

Group-Analytic Psychotherapy of Psychosis

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This article describes some ideas, both theoretical and clinical, related to the group-analytic treatment of psychosis, in the context of a Psychotherapy Day-Hospital that runs weekly in a multi-racial and deprived district in England. Clinical vignettes refer to different developmental stages in the life of a slow-open group. Strikingly, after certain initial misgivings, therapists and patients felt that the group experience increased their enthusiasm.

Key words: group-analytic psychotherapy, manic-depressive psychosis, schizophrenia

The group of blind mice were sent to the jungle with the task of finding out what an elephant was like. All came back with different accounts. Each was convinced that their version was the right one. They started arguing with one another and spent the rest of their lives in sterile discussions, never agreeing on what an elephant was like. If only they would have been able to put together their different pieces of information. . . . The internal world of psychotic patients sometimes resembles the metaphor of the group of blind mice and the elephant.

The Literature

We started our reading with a disturbing question in mind: is therapeutic group-analysis of psychosis possible? On the one hand, we had learnt: 'The group-analytic situation privileges the development of intimate dialogue between persons who are otherwise strangers to each other' (Pines, 1995). On the other hand, psychotic patients often mistrust people deeply and attempt to ignore the very existence of the group. Psychotic denial is a powerful defence.

Group therapy has been used for more than 70 years in the treatment of schizophrenia. Research (for example, Kanas, 1986; Meltzer, 1979; and Parloff and Dies, 1977) suggests that, while in a

protective group therapeutic setting, psychotic patients can learn to overcome some of their basic mistrust in other people. Improvement in social functioning is the therapeutic factor most consistently reported, which is reassuring for group psychotherapists considering the difficulties these patients have in forming relationships.

There is general agreement (Claghorn et al., 1974; Ellenberg et al., 1980) that medication in psychosis does not usually interfere with group therapy; in fact, the two treatments may facilitate one another. Patients doing well in groups seem able to maintain stability on less medication. Group sessions enable therapists to see their patients expressing a greater variety of behaviours than they do in individual sessions. Therapists may feel more comfortable about trials of reduced medication or no medication. The risk of long-term neuroleptic side effects is kept to a minimum.

In contrast to neurotic patients, the major anxiety against which psychotic patients defend is 'annihilation anxiety' (Frosh in Cohn, 1988). In this context, the maintenance of group life is crucial for the survival of the individual members contained in it. Group belonging requires from members both a degree of emotional autonomy and an ability to relate meaningfully to others. Autonomy and relatedness are threatening experiences to psychotic patients who are highly defended in order to function, no matter how marginally, in the outside world. A group, by its very nature, disturbs the core around which psychotic defences are built: the need to avoid new experiences representing the challenge of life. Repetitive and stereotyped psychotic behaviour can be understood as a defensive attempt to secure boundaries. Therapeutic groups need to renegotiate boundaries to open up to new experience in a way that enables meaning and growth to occur.

We continued reading with interest much of the literature; and had all the usual reactions. But we were haunted by Cox (1995): 'The ability to laugh at himself is, paradoxically, an indication that a man is able to take himself seriously. Similarly, a group that dares to accept laughter, will also be able to tolerate tears.' Well, we knew we might have tears; we did not expect laughter.

The Therapeutic Group

One of us, María Cañete, is the conductor and narrator of the following passages. Patients' names and circumstances have been changed to preserve confidentiality.

Patrick is an intelligent 45-year-old writer, with a diagnosis of paranoid schizophrenia. He believed that the 'CIA' was after him. He felt that the staff and the other patients were also conspiring against him. In the group he would not talk to anybody except myself. At one point, he said to me that I should go back to my country, because if I stayed here the 'CIA' would try to kill me. A number of questions came to my mind, as he had now 'included' me in his paranoid system. I wondered about a conflict between his obvious need for a protective 'alliance' with me and his possible unconscious wish to 'kill me off'. As I was inviting him to relate to other people in the group, could I be a disguised threat? I did not verbalize any of my mental speculations but decided to ask him: 'Patrick, would you like me to go back to my country?' He responded: 'No, I don't want you to go because you are a good person and you are kind to me.' Other group members seemed to listen with curiosity, but did not join in the conversation. The rest of the meeting was rather fragmented.

One of the most remarkable aspects of psychosis is the way in which life changes are experienced and interpreted. Change is resisted fiercely as it is often associated with breakdown and deterioration. Normal mood fluctuations and other emotional responses are interpreted as presaging catastrophe. Fears of rejection and abandonment are manifested by being at odds with others, which can lead to extreme isolation. In the group, one patient was very reluctant to give up his fatalistic view of life because he thought that it was more real than hanging on to a futile sense of hope. On another occasion, the same patient said that 'being schizophrenic' had become his profession.

Therapeutic group-analytic 'exchange' aims to integrate the lost meaning with the experience.

Following a discussion in the group about the 'meaning' of dreams, Roger, a 45-year-old lorry-driver with a diagnosis of schizo-affective psychosis, said that he had had a horrible dream the previous night, about which he was feeling very upset and frightened. I asked him what the dream was about. Roger replied that, in the beginning of the dream, he went to visit his ex-girlfriend. It was cold and raining. As he approached her house, he saw her with a new boyfriend. When she saw him she closed the gate and went into the house, leaving him cold and wet. After a pause, Roger reported that the dream had a second part in which his mother was going on holiday, again, leaving him alone. He explained that, in fact, his mother had left for the Continent on that very day. He added that he woke up in a state of panic, remembering the last time he was admitted to a psychiatric hospital. Then, nobody believed that he was a devil. The more nurses and doctors tried to reassure him that he was not the devil, the more guilty and isolated he felt.

My male co-therapist had the previous week announced that he would be leaving soon. He commented that Roger appeared to be

a very guilty devil who could not enjoy being a real devil. He added that, in contrast to Roger, the real devil enjoys doing devilish things. Roger looked surprised, while other group members smiled mischievously. Roger said that he was feeling so guilty in the dream that he was very anxious about having another breakdown. He looked down and seemed disconnected. I was aware of my co-therapist's imminent departure. I told Roger that his guilt seemed related to other people's departures, both in the group and his own life, like his mother's and his girlfriend's, perhaps wrongly believing that it was his fault. Roger slowly looked up and said: 'Yes, it happened to me when I was nine. My parents separated and I thought it was my fault.' I added: 'Carrying guilty feelings on behalf of other people must be a heavy burden, which can make you feel on the verge of a breakdown.'

Roger was silent for a few moments and looked very close to tears. He then talked of the day when his mother left home; he saw the luggage by the door and knew his mother was leaving home but nobody said anything to him. He remembered going to school on that very day with the conviction that he would never see his mother again, because he had been a 'bad boy'. He sighed and added: 'I can now see that I have been always taking responsibility for what happened to my parents and to other people.' He recalled that, during his psychotic breakdowns, he had an overwhelming feeling of guilt and responsibility for everything that was going wrong in the world. After the session, my co-therapist and I felt more optimistic about Roger's capacity to build a new bridge to connect more meaningfully with the world around him.

A Compromise with Chaos

Patients referred to the project are usually too fragmented for group-analytic psychotherapy. After the initial assessment, they are invited to participate in a community-style large group meeting: the 'news and views'. This forum provides opportunities to welcome new members, share developments in the life of the project, discuss general themes in the patients' lives, and express ideas or feelings about national and world events. As they become ready, patients are offered a place in a small psychotherapy group of up to eight members.

Frank, a 40-year-old unemployed musician with a diagnosis of manic

depressive psychosis, started a session feeling quite energetic. He reported that, during one of his past breakdowns, he took his clothes off in the park. He then walked naked until he was stopped by the police in front of the local library. As he wanted to avoid going back to prison, he told the police that he was a mentally ill patient and they took him to a psychiatric hospital. I could think of nothing to say. Roger, who had also had the experience of serving a prison sentence, said: 'You could have told the police that you were going to return the books to the library.' For the first time there was a unanimous laughter in the group, which lasted several minutes. This was followed by a deeper level of communication and disclosure in the group. Members shared their experiences of getting into trouble with people and, sometimes, being put in jail.

In the next few weeks, members seemed to participate with a newly found enthusiasm and a basic sense of trust appeared to develop. They gradually started to show curiosity about other peoples' stories and became more interested in one another.

Mark, a 29-year-old law student with a diagnosis of transient psychotic episodes and schizoid personality disorder, told us at the beginning of a session that he always tried to arrive early. He said that he could not bear lateness, because he remembered his shame when he was late at school and the other children stared at him, as he went into the classroom. He continued saying that he would rather be absent than late and he would play truant from school, which was met with severe physical punishment by his father.

Jacob, a 37-year-old milkman with a diagnosis of schizophrenia, said that he was glad to see him every week in the group because Mark was kind. Jacob added that he would prefer to have him late rather than not having him at all. To my surprise, Patrick joined the conversation saying that he agreed with Jacob. Like him, he also thought that Mark was a good person. Then Mark talked more openly about his current difficulties and his struggle to concentrate in his studies.

It appeared that the positive comments from other group members were helping Mark to talk to other people about himself more freely. In the beginning of the group, communications were mainly addressed to the therapists and members tended to take turns individually, without interacting with each other. Progressively, they became more able to communicate verbally and to relate with one another in the group, but the equilibrium felt rather fragile.

In the initial stages, one of the most striking issues was a general lack of acknowledgement of other group members. This happened in respect of the members who were present and in respect of the absent ones. When some people did not attend, nobody mentioned or asked for anybody. We, the therapists, had to name in the group the people who were absent and said that we would write to them.

When we asked why they did not telephone to let the group know about their absences, one member said that it had not occurred to him to contact us to leave a message, because he thought that his absence would not be noticed and it would make no impact on the group. For several months, despite our efforts to involve the whole group, there had been little spontaneous participation. In recent sessions, however, an incipient form of emotional exchange was beginning to be developed.

A year after the group started, Bob, a 33-year-old carpenter with a diagnosis of schizophrenia, announced that he intended to leave the group. He had attended every week for 11 months, having only missed two meetings due to day trips organized by the hospital. Some group members said that they were surprised. Bob explained that he needed to do other things in his own life and to participate more actively in the community, because he wanted to feel that he was part of it again. Most people in the room said: 'Good luck'. Frank added: 'Bob, I will miss you.' Other people also said that they would miss Bob.

In contrast to how the group had functioned in the past, the session that followed Bob's departure was devoted to him. Frank said that he had enjoyed the comments Bob usually made about films. They stimulated him to the point that, the previous weekend, he went to the cinema – something he had not done for the last 20 years. Roger conveyed that, in his opinion, Bob was an intelligent person who underestimated his own abilities, because he had not had the chance to obtain a university degree. Jacob agreed with Roger and added that he was feeling sad because he was missing Bob's 'down to earth and common sense contributions'. For him, Bob often acted as an anchor for the group. Frank suggested that Bob may have left because he did not want to become too intimate with other people in the group. He recalled that Bob had spent most of his childhood in children's homes and could not feel close to anybody. Roger confessed that he was feeling envious of Bob's capacity to go out and enjoy himself, while he was still spending too much time at home.

Concluding Remarks

Group therapy can allow psychotic patients to participate to the degree with which they feel comfortable. They may be silent for weeks and only after this holding time feel safe enough to join the group verbally. The conductor has to learn to intervene in these groups more frequently than in groups for non-psychotic patients. In

contrast to individual therapy, where the patient is supposed to be only at the receiving end, a group also provides opportunities to help fellow members. This promotes a sense of confidence and well-being when they realize that, besides their problems, they have something to give to others.

For psychotic patients, chronicity paradoxically equals stability. This results in a group process that appears to be stagnated. One of the paramount tasks of the therapist is to modify the state of the group, from one of stagnation into one of development. In the group-analytic model, the conductor, who progressively becomes a 'member', may need to 'join' with the psychotic resistance and articulate it for the group.

A modified group-analytic approach that stimulates interaction with a high level of structuring and activity in the group conductor, often encouraging members to relate with one another, can be beneficial for psychotic patients. As the transference of these patients is not always a psychotic one, the conductor has to decide when it is 'workable' in psychoanalytic terms and when other types of intervention are safer and more effective. The group-analytic process of 'translation' is the group equivalent of 'making the unconscious conscious' in the interpretations of the individual psychoanalytic situation. Translation offers a wider range of responses: the conductor may choose to link, highlight, challenge, explain, confront or clarify, depending on the patients' capacity to digest them.

The use of humour, playfulness and well-intentioned irony can help to detoxify primitive affects and to promote healthier levels of communication. Paraphrasing the late Murray Cox: 'When laughter is not a defence it may be an enriching reinforcement of corporate solidarity.' We had our laughter. Defence or enriching reinforcement? How we long to know.

Acknowledgements

Rufus May (group co-therapist), Brigid MacCarthy (project leader), the team and Peter Bruggen (our supervisor).

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