HOW THE PSYCHOLOGIST HELPS THE PSYCHIATRIST
IN THE EVALUATION OF THERAPY

The following is an abstract of a talk given before the Brooklyn State Hospital Psychiatric Forum on March 6, 1955 by Dr. Joseph Zubin, of the New York Psychiatric Institute, Columbia University.

The first point I wish to make relevant to the topic to be discussed this evening is that it should be recognized that neither scientists nor clinicians today can engage successfully in "Private Practice" in isolation. That is to say, there is no specific psychological point of view. Today, the boundaries between the disciplines have worn thin and internists must be sensitive to psychological problems and know when to ask for psychiatric and psychological help, and, by the same token, psychiatrists and psychologists must know when to call on the neurologist, internist or other specialist.

As an example of the degree of interpenetration which has occurred between the disciplines, it may be pointed out that in the recent evaluation of the outcomes of psycho-surgery conducted by the Columbia Greystone Associates, 13 disciplines were involved: Psychiatry, Psychology, Social Work, Neurology, Surgery, Anatomy, Internal Medicine, Physiology, Neuropathology, Bio-chemistry, Anesthesiology, Hospital Administration and Statistics, not to mention Nursing and the various types of rehabilitation work.

The second point I wish to stress is the need for evaluating the outcome of therapy. Hospitals like other social agencies must provide evidence for the effectiveness of their methods if they are to justify their existence and enjoy continued public support. In the last analysis, hospitals exist for the purpose of administering therapy and returning patients to the community, and if bookkeeping methods are not available to demonstrate their effectiveness, they will eventually go out of business. In mental disorders, the problems or diagnosis, prognosis and outcome of treatment are still so involved that the simple bookkeeping system available to some of the other disciplines does not generally apply.

This brings us to our third point, the difficulty of evaluating outcome of therapy. Although there is generally little disagreement regarding the presence or absence of a mental illness in a patient who comes for examination, the agreement on the diagnostic category to which the patient belongs, and on his prognostic outlook, — or chance for improvement — is sometimes difficult to arrive at. Furthermore, agreement cannot always be reached on the degree of improvement obtained by the patient. Some, who seem quite well improved, suffer relapses, while others, who appear to be little improved, eventually become well. However, we must remember that the goal of treatment of the chronic illnesses must, perforce, differ from the goal of acute illness, since patients who have suffered a chronic illness rarely return to their pre-morbid level of adjustment, have a shorter life expectancy and narrower possibilities in our present culture for social and marital happiness. In the case of mental illness, the onset is difficult to determine, the diagnostic symptomology is rather weak, the natural causes of the illness largely unknown and the goal of therapy uncertain. For example, to expect a patient who has suffered a severe psychosis to return to his pre-morbid state of health as if nothing had happened is too high a goal for therapy in the mental disorders at this present state of our knowledge.

What has been accomplished? Beginning with diagnosis, the psychologist has provided intelligence tests for diagnosing mental deficiency and for establishing the level of intelligence operating in mental disorders in general. It is quite apparent that these tests cannot be used blindly, anymore than an x-ray can be used without reference to the history and general characteristics of the patient. Psychologists have also been able to demonstrate that not all feeble-mindedness is necessarily hereditary in nature. In large surveys of mentally defective children it was found that the brothers
and sisters of most low grade mental defectives are themselves quite normal. Only the relatives of the high grade mental defectives are found themselves to be lower than average in intelligence. Apparently many low grade mental defectives have sustained brain injury during birth or subsequently. Had they not sustained this injury they would have developed normally. Special tests have been developed for separating the brain injured mental defectives from the so-called “normal” or intact mental defectives. Glutamic acid, which had been thought capable of improving mental deficiency seems to be effective only with the brain injured, but not with intact defectives. In the mental disorders, intelligence tests have not proved as useful as in mental deficiency because mental illness is not limited to the lower or higher levels of intelligence.

Personality tests are sometimes found helpful, but the reliability and trustworthiness of these tests have not yet reached the high level of proficiency which characterizes intelligence tests. However, the detection of military personnel who break down during training or later stress of war has been accomplished by administering a psychological questionnaire followed by a brief interview for those whose questionnaire seem suspicious. Rating scales on which specific traits of patients are measured, have been provided for obtaining information on patient behavior on the ward so that better knowledge can be made available to the diagnostician regarding the patient’s general behavior.

As for therapy itself, the psychologist has worked out certain experimental designs for evaluation. As is well known, the patient under treatment cannot serve as a criterion for the evaluation of therapy that he receives, since many patients improve even when no special therapies are given. For this reason, in evaluating a given therapy, the psychologist provides himself with a group of control patients who do not receive the therapy in question, and the improvement rates in a treated and untreated group are contrasted. If the therapy brings about a greater improvement than that which is obtained in the control group, the therapy has proved its value. If it brings about a lower improvement, the therapy is interfering with outcome and should be discarded.

What have been the results of the application of measurement to the various types of therapies? In electric shock therapy, measurement of memory functioning before and after shock has indicated that the fear which some patients have of losing their memory is unfounded. Some temporary loss occurs, but psychological tests reveal that the memory traces themselves are never lost, and in several months after therapy become usually fully reinstated.

In psycho-surgery, the fears of relatives of and friends that the patient will sustain an injury to his personality, are also baseless. If the psycho-surgery is conducted in such a manner that the vital tissues are left undamaged, patients often recover without showing any demonstrable change in personality except improvement initiated by the relief of psychotic anguish.

It should be remembered that the term “cure” is borrowed from the acute illnesses like typhoid fever, malaria or appendicitis. In chronic illnesses like tuberculosis or mental disease, the word “cure” may be inapplicable in the sense that once a patient has had a chronic illness certain residual effects may persist.

The results of studies in the evaluation of therapy have yielded some interesting though tentative conclusions. The immediate outcome of all the therapies, whether they be psychotherapy or somatotherapy are always very encouraging since they invariably exceed the outcome in comparable but untreated cases. When the follow-up lasts as long as five years, the outcome in the treated and the untreated group do not differ very much. It seems as if the untreated group catches up while the treated group has a proportion of relapses which cut down its advantage. It should be remembered, however, that even the temporary relief from mental disorder is a blessing to the patient and a source of considerable financial saving to society. Furthermore, psychiatrists are more modest in claiming credit for their achievements than some other disciplines seem to be. Since the introduction of shock ther-
apy, the number of patients dying of inanition because of refusal of food, or dying from exhaustion because of their agitation, has been reduced to a vanishing point. The credit for prolonging life in this manner has never been given to psychiatry, though in other fields of medicine prolongation of life is the sumum bonum of medical practice.

Another contribution to the evaluation of therapy comes from the attempt to investigate the sources of mental illness itself. Psychologists have investigated the role of early maternal attitude and subsequent development of mental disorders. Thus far the evidence is not too clear whether early maternal rejection will produce an early psychosis. There is some evidence that children brought up in foster homes fare better than those that are brought up more impersonally in orphan asylums. At the present time, psychological research in this area can be summarized as follows:

Environmentalists believe that anyone undergoing sufficient stress develops a mental disorder. Geneticists maintain that only those with an inborn disposition will become seriously mentally ill. Only deeper knowledge of the genetic process will resolve this dilemma.

Lastly, the psychologist has been concerned with the evidence of an epidemiological nature insofar as it throws light on mental disorders. Studies of entire communities conducted in this country in Williamson County, Tennessee and in the island of Bornholm off the coast of Denmark, and in regions of England all seem to indicate that mental disease and defects is a rather constant blight of the human race, engulfing a constant proportion—12% of the population—for a longer or a shorter period. In the Eastern health district of Baltimore, about 6% of the population were found to have had help of some type for mental illness. Thus the proportion of deviant personalities is twice as large as those that actually come for help, if we accept the figure of 12% as an indicating the expectancy of mental illness and defect.

To summarize, the psychologist, like other specialists concerned with therapy, cannot afford to limit himself to the narrow confines that his discipline was cramp'd into when he received his training. If the evaluation of therapy is to become scientific each discipline must be fearless in crossing boundaries and expanding his horizon.

The difficulties in the evaluation of therapy in the mental disorders are tremendous. Without sufficient knowledge of cause and of attainable goals, we shall be forced to flounder until research provides us with more insight. Meantime, the achievements of therapy, despite these difficulties, are not insignificant, especially when measured in terms of prolongation of life and alleviation of anguish in patient and family. The next steps in promoting evaluation of therapy is to provide better baselines, better prognostic tests, and better yardsticks for evaluating changes.