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COUNTERTRANSFERENCE IN GROUPS OF THE

CHRONICALLY SCHIZOPHRENIC

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CHAPTER I

INTRODUCTION

It is the purpose of this study to investigate the proposition that groups of chronically schizophrenic patients tend to elicit emotional disinvolvement and apathy from non-hospitalized group leaders. Much of the psychoanalytic writing on countertransference is rather forbidding in tone, emphasizing the neurotic elements in the analyst's character which are responsible for its development (Alexander, 1954; Fliess, 1953; Freud, 1910; 1912; Glover, 1955). On the other hand, many recent authors emphasize the useful, perhaps necessary functions which countertransference feelings serve (Haak, 1957; Searles, 1965; Spitz, 1956; Tower, 1956; Wolstein, 1959). To date, no experimental studies of countertransference phenomena have been found. This study proposes to employ an experimental prototype to examine a common group therapy situation with chronically schizophrenic patients. Generally the present study centers on the notion that such patients

maintain a safe emotional distance from the group leader by behaving in a manner to which the leader is likely to respond with apathy and emotional withdrawal.

Many writers emphasize the passivity and withdrawal of the schizophrenic in the face of a world too overwhelming to deal with directly (Arieti, 1955; Bleuler, 1950; Fenichel, 1946; Jenkins, Holsopple, & Lorr, 1954). On the other hand, increasing awareness of the interpersonal character of the psychotherapeutic endeavor has been accompanied by a view of the schizophrenic's symptoms as representing an active attempt at coping with current as well as past interpersonal dilemmas (Laing, 1960; 1961; Sullivan, 1962). One manifestation of such coping may be the creation of a kind of interpersonal relationship in which the person's defensive styles are supported. In such relationships subtle pressures may be exerted to minimize behavior on the part of others which seems likely either to increase the anxiety of the psychotic person or to undermine his characteristic defenses (Searles, 1965; Wolstein, 1959). Recent experience at Central State Griffin Memorial Hospital in Norman, Oklahoma, supports the notion that some of the most common feelings first experienced by the therapists of schizophrenic persons are apathy and despair. All too often such feelings may be expressed by the therapist in the form of affective withdrawal. Emotional participation in the therapeutic process by the therapist appears to be a crucial

determinant of patient prognosis (Betz, 1962; Gendlin, 1966; Searles, 1965; Szasz, 1957). Therefore, the study of an experimental situation in which groups of schizophrenic patients interact with non-psychotic leaders might be expected to yield results of both practical and theoretical value.

Countertransference

Freud distrusted the therapists's affective participation in the psychotherapeutic process. He emphasized the corrective influence of the objective, non-evaluative attitude of the analyst. Thus he stated:

> We have begun to consider the "countertransference" . . . arising as a result of the patient's influence on his (the analyst's) unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this counter-transference in himself (1910, p. 289).

> I cannot recommend my colleagues emphatically enough to take as a model in psychoanalytic treatment the surgeon who puts aside all his own feelings, including those of human sympathy. . . . This coldness in feeling in the analyst brings the greatest advantage to both persons involved (1912, p. 327).

Since Freud's early writing, however, the range of conceptions as to the meaning of the term has been great:

> There were early ideas that it was the analyst's conscious emotional reaction to the patient's transference; attitudes that it covered every conscious or unconscious reaction about the patient, normal or neurotic; mechanistic constructions of the interpersonal relation between patient and analyst into some schematized oedipal picture; characterological disposition and personal eccentricities of the analyst were included; reactions to the patient as a whole were considered transferences, and to partial aspects of the

> patient, countertransferences; anxiety in the analyst has been taken to be the common denominator to all countertransference reactions and every anxiety-producing response in the analyst considered countertransference; and finally, only sexual impulses toward patients have been regarded as countertransference. Major differences center around "seeing the analyst as a mirror--versus the analyst as a human being" (Tower, 1956, p. 225).

For the sake of clarity the position will be taken in this study that the transference of the therapist to his client, i.e., the neurotically-based misperception of the client by the therapist, is best labeled as just that. Countertransference, on the other hand, will be used to refer to the feelings which occur--perhaps unconsciously--in the therapist, predominantly as a result of the non-verbal behavior of the client. Countertransference is then the affective, non-rational, and perhaps often unrecognized reception given to a pre-logical communication (Tauber & Green, 1959). Such communications appear to be more valued now than previously:

> By counter-transference I mean the analyst's emotional reactions to the patient's behavior and his analytic material, above all his transference, not the analyst's neurotic transference to his patient. . . . the psychoanalytical technique has more or less certainly entered a new phase. If the preceding phase was chiefly interested in the analysis of the transference, i.e., the patient's contribution, in the new phase interest is concentrated on the counter-transference, i.e., the analyst's contribution (Haak, 1957, p. 194).

> . . . . all therapy, but probably especially modified psycho-analytic psychotherapy with schizophrenics, consists of deeply significant emotional experience in each of the two parties to the therapeutic relationship, and . . . progress toward a good outcome requires ruthlessly honest self-awareness on both sides (Knight, 1965, p. 17).

Wolstein (1959) has made a particularly clear statement of the phenomenology of countertransference as viewed from the standpoint of this study:

> In the experiential field, an anticipation that a given sort of reaction is required for the continuation of relatedness can in itself initiate a desire to seek out and instate the very conditions that are anticipated. . . . The processes in one participant tend to produce the very experiential conditions that they require in the other for ongoing relatedness, a fact that is equally true of the analyst and his patient (Wolstein, 1959, pp. 42 f.).

Wolstein's statement in particular is of interest with respect to the psychotherapy of schizophrenic patients. Searles, throughout his writings, stresses repeatedly the relevance of the therapists's feelings to the defensive activities of the schizophrenic patient. He states that there is a definite "evolutionary sequence of specific, and very deep, feeling-involvements in which the therapist as well as the patient becomes caught up" (1965, p. 521). Noting that the various forms taken by the schizophrenic's transference tend forcibly to evoke complementary feeling-states in the therapist, Searles nonetheless characterizes the first stage as an "out-of-contact" phase in which neither of the parties concerned is particularly involved with the other.

> . . . the therapist experiences comparatively little in the way of feeling responses to the patient's behavior, except for a sense of strangeness, of alienness, in reaction to the bizarre symptomatology into which the patient's feeling-potentialities have long ago become condensed. . . . It is seldom that the therapist feels

> that the patient even perceives him, undistortedly enough for the therapist to sense that he as a person in the here and now is being seen, or heard, or otherwise perceived, by the patient who much more often shows, instead every evidence of being lost in a world of chaotically disturbed and distorted perceptions. Patient and therapist, so long as this phase endures, have clearly not yet entered into a deep feeling-relatedness with one another (Ibid., p. 525).

He then suggests that the therapist's most constructive approach to the patient in this phase is a predominantly calm, neutral, and investigative orientation.

> In working with the patient during weeks or months of silence on the latter's part, he will not, out of a compulsion to help the tragic victim of schizophrenia, rack his brain with diligent therapeutic efforts focused upon the patient, who is already afflicted with overwhelming intrapsychic pressures. Rather, the therapist will feel free to let his thoughts roam where they will, leaf through magazines, do some serious reading of current interest to him, and otherwise see to his own personal comfort and freedom from anxiety. This may at times involve periodic letting off steam at the inarticulate patient, but such blasts do, in my experience, the patient no harm and help one to become again, for a relatively long period, genuinely accepting of this difficult situation. Thus one places in the long run a minimum of pressure on the patient who is already paralysed with pressure, and keeps oneself in a comparatively unanxious and receptive state which, better than anything else, helps eventually to relieve the patient's anxiety and unlock his tongue (Ibid., p. 529).

In apparent contrast to this approach are the findings reported by Gendlin (1966) of an intensive study of all psychotherapy interviews conducted in a state hospital over a fairly extensive time span. His data appear to support a much more active approach to the patient than that described by Searles. Searles appears to conceptualize the initial phase of the psychotherapeutic relationship as

a period in which the felt involvement of the therapist is not yet present. Gendlin, on the other hand, reports that even at this early stage both patient and therapist have feelings about their embryonic endeavor.

> It used to be common that if the client was silent and had nothing to say, the client-centered therapist also sat in a receptive, respectful silence, and waited for the inner process of the client to produce something. I still advocate silence when it is the kind where a person (who has been talking) goes deeply into himself. I still feel strongly that psychotherapy needs periods of silence. These permit concretely felt depth. But, with schizophrenic people we meet a different kind of silence, one in which a patient is simply cut off, in which little is happening, clearly an impasse. Here the patient does not know what to do and I do not always know what to do. In that kind of silence I have now learned always to do something. I may talk about the feelings I have. . . . I do not say many different things at one moment. I stand or sit for a few silent minutes. I have many feelings. I express one feeling that seems all right to express. A few silent minutes later, I may again say something of what is going on in me. I find that when I am not getting anywhere with a patient, quite a lot is going on in me (p. 8).

He reports striking evidence that positive patient change is strongly linked to the degree to which the therapist is able to remain personally involved with his feelings and fantasies about the patient and about himself in relation to the patient.

Local experience at Central State Griffin Memorial Hospital in attempting to institute an intensified program of group psychotherapy with chronically schizophrenic patients, however, has dramatically spotlighted the difficulties inherent in the first phase of the psychotherapeutic

process. Several competent, well-trained therapists began the program with enthusiasm, yet within six months a majority of the initial group of therapists had terminated their groups out of a profound sense of frustration and discouragement. Typical of the feelings expressed was the comment, "They wouldn't listen to me even when I had something that I could say, which was seldom. All I could do was just sit and that was frustrating and seemed to get us nowhere." Nor is this experience particularly unique. Searles, in writing of his experience in supervising analytic students who were doing intensive psychotherapy with chronically schizophrenic people, notes:

> Typically, the student comes to the supervisory hour, week after week and month after month, in a state of chronic boredom, exasperation, dissatisfaction, discouragement, and despair concerning the treatment (1965, p. 591).

The temptation presented to the therapist by such a situation is either to break off the relationship entirely or to withdraw affectively from the relationship while continuing to go through the motions of meeting with the patients. Interestingly enough, such behavior parallels the patients' passivity and withdrawal.

Betz (1962) reports clear evidence that the therapist's personality is an extremely important determinant of the prognosis of the schizophrenic patient. She notes, however, that the therapeutic effectiveness of some therapists who might otherwise be unsuited for work with

schizophrenic patients can be enhanced with proper guidance. If it could be shown that groups of schizophrenic patients tend to elicit apathy, anger and withdrawal from non-psychotic group leaders, then future therapists could be forewarned and perhaps aided in finding more therapeutically useful ways of dealing with their countertransference.

Statement of the Problem

The present study seeks to determine whether, during the initial group meetings, chronically schizophrenic group members influence group leaders in the direction of acting out apathy and despair in ways likely to lead in group therapy to therapeutic failure, viz., a reduction of the leader's level of overt personal involvement.

That the therapist of the schizophrenic person must be personally affectively available in the therapeutic session is documented by a large variety of people of differing theoretical persuasions (Bettelheim, 1967; Brody & Redlich, 1952; Fromm-Reichmann, 1950; Gendlin, 1966; Rosen, 1953; Schwing, 1954; Sechehaye, 1951; Searles, 1965; Szasz, 1957). Gendlin (1966) has separated out two aspects of overt personal involvement which he has demonstrated persuasively to be related to the effectiveness of psychotherapy. The first--realness or genuineness--he describes as "a very active self-expressive mode of making an

interaction" (p. 8). The second he describes as:

> . . . . responding to what is going on in the client. . . .we used to limit ourselves to what the client said or conveyed, what we knew to be going on. Now we find we can respond to "what goes on in the client" even if he does not say anything. Of course, we may not know what it is we are responding to, but that does not mean we cannot respond! (Ibid., p. 9).

Gendlin appears to be describing here the conveying of the therapist's personal affective response to his client. To speak of one's personal affective experience as it occurs would seem to be one good index of therapeutic involvement.

It is proposed in this study to utilize various concrete behaviors as indicants of the group leader's personal affective involvement in the group process. These indicants grew out of the author's experience in working with chronically schizophrenic patients and have been found to be reliably obtainable. The following predictions relate to these measures:

1. In groups of chronically schizophrenic patients, the non-patient leaders will say less than the same leaders will in a group of non-psychotic individuals.

2. In groups of chronically schizophrenic patients, the leaders will be less likely to talk about themselves than they will in non-psychotic groups.

3. In groups of chronically schizophrenic patients, the leaders will tend to make more affectively neutral and impersonal self-referent statements than they will in the non-psychotic groups.

CHAPTER II

METHOD

First Pilot Study

Drawing upon the author's experience with therapy groups in a state hospital setting and upon Gendlin's (1966) rating scales of therapist behavior, the following tentative measures were proposed:

1. the frequency of therapist responses.
2. the mean length of therapist responses, in seconds.
3. the number of silences lasting longer than five seconds.
4. the number of times the therapist said "I".
5. the level of affective involvement reflected by the leader's self-referent statements.

The last variable appeared likely to be the most complex. Accordingly, an attempt was made to create an ordered scale consisting of a number of different classes of statements. The scale was to be ordered according to the degree of involvement likely to be reflected by the statements falling within each of the scale categories. One non-self-referent category and twelve self-referent levels were thus created. Descriptions of the proposed

levels were given to several experienced psychotherapists who ranked them independently. There appeared to be little agreement as to the most reasonable ranking. The categories were redefined, one new category was created, and four categories were merged into two. The resulting levels were resubmitted to the same judges as well as to other experienced therapists. While agreement was greater this time, it was apparent that individual differences between judges were to some extent irreconcilable. Examination of the rankings arrived at by the judges seemed, however, to suggest that three self-referent levels could be obtained which would include all the previous categories and which would hold promise of being reliably ranked. Accordingly, the same categories were resubmitted independently to eight judges, all of whom were experienced therapists and three of whom had taken part in the two previous rankings. This time they were told to place the various statement classes into one of three levels. Level I was to reflect the least overt personal involvement, Level III was to reflect the most. Complete agreement was reached. A scale was then drawn up, based upon the results of this ranking. The affective involvement of the leader's self-referent statements (AISR) was thus categorized into four levels representing differing degrees to which the therapist was likely to be conveying something immediate and personal about himself through his words. Level 0, which includes all non-self-

referent statements, is the first level. This level seems likely to represent the greatest defensiveness, or, put in another way, the least overt exposure to personal risk. For these purposes, this level is constituted by statements which do not include the word "I" and which are factual in content. Also included are exclamations and otherwise unscorable sentence fragments. The second level, Level I, is limited to statements either 1) containing the word "I" without reference to the speaker's affective state, or 2) having to do with feelings and opinions about people, things or situations outside the group as it currently existed. These statements for the most part seem to defend the speaker from personal involvement by focusing attention away from the group. Third level statements (Level II) are those in which the speaker is more directly affectively involved but the risk of the involvement is diluted. The dilution is either accomplished by speaking of personal experiences drawn from another, perhaps hypothetical, time or by stating a judgment about one of the group members as though it were a fact. Perhaps such statements represent both covert involvement with and covert detachment from the group process. Level III statements, on the other hand, contain only personal feelings and fantasies. The AISR scale is reproduced in full in Appendix A.

Group therapy tapes from relatively inexperienced therapists were used as a source for reliability data on

these measures. The choice of inexperienced therapists was made under the presumption that greater experience would be associated with more sophisticated methods of staying involved with the patients, thus obscuring the dimensions of the problem. Group therapy sessions were chosen because of the emphasis on group therapy in the state hospital in which the study was conducted. Tape recordings were made of all group therapy hours conducted by three student therapists (all graduate students in clinical psychology) over a period of two weeks. Six two-minute segments were selected randomly, two from each of three different therapy tapes. The choice of tapes was made by drawing the tapes out of the drawer in which they had been stored until all three therapists were represented. On each tape segment ratings of AISR were made by four judges independently: three non-psychologists and the author.

A therapist was said to have made a statement when he uttered as much as one word, regardless of whether he was interrupted. A statement was categorized as self-referent only if it contained a first-person pronoun or expressed a feeling or opinion not specifically stated to belong to someone else. Words signifying only agreement or disagreement were not considered as self-referent statements. Out of 79 statements made by the therapists in the sampled segments, 26 were judged to be self-referent by

three of the judges; there was 100% agreement among these judges on all judgments. The fourth judge agreed with the other three on all but one statement and thus called only 25 self-referent. Each of the 25 statements on which there was agreement with respect to self-reference were placed within the same AISR level by each judge. Thus it appears that such ratings are reliably obtainable.

Second Pilot Study

A second pilot study was designed to serve as a source for further hypotheses and to investigate possible problems which might arise with groups of non-hospitalized subjects. The responses of naive leaders to two different kinds of groups were compared. The leaders were all volunteers taken from an orientation course given to all newly-hired psychiatric aides during their first two weeks of employment at the hospital. Thus their familiarity with the hospital and with the patients was at a minimum. One group was composed of four chronic schizophrenic patients. The other consisted of four non-hospitalized paid volunteers who were introduced to the leader as "cured mental patients." The groups each contained two men and two women and were of roughly equivalent composition with respect to age. The non-hospitalized volunteers (Normal group) were instructed as follows:

> This is an experiment about the role of the leader in the formation of groups. The leader of your group will

> be an aide who is brand new to the hospital and is as yet as unfamiliar with it as you are.
>
> The experiment in which you are about to participate involves testing the proposition that most people tend to relate differently to chronically schizophrenic people than they do to healthier folk. In order to test this hypothesis, it is necessary that you be thought by the group leader to be a patient prepared to leave the hospital as cured. Thus there is no need to feign craziness, though you will probably need some sort of story or "cover." Act however you feel to be appropriate. Remember, there is nothing wrong with refusing to answer a question if you desire to do so.
>
> Is there anything which you would like to ask me about before I bring in your group leader?
>
> Fine. Any other questions about the study and its specifics I can go into more fully after the group is over.

The groups each met for two, one-half hour sessions one day apart. The second session of each group was secretly recorded on tape. The second session was chosen since the groups would by that time have had an opportunity to get through the formalities of introductions and differences between the groups would then be at a maximum.

The people in the Patients' groups were given the following instructions:

> We are trying a new program to let brand new aides get a chance to get acquainted with people who are here in the hospital. Too often, we think, during orientation aides rush around the hospital looking at it but never getting a chance to talk in a relatively relaxed way with just a few of the people they will be working with here. Tonight we would like for you to spend some time getting acquainted with one of the new aides who has just come to work here. Do you have any questions you would like to ask me before we go?

All questions were answered and if the patient appeared at all reluctant he was allowed to remain behind and

a substitute was chosen.

The group leaders were told:

> We are attempting to try out a new orientation program for this hospital. We think that people who are going to work as aides should have a better opportunity to get to know what patients are really like as people before being assigned to a ward of their own. We have a new program developed which we think is a good idea, but we are not certain how practical it is. We are hoping to begin trying it experimentally with your orientation group. In essence what we want to do is put you in a room with four people and give you a chance to get acquainted. There will be two groups of four patients for you to get to know. One group will be ready to leave the hospital--our finished product, so to speak. The other group will be composed of patients who have been around for a while and who still are likely to stay around a while yet. It is the latter group that most of us spend most of our time working with. So that you might have more of a chance to get acquainted, the groups will each meet two nights running.
>
> Because this is an experiment your participation in this program is purely voluntary and is totally up to you. As a matter of fact we can only take three this time because we want to start slowly enough to work out the bugs. Are there any volunteers?

All seven members of the orientation class for that week volunteered. Two males and one female were selected by lot. Scoreable data was obtained from only one of the three, however, owing to technical problems with the tape recordings. The other two provided reports of their sessions which generally supported the hypotheses being tested. Thus both found the Patient groups dull, especially as contrasted with the Normal group. In one of the groups the leader spent one session trying to get the members of the Patient group to do math problems, something which he never

considered doing with the Normal group. The other leader allowed one patient to return to her ward unescorted about mid-way into the second session.

The useable tape was divided into three ten-minute segments. From each of these segments, one continuous two-minute sample was selected and scored. Each sample was scored on each of the measures and the mean of the three scores was obtained. The distribution of the Length score is badly skewed in the Patient group so that both a median and a mean score are presented for this measure. In the case of the AISR Levels measure, the mean frequency within each level was obtained. Table 1 presents these results.

The leader's response frequency appears to be greatest in the chronic group. Qualitatively, a hearing of the tape suggests that the leader is interrupted so often in the Patient group that if he is to say anything he must begin over several times. Such a possibility is supported by the large number of very short responses given by the leader in the Patient group. Although no silences lasting longer than five seconds occurred in either group, the measure was retained in order to see if it might yet prove to have some discriminating power. The other scores appear strikingly in line with the predictions, although statistical significance could not be established with so few observations.

TABLE 1

Measures of Group Leader Involvement

Measure	Patient Group	Normal Group
1. Mean response frequency ($\sum$R/2 minutes)	15.7	14.3
2. Mean response length (in seconds)	7.1	16.3
Median response length (in seconds)	1.0	13.0
3. Frequency of silences ($\sum$S/2 minutes)	0.0	0.0
4. Mean "I" frequency ($\sum$"I"/2 minutes)	4.3	7.0
5. AISR levels (mean frequency/level/ 2 minutes)		
Level I	3.0	0.0
Level II	2.4	3.3
Level III	0.0	1.0

Procedure

Group Leader Subjects.-Four subjects, two males and two females, were selected by lot from among a group of eight new psychiatric aides going through the first week's orientation to the hospital. They had been given the same orientation to the experiment as was given to the subjects in the second pilot study except that they were told that the two different types of groups would meet for one hour each on separate nights. The four ranged in age from 19 to 27. All had had at least one year of college and had scored within at least the average range of intelligence according to a pre-employment testing using the Henmon-Nelson Short Form Intelligence Test (1957).

Normal Group Members.-The members of the Normal groups were paid volunteers who received the same instructions as were given to their counterparts in the second pilot study. Those who were asked to volunteer for the study were accepted primarily on the basis of the examiner's judgment of their ability to form warm relationships with other people. Some effort was devoted to insure that no two people in any group were well-known to one another. However, one of the groups contained two people who knew each other well enough to have visited in one another's houses. Each group contained, in addition to the leader, two men and two women.

Patient Group Members.-Patients were selected from one male ward and one female ward in a treatment area for chronic patients. All patients met the following criteria:

1) Diagnosis of schizophrenia, any subtype.
2) At least two years of continuous hospitalization during the current admission.
3) Completion of at least the sixth grade.

In addition the following conditions were used as criteria for excluding schizophrenic subjects:

1) Known or suspected brain pathology.
2) Chronic alcoholism.
3) Supplementary diagnosis of mental deficiency.
4) Twenty-five or more shock treatments.
5) Any shock treatments within the last six months prior to the experimental sessions.

Beyond these conditions each patient was chosen by a process of age-matching in which each member of the Normal Group was assigned a counterpart of the same sex in the chronic group who was within five years of his age.

The participants were given the same instructions as were given in the second pilot study. As before, a substitution was made for any patient who appeared reluctant.

Table 2 presents data relating to the age, sex, and educational level of all group members as well as to the length of hospitalization of all schizophrenic group members.

Group Procedures.-All groups were assembled in

TABLE 2

Background Data on Group Members

	Age	Sex	Education	Length of Hospitalization	Leader
Normal					
1	45	F	Coll.Grad.		A
2	18	F	H.S. Grad.		A,(D)[a]
3	26	M	Coll.Grad.		A
4	27	M	H.S. Grad.		A
5	26	F	Coll.Grad.		B
6	28	F	Coll.Grad.		B
7	45	M	Coll.Grad.		B,(C)
8	28	M	H.S. Grad.		B
9	30	F	Coll.Grad.		C
10	25	F	Coll.Grad.		C,(D)
11	45	M	Coll.Grad.		C,(B)
12	30	M	Coll.Grad.		C
13	25	F	Coll.Grad.		D,(C)
14	18	F	H.S. Grad.		D,(A)
15	31	M	Coll.Grad.		D
16	31	M	H.S. Grad.		D
Patient					
1	17	F	10	7	A
2	48	F	H.S. Grad.	12	A
3	29	M	11	3	A
4	32	M	H.S. Grad.	2	A
5	28	F	1 yr.Coll.	2	B
6	19	F	10	3	B
7	43	M	8	3	B
8	35	M	H.S. Grad.	9	B
9	29	F	8	3	C
10	31	F	H.S. Grad.	2	C
11	47	M	6	2	C
12	33	M	H.S. Grad.	4	C
13	16	F	9	3	D
14	21	F	11	5	D
15	36	M	7	7	D
16	27	M	1 yr.Coll.	4	D

Note.--[a]Three subjects appeared in more than one group.

assigned offices prior to the leader's arrival. The group leader was brought into the room and introduced to the group. The introduction of the individual group members was left up to the group. At the end of the session the patients were escorted back to their wards and the normal subjects were escorted to a hiding place until their group leaders were out of the way. All sessions lasted for one hour and were secretly recorded in full. Two of the leaders --one male and one female--met with the Patient group the first night while the other two met first with the Normal group. The next night they met with the remaining groups. The leaders were not told until the close of the experiment the order in which they were to meet with the groups. Thus they could not know ahead of time, at least on the first night, the type of group with which they were to meet.

At the end of the experiment the true nature of the study was explained to the group leaders and they were given another chance to withdraw their recordings from the data pool. Any other questions were answered as fully as possible and time was provided to listen to the tapes and to discuss them in private if desired.

Scoring.-The last thirty minutes of each tape was divided into thirds with a two-minute sample being taken from each third. Each sample was recorded on a master tape for ease in scoring with each segment coded for ease in identification. The samples were drawn using the tape

recorder's index counter and a table of random numbers. In case the index number appeared within the last two minutes of the ten-minute segment, the entire two-minute terminal section was used.

Since the statements of some of the groups leaders become rather lengthy, an arbitrary definition of a scorable statement was adopted. For the purposes of timing (Hypotheses II and III), a statement was said to continue until interrupted either by five or more seconds of silence or by another group member's statement. For the purpose of tabulating the total number of statements or of AISR scale scoring (Hypotheses I and V), however, a statement was considered to exist whenever the leader uttered at least one word. For these purposes, statements were considered to be terminated either by interruption by another person in the group or by natural pauses within the conversation. Such statements did not necessarily follow the grammatical form ordinarily expected of a sentence. Nonetheless, each statement thus delimited was scored individually on the AISR scale.

Hypotheses

Listed below are the hypothesized results of the present investigation.

I. In the Patient groups the group leaders will have a significantly lower frequency of verbal participation than they will in the Normal groups.

II. In the Patient groups the group leaders will make significantly shorter statements then they will in the Normal groups.

III. In the Patient groups the mean length of silences will be greater than it will be in the Normal groups.

IV. In the Patient groups the group leaders will say "I" less often then they will in the Normal groups.

V. In the Patient groups the AISR Level scores of the group leaders' statements will be lower than they will be in the Normal group.

For all hypotheses a confidence level of 5% was chosen (one-tailed test).

CHAPTER III

RESULTS

Reliability Data

Since the first pilot study established the reliability of the AISR ratings in a somewhat different situation from that utilized in the present investigation, a further reliability check was undertaken. Starting at a randomly selected spot in the first sample segment on the master sample tape, every eighth leader verbalization was transcribed onto index cards. The 33 resulting statements were then given independently to three naive judges (undergraduate non-psychology majors) with instructions to place each in the appropriate category. The author independently rated the statements also. On all but two statements there was complete unanimity as to placement. The two were agreed upon by two of the three judges but not by the third. The author's judgments were in line with the majority in each case. Thus it appears that in this situation also, the AISR ratings are sufficiently reliable to allow the use of a single judge.

The ability of judges to identify reliably separable

statements was measured. Three judges--the author and two non-psychologists--listened independently to each sample and counted the number of statements made. Agreement was complete on all segments. In addition, all verbalizations by group leaders in the last sample segment from each group were separated into component statements independently by each of the three judges. As before, statements were defined by the natural pauses in the leader's speech. Again there was complete agreement in the judgments.

Measures

Table 3 presents the data with respect to the first four hypotheses of this study.

Hypothesis I stated that in the Patient groups the group leaders would have a significantly lower frequency of verbal participation than in the Normal groups. Frequency was defined as the number of statements made by the leader in each two-minute sample. The large inter-individual variability made the usual parametric statistical tests inappropriate. Instead, each sample taken from the Patient group was scored and its score was compared with that of the sample taken from the corresponding part of the Normal group tape. Each comparison was assigned either a plus or a minus, depending on whether the difference between the two groups was in the hypothesized direction. The Sign Test tables (Dixon & Massey, 1957) were then used to determine

TABLE 3

Scores on Involvement Variables for Each Leader in Each Group

Leader	Sample	Frequency			Length			"I" Count			Silence		
		P[a]	N[b]	±[c]	P	N	±	P	N	±	P	N	±
A	1	20	16	-	5.1	6.2	+	4	6	+			
	2	13	14	+	7.1	5.8	-	2	7	+			
	3	14	17	+	2.1	4.8	+	0	8	+			
B	1	0	4	+	0.0	8.0	+	0	1	+	21.0	16.5	+
	2	0	2	+	0.0	3.0	+	0	0	=	6.0	15.0	-
	3	2	7	+	5.5	3.0	-	1	2	+	7.0	0.0	+
C	1	11	15	+	4.6	5.6	+	5	18	+			
	2	13	16	+	4.7	4.9	+	5	20	+			
	3	12	17	+	2.4	39.3	+	2	17	+			
D	1	6	15	+	2.0	7.6	+	0	3	+			
	2	9	21	+	3.2	6.8	+	0	2	+			
	3	8	13	+	1.9	11.2	+	1	5	+			

Note.--[a]Patient group.

[b]Normal group.

[c]Direction of difference.

the probability of occurrence of the resulting array. With three samples from each group and four different group leaders, there were twelve comparisons to be made. In eleven of the twelve comparisons, the group leader made more statements in the Normal group than in the comparable sample from the Patient group. Such a result is significant beyond the .05 level according to the sign test, and Hypothesis I is supported.

Hypothesis II stated that in the Patient groups the group leaders will make shorter statements than they will in the Normal groups. Statement Length was defined in terms of the mean length in seconds of the leader's statements in each two-minute sample. As before, use was made of the Sign Test. The prediction was sustained in ten of the twelve comparisons which is significant beyond the .05 level. Thus Hypothesis II is supported.

Hypothesis III stated that in the Patient groups the mean length of silences would be greater than it will be in the Normal groups. Silences only occurred in the groups of one of the group leaders, however, thus making impossible any meaningful comparison of the two types of groups on this variable.

Hypothesis IV stated that in the Patient groups the leaders will say "I" less often than they will in the Normal groups. "I" count was defined as the number of times the leader uttered the word "I" during each

two-minute sample. All of the eleven non-tied comparisons were in the predicted directions, thus allowing for acceptance of the hypothesis beyond the .05 level of confidence.

Hypothesis V states that in the Patient groups the group leaders will make less personal self-referent statements (lower AISR level) than they will in the Normal group. The total frequency within each Level for each type of group was obtained. The results are shown in Figure 1. Also a difference score was obtained for each AISR level by subtracting each leader's frequency of response at that level in the Patient group from that in the Normal group. Because of the paucity of responses at Levels II and III, the data at these levels were combined. A t-test was then calculated on these differences. Table 4 shows these results. The frequencies of response occurrence at the AISR Level 0 are not significantly different (t = 0.16). At Level I, the difference between the frequencies in the Normal and the Patient groups is significant, however, beyond the 5% level (t = 2.88). Significant differences were also established between groups when Levels II and III were combined (t = 2.81). Hypothesis V is thus accepted.

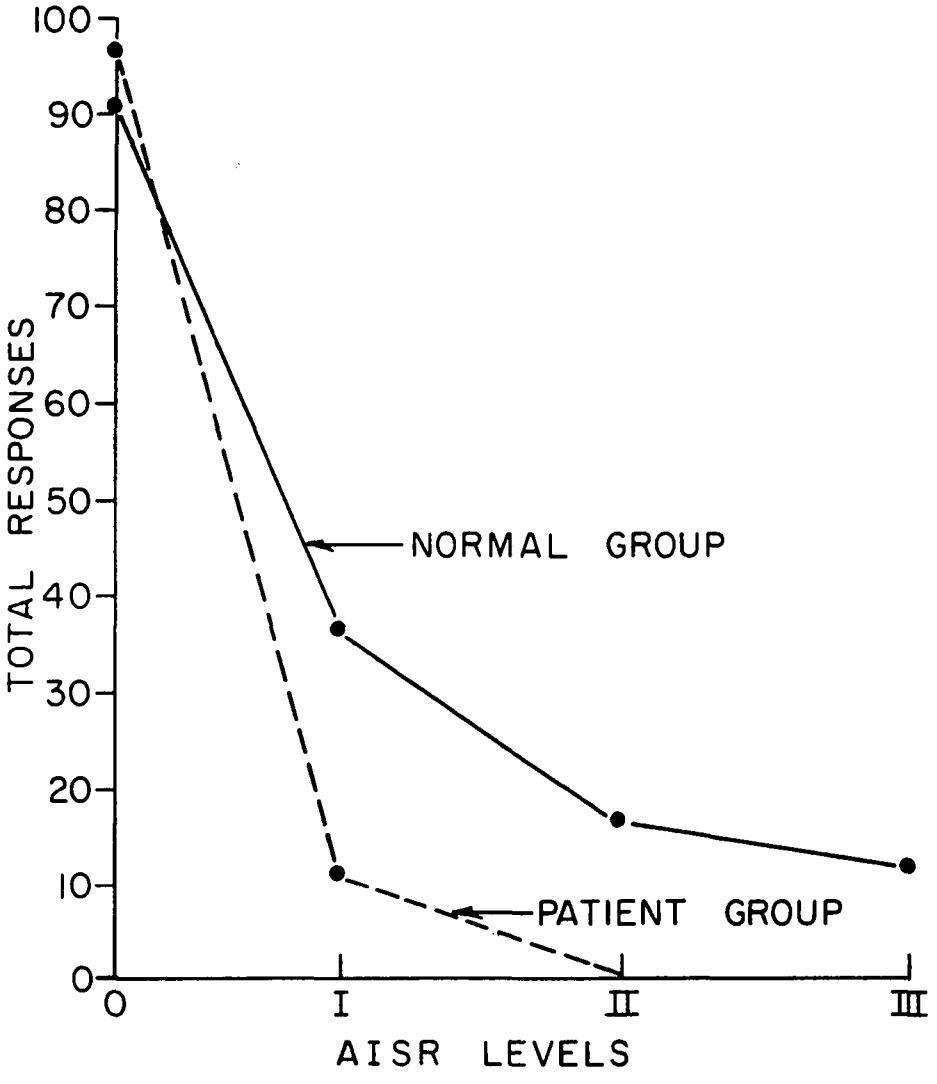

Fig. 1. Total responses at each AISR level for Normal and Patient groups.

TABLE 4

Total Frequencies at Each AISR Level for Each Leader in Each Group and Difference Scores at Each Level for Each Leader

Leader	Group	Level 0	I	II	III	Difference Score 0	I	II & III
	P	44	3	0	0			
A						-24	13	11
	N	20	16	7	4			
	P	1	1	0	0			
B						8	3	0
	N	9	4	0	0			
	P	29	7	0	0			
C						- 9	4	17
	N	20	11	9	8			
	P	23	0	0	0			
D						19	6	1
	N	42	6	1	0			
				t values		0.158	2.88*	2.81*

*Significant beyond 5% level.

CHAPTER IV

DISCUSSION

The purpose of this investigation was to explore the proposition that chronically schizophrenic patients tend to elicit emotional disinvolvement and apathy from group leaders. Since the study is exploratory in nature, only some of the possible relationships between group composition and the behavior of the group leader were investigated. Nonetheless, analysis of the data generally supports the notion that the initial response of a group leader to a group of hospitalized chronically schizophrenic patients as compared with the same person's response to a group of non-patients tends to reflect less overt personal involvement. In particular, it was found that group leaders in groups of non-hospitalized normal subjects, to a statistically significant degree, tend: a) to make more statements, b) to make longer statements, c) to say "I" more often, and d) to make more personal statements, than do the same leaders in groups composed of chronically schizophrenic people.

The one rejected hypothesis of this study concerns

a suspected relationship between group composition and a tolerance for silence, viz., that a leader in a group of chronically schizophrenic patients is likely to allow longer silences than he will in a non-patient group. When stated in this way, it becomes clearer that perhaps one reason for the extremely low incidence of silences in both groups has to do with the anxiety arising from the relative newness of the groups. Such a suggestion would limit the generality of all of the results, since, in fact, they might all be artifacts of the short time that the groups met together. Thus it may be that the differences which were found to exist between the leaders' responses to the two groups would disappear if the groups were to continue over a longer time. Nonetheless, the fact that the same group leaders behaved so differently under two conditions which were identical in all respects with the exception of the composition of the groups suggests that the kind of pressure exerted on the group leader varies with group composition. That such pressures would change if the groups continued to meet is likely. The purpose of the current study, however, was to investigate some possible differential effects of varied group compositions on the behavior of the leader. In fact such effects appear to have been demonstrated.

An objection might be raised at this point that the initial instructions to the leaders, by calling their

attention to the differences in the composition of the two groups with which they would meet, served to create differing expectations in the leaders for the two different groups. Thus the mere knowledge that the groups would differ in composition might have been productive of the results found, even though the leaders were not aware ahead of time of the order in which they would see them. If this objection were valid, then the differences demonstrated might simply be the result of the instructions given.

Such a possibility could be eliminated if it were shown that in the initial portion of the groups' interaction--when the effect of the initial instructions would presumably be at its peak--hypothesized differences in the behavior of the leader did not accur. Since it has been demonstrated that differences did occur later in the hour, the lack of differences would strongly suggest that the initial instructions were not a primary cause of the results previously discussed. Accordingly, a two minute sample was extracted from the first ten minutes of each recorded interview (Segment I). Each of these samples was scored as before for frequency of the word "I." This measure was chosen because it was effective in differentiating leader behavior under the experimental conditions.

Table 5 presents the results of this sampling. A *t*-test of the difference between the two groups was calculated, along with the Sign Test. Neither statistic

TABLE 5

Frequency of Occurrence of the Word "I" in Normal and Patient Groups in a Two-Minute Sample from the First Ten Minutes

Leader	Group	First Sample
A	P	1
	N	2
B	P	0
	N	0
C	P	6
	N	4
D	P	1
	N	0

$t=0.77$, df=3

approached significance at the 5% level (t=0.77, df=3). Thus the differences between the behavior of the leaders in the two types of groups were not present initially and therefore such differences were not likely to be a result of the preliminary instructions to the leaders.

As a further check, the total of the leaders' "I" count scores was obtained for each of the time segments I, IV, V, and VI. The difference between the leaders' initial mode of relating to the groups and the way in which they later related to them is demonstrated by Figure 2. As measured by the "I" count, the leaders appear to behave quite similarly in the groups at first. By the fourth segment (30-40 minutes into the hour), however, the group leaders are saying "I" much more often in the Normal group, while the rate remains fairly constant and low in the Patient group throughout.

An extensive interview with the leaders after both group sessions were completed revealed several inter-leader differences in their reactions to the different types of groups. One of the group leaders reported experiencing extreme boredom and impatience in the Patient group, so much so that she let the group out almost five minutes early. The same person requested that the Normal group be allowed to continue beyond its appointed time of termination. Another of the leaders reported having felt bored and uncomfortable in the Patient group, but said that in

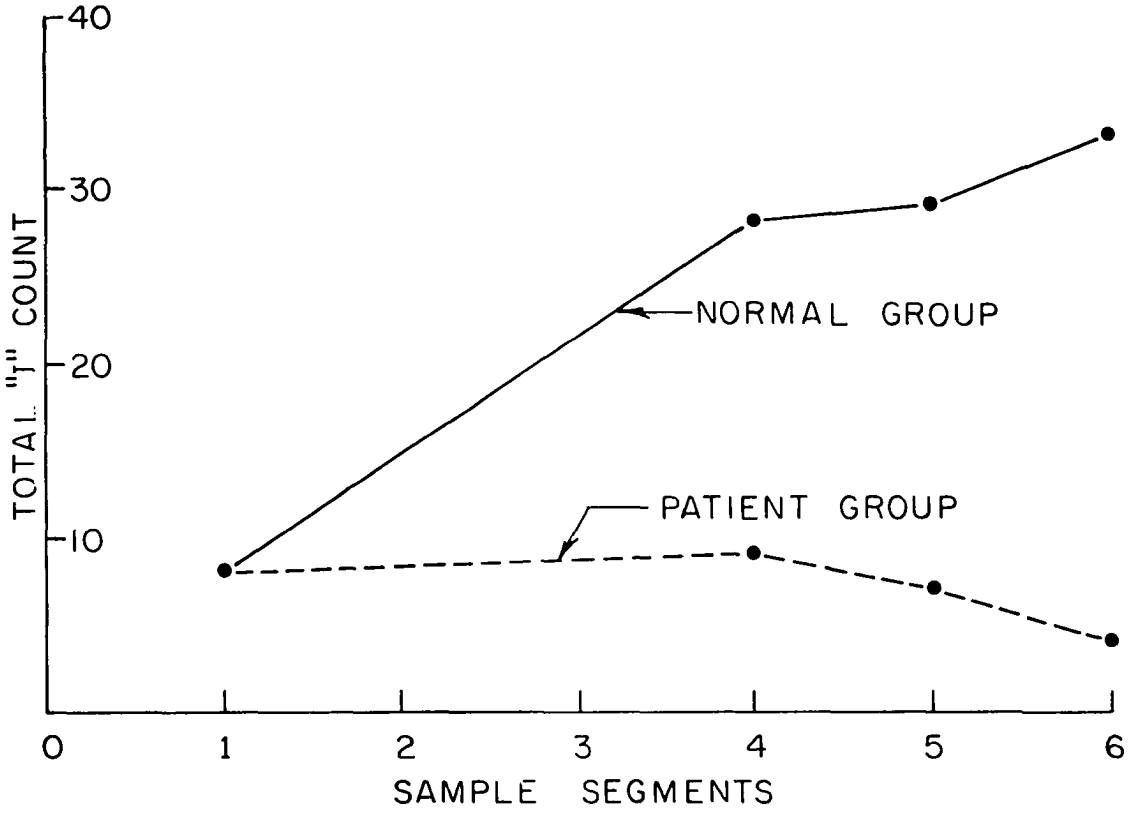

Fig. 2. Total "I" count for samples from the first, fourth, fifth, and sixth ten-minute segments of Patient and Normal groups.

the Normal group "too much was going on" for there to be a chance to be bored. The third leader also reported being bored in the Patient group, but said that the Normal group was only slightly more interesting. The fourth leader reported that the Patient group provided an exciting experience but that the Normal group was extremely hostile. The intensity of the latter leader's involvement in the Normal group was demonstrated in two ways. First, upon being apprised of the true composition of the group she broke into tears. Second, she requested a copy of the recording of the session. In general the group leaders reported the Normal groups to be more vocal, to be less easily influenced, and to have a more equal distribution of participation among the members. Two of the leaders reported the Normal groups to be more hostile than the Patient groups.

The diversity of perceptions of the groups also strongly suggests that these similarities of response which occurred are not likely to be the result of basic personality similarities among the leaders. Instead these similarities seem most reasonably attributable to the similarities in the behavior of members.

One question left unanswered by this study concerns the manner in which the differences between the leaders' behavior in the two groups were produced; i.e., to what specific differences, if any, in the behavior of the two groups was the leader responding differentially. It would seem

that such a question could be approached by using a design similar to that of the present study. Also of some interest is the question of what would happen in groups composed as these were if they were to continue over a more extended period. Any future studies utilizing the design of this study should probably attempt to select the subjects in a way that would decrease the inter-subject variability. Probably it would also be useful to increase the number of subjects studied.

It then appears justifiable on the basis of the data here presented to conclude that the predictions thus made are in fact supported, at least during the early phases of group formation. Such disinvolvement is demonstrated in the decreased number and length of the leader's statements, the smaller frequency with which he uses the word "I", and the less personalized quality of his self-referent statements.

Gendlin (1966) has written of the beginning stage of psychotherapy with schizophrenic patients as a time in which the therapist creates any interaction which occurs between himself and the patient. Searles (1965), on the other hand, has suggested that it is necessary to wait for the beginnings of interaction to arise between therapist and patient and then to respond to these beginnings. Basically, his is a conception of the early stage as necessarily one in which the therapist waits for an extended

period for something to happen. The results of this study suggest that something quite powerful is happening almost from the beginning. From this point of view, the early stages of psychotherapy appear to be a testing ground in which the therapist's ability to keep trying and to stay involved is pitted against the schizophrenic person's ability to isolate himself and others from his life. If this viewpoint holds, then it may also be that the greater the struggle the therapist experiences to get involved with the schizophrenic person, the more he is likely to be already involved. At least it appears that such a struggle is an inevitable part of the initial phase of an encounter with such people.

CHAPTER V

SUMMARY

The present study was undertaken in order to investigate the proposition that groups of chronically schizophrenic patients tend to elicit emotional disinvolvement and apathy from non-hospitalized group leaders. Such affective withdrawal was described as a countertransference response to the patients' needs to maintain a safe emotional distance from the group leader. Specifically it was hypothesized that when compared with the same leader's behavior in a normal group, such withdrawal by the leader would manifest itself by a reduction in frequency and length of verbalizations, by an increase in the frequency of silences allowed to occur, and by a greater impersonality of verbal response. The latter was indexed both by the frequency with which the leader uttered the word "I" and by a scale constructed in a pilot study to measure the degree of personal involvement reflected by the leader's statements.

In order to test these hypotheses, four unsophisticated volunteers were selected from an orientation class for new aides at a large state hospital. These four served

as group leaders for one hour each in two groups. One group was composed of four chronically schizophrenic patients; the other group was composed of four non-hospitalized paid volunteers. Recordings were secretly made of the entire group sessions and three two-minute samples were taken from the last thirty minutes of each session. These samples were scored on each of the measures. The data supported all of the hypotheses advanced, with the exception that there were too few silences in either group for meaningful statistical comparison to be possible. It was suggested that the initial instructions given to the leaders might have predisposed them to treat the two groups differently. A new sample was drawn from the first ten minutes of each of the tapes and scored on the measure most significantly differentiating between the two groups, the "I" count. No difference between the two groups was found on this measure for this sample from the first ten minutes. It was concluded that the previously demonstrated results were not a product of the initial instructions. The contention that hospitalized schizophrenic people tend to be responded to by withdrawal and heightened apathy on the part of people who are otherwise capable of considerable personal involvement was thus supported.

Two possible avenues of future research were discussed. It was concluded that the process of psychotherapy with hospitalized schizophrenic patients is an intense

process which starts very rapidly even though it may not always be easily recognizable as such.

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APPENDIX A

Description of AISR Rating Scale Levels

Guides to the use of this scale.

1. All statements belong in one of the four levels.
2. All statements in which the word "I" appears must be assigned to one of the upper three levels.
3. Judge only on the actual content of the statement, not upon any implicit possible content.
4. If in doubt, assign the statement to the lowest category in which it might possibly be accurately placed. Thus a doubtful statement containing the word "I" would be rated as Level I, etc.

Level 0.

This is the level of objectivity, of factual statement, of non-rhetorical questions, and of simple affirmations and denials. There is essentially no reference to the speaker or to his experience, i.e., neither opinion nor feeling enter overtly into statements at this level. Statements or questions involving the word "we" are always at this level unless the word "I" also appears in the same statement. The following are examples:

"Two plus two are four."

"We have been happy."

Level I.

At this level, if the word "I" appears in a sentence at all, there is no necessary overt affective involvement implied. All sentences involving the use of the word "I", however, must be rated at least at Level I. Such incidental uses of the pronoun are exemplified by the following:

"Well, I should hope so!"

"I don't think so."

"I know."

More often at this level the self of the speaker is implied without explicit self-reference. Such statements include all giving of instructions and all stated opinions and feelings about people, places or things not physically present in the group. Opinions are defined as those statements in which a judged quality is attributed to some person, place or thing without explicit reference to the speaker's role as judge. For example:

"Denver is nice."

"It is such pleasant weather these days."

Statements of feelings, on the other hand, may explicitly take notice of the speaker's responsibility as judge. For example:

"I like Denver."

"I think that Denver is nice."

"It seems to me that that guy must be a louse."

Level II.

Statements at this level are more likely to involve explicit use of the word "I". At this level the leader responds to others either in terms of 1) a personal anecdote about an experience not occurring in the immediate present; 2) opinions (as previously defined) about the others in the room; or 3) speculations about the motives and feelings of those others. Examples of the first type of statement might be:

"I was once a dancer in the Paris Opera."

"I could have done that but I didn't."

"In your place I can see how I might feel attacked."

"I remember feeling very warm and cozy."

The second type of statement--opinions--may be exemplified by the following:

"You're a clod!"

"You seem happy."

Examples of speculations are:

"I think that you are feeling bad and taking it out on us."

"You are happy about something."

Level III.

Level III statements are characterized by immediacy and self-revelation. At this level, the speaker is talking about his experience as it occurs and is taking the risk of speaking solely of his feelings, desires, thoughts and

fantasies. Thus he may be describing his current bodily responses, his current feeling about another person present with him, his fantasies as they occur to him, etc. Examples are:

"I feel sleepy."

"I am very angry with you."

"I feel dizzy."

"I am full."