

# The Use of The Hoffer-Osmond Diagnostic Test (H.O.D.) in Relationship to Hypnosis

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## Abstract

*The original purpose of the Hoffer-Osmond Diagnostic test (H.O.D.) was to help differentiate schizophrenic patients.*

*This paper aims to outline the basic structure of the H.O.D.; secondly to illustrate the need for the therapist to utilize the H.O.D. as part of the diagnostic procedures prior to Hypnosis and, thirdly, to suggest treatments to use in reducing the H.O.D. scores.*

## The Purpose and Structure of the H.O.D.

During the course of time, medicine and psychology have progressed through trial and error to today's sophisticated array of tests and procedures aimed at establishing diagnosis and prognosis. The tests enable the therapist to understand the patient's problems and/or distress and to treat them in a logical and effective manner, thereby saving the patient distress, time and expense.

The Hoffer and Osmond Diagnostic Test, known as the H.O.D., was developed primarily for the purpose of differentiating between schizophrenic and non-schizophrenic patients. The status of the H.O.D. in psychiatry may become similar to the use of the clinical thermometer in medicine.<sup>1</sup> Furthermore, Hoffer in his

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writings on the H.O.D. scores and Clinical Description of Patients has stated that the H.O.D. will reflect the course of the illness much as temperature will record the progress of fever producing diseases.<sup>2</sup> In addition it has been found that the test may be used to measure changes in perception, mood, thought disturbances, visual, auditory, olfactory, touch, taste and time perception.<sup>3</sup> The H.O.D. may assist the therapist to assess the psyche in much the same manner as the E.C.G. test gives an indication of Cardiac Function.<sup>4</sup> Hoffer and Osmond believed that it was essential to develop a test that was little affected by intelligence, would not attempt to measure personality, and would be as free of cultural/religious bias as possible.<sup>5</sup>

Hoffer and Osmond further maintained that an ideal diagnostic test for general clinical use in the identification and treatment of schizophrenia should have the following characteristics:

1. It should be easily administered and should not require either a psychologist or a psychiatrist to give it.
2. It should be scored simply and objectively with complete reliability between scores.
3. It must make complete separation between normal subjects and schizophrenic patients.
4. It should measure the severity of the illness quantitatively.
5. It should be applicable to most people — over 90%.
6. It should have little relationship to intelligence between an IQ of 90 and 130.

7. It should yield reliable re-test scores when administered again after there has been little clinical change.
8. It should have some built-in measure of the consistency of response.<sup>6</sup>

In order to understand and gain knowledge of the world of the schizophrenic, research was conducted in four main areas:

1. The study of case histories and records.
2. The reading of auto-biographies of mentally ill people.
3. The direct examination of patients and the discussion with patients who had recovered.
4. The temporary living in the world of the schizophrenic (over two hundred volunteers took a variety of substances such as L.S.D. and Mescaline)<sup>7</sup>.

From this body of knowledge one hundred and forty-five questions were prepared in 1960 and first published in 1961, as the H.O.D.<sup>8</sup>.

"The H.O.D. does not yet meet all these exacting requirements, but it comes close to most of them."<sup>9</sup> It was suggested that the True - False basis of questioning is a very simple method of identifying a perceptual distress of a degree of paranoia or depression, in much the same way for example that you could identify diabetes by asking on a True - False basis,"e.g.

1. Are you excessively hungry?
2. Are you losing weight?
3. Are you passing more urine?
4. Are you excessively thirsty?"<sup>10</sup>

The use of Hypnosis in the treatment of stress-related conditions has increased dramatically during the past few years. Therapists receiving training in the use of Hypnosis as an adjunct to their existing skills need not necessarily hold a full degree in Psychology or Medicine. It is essential, therefore, that accurate diagnostic procedures be available to them.

With full understanding and practical experience, the therapist may use the H.O.D. to assist in the identification of not only schizophrenia, but psychosis in general, whether

it be manic depression, paranoia or a toxic or organic psychosis. In some cases, the degrees of depression being suffered by the client may be useful in terms of identifying reactive depression or an endogenous state. If it is the intention of the therapist to use hypnosis as part of a treatment procedure then this particular area is of great importance. Because of the ease of application, the H.O.D. may be administered not only by Psychiatrists, Psychologists, and Doctors, but also Hypnotherapists, Naturopaths, Chiropractors, Social Workers, Dentists. The H.O.D. covers many areas - visual, auditory, taste, tactile, olfactory, time perceptions, thought processes, affect or mood of the individual, and consists of 145 statements<sup>11</sup>. The client is requested to answer True or False to each statement in relation to how he/she *feels that day*.<sup>12</sup>

It may sometimes assist the client to know that all the therapist is interested in, *at this stage*, is not why *he/she feels or thinks the way he/she does*, but just that he/she identifies with the statements. It may be reassuring for the client to be told that the therapist is, *for the present*, interested only in the "Number" references on the back of the cards. Initially, the client if not reassured may deny the existence of a perceptual disorder. Denial or embarrassment may sometimes be avoided if the client reads the statements privately without the presence of family or friends. Additional assistance may be given to the client if he/she is advised that the H.O.D. does not study intelligence or personality; that there are no right or wrong answers, or time limit, explaining to the testee that the test gives "us a window on their experience", which enables us to "increase our joint understanding of how they perceive the world."<sup>13</sup>

The test is separated into eight sections.

**Total Score** has three sections of different weighting which provide "an overall assessment of the patient's condition".<sup>14</sup> Cut off score for 18 years and over is 30 points. Total possible score is 243 points.<sup>15</sup> (The cut off score is related to

total points scored after answering the questions. Below the cut off score people are generally regarded to be non-schizophrenic. Higher than cut off score indicates the possibility of schizophrenia.)

**Perceptual Score** covers "visual, auditory, tactile, taste and time perception".<sup>16</sup> Cut off score for 18 years and over is 3 points. Total possible score 53 points<sup>17</sup>. If scores are high, a person's ability to understand a given situation may be distorted and hypnosis is contra-indicated.

**Paranoid Score** covers levels of suspicion. If the score is high, difficulty in interpersonal relationships may be experienced, and hypnosis is contraindicated<sup>18</sup>. Cut off score for 21 years and over is 2 points. Total possible score 15 points<sup>19</sup>.

**Depression Score** covers "insight into the patient's affective state", and is "meaningful in terms of its relationship to the total score in helping to estimate the risk of suicide and indicates specific treatment, for example, the use of antidepressant"<sup>20</sup> or if using Orthomolecular treatment, the amino-acid L-Tryptophan. If score is high and used in conjunction with a Phobic-Anxiety questionnaire assessment, added information may be gained, especially if hypnosis is requested. *Hypnosis is contra-indicated* if scores are high. Cut off score 3, 18 years and over. Total possible score 18 points<sup>21</sup>.

**Ratio Score** is gained by dividing the depression score into the Total Score<sup>22</sup>. "Schizophrenia may be regarded as primarily a disease of perception and thinking, with affect being appropriate to the degree of perceptual and thought disturbance. Psychotic and Neurotic depression, on the other hand, with relatively little perceptual and thought disturbance, but with considerable mood changes, are regarded as having mood that is not appropriate to their relatively minor perceptual-thought changes."<sup>23</sup> However, much added research is needed in this area and until that has been completed it would appear that the main use of the Ratio Score is in psychiatric hospitals dealing specifically with

schizophrenia.

**Short Form Score** is made of 17 items "useful as a short emergency scale when time does not permit the administration of the full test."<sup>24</sup> Differentiates between schizophrenic and non-schizophrenic patients. However, it is possible to have a low Short Form, possible score 17 points and still be hypoglycemic or alcoholic. Additional tests can be done using a hypoglycemia questionnaire chart and phobic anxiety questionnaire test to determine the degree of distress, especially if the other H.O.D. scores are positive. Hypnosis is contra-indicated if the short form score is high<sup>25</sup>. Initially the cut off score was 1 for the Short Form. However, there is growing acceptance that in fact the cut off score should be 2 - 3. This varies of course with the age of the client and additional research is being conducted in this area. All the above cut off scores are considerably higher for 17 years and younger<sup>26</sup>. In addition, pre-menstrual tension (P.M.T.) must be taken into account when considering females<sup>27</sup>.

#### **Using the H.O.D. as a Diagnostic Procedure Prior to Hypnosis.**

Because hypnotherapy is generally contra-indicated when the client is believed to be suffering from schizophrenia, manic depression or in fact any form of psychosis, an accurate diagnostic procedure must be adopted to determine an overall assessment of the client. Primarily formulated to assist in identifying and monitoring the schizophrenic patient, additional use of the H.O.D. has shown that considerable assistance to therapists outside the psychiatric profession can be gained<sup>28</sup>. For a Hypnotherapist, it is essential that accurate diagnosis be the fundamental and primary objective in the initial assessment. By using the H.O.D. as a diagnostic tool this complicated procedure of initial diagnosis becomes relatively straightforward. If psychosis is suspected, a referral must be made to the appropriate therapist if the hypnotherapist is not qualified in the field of psychosis.

However the diagnosis that has been initially determined by the therapist may in

reality be incorrect, because, if Sub-Clinical - Pellagra (B3 deficiency) and Schizophrenia (B3 dependency) are identical Orthomolecular diseases<sup>29</sup> and, if hypoglycemia can masquerade as a hundred or more physical diseases, ranging from epilepsy to obesity, and has been misdiagnosed as neurosis through to psychosis<sup>30</sup>, it is essential to make sure that any possibility of toxic or organic psychosis has been eliminated. The H.O.D. enables the therapist to estimate quickly the client's state of development in the illness, be it improvement or regression. The H.O.D. is a tool of measurement allowing client and therapist to monitor visually the rate of progress. This is very useful as it tends to give the client a sense of achievement and well being, so conducive to healing. As well as accurately determining the degree of improvement, the test is also used to detect the recurrence or beginning of a relapse<sup>31</sup>. Passive aggression may sometimes be overcome by the use of the H.O.D., mainly because so many questions covering a diversified area have been asked. Many times a comment is made by a client that, "he didn't tell the therapist about the voices he was hearing because the therapist didn't ask"!<sup>32</sup> It is recommended that the perceptual disturbance of the client should be monitored before there is any involvement in group activities, such as interpersonal growth workshops, sensory awareness groups, psychotherapy or behavior modification programmes. Clients with high perceptual scores and total scores of 80 and above should be advised not to participate. The client's perceptual distress, thought and mood disturbance would make it difficult for him/her to cope with relationships, be they social or group, because of the distortion of time, space, self and other perceptions<sup>33</sup>.

Great care must also be used in establishing the contributing effect that alcoholism has in the overall score of the client's H.O.D. It is unwise to accept the first answer from the client with regard to the quantity of alcohol that has been consumed. If scores are high, the wise therapist always probes for more details.

Alcoholism is one of today's major health problems.

Robert L. Meiers maintains that as 95% of alcoholics are hypoglycemic<sup>34</sup>, it is therefore not the alcoholism *exclusively* that requires treatment, but rather the possible underlying cause of alcoholism such as Hypoglycemia. The H.O.D. will not identify the particular toxin causing an elevation of scores but will determine when a toxic state is present.

The H.O.D. should be used if it is considered the client is depressed or his/her behaviour and reactions to a given situation are not appropriate. Care must be taken (when assessing the client's case history and the H.O.D. results) that religious beliefs are taken into account. Many spiritualists, for example, may indicate True to Statement No. 33 "I often hear or have heard voices" or No. 7 "Most people have haloes (areas of brightness) around their heads."<sup>35</sup> The reason for this may be because of their spiritual beliefs rather than because they have a perceptual imbalance.

After the therapist has commenced treatment, the tests are used as a tool of measurement<sup>36</sup>. For example, if dealing with a high depression score, behavior modification may commence when the scores return to an acceptable level. Sub-Clinical Pellagra (S.C.P.), which normally identifies with high Short Form and high Perceptual Scores, would require the stabilizing of the B3 deficiency and would require the perceptual disorder to reduce before any therapy of an hypnotic nature could commence. The improvement or otherwise would be accurately assessed by the client repeating the tests, and it is recommended that this be done every seven days initially.

Denial or faking may occur. However, this may normally be overcome by discussing with the client the reasons why he/she needs the tests. Furthermore, after these tests have been completed it may be helpful in some cases to discuss the reasons behind a statement answered True.

The H.O.D. Question 82 - 101 (sometimes known as the 'H' items) may

also indicate whether the test is correct<sup>37</sup> and clearly understood and answered honestly by the client.

"A subject making a consistent functional classification would answer the odd numbered items True and even numbered ones False. A consistent visual classification would be one in which all the numbered items are answered False, and the even numbered ones True. These items may therefore be used to provide information about the nature and consistency of the patient's thinking. It has also been suggested that these items may be used to uncover possible faking or denial behavior, although no systematic study of this has yet been made"<sup>38</sup>.

In some cases, after treatment has commenced, the second H.O.D. scores may increase rather than decrease. If this occurs, the client ought to be asked to score his/her improvement on a scale 0-10, zero indicating the way he/she felt the previous week and ten indicating 100% well. The client is requested to identify an improvement or reversal at both the physical and emotional levels. Occasionally it has been found that the client's perception has improved, thereby allowing a deeper understanding of the statements.

It is interesting to note when the improvement does commence whether the improvement is in the physical or emotional areas. In a study of characteristics of physical and emotional suggestibility it was suggested that, "the emotional somnambulist (100% emotional) responds with the same intensity to suggestions affecting his behaviour as the physical somnambulist (100% physical) responds to suggestions relating to his physical body, but his reactions are not as immediately obvious"<sup>39</sup>. One may ask the question, does this difference of response also indicate why hypoglycemics respond in different degrees and in various areas? Research may identify whether or not the client's physical or emotional personality prior to treatment of hypoglycemia has any relevance.

An additional benefit for the therapist using the H.O.D. is to help overcome the client's embarrassment in admitting certain perceptual disorders, especially when dealing with the

visual symptoms of Sub-Clinical Pellagra<sup>40</sup>. The test may be administered quickly, taking approximately twenty minutes. Passive aggression is also a factor that must be taken into consideration, but may in some cases be eliminated because so many questions are asked which could normally be outside the time factor for a consultation if verbally asked<sup>41</sup>.

### **Suggested Treatment Used to Reduce the H.O.D. Scores**

Many eminent medical specialists throughout the world are still in the process of evaluating the Orthomolecular approach to both psychosis and neurosis and much additional research needs to be conducted in this area of medicine. It is interesting to note that Salzer (1966) observed "Relative hypoglycemia is a clinical syndrome in which patients develop systems referable to any system of the body as a result of a relative drop in the blood sugar level in response to a high carbohydrate intake and/or stimulants such as caffeine. This condition which was first described by Harris (1924), has been referred to as functional hyperinsulinism, functional hypoglycemia, neurogenic hypoglycemia, idiopathic hypoglycemia, benign hypoglycemia, functional hypoadrenal corticism, and reactive hypoglycemia"<sup>42</sup>. "Many factors have been identified that influence the blood glucose level, including diet, alcohol consumption, stimulants, the gastric secretion of insulin-stimulating hormones, glucose absorption rate from the intestinal tract, the liver's ability to store and convert glucose as well as release it, the pancreas' rate of producing insulin and glucagon, the human adrenal's capacity to produce adrenalin and glucosteroids, the thyroid, human growth hormone, central glucose regulating centers in the emotions acting through the higher cerebral structures on the regulating centers".<sup>43</sup>

In other words "at any given time the blood glucose level is the result of many complex factors."<sup>44</sup> In 1977 it was suggested that in excess of fifty million Americans in varying degrees of severity

suffer from this "insidious and tragic disorder".<sup>45</sup>

It would be interesting to know in terms of today's society what that figure or percentage of population would be now. Additionally, it has been suggested that, "provided you can get your physician to do the proper testing the chance of a proper diagnosis is about 5%."<sup>46</sup>

Additionally Sub-Clinical Pellagra (border line Pellagra) according to Hoffer and others is "a deficiency syndrome characterized by the presence of perceptual changes involving any or all of the special and proprioceptive senses plus an unusual sensitivity to refined carbohydrate which results in neurasthenia. It is due to a deficiency of, or increased demands for niacin, the administration of which causes prompt disappearances of the perceptual changes. The neurasthenia is improved slowly by restricting refined carbohydrates combined with megavitamin therapy"<sup>47</sup>. In other words, it is a disease of nutritional origin resulting from too little niacin in the diet.

Adolescent behavior problems, schizophrenia and alcoholism as a possible result of that deficiency could produce symptoms of mental disability, hyperactivity in children, insomnia, drug addiction, senility, heart disorders, arthritis and many other complications. Presenting problems cover an even wider range of complaints, headaches, earaches, throat complaints, chest pains, heart distress, G.I. tract, locomotor system, somatic complaints, fatigue, sleep disturbances, temper, forget-fulness, psychic complaints, perceptual changes, visual distress, tactile dyspercep-tion, olfactory and gustatory<sup>48</sup>. It has been suggested that Sub-Clinical Pellagra and hypoglycemia could be called the great imitators in Medicine<sup>49</sup>.

In conclusion, whether the treatment used to reduce the H.O.D. scores is drug or Orthomolecular therapy or a combination of both, great care must be taken to monitor the diet of the client. As time progresses and more is learned of the complicated and interrelating symptoms within the mind and body, no doubt this long discussed conflict relating to alternatives and additions to drug therapy will be resolved. As stated previously the H.O.D. will

not "identify the particular toxin causing an elevation in scores, but it will help determine when a toxic state is present."<sup>50</sup> In such cases scores will reduce quickly if the toxic substance is removed,<sup>51</sup> or if the necessary drug/orthomolecular treatment is commenced. The weight, height, age and sex of the client must also be taken into consideration when determining the method of treatment.

## Summary

Because hypnosis is generally contraindicated when psychosis symptoms of any description are evident or when depression is high, it is essential that hypnotherapists become proficient in the understanding and the use of the H.O.D. Such use of the H.O.D. permits the therapists to devote his/her energies to the illness rather than to the diagnosis, and enables the thoughtful therapist to monitor more accurately the clients' progress especially when dealing with Sub-Clinical Pellagra-type symptoms and/or hypoglycemia. The test enables the therapist to assess the client accurately and effectively, and if necessary refer the client to a more appropriate therapist. As a diagnostic tool the H.O.D. enhances the ability of the hypnotherapist to determine whether or not S.C.P. or hypoglycemia are contributing factors to the presenting problem and whether hypnosis is contra-indicated.

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