Brit. J. Psychiat. (1983), **142**, 524–528

Verbal Participation and Group Therapy Outcome

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Summary: The relationships between patients speaking out and measured outcome were investigated over 18 months in an out-patient group. The parameters of therapeutic progress were derived from the Symptom Check List and individualized repertory grid rating scales. Each patient's verbal participation was compared to that of other group members and to his own participation over other measurement phases. Speaking out phases were associated with more chance of change and improvement, while silent phases were associated with less chance of change and an increased likelihood of negative change. This study demonstrates the use of a relatively non-disruptive measurement model in testing clinical hypotheses in single psychotherapy groups.

Communication is important in the therapeutic processes of groups. Higher verbal participation in groups correlates with a greater sense of involvement, with the patient being valued more by others and ultimately by himself (Yalom, 1970). Verbal participation is a group process variable that can be derived from relatively hard data. It has been shown that the more words spoken in a group, the greater was the positive change in the patients' views of themselves, regardless of content (Lundgren and Miller, 1965). There have been many problems in the development of measured outcome criteria for therapy groups (Fielding, 1974) and there is a paucity of studies relating verbal participation in groups to measures of therapeutic change in patients. This study aims to investigate possible relationships between patients' verbal participation and therapeutic change in a psychotherapy group.

Method

The experimental group

Eight patients were treated in the out-patient group over an 18-month period. The four male and four female patients had a mean age of 23 years (range 19–27 years). All had a diagnosis of depressive neurosis and had significant symptoms, with treatment from other psychiatrists for more than 18 months prior to starting in the group. Six of the patients had some tertiary education. The group therapeutic methods were psychoanalytically orientated and insight directed. The sessions lasted for 90 minutes and were partly supportive; none of the patients were on medication. No socialization between group members occurred outside the group sessions.

Measured parameters of outcome

A technique for measuring individual progress in group therapy, using the Symptom Check List rating scale (SCL) and Individualized Repertory Grids, was employed (Fielding, 1975). The self-rated SCL has been used as a criterion of improvement in patients with psychoneurotic disorders (Frank *et al*, 1963; Derogatis *et al*, 1970; Uhlenhuth and Duncan, 1968a, b).

Individualized repertory grids were also used (Kelly, 1955; Fransella and Joyston-Bechal, 1971; Watson, 1970a, b). Each patient provided the names of five persons who were most significant in his life. These significant others, with the self, became the six elements used to elicit each person's set of individualized bipolar constructs. The patient indicated his desired direction of change for each of these construct pairs, so change could be quantified and reduced to a mean rated score. The therapist/investigator constructed a grid rating for himself, with an individualized desired direction of change for each construct pair for each group member. Over the course of the therapy each patient rated himself, his significant others, the other group patients and the therapist. A variety of 'distance' scores were also obtained by comparing a person's self-rating with his rating of others on the 10-point scale for each construct pair. Thirteen measured parameters were thus derived and tested on the experimental group. These were:

1. Symptom check list rating scale score
2. Individualized self-rated score
3. Total self-rated change score
4. Rating of significant others score

https://doi.org/10.1192/bjp.142.5.524 Published online by Cambridge University Press

5. Rating of other group patients score
6. Patients' rating of therapist
7. Patient-related distance from significant others
8. Patient-rated distance from other group patients
9. Patient-rated distance from group therapist
10. Patient-rated distance from all persons rated
11. Patients' rating of each patient
12. Therapist's individualized ratings of each patient
13. Therapist-rated distance from each patient

The parameters were applied to the eight patients initially, after four sessions, and every eight sessions thereafter. The problem of statistically testing clinical hypotheses on a small number of patients was thus overcome by the use of repeated measures (Fielding *et al*, 1969). The therapist/investigator and the group members all became raters of each individual patient's progress.

Verbal participation

Every third group session was audio-tape recorded, using a permanent fixture wall microphone connected to a recorder in another room. The first 60 seconds of each 10-minute segment of group conversation was studied. The measurements of therapeutic change occurred every eight sessions and so there were 20 or 30 segments of group conversation for each measurement period. The amount of time each person spoke during the sample periods was then measured and adjustments were made for any absences.

Each patient's verbal participation over each of the measurement phases was expressed as a percentage of the available group time. The measures of verbal participation were then extrapolated, namely group verbal participation and individual verbal participation. A person's total speaking time over each phase was compared with that of other patients, and each patient was then classified as showing high, medium or low group verbal participation. The person's total speaking time over each phase was also compared with that same person's average speaking time over all the measurement phases and was then scored as above average, average or below average individual verbal participation.

Changes in the various measured parameters were also classified for each person, over each measurement phase, as improved, unchanged or worse. The verbal participation scores were then related to measurement change scores in a series of 3×3 tables. Hypothesized relationships between high or low verbal participation in the therapy group and changes in the various measured parameters were then tested using Chi square and Fisher Exact tests of statistical significance.

Results

A patient's verbal participation in the group, compared with all other members, did not correlate significantly with improvement criteria, except that

TABLE I

Patient rated distance from all persons rated

	Duration in group (sessions)									
Patient	0 4	12	20	28	36	44	52	60	68	76
1	4.02	2.36	2.65	2.11	3.05	2.65	2.48	2.66	—	2.05
2	5.09	4.94	3.94	4.26	3.63	3.17	4.68	4.49	—	3.99
3	3.73	3.18	3.07	3.83	2.60	2.75	2.90	2.66	—	3.29
4	3.30	2.55	3.00	2.44	2.70	2.40	2.40			
5	2.25	1.78	1.69	1.60						
6	4.22	3.19	2.96	3.51						
7					3.72	3.01	3.94	3.49	—	3.68
8					3.73	4.05	3.24	3.67	—	3.66
Means	3.77	3.00	2.89	2.96	3.24	3.01	3.27	3.43		3.33

https://doi.org/10.1192/bjp.142.5.524 Published online by Cambridge University Press

TABLE II
Individual verbal participation scores

		Sessions									
		0–4	5–12	13–20	21–28	29–36	37–44	45–52	53–60	61–68	69–76
Patient	1	−	−	+	+	−	+	+	−	−	+
	2	−	−	−	+	+	+	−	−	+	+
	3	+	+	−	−	+	−	−	+	+	−
	4	+	−	−	+	+	0	−			
	5	+	+	−	−						
	6	−	+	+	−						
	7					−	−	+	+	+	−
	8					−	0	+	+	0	−
Therapist		+	+	+	−	0	+	−	−	−	−
Silence		−	0	0	+	+	0	−	+	+	−

TABLE III
Correlations for all the patients over all of the measurement phases

		Changes in patient rated distance from all persons rated		
		+	o	−
Individual verbal participation	+	14	2	5
	o	1	0	1
	−	5	10	6

more verbal patients were less likely to see themselves as more different from their significant others ($P < 0.05$).

A patient's verbal participation in the group, compared with his participation over other phases, correlated significantly with a number of improvement criteria. The most significant results occurred in relation to the distance measures, especially the patient self-rated distance from all persons rated (therapist, other group members and significant others). Each patient's self-rated distance from all persons rated at each of the measurement points is shown in Table I. Changes in these distances were then classified as closer (+) unchanged (0) or more distant (−). Each member's verbal participation over each of the measurement phases is shown in Table II as greater (+), equal to (0) or less (−) than his average participation over the whole therapy. The change in each patient's self-rated distance measure (+, 0 or −) was then coupled with his verbal participation scores (+, 0 or −) over each measurement phase and the correlations for all the patients over all of the measurement phases are shown in Table III. A rank correlation analysis of each member's verbal participation with the therapist's verbal participation and the group silences showed no significant correlations.

After high individual verbal participation phases, patients were:

(a) Less likely to rate their significant others as more different ($P < 0.05$);

(b) More likely to rate themselves at a changed distance from the rest of the group ($P < 0.05$) and this was more often closer ($P < 0.01$);

(c) More likely to rate themselves at a changed distance from all persons rated ($P < 0.05$) and this was more often closer ($P < 0.05$).

After low individual verbal participation phases, patients were:

(a) More likely to rate themselves as more different from their significant others ($P < 0.05$);

(b) Less likely to rate themselves as more similar to other group patients ($P < 0.01$);

https://doi.org/10.1192/bjp.142.5.524 Published online by Cambridge University Press

(c) Less likely to rate themselves at a changed distance from all persons rated ($P < 0.05$);

(d) Less likely to rate themselves as more similar to all persons rated ($P < 0.05$).

Discussion and Conclusions

The safest conclusion is that there was no clear relationship between the amount of time a person spoke relative to other members' speaking time, and therapeutic change as reflected in the measurement parameters.

The number of statistically significant relationships between individual verbal participation, relative to speaking time by the same patient at other phases, was greater than could be expected by chance. These results were especially clustered in relation to the 'distance' measures 7, 8 and 10. The highest proportion of significant results occurred in relation to measurement method 10, which is the mean, patient self-rated distance from all persons rated. Measurement method 10 was also the criterion measure for factor I in the factor analytic study of the measurement parameters (Fielding, 1975). Factor I accounted for 45 per cent of the variance and correlated with measure 7 ($+0.88$, $P < 0.01$), measure 8 ($+0.915$, $P < 0.01$) and measure 10 ($+0.987$, $P < 0.01$).

A person's perception of himself in relation to other people has been considered important in determining the phenomenon of alienation (Horney, 1950). Neurotic patients rate themselves as more distant (or more different) from their families than normal controls on repertory grids, and this distance reduces with psychotherapeutically induced improvement (Ryle and Lunghi, 1969). Ryle and Breen (1972) described a personal construct model of neurosis based on a repertory grid study and they defined a neurotic as someone who sees himself as unlike others in general and unlike his parents in particular.

If a reduced self-rated distance from others is taken as an operational definition of improvement in group therapy, then it can be said of this group that:

1. High individual verbal participation was associated with more change in self-rated distance measures and/or an increased likelihood of improvement.
2. Low individual verbal participation was associated with less change in self-rated distance measures and/or an increased likelihood of negative change.

In terms of the measured outcome criteria, a patient's speaking out phases were more important therapeutically than his verbal participation compared with other group patients. This study therefore affirms the notion that if a patient speaks out in group therapy, there is a greater chance of positive therapeutic change. Replicatory studies from diverse sources are needed before these conclusions may be generalized. The study has illustrated the application of a relatively non-disruptive model for testing hypotheses in group psychotherapy.

Acknowledgements

The Mental Health Authority of Victoria provided facilities for this study. Mr Norman Carson and Mr George Foenander of the Victorian Mental Health Research Institute helped with the statistics and computer programmes. This study is part of a thesis for MD awarded by the University of Melbourne.

References

DEROGATIS, L. R., LIPMAN, R. S., COVI, L., RICKELS, K. & UHLENHUTH, E. H. (1970) Dimensions of out-patient neurotic pathology: Comparison of a clinical and empirical assessment. *Journal of Consulting and Clinical Psychology*, **34**, 164–71.

FIELDING, J. M., MOWBRAY, R. M. & DAVIES, B. H. (1969) Trial of antianxiety compound—Doxepin (Sinequan). *Psychopharmacologia, (Berl.)*, **15**, 134–43.

—— (1974) Problems of evaluative research into group psychotherapy outcome. *Australian and New Zealand Journal of Psychiatry*, **8**, 97–102.

—— (1975) A technique for measuring outcome in group psychotherapy. *British Journal of Medical Psychology*, **48**, 189–98.

FRANK, J. D., NASH, E. H., STONE, A. R. & IMBER, S. D. (1963) Immediate and long-term symptomatic course of psychiatric in-patients. *American Journal of Psychiatry*, **120**, 429–39.

FRANSELLA, F. & JOYSTON-BECHAL, M. P. (1971) An investigation of conceptual process and pattern change in a psychotherapy group over one year. *British Journal of Psychiatry*, **119**, 199–206.

HORNEY, K. (1950) *Neurosis and Human Growth: The Struggle Toward Self-Realisation*. New York: W. W. Norton.

KELLY, G. A. (1955) *The Psychology of Personal Constructs*, Vols. 1–2. New York: W. W. Norton.

LUNDGREN, D. & MILLER, D. (1965) Identity and behavioural changes in training groups. *Human Relations Training News*, Spring 1965.

RYLE, A. & LUNGHI, M. E. (1969) The dyad grid: A modification of repertory grid technique. *British Journal of Psychiatry*, **115**, 1297–304.

—— & BREEN, D. (1972) Some differences in the personal constructs of neurotic and normal subjects. *British Journal of Psychiatry*, **120**, 483–9.

UHLENHUTH, E. H. & DUNCAN, D. B. (1968a) Subjective change with medical student therapists: I. Course of relief of psychoneurotic out-patients. *Archives of General Psychiatry*, **18**, 428–38.

https://doi.org/10.1192/bjp.142.5.524 Published online by Cambridge University Press

—— —— (1968b) Subjective change with medical student therapists: II. Some determinants of change in psychoneurotic out-patients. *Archives of General Psychiatry*, **18**, 532–40.

WATSON, J. P. (1970a) A measure of therapist-patient understanding. *British Journal of Psychiatry*, **117**, 319–21.

—— (1970b) A repertory grid method of studying groups. *British Journal of Psychiatry*, **117**, 309–18.

YALOM, I. D. (1970) *The Theory and Practice of Group Psychotherapy*. New York: Basic Books.

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(*Received 15 June 1981; revised 21 January 1982*)

https://doi.org/10.1192/bjp.142.5.524 Published online by Cambridge University Press