Staff Meeting Bulletin
Hospitals of the » » »
University of Minnesota

Minnesota Multiphasic Personality Inventory

Volume XIV | Friday, November 20, 1942 | Number 8

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

Volume XIV | Friday, November 20, 1942 | Number 8

INDEX

Published for the General Staff Meeting each week during the school year, October to June, inclusive.

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William A. O'Brien, M.D.

I. LAST WEEK

Date: November 13, 1942

Place: Recreation Room
Powell Hall

Time: 12:15 to 1:10 P.M.

Program: "Surgical Treatment of Hemorrhoids"
W. C. Bernstein
W. A. Fansler

Attendance: 109

Gertrude Gunn,
Record Librarian

- - -

II. MEETINGS

1. ANATOMY SEMINAR

Saturday, November 21 at 11:30 A.M. in room 226, Institute of Anatomy.

"A Descending Visceral Pathway in the Spinal Cord," Robert L. Merrick.
"Cell and Fiber Counts in the Human Facial Nerve," Charles Van Buskirk.

- - -

2. PATHOLOGY SEMINAR

November 23, 1942 at 12:30 P.M. in 104 Anatomy.

"Adreno-cortical Insufficiency with Androgenic Zone Hyperplasia,"
T. E. Bratrud.

- - -

3. MINNESOTA PATHOLOGICAL SOCIETY

Tuesday, November 24, 1942 at 8:00 P.M.

"Nutritional Edema and Its Treatment with Amino-Acids," Richard M. Johnson, Detroit, Michigan.

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4. INTERDEPARTMENTAL SEMINAR

Wednesday, November 25, 1942, at 8:00 P.M. in Eustis Amphitheater.

"Earliest Evidence of Deficiency of Thiamin and Riboflavin," Russell M. Wilder, H. L. Mason, and M. M. Williams.

"Manifestation of Prolonged Use of Diets Low in Fat in Dogs," Arild E. Hansen, Hilda F. Wiese, and Erma Miller.

"Reaction of Human Gall Bladder and Sphincter to Magnesium Sulphate," and "The Effect of Sectioning Nerves to the Sphincter of Oddi," E. A. Boyden.

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III. ADVANCE ASSIGNMENTS

GENERAL STAFF MEETING
Winter Quarter

January	8	Bacteriology - W. P. Larson
January	15	Surgery - O. H. Wangensteen
January	22	Obstetrics and Gynecology - John L. McKelvey
January	29	Medicine - C. J. Watson
February	5	Ophthalmology - Frank E. Burch
February	12	Dermatology - H. E. Michelson
February	19	Pediatrics - Irvine McQuarrie
February	26	Orthopedic Surgery - Wallace H. Cole
March	5	Neurosurgery - William T. Peyton
March	12	Radiology - K. W. Stenstrom

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IV. THE MINNESOTA MULTIPHASIC PERSONALITY INVENTORY

Starke R. Hathaway
Burtrum C. Schiele
A. B. Baker

Introduction

From both clinical and research aspects there has been increasing need in modern psychiatry for the development of mental measurement devices that would provide objective scales with known limits of error to estimate the strength of abnormal components of personality, and to permit the measurement of personality change and the comparison of clinical material seen in different settings.

As an example, some five years ago the growing need for a measurement procedure was especially high-lighted by the controversy regarding the value of the shock treatment of early schizophrenia. Statistical reports appearing from various investigators differed radically in the claimed percentage of beneficial effect from the therapy. The common explanation for wide discrepancies was that the cases being treated in one clinic differed in psychological severity or make-up from those in another. A test for this difference between two sets of patients was impossible of satisfactory accomplishment because the judgment of psychological make-up, although dependent upon specific training, was personal and nonrepetitive. The detailed language of psychiatry is only roughly adapted to qualitative description and is still less effective quantitatively. About the only way two such groups of patients could be compared was the rather unsatisfactory method of evaluation of the history of the present attack with the assumption that illnesses of more recent onset were relatively less fixed and deep. This type of evaluation was subject to many errors. It was obvious that what was needed was an impartial and repeatable technique for personality evaluation that would provide in understandable terms and within reasonable limits a method of equating groups of individuals so that experimental groups in one institute could be assumed reasonably similar to those in another, and so that the result of any therapeutic procedure could be measured in terms that would be independent of the personal equation of observers. The problem of measurement as related to shock therapy is merely illustrative of the type. Psychiatric research problems are rarely free from a similar need for control whether they are strictly psychological or physiological.

The psychometric concept basic to our study is that a psychological quality can be objectively measured if it is clear enough to permit us to judge subjectively that one person has more or less of the quality than an "average" or "normal" amount. "Objectively" as used here means that findings can be repeated and consistent agreement reached. This characteristic is common with clinical tests that permit some form of physical measurement. However, special techniques are necessary for personality measurement. Except very grossly psychological qualities have no known physical variables and cannot at present be transformed into material with such physical dimensions.

The special units of measurement for psychometrics are behavioral reactions of the subject. These reactions may be regarded as small bits of behavior, each having an identified significance. Examples of such behavior bits would be an association word, a problem in algebra, a test question in an examination or any other behavioral response to a restricted stimulus situation. This concept is not new basically. The subjective evaluations we all make of those about us are really so determined. We see a person presented with an opportunity to spend money and he refuses; this is one unit in our minds indicating him to be stingy. If he subsequently reacts more times in a similar way we judge him as stingy in proportion to the judged number of times and to the importance of the individual times he has so reacted.

Diagnostic judgment in psychiatry proceeds likewise. The patient is observed and his behavior assorted. For example, he posturizes, he appears to listen, he says irrelevant things, he smiles enigmatically - these are heavily weighted items for schizophrenia and if all are present he is pretty safely assumed to be schizoid. Final decision cannot be made, however, until he is shown not to score heavily on other behavior points, indicating other diagnoses or negating the significance of the first observations.

There are several sources of the symptoms or bits of behavior that one uses to form a psychiatric judgment. One may passively observe a patient as he moves and speaks and one may actively interfere with the patient by bodily manipulation or by social restriction, meanwhile observing the results. The most common and useful manner of discovering significant points in a non-psychotic patient, however, is to ask specific questions or make specific statements and note the answers. For every answer a judgment is made as to whether it is common and normal or symptomatic. The latter approach is also that most widely used in psychometric evaluation.

Objective measurement must, in the first instance, eliminate the examiner's variability in manner of presenting the statement or question to the patient. This does not assume that a particular examiner may not be capable of reliable presentation but it is a recognition that not all examiners are reliable and unbiased. The most common way of removing the influence of an examiner is to print the question or statement, present it to the patient without comment and permit him to react. It is essential to note that neither the personal nor the printed examination guarantees truth or candidness on the patient's part. Both methods must rely on what a patient does. It is true that a subjective personal examination permits the examiner to intuitively follow certain leads but, in the objective examination, many more and carefully prepared items can be presented. The essential truths about the patient may be subtly discovered through the patient's inability to consistently mislead through a maze of items cunningly designed to bring out the truth.

Although there were minor exceptions, the objective personality test for components other than intelligence first appeared as the Woodworth Psychoneurotic Inventory. This inventory was developed during the first World War but the war ended before it was widely used. Since the Woodworth Inventory is a prototype of subsequent devices, it is well to review its development and structure. The need then, as now, was acute for a mass examination technique to afford a prediction of which soldiers were more likely to develop symptoms or break under the strain of war participation. As chairman of the committee on emotional fitness under the National Research Foundation, Woodworth carried chief responsibility for this type of research. The Psychoneurotic Inventory was developed by reviewing current literature on war neurosis symptomatology and data on actual current cases. Two hundred provisional symptomatic statements in question form were prepared. These were tried in preliminary fashion and some were omitted, some changed until 116 remained. These were arranged to be responded to by either a 'yes' or a 'no' and a single score was obtained. This score was simply the number of items answered with the unfavorable alternative. Unfortunately, there was no good validation of the assumed significance of the answers by statistical studies of selected abnormal groups and the emergency ended before extensive research was completed.

The 116 items of the Woodworth Inventory have been classified by Symonds as in Table I.

TABLE I

Physical symptoms, pains, weariness and coordinations	28
Adjustment with the environment	20
Fears, worries	16
Unhappiness, unsocial and antisocial moods and conduct	16
Dreams, fantasies, sleep disturbance	10
Reactions to drink, tobacco, drugs, sex	7
Mental symptoms	6
Vacillations	5
Compulsions	4
Questions about one's family	4
	116

Two examples of the items are:

"Is it easy to get you angry?"

"Have you ever had heart disease?"

In the years following the first World War a number of modifications of the Woodworth Inventory appeared. Some were general and some more specific in their intent. Examples of more specific tests are those measuring the inferiority feelings postulated by Adler and the introversion-extroversion scales inspired by the clinical concepts of Jung. Although some of these scales were useful and valid for educational purposes, none was developed that adequately fitted into the psychiatric field.

There were a number of reasons for the failure to evolve a clinical scale. A chief point was that the psychologists working on their development were in greater part academic teachers and naturally tended to adapt their instruments to the school student. Furthermore, adequate validity and flexibility needed the cooperative efforts of psychiatrists and psychologists working in a psychiatric clinic treating a wide variety of borderline cases.

With the completion of the housing and staff of the Neuropsychiatric Division of the University Hospitals an unusual opportunity was provided for such research and the Minnesota Multiphasic Personality Inventory was begun. The basic principles of the approach to the problem were similar to those established twenty years before by Woodworth. Details differed, however. More items were used, simple wording was stressed, the question was changed to a positive statement usually in the first person and instead of a forced restriction of the patient to two answers he was permitted to answer that he did not know. From more than a thousand items initially selected, five hundred and fifty have been retained for the final inventory. Each of the five hundred and fifty items is printed on a separate card and the whole collected into a box with three index cards marked "True," "False," and "Cannot Say." The patient takes the cards one at a time and places them behind the index card he feels most nearly represents his attitude toward the statement. Sample statements are:

1. "Often I feel as if there were a tight band about my head."
2. "It is always a good thing to be frank."
3. "The future seems hopeless to me."

A classification of the five hundred and fifty items is given in Table II.

TABLE II

1. General health (9 items)
2. General neurologic (19 items)
3. Cranial nerves (11 items)
4. Motility and coordination (6 items)
5. Sensibility (5 items)
6. Vasomotor, trophic, speech, secretory (10 items)
7. Cardiorespiratory system (5 items)
8. Gastrointestinal system (11 items)
9. Genitourinary system (5 items)
10. Habits (19 items)
11. Family and marital (26 items)
12. Occupational (18 items)
13. Educational (12 items)
14. Sexual attitudes (16 items)
15. Religious attitudes (19 items)
16. Political attitudes - law and order (46 items)
17. Social attitudes (72 items)
18. Affect, depressive (32 items)
19. Affect, manic (24 items)
20. Obsessive and compulsive states (15 items)
21. Delusions, hallucinations, illusions, ideas of reference (31 items)
22. Phobias (29 items)
23. Sadistic, masochistic trends (7 items)
24. Morale (33 items)
25. Items primarily related to masculinity-femininity (55 items)
26. Items to indicate whether the individual is trying to place himself in an improbably acceptable light (15 items)

The Minnesota Multiphasic Personality Inventory is the first inventory measuring common specific clinical syndromes in contrast to the earlier schedules designed for either the more general concept of "neuroticism" or special states like "inferiority." The scales now available for scoring in the Minnesota Multiphasic Personality Inventory are Hypochondriasis, Depression, Hysteria, Psychopathic Personality, Paranoia, Psychasthenia, Masculinity-Femininity of Interests and Schizophrenia. Some of these are in a more advanced stage of development than are others.

These scales have been derived by comparing the responses of clinically diagnosed patients with those of persons not under the care of a doctor. It is important to note that the particular items characterizing a symptom complex are identified by the contrasting tendency for normal and abnormal patients to respond "True" or "False" without regard to the verbal content of the item. This procedure assures that the given abnormal group differs from normals in the way the item is responded to, and for scoring no assumption is made or needs to be made regarding the import of the item. Three tests to indicate whether or not the cards are carefully and reliably sorted are provided. These validating scores help to eliminate cases where the patient does not understand the items or tries to place himself in too favorable a light or is not cooperative.

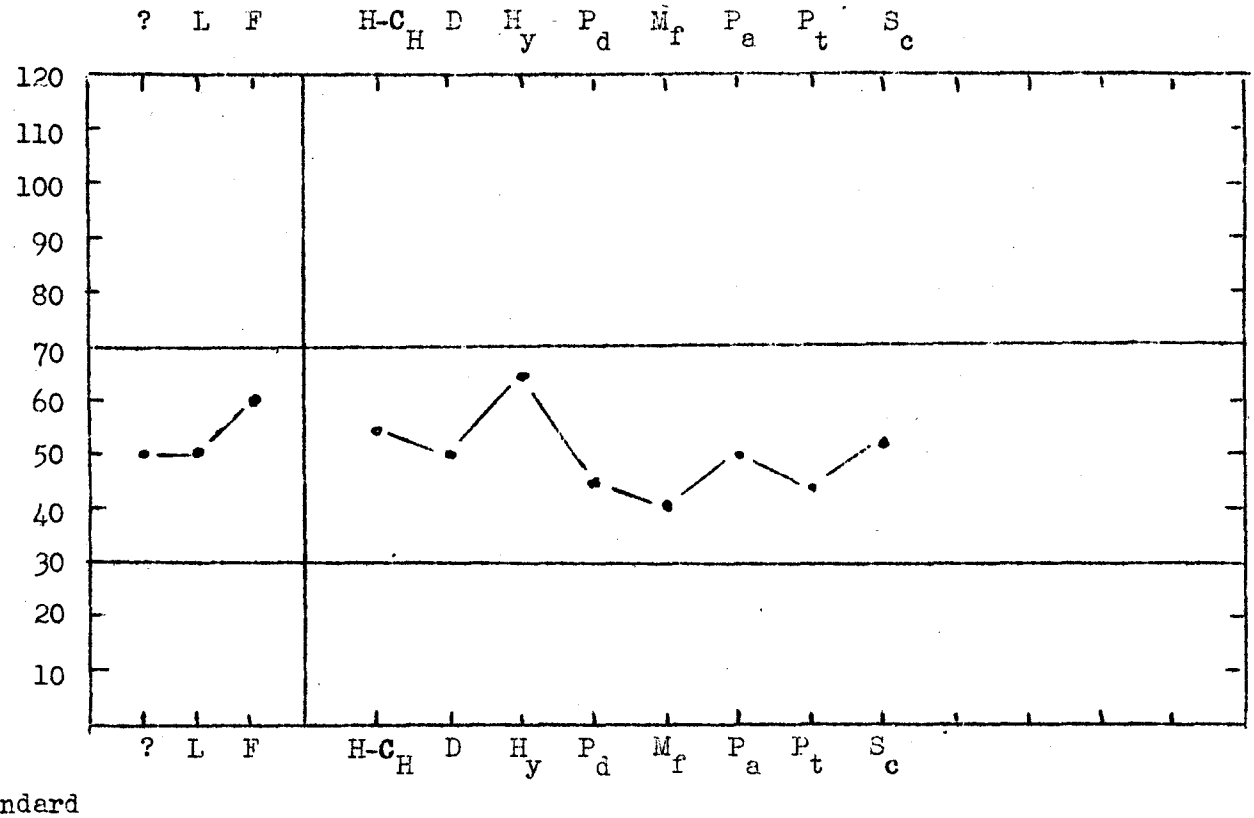
For final interpretation, the various responses are translated into a standard scale system. On this, the

average value is always 50 and a value high enough to be safely called borderline is 70. All the scores are arranged so that a score higher than 50 is in the direction usually regarded as abnormal although scores below 50 may have some significance. A typical result is given in figure 1.

This is an essentially normal profile. No score is as high as the borderline. The three scores at the left are the validating scores, and, being within average range, they may be disregarded. The key to the remaining symbols is as follows:

$H\text{-}C_H$	Hypochondriasis	M_f	Masculinity-Femininity
D	Depression	P_a	Paranoia
H_y	Hysteria	P_t	Psychasthenia
P_d	Psychopathic deviate (Psychopathic personality)	S_c	Schizophrenia

Figure 1 PROFILE CHART



Standard (T) Score	?	L	F	$H\text{-}C_H$	D	H_y	P_d	M_f	P_a	P_t	S_c
	50	50	60	55	50	65	45	40	50	44	52

Although none of these scores is as high as the borderline in the example given, the highest point is hysteria; this is frequently seen in young intelligent persons. Even in these normal cases, where the hysteria score is the highest point, a careful review of the person's history will usually elicit examples of personal problems being solved by physical "playing sick" or also if this person is placed under great abnormal strain he may break and his most probable neurotic type will be hysteria.

Examples of abnormal curves will be given below. Such curves may be high in one or nearly all components accord-

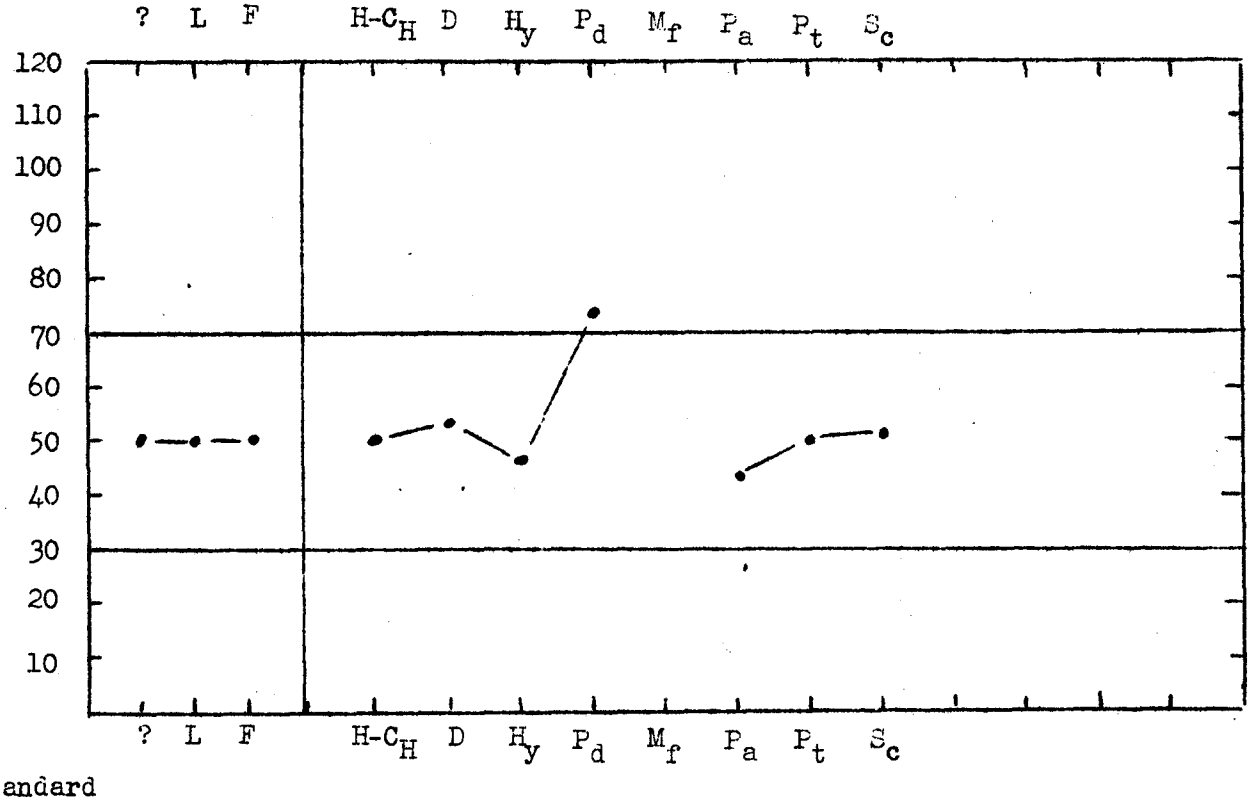
ing to the complexity of the psychological system. It must be repeatedly stressed that persons called normal by default of critical examination are common among us. Thus abnormal curves may be discovered among persons who for one reason or another have shown no disablement. Similarly, some who are psychologically disabled have relatively normal curves. A few of these may have abnormalities not yet measured on the profile, but more often they are persons who have been placed under unusual environmental stress.

To illustrate the use of the Multiphasic Personality Inventory in the matching of groups, a series of 100 cases of psychopathic personality is available. These records were obtained at the Federal Reformatory, El Reno, Oklahoma, by H. D. Remple, psychologist, and released to us for study through the courtesy of Dr. John W. Cronin and the United States Public Health Service.

All the cases were diagnosed by the Reformatory staff as Constitutional Psychopathic Inferior. This diagnostic

Figure 2

PROFILE CHART



	?	L	F	H-C$_H$	D	H$_y$	P$_d$	M$_f$	P$_a$	P$_t$	S$_c$
Standard (T) Score	50	50	50	50	53	47	73		44	50	51

class has been known to include a heterogeneous group of personalities. It thus becomes of interest to study the Oklahoma cases with regard to consistency of the personality profiles.

For the diagnosis, Constitutional Psychopathic Inferior (or in more recent terminology, Psychopathic Personality) the profile in figure 2 is typical.

The summaary coming with this case is:

"Neuropsychiatric:
"PSYCHOLOGICAL: U.S.P.H.S. Classification Test, Class C.

Army Alpha mental age 14-3, I.Q. 103, superior to 55%. Normal test intelligence. Alert appearing. Intellectually capable of profiting from trade

training.

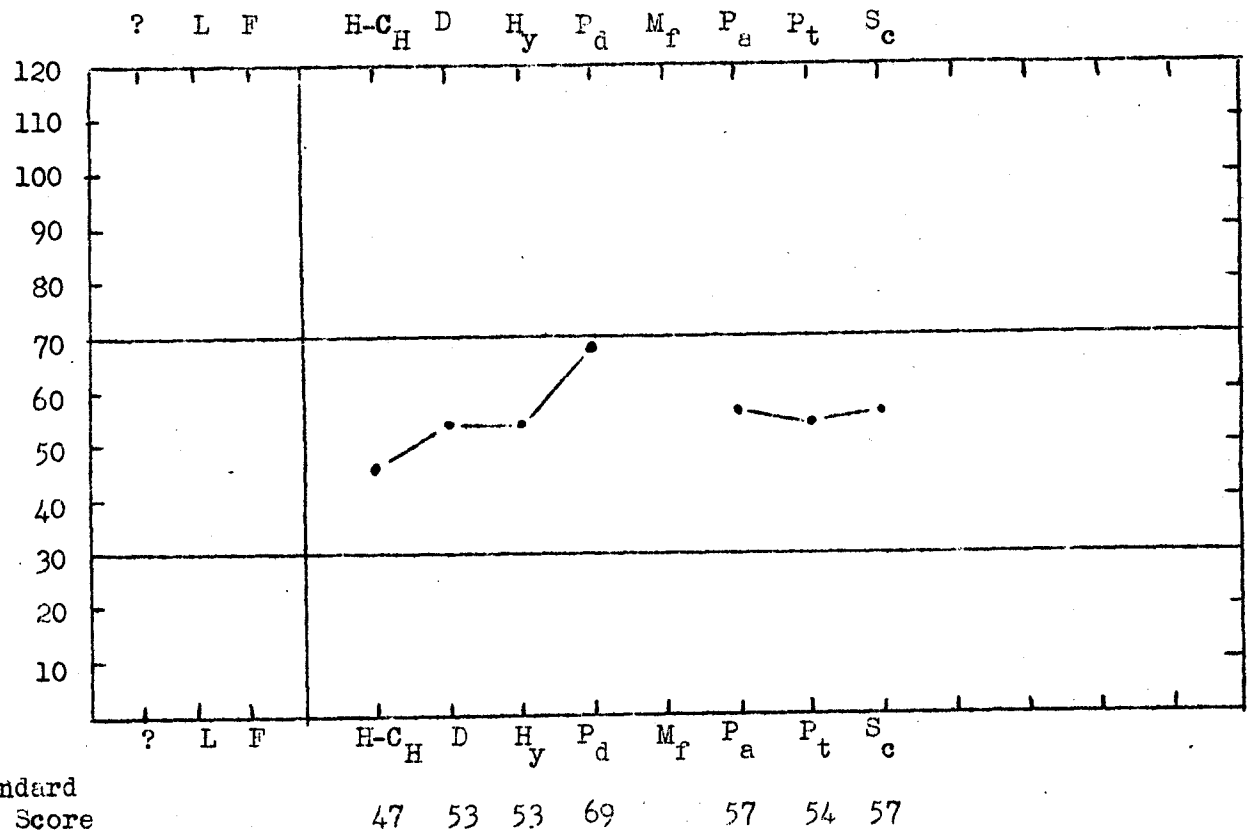
"PSYCHIATRIST: This is an alert, unstable, irresponsible youth whose past history indicates he has been in difficulty with the law on numerous occasions. He has served previous sentences at State reformatories. He is lacking in definite vocational interest, and it is believed that he should be considered a Constitutional Psychopathic Inferior. There is no evidence of a frank psychosis at this time.

"NEUROLOGICAL: Negative.

"DIAGNOSIS: Constitutional psychopathic inferiority, without psychosis.

"SUMMARY: This is an 18 year old single white youth from Oklahoma serving 2 years and 11 months under the F.J.D.A. (Dyer Act). He has served terms in the Boy's Industrial School and the Oklahoma State Reformatory....The Reformatory records indicate that his record there was none too good. He was considered to be inefficient, not conscientious, stolid, lazy, indifferent, untrustworthy and an agitator; also he escaped from that institution. While acting as a trusty he

Figure 3 PROFILE CHART



Standard (T) Score	47	53	53	69	57	54	57

and two more youths became intoxicated, knocked a man on the head and took his car....His father is a law-abiding citizen and owns about 160 acres of land; his mother died when he was about 2 years of age and his father remarried...He has an 8th grade education and a mental age of 14-3. Has been employed chiefly as a farm worker and plans to return to farming after his release; he will be given an opportunity to learn construction work here. It is felt that he is very definitely a custodial risk and may get into disciplinary difficulties."

The outstanding high point of the profile is at P_d (psychopathic personality). In this case there are no other high points that seriously confuse the diagnosis. If other high points occur in these cases the tendency is for them to be at P_a or S_c (paranoia or schizophrenia) From psychiatric experience, this is an expected finding and is illustrated on

the composite curve made from the average scores for the whole group of 100 prisoners (fig. 3).

If these persons are measured soon after being caught, D is likely to be high. This depression is apparently dynamically related to the revulsion of feeling coming with the discovery of the acts leading to the patient's difficulty.

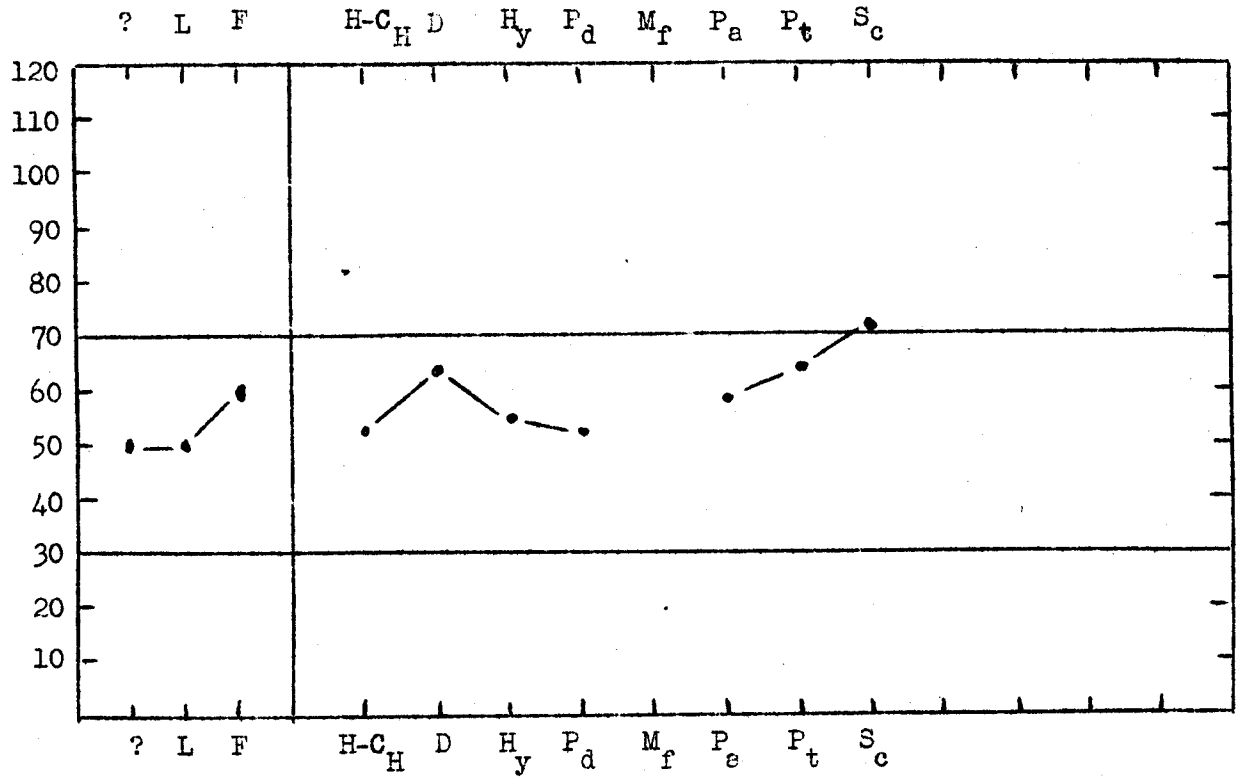
Although from 55 to 65 per cent of the 100 cases had profiles clearly enough similar to figure 2 to warrant the diagnosis, some were clearly of other types. Figure 4 will serve to illustrate the point.

The case summary from the Oklahoma institution is as follows:

"Neuropsychiatric:

"PSYCHOLOGICAL: U.S.P.H.S. Classification Test, Class C. Army Alpha mental age 18-4, I.Q. 132, superior to 94%. Superior on Alpha. Alert. Would like to learn electrical work here. Capable of learning work on skilled occupational level.

Figure 4 PROFILE CHART



Standard (T) Score	50	50	60		52	63	55	52		59	64	71

"PSYCHIATRIC: This is an alert, unstable, irresponsible individual whose longitudinal history indicates he had difficulty adjusting at home and in school. Was a chronic truant. Has been quite nomadic, vocationally unstable, lacking definite vocational interests. Although he denies any overt homosexual interests he impresses the examiner as having some latent homosexual characteristics. Believe he should be guarded against homosexual assault. There is no evidence of a frank psychosis at this time. Believe this individual should be considered a Constitutional Psychopathic Inferior and

because of psychopathic tendencies may have some difficulty making a satisfactory institutional adjustment.

"NEUROLOGICAL: Negative with the exception that deep reflexes are slightly hyperactive.

"DIAGNOSES: Constitutional Psychopathic Inferiority, without psychosis.

"SUMMARY: This is a 20 year old single white youth from Kansas serving 5 years for the Dyer Act. He is a probation violator in this case. Father was a successful real estate man and was recently killed in an automobile accident. Parents were separated at the time of his death. Mother is employed by a doctor. Subject is reported to have been seriously ill when he was nearly 3 years old and while in school did not adjust satisfactorily. Completed the 10th grade in school and is of superior intelligence. Has worked as a service station operator and garage man. Would like to learn the electrical trade and will be given an opportunity to do so, also was encouraged to further his educational training. He is diagnosed as a constitutional psychopathic inferior and should be guarded against homosexual assault. May have difficulty making a satisfactory institutional adjustment. Was thought to be a potential problem case and was assigned to the Catholic Chaplain for observation, consultation and assistance."

This case appears to belong more to the schizophrenic type than to the predominant psychopathic personality type. Cases with significant abnormality other than P_d made up the majority of the records not clearly belonging to the main type. Only about 10 per cent of the records could be confused with clearly normal records.

This brief summary of a sample group from another institution shows the progress that has been made in the establishment of an objective method of group evaluation. The chief scale in the above evaluation was still in preliminary form. A new and more reliable P_d scale has now been derived which accentuates the above findings. Other scales as they are evolved will afford more inclusive personality evaluations for general purposes of group comparison and individual analysis.

University of Minnesota Cases

A 50-year-old housewife, described a variety of "nervous spells" which occurred several times daily. In some of these she would shake so severely that she was unable to walk or stand; in others one side of her body would become numb, she would lose her voice and "almost pass out." This latter type of spell was very frightening to her. In addition, she complained of marked fatigue, loss of weight, constant headache, poor vision, dizzy spells, ringing of the ears, night sweats, hot flashes, and vague pains in the extremities.

During the past six years, because of increasing nervousness, she made frequent visits to the family physician who blamed her trouble onto the "change of life." In December, 1940, another physician found that she had syphilis. The patient was acutely distressed at this discovery and soon thereafter began to have the above described nervous spells. Though she received fairly adequate antiluetic therapy, the symptoms continued to progress; she was referred to the University Hospitals for study on 9-23-42.

The past history gave no evidence of previous psychiatric breakdown or of other serious physical diseases. However, the patient had numerous and scattered complaints.

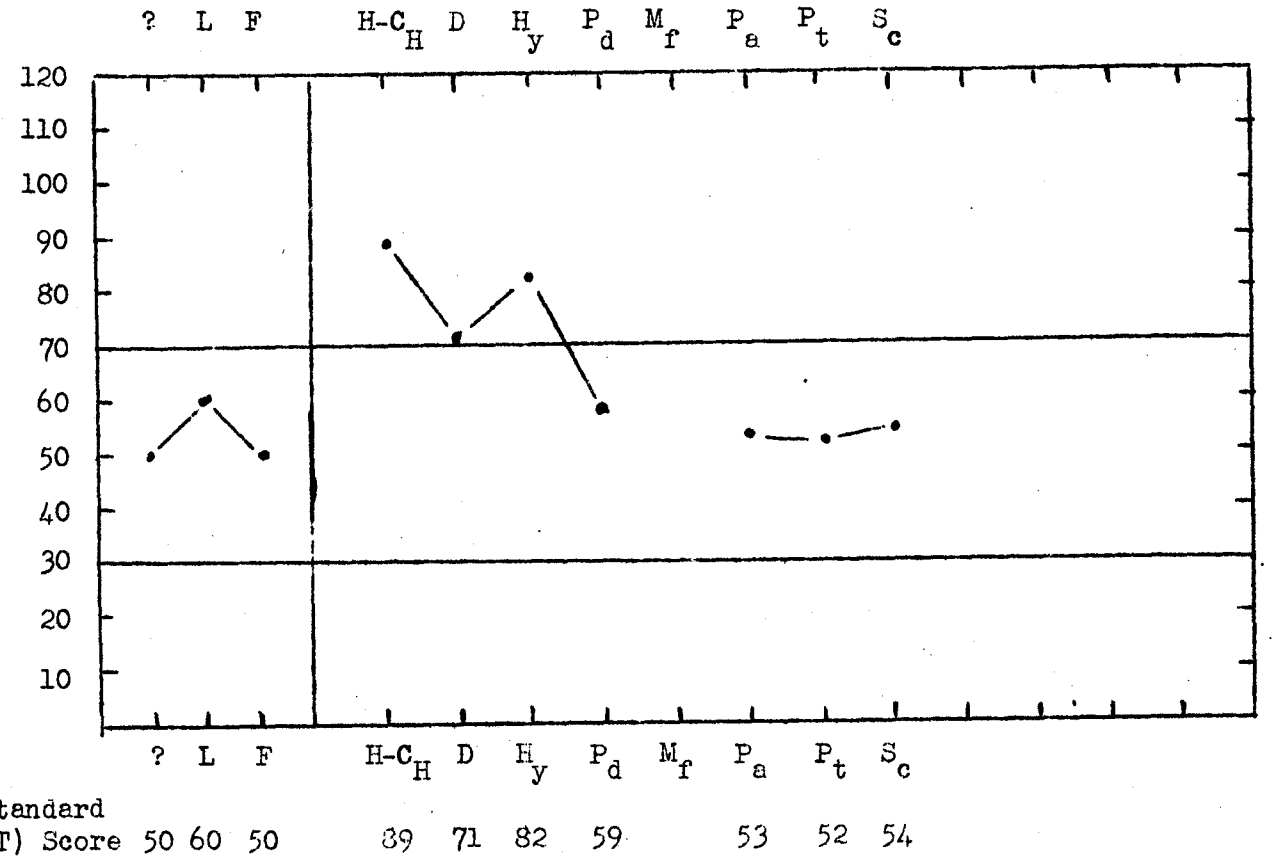
The history indicated that the patient had been "nervous and fidgety" from childhood. For years she had exhibited neurotic tendencies in the form of fear of high places and fear of automobiles. She blamed this temperamental handicap on an unhappy childhood. She had very little schooling. Her father was an improvident drunkard. She and her mother lived in various mining camps of the West until she

married at the age of 18. Her married life was uneventful except that her husband developed arthritis ten years ago. Now he is severely handicapped and thus a burden and worry to her.

The general physical examination was negative. The positive neurologic findings of unequal fixed pupils, partial loss of deep sensibility in lower extremities and slurred speech suggested a diagnosis of early taboparesis. This was supported by the spinal fluid findings: Kline and Kolmer 4+; colloidal gold curve 5555531000.

The mental examination revealed no evidence of psychosis. Her memory and orientation were intact. The nervous spells described in the history were frequently observed in the hospital; they were lessened by the use of phenobarbital and further decreased by reassurance. The patient had been convinced that her condition was hopeless and she was anxious over the consequences of the "dread disease" from which she suffered.

Figure 5 PROFILE CHART



Standard (T) Score	?	L	F	H-C$_H$	D	H$_y$	P$_d$	M$_f$	P$_a$	P$_t$	S$_c$
	50	60	50	89	71	82	59		53	52	54

Figure 5 shows the test profile of the Minnesota Multiphasic Personality Inventory taken on admission. It illustrates the mixed type of neurotic reaction commonly seen in this hospital. The hypochondriacal score of 89 fits perfectly with her long list of complaints and her evident concern over her health. Consistent with the hysterical score of 82 are the shaking attacks, numb spells, and aphonia which almost certainly are hysterical in origin. The depressive score (71) is relatively high. If it stood alone we would be inclined to interpret it as evidence of a predominantly depressive reaction. But in combination with higher hypochondriasis and hysteria scores we have found it to be a characteristic accompaniment of severe neurosis.

The indication in a test result of this type obtained on any patient is emphatically not that the patient should be regarded and treated exclusively as a neurotic patient. Rather such a patient must be clinically evaluated, making due allowance for her neurotic temperament and its effect on any somatic symptoms that may be present as well as a careful evaluation of the role the somatic problem plays in the neurotic complex. In other words, a neurotic score indicates the presence of a neurotic temperament but does not prove the absence of organic disease. Conversely we have already shown that stable persons, even though suffering from widespread organic disease, score little higher on hypochondriasis and hysteria than do the normal.

In this case, concurrent therapies were instituted for the somatic and the psychic components. Either one alone would leave the patient incapacitated and the prognosis, like the diagnostic formulations, is dependent upon a combination of the separate futures for the two conditions as well as their interrelation.

. was a 58-year-old male who came to the hospital for psychiatric study on the insistence of his relatives. Although he had been partially incapacitated because of his complaints for a period of 5 years, psychiatric consultation was not previously considered necessary by the patient or his relatives. His outstanding complaints were nervousness, anxiety, loss of confidence, inability to concentrate, inability to work, occasional mild headaches and a morbid desire to pull out his hair (trichotillomania).

The present illness began 5 years previously when the drug company for which the patient was working changed hands, and the nature of the patient's work was changed from the purchasing to the adjustment department. Although he was unable to cite any tangible reason, he became afraid that he would lose his position. Shortly thereafter the company's business increased in volume with a resultant increase in the patient's work and duties. He then became concerned over his lack of ability to complete his work and soon found that it was difficult for him to concentrate on mental tasks. He, therefore, requested and was granted a leave of absence. He returned to work after two months but was still unable to function at his job. Rather than be discharged he resigned and moved to another city. After spending the summer at a lake cottage he improved remarkably. He then worked for a period of time in a relative's toy factory, but was restless and inefficient. He later returned to his former place of residence to seek re-employment in some drug firm. He was unsuccessful in finding work and as a result of this disappointment, developed a complete relapse of his nervoussness, anxiety, inability to concentrate and trichotillomania. He lost interest in his surroundings and would sit around the home wringing his hands. He only occasionally complained of headache or insomnia. It was because of these persisting complaints that he presented himself for psychiatric care.

His past history was essentially negative. As he was a member of a large family he had been forced to go to work after finishing the eighth grade. He had received a series of increases in pay at his various jobs and had worked 17 years for his last employer. He was happily married and took a mild but normal interest in various social activities and had been active in several fraternal organizations. His only disappointment occurred shortly after he was married; at this time he wanted to return to school to study pharmacy but was financially unable to do so.

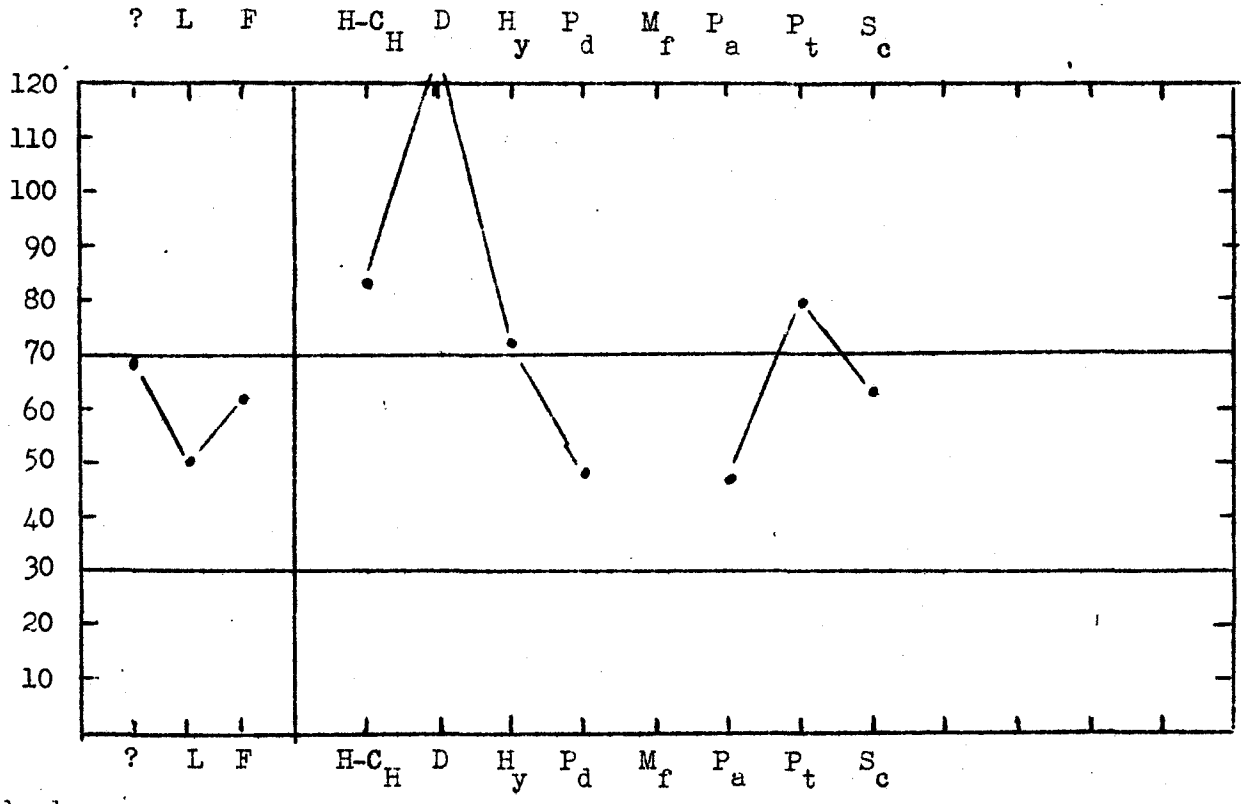
The general physical and neurological examinations were essentially negative as were also the laboratory studies. At the first interview the patient appeared somewhat tense and moderately agitated. He moved his hands about constantly and picked at his scalp until it had become almost bald. Other than this he displayed no signs of severe emotional fluctuations. At times he appeared almost apathetic. He denied any profound depression or suicidal desire. His answers to questions, although brief, were adequate and to the point. He was

unable to offer any explanation for the development of his symptoms. In fact, he stated that this question had bothered him a great deal. There was no pronounced intellectual disturbance.

After this initial examination the diagnosis was still not clear. Although the patient was severely maladjusted and somewhat incapacitated by his apparent anxiety reactions, he did not seem to be psychotic. Therefore, his condition was temporarily regarded as a severe anxiety state. The Minnesota Multiphasic Personality profile, to the surprise of the staff, revealed an exceedingly high score for depression, 125. The case was further shown to be an involved one in that the hypochondriacal and psychasthenic scores were also definitely in the abnormal levels. In view of this new information the patient was interviewed more thoroughly in respect to his emotional depression and now much new and significant information was forthcoming. It was discovered that he was and had been much more depressed than he appeared to be on casual examination. He stated

Figure 6

PROFILE CHART



Standard (T) Score	?	L	F	H-C$_H$	D	H$_y$	P$_d$	M$_f$	P$_a$	P$_t$	S$_c$
	69	50	62	83	125	71	48		47	79	63

that for many years he had felt very unhappy and extremely unworthy of his wife and family. The future to him had become quite hopeless. He often felt that his presence was not desired by others and he therefore refused to accompany his family on any social functions. During the past year he had also noticed a marked difficulty in thinking which had become progressively worse.

The findings obtained from the subsequent interviews necessitated a change in our diagnosis from that of anxiety state to one of agitated depression. The condition thus seems much more serious than was first appreciated. The patient has been receiving rather intensive psychotherapy consisting of reassurance, reeducation, hydrotherapy and mild sedation with the result that he has become much

less agitated. His speech defect has vanished and he has started to take at least a minimal interest in the ward activities. The trichotillomania has also disappeared and his hair has begun to return. However, he still remains profoundly depressed although his appearance and ward behavior might lead one to become falsely optimistic about his progress.

Comment

The Minnesota Multiphasic Personality Inventory, in the role of a clinical aid, applies not alone to the case obviously needing neuropsychiatric consultation, but also to any clinical problem in which psychic factors could play a part in diagnosis or therapy.

The negative or normal profile obtained on such a case is a reassurance to the clinician that relieves him in part from disturbing concern with psychological factors. An abnormal profile, especially if several scales are above the borderline, indicates in all cases the advisability of psychiatric referral.

To further illustrate, a recent medical case was referred merely on the basis of the fact that there was a lack of reasonable cooperation and concern in the patient over symptoms that indicated stomach ulcers. Ordinarily, such a case would likely not receive psychiatric attention but the multiphasic profile was simply obtained by clerical help alone. The result was a profile with moderate depression and definite psychopathic personality. With this cue the patient was interviewed and after considerable resistance admitted to a quasi malingering to obtain drugs. It became clear as the history developed that the addiction was on the basis of psychopathic personality and the ulcer problem became a minor one. As in the case of most patients with psychopathic personality, psychotherapy was not effective and shortly after discharge the patient committed suicide by overdosage with a barbiturate.

These cases serve to show the objective complexity of the personalities with which we are dealing in the psychiatric field. In psychiatry, as in other fields of medicine, rapid progress can not be made in therapeutic effort and in research until the clinician is relieved of the labor and prolonged procedures necessary for diagnosis. In proportional degree, as direct and reliable diagnostic techniques are developed the present overemphasis of psychiatric time spent on the diagnostic formulation will be relieved in favor of more constructively active time on therapy and management.

In the foregoing description of the development of the Minnesota Multiphasic Personality Inventory there is no intention to minimize the imperfection of the particular device. From the outset, we have recognized that this whole approach might be inadequate. The results have gratifyingly vindicated the method and promise fruitful future development.

With the Minnesota Multiphasic Personality Inventory in its present form, a few cases still show abnormal test records in the absence of symptoms or disability brought out by other types of examination. A somewhat larger number of patients have easily observable disabilities but relatively normal test profiles. Whether these latter are successfully dissembling, inadequately questioned by the test, or have traits not yet measured has not been determined. It is likely that several sources of error exist.

Nevertheless, making cautious allowance for present imperfections, the validity of the scales is surprising. One should hardly expect to accurately and completely assay an individual's personality in a single test session of an hour or two. It does not seem likely that personality could be more simply and quickly surveyed than the physical system - a complete physical evaluation will hardly be possible in several times the test period for the Inventory.

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V. GOSSIP

To speak at another session of the fathers' section of the maternal hygiene course sponsored by the council of social agencies and the Hennepin County Medical Society at the Young Women's Christian Association. These courses patterned after similar efforts elsewhere, notably in Cleveland, are arranged exclusively for private patients. Physicians encountering women in the earlier months of pregnancy are urged to send them to the lecture demonstration series. Only standard practices are taught. The men's night consists largely of helpful hints on how to be useful and important at the same time. Nothing is quite so unimportant as an expectant father. He is much like the small boy who sets the barn on fire and then loses out to the fire department. Fathers "to be" are only mildly interested in their wives' insides. The biologic aspect of pregnancy does not do much for them. They are interested in such practical problems as when to take their wife to the hospital, how long she must stay, and what to do after she gets home. As expectant mothers are supposed to eat a well-balanced diet, the father is asked to share in the ordeal by doing likewise. All of our group are young parents living in modest quarters. It is easier to buy and cook for two if the same menu is followed. A word about breast and its advantages always creates surprise as most of them have never given it a thought. I can still recall our early days in Minneapolis when we came under the influence of Dr. Sedgwick's breast feeding campaign. No stone was left unturned to reach mothers with the breast feeding message. Through the years the subject has been allowed to lapse except for the mothers in the lower income levels. Larry Richdorf still carries on with missionary zeal at Minneapolis General Hospital. Alexis Carrel felt the subject important enough from the sociologic standpoint to write a dandy essay on it in Reader's Digest. Obstetricians have been accused of cooperating in a program to eliminate all effects of pregnancy which leaves them indifferent to the subject of breast feeding. Maybe our little classes will succeed in convincing a few of these mothers and fathers that breast feeding is one of the easiest ways of raising a baby, giving it a feeling of security, and assuring the mother of an adequate number of rest periods each day. There is much that can be done in anticipation of problems which arise in the first year of life. Frankly, the plan of instructing the mother before the baby is born is much more logical than trying to show her in one hurried lesson how to do her chores after she gets home. After our bull session the fathers go on to learn how to give a bath, dress a baby, change diapers, and care for ordinary crying problems. The thing that amazes me is how eagerly they seek information and how earnestly they listen to the discussion and observe the demonstrations....To my own parent-teacher association to speak to my fellow parents and my child's teachers. Through force of circumstance I am limited to few such engagements, but this one is important. As I relate the various advances made in medicine which directly relate to child welfare, it seems that the modern parent would be dizzy attempting to satisfy all the special needs unless some systematic plan was worked out for supervision of child health. Families who follow a regular scheme of supervision at the physician's office get the best results in the long run. This is also true of dentistry. Some children need to go to the dentist every 3 months, others every 6 months, and some only once a year. Visits to the dentist in the earlier stage of dental development result in saving teeth, even though small cavities have to be filled. When all the cards are down modern dentistry tells its story in a simple way. Take your child early and often, examine with meticulous care for small cavities, fill them before tooth structure is damaged and preservation of the teeth is accomplished....To the Coffman Memorial Union to speak to the students on campus etiquette. Students must live with other students, students and faculty must live together. Many irritating events occur in the day's work---Some from the students' side, some from the faculty side. In addition, the public observes our conduct, all of which indicates that to enjoy privileges we must also have restrictions....This night to reception for Sara Jordan, famed gastro-enterologist of Lahey Clinic, Boston.