My pathway to Dr. Reitan began when I was a psychometrist, working in the psychology department at Hamilton Psychiatric Hospital. Among other tasks, I was often asked to conduct psychological examinations with the goal of differentiating between “organic” or “functional” disorders in the patients referred to our department. This was generally accomplished with instruments such as the WAIS, Bender Gestalt, etc. One day while in the supply cupboard, I noticed a large grey box with a screen and numbered levers on the front. There was also a triangular box with odd shapes within, as well as other instruments that caught my attention. Psychologist Dr. Jean Wallace, kindly agreed to introduce me to these measures, using me as a test subject, further fuelling my curiosity. Coincidentally, a psychologist, Dr. Ray Daly from the University of Windsor, gave a lecture on epilepsy. That institution was added to my list of graduate programs that might fulfill my wish for further clinical training and additional education about neuropsychology. The late Dr. Byron Rourke was establishing a clinical neuropsychology curriculum at the University of Windsor and accepted me into the program and as my mentor, guided me throughout my studies there. I learned much more about those funny boxes in the cupboard and also was introduced to the person primarily responsible for their development and validation.

My first meeting with Dr. Reitan occurred at the APA convention in Montréal and, as was typical of Ralph and Byron, occurred in a fine restaurant. My initial offering to the conversation was an observation that I had recently seen a shirtless bagpiper who seemed to me to have “an extra set of muscles on his chest.” Ralph’s comment was to the effect of having never seen “extra chest muscles” in any of his anatomical studies. This was my first lesson learned—this man does not suffer fools gladly! It also served as my initiation to increased precision and conciseness in the use of language in communication whether that be casual conversation, teaching, or writing.

The rationale and methodology associated with the development and validation of the Halstead–Reitan Neuropsychological Test Battery has been well documented elsewhere in this edition. As a student, I recall his emphasis on empirical validation. During one seminar, the question of the Seashore Rhythm Test as an indicator of right hemisphere dysfunction was raised. Ralph’s response was an instruction to search the literature, as there we would find evidence that the performance of patients with vascular disease involving either the left or right hemispheres did not differ on this test. While there might be theoretical reasons for considering the role of the right hemisphere in music, it was not the case for this particular instrument. In a similar vein, a comment about the lengthy time required to administer the Category Test lead my colleagues Dr. Alfano, John Sullivan, and I to empirically examine the question. Our findings, based on two independent samples, indicated far less time is required than postulated. Furthermore, the mean Category Test scores for the patient samples were highly similar to those published by Dr. Reitan. This same approach to science was evident in a discussion of the methodology and work of Professor Luria. While it was clear to me that Ralph was impressed by Professor Luria’s findings and clinical intuition, he also expressed concern about the manner in which that methodology could be taught or studied. Sound methodology and standardized procedures were central to his teaching. It was critical that as examiners we knew both the tests and instructions sufficiently well that most of our attention could be directed toward observing actual performance. I recall one training session in which Ralph was serving as the patient and managed to contort his face in such a manner that he was able to see over the blindfold, while the student examiner was busy with the test manual. However, standardized procedures did not mean merely repeating the instructions. It was important for the examiner to ensure that the subject or patient was aware of the task requirements so that failure could be attributed to ability rather than misunderstanding.
Clinical interpretation has been discussed by other contributors. In the interpretation sessions and workshops, blind interpretation was emphasized. As students, we were presented information regarding sex and age along with the test findings, including drawings, from the examination. The emphasis was on predicting such neurological variables as location, type, and status of the brain lesion. It was also important to be able to say something meaningful about the person who was the subject of the examination. These were both difficult tasks. Additionally, the interpretation was guided by determining the level of impairment on individual procedures and considering them within the context of right hemisphere, left hemisphere, or more general brain functions. This could then lead to considerations of input/output differences and other patterns of performance that could help define the clinical picture. The complexity of this interaction became clear to me in one seminar when the question of how to determine a good drawing of a cross from a poor one. Ralph’s initial response to this question was “I do not know.” Following a brief pause, he indicated that drawings in the test manuals could be used for guidelines, but it was also important to consider that particular finding in the context of other measures from the test battery. The subsequent development of the GNDS (the General Neuropsychological Deficit Scale) would assist in this process.

An outgrowth of this approach to the measurement and understanding of the complex, interactive nature of brain functioning was a development of a rehabilitation strategy known as REHABIT (Reitan Evaluation of Hemispheric Abilities and Brain Improvement Training), the name rumored to have been created by a graduate student. Specific tasks were selected to comprise five procedural tracks labeled, A, B, C, D, E. Track A represented basic input and output verbal functions, while Track B is composed of such verbal functions involving increased abstraction and conceptualization. Similarly, Track E represents basic input and output components of visual and spatial abilities and Track D contains similar measures but with increased complexity. Track C is composed of procedures reflecting more complex, general brain functions involving conceptual and logical thinking and reasoning.

REHABIT has been described as a program “designed to restore the individual’s functional ability structure.” Rather than targeting functional abilities, it is most likely that cognitive ability and cognitive function is addressed in this and other similar interventions. While there has been some evidence of improvement with this and other remedial programs on basic cognitive skills, there is little evidence for the generalization of such procedures to functional or real-life abilities. Without diminishing the role of cognitive factors in the successful completion of activities of daily living, other psychological factors including mood, self-acceptance, and social engagement are also known to determine successful rehabilitation outcome. This has led many neuropsychologists and rehabilitation psychologists to develop intervention strategies directly addressing functional behaviors. The success of rehabilitation programs can also be enhanced through the modification of societal perceptions and expectations of individuals living with a disability as well as the modification or removal of environmental barriers that reduce an individual’s opportunity to maximize his or her abilities.

Dr. Reitan’s contribution to the field of neuropsychology cannot be underestimated. He shared his knowledge and experience generously through teaching, seminars, workshops, and in print. His contributions to scientific journals were prolific; however, he always seemed reluctant to write textbooks. He attributed this to his belief that only toward the end of your career has sufficient knowledge and experience been accumulated to say something meaningful. Fortunately for our field, Dr. Wolfson joined his lab and encouraged him and collaborated with him in the compilation of this body of knowledge and clinical and scientific procedures. This was helpful to him as he occasionally thought that he might be known as only as the creator of a test battery. Instead, his legacy is assured.

Dr. Reitan’s contribution to my own career cannot be underestimated either. Not only did he share scientific and clinical knowledge and methods, but also he spoke of life values. A significant lesson for me was discovering the hard work necessary to balance competing values and interests in order to lead a meaningful and purposeful life. He was a generous man and provided ready access to yet to be completed projects for interested students in order that they might develop further methodological and writing skills and publish works of scientific merit. He enjoyed humor, and I can still recall his laughter when, during a tour of his home, my wife observed stacks of triangular-shaped boxes with round holes and asked him how long he had been interested in birds.

Conflict of Interest

None.