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THE GROUP PSYCHODYNAMIC PSYCHOTHERAPY APPROACH TO PATIENTS WITH PSYCHOSIS

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SUMMARY

In writing about the group setting in treatment of patients with psychosis the author is drawing from his long clinical practice and his writings on the subject. He underlines the value of group-analytic concepts, formulated by S.H.Foulkes, as well as needed modifications when patients with psychosis are in question. Through clinical examples he will explain his experiences and discuss some specific features concerning inpatients and outpatients group psychodynamic psychotherapy for patients with psychosis. A special attention will be directed towards the dynamics of the therapist's/therapeutic team's roles, and to the need of continuous supervision.

Key words: *group psychodynamic psychotherapy – psychosis - group analysis - therapist's roles - supervision*

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Introduction

The group psychotherapeutic approach to patients suffering from psychosis has been developing since the 1930s. It was long process until the communication of patients with psychosis could be understood and used for diagnostic and therapeutic purposes. The basic understanding of the psychodynamics, found in patients suffering from psychosis, originally stemmed from psychoanalytical concepts. The psychotic defense mechanisms (splitting, denial, primitive idealization, massive projection, etc.) had been for a long time considered as a hindrance in applying the group setting to the comprehensive treatment of patients with psychosis. Among many theoretical and clinical modalities developed through decades of experience the modified group-analytic model was adopted in our clinic and has been s shown to be a reliable basic ground for psychotherapy of these patients. Developing the group-analytic theoretical framework and therapeutic applicability in the war situation of the 1940s, in an ambience where ex-soldiers were severely psychotraumatized, S.H.Foulkes included social science components in his group-analytic approach. His work was primarily directed towards the neurotic spectrum of disturbances.

When a psychotherapist decides to include the group in his armamentarium for the treatment of patients with psychosis, he/she should first carefully define the concept of psychosis, and in particular that of schizophrenia. His/her attitude toward the application of the group medium will derive from this foundation. This is especially important if the therapist's aims include issues of personal growth and transcending the mere restitution of the patient's psyche to the level preceding psychotic decompensation, if this is possible.

This situation imposes on the psychiatrist/group psychotherapist a change of the usual psychotherapeutic techniques in order to adjust them to the specific ways of functioning of patients with psychosis. Nowadays, the psychotic symptoms are thought of as having an essential communication value in spite of their at times very hermetic, autistic appearance. This means that the therapist's role in a group of patients with psychosis should be modified in order to meet the specific features and needs of these patients.

Some considerations regarding the nature of psychotic processes and their consequences

Since it is known that emotional states affect the direction of thought processes, along the analogy of the early developmental lines of the brain and its manifestations I would advocate the view that affective states can have basic regulatory effects on the modelling of later thinking processes and their vicissitudes. The supposed innate hypersensibility leading to hightened vulnerability of the developing personality, especially connected with the quality of the human environment for that specific human being, gives to the notion of the group as such the specific ambience where the human being starts his/her developments and where developmental inappropriatedness can distort and/or hold it up to the point of deep regression to earlier developmental phases. I am suggesting (Urlić 1999) that the clarification and basic comprehension of what occurs in a psychotic state or in personality functioning has more than an academic meaning, since it can considerably affect the choice of therapeutic approaches to the patient with schizophrenia, and the definition of roles that the psychotherapist will be able to utilize in the relationship with the patient.

In this sense Skolnick (1994) considers that „there are a multiplicity of meanings embedded in processes that culminate in breakdown, whether the breakdown is categorized as major depression, bipolar disorder, addiction, borderline disorder or schizophrenia. Meaning, relevant for the self of the patient, the family and

the larger social system is buried when the field of inquiry and action is reduced to the study and treatment of the patient's diseased or 'chemically imbalanced brain"".

Among many researchers regarding the nature of the psychotic process and the ways it can affect one's personality functioning Bion was certainly one of the most intuitive. He distinguished between two separate entities: the psychotic and non-psychotic parts of the personality. Lucas (2002) writes that they function quite differently, the fundamental issue being how they cope with psychic pain. According to Bion „here is always an underlying non-psychotic part capable of taking in and thinking, and through tolerating frustrations learning from experience. This means that even in the case of the most disturbed of patients one is invited still to seek an unaffected part of the patient with whom to communicate".

Clinical experience confirms the value of this way of approach to the patient suffering from psychosis. The further meaning of such recognition puts in evidence the value of the psychodynamic culture of the psychotherapist and the whole therapeutic team, be it of group-analytic or some other interpretative theoretical orientation. The psychodynamic culture opens up possibilities of deeper and more complex understanding of the psychic functioning of the patient, and enlarges the containing capacity for the patient's most overwhelming symptoms.

The clinical example I

The clinical example I from group psychotherapy of the inpatient group of patients with psychosis will illustrate one of the very characteristic features of a kind.

Sebastian tells his dream. In the dream he should travel to France with a Croatian passport. The French don't let him enter the country because the document isn't theirs. Than he returns to Croatia with a French passport and the Croatians don't accept it because it is not their document. He remains in a 'no-man's land' and talks with himself about how desperate he is .

Yesterday he was almost crying, but when he was a child his father told him that men don't cry.

Ana adds her recollections that she was always good in school. Sometimes, for some minor errors her mother would have beaten her and Ana would have cried and screamed. Her mother would say that if she were continuing in that way she would become crazy.

George said: "Does it mean that if you protest you're crazy?" He said he used to be angry with his father. His mother was 17 when she delivered him. His father had his affairs, his mother hers, and in his house there were no rules... When he was 15 his father was telling him about his relationships with women. He was in confusion. He wanted his father and not his secrets (he remained near to crying).

Jane said that her mother remained a widow after she was born and her father's brother married her. She got to know that family secret when she was an adolescent... There was another secret in her family, her mother's sister committed suicide... She was asking why it is not possible to have more open and sincere talks inside the family.

Julie said that her late mother was a seamstress. Her mother never asked her how Julie would like to have a dress done. Julie was always fat, but her mother was sewing very tight dresses that she could barely pull on her. Strange...

It is not often that patients with psychosis remember their dreams. Sebastian's dream about being in no-man's land and not-belonging had prompt resonance from the other group members, each mirroring his/her distressing experiences. The inability to express their own feelings, wishes and needs, and facing up to the family incomprehensible secrets was clearly delineating the unfavorable family relationships toward the child that later showed psychotic symptoms and inability to cope with for him/her unbearable stresses.

On some group-analytic specific features in organising and understanding the psychotherapeutic group

When organising outpatients group psychotherapy for patients with psychosis the inpatients group serves for deeper understanding of suffering of each patient and helps to select him/her for the appropriate group. It is known that not all patients with psychosis can benefit from group psychotherapy, especially ones with paranoid symptoms, or acute psychotic, deeply depressive, and borderline and narcissistically structured patients, as well as those who are organically dammaged. For patients with these disturbances homogenous groups are indicated according to the diagnosis, while for patients with other psychotic features heterogenous groups of male and female patients are offered because they are more adequate.

The therapeutic groups can be small (4-8 patients) or median (up to 15 patients). Larger groups are not indicated for patients with psychosis, because It is not possible to establish and develop personal contact between the psychotherapist/therapeutic team and patients in the group (Urlić 1999, Restek-Petrović et al. 2007, Bernard et al. 2008).

During the therapeutic group process group members can unconsciously assume different roles (Foulkes & Anthony 1965): (1) the scapegoat: represents the manifestation of massive projections; (2) the new member: the group has difficulties with tolerance of the new member; (3) the historian: defensive regressive phenomenon; (4) the monopolist: often represents an effort to ease own or group anxiety; (5) the parallel conductor: the effort to diminish own simbiotic needs or separation anxiety 'allying' with the psychotherapist by imitation, working for or instead of him/her; (6) the weakest group member: might become the group's child, expressing simbiotic needs and separation anxieties.

There are observable phenomena emerging during the group process that are specific for group psychotherapy (analysis, according to Foulkes): (1) Feedback: the reaction of one or more members to the behavior of one group participant, verbal or non-verbal. (2) Condenser: sudden expression of deep and primitive material, 'collective unconscious'. (3) Resonance: primarily on the unconscious level. In the group conflicts become amplified and better visible. (4) Translation: through communication unconscious contents become conscious during the group process. (5) Location: the group becomes ground for freer social interactions, showing where the fixations of disturbances are located. (6) Occupation: the meaning and significance of getting together of the group in order to organise some activity, consider common interests, etc. (7) Mirroring: mirroring in the group, where previously unknown persons expose their experiences, 'mirror' similar situations, might become a therapeutic factor. One should distinguish 'benign' from 'malign' mirroring with destructive, aggressive elements prevailing.

All these group specific phenomena make up part of the process of communication. The patient is able to see him/herself or parts of him/herself in other group members. Some reactions of others could be seen as one's own way of reacting. The therapeutic group, as with many other groups, is offering a learning experience, and one of the roles of the psychotherapist/therapeutic team is to foster this kind of exchange and learning.

During the group psychotherapeutic process the following therapeutic factors were recognized (according to Yalom), (Yalom & Leszcz 2005, Bernard et al. 2008): (1) Universality: sharing and recognizing similar feelings, thoughts and problems;(2) Altruism: helping other group members helps expand self-esteem; (3) Instillation of hope: other members' therapy success can be helpful in developing optimism regarding one's own improvement; (4) Imparting information: explanation or advice provided by the therapist or group members; (5) Corrective recapitulation of primary family experience: opportunity to reenact critical family dynamics with group members in a corrective manner; (6) Development of socializing techniques: the group provides members with an environment that fosters adaptive and effective communication; (7) Imitative behavior: expansion of knowledge and skills observing the group members' self-exploration, working through, and personal development; (8) Cohesiveness: feelings of trust, belonging, and togetherness experienced by the group members; (9) Existential factors: acceptance of responsibility for life decisions; (10) Catharsis: members release strong feelings about past or present experiences; (11) Interpersonal learning – input: members gain personal insight about their interpersonal impact through feedback provided from other members; (12) Interpersonal learning – output: members provide an environment that allows members to interact in a more adaptive manner; (13) Self-understanding: members gain insight into psychological motivation underlying behavior and emotional reactions.

The clinical example II

Many of the above mentioned roles, phenomena, and therapeutic factors could be followed through one part of the outpatients heterogenous group of patients with schizophrenia, exposed in clinical example II:

The group has 13 patients, including two new participants: PR and MM .

RS said that today she will take again her name Roberta, otherwise she can't recollect her life. She is happy to be with the others, she likes them.

The therapist commented that last time somebody was missing her.

Roberta: „I am missing everywhere. It is obvious that people like me are missing because I am very open".

PR.: „I was in many groups where I was feeling good. There were always something new to say, like in the factory. When there were strikes there were meetings as well. This group could be of a kind and everybody could express his feelings".

He then explained that he did not think about therapeutic groups but about workers' group, where they were discussing various problems. They were voting and the majority was winning.

Roberta talking to PR: „Have you been the boy-friend of my sister".

PR said he was going around with his friends but that he was not close to her sister.

The dialogue transformed into a short silence.

DP: „I would like to know from this group of friends what it means to work. I believe that to work means to live. There are people that think that work is sweat and fatigue, while others feel good when working".

Roberta: „Work is a spiritual initiative. When I am recovered I always try to work and to put everything in order. There is always something that could be done but very few persons or no one does anything. If you don't work you don't have money for holidays".

PD: „Many times I was searching for work, over the last 20 years, but I was always running into controversies and I couldn't be able to express myself, i.e. what does it mean to be a trainer for the handicapped, thinking that we are all handicapped. I think when I give I have (thinking on one earlier experience). To be with one handicapped adolescent means to satisfy completely his needs".

Roberta: „Work is mental gymnastics, as well".

RP: „I am very unhappy because I don't work. I am unemployed and I am desperatly searching for a work, nervertheless I have my retirement money and the salary of my wife... If I don't work I don't feel equal to others. I hope to find a job and go to 'night hospital' and then to go to the community".

Roberta: „I am the only one who is working“.

RS.: „I had a nice work, even creative, but I didn't succeed to save my job“.

PRO.: „They have changed my role and I was working more and more“.

Roberta: „When I used to go to work in the bus they were always putting the song 'I wish to die'. I was depressed and I had the ugliest works to do ... I had an accident, for three days I was in a coma, but after that I continued to work because the work is the source of life. Who does not work becomes mad. My life was always full of efforts, I was feeling inferior when confronted with the others“.

In this part of one session some group members enter the mutual verbal exchanges, while some others remain silent. The range of topics went from identity issues to the meanings of work, i.e. social inclusion on equal ground with anybody else. The image of the handicapped adolescent was uncovering the underlying feeling of being handicapped, feeling inferior due to some difficulties in psychic functioning. Here the group conductor/therapeutic team in the further course of therapy found some space to support healthy tendencies, clarify expressed difficulties on personal, interpersonal and social levels, and take care that the comprehensive treatment schedule is adequately and regularly applied. It is important to underline that the group becomes a container for unbeareble feelings (v.Wallenberg Pachaly 2008). Because it offers especially protected space for free exchange of feelings and thoughts, group psychotherapy with its specific features has great therapeutic potential (Gonzalez de Chavez 2009).

The interpretative, psychodynamic, or group-analytic culture of the conductor/psychotherapeutic team will be of great importance in choosing the working style with the group.

On conducting style in group psychotherapy with patients with psychosis

While approaching the therapeutic group of patients with psychosis from a psychodynamic/group-analytic understanding, the dilemma of the group therapist is the possible transformation of the leadership into a 'conducting' role (Urlić 1999). In that respect Foulkes (1964) states that 'while the therapist does not assume active leadership of the group, he conducts it continuously... He follows the lead of the group and makes himself an instrument of the group'. Of course, when working with patients with psychosis this 'ideal' possible development of the group dynamics has to be adapted to much more regressive levels of functioning of patients with psychosis that of those with neurotic symptoms. However, I am suggesting that if the therapist is not a rigid and conformist person, but one who accepts the analytic approach to the group as a continuous challenge, the shift from leader to conductor type of working with the group will be likely to occur, more frequently in outpatient groups where psychic functioning is less regressive.

In groups of patients with psychosis the psychotherapist/therapeutic team is available and ready to get involved when the group members require it, and the members learn how to engage him/her (or the team) when they are unable to reach a satisfactory resolution of their issues. If during development of the group process the focus is on group-as-a-whole, it will primarily assume a shape of the care for the relationship to reality and coping styles.

The question can be also raised with regard to the roles and their range, or flexibility, that the group therapist/therapeutic team can assume in the group of psychotic patients in hospital and outpatient settings. According to clinical experience (Urlić 1999) it could be said that: (1) the therapist conducts the individual in the group. In hospital conditions this situation does not change considerably from the beginning to the end of group treatment due to deep regression and fragmentation of the psychic functioning of the patients, while in case of outpatients, a more flexible approach is possible, with the transformation of the ‘infinite‘ into a more defined course of the treatment; (2) in hospital groups, due to time limitations in terms of the ward treatment and heterogeneity in the regression depth, the therapeutic aims are necessarily limited; (3) the outpatient group, on the contrary, needs constancy, or spatial and temporal continuity, with an open and adjustable perspective at the level of the ego functions and stability of the patient's object relations; (4) in the outpatient group of patients with psychosis the possibility of the evolution of the therapist's role from leader to conductor is more realistic and often more adequate than in hospital conditions. This means that the ‘distinctions’ between these two ways of conduct become more permeable for a wide range of influences and, therefore, considerably more flexible in their exchange; (5) the therapeutic work in the group setting can be aimed at corrective symbiotic experience, as well as at ‘dilution’ of the dyadic transference relationship in terms of the development directed at the triadic, socially better adjusted, one (Urlić 1999, Chazan 2001); (6) group psychotherapy of patients with psychosis represents in both hospital and outpatient conditions, together with psychopharmacological therapy, an essential complementary part of the treatment of patients suffering from psychosis (with the exception of manic patients, or those inclined to acting-out, and with a questionable benefit for acute paranoiacs); (7) group psychotherapy of patients with psychosis represents an important part of both therapeutic and diagnostic approach to the patient. It can represent a technique of professional approach, and part of usual routine, or it can reach high levels of creativity and represent a challenge for further scientific research.

Concluding remarks

In adopting the group psychodynamic psychotherapy approach to patients with psychosis, especially the group-analytic paradigm according to Foulkes, the most valuable therapeutic element is represented by the possibility of understanding the multilayered meanings of 'psychotic language' in the psychodynamic sense (Urlić et al. 2009), this requires special training and continuous supervision (Urlić et al. 2007). In this respect it is important to remember Foulkes' comment that ‘a mature group therapist is a genuinely modest person, who can say sincerely to his group: We are here to consider together realities and basic problems of human existence. I am just one among you, nothing more or less.’ Though this attitude may look like idealization, it can represent a model to which the psychotherapist working in the group of patients with psychosis can be directed to maintain his flexible, but always very reliable role and his/her creativity in elaborating and fostering communication, respect and understanding.

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