Notes on the Uses of the HOD In Clinical and Other Situations

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Psychiatry has very few simple formal tests which are widely used and understood and whose value and worth are universally accepted. This is a misfortune. One has only to imagine practicing medicine without a thermometer, a timed quantitative pulse, blood pressure apparatus, and stethoscope. With these three quantitative and one qualitative measures combined with history taking and careful observation of the patient's immediate condition and a complete physical examination, many useful conclusions can be reached. Lacking such instruments, psychiatry is in very much the position of internal medicine in the 1840's which, as Sir Charles Newman noted in his history of Medical Education, was most unsatisfactory. The HOD is a crude, simple quantified test whose virtue and limitations have to be fully understood before its usefulness can be fully appreciated. It was developed only because in a series of expensive, controlled studies lasting several years the available tests of that time (1957 - 1960) had been found of little scientific and no clinical use.

Our knowledge of narratives written by mentally ill people of which Robert Sommer and I had made one of the first systematic studies, our studies of the perceptions of the mentally ill of which Sommer and Weckowicz's work are examples, and our extensive knowledge of hallucinogens, combined with our belief that mentally ill people wanted to tell us what was wrong, allowed us to make the initial steps. The HOD differs from other tests because it is aimed in a different direction. Had our aim been mistaken, so crude a test could not have competed with, let alone excelled, the many elegant and carefully designed tests in use. This does not, of course, prove that our aim was necessarily correct. It is possible that we hit the bull's eye in spite of our aim. I do not think so, but it is possible.

The HOD consists of 145 cards, two boxes labelled True and False, plus the necessary score forms, keys, manual, etc. What does it do? It takes most patients, even very ill ones, no more than 15 minutes to do the test. It must be explained that since this is **not** an intelligence test there are no "correct" answers. There is no time limit. We are inviting the patient to give us a window on his or her experience to increase our joint understanding of his or her affairs. Very few patients refuse, and it seems few fake. The patient is always asked to do the test as he or she feels now.

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The First Use of the HOD

This is to give us *a* rough map of our patients' current condition now. Scoring takes 5-10 minutes, depending on the detail one requires and the skill of the scorer.

A. **The Total Score** gives one a quick though rough and ready assessment of the patient's current condition. Anything over 40 in adults is suspicious and scores over 50 always call for careful scrutiny.

B. **The Depression Score** with a ceiling of 18 gives one a clear and frequently surprising insight into the patient's affective state.

C. **The Ratio Score** (Total Score divided by Depression Score) is frequently associated with schizophrenia if over 5.

D. **The Paranoid Score** with a ceiling of 15 is valuable in deciding just how suspicious the patient may currently be.

E **Perceptual Scores and Subscores** give much valuable information about the patient's experiences.

F. **Cards 82-101** show the degree to which formal thinking is intact. The highest score is 15; scores below 5 suggest well-preserved thinking.

G. **The Special Cards** — 76 shows the presence of insight, when true. 106, 107 suggest severe depression. 131, 145 suggest failure in self perception. 143 shows belief that others hate the testee. It is evident that if card 76 is scored false and the others are scored true, suicide should be inquired into. If 76 is scored false**,** 143 true, and the paranoid score is high — say 8 or over, one might be well-advised to inquire about homicide. The first use of the test is to give one a rapid, simplified "map" of the patient's current experience.

Retrospective Use at or Before Initial Interview

I frequently have a second HOD set on hand, and while I'm scoring the first, I ask the patient to do this test "as if you were at your very worst." Most set to with zeal, and I am thus able in about half an hour not only to gauge the patient's present condition but to relate it to his illness more generally. This is often vitally important.

Who Can Give the Test?

A. Psychiatrist

B. Psychologist

C. Nurse, technician, attendant, or aide.

D. Secretary

E. Social worker

F. Family member

Who Can Score the Test?

At a pinch, any of the above. In my experience, nurses and secretaries are very adept.

Who Can Assess the Test?

Any professional person can learn to assess the results within the limits of his or her expertise**.** I mean by this that, while a psychiatrist and a psychologist would most usefully relate the findings to diagnostic and prognostic categories, it seems likely that nurses would be better able to note their relevance toward behavior and social workers to home and employment behavior. NB:

It should be noted that outside psychiatry a number of general practitioners and internists find the HOD of much use in their practices. They score the test themselves and use it as a basis for referral.

The HOD and Diagnosis

Several studies have already shown that the HOD is a useful and rapid diagnostic instrument. Dr. Hawkins' study suggests that its diagnosis approximates more closely, more often, to the final diagnosis than the diagnosis at the first interview. Speed of diagnosis is often as important as accuracy, so that when the two can be combined economically great advantage accrues to everyone.

Measuring Response to Treatment

Several studies have shown that the HOD is an effective way of measuring response to treatment. In patients who have either been discharged from hospital to become outpatients or have never been in hospital, it is often possible to head off relapse or detect failure to use medication by means of the HOD. Unfavorable as well as favorable responses to treatment are shown well.

Prognosis

Since the amount of improvement obtained from a particular treatment and sustained for a particular length of time can be very easily measured with the HOD, it becomes possible to extrapolate from several HOD findings towards normal scores. For instance, if someone has a HOD score of 100 which after 3 months has dropped to 70, it becomes reasonable to predict that, if the patient continues to follow his physician's advice for another three months, he will be very nearly well. This encourages the patient to continue with treatment and may itself speed recovery. Other studies have shown that patients who leave hospital with unstable perception, however cheerful they and their relatives may feel, are far more likely to return to hospital within the next year. The patient who knows how far he or she is recovered and what dangers still exist is far more likely to be prudent and continue treatment than one who does not.

The HOD and the Family

The HOD can play an invaluable part in letting the patient's family know just how ill he or she has been. The fact that the illness has been "measured" and is known to be a "real" illness frequently results in far better cooperation from family members than those sermons and admonitions which our colleagues choose to indulge in. The family are much more likely to heed professional advice when they are sure that they are up against a "real" and not an "imaginary" illness. One hallmark of a real illness is that it can be measured.

Of particular importance today, when many professionals follow theories which involve accusations of a harsh kind against family members, is to see how many of them are in fact themselves ill. The HOD can be used very conveniently to do just this. Puzzling cases where spouses claim that the other is psychotic can often very quickly be resolved, with great benefit to everyone involved and at modest expense.

When progress is occurring slowly, family morale can be maintained by showing that it is occurring at all.

HOD and Counselling

Two recent papers have shown that in school and other counselling the HOD can be very helpful in assisting counselors to seek psychiatric advice early rather than late. Much time can be expended and efforts wasted "counselling" those who require immediate psychiatric treatment. Thus counselled and counselors alike are saved much anguish and disappointment.

HOD and Psychedelics

It is not surprising that some, and if our experience is a sample which is representative, many fairly ill young people believe that a "trip" will help them get rid of "hang-ups". If they already have many perceptual anomalies, the odds are against a trip helping; indeed, it may well do harm. If the HOD was available to young people many would desist if the matter was presented without rancor and punitiveness, especially if another and more effective course was suggested.

Those who have had "bad trips" frequently believe that another trip is the answer to break through the hang-ups. This is a mistake. The odds are in favor of another bad trip, especially if perceptual anomalies have persisted after the original trip or if they predated it. The HOD is simple enough to be used to intercept and head off many of these potential misfortunes in an inconspicuous way.

HOD Medico-Legal and Penological Problems

The HOD has been used in a number of cases in Saskatchewan where the judges and lawyers find that it makes very good sense. It is easy for judges, lawyers, and jurymen to grasp the idea that an accused might have extensive malperceptions. This is something from which most people do not suffer frequently. On the other hand, most psychodynamic formulations are exaggerations or distortions of universal experiences, at least so their discoverers have usually claimed. Judges, lawyers, and jurymen, being humans who have lived some time, have doubtless had some rough knocks themselves, and since they have not committed grave crimes (or at least not been arraigned for them), a defense based on earlier misfortune frequently arouses hostility rather than sympathy. Many psychiatrists and psychologists seem unaware of this and, as in the case of Sirhan Sirhan, put up an extensive, long-winded, and often fatal defense. Very often the court would be far less unfavorably disposed to a simple and straightforward account of illness backed by evidence.

Prisons contain an unknown number of psychotic offenders either awaiting trial or already sentenced. These unfortunates are usually a nuisance and sometimes a danger to others, though more often to themselves. A recent HOD study at the Federal Penitentiary, Prince Albert, Saskatchewan, Canada, showed that, from the 12 men rated by the warders as the most unpleasant in the prison, nine scored over 60 on the HOD, two scored under 30, and one could not complete the test and seemed to be catatonic. Only one man thought he might be ill. The warders said these men were the equivalent of 50 normal prisoners in nuisance value. Most penologists believe that about 10 percent of their inmates are psychotic. A good deal of misfortune might be saved by picking them up early.

The HOD in Medicine, Surgery, and Obstetrics

This is an age when a great number of complex procedures are undertaken involving physiological, biochemical, and often anatomical changes accompanied by the use of a great variety of pharmacological substance, and many of them have secondary and some primary effects on perception. It may be vitally important, indeed life preserving, to know when these exist to counter their effects or provide for them some other way. While there are many examples, some obvious ones are:

1. Pre- and postoperative HODs to check minor and major misperceptions.
2. Effects of steroid hormones, not infrequently associated with psychological changes.
3. Effects of long incarceration in casts following severe physical injury.
4. Puerperal psychoses — a great variety of these occur in several forms. I especially recall a young woman in Saskatchewan who became very suspicious and seclusive. Unknown to her doctor she had become convinced that her child was some kind of changeling who looked like a pig. She bashed this monster's brains out, but to everyone else it seemed that she had killed a lovely child. This disaster could have been easily avoided had her doctor had an instrument like the HOD. The doctor was sensible, observant man but had no instrument which told him, "How ill?"
5. Monitoring effects of many brain-stimulating substances used for unlikely purposes such as weight loss, antimalarials, a great variety of atropine-like substances, etc.
6. Studying psychological changes in menstruation and in the premenstrual period. From a small EWI study and reports from our colleagues who use the HOD, there is

evidence that a proportion of women, perhaps one-fifth or one-sixth, suffer from changes of both mood and perception during the premenstrual and menstrual state. This has many implications and allows one to consider both the consequences of these changes in any particular woman and the possibilities for preventing them by various means. There is some evidence that women are involved in more crimes and accidents during the premenstrual phase. It also seems that some schizophrenic women are more disturbed during this period.

The HOD and Alcoholism, Narcotics Addiction

A proportion of alcoholics and narcotics addicts, as yet the size of this is unclear, suffer from what seems to be clinical schizophrenia which they are "treating" in this expensive, unorthodox, and dangerous manner.

These cases are far better treated first as schizophrenics. Their alcoholism or narcotics addiction must be treated, too, but with the disappearance of the schizophrenia this frequently becomes much easier and more effective.

The HOD and Driving Accidents

There is much evidence that some people are far more likely to be involved in driving accidents than others. We have clinical evidence that many schizophrenic patients have very peculiar changes of perception when driving or being driven. The evidence from those who have taken psychedelics supports this and suggests that it is frequently due to a breakdown in constancy of perception, resulting in a failure to relate size, distance, and time accurately enough to ensure safety on the road. Bernard Aaronson has produced striking evidence of the existence of these changes in his posthypnotic studies. Inquiries with the help of a Motor Vehicle Authority should be very valuable and likely to save lives. One would naturally consider flying to be a similar hazard and especially skin diving with its peculiarities of oxygen supply and pressure. It would seem hazardous for anyone afflicted by inconstancy in the perception of time or space to undertake these activities. It is certain, however, that thousands do, to the peril of themselves and others.

The HOD and Psychotherapy

While not underestimating the value of psychotherapy, in my experience Freud and Federn were not mistaken in supposing that "uncovering" therapy rarely helped those with schizophrenia. The evidence today supports Freud and Federn, and their findings simply supported the earlier formulations of those who used the moral treatment. It should be evident that psychotherapy undertaken with single patients or in groups in which the ill people involved are subject to unknown and unpredictable malperceptions is likely to be an uncertain business, liable to do as much harm as good. The experience of the last 30 years bears this out. The effort to employ psychotherapy with schizophrenic people has been prodigious, and a tribute to our persistence. Since psychotherapy has, as its basis, a learned relationship involving a greater understanding by the ill person of what is "real" and what is not, it is difficult to believe that much useful information will be learned when the learner's perceptions are more or less distorted. It is of considerable interest that those psychotherapies which do seem to have been at least not harmful to schizophrenics have been those that emphasize the simple realities and actualities of the world. The moral treatment, the most successful of these, dealt largely with encouraging good behavior in the sick by according them the sick role and relating to them appropriately. The currently fashionable behavioral therapy uses an updated variation on this theme with, it seems, about the same kind of success. There is good reason to suppose, from their writings and from discussions with those who have been ill and suffered grave malperceptions, that

many mentally ill people do indeed require psychotherapy after their perceptions have been stabilized. Once this has happened, psychotherapy is effective and can be directed appropriately, thus taking a shorter time than when perceptions are unstable.

HOD and Teaching Professionals

Psychiatrists and psychologists, people of wide experience, who have used the HOD, have frequently remarked that they were much surprised to discover the extent of the perceptual anomalies found in their patients. It is clear from a careful examination of the HOD (and similar) test findings that we are still ignorant about the experience of many of our patients. This ignorance results in our being able to understand their behavior less than we should; and so less able to give useful advice. Such ignorance can be remedied by having the HOD test taught early in their career to young psychiatrists and psychologists, so giving them a common ground for discussion. It should be possible, after interviewing, observing, and testing patients, for novice psychologists to do the HOD test as if they were a particular patient. Clearly, if their clinical studies had given them a perfect understanding of their patient's experience, they would be able to do a HOD test which would exactly correspond with that done by their particular patient. Once the importance of the patient's experiential world is grasped, techniques for diagnosis, treatment, and aftercare can be related to the HOD findings in a rational manner.

The HOD proves a useful bridge between, psychiatric and psychological procedures and the technical languages which the two disciplines use. HOD findings can be related easily to tests such as the Rorschach, the MMPI, the Bender Gestalt, Association Tests, etc.

HOD, EWI, and PIQ

The two latter tests derive from the same principles as the HOD and can be used to explore areas of experience only modestly represented in the HOD. It seems likely that other experiential tests will be developed, and are most likely to be used by psychologists for answering questions which, as a result of the older tests, can now be asked and must be answered. In my opinion, the HOD is an ideal introduction to the EWI, etc., because its use can be learned so quickly and because the user learns almost automatically the basic principles underlying this kind of quantification of experience. The HOD user learns by doing and from the start obtains useful and sometimes vital information.

Limitations of the HOD

Although a valuable and for me now an indispensable tool, the HOD is crude, limited, and has many obvious shortcomings. It can be refined, elaborated, and improved in a great variety of ways. It may be that its self-evident limitations are much to its credit. No one in his senses will try, as has been done with other tests, to turn it into an instrument for the study of normal personality for which it is not intended and would be wholly unsuitable.