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THE STABLEMATE CONCEPT OF THERAPY AS AFFECTED BY LSD IN SCHIZOPHRENIA*¹

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A. INTRODUCTION

It is generally agreed that the identification processes are disturbed in the schizophrenic state (3, 11). The frames of reference used by the non-psychotic individual during the adaptation process in daily living are to a certain extent replaced in the schizophrenic individual by internalized symbolic versions of the poignant personalized parts of the schizophrenic's environment. It appeared to the authors that a study of a special type of group process might provide: (a) a better understanding of the nature of the distorted identification process, and (b) improved techniques for communicating with schizophrenic patients, thereby developing better methods of therapy.

Although group methods have previously been employed with the relatives of schizophrenic patients or with other psychotic patients, the present investigation was designed to avoid the conflict situation produced by group therapy with relatives and the contaminated situation produced by contact with other schizophrenics.

We have therefore set up a group process for study which involves contact of a schizophrenic patient only with non-psychotic individuals. Our group consists of (a) the patient, (b) a stablemate, the second member of the group who is in general of the same age and sex as the patient himself, and (c) the interviewer who, in our study, is a scientifically trained, psychiatrically sympathetic and emotionally suitable person for the experiment. In general, we feel that the interviewer, or group leader, need not be a trained psychiatrist but should be part of a psychiatric group with adequate psychiatric guidance. This technique avoids the use of highly trained personnel and

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makes possible an approach to the psychotherapy of the schizophrenic patient by such non-technical personnel who can understand the nature of the reconstruction process involved in relieving the confusion engendered by abnormal frames of reference for identification. As a matter of fact, in our project the stablemate and the group leader are unpaid volunteers.

B. THE STABLEMATE CONCEPT OF GROUP THERAPY

Masserman (8) has described how cats, rendered "neurotic" by air blasts at the food box, may recover previous behavior when a normal cat is placed in the box with the neurotic one. The normal cat goes to the food box readily.

The stablemate concept might be visualized by considering what occurs when two horses from the same stable are entered in a race. The potentially winning horse, by having a familiar partner in the race to whom he is conditioned, is motivated to overcome the stresses of a strange competition because of adaptation to a familiar and safe object, the stablemate. Everyone is familiar with the ways in which a leader collects followers whose actions are patterned after those of the one who shows how something may and can be done. It was the thought of the senior author that this phenomenon might be used to advantage in the psychotherapy of schizophrenia. Earlier experiences led to the hope that under the action of *LSD* this process of identification with a stablemate might be potentiated.

1. *Description of Stablemate Interview Situation*

The present experiments were conducted in the special section of the Research Division of the State Hospital at Central Islip, New York. A tape recorder with its microphone concealed in a small radio cabinet was in an adjoining room which was equipped with a one-way screen.

Three elements were used to structure the interview: (a) the patient was given either a placebo or *LSD-25* in tap water; (b) the questionnaire, previously employed to study *LSD* in non-psychotics, was used as a basis for interrogation (1), and (c) selected pictures of the Thematic Apperception Test (9) were discussed. However, as occasion demanded, games or unstructured discussion was permitted. The formal therapeutic interview, in general, lasted approximately three hours. Interviews were conducted once a week. Some experiments lasted over a period of several months for a single patient, others for two weeks. The taped interviews were transcribed, and the questionnaire charts were analyzed. Content analyses of the group interactions were made by content analysis techniques and by modifications of the Bales' categories (2). The details of the con-

tent analysis code for therapy interactions will be described later. The general nature of the technique used was described to some extent in a previous paper (7). The following examples illustrate some of the categories of the content analysis used:

Positive Affective Statement Towards or About Self

Examples: "I am very happy today"

"I liked to be with nice people"

Negative Affect Towards or About Self

Examples: "I am very anxious"

"I want to go home badly"

Positive Affective Statements Towards or About Others

Examples: "That's very kind of you"

"He looks as if he loves her"

"She looks as if she has just given birth and is very, very happy to have just given birth"

Negative Affective Statements Towards or About Others

Examples: "She looks frantic"

"She is afraid of the darkness"

Mixed Affective Statements Towards or About Others

Example: "She feels strange"

Statements Referring to Positive Affect of Others Towards Self

Examples: "The doctor seems to like me"

"The other patients like me to talk to them and mother them"

Statements Referring to Negative Affect of Others Towards Self

Example: "The patients always try to annoy me"

Statements Without Affective Content

Examples: "Today is Tuesday"

"We keep our clothes in a clothes room"

2. Experiences of "Stablemate"

The stablemate in this experiment was a 39-year-old married woman, mother of two children. The education and experience of the stablemate were essentially in secretarial work. She was somewhat apprehensive at the outset, never having been inside a mental institution before and fearing that she might say or do the wrong thing and thus jeopardize the experiment. At first, the stablemate had headache and insomnia each night after the group meeting. After explanations and encouragement to relax and to avoid structuring the situation or conversation, she became much less apprehensive and was shortly able to look upon the sessions with various patients as interesting experiences.

The stablemate reported that upon two separate occasions, with two different patients, she experienced a fleeting moment of utter confusion. She had to force herself back to reality—mentally shake herself in order to recover control of her thoughts. She could not understand this feeling and wondered if perhaps she was being affected by her association with these patients. This terrified her and, unfortunately, she was afraid to ask for help immediately. Later, during a conference on the experiment, while identification process of schizophrenic with normal was being discussed, it suddenly dawned on her that it might be possible for the identification process to reverse itself, and if so, what had occurred was a momentary identification of the normal with the schizophrenic. Only then was she able to tell us about her feelings during this experience. These experiences have not recurred.

C. EXPERIMENTAL

Although it has been reported that certain schizophrenics do not respond to small doses of *LSD-25* (4, 10) we have begun an extended study of hospitalized schizophrenics who are sufficiently capable of communicating in the group situation to ascertain if this group responds to *LSD-25* similarly to normal individuals. The experiments were run so that the stablemate always received a placebo with the schizophrenic receiving either a placebo or *LSD-25*.

The type of patient that we have been studying usually responds to 50 mcg of *LSD-25* taken orally when studied by our technique. The questionnaire method has been found to be not as useful with schizophrenic patients as with non-psychotic individuals.

1. *Observations and Results*

At the present time data for two series have been partly analyzed. Each series involving one schizophrenic patient lasted over several months. All of the group sessions were recorded and transcribed. It was possible to undertake the Bales' and content analyses for most of the sessions. The findings reported below are based on eight sessions for Patient *A* (four placebo and four *LSD* sessions) and on seven sessions for Patient *B* (three placebo and four *LSD* sessions). The transcripts of some individual sessions exceed 100 pages.

While almost all of the real relationships in the data show a similar trend in both series, we feel that further analysis of our data as well as replications of our studies are in order before full confidence can be placed in the findings. Selected findings are given in Table 1.

TABLE 1
RELATIONSHIP BETWEEN NUMBER OF PATIENT AND STABLEMATE INTERACTIONS IN
LSD AND PLACEBO SESSIONS

	Series A		Series B	
	Placebo (four sessions)	<i>LSD</i> (four sessions)	Placebo (three sessions)	<i>LSD</i> (four sessions)
Number of patient interactions	403	445	1,372	2,095
Number of stablemate interactions	404	381	1,171	1,269
Ratio	1.0	1.2	1.2	1.7

The data in Table 1 indicate that the ratio of patient interaction to stablemate interaction is higher for the *LSD* than for the placebo sessions. For Series A this increase is about 20 per cent and for Series B about 50 per cent. Under *LSD* then the patient's participation in the group process is increased relative to that of the stablemate. Patient's increased participation could be interpreted as an indication of more patient interest in and more patient awareness of the interaction situation. It may also be the result of some intra-group mechanisms involving patient and stablemate which is brought about by the administration of *LSD* to the patient.

In Table 1 we have seen that patient's participation increases in the *LSD* sessions; that is, the patient speaks more often. However, it would have been conceivable that though the patient speaks more often, he contributes as much or less (in terms of quantity) than in the placebo sessions. Table 2

TABLE 2
RELATIONSHIP BETWEEN AMOUNT OF PATIENT VERBAL CONTRIBUTION TO STABLEMATE
VERBAL CONTRIBUTION IN *LSD* AND PLACEBO SESSIONS

	Series A		Series B	
	Placebo (four sessions)	<i>LSD</i> (four sessions)	Placebo (three sessions)	<i>LSD</i> (four sessions)
Patient's verbal contribution (in lines)	764	793	2,964	4,909
Stablemate's verbal contribution (in lines)	1,083	981	1,749	2,153
Ratio	0.7	0.8	1.6	2.3

shows that quantity of verbal input by patient is also increased in the *LSD* sessions. This increase amounts to about 10 per cent for Series A and to about 50 per cent for Series B. For Series A the data also manifests a downward trend for the ratio over time. The decrease in ratio over time occurs both for the *LSD* and the placebo sessions. This trend seems to be a factor in the comparatively lower increase noted for Series A than for Series B.

The relationships emerging from Table 1 and Table 2 should be considered complementary. They point to two aspects of increased patient participation (frequency of interaction and the amount of verbal contribution) which are noticeable for the *LSD* sessions.

TABLE 3
THE RELATIONSHIP BETWEEN SELF-ORIENTED AFFECTIVE STATEMENTS AND OTHER-ORIENTED AFFECTIVE STATEMENTS FOR PATIENT IN *LSD* AND PLACEBO SESSIONS

	Series A		Series B	
	Placebo (three sessions)	<i>LSD</i> (two sessions)	Placebo (three sessions)	<i>LSD</i> (four sessions)
No. of self-oriented affective statements	62	23	89	78
No. of other-oriented affective statements	25	37	63	77
Ratio	2.5	0.6	1.4	1.0

TABLE 4
THE RELATIONSHIP BETWEEN OTHER-ORIENTED STATEMENTS AND NON-PERSON ORIENTED STATEMENTS FOR PATIENT IN *LSD* AND PLACEBO SESSIONS

	Series B*				<i>LSD</i>			
	Placebo							
	Oct. 11	Nov. 8	Nov. 29	Total	Oct. 25	Nov. 2	Nov. 15	Dec. 6
No. of other-oriented statements	241	138	110	489	207	80	137	158
No. of non-person oriented statements	126	96	92	314	36	37	64	65
Ratio	1.8	1.4	1.2	1.5	5.7	2.2	2.1	2.6
								202
								2.9

*Data available for Series B only because category of non-person oriented statement had not been included in content analysis of Series A.

Tables 3-5 are based on the content and Bales' analyses of the verbatim data. The categories of the content analysis have been briefly illustrated earlier in the paper. We believe that the "target" reference of a communication is related to the involvement of an individual with himself or with the group situation. The ratio of Self-Oriented Affective Statements is considerably greater in the placebo than in the *LSD* sessions in both Series A and in Series B. This implies that during *LSD* the patient's affective references revolving around the self decrease and affective references toward or centering around other persons increase.

While we previously noted increased patient participation under *LSD*,

we now note that this increased participation and communication is *other* directed. It is on the basis of these findings that we tentatively suggest that *LSD* might prove useful in facilitating communication in psychotherapy.

We noted that during the *LSD* sessions the number of non-person oriented references on the part of the patient decrease considerably and the number of other-oriented references increase. This further documents the point made in relation to Table 3. It seems that under *LSD* both self-oriented and non-person oriented references decrease while references toward and about others show a steady and considerable increase.

TABLE 5
THE RATIO OF EXPRESSIVE TO INSTRUMENTAL ACTIVITY FOR PATIENT IN *LSD* AND PLACEBO SESSIONS

	Series A*					
	2/9	Placebo 3/22	Total	3/1	<i>LSD</i> 3/15	Total
No. of expressive acts**	19	24	43	44	19	63
No. of instrumental acts***	129	183	312	192	86	278
Ratio	0.15	0.13	0.14	0.23	0.22	0.23

*Data not available on Series B for this dimension since Bales' coding of this series has not yet been completed.

***Expressive Acts* include the showing of solidarity and antagonism, the showing of tension and of tension release, the expression of agreement and disagreement. They pertain to the socio-emotional area.

****Instrumental Acts* include the giving and asking for orientation, the giving and asking for opinion, the giving and asking for suggestion. They pertain to the task area.

(a). The ratio of expressive to instrumental acts is almost twice as high for the patient during the *LSD* sessions than during the placebo sessions.

(b). This finding is to some extent but by no means wholly accounted for by the greater number of laughter acts under the *LSD* condition.

(c). The *change in the ratio* between the two kinds of behaviors occurring for this patient under the two conditions should be contrasted to the *stability in the ratio* of expressive to instrumental activity found in our group experiment with "normal" subjects (7).

(d). This difference from the reaction of "normals" to *LSD* is interesting since contrary to some previous claims (4, 10) the schizophrenic patient shows *more* change in behavior (in this aspect) than do the normals. In other words the chronic schizophrenic responds to the same small dose of *LSD* as does the "normal," but the response is not the same in the two.

D. COMMENTS

In the design of this present experiment we were first concerned to test the stablemate hypothesis, second to test the hypothesis that identification by a schizophrenic with a normal person might take place under the conditions of the test. Corollary to this we wished to ascertain whether *LSD* would alter the disposition of psychic "forces" in the schizophrenic, and if so, whether this would favor the identification process. We were not quite prepared for the degree to which this change did occur. It may prove salutary to comment on the implications of what happened as a consequence of our inability to spend the time or to devote the attention to the patients following *LSD*, which their response to *LSD* called for.

The arrangement was such that the medication or placebo was administered about 10:30 A.M. This would be followed by interviewing during the next four to six hours. During this time, in the earlier experiments, the patient briefly returned to the ward for lunch; later lunch was shared by interviewer, stablemate, and subject. Following the departure of the interviewer and stablemate, it was the custom of one of us to visit the ward, where usually, the patient would be spoken with unless she herself withdrew, e.g., by going to the lavatory. The patients were never in doubt as to whether or not they had received medication, even when the dose was as low as 40 micrograms of *LSD*. Often they inquired, "What did you do to me?" "What has happened? My mind won't hold still. My legs feel funny. Oh, oh, oh, . . . this is something." In this state there was almost invariably an intensification of clinging dependency. The few apparent exceptions were transparently intensifications of prior defensive behavioral patterns, e.g., R.S. and B.R., both of whom became more withdrawn, mute, and giggly.

By checking back over the content of the patients' communications during the *LSD* sessions, and by reference to the attitudes to the interviewers expressed subsequent to the sessions, it was evident that the patients had formed hopes of someone listening to them, being genuinely interested, and of "doing something" (magical?) which would change everything for the better. This degree of expectation is rarely encountered with this type of patient. It seems directly related to the stablemate design of the experiment.

The immediate consequences of *LSD* were often followed within a few days, or in some instances after the second or third visit of the interviewing pair, with or without subsequent *LSD*, by increasing agitation, expressions of despair, and interferences with thought processes. In A.R., for instance,

the patient who had felt guilty and sinful and thought that she should be killed, increased her stealing, tried to make love to a passing male patient, cried, wrote letters to the sheriff to arrest her so she might be executed, and finally became so suicidal we had to offer her maximal protection. A.B. lost weight, became very restless, increased her water drinking and consequent urination (her form of infantile sexual gratification), sighed constantly for a lover and a baby to have for her own. She went on to sitting naked on the bathroom floor, and her inability to eat became so alarming we had to transfer her to less exciting and threatening surroundings. There she improved after a period of several months to her prior state.

We recognize that these observations are not entirely new. The long delayed reactions to *LSD* sometimes reported (6) are, we believe, more psychological than pharmacological, and are to be understood as the consequence of release of preconscious or unconscious material. This may be of no great consequence in relatively normal persons, or in those who dissociate affect and content, or in those whose contact with a psychotherapist or friend is sufficiently supportive, but in the psychotic it can be disruptive.

We hope that these studies may lead to a new type of therapeutic approach. This procedure would endeavor to reconstruct the schizophrenic personality via the route of identification with a non-psychotic group. It appears that *LSD-25* may facilitate this process.

E. SUMMARY

1. Group process for study involving contact of schizophrenic patients with non-psychotic individuals is described. A non-psychotic "stablemate" is the second member of the group. The psychotic patient and the non-psychotic stablemate formed a therapeutic group with a third person, the group leader.

2. Under *LSD* the patient's participation in the group process is increased. Both the frequency of patient interaction and the amount of patient verbal contribution in the group situation is higher in the *LSD* than in the placebo sessions.

3. Under *LSD* the patient's affective references revolving around the self decrease and affective references toward or centering around other persons increase.

4. Under *LSD* the patient's non-personal references decrease and other-oriented references increase.

5. The ratio of expressive to instrumental acts is almost twice as high for the patient during the *LSD* sessions than during the placebo sessions.

6. On the average the patients exhibit a higher ratio of positive over negative socio-emotional acts during the *LSD* sessions than during the placebo sessions.

7. In general, there is just as much if not more change of behavior under *LSD* for schizophrenic patients than for "normal" subjects.

8. Communication between patient and stablemate during *LSD* sessions is characterized by a greater amount of other-oriented references than during placebo sessions.

9. The release of preconscious material is associated with greatly increased anacritic needs.

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