

SPECIFIC DETAILS OF THE THERAPIST'S ENGAGEMENT IN GROUP PSYCHOTHERAPY OF SCHIZOPHRENIC AND PARANOID PATIENTS

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Summary. *Group therapist forms the psychotherapeutic group by selection of group members, structures the therapeutic situation by influencing the characteristics of the group culture, and defines the objectives. Activity and responsibility of a therapist for the therapeutic process is greater in group psychotherapy of psychotic patients. The consequences of different pathological processes (schizophrenic and paranoid) for the group psychotherapeutic process are visible in the specific requirements which each group puts in front of the therapist. Precise determination and comparison of therapeutic modifications (determined by the structure of therapeutic interventions) represent the main topic of this paper. The research has included five small groups of schizophrenic (40 patients altogether) and five small groups of paranoid patients (48 patients in total). The engagement of the group therapist has been determined by the scale of therapist's interventions (Cook and Kipnis, 1986). Comparison of therapist's interventions in groups of schizophrenic and paranoid patients in the first measurement points to a statistically considerable difference in relation to seeking of information, and instructions, provision of information and therapist's interruption. In the second measurement, despite the change of frequency of therapist's interventions within groups themselves, the differences in therapist's interventions between the groups of paranoid and schizophrenic patients noted in the first measurement are still present. Different pathological processes (schizophrenic and paranoid) endanger or disable the testing of reality with their specific mechanisms and dynamics. The therapist must accept and respect these particularities which is partly shown in the way he/she leads the group.*

Key words: *Therapist intervention, group psychotherapy, schizophrenia, paranoid*

Introduction

Group therapist forms the psychotherapeutic group by selection of group members, structures the therapeutic situation by influencing the characteristics of the group culture, and defines the objectives. The primary task of the group therapist is providing a favourable, therapeutic atmosphere in the group. The position of the group therapist is complex: he/she is a member of the group but with a special status of a leader, by which his participation stands out as the organizational, facilitative and therapeutic function (1).

The activity and responsibility of a therapist for the therapeutic process is greater in group psychotherapy of psychotic patients. Forming the group with psychotic members represents the gathering of individuals, who are all, individually, trying to set up an idiosyncratic, fragmentary, distorted, often very bizarre relation with what they recognize outside themselves. For the schizophrenic patients, the psychotherapeutic group, with its formal (time and place of happening, group members) and content benchmarks (happenings within the group – interactions, communication, group topic) represents, above all, the reality benchmarks, sometimes the basic and the only ones they have (2). The therapist provides

the constancy and reliability of these determinants (above all the ones from the group of formal benchmarks) turning them into basic, starting coordinates on which the relations with reality are built and strengthened. The group offers and enables the participation (by acceptance and support) to each of its members, but simultaneously also respects the individuality and specificity of each member, thus enabling the lessening of the basic fear and ambivalence of the schizophrenics. The schizophrenic patient in a group has the opportunity to approach others, in the atmosphere of tolerance built actively by the therapist, and in their own zone of security (the borders of which are individual and changeable). The therapist is shared with other group members which lessens the intensity of both positive and negative feelings towards him/her and softens the transfer relations. In that way, the disorganizing intensity of emotional relations and dependency that the patient defends of is avoided. At the same time, the group creates an obligation to participate for the withdrawn (silent) members. The tolerance of the patient's abilities and neutralization of hostility (by letting it pass if it is not directed towards other patients or interpreting it into a more acceptable context) lessens the intensity of conflict with reality, thus also lessening the need for further

regression. The group situation itself, which expects and requires interaction as the means of participation (in the form of communication, preferably verbal, but also non-verbal), and not introspection, lessens regression to the lowest possible level (3,4).

Patients with dominant paranoid symptomatology, unlike the schizophrenic patients, have always been classified as the "contra-indicated", "difficult" or "unfavorable" for psychotherapeutic treatment. In the recent years, a slightly more favorable approach can be found in related literature – it allows the possibility for psychotherapy (both individual and group) of paranoid patients, but only those who have the preserved ability for reality testing (5). The structure and determining of identity and integrity of the paranoid patients, whose lack of trust in others and the projection of aggressive and hostile impulses are the precondition for keeping the autonomy, make it difficult to create relations with others including the psychotherapeutic relations. Relations with others in paranoid patients are constantly moving on an axis of submissiveness-dominance, victim-persecutor, obedience-revolt, inferiority-superiority. Patient's expectance can interpret every move of the therapist as hostility: clear, open (if the therapist uses direct confrontation) or cunning, hidden (in case of indirect confrontation).

Experience in psychotherapy of hospitalized psychotic paranoid patients, (which has been gathered during the past 20 years at the Psychiatric Clinic in G.Toponica), shows that the homogenous group of patients provides a place for the unusual encounter of the paranoid with the paranoid. The paranoid patient, in his own impression separated and distinct in the role of a victim, enters direct relations with others who have the same impression about themselves. This recognizable similarity enables mutual identification of group members which lessens the anxiety and provides the context for unthreatening participation (6). The result is increased cohesiveness and lessening of the need for a defensive attitude. Paranoid mechanisms take place within the group itself due to inevitable differences that exist among the group members and due to the relationship created with the therapist and with other group members. In that way, the structuring of the group as a paranoid entity is avoided, placed in opposition to everything outside of it. Interactions are encouraged by consideration of paranoid constructions, i.e. by elaboration of delusional contexts. The development of interactions is accompanied by the projections of hostility and aggression, and they are not avoided in the group but rather used in the group. First of all, by evaluation of their "correctness" (by confrontation in the here-and-now situation) reality is determined, and the considered projection is "returned" back to the one who sent it in the first place. Secondly, the paranoid gains the experience that the aggression manifested by projection can be tolerated (interpreted as the possibility for a mistake) and that it does not have destructive quality. Group situation provides the support by confirmation of the

patient's identity and outside the relationship aggressor-victim, offering its members the opportunity to recognize, accept and experience a whole line of varieties in mutual relationships. Connecting the contents of introjective configurations with primary objects and models of interactions which they originated from, enables the gradual reduction of the defensive need and then also the transfer and generalization of these models to other relationships.

The consequences of different pathological processes (schizophrenic and paranoid) for the group psychotherapeutic process are visible in this global overview. It logically comes out of this that the specific requirements which each group puts in front of the therapist condition the modifications of his/her therapeutic engagement. Precise determination and comparison of these modifications (determined by the structure of therapeutic interventions) represent the main topic of this paper.

Subjects and Methods

The research has been carried out at the Psychiatric Clinic and it lasted for two years. Group psychotherapy has been carried out in small groups of schizophrenic and small groups of paranoid patients. The groups consisted of 7-11 patients, whereas the constitution of the groups was mostly kept unchanged during the average duration of the hospital psychotherapeutic treatment (2 months), with maximum change of one or two members of the group (due to unplanned termination of hospitalization). Psychotherapeutic sessions have been held twice a week, in the duration of 60 minutes (the usual duration of 90 minute group work for other population groups is considered too demanding for psychotic patients). Groups have been lead co-therapeutically, and sessions have been attended by the observer who has also kept the protocol of the group.

The research has included five Small groups of the schizophrenic (40 patients altogether) and five Small groups of paranoid patients (48 patients in total). The patients have been included in the research after the diagnostic procedure was undertaken and indications for group psychotherapeutic work were determined. Subjects from both groups have been involved in group psychotherapeutic treatment from the very beginning of their hospitalization. Patients have been on the psychopharmacological treatment at the same time (free choice of psychopharmacs by the psychiatrist in charge) and also on individual psychotherapeutic treatment (persuasion). All therapeutic processes have been incorporated in the milieu of the therapeutic community.

The engagement of the group therapist has been determined by the scale of therapist's interventions (7). The main objective is the identification of the ways in which psychotherapists manifest their influence in the psychotherapeutic process. A classification scheme of therapist's interventions was developed, primarily based on the objective of psychotherapeutic influence. Thera-

peutic influence is defined as every attempt of the therapist to elicit a change in the patient's behaviour, opinion or feelings. The authors have, without relying on specific psychotherapeutic branches but on basic psychotherapeutic principles, defined 8 types of the therapist's interventions: instructions, explanation, focusing, encouragement of verbalization, seeking information, providing the information, support and therapist's interruption. The current verbalization of the therapist is coded, which represents one type of therapist's intervention, independent of the amount of verbalization. The usage of the therapist's interventions in one session is stated in percentages.

At the beginning of the psychotherapeutic treatment the observer codes the therapist's interventions, after the psychotherapeutic session, into defined categories on the Scale of therapist's interventions using the protocol of the psychotherapeutic session which he attended. In the final phase of the group psychotherapeutic treatment (about two months after the first testing) the procedure of coding therapist's interventions is repeated in the same conditions and in the same way as at the beginning.

Results

In small groups of schizophrenic patients, in the first measurement, the most frequent are the therapist's interruption, but afterwards, equally frequent are the support, instructions, focusing. Encouragement of verbalization is present about 11% and provision of information with 9%. The least present interventions are seeking information (6.2%) and providing explanations (5.6%).

In the second measurement, there is still great presence of the therapist's interruption (in the same amount as in the first measurement), supportive function is on the similar level as in the first measurement (12.4%), but the presence of other interventions has changed. Statistically looking, a considerable increase is seen in the frequency of focusing and giving of explanations, and decrease in provision of information and encouragement of verbalization (Fig.1).

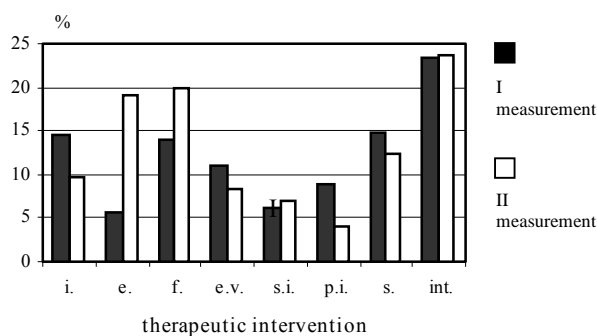


Fig. 1. Structure of therapist interventions in group of schizophrenics (1st and 2nd measurement)
 Legend: i. instruction; e. explanation; f. focusing; e.v. encouragement of verbalization; s.i. seeking information; p.i. providing information; s. support; int. interruption

In small groups of paranoid patients, determining of the therapist's interventions in the first measurement shows that the most frequent is seeking information (20.8%), and then focusing (17.8%) while the relatively equally frequent interventions are from the categories: encouragement of verbalization, support and therapist's interruption. Not very frequent are explanations (7.4%), instructions (6.4%) while provision of information has the frequency of only 1,6%.

In the second measurement half of the therapist's interventions are focusing (28.8%) and explanations (22.6%), while relatively equally frequent are seeking of information, therapist's interruption, encouragement of verbalization and support (Fig. 2).

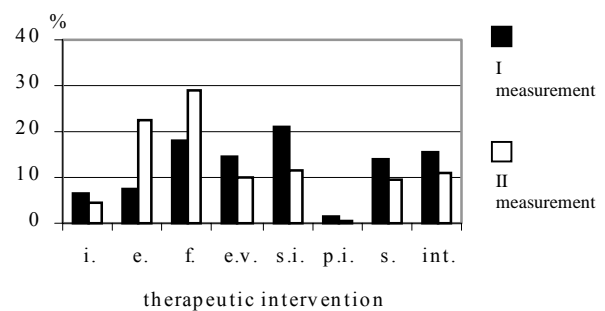


Fig. 2. Structure of therapist interventions in group of paranoids (1st and 2nd measurement)

Comparison of the therapist's interventions in groups of schizophrenic and paranoid patients in the first measurement points to a statistically considerable difference in relation to seeking of information (more frequent in groups of paranoid patients), and instructions, provision of information and therapist's interruption (more frequent in groups of schizophrenic patients). In the second measurement, despite the change of frequency of the therapist's interventions within groups themselves, the differences in therapist's interventions between the groups of paranoid and schizophrenic patients noted in the first measurement are still present (Table 1).

Table 1. Comparison of therapeutic interventions between schizophrenic and paranoid group in first and second measurement

intervention	1 st measurement (p<)	2 nd measurement (p<)
Instruction	0.01	0.01
Explanation	—	—
Focusing	0.05	0.01
Encouragement of verbalization	0.1	—
Seeking information	0.001	0.05
Providing information	0.01	0.01
Support	—	—
Interruption	0.01	0.01

Discussion

Data available in relevant literature refer to the therapist's engagement in homogenous, dynamic oriented groups for schizophrenic patients. The analysis of therapist's interventions is viewed in view of the principle and general differentiation of their characteristics from the ones of patients in the groups of the non-psychotic. As the most important techniques Kanas notes: clarification, research, support, focusing to here-and-now (8). Takahashi (9), Milders (10) take into consideration quality and means of interpretation in the psychotherapeutic process pointing to the harmfulness of active interpretation of the discovered unconscious conflicts.

The results of this paper show that in the initial phase of the group process with schizophrenic patients the attitude of the group therapist is active (manifested through great presence of the therapist's interruption). The therapist, by intervening all the time, keeps the boundaries, structure and content of the psychotherapeutic session with the objective to bring some elementary order in the disorganized schizophrenic impression of the world. That is achieved with interventions which are directed at the manifest, concrete behaviour in the group. The therapist's interventions are concrete, simple, often direct instructions and pieces of information. They have the purpose of enabling all members of the group to understand the basic message in the communication of the schizophrenic which is very difficult to understand, and to direct the endeavor of group members towards the others, i.e. towards the group (which also means towards organizing their own process of thinking in order to be able to communicate it to others) (11). All actions of the therapist are directed towards providing the supportive, tolerant and permissive atmosphere in the group where participation of each member is encouraged (therapist's interventions: support, encouragement of verbalization). The atmosphere in which tolerance is insisted on, not only enables the acceptance of the group as a whole as well as of all its members, but also enables the establishment of its own limits. This is achieved by gradual noticing, defining and dividing of incomprehensible and confusing experiences by establishing order, meaning and sense (therapist's interventions: focusing and explanation). In that way, the testing of reality is gradually being established, which in the groups of schizophrenic patients constantly shows its fragility.

In the final phase of group psychotherapy of schizophrenic patients, "directive" therapist's interventions (instructions and giving information) are being reduced which comes out of the establishment of basic testing of reality and placing part of the responsibility for what is going on in the group on the group itself and each individual member. This is made possible by the increase of the group's cohesion and activation of therapeutic capacity of the group. The therapist still assesses the potential and capability of the group and each of its members, not allowing the disorganization and growing of

helplessness (therapist's interventions: therapist's interruption and support). His/her interventions are now more directly leading to further stabilization and integration (by focusing and giving explanations – interpretation). By assessing the patient's experience which appears quite openly in the group and is often directly expressed, the therapist is trying to offer an acceptable framework to the patients and the group, in which the meaning of the events will simultaneously be realistic, comprehensible and will not provoke destructive and disintegrative tendencies (12).

The group psychotherapy of the schizophrenic in hospital conditions is limited by the duration of hospitalization which is often just a part of the time necessary for psychotherapy (13). The time, together with the acceptance of the group and feeling of belonging, is the necessary factor for the internalisation of the group and its standards which can, at least partly, compensate the basic representational deficit.

At the beginning of group psychotherapeutic work with paranoid psychotic patients the tasks of the group therapist are complex. The therapist not only provides elementary milestones of the group's existence and going on, but also accepts and softens particularities which come out of the paranoid process. That means that the therapist must build the group atmosphere where security and trust are offered, but lack of trust and hostility are tolerated as well. The therapist's task is to enable the establishment of relationships between group members by playing on the mutual similarity of group members. The trust based on multiple identifications is the only form of trust offered by the paranoid patient and the therapist does not forget that this trust is constantly being assessed and should be confirmed over and over. In groups of paranoid patients, the therapist's interventions used for building cohesion (giving support, encouraging verbalization, therapist's interruption) make up almost a half of all therapist's interventions. They are necessary in order to conquer the resistance of all group members towards the acceptance of the group. The basic task in the initial phase of group psychotherapy of paranoid psychotic patients is reality testing. According to Meissner (14), this is achieved with the process of detailed assessment of the paranoid construction. The therapist is trying to get as many concrete, explicit details about events, the patient's perception of events and his feelings (therapist's interventions: seeking information). Insisting on details enables that the patients are confronted with more and more elements of reality. Parallel to seeking information, the therapist must focus the attention of the group to the projections of its individual members but also the group as a whole. Focusing on the projections and questioning of their realism places a question of affect in basis. The answer to this question leads to understanding the motivational conditioning of paranoid ideas (therapist's intervention: explanation) and it is characteristic for the final phase of group psychotherapy.

The way the patient experiences himself in the group is directly observed from the behaviour or can be found out from what the patient's himself explains as his own feeling. The basic introject of the paranoid, around which an experience of the self is formed, determines the viewing of the self as inadequate, weak, unworthy and helpless. This kind of introjective polarization requests two things: reality testing in relation to the experience of the self, and connecting with the suppressed or negated pole of introjective configuration. The therapist here also seeks the details of the concrete situations when the experience of the self appears or from which it comes out. Reduction in the seeking of information is the consequence of more active inclusion of other members which enables the therapist to selectively focus and explain different aspects of behaviour and by that to lead the group to insight.

Psychotic condition is the common pointer both for small groups of schizophrenic and for paranoid patients, and as such it places formally the same task before of the therapist: establishment of the reality test. Different

pathological processes (schizophrenic and paranoid) endanger or disable the testing of reality with their specific mechanisms and dynamics. The therapist must accept and respect these particularities which is partly shown in the way he/she leads the group (in the group of schizophrenics by emphasized activity, giving instructions and information, and in the group of the paranoid by seeking information). The interventions which have the task of creating and keeping the group cohesion (as the precondition and important therapeutic agent) are common for both groups (support, encouragement of verbalization). Focusing and explanation are relatively evenly present, representing the therapist's interventions which are effective in all groups. Their somewhat greater presence in the groups of paranoid patients is the consequence of better integration and bigger ego power of these patients. The difference in the therapist's interventions is kept also in the closing phase of group psychotherapy, thus confirming the particularities of the therapist's engagement depending on the particular pathological process.

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SPECIFIČNOSTI TERAPIJSKOG ANGAŽMANA U GRUPNOJ PSIHOTERAPIJI SHIZOFRENIH I PARANOIDNIH PACIJENATA

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Kratak sadržaj: *Grupni terapeut formira psihoterapijsku grupu selekcijom članova grupe, strukturira terapijsku situaciju utičući na karakteristike grupne kulture i definiše ciljeve. Aktivnost i odgovornost terapeuta za terapijski proces veća je u grupnoj psihoterapiji psihotičnih pacijenata. Posljedice različitih patoloških procesa (shizofrenog i paranoidnog) na grupno psihoterapijski proces vidljive su i kao specifični zahtevi koje svaka grupa stavlja pred terapeuta. Preciziranje i upoređivanje terapijskih modifikacija (određeno strukturom terapijskih intervencija) predstavlja predmet ovog rada. Istraživanjem je obuhvaćeno pet Malih grupa shizofrenih (ukupno 40 pacijenata) i pet Malih grupa paranoidnih pacijenata (ukupno 48 pacijenata). Angažman grupnog terapeuta određivan je Skalom*

terapeutovih intervencija (Cook i Kipnis). Upoređivanjem terapijskih intervencija u grupama shizofrenih i paranoidnih pacijenata u prvom merenju ukazuje na statistički značajnu razliku u odnosu na traženje informacija, instrukcije, davanje informacija i terapeutove upadice (zastupljenije u grupama shizofrenih). U drugom merenju, i pored promene zastupljenosti terapijskih intervencija unutar grupa, između grupa paranoidnih i shizofrenih održavaju se razlike u terapijskim intervencijama nađene u prvom merenju. Različiti patološki procesi (shizofreni i paranoidni) svojim specifičnim mehanizmima i dinamikom narušavaju testiranje realnosti. Terapeut mora da uvažava ove specifičnosti što se delom pokazuje i u načinu na koji vodi grupu.

Ključne reči: Terapijske intervencije, grupna psihoterapija, shizofrenija, paranoidnost