Q-THERAPY AND SCHIZOPHRENIC GAZE

J. DESMOND RAINEY

Department of Psychology
Auckland Hospital

A single case was selected to demonstrate a therapeutic procedure designed to assist individuals participating in a group activity to modify aspects of their behaviour by means of an active therapeutic intervention, yet without interruption to the group process. The "gazing" style of a schizophrenic patient was chosen for study. Q-apparatus enabled "cues" or signals to be sent from an observing therapist to any or all members of a treatment group. In the present study only two cues were used, a "negative" cue with prompting and punishing connotation and a "positive" cue amounting to a reinforcer. The cues informed the patient whether he was keeping to his contract, in this case maintaining his gaze well during conversation, or failing. Spectacularly lengthy duration of gaze was achieved and very satisfactory levels were maintained when the cues were withdrawn. Results highlighted to the patient his own capabilities for control of the behaviour in question.

In group therapy in a hospital setting it had been noted that certain types of behaviour were conspicuously less well able to be modified by ordinary group therapy procedures than others. Certain minor behaviours or mannerisms, for example, had been found hard to manage. In part this was because they often occurred while other therapeutic endeavours were in progress so that attention given to them (and particularly the continual attention they required) interrupted these activities. Secondly, the mannerisms seemed to require in therapy a more rigorous application of principles of learning than group members were able to apply. Q-therapy procedures were devised to overcome these difficulties. The first application to the "gazing" inadequacies or peculiarities of a schizophrenic patient is recorded.

METHOD

Subject

"W" was a 35 year old male, living at home with his parents, who had been presented several months previously as a psychiatric day-patient. He had been out of work for two years, had withdrawn from social engagements, was considered "very suspicious" and a "virtual recluse". He had a history of previous admissions to psychiatric hospitals, had had E.C.T., attended groups and taken pills, with, as he said, "nothing happening". Of particular concern to him were his present illness, his sensitivity to the remarks of others, excessive drinking, and having no friends. He believed, with delusional intensity, that

people suspected he was 'gay' and reported increasing discomfort in the presence of mixed company. He summed himself up, "So I am inclining towards the life of a recluse. I don't know how I will get on when my parents die; how I'll get out of bed. I'm a stone's throw still from suicide."

In group therapy he came to speak fairly freely of his experiences throughout life, of his present and past concerns, sexual identity, family problems, and so on. He was making encouraging progress with conversational and general social skills, as well as making sensible work plans and readying himself for return to the community. Unsatisfactory aspects remained, however, including rigid paranoid delusions, slow monotonous speech, and the distinctive and highly off-putting "gaze" or lack of gaze which came to be singled out for attention in this study. W's typical posture in the group was with his head heavily bowed upon his chest, his eyes apparently contemplating either his navel or the floor. He could smile on occasion and glance at people in the course of conversation, but more sustained eye contact was unusual. He was confronted with this fact at various times in group and given quite strong emotional feedback, but to no effect. Accordingly, after a period of base-line measurement, the use of Q-therapy was discussed with W and his "group". As a result, and not without resistance, W contracted to maintain eye-contact during his involvement in conversation in group to the best of his ability, using aids provided.

Procedure

Satisfactory eye-contact was defined to the patient in terms of whether, while addressing or being addressed in group, he met the eye of a particular person and/or glanced from face to face in the group and/or moved his eyes in the horizontal plane. "Horizontal", in turn, implied not necessarily looking into someone's eyes, but at least having the eyes directed at or around the group in a level and acceptable fashion, as opposed to looking at the floor or ceiling. The term "gaze" was not used with W though it more accurately defines the target-behaviour. (Usual process distinction distinguishes gazing or looking at another person's face from eye-contact or mutual gazing.)

In the active therapy situation, up to nine group members, including a co-therapist, sat wearing ear-pieces attached to a cable skirting the room. A microphone relayed group discussion to the adjoining room where the therapist was stationed in front of a one-way screen. "Q controls" built into a small box enabled the therapist to press one of ten switches in such a way as to speak or signal to the whole group or any individual member or combination of individuals. More specifically he signalled "W" in one of two ways. A single "beep" cue carried the positive message: "Good! Eye-contact is established. You are succeeding in your aim". A double "beep" had the negative implication: "Hey! Eye-contact not established. You are not meeting your contract". Thus it was envisaged that the therapist function as

a control stimulus, a supportive cueing device, to elicit specified behaviour. Once emitted this would be reinforced in two ways, by positive cues from the therapist (secondary reinforcers), and by the natural reinforcements which the group might offer to the new behaviour.

Measurement presented certain difficulties. To reduce variance as far as practicable, it was decided that at some point in the hour's group therapy, the co-therapist would signal the commencement of a ten-minute period of group-focus on W. That is, in this time he was to be the sole subject of attention and was under a natural constraint to talk or respond to questions and comments. A tape-recorder signalled to the therapist the end of every minute in this ten-minute period, enabling him with the aid of a stop-watch to record the cumulative time each minute when the patient's eyes were in contact or horizontal. By dividing by ten, the average time-per-minute or successful response was obtained. In passing, it may be noted that no rigorous efforts were made to obtain relevant normative data, but for three of W's group-mates the average time-per-minute of gaze during conversational involvement (whether talking or listening) was 24 seconds, 46 seconds, and 35 seconds.

RESULTS

Figure 1 traces developments stage by stage. "A" represents baseline data. Mean duration of gaze was only 6″ per minute. "B" represents the first post-intervention results. Here W was trying to maintain gaze during conversation and was being aided by the application of positive and negative cues as described above. Gaze increased dramatically to around 44″ per minute over a four session period! In the next condition, "C", W was left to his own devices. That is, no cues were provided; he was merely observed. He maintained gaze at a fairly stable 30″ average over four sessions. In "D" the therapist introduced a session of "negative practice" to dramatise to W the control he had of his own behaviour. Told to look at the floor and avoid eye-contact, W succeeded admirably. In "E" W was returned to the "B" condition, that is, with use of cues. He soared to a new peak. "F" shows the return to the "C" condition. He was told that it was perfectly clear that he could maintain eye-contact in a normal way whenever he chose to do so and would henceforward be left to manage on his own. On the first of the four measured sessions his gaze was close to base-line, but at subsequent sessions he obtained very satisfactory levels.

"G" is a follow-up measure, showing a return to baseline level. A week after completion of the programme proper "W" went into an adamant deep withdrawal phase and discharged himself. Two weeks

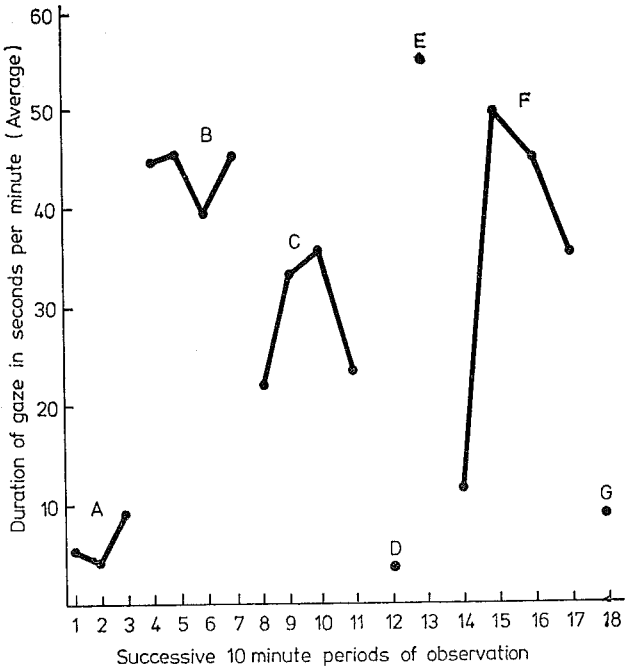

Figure 1. Duration of Gaze: (A) Baseline. (B) Application of Q. (C) Left to self. (D) Negative practise. (E) Reinstatement of Q. (F) Left to self. (G) Final observation.

later he was re-admitted after a near fatal overdose, a psychiatrist commenting "residual schizophrenia, depressive episode". The final measure, "G", was made a few days later on his return to group and before his transfer for long-term psychiatric care.

DISCUSSION

Post-intervention procedures were dramatically effective. Marked increase of gaze was obtained by the combination of eliciting and reinforcing cues or signals, in fact the levels attained were obviously far and away above normal. W maintained, on the whole, very satisfactory levels when the cues were withdrawn.

Another effect was very clear. The new behaviour elicited new response. W won appreciative comments from staff and fellow patients. He achieved a new control of responses in his environment, created a social setting where others saw him as less odd, or as more "belonging". W himself expressed satisfaction with the results and with his new social image, but there is doubt as to the "depth" of his own feelings

of belonging. Assessment of longer-term effects and checks on generalisation of response to social situations at large was disrupted by W's withdrawal from hospital and subsequent overdose. No effort was made to try and determine any possible optimal ratio or scheduling of the two forms of cue in Q-therapy. Neither was attempt made to ascertain the general classes of behaviour for which modification by Q-procedure might be particularly effective. Investigations in both of these areas could have useful therapeutic implications.

I would like to thank Dr J. S. B. Lindsay and Professor W. R. McLeod for their free hand and encouragement. Special appreciation is accorded Professor Hal. Schaefer of Auckland University for constructive comments. Criticisms by the Journal's independent assessors were also helpful. Thanks are due to Gerard Denissen, medical electronics technician at Auckland Hospital, for constructing and installing the equipment, and to Professor John Werry of the Auckland Medical School who was instrumental in arranging a small grant to cover costs.