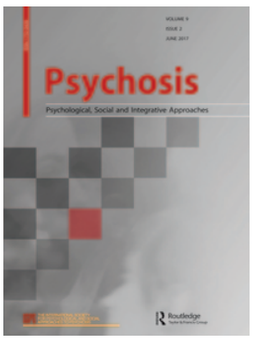

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Developing a group-analytic culture in a day project for psychotic patients

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ABSTRACT

This article describes the flexible application of group-analytic principles in a long-term group psychotherapy programme for psychotic patients, within the wider containing structure of a weekly day project in a community setting. Clinical vignettes illustrate the steady development of a benign group therapeutic culture which helped patients achieve deeper levels of communication and understanding, resulting in better functioning and a greater capacity to cope with everyday life and establish satisfactory relationships. Reference is made to some of the relevant literature as back-up to evidence-based practice. The paper aims to stimulate further group case studies and process research with this population, as well as to encourage practitioners to increasingly use psychodynamic therapy groups in the treatment of psychosis.

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Group-analytic psychotherapy; psychosis; metaphors

Introduction

"Schizophrenia" and other "psychoses" are constructs and diagnoses which, unfortunately, have often been used to exclude people or treat them differently. Having worked in mental health for 40 years (MC) and 37 years (AE) respectively, we agree with the view that psychosis is part of a continuum. Any person can potentially have psychotic experiences. In our work we have seen many people using their resources to recover and work through such experiences. This healing process is enhanced when a proper therapeutic alliance is established, in which the patient is an active collaborator – as can happen in sensitive, user-friendly psychotherapy groups.

In 1979, one of us (AE) was anxious while waiting to see his first psychiatric patient: a young man with a diagnosis of "paranoid schizophrenia". The patient was looking withdrawn and suspicious. I (AE) asked a naïve question: "What is psychosis for you?" I was touched by the patient's spontaneous response: "Psychosis is an overwhelming inability to cope with everyday life".

As mental health professionals we are responsible for trying our best to mitigate human suffering, and to provide the conditions within which our patients can best develop their resources to cope and relate meaningfully to other people. That is the driving force behind this group case study. We shall first outline what we have learned from other authors. We will then share our own experience of working with and learning from our patients.

The literature

Group methods in the treatment of schizophrenia have been used for nearly a century. Lazell (l921) reported educational techniques in a lecture format followed by group discussion. In the following

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decades, some psychoanalytic group approaches were tried – although with caution. For example, Semrad (1948), Standish and Semrad (1951), and Spotnitz (1957) acknowledged that purely insight-oriented work was too stressful for psychotic patients, as they require significant support and structure in the group. Sullivan (1953) advocated an interpersonal model, which emphasised the relationship problems in psychosis and encouraged patients to interact in the "here and now" of the group sessions.

In the 1970s and 1980s, the stress was gradually put on eclectic approaches combining flexibly the educational, psychodynamic and interpersonal models. One of the main exponents of this "integrative" approach has been Kanas (1986, 1996). He concluded that approaches that encourage interaction were more successful than those based on the use of interpretations. Other authors (Meltzer, 1979; Parloff & Dies, 1977) reported that improvement in social functioning is the main beneficial effect of group therapy, as psychotic patients learn to overcome some of their mistrust in other people while in the safe atmosphere of the group.

Since the early 1990s, there has been a significant growth in the reports of group-analytic work with psychotic patients (Canete & Ezquerro, 1999, 2012; Chazan, 1993, 1999; Correale, 1999; Hummelen, 1994; Koukis, 2009; Lefevre, 1994; Milders, 1994; Prior, 2007; Resnik, 1999; Sandison, 1991, 1994; Smith, 1999; Urlic, 1999, 2010, 2012). All these authors agree that, in order to engage patients and make the treatment effective, it is necessary to apply group-analytic principles flexibly.

A number of research studies have concluded that group psychotherapy with psychotic patients can be as effective as individual psychotherapy (García-Cabeza & González de Chávez, 2009; García-Cabeza et al., 2011; González de Chávez, 2009; González de Chávez et al., 2000; Rico & Sunyer, 2001). Main findings on outcomes include reports of group patients becoming more hopeful, overcoming their isolation, improving self-knowledge, and achieving greater personal autonomy. In another study Kapur (Kapur, 1999) concluded that group therapy is more effective when combined with other treatment methods.

The setting

In the mid-1990s, a steering group was formed and joint funding from Health and Social Services was agreed to create a weekly psychotherapy day project for adult psychotic patients; which was based in a community centre in a deprived London district. One of us (MC) was appointed as consultant group analyst to the project. The wider team consisted of clinical psychologists, social workers, junior doctors, community psychiatric nurses and occupational therapists.

We offered a multi-layered and democratic group therapy service within the framework of a care programme approach. We believe that patients have a capacity to be therapeutic to each other, which can be developed through building a genuine relationship between equals between themselves and the staff.

The group therapy programme was combined with a range of individual and family-based psychological interventions. Patients had an extended assessment of their attachment history and difficulties. We gave them information about the project and realistic therapeutic goals were agreed. We also gave them a copy of our assessment report for their comments and changes before sending it to their referrers. Most of them told us that they felt understood. This open communication helped patients and staff build a therapeutic alliance. Following the initial assessment, they were invited to a meeting where they met other patients and staff in order to become familiar with the project.

As an outpatient service, attendance was voluntary. After a minimum of four weeks, during which everyone is invited to attend the drop-in session and the community meeting, new patients can decide to join the formal therapy programme. All patients had a keyworker with whom they held regular individual meetings to discuss treatment goals and progress, as well as any worries or concerns. Staff and patients had lunch together. Everyone was encouraged to help with preparing food, moving furniture and clearing up. The overall timetable was as follows:

09.30 am	Staff meeting
10.30 am	Individual, family or small group therapy.
11.30 am	Drop-in session.
12.00 pm	"News and views" community group.
12.45 pm	Community lunch
01.30 pm	Individual, family or small group therapy. Psycho-educational groups.
02.30 pm	Staff supervision
04.00 pm	Staff reflective practice meeting or consultation with an external facilitator.

Patients and staff participated in a community-style large group, called "news and views": a forum where people talked about local, national or world events, shared personal news, delivered messages from other people, and made democratic and consensual decisions affecting the project as a whole. For example, the name "Discovery Project" was chosen by the patients themselves. In addition, they gave consent for outside professionals to visit the project. This community group also provided opportunities to talk about how people were getting on with one another.

All new patients were invited to join an introductory psycho-educational group for six to eight weeks, in which they shared their experiences and asked any questions. This group was very popular. Staff and patients learned from each other. Whenever possible we invited professionals with expertise on particular themes. For example, guest speakers included pharmacists, nutritionists, social workers, and lawyers from advocacy services and ex-service users. At the end of each meeting, patients were asked to evaluate the session and state how relevant it was for them. Sessions on medication, welfare and recovery scored very high.

The small therapy group

After the psycho-educational sessions, patients joined one of the small psychotherapy groups. Each group had up to eight members and was conducted by two co-therapists. Everyone sat on equal chairs in a circle. Following consultation with the patients, it was decided to have an observer in the room who sat outside the circle. We included this role primarily to help the therapists monitor group boundaries and communication.

The observer provided live supervision for the therapists in a way similar to systemic family therapy. Support systems outside the group were an important part of the care programme. Most patients were happy about having an observer who helped the therapists to help them. Some new members had reservations about this arrangement, but the old members reassured them that it was safe and helpful.

One of us (MC) shall now concentrate on a group that she co-conducted for fifteen years. On average, the co-therapist (usually a trainee) changed every one or two years. The group was "slow-open": people joined and left when ready after which they were replaced by newcomers. Average group membership was three years. The rate of attendance was significantly high at above 75%. We used a version of Larsen et al.'s (1979) patient satisfaction questionnaire to monitor overall progress. The mean satisfaction score fell within the high range level. The most helpful aspects of the treatment, as reported by the patients, were:

- the opportunity of communicating and relating with other people who had the same problems
- keeping in touch with reality
- learning strategies about coping
- being helped to be more independent and deal with day to day life

The first few months of the group were characterised by little spontaneous participation, despite our efforts to involve everyone. Some patients were restless and found it difficult to sit for one hour. We asked them to stay in the room and invited them to talk about what had prompted them to stand up. Some blamed the medication; others felt uncomfortable and tense; one said that he needed to be "vigilant" about noises in the surroundings.

> Harold, with a diagnosis of paranoid schizophrenia, commented at the beginning of a group session that he was expecting some directives from the therapists. He added that his psychiatrist had always told him what to do. I (MC)

acknowledged his expectations and said that, perhaps, this was an opportunity for him to learn how to make his own decisions. Neither Harold nor the other members responded to this comment. In his second session, Harold was silent. Suddenly, he stood up and walked towards the door. I asked him to stay but he left.

As an additional layer of containment there was a staff member in the common room doing admin work, while being available to talk to patients who might feel distressed or unable to complete a therapy session. This arrangement enabled the therapists to stay with the group. Harold said to our "gatekeeper" colleague that there was a plot to make him believe that the other group members were patients, but he knew that everybody was a therapist pretending to be a patient. He was adamant that he did not want to return to the group.

Following this, Harold had a review meeting with his keyworker in which he said that he wanted a more directive approach. Following his request, individual CBT sessions were offered to him. He agreed to participate in all the other therapeutic activities of the programme, except the small group. He attended the project regularly for three years and made steady progress. He was pleased to be offered a protected job in a picture-framing workshop and felt confident enough to move on.

Our small therapy group did not contain Harold's initial anxieties. However, the wider multidisciplinary structure of our day setting provided enough therapeutic containment to help him achieve the positive outcome he was looking for. We were left with a feeling that we would have liked Harold to explore a wider context of relationships in the intimate atmosphere of our group setting; but we were happy to respect his wishes and to see him grow more autonomously.

The remaining members of the small therapy group became gradually able to disclose some of their personal experiences. However, during most of the first year, they shared their stories without personally relating to one another; eye contact between them was minimal. They mainly addressed their communications to the therapists, who had to provide the glue that would keep the group together by making links between their stories. Disclosure did not necessarily mean that the patients had developed an attachment to the group or a capacity to trust others. We thought that they really struggled to emotionally regulate the distance.

Jerry, with a diagnosis of schizoaffective disorder, reported one day that he had offered shelter to a stranger he met in the street. The following morning, Jerry was shocked to find out that the stranger had stolen his most valuable and cherished possessions. He felt devastated by the experience and decided to carry a kitchen knife when he was at home. Following his disclosure, he received sympathetic responses from other members. In spite of this, he remained withdrawn and left prematurely after seven months.

Between six and nine months, babies who are securely attached begin to experience a wariness of strangers. This is a two-way process through which the child learns to regulate the distance – trusting and becoming close to people who are familiar and reliable, while being cautious about strangers who might be potentially dangerous. The capacity to regulate the distance can be impaired, as in Jerry's case, when the early attachment figures are abusive (Bowlby, 1988; Ezquerro, 2010). In these harmful circumstances, the child's unmet attachment needs could lead to seeking inappropriate or unsafe contacts while being unable to form close relationships.

The development of a therapeutic group culture

We, the therapists, were learning from the difficulties in holding the patients together during the early stages of the group. We tried to identify a common language with them for which the use of metaphors proved to be crucial. This was a gradual process which developed over the next two or three years in the life of the group. A metaphor resembles reality from the distance. This enabled our patients to feel safe enough to connect emotionally with each other and make sense of their psychotic experiences, without feeling too threatened or exposed. The group culture became more trusting and reflective, as illustrated in the following material.

In the middle of the group room we had two small tables that were joined together. On top of the tables there was a pot with a spider plant.

> At the beginning of the session, Greg and Liza engaged in a conversation as they were trying to close the gap between the tables, and to align them perfectly. I commented that they seemed to want to arrange the tables on behalf of the whole group. Liza replied: "Well, I am a perfectionist and I am disturbed by the gap". Then, Greg said that he also was a perfectionist and felt concerned that, if the gap increased, the pot would fall and would be smashed. Jim became interested in the conversation and said: "If the pot breaks it would be a mess; the soil would spread all over the carpet. Who would then clean the mess?"
>
> At that point everybody was participating in the discussion. Jacob said that he was not so concerned about the mess, but he was more worried about what would happen to the plant if it lost the soil that was feeding it. Sophie looked anxious and said: "Without the container and the soil the plant would die". Then, Greg commented that the spider plant was very resilient and could survive with little care. Roger responded: "If the container is broken the plant would need a new container". Sophie intervened again and said: "Containers can be replaced but life cannot."

Following their reflections about containers and life, there was a brief pause. After this, I (MC) said that their thinking around the plant could be used as a metaphor for their own experiences of breaking down and surviving. The metaphor of the tables and the spider plant enabled group members to explore more openly the factors that had contributed to their illness. For a number of sessions this was the main theme of our group discussions. All members had strong feelings of loss; some felt that their lives had been broken in two parts with a big gap in the middle, like our two tables in the room.

For the majority, the gap consisted of those years when they were just drifting through life, unable to align their thoughts and acts together. Nearly all of them had the first breakdown during the formative years of adolescence or early adulthood. They believed that, no matter how much they could achieve now, they would always feel short-changed for what they could have achieved if they had not had a breakdown.

Their expectation of an ordinary life (career, marriage, children, etc.) was smashed by their illness and the "empty" years that followed. This overwhelming feeling of loss was particularly strong in the older members.

Despite their pessimism, most of them appreciated the opportunity to gain a deeper understanding and a stronger sense of group belonging. Understanding and supporting one another helped them feel they had something useful to give to others. Their self-esteem improved and they felt more hopeful about having meaningful relationships with other people. A number of them said that they would have liked a treatment of this kind many years earlier, as it might have protected them from breaking down and being derailed from their expectations.

In our own reflections in between sessions, it was helpful to read Cox and Theilgaard (1987). They describe their experience using mutative metaphors in group psychotherapy for people with severe mental illness. They explain how a metaphor can help to touch the depths before it stirs the surface, in contrast to sharper or more direct interpretations. Metaphors facilitate understanding without threatening the patients' equilibrium.

A similar view had been expressed by Powell (1982, pp. 130–131):

> Metaphor is often paradoxically primitive and concrete in its imagery and abstract in its implications ... when a metaphor is assimilated and understood, reflective self-awareness is enhanced, the capacity for abstract discrimination widens and ... the need for defensive operations to come into play is reduced

The lower level of defensiveness in the group enabled us to be more open about the use of transference interpretations. Jacob, with a diagnosis of schizophrenia, had attended every single group meeting for more than two years and participated actively. He started a group session talking about his anxieties when, on his way to the project, he saw some workers removing asbestos from a crack in the wall in his block of flats. The workers were wearing special protective clothes and masks, but there was no warning for the tenants or the public.

Jacob was worried about contamination. Other group members discussed some actions Jacob could take, like contacting the local Council to make a complaint or writing to the department of environmental affairs for advice. I thought that these practical suggestions were a good way of offering support to him, as his fears were based on a real threat. In fact, these comments from other group members

helped him manage his anxiety better. As Jacob's anxiety was contained, I thought it would be safe enough to explore the transference. I said to him:

> "Jacob, maybe you are also expressing a fear about being contaminated in the group – something about which we, the therapists (like the workers), have not given you any warning". Most group members said that they could recognise their fear of being contaminated by other people's problems in the group.
>
> Richard, a musician with a diagnosis of bipolar affective disorder, intervened to say that after the sessions he often found himself ruminating about things that people had said. Sometimes, he felt suspicious or angry; which made it difficult for him to come back to the group. Then, Jacob said that he was also feeling angry and depressed in between sessions. He added that being in touch with other people's problems was difficult for him and contributed to his wish to withdraw. However, the understanding and support received in the group was helping him overcome his isolation.

Stone (1996) suggests that some of the most difficult feelings for psychotic patients in therapy groups are triggered by the multiple transferences that emerge, as a result of the complex interactions between the "here and now" and the "then and there". Interpretations in such groups may have to be delivered gradually over weeks or even months. It is usually more effective to start with a description of what is easily observable and accessible, until it becomes safer to dig into the less obvious meaning, step by step – something that can be described as "cumulative" interpretation.

The following clinical material corresponds to the seventh year in the life of the group. Ron, an unemployed plumber with a diagnosis of schizophrenia and the youngest of three children, recalled traumatic events in his family. As his mother had necessitated a number of psychiatric in-patient admissions and his father was often absent, Ron was at times left alone with his older brothers who bullied him. It happened that the announcements of my holiday breaks were followed by weeks of anxiety, during which Ron talked repeatedly about his fear of being assaulted by his neighbours. He in fact had several in-patient admissions coinciding with the periods of my annual leave.

> I tentatively suggested to Ron that my absences, as it had happened with his parents' absences, could be contributing to his feeling of being in danger. He responded saying that he admired my extraordinary imagination and that his fears had nothing to do with my being away.

The turning point for him came four years after he had joined the group. The help came from other members who made a link between my absences and their own heightened anxieties. Ron took on board what his fellow groups members were saying and commented that he realised my absences reactivated the fears he had experienced as a child during his mother's absences. He said that on those occasions his brothers were cruel to him, and made him feel unprotected and frightened.

> Ron became emotional when he disclosed an incident in which his eldest brother took his pet fish from its bowl and put it in a pan of boiling water. The little fish popped and exploded like a balloon. People in the group were shocked and supported Ron movingly. The experience strongly resonated with Jacob who had been a victim of bullying. At the following session, Jacob said that the image of a fish exploding had haunted him during the whole week. He added that he was particularly disturbed by the thought that the environment you depend on, like the water for the fish, could turn against you.

In contrast to the disclosures in the early group, when people hardly engaged with one another, Ron's communication had a deeper and more meaningful impact leading to powerful resonances in other members. Some talked about depending as children on their parents who, by becoming ill or abusive, turned against them. In many ways, their life experiences were constantly corroborating their belief that they were alone, had nobody to turn to and had to fend for themselves.

This painful realisation helped some of them to feel stronger and more determined to survive. Two years later, Ron completed his "A" levels and went to University to study sociology – something he had wanted to do for a long time.

Conclusion

Psychotic patients frequently have a background of traumatic experiences and damaging disruptions of their early attachments, which hinders their capacity to trust people and to establish satisfactory

relationships. Their capacity for communication, intimacy and participation in groups is usually impaired. However, a group-analytic approach with its flexibility of interventions and the support of a wider multi-layered milieu can be highly beneficial. Group conductors have to be particularly proactive in situations that threaten the life of the group. Boundaries have to be negotiated carefully in order to foster a benign group culture that encourages members to interact with each other.

The perception of the group as a caring space where members can communicate safely is particularly important – something that is difficult to achieve in the early stages of the group treatment. The therapists have to persevere in the task of connecting up apparently disjoined communications until the patients gradually learn to relate to one another more directly. In a group there are multiple transferences, which for psychotic patients can be more difficult to digest than for non-psychotic patients. However, as the group matures it is possible to make some use of the transference to link the "here and now" with past experiences.

The limited use of transference interpretations can be compensated by a broader range of group-analytic interventions. The conductors may choose to "translate", link, highlight, challenge, explain, confront or clarify the material presented, depending on the patients' capacity to process it. We found that metaphors can be an effective and helpful way of communicating thoughts and feelings in a non-threatening way. Metaphors are an important part of the group-analytic therapeutic currency and facilitate a deeper understanding of the psychotic experience from a safe emotional distance.

The long-term continuity and stability of the service, in the context of a therapeutic community approach, helped most of our patients to progress towards a more autonomous life. The task was challenging and daunting at times – but the overall experience fulfilling and rewarding.

Disclosure statement

All the clinical material has been anonymised. The authors have followed strict GMC guidelines about disguising names, stories and circumstances in order to protect the confidentiality due to the patients. The authors have no potential conflict of interest.

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