

## **INPATIENT GROUP THERAPY OF PATIENTS WITH SCHIZOPHRENIA**

**Vita Pukl Gabrovšek**

*University Psychiatric Hospital Ljubljana, Slovenia*

### **Introduction**

The treatment of psychoses, particularly of schizophrenics, occupies a special place within the evolution of psychiatry and psychotherapy. Group therapy has come to play an important role in the treatment of psychotic disorder. It is known that the best results of the treatment are achieved with combination of antipsychotic medications, psychotherapeutic treatment, family therapy, and a variety of social and rehabilitative interventions.

The purpose of this lecture is to demonstrate inpatient and outpatient group psychotherapy of schizophrenic in small therapeutic groups, employed by group psychotherapists with different theoretical orientations. Certain characteristics of psychodynamics of these small groups are discussed.

In spite of lengthy experience in the application of group psychotherapy with schizophrenic patients, there are few studies regarding this issue. This appears to be more due to the vagueness of the concept of psychoses than to clinical practice. There are a lot of different therapeutic approaches, which make the comparison difficult in terms of their efficiency in treatment of psychotic patients.

Generally, the following three conditions must be met in group psychotherapy:

- The group primarily relies on verbal communication;
- The individual group member is the object of the treatment;
- The group itself is the main therapeutic factor.

To make the shift from ego-supportive group psychotherapy towards analytic group therapy (group analysis), modified for psychotic patients, another three conditions should be met:

- Verbal communication should develop into "group associations" by means of "free floating discussion". Everything manifested in the group is analyzed. Such group uses the manifest content to reach the latent level by the process of identification.
- The group therapist directs group process in agreement with those assumptions.

- The analytic group is basically a transference group.

### **An historical overview**

Schizophrenics have been treated in therapy groups for over 80 years. Edward W. Lazell, a psychoanalytically oriented psychiatrist, was a pioneer in using group techniques with inpatient psychotics' at St. Elizabeth's Hospital in Washington, D. C. He reported on such a group in 1921. His approach consisted of a lecture classes which utilized psychoanalytic principles and the giving of information. He reported some advantages to the group method included socialization, reduction of fear of the psychiatrist, and minimal social contact for the inaccessibly regressed.

Ten years later ward discussion groups were added to the lecture format at Worcester State Hospital in Massachusetts.

Freud's follower Louis Wender was the first to apply psychoanalytic concepts to the small inpatient group with non-psychotic patients in a private mental hospital. He tried to distinguish his group method from the educational and directive techniques of his time.

**During World War II**, group therapy was practiced in a number of military hospitals. In Northfield Military Hospital in England Bion, Foulkes and Main developed group analytic approach which was later applied to outpatients. Foulkes pioneered the group-centered method of group psychotherapy and noted the healing qualities of the group as a whole. He came to view the hospital itself as large therapeutic group of which the small therapy groups were only a part. He appreciated the complex interrelationship between the group and the psychiatric unit so that the work in the small group helped the unit develop a therapeutic milieu.

**After World War II**, there were several years in which group work flourished. It was in 1950's that the awareness of the advantages of the group setting increased in terms of helping schizophrenic

patients to express their feelings and thoughts. This approach was considerably facilitated and aided by the development of psychopharmacotherapy.

Unfortunately inpatient groups were initially modeled after outpatient treatments, which failed. The focus on feelings heightened anxiety in a way that impeded therapy. Part of the problem has been that the conditions for inpatient treatment for psychotics are markedly different. The average length of stay on an inpatient unit is less than one month, patient turnover is rapid, the population is heterogeneous and motivation is questionable. Consequently the enthusiasm for inpatient group psychotherapy waned together with the interest for other verbal psychotherapies.

Some have introduced non-verbal exercises into these groups; others have used psychodrama and related techniques or didactic approaches. Those, who still used inpatient small groups for schizophrenics, structured them in such way, so that they control the many aspects that make inpatient group psychotherapy difficult and confusing. Common to most inpatient methods are the use of support and structure, active interpersonal engagement by the therapist, problem spotting and problem-solving orientation.

### Variations of group therapy approaches

The way in which group therapy is conducted with the psychotic population is largely dependent on the therapist's theoretical orientation. The therapist who believes in a psychodynamic model of the mind and sees the psychoses on a continuum with other disorders is likely to conduct the group in a relatively unstructured way to allow the partial emergence of regressive and transference experiences which can ideally be resolved through interpersonal interactions and interpretations. The therapist who holds to a biological deficit model is more likely to provide a structure which will minimize anxiety and regression and foster coping skills (Pines 1999).

Pines in his book formulated following approaches:

- the supportive/ problem-solving/educative;
- interpersonal/interactive/relational;
- psychoanalytic/ psychodynamic;
- group analytic and group-as-a-whole approaches;
- Kanas' "integrative" model.

Kanas (1996) mentions three fundamental treatment approaches:

- Educative;
- Psychodynamic;
- Interpersonal.

Foulkes distinguished between "leader-centered" and "group centered-group"

### Inpatient group psychotherapy

The contemporary psychiatric ward is conceived of as sociotherapeutic community. Today it is impossible to imagine a psychiatric ward where different forms of group therapy are not used as basic methods of treatment. Group therapy in hospital conditions can be appropriate if it is adjusted to the reality of the setting in which it is conducted.

#### *Theme-oriented group psychotherapy of psychotics (P. Opalić, 1988)*

The theme must originate from within the group and not from the therapist the first five to ten minutes of the session. Each session must be dedicated to one theme only, with the possible exception of another theme closely connected to it. It must be related to the recent experience, communication and preoccupations of group members and it must be sufficiently close to reality and well known and understandable to all and has an interpersonal relation. Preferably it should be directly related to psychotic experiences or unusual and unpleasant feelings. The therapist must behave as "first among equals". The theme is used for making comparisons between psychotic content and reality. At the end of every session, it is necessary to make a summary of what has been said in regard to the theme, to opinions of group members and to situations which arose during the session.

#### *Therapy effects*

The group tries to satisfy the psychotics' vast need for orientation. A specific theme represents a cognitive framework to express unpleasant, insufficiently clear and unknown feelings. It also represents a kind of therapy contract, which excludes destructive behavior, or "acting-out".

The question remains to what extent this approach as well as other highly structured group methods serves the therapist to conquer his own insecurity and disorientation, especially when he is

under attack or when the continuity of the group sessions are threatened.

#### *Kanas' "integrative" model*

Kanas has developed a method designed for homogenous groups of schizophrenic patients which is preferred, since specifically oriented techniques for this population can be used. He uses integrative approach that utilizes educational, psychodynamic and interpersonal theories and techniques. It is supportive and discussion oriented and helps patients to learn to cope with psychotic symptoms and to improve their interpersonal relationships. Patients are encouraged to talk about the problems they have interacting with others. Sharing of emotions and symptoms is promoted. These include feelings of loneliness and depression, as well as psychotic productions such as hallucinations and delusions. There is an attempt to improve reality testing and to help patients cope with disorganizing experiences. Advice is given about practical matters. However expression of anger towards other group members is discouraged since it is seen as poorly tolerated, leads to increased anxiety and is potentially disruptive. Insight oriented issues are avoided.

Important group topics are:

- encouragement of contact with others;
- reality testing;
- expression of emotions;
- giving advice about practical matters.

This model is suitable for short-term units where patients stay less than six weeks. The patients valued such groups as a place to express emotions and learn ways of interacting with others. Patients are also encouraged to interact to each other on the ward after the group sessions (Kanas, 1999).

Hospital group psychotherapy of psychoses serves the functions of:

- the establishment and regulation of ego boundaries;
- the occurrence of the corrective symbiotic experience;
- the more adequate relation towards outer and inner reality;
- the stimulation of interpersonal exchange;
- the support of healthy ego (Urlić, 1999).

#### *Psychoanalytically orientated group project with chronically psychotic inpatient (Hawthorn project, D. Campbell LeFevre, 1994, 1999)*

Such groups have been held in hospitals throughout the U.K. last 30 years. Author supervised four to six member groups of long-term inpatients (8-40 years) on rehabilitations wards, mainly schizophrenic, that met for an hour per week, conducted by nurse-facilitators. All groups went through phases resembling a bereavement reaction. Each phase lasted for about six months.

These phases were:

- Denial of reality ("There is nothing wrong with me, I'm OK.").
- Anger, culminating in rage ("Why are you talking to me now after all these years? Where were you when I needed you?").
- Sadness at a lost life.
- Anxiety ("What's going to happen to me?").
- Reality-testing (about the long-planned move out of the wards).

None of the patients who moved into group homes have yet been readmitted.

In the staff powerful countertransference reactions were observed like feeling disorganized, frustration, exhaustion, hopelessness... and some people became ill. Not enough attention is paid to countertransference evoked in the facilitators of groups with psychotic patients.

Group-analytic family and couples psychotherapy is a methodology based on a development of group-analytic theory.

#### **Outpatient group psychotherapy**

Kanas (1999) suggest that for many patients group therapy is their primary socializing experience and that patients should be encouraged to look at each other and relate interpersonally in the here-and-now. He suggests to therapists to be generally less active and revealing than in the inpatient setting, but to be more supportive and active than in outpatient groups with nonpsychotic patients. Insight-oriented techniques should be avoided, since some schizophrenics may be harmed by too much uncovering and self-disclosure.

The therapist is: 1. active and directive in keeping group members focused on the topic; 2. clear, consistent and concrete with interventions; 3. supportive and diplomatic with comments; 4. open and willing to give opinions appropriate to discussion; 5. here-and-now focused; 6. encouraging of patient-to-patient interactions.

### *Group analytic therapy with schizophrenic outpatients*

In contrast to previous view some authors (Chazan, 1993, Urlič, 1999, Ivezic, 2004) believe, that group analytic therapy is an effective method to treat schizophrenic out-patients, but the conductor must take more active approach at the beginning. The group analytic psychotherapy is in advantage from individual therapy in relation to transference and reality testing.

Schizophrenics living in a community often suffer from loneliness, emotional dependence, and a sense of not being needed and not being effective as a person. Some find it difficult to cope with the company of others. They never meet their parents as adult to adult.

Chanas (1993, 1999) presented some reasons, why groups for schizophrenics work so well for these patients:

1. The first task of a group is to learn to communicate, which has two components: -finding a common language, and -learning to take part in the group dialogue. Some psychotics use esoteric, private language which can be anything from neologisms to somatization or communicating anxiety by expressing confusion. In the group, the patient has to use the common language to be understood. The individual member has to learn to be part of the group, neither to recede into background nor to dominate, to listen as well as to speak. This is particularly difficult for the immature patients, who, in many cases, like a small child, crave to be the center of attention.
2. To use the group as workshop in interpersonal relating. Group members behave toward the group as they behave toward significant others in life. The group reflects back to them how they are perceived by others. This is particularly important for schizophrenics to develop new forms of relating.
3. Reality testing. The group is not perceived as an authority figure. In a delusional system which divides the world into "us" and "them", the therapist becomes part of "them" and resistance develops. Since group members are perceived as "us", the patient is more likely to come to accept their observation concerning reality distortion.
4. To be accepted as an equal and not as a dependent and as an equal though one is "different" or "crazy". The schizophrenic on the community knows he is different from

others. In the group the patient may talk about his craziness without being criticized or rejected.

5. To be expected to help others and to take responsibility for others.
6. Finding that one can make a difference to others and gaining feelings of competence. To the schizophrenic discovery to be able to help other group members often comes as a complete surprise. In many cases, family and community have conveyed to schizophrenics that they are not expected to do anything for others. The group member is given to understand that his opinion is valued and his interpretations have importance.

Members often meet outside the group, which is encouraged, giving practical help and encouragement to one another. The group is an important real object to the patient.

The group therapist of schizophrenic patients must possess:

- unpossessive warmth (a primary, non-verbal capacity for relatedness);
- empathy;
- genuineness (to spontaneously direct and measure his behavior toward the patient).

Conducting a group of schizophrenics, the therapist acts differently than with group members who are able to function at a higher level. The aims of group work are related to the needs of the patients.

In the group the transference can be less intense because the patient has the opportunity to view the therapist as a more real person. The patient with schizophrenia has a conflict to be at the same time close and distant from others, to be fused with and separated from other (Pao, 1979) and has fear to be overwhelmed by emotions. He believes that his rage can kill.

From the object point of view transference in the group is ranging from primitive to mature. In primitive transference the group as a whole can represent good mother image, as well as the hostile, attacking, bad mother image (Ivezic, 2004). Schizophrenics' can be less influenced by therapist's words than by his feelings. There is always danger that malignant symbiotic transference might develop.

Ivezic (2004) reports, that all selected patients in her group had previous two to six months lasting supportive individual therapy by the group therapist.

### Inpatient versus outpatient group therapy

1. The therapist conducts the individual in the group. This does not change considerably in hospital conditions due to patient's deep regression and fragmentation, while in outpatient situation more flexible approach is possible.
2. In hospital groups the therapeutic aims are necessarily limited. The outpatient group needs constancy with an open perspective at the level of the ego functions and stability of the patients object's relations.
3. In the outpatient group of psychotics, 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.
4. The therapeutic work in the group setting can be aimed at corrective symbiotic experience as well as at dilution of the dyadic transference.

### Cognitive, behavioral, education, supportive therapies

In last years we witness increasing amount of reports of cognitive-behavioral therapies. One of reasons is that they can be easily measured and that they follow medical model. They are highly structured. A set of cognitive-behavioral interventions has been developed for schizophrenic patients in acute and in chronic state of illness. I will present some of them.

The use of CBT on the reception ward described (Osterman 2004).

Reports are, that group CBT with patients following the first episode of schizophrenia (24 sessions) increases coping with psychotic symptoms as well as help clients deal with low self-esteem, stress, anxiety, social anxiety, depression, suicide and substance abuse. (Lacomte et al. 2003, Patrick 2003) or CBT for negative symptoms of schizophrenia (Johns 2002).

A long-term group therapy for schizophrenia called multimodal integrative cognitive stimulating group therapy (MICST) is founded upon a theoretical model that views schizophrenia as a condition characterized by information-processing and memory deficits, which interfere with communication. MICST is designed to stimulate clients' cognitive and memory functioning, improve information processing, and enhance clients' abilities to engage in reality-based conversations. The therapy combines elements of social skills,

relaxation exercise, cognitive rehabilitation, and traditional psychotherapy (Ahmed 2003).

Functional adaptation skills training – psychosocial intervention (24 group sessions) designed to improve everyday living skills of middle-aged and older outpatients with very chronic psychotic disorder (Patterson 2003).

Integrating psychoeducation in group with first episode schizophrenia clients is used to provide optimal adjustment to the disease (Miller 1998).

Psychoeducational multiple-family group treatment among patients with schizophrenia resulted in a lower rate of psychiatric hospitalization (Dyck 2002).

Combining psychoeducational model with supportive psychotherapy with schizophrenics with problematic behavioral histories and recurrent active psychoses enabled them to participate productively, to work toward greater independence, and achieve community living (Nightingale 1996).

Supportive – expressive group psychotherapy is used with chronic mental illness (Takahashi 1999).

### REFERENCES

1. Ahmed M, Boisvert CM. *Multimodal Integrative Cognitive Stimulating Group Therapy: Moving Beyond the Reduction of Psychopathology in Schizophrenia*. *Professional Psychology: Research & Practice* 2003, 34: 644-51.
2. Campbell LeFevre D. *The Power of Countertransference in Groups for the Severely Mentally Ill*. *Group Analysis* 1994; 27: 441-7.
3. Chazan R. *Group Analytic Therapy with Schizophrenic Outpatients: Group* 1993, 17: 164-78.
4. Chazan R. *The Group as Therapist for Psychotic and Borderline Personalities*. In: Schermer VL, Pines M. *Group Psychotherapy of the Psychoses*. London and Philadelphia: Jessica Kingsley Publishers, 1999: 200-20.
5. Dyck DG, Hendryx MS, Short RA et al. *Service use among patients with schizophrenia in psychoeducational multiple-family group treatment*. *Psychiatric Services* 2002, 53: 749-54.
6. Fromm-Reichmann F. *Principles of Intensive Psychotherapy*. London: George Allen & Unwin, 1953.
7. Ivezić S, Goreta M, Hećimović V et al. *O nekim pitanjima taktike i metodike rada s transferom unutar grupne analitičke psihoterapije shizofrenih bolesnika*. *Soc psihijat*. 1994; 22: 149-60.
8. Kanas N. *Inpatient and Outpatient Group Therapy for Schizophrenic Patients*. *Am. J. Psychother.* 1985; 39: 431-9.
9. Kanas N. *Group Therapy with Schizophrenics*. *Int. J. Group Psychother.* 1986; 36: 339-60.

10. Kanas N. *Group Therapy with Schizophrenic Patients: A Short-term Homogeneous Approach*. *Int. J. Group Psychother.* 1991; 4: 33-47.
11. Kanas N. *Group Therapy with Schizophrenic and Bipolar Patients*. In: Schermer VL, Pines M. *Group Psychotherapy of the Psychoses*. London and Philadelphia: Jessica Kingsley Publishers, 1999:129-147.
12. Kibel HD. *A Conceptual Model for Short-Term Inpatient Group Psychotherapy*. *Amer. J. Psychiat.* 1981; 138: 74-80.
13. Kibel HD. *Symposium: Contrasting Techniques of Short-Term Inpatient Group Psychotherapy*. *Int. J. Group Psychother.* 1984; 34: 335-8.
14. Lecomte T, Leclerc C, Wykes T, Lecomte J. *Group CBT for clients with a first episode of schizophrenia*. *Journal of Cognitive Psychotherapy* 2003, 17: 375-83.
15. Leopold HS. *Selective Group Approaches with Psychotic Patients in Hospital Settings*. *Am. J. Psychother.* 1976; 30: 95-102.
16. Maxmen JS. *Helping Patients Survive Theories: The Practice of an Educative Model*. *Int. J. Group Psychother.* 1984; 34: 355-68.
17. Opalić P. *Theme Orientated Group Psychotherapy of Psychotics*. *Group Analysis*. 1988; 21: 289-97.
18. Osterman F. *Kognitivno vedenjski pristop skupinske psihoterapije bolnikov z akutno shizofrenijo*. *Viceversa* 2004, 42: 41-50.
19. Patterson TL, McKibbin C, Taylor M et al. *Functional adaptation skills training (FAST)*. *Am. J. Geriatric Psych.* 2003, 11: 17-32.
20. Russakoff LM, Oldham JM. *Group Psychotherapy on a Short-Term Treatment Unit: An Application of Object Relations Theory*. *Int. J. Group Psychother.* 1984; 34: 339-54.
21. Schermer VL, Pines M. *Introduction: Reality and Relationship in "Psyche's Web"* In: Schermer VL, Pines M. *Group Psychotherapy of the Psychoses*. London and Philadelphia: Jessica Kingsley Publishers, 1999: 13-42.
22. Urlič I, Delić A. *Karakteristike psihodinamike male grupe psihotičnih bolesnika u stacionarnim i ambulantnim uvjetima*. *Med Jad* 1993; 23: 191-203.
23. Urlič I. *The Therapist's Role in the Group Treatment of Psychotic Patients and Outpatients*. In: Schermer VL, Pines M. *Group Psychotherapy of the Psychoses*. London and Philadelphia: Jessica Kingsley Publishers, 1999: 146-80.
24. Yalom ID. *Inpatient Group Psychotherapy*. New York: Basic Books, 1983.

Correspondence:

Vita Pukl Gabrovšek  
University Psychiatric Hospital Ljubljana, Slovenia