manifestations.

We essentially say to the patient, "You have loused things

up to a rather remarkable degree. We have no magic to offer you. We will offer you an environment in which you may learn to modify your behavior to the extent that you can live comfortably in the world with other people."

As a case illustration, we will take that of a nineteen-year-old Marine. He had married at age seventeen to a girl of fifteen. They had one child and she was pregnant at the time of his admission to our hospital.

Throughout his life this patient had been a problem to his mother, his grandparents, his teachers, Sunday School teachers, police authority, and others. While in the Marines he was diagnosed as being schizophrenic. However, his behavior was essentially psychopathic.

This patient was a nice looking, manipulative, charming, seductive individual. He was told that we felt he had sufficiently ruined his life for nineteen years and that we felt the time had come when he needed assistance in redirecting his life. We told him that he had long enough ignored the demands of society and that he was to be given an environment where he could see that in many ways he was his own worst enemy. He was placed on a full activity schedule and helped to see that he had to assume full self-responsibility. We predicted to him at the treatment planning conference that he would run away from the hospital, but that in spite of this we would keep him on an open ward so he could learn self-responsibility. He did run away within a matter of three weeks, but was brought back by the police. He was returned to an open ward and told again that he had to assume self-responsibility. He was most surprised by this.

After a period of time the patient learned he could no longer manipulate everyone, that his many charms and seductive skills got him nowhere with this group of people dedicated to helping him realize that his healthy adjustment revolved around his assuming responsibility.

Currently this patient is back in a community setting. He is completing a course in drafting in a local trade school, and while doing this has held down a part-time job as a draftsman. He and his wife have become actively involved in teaching a children's class

in the church. His not being willing to go to church had been a source of a lot of conflict between him and his wife, and now he is very eagerly involved in church activity.

This completes the description of the major attitudes which have been utilized by the staff at this hospital. Through identifying particular behavior patterns, it is possible to prescribe and carry out the specific attitudes indicated which will serve to reinforce desirable behavior and extinquish maladaptive behavior.

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THE APPLICATION OF A MODIFIED BALESEAN PARADIGM TO THE STUDY OF PSYCHIATRIC TEAM INTERACTION

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In response to the desire of a Fort Logan (11) team to gain knowledge of its own functioning, this study was designed to test some specific hypotheses in the areas of leadership and style of interaction.

Since there are a number of ways in which such a variably defined phenomenon as interaction may be studied (5, 9, 10, 13, 16, 18, 19), an extensive review of the literature was made to determine which models were most appropriate both theoretically and practically. The theoretical framework which seemed most pertinent from an a priori viewpoint and which had had considerable testing through research was Bales' Interaction Process Analysis (1, 2, 4, 5, 6, 12, 14, 15).

Bales postulates two classes of goals for groups. Task goals are ascribed to the group and are its *raison d'etre.* Social-emotional goals are feelings of comfort, mutual support and belonging which should result from membership in the group. The suitability of such a model to a psychiatric team seems clear and the dual goals postulated by Bales are especially appropriate because of the nature of the therapeutic task.

In numerous studies (1, 2, 4, 5, 6) Bales identified different styles of interacting among members of groups trying to meet these two classes of goals. He also derived norms (4) for the use of these

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styles to permit comparisons and interpretations.

There are a number of ways in which a psychiatric team at Fort Logan differs from most of Bales' groups. Generally, Bales' groups have five to six members, are leaderless at inception (no ascribed leaders), are ahistorical, and have an experimentally imposed, specific task (14). These limitations may be somewhat mitigated by published claims that the system and resulting norms have been found applicable to groups widely differing from experimental ones (5, 14).

Other troubles attend the use of the Bales' system. Consistently, the training of judges has been a cumbersome task, requiring considerable time and yielding questionable results insofar as the crucial question of interrater reliability is concerned (3, 12). It was felt that the suitability of the system to the present study was sufficient to justify attempts to improve it. Major efforts were directed towards increased reliability. Pilot work resulted in two types of modifications: the reduction of the number of categories and a limitation in the raw data. It is hoped that data lost by these modifications are more than made up for by increased confidence which can be placed in the results.

Three hypotheses, more properly called hunches, guided this study. Two tentative hypotheses were advanced with regard to leadership in this group:

1. That because of its total treatment responsibility, team leadership tends to become specialized, with particular members having leadership in some areas and others in other areas. This is the *specialization of leadership hypothesis.*

2. That because of its multidisciplinary makeup, team leadership tends to generalize across disciplinary lines, with representatives from many groups leading in many areas. This is the *diffusion of leadership hypothesis.*

Norms obtained by Bales in his studies of interaction within a group were compared with results obtained in team interactions. Comparison seems justified on the basis that the primary focus of the group is a task one and that there is assumed to be some shifting in achieved leadership. On the basis of some limited experience with this group, the following hypothesis concerning style was advanced:

3. That because of the predominant task orientation of this group, the most used style of verbal interaction is attempted answers, and because of the social-emotional purpose, there are more supportive (positive) than negative interactions. This is the *task-positive hypothesis.*

METHOD

Since Bales in his assessment and proposal of norm groups has combined his original twelve categories into two social-emotional (positive reactions, negative reactions) and two task-oriented categories (attempted answers, questions), it was felt that use of these four subsuming categories would raise interjudge agreement with no loss of pertinent data. It would permit comparison of Balesean curves with curves on Hospital Improvement Project judgments, so that interpretations of similarities or differences could be made. The modified Balesean categories adopted for the purposes of this study are defined as follows:

Positive Reactions: Approves of previous suggestion; supports preceding statements. Subsumes the Balesean subcategories of showing solidarity, tension release (including jokes and laughs) and agreement.

Attempted Answers: Suggests solution, problem solving, offers idea or information to task achievement. Subsumes the Balesean subcategories of giving suggestion, giving opinion, and giving orientation.

Questions: Requests clarification, repetition, additional information, needed for task achievement. A question followed by possible answers in the same item will be judged as a question because unsureness is inferred. Subsumes the Balesean subcategories of asking for orientation, asking for opinion, and asking for suggestion.

Disagreement: Disapproves of suggestion, has counter-proposal to preceding statements. Subsumes the Balesean subcategories of disagreement, showing tension and showing antagonism.

Bales' method is an analysis of style. It was felt that content of interaction was also important, and therefore a set of content categories was devised, according to Berelson's (9) procedure. The two types of content were *issue* and *treatment*. Issue categories are general topics, not limited to specific patients. Treatment categories, on the other hand, are specific and deal with treatment planning for any given patient.

Issue categories were derived empirically by reviewing team meeting transcripts between March 7 and June 24, 1966. Categories are issues when they concern matters of policy not limited to a given patient and are statistically numerous enough to crop up again and be tallied as a clearly defined class.

Goal Setting: This category refers to comments on the policy level made about long range planning of treatment to meet patient goals. It includes comments on contrasts between crisis orientation and long term planning program.

Leadership: This category includes discussions about styles of leadership, locus decision-making power, single versus multiple leadership (in groups) and change in ascribed leadership.

Home Treatment: This category is operationally defined as including policy, but not specific treatment decisions. The value of keeping patients in the community, the family versus I.P. orientation, the goals, record keeping and admission policies for all included, as are follow-up and OPD programs as they should relate to home treatment.

Limit Setting: This category refers to discussions of principles of rule enforcement. Policy on violation of passes, disciplinary discharge, and dynamic versus objective standards for penalties are included. Consistency within the team as well as between team and leaders makes a quantitatively large contribution to this category from particular patients.

Organization for Treatment: This category refers to the subteam structure and to the locus of final authority. Policy on visits and planning are included.

OPD: This category refers to policy discussions on the Tuesday evening program and questions as to its purposes, organization, etc. Its use for H.I.P. patients is included.

Staffing: The definition of, purpose for, and scheduling of staffing during the patient's treatment career are included in this category. The use of staffing for OPD purposes is also covered.

Talking: This category could have been called "non-talking in large group" and covers speculation on causes for non-talking, suggesting solutions for correction, and evaluation of the quality of patient response.

Miscellaneous: This includes categories not numerous enough to be included in any of the above. Community pressure for admission, evaluation procedures, student nurses' reports, content of team meetings, and in-service training are among these categories.

Treatment categories were derived empirically by reviewing team meeting transcripts between March 7 and June 24, 1966. Categories describe treatment when they concern specific patients rather than more generalized issue categories related to treatment.

Causality: This category has to do with past reasons for a person's present behavior in genetic, dynamic terms.

Labelling: This refers to abstracting from behavior to a label for a group of such behaviors and includes ascribed present reasons and motivation for a person's behavior.

Reporting: Included here are descriptions of patient behavior, problems, statements of fact. Objective-subjective reporting is also included when it concerns data on which agreement could reasonably be expected.

Procedures: This involves formulae for interacting with patients: "Rules of the road" ad hoc, and day by day, rather than long range; modality assignments; and administrative judgment.

Purposes: This category includes results—long range, social, and extra-hospital, hoped for in treatment.

Prognosis: This category refers to length of treatment career predicted; response to treatment (cure, some improvement, some greater functioning, etc.); expectations of staff.

Verbatim transcripts of all daily team meetings between March 7 and June 24, 1966 constituted the raw data. Such transcripts, although as close as possible to the verbatim record, did not have gestures, film records or other evidence of affect which the Bales' paradigm employs (1, 2, 9). No outside sources of data

(other team functions, casual contacts or subgroup meetings) were included. For each of the selected weeks four complete transcripts of team meetings were available.

Speakers were identified by random numbers and each item was separately numbered. The item was the unit of analysis as recommended by Berelson (9), and is operationally defined as indicated below. It was the task of the judges to assign each item to a content by Balesean category as indicated in "Instructions to Judges."

Instructions to Judges

Rate each numbered item according to its best fit into one of 4 Bales' categories, and one of the content categories. Each speaker, who is randomly numbered, has a separate score sheet. Write the item number in the appropriate Bales X Content box.

For the purposes of this study, an item is an uninterrupted speech by any person. It is operationally defined as a statement or group of statements to which a number has been assigned.

A three-hour training session was held in which judges were given a practice transcript not to be used in the main body of analysis. This session lasted three hours, and at the end, an attempt was made to assess their percentage of agreement. Based on the criterion that three out of four judges concurring was agreement, reliability as measured by percent agreement was 85% for Bales by content judgments.

Assessment of interjudge reliability was also based on the percentage-of-agreement statistic and was arrived at by having each judge rate independently the same two days' transcripts. This transcript contained 172 items, five of which had to be eliminated because of their ambiguity. Agreement was according to the following criteria:

1. Agreement - 3 out of 4 judges place the item in a given category.

2. An item questioned by 3 out of 4 judges is to be a) dropped from the analysis and b) dropped from determination as basis for interjudge reliability.

3. In areas of 2/2 split between judges where the subject is one in which knowledge of Fort Logan operation is a necessary

qualification to accurate judgment, agreement between two Fort Logan judges meets the criterion of agreement.

Interrater reliability achieved on judgments of the above named data according to the criteria outlined are shown in Table 1.

TABLE 1

INTERJUDGE RELIABILITY AS MEASURED BY PERCENTAGE OF AGREEMENT ACROSS FOUR JUDGES

Bales =	97%
Content category =	75%
Combined =	75%

RESULTS

Table 2 shows one speaker (number 23) led in more than two-thirds of the categories, giving only qualified confirmation to the specialization hypothesis; however, as indicated in Table 3, half of the team members led in one or more categories. Therefore, although leadership as defined was not as specialized as predicted, there was evidence of considerable specialization among other team members.

(See Tables 2 on pages 66 and 67.)

TABLE 2

RANKED ORDER OF NUMBER OF ITEMS ON A GIVEN TOPIC CONTRIBUTED BY SPEAKERS*

GOAL SETTING		HOME TREATMENT		LEADER-SHIP		ORGANIZ.		STAFFING		MISC.	
Sp. No.	Items	Sp. No.	Items	Sp. No.	Items	Sp. No.	Items	Sp. No.	Items	Sp. No.	Items
5	8	49	7	5	13	23	37	5	1	23	40
23	6	93	5	49	10	93	37	23	1	93	38
11	5	97	4	23	8	5	26	36	1	5	17
49	5	6	3	43	8	49	25	49	1	49	15
93	5	23	2	97	8	38	22	93	1	38	13
97	3	38	2	11	4	11	14	6	0	43	11
38	3	71	2	38	4	97	12	7	0	11	10
25	1	81	1	93	4	43	10	11	0	71	9
43	1	83	1	57	2	57	5	14	0	31	8
47	1	11	1	31	1	71	6	25	0	97	8
57	1	43	1	61	1	25	5	31	0	6	4
72	1	57	1	6	0	7	4	37	0	83	4
6	0	36	1	7	0	31	4	38	0	57	3
7	0	5	0	14	0	6	3	43	0	14	1
14	0	7	0	25	0	14	1	47	0	36	1
31	0	14	0	36	0	47	1	57	0	37	1
36	0	25	0	37	0	81	1	60	0	47	1
37	0	31	0	47	0	36	0	61	0	60	1
60	0	37	0	60	0	37	0	72	0	81	1
61	0	47	0	72	0	60	0	81	0	7	0
81	0	60	0	81	0	61	0	83	0	25	0
83	0	61	0	83	0	72	0	89	0	61	0
89	0	72	0	89	0	83	0	97	0	72	0
71	0	89	0	71	0	89	0	71	0	89	0

*Mean number per speaker:
Goal Setting - (mean score = 1.7)
Home Treatment - (mean score = 1.3)
Leadership - (mean score = 2.6)
Limit Setting - (mean score = 0)
OPD - (mean score = 0)
Organization - (mean score = 8.9)
Staffing - (mean score = 0.2)
Talking - (mean score = 0)
Miscellaneous - (mean score = 7.8)

(TABLE 2 continued)

CAUSALITY		LABELLING		REPORTING		PROCEDURES		PURPOSES		PROGNOSIS	
Sp. No.	Items	Sp. No.	Items	Sp. No.	Items	Sp. No.	Items	Sp. No.	Items	Sp. No.	Items
23	2	23	17	23	29	23	44	23	9	23	4
6	1	38	14	11	21	97	31	38	3	6	1
11	1	11	11	38	19	11	22	97	4	11	1
81	1	97	10	43	17	38	20	93	3	31	1
93	1	43	5	93	17	43	17	43	2	47	1
5	0	81	5	97	17	93	17	47	1	5	0
7	0	93	5	83	10	6	12	49	1	7	0
14	0	5	2	5	8	5	9	81	1	14	0
25	0	6	4	57	9	81	9	5	0	25	0
31	0	49	4	31	7	49	7	6	0	36	0
36	0	57	4	61	7	47	5	7	0	37	0
37	0	89	2	25	6	57	5	11	0	38	0
38	0	31	1	81	6	25	4	14	0	43	0
43	0	72	1	6	5	31	3	25	0	49	0
47	0	83	1	47	4	83	3	31	0	57	0
49	0	7	0	49	4	89	2	36	0	60	0
57	0	14	0	36	3	36	1	37	0	61	0
60	0	25	0	72	3	61	1	57	0	72	0
61	0	36	0	37	1	72	1	60	0	81	0
72	0	37	0	7	0	71	1	61	0	83	0
83	0	47	0	14	0	7	0.	72	0	89	0
89	0	60	0	60	0	14	0	83	0	93	0
97	0	61	0	89	0	37	0	89	0	97	0
71	0	71	0	71	0	60	0	71	0	71	0

*Mean number per speaker:
Causality - (mean score = 0.3)
Labelling - (mean score = 3.6)
Reporting - (mean score = 8.0)
Procedures - (mean score = 8.9)
Purposes - (mean score = 1.0)
Prognosis - (mean score = 0.3)

TABLE 3

NUMBER OF CATEGORIES IN WHICH THE SPEAKER WAS FOUND TO BE A LEADER ACCORDING TO THE CRITERION

SPEAKER NO.	CATEGORIES IN WHICH LEADING
23	11
5	6
49	6
11	5
93	4
97	4
6	3
38	3
43	2
36	1
31	1
81	1

The *diversity of leadership* hypothesis suggested that all disciplines would be represented in the leader group. In fact, the leader group, defined as indicated above, was composed of all disciplines, including four nurses, four social workers, psychologist, psychology intern, one psychiatric technician, and the two ascribed team leaders. The accuracy of the test of this hypothesis was limited by rotation requirements of the nurse - tech group whose absence from team meetings did not give that group an equal chance at leadership. However, the diffusion also was limited by ascribed leadership. When status ranks were correlated with rank of achieved leadership (talking), the relationship was found to be highly significant (rho = .80, $p < .001$).

Hypothesis 3 predicted that this team would be task-positive as shown by higher percentages of items in the positive and attempted answers categories than in the negative and question categories. Results are shown in Table 4 and in Figure 1.

TABLE 4

DISTRIBUTION OF ITEMS BY PERCENTAGE ACROSS COLLAPSED BALESEAN CATEGORIES AND PROFILE FIGURES USED BY BALES AS NORMATIVE FOR SMALL GROUPS (4, 6)

COLLAPSED BALESEAN CATEGORY	%, D-5	% BALES NORMATIVE GROUPS
Positive reactions	2.0%	25.0%
Attempted answers	71.0%	56.7%
Questions	25.7%	6.9%
Disagreement	1.3%	11.4%
	100.0%	100.0%

$X^2 = 903.7$, $df = 3$, $p < .001$

Figure 1 is a graphic representation of the data in Table 4, and shows the differences between Bales' norms on the frequencies obtained from the D-5 team.

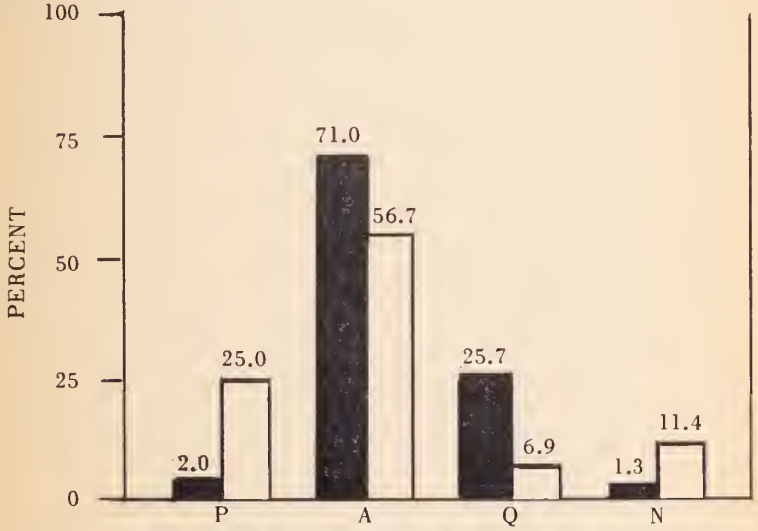

Fig. 1. Differences between Bales' normative data (plain bars) and data obtained from the D-5 team (solid bars) on categories of positive reactions (P), answers (A), questions (Q), and negative reactions (N).

The third hypothesis was partially confirmed. As predicted, the style of interaction most often used was "attempted answers." However, the difference between positive and negative reactions was too small to support this part of the hypothesis. A chi square analysis showed the differences between team and Bales' (4) normative profile group to be significant beyond the .01 level. Although not part of the hypothesis, the results indicated a difference not only in percentage frequencies but also in rank order of the Balesean styles used. Attempted answers are used most by both; team uses the question style second in frequency, while Bales' normative groups have used positive reactions more than questions (4, 6).

An additional finding, which was not related to the hypothesis but which gave pertinent information as to special task concerns of the group, is shown in Table 5.

TABLE 5

DISTRIBUTION OF ITEMS BY CONTENT CATEGORY, SHOWING PERCENTAGES OF ITEMS FOR GIVEN CATEGORIES AND MEAN NUMBER OF ITEMS EMITTED PER TEAM MEMBER

ISSUE CATEGORIES	%	X
Goal Setting	3.0	1.7
Home Treatment	2.5	1.3
Leadership	6.0	2.6
Limit Setting	0	0
OPD	0	0
Organization	20.5	8.9
Staffing	0.5	0.2
Talking	0	0
Miscellaneous	17.5	7.8
TREATMENT CATEGORIES		
Causality	0.5	0.3
Labelling	8.5	3.6
Reporting	18.5	8.0
Procedures	19.5	8.9
Purposes	2.0	1.0
Prognosis	1.0	0.3
	100.0%	

Table 5 indicated quite different amounts of emphases for different categories. There seemed to be least emphasis in areas requiring long range planning and commitment, and most emphasis on immediate problems. Thus, Limit Setting, OPD and Goal Setting, all of which include program definition and policy consideration, received 0, 0 and 3%.

DISCUSSION

Hypotheses tested in this study concern the two major areas of leadership and style of interaction.

Leadership in the psychiatric team was found to be specialized and diffused to some extent. A qualification was made necessary by the finding that one individual led in many categories, thus limiting the degree to which leadership in this group could be said to be multiple or specialized. This result is at odds with one value of the institution--that of distributed leadership across team membership. While most members contributed to most categories, each category tended to be heavily weighted with the contributions of a relatively restricted number of team members. Despite espousals of the principle of shared authority, vestiges of a power or influence hierarchy were evident. Since the corollary to power is responsibility, those who wield greater influence bear greater responsibility. If this premise is accepted, the conclusion must be that a large share of the responsibility for eschewing policy discussions belongs to the achieved leaders of the team.

Style of interaction in this group was markedly deviant from that in Bales' groups (5, 14). The question of validity of application of these norms to psychiatric teams is an open question. It may be that such a group suggests more answers for day to day problems (as borne out by the high mean score per speaker in the content category *Procedures*, Table 2, Table 5) than it supports or rejects. The implicit value placed on individual contributions to the task goal might encourage team members to put more energy into advancing possible answers than to consider those given by others for acceptance or rejection. Such a pile-up in task categories could be task dysfunctional. When no response is given to one solution

and another solution is immediately put forth, it is difficult for members to assess the direction of the group. If this is so, the tendency to withhold decisions for an extended period while the various solutions are sorted out would delay or prevent task achievement.

Social-emotional achievement is also undermined by the frequency of solutions. Individual members do not know how their ideas are received. This unsureness is accompanied by members' anxiety about acceptance by the group. Over time, such anxiety would probably become a group, as well as an individual, characteristic.

The implications of these findings could be variously interpreted. It would appear that task as well as social-emotional goals might better be met if it were possible for members to devote more energy to considering tentative solutions offered by others, agreeing or disagreeing before suggesting additional solutions.

If it is dysfunctional for psychiatric teams to continue to interact in the manner described, the question of change must be considered. Although the present descriptive study cannot isolate causal variables, it can serve as the basis for educated guesses about them. It is proposed here that the leadership could be exploited to induce desired changes in styles and content of interaction. Thus, greater use of social-emotional categories by leaders would result in their greater use by the group as a whole; greater leader emphasis on long-range rather than short-range areas would result in greater team emphasis on policy. It is predicted that these changes would lead to greater task and social-emotional goal achievement.

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ISSUES FOR CLOSURE*

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This study of decision-making processes is a continuation of the analysis of team leadership and style of interaction according to the Balesean paradigm (3). Leadership was found to be diffused, as indicated by the fact that all disciplines were represented in the ranks of achieved leaders; and it was also specialized to an extent, with some persons leading in some content categories and other persons leading in different categories. Stylistically, the team differed significantly from Bales' norms in having little social-emotional interaction, and in exhibiting a disproportionately great number of attempted answers.

It was concluded, on the basis of these findings, that the team was dysfunctional in both task and social-emotional areas. Each problem facing the team elicits a deluge of suggestions, but there is no effort to select or focus upon the best answers. Consequently, final solutions tend to be postponed, and problems accumulate. The present study was an independent test of the hypothesis that the team is not effective in accomplishing its task goals.

METHOD

The aspect of task effectiveness chosen for investigation

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was closure, defined as the resolution of issues and the adoption of guidelines for disposition of classes of problems that arise frequently. The issues considered were not limited in their application to the career of any single patient, but were general policy matters which could not be settled within the confines of one team meeting.

Using these criteria (generalizability and duration), nine issues were identified from verbatim transcripts of team meetings. Seven issues were chronic, low intensity issues since they recur less often but over an extended period of time. The two acute, high intensity issues were problems occurring within a short period of time.

Chronic, low intensity issues:

1) the ability of the staff to treat patients with chronic brain syndromes,

2) the question of accepting and planning treatment for potential deportees,

3) the definition of home treatment: goal setting, length of treatment, and the distinction between follow-up and treatment in the home treatment case,

4) the value of limit setting,

5) the methods of achieving greater patient participation in group therapy,

6) the purpose, function, and organization of the outpatient program,

7) the proper use and design of staffing (case conferences) in planning treatment.

Acute, high intensity issues:

8) the question of forming a comprehensive mental health center, by merging with another team (This issue was closed after two meetings.)

9) the problem of organization: the flow of authority and responsibility for the intramural and extramural programs (This issue was closed within one month.)

RESULTS

The frequency with which these issues were discussed over the 22-week period of study, and the state of the issues at the end of the period, are shown in Figure 1.

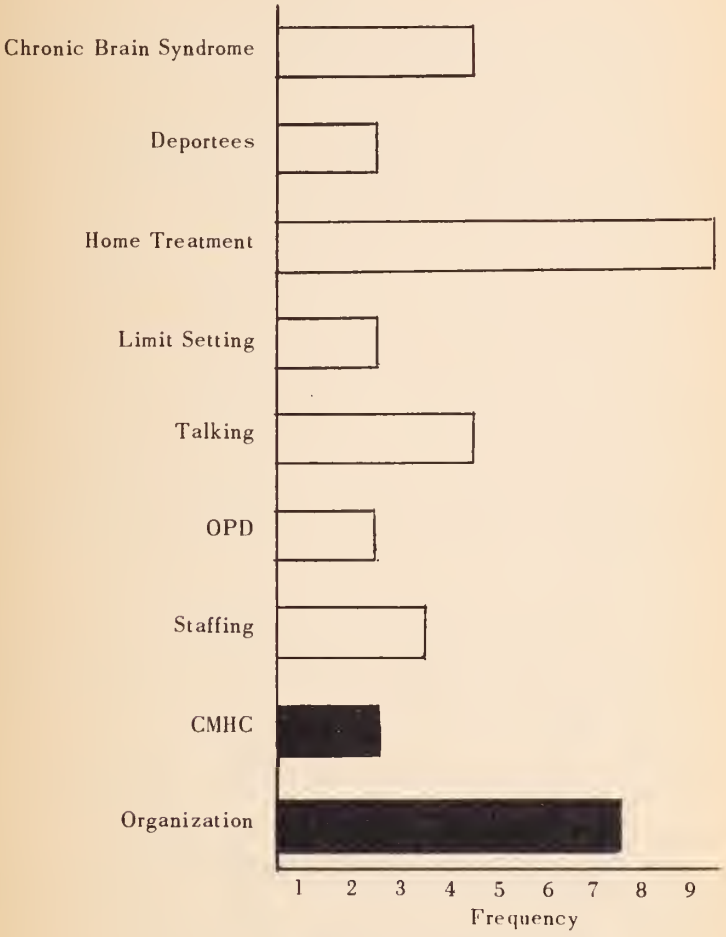

Fig. 1. Frequency of discussion of the nine issues over the 22 week period of study. The solid bars indicate the issues on which closure was achieved, while the open bars represent lack of closure.

Only the two acute, high intensity issues were finally resolved. This finding strongly supports the hypothesis that the team is not successful in fulfilling its task functions, in terms of closure or policy formulation.

DISCUSSION

Considering the nine issues as a whole, the team is only 22 percent effective in reaching policy level decisions. However, the two groups of issues were not similar. The two acute, high intensity issues were introduced by the ascribed leaders, were presented as crucial problems demanding answers, were given intense consideration, and tended to be leader-dominated. These features seem to have contributed to task achievement. In contrast, the chronic, low intensity issues were broached more often by lower status team members and were not discussed so intensely. Intensity and duration, in interaction with leadership responsibility, apparently are crucial variables in team decision making. The practical implication of these findings is that policy definition (or decision-making) is associated with leader initiative, concentrated effort toward the resolution of issues, and adoption of broad policy level guidelines.

From a theoretical viewpoint, task dysfunction presumably interfers with the attainment of social-emotional goals. There is some evidence in the literature to support the idea that continued lack of closure produces anxiety. Borgatta and Bales (1, 2) sum up this relationship:

> ...adequate integration of the group requires that task efforts receive response in arriving at a satisfactory solution of the task problem (8, p. 393)

In other words, some minimal task achievement is as necessary to reaching social-emotional goals as social-emotional achievement seems to be in attaining task accomplishment. Beyond the absence of policy guidelines, task dysfunction reduces the psychological value of belonging to the group. Individual members will feel there is no satisfaction to be gained from a group that cannot meet their needs for a sense of accomplishment.

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FAMILY SYSTEMS AND APPROACHES TO FAMILY THERAPY*

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I would like to put together some things and some ideas that have proved very interesting and exciting to me, and, I think, to others in this country and elsewhere. I am connected with working people and their problems by working through the medium of the family unit. Because I believe we are living in a very magnificent time as far as human beings are concerned, I would like to trace for you what I think are the origins of both their growth and change. Many new things are coming up—social psychiatry, community psychiatry, the influences of existentialism and of self-actualization. There is a spirit of experimentation around, which is always exciting. Let me develop some of the ideas that I think lead to the family unit, which I see as a step in evolvement more than any particular form of therapy, as opposed for instance, to working with an individual, or a group.

I want to cover hundreds of years of history very quickly. The origins of any of the therapeutic entities we deal with at present, it seems to me, come from the witch, the pauper, the idiot, the sick person, and the criminal. Our present areas of interest have evolved from these five kinds of people. We got psychiatry from the witch, criminology from the criminal, medicine from the sick person, social work from the pauper, and psychology from the idiot. It is not exactly one to one, but all of these entities were, at one point, perceived as deviations. With the first deviation, the

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source and the cause were looked upon as unknown. From these, however, came the first diagnostic categories. And then, as in all diagnostic categories, there were series of causations, and for each of the diagnostic categories there were also series of therapies. Starting from the labeling and the causation of deviations and their treatment, we look back and see that the first theories of causation about deviation were unknown, but the treatment was death, death by indirection or by direction.

I am going back many years to try to develop these three lines: the labeling, the causation, and the treatment within this framework and see what I can do to make some sense out of where we are today. People were not content to look upon deviation and the fact that its causes were unknown. Human beings are a curious lot, and they try to figure out things. As they began to look at these deviations, one of their first ideas about causation was some kind of unknown infiltration from without, some kind of magic. When the cause is thought to be infiltration from the outside, you treat this with whatever is in keeping with the knowledge about magic at that particular point. We have in some cultures today, certain religious beliefs which would be used for this. As the years progressed, it was thought that perhaps it was not all magic; maybe it had something to do with what you were like when you were born—your genetic heritage. If it was something that you were born with, there was not much you could do about it; you had to be content to endure it. You might try to segregate the genetically unwhole people and place them somewhere else.

We had by this time, then, three theories about causation: unknown, infiltration from outside, and genetic. Treatment could be death, or it could be separation of some sort. As the years went on, it looked as if a person's behavior had something to do with his will; that is, he was an "ornery cuss," and that was his trouble. As the idea developed that man was just an "ornery cuss," it seemed that if this were the cause of his behavior, one way of taking care of it was to punish him. Now we had another form of treatment. It looks like man explored a little bit more and got the idea that perhaps where a person lived had something to do with how he behaved. The natural and logical conclusion to that was to move

him to a place with different surroundings; thus custodial care came into being, and we have many residuals of that.

Later, it looked as though behavior had something to do with some part of man or woman that motivated him but was out of sight of his awareness. This was, of course, the unconscious. The treatment for that was to discover the unconscious and try to help man by putting him more in charge of himself. Psychoanalysis was one of the main tools for that particular form of treatment. Then it seemed as though the way one person behaved had something to do with the person with whom he was interacting, and the theory of interpersonal behavior was born. Therefore, it seemed sensible to treat the interpersonal relationship and the milieu.

In a brief way I have covered the general kinds of theories of causation and treatment, and these were all one-to-one things. As different ideas came into being, such as the interpersonal theory which Sullivan wrote about in the 1920's, and we saw the rise of something called group therapy in the 1920's with Moreno, Slavson and some of the others, there was born a new idea about how to treat an individual. That is, the additional idea of treating an individual with his peers who were in the same spot. This group treatment, or treatment within a peer group, was based upon one principle, that changes in behavior of an individual were brought about through interpersonal operation. Before World War II, these two ways of treating were invoked—the individual and the group.

At the beginning of the century there developed something called child guidance clinics which provided the first form of treatment based on an interpersonal relationship. These used the unit of the mother and the child on the premise that the child's behavior was influenced by what the mother did. Fathers were discovered later. We had two uses of the interpersonal relationship, that is, that which was perceived in self, child guidance, and that which was worked out in group therapy. After World War II came another kind of treatment, known as marital counseling, for the husband and wife pair. For the most part, marital counseling was not brought into the profession by psychiatrists, social workers, and such, but rather by clergymen, sociologists, and other people outside of the usual (forgive the expression) "mental ill health" disciplines.

I use that term because all of us in the psychiatry, social work, or psychology professions are mental ill health specialists. We had another form of the mental treatment unit then, the husband and wife. So, at this point we have the picture of how to treat an individual, how to treat groups of individuals, the mother-child unit, and the husband-wife unit. If you look at this in terms of a family, you will see that there are only two other units present in the family, but still left out, the father-child unit and the sibling unit. So if we add the sibling unit and the father-child unit to the mother-child unit and the husband and wife unit, we have all the units in a family.

We had the beginnings, if we put them all together, of what would go into a family. To take a little further look, along came the idea that children were there to help, in an indirect way, a husband and wife to get along together. Also, running through all of this was an idea that people could be taught how to take on marital and parental responsibilities. So much, then, for the evolvement up to the time of World War II.

There was a psychiatric entity called schizophrenia, which has been around for a long time and which happens to be a label that in years past usually meant that nothing much could be done for people to whom it was applied. Occasionally, there were scattered reports of improvement or recovery but, by and large, in the treatment of that entity called schizophrenia, the prognosis was not very good. After the last war, some curious people began to think about how a person who was labelled a schizophrenic might look to his own family. Gregory Bateson, an anthropologist who was associated with us at the Mental Research Institute, was one of the people who became curious as to what the whole family looked like if it contained someone with this label. He began his studies in 1954, and around the same time, Murray Bowen, who was at the National Institute of Mental Health, hospitalized whole families just to look at this situation. Some interesting things emerged in the studies of the schizophrenic and his family—when I say "schizophrenic," I mean somebody who has that label. There seemed to be a repetitious and predictable pattern, a direct link between what the labelled person was presenting and the family of

which he was a part. This excited people because, again, theories of behavior ranged all the way from the unknown and genetics to the other things I have mentioned. The idea developed that maybe we had something new that would shed some light on the behavior of a person—in this instance, the behavior of a schizophrenic. It was not a very long step then to looking at all other kinds of behavior to see if the behavior of any individual could be linked to the system of which he was a part.

In the earlier days we did not talk much about systems. We just knew that we were seeing a series of patterns that certainly seemed to be a type of link. Now it appears that every group of essential ingredients that must belong together in order to emerge with a single outcome forms a system. The parts have to work together in some kind of organized, orderly, sequential form which begins to develop a rhythm and a balance in order to obtain the outcome that the particular ingredients are designed to do. It began to look as though each family developed a system from its ingredients, a system that somehow kept the whole family in balance. This was a crude beginning, that is, the observation that families were systems which worked like cars. In biology you were well acquainted with systems; it seemed that a similar thing went on in families. At the Mental Research Institute we have done a great deal of work trying to find out about family systems, trying to see how they work, and trying to see what kinds of intervention one needs to change a system that is not functioning toward growth to one that is. This brought a new idea into focus, because when we tried to determine whether or not the behavior of an individual was healthy, we used a whole set of criteria. But when we looked at behavior in relation to a system, these criteria did not fit and we had to look at something else. The words which would describe a functioning person would not necessarily describe a functional system. We had no words to talk about human systems, and we had to devise a new language. I am not satisfied with the language we have worked out for talking about systems, but I think we will learn more about it.

The Mental Research Institute was founded in 1959 to study the relationship of individual behavior to the system of which it

was a part. When we started to explore this, we had to review certain things that we knew about the development of a person. And then the "system" idea became even more sensible. All of you probably know, when you think about it, that you arrived where you are right now and became the person you are at this moment in time because of a three-person learning system—a male and a female forbear and yourself. If you did not actually have one of these persons on the premises, their images were on the premises. So we knew that every individual becomes the product of a three-person learning system, a male adult and a female adult, who were his parents, and himself. We also knew, when we reminded ourselves, that every child comes into this world only with ingredients to grow and not a blueprint already developed. There are no cases on record where there was a little bag of directions about how to grow and develop. The important thing we all recognized was that this blueprint had to be drawn as the child went along. Obviously, the blueprint depended upon the way in which the male and the female adult handed down, or over, to their child the directions for how he was to grow. On the face of it that sounds easy—a couple of adults put their heads together and work out, or write out, a blueprint for the kids. It does not seem to work that easily in practice. When two adults get together, even though they are the parents of a child, they are not always in agreement about what makes for the best kind of blueprinting. They are not always able to communicate their messages to the child, or to each other, so there is no particular guarantee that a child will get a clear message from his parents about how he should grow and develop. However, as we looked at how adults pass on to the child their ideas for the child's development, we came onto this very important thing, communication.

Communication has been known about for a long time; in mass communication everybody is connected, that is, knows something about it. But we defined this a little bit further; we said that communication was a two-way street and that it took place between a sender and a receiver, and that whether or not the communication came across depended both upon the sender and upon the receiver. Every child has two senders, the male adult and the female adult.

I don't know whether he is lucky or unlucky, but he may have also some other senders around, like grandparents, or aunts. There are at least two senders, but the child is only one receiver. We therefore concocted this idea: Suppose that you were a radio receiver and you were being sent signals from two different stations, neither of which knew that the other one was sending, and they had to come in on the same wave length. You know what happens with that; you get static. You also have a commitment on the receiving end, regardless of what is going on or what the reality is, to make sense of the signals and to use them as though they fit. This is especially true if there is a rule that the sender and receiver cannot comment for one another, or that the receiver cannot send anything back, or that he cannot even comment on the fact that what he was sent does not fit. In a rather homely analysis, it looked to us as if every child was involved in such a situation and dependent upon it for the development of his self-concepts. All of us who have any knowledge from working with individuals knew that the picture a self had of himself, and the feeling of worth that a self had of himself, was going to be very important in determining how that self would behave, how that self would grow, how that self would feel, and how that self would act. It seemed then that it would be worthwhile to scrutinize more carefully the operation between the male adult and the female adult in the interests of their child.

One of the things that we discovered, contrary to what had been thought originally, was that everything the child got from the parent, the parent intended to give. We went through a period when it was quite clear that all the bad things of the world were related to mothers, the bad mothers that did all the harm, and we had techniques that dealt with that, too. But we found that there was not much relationship between what the parent intended and what the child received. Neither was there much relationship between what one parent sent out and what the other sent out, particularly if the two were not aware that they could send out different messages. We learned that the knowledge of the child, in contrast to the intentions of the parent toward the child, would not necessarily be refused by the child. For the first time, someone could look at

assistance outside the "blame" frame. There is a difference between seeing how things work and finding blame or credit for the way things work. And I would say at this point in time that all over the world and in all groups that I work with, when people are trying to explain causes, they still get into the "blame" frame. It is very difficult not to do this without raising defenses, without making people feel badly, without making people fight, and fight in a purposeless kind of way.

If it were true that the messages of the adults were not necessarily communicated to the child and received by him as intended, then we needed to look at this more carefully. In doing so, we came upon some very simple things. I am quite convinced that it is the simple things in the world that we overlook most often, and, if I am an expert in anything, I would consider myself an expert in the obvious which most likely gets overlooked. We discovered that it is quite possible for us, in sending messages, to give the receiver clues that we are not aware of giving. There is a very simple explanation: When we are preoccupied with our inner selves we do not recognize what we are presenting outside. But the children do! We discovered that parents had the delusion that their children only heard what their parents intended them to hear and only saw what they intended them to see. We discovered also that parents gave out what is known as "double-level messages."

This was one of the contributions that Gregory Bateson made, and I want to tell you about a "double-level," because we're double-leveling all the time. Double-leveling in itself is not pathological. These messages gave us clues that the parents' intent was not received by the child. Let me give you the definition of a double-level message. Suppose that I announce, with a big grin on my face, that the building is burning down. There is something here that does not quite fit. Now, if you are in my presence when I have a big grin on my face and I say to you, "The place is burning down," you are in a dilemma. If you take your message from my smile there is something funny about this; you are not supposed to have joy and pleasure when the place is burning down. If you listen to my words about the place burning down, then what are you going to do with my smile? This is a double-level. Or,

suppose I get a bad pain while I am with a friend. I do not want my friend to know that I am in pain because we have other things to do, but she observes that my facial muscles get stiff and taut, and says, "How are you feeling?" If I reply, "Fine," I am really saying, "You don't have to look at my pain, we can go on with what we are doing." But, seeing my face, my friend may very well conclude that I am an idiot, that I am lying to her, or that I do not consider her enough of a friend that I can level with her and other things of this sort. These are double-levels again.

Double-levels come about without people knowing it, and, in my opinion there is nothing pathological about that. It is pathological when double-levels are not commented upon or acknowledged in some way by those to whom they are directed. This can give a chance, at least, for an explanation of what does not fit. Many times in talking to groups, people want to make the point that it is bad if you give out double-levels. I do not think you can live without them. I believe that our whole physical system is made up of so many parts with which we are not in connection that we are unaware of a great many of our clues.

As persons, each of us relates more to what is inside than what is outside; others are more aware of what is presented on our outsides and take their clues from what they see and hear. If they cannot comment on the clues, they must determine for themselves the reasons for the discrepancies. Now, if you happen to be a person with low self-esteem, you probably are going to interpret a discrepancy in some impulsive way. You may conclude that it is a lie, or some form of sick, bad, stupid, or crazy behavior. Unless you can check it out, you are likely to retain a false interpretation of the discrepancy.

Children come into the world unequipped to give any kind of specific feedback. They usually do not learn to talk until the age of twelve months or beyond, and that means that for those twelve months of the child's life he has had to interpret on his own whatever discrepancies he has envisaged or experienced with his parents. By the time the child is talking, he already has a wealth of clues defined; he has a set of expectations to which he will give words later on, much to the surprise of the adults. We were

interested in looking at what we thought would help us with the mystery of how a person with good intentions, who is right and loving, could give out faulty messages to a child. I am sure that you have noticed that there is not much relationship between love, niceness, and hard work among the people who have problems in your family. So how could it be that a person, who was well intentioned, loving and bright, still managed to have children who were not growing properly? I think the answer is in not knowing that adults are capable of giving double-levels and that the child has to make some kind of sense out of them. I sometimes wonder how any child, especially if he is around many adults in his first year of life, manages some kind of integration with himself.

One of the things that has been very interesting at the Mental Health Institute is the use of video tapes. I felt that it was most important to acquaint families with the fact that the way they thought they looked and sounded was not the way they really looked and sounded. What somebody else got from them was not necessarily what they thought was there. Another myth was that one should always be one hundred percent in control of the way he manages himself. It was easy to dispel that kind of expectation with television, but you cannot run around with your tape recorder all the time. We looked for other ways in which a person could find out that he did not always look and sound as he thought he did. If you do not believe me, go home tonight, walk in the door and tell the first person you see to look at you, and then you tell him what you think he saw. Describe fully your eyes and your nose, what your ears are doing, and what the muscles in your neck are doing, and whether you are red or not. Then compare the picture with his view. This is a descriptive exercise. Nobody is telling you that anything is wrong with you; you are just comparing pictures.

There is another thing that you can do. Very few of us have ever seen ourselves as we really look. Go to your mirror and put on a name tag. Look in the mirror. You will see that your name tag is backwards. Now if your tag is backwards, your face also will be backwards. If you have never seen yourself on a video tape or in moving pictures, you have been running around all your life with a delusion of what you look like. You have been comparing

the feedback to you with a delusion instead of with reality. Similarly, the first time you hear your voice on a tape recorder, you say to yourself, "That is not me, my voice is lower than that, or, it is higher than that." But everybody says that is exactly the way you sound. A very simple physics principle governs that little discrepancy: sound which originates in the same orifice is heard differently than the sound that comes from outside of that orifice. Again, we have the possibility for a delusion, and I use delusion in a nice sense because I am not afraid of them. I used to be, but I am not any more. People run around with some mistaken ideas that they know what they look like, what they intend to say, and what they sound like. There is a fourth part to that; whatever they tend to look like and sound like, they do look like and sound like.

Much of what we have developed in the way of treatment intervention has been based upon these kinds of things, the ways in which the child receives his messages initially on how to develop his blueprints. There are many ways of doing it, and you can see now how many traps there would be for a child in getting messages from his mother and from his father within the expectations that I have described. If this is accompanied by the rule against commenting upon what the child sees and hears when he cannot talk, you can see how the child could continue his early misconceptions of what was intended without his parents being aware of them. Maybe this is so until the child goes to school when suddenly there comes some demand on his growth which he cannot see, and then the whole story comes out. One other point in looking at the development of the child, we were all children once. It sounds a little facetious when I say it, but many adults forget this—that they were once children, and that their origins were as children. Because we were all children, we all have ideas about how children should be different. All adults have in their minds a picture of the ideal child. And from where do they get that ideal child? Where did you get your ideas of what your ideal child is like? You got them from what you were not, from what your parents did not do properly, and from how they told you you ought to be. Everybody wants things to fit their ideals, so each adult applies these same things to his child when he comes along, and we think

this is one of the ways that social heredity takes place. It seems that because of the ways in which rules about commenting are made in the family, people develop rules about themselves—whether or not they can comment, whether they can ask questions, whether they can challenge, whether they can criticize, or whether they can make loving comments. And the less the ability and freedom to comment, the more likely are going to be the distortions, inhibitions, and prohibitions about what people can comment on later.

People can grow to adulthood with rules which permit them to comment only on certain things, and the rest of it may be just imagined or believed, even though it may not even be in reality. Then people get married. Their marriage relationship may be founded upon their ideals of what should be, which can be filled in easily if you do not ask for reality to be validated. It is very easy for a woman to believe that a man must always be the leader, because her father was not the leader and her mother said that he should be. Her idea then is that the man tells her what to do; but his telling her what to do in the courtship period means that he always has an idea about where the two can go. Later on, the same things happen except it feels different. What at one point in time felt like a strong man taking care of her, later feels like a bully trying to squash her. Where would she get such delusions? Not only from inside herself, but also when he once said, "Let's go to the movies," and she said, "No." He said, "Yes," and she felt that he was a strong man. So this is her fantasy, and she begins relating herself to him in terms of the fantasy. As long as you do not comment upon it, you do not have to break up your fantasy; you can continue.

However, at some time reality presents itself, and it is no longer possible to continue life with a fantasy. We think that a symptom breaks out when the reality can no longer sustain the fantasy. We have quite a bit of evidence to get us on this track, and I think this is a very fruitful way of beginning. Human beings, we find, do not give up easily. Even when the woman should decide her husband is trying to squash her, she will still try to make it out some way, even with her symptom because people do not give up easily. There begin to be such things developing as, "I'm

unlovable, now here is the evidence." Then she withdraws more, and of course he sees that he is being withdrawn from, so there must be something wrong with him. Then we get back to the magical thinking—born that way, lived with the wrong people, got a little man in his head telling him what to do. These begin to be some of the explanations that take place. Isn't it interesting that the explanations these people make at this point in time are so similar to what we did, over the ages to the present, to explain deviations?

We are at a very exciting time in looking at these relationships. First of all, there is evolvement of the self-concept within the family system, and the kinds of communications patterns that go into it. Right now we are working on some ideas about child rearing, by having adults know more. It is much easier to know about communication than it is to know about your self-concepts, and apparently it is not so defense-producing. We are working on ways to make it possible for young parents to do a different kind of job regarding what they pay attention to in rearing their children. We are working also on the "well family service," which we think will develop into a preventive device. We see now that every family has a predictable system of operations and a set of expectations and predictions. These expectations and predictions are part of the evolvement of self-concepts of each person involved. They will be expressed through behavior and through communication. If we put all these together we can begin to know something about helping with behavior that is on the road to some kind of destruction. We hope that many people will help us with this; but it is exciting for me, I think that it is for others, and I hope that it is for you, too.

BOOK REVIEW

CONTROL OF HUMAN BEHAVIOR. *By Roger E. Ulrich, Thomas Stachnik, and John H. Mabry, eds.* Glenview, Illinois, Scott, Foresman and Company, 1966, 349 pp.

This excellent collection of papers ranges from individual to sociocultural emphases, with clear explication of the assumptions, principles, and practical applications of behavior modification techniques. Also included are chapters on fallacies of interpretation and method, and on axiological issues. Anyone connected with the reparation of disturbed persons will find this a provocative and challenging book.

If it is accepted that the behavior of organisms is subject to natural (causal) laws, it follows that behavior can be regulated through the identification and manipulation of causal variables. These propositions are basic to the science of behavior control.

In order to maximize the probability that certain desired behaviors will be emmitted, the physical and social environment must be structured to provide specific reinforcing events contingent upon the behavior. Candy and praise as rewards and withdrawal of attention as punishment are typical reinforcements which strengthen or weaken the preceding responses.

The behavioral engineer, then, is concerned with the concrete features of organism and environment. The worker manipulates an independent variable and measures the resulting dependent variable. This concern with observables precludes any reliance upon inner forces as explanatory constructs.

Behavior therapists maintain that there is no practical advantage to invoking such concepts as mind, self, identity problem, or inferiority complex. The behavior therapist sees the problem as the disordered behavior itself. He attempts to extinguish or modify the behavior, rejecting the notion that the behavior is merely symptomatic of some underlying cause or vague inner state.

Behavior control in the clinical setting has certain unique advantages. Foremost is the actual modification of behavior toward clearly defined goals by the use of specific procedures. Since the

procedure and goals are well defined, the techniques designed by the psychologist can be implemented by nonprofessionals. Effectiveness is readily assessed by measuring overt changes in the subject's behavior.

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The Fort Logan Mental Health Center is Colorado's second state hospital. Currently serving almost half the population of the state, its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with emphasis on expansion of professional roles and the involvement of the patient's family and his community in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. Approximately one-half of its patients are admitted directly to day care, and evening care is offered. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient from the time of admission through all phases of treatment.