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GROUP ANALYTIC PSYCHOTHERAPY OF PSYCHOTIC PATIENTS

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group analysis
psychosis
countertransference

Summary

Goal: The article presents a theoretical rationale for group analytic therapy of psychotic patients, as well as benefits resulting from the application of this form of psychotherapy to this specific patient group.
Method: Modifications of group techniques recommended in the literature are discussed with reference to the author's own clinical experiences.
Results: The author believes that recommendations concerning a more directive and more structured leadership style in group psychotherapy are associated with the institutional form of treatment provided to these patients and with countertransferential mechanisms, and not with their genuine psychological needs. In her opinion, firstly, psychotic patients may benefit from their inclusion into heterogeneous groups that comprise patients with different diagnoses, and secondly, the presence of psychotic patients may be beneficial to other group members.
Conclusions:
1. Analytic group therapy is an appropriate method of treatment for "psychotic" patients.
2. Persons who have experienced psychosis should be included into analytic groups in the same way as other patients, on the Noah's ark principle. Obviously, the therapist must be convinced that patients with psychotic symptoms are able to benefit from psychotherapy, and besides, he must have clinical skills required when working with psychotic symptoms.
3. "Psychotic" patients are affected by exclusion not only in their communities but also due to the way of thinking about them that predominates among therapists and in treating institutions.

In this paper, I would like to summarize my experiences gained from group analytic psychotherapy and supervision of groups for psychotic patients based on group analysis. The latter are conducted in different contexts - private offices, day wards, community self-help centers, mental health clinics.

I lead my own group in my office, currently in cotherapy. All persons participating in the group have experienced an acute psychosis, which has led to their hospitalization. The group is led using the classical method of group analysis as understood by Foulkes's "free-floating discussion" with the use of both individual and group interpretations. The group is semi-open, consists of no more than 8 people, meets once a week for 1.5 hours. Patients must be abstinent.

To say that the method of group therapy is beneficial for the recovery of patients diagnosed with psychotic disorders is like pushing at an open door. Such groups are commonly conducted at day clinics, rehabilitation centers, or departments for patients with first-episode

psychosis. The groups are often psychoeducational in nature, being designed to teach patients how to better cope with their symptoms. A question arises whether a group of this type can be regarded as psychotherapeutic, i.e. whether psychoeducation is equivalent to psychotherapy. This seems to depend greatly on how "psychoeducation" is understood by therapists. If psychoeducational interventions help the patients recognize their psychological states, show that the symptoms can be interpreted in the context of their previous life experiences, and reach the meaning of their symptoms, then the nature of such interventions is definitely psychotherapeutic. Psychoeducational groups are at risk of describing the patients' disorders in biomedical terms – in other words, their experiences are not included in the normal human range but instead classified into a separate category as "bizarre" or "abnormal". Sometimes the patients may be taught to recognize their symptoms as something separate and different from their "self". They are encouraged to write down the first symptoms of their illness as if these were detached from their experience or impossible to understand. This may enhance the patient's feelings of disconnection between the "normal self" and "sick self" that are not susceptible to integration.

Group analysis

When speaking about "group analysis" I mean group treatment defined in terms of the Foulkesian approach above all, i.e. as group therapy conducted by the group and supported by the therapist [1]. The therapist facilitates the group development, follows the group, intervenes if the group members are unable to cope with a situation by themselves. In his/her work, group interventions (addressed to the group as a whole) are used predominantly, although individual interpretations are permissible as well. Foulkes assumed that a psychotic patient could be admitted to a group-analytic group, but neither had ever conducted groups of psychotic patients himself nor has ever been reported to do so by other authors from his school.

In the context of psychotic patient groups, also the ideas proposed by Bion [2] seem important, first and foremost his regarding the group as a container into which beta elements are projected by means of projective identification and subsequently transformed into meaningful thoughts (alpha elements). Containing is the individual's capacity to take in another person's projections so as to experience and understand them [3]. This enables the container to transform the projections and return them as a modified message. The process in its primary form, in the mother-child relationship, enables the infant to experience its own feelings and aids the development of thinking. It constitutes a basis of any analytic therapy, being pivotal in the treatment of psychotic patients affected not only by difficulty in recognizing their own affective states but also by considerable thought disorder. In the therapy of psychotic patients, it is important to translate their experiences into words and to integrate the diffuse, incoherent, or dissociated aspects of the patient's pre-thinking processes in the therapist's mind in order to make them meaningful and significant.

Psychotic patients from the analytic perspective

When writing about groups of psychotic patients, it is essential to define how psychosis is understood. Psychoanalysts are known to use this term often to denote disorders at a psychotic level, i.e. fixation at the symbiotic phase [4] or psychotic structure of personality in which it is

important to develop a separate area of the psyche – an "asylum" [5]. In consequence of this fixation, difficulties arise in differentiating between inner and outer realities. In the clinical understanding of psychosis, greater emphasis is laid on reality testing disorders and on symptoms in the form of hallucinations or delusions. Kernberg [6] proposed a structural diagnosis of psychoses including all the above-listed deficits, where reality testing disorders are associated with impaired differentiation between the inner and the outer, as well as between self and object, due to which the patients are incapable of realistic evaluation of their behavior, affect, and thinking in the domain of social rules. As a consequence, states described as psychosis occur periodically – auditory hallucinations, delusions, problems with thinking and concentration, and withdrawal and lack of motivation.

Summarizing the analytic approach contribution to understanding psychotic patients, I believe the essential discovery to be the Freudian idea that incomprehensible narratives and symptoms of psychotic patients can be comprehended in the context of their earlier life experiences, and that the process of psychotherapy consists in making sense of apparently meaningless symptoms.

The most coherent concepts of psychosis and of the ensuing therapeutic technique have been created by the Kleinians [7]. According to this school, the child uses dissociation and projective identification to retain the early object, and since with time the child becomes able to contain dissociated parts of self and others, primitive defenses are not useful any more. According to the Kleinian school, psychotic patients do not attain this level of maturity. Proximity and entering a relationship lead to their regression and trigger primitive defenses. Any attack at these defenses results in the patient's withdrawal from relationships or in a psychotic breakdown. Along these lines, the main dysfunction in psychosis consists in an impaired ability to establish relationships with others. The aim of therapy according to Klein is a reconstruction of the dissociated ego and its further development through the paranoid-schizoid phase to the depressive stage. Such a transition is possible on condition that a profound therapeutic relationship is established, transference analysis is conducted, and less disturbed ego elements (the "non-psychotic part" in Bion's terminology [8]) are reinforced.

Thus, Klein [7, 9] has distinguished two positions: paranoid-schizoid and depressive, fulfilling also the function of developmental stages. The depressive position is often perceived as a sign of health, while the paranoid-schizoid position is regarded as "sick". The formation of the paranoid-schizoid position bipolarity may be also seen as a developmental achievement [10], enabling the individual to easily oscillate between the positions over the lifetime. In psychotic patients, an excessive dissociation due to persecutory anxiety and envy leads to fragmentation.

As mentioned earlier, Bion's concept of containing [11] seems to be of particular importance in the therapy of psychotic patients. According to Bion [8], the source of psychosis is a breakdown of the mother-infant process due to the mother's inability to transform her child's projections. This may result from the powerfulness and destructiveness of these projections, or from difficulties on the mother's part. Under these circumstances, a destructive, exploitative, and evaluating object becomes instilled in the infant. In further consequence, it becomes the strict and unforgiving superego of psychotic patients that we may see during their therapy. Bion believes this overrepresentation of destructive forces leads to an attack at the ego

and to its fragmentation into particles described as "bizarre objects" constituting beta-elements with traces of ego and superego [12].

Therefore, therapy of psychotic patients will be based on the modification of the strict, archaic superego via mutative interpretations, i.e. transference interpretations changing the nature of the superego. It is important that the therapist does not act as a "good object" (which is a frequent temptation in the treatment of psychotic patients), since this reinforces the dissociation between the patient's persecutory and idealized superego [13].

An important element connecting therapy of patients with traumatic experiences and those with the experience of psychosis are the concepts proposed by Hanna Segal [14] concerning the destruction of the ability to symbolize after a traumatic experience where a symbol is experienced as an object. According to Segal, trauma is followed by a symbolic equation where the subject is perceived as an object. This way of thinking is also typical of concrete psychotic thinking. As in Bleuler's comment on schizophrenia: "Not infrequently, after a thorough analysis, we should ask ourselves the question of whether we are indeed dealing with effects of a particularly severe trauma in a sensitive person, and not with a disease in the narrow sense of the word" [15, p. 300].

Both the paranoid-schizoid phase and the depressive phase are ways of the organization of experience. A question arises about preceding stages, when the individual's experience is disintegrated and the fear of annihilation is the basic anxiety. An attempt to describe such a situation was made by Ogden regarding the autistic-contiguous phase [16]. This is a sensory stage, where the self-development is based on the experience of skin-to-skin contact. Traumatic, but also psychotic experiences lead to the emergence of autistic defenses – cutting oneself off from the reality which allows for encapsulation or encystation of trauma understood as an internal or external experience.

An important discovery of the Kleinian school was the description of the role and character of the projection – the basic defense mechanism of psychotic patients in the concept of projective identification [17, 18]. Psychotic patients place parts of their self in other persons, and in consequence, they experience emptiness and derealization. The experience of projecting a part of oneself into another person may be regarded as a source of psychotic experiences – delusions of control or thought broadcasting. Through the projection of the self into an object the self can acquire the object's features, which results in his beliefs that he actually *is* the other person, or is in the power of external forces. Projective identification as understood by the British school is an unconscious phantasy in which aspects of self can be attributed to other objects.

Representatives of the American school assume projective identification to be the ability to evoke emotions in the object [19]. Recognition of the phenomenon of projective identification enabled to use countertransference feelings to understand the patient's inner world. The concept of understanding a psychotic patient based on projective identification has been described in detail by Rosenfeld [20]. According to his theory, the patient gets rid of unbearable thoughts by placing them in the mind of the therapist. On the part of the patient, it is both an attempt to communicate, as well as showing hope that the therapist can cope better with the patient's problems and difficult feelings.

Nonspecific factors in group therapy

The category of nonspecific factors comprises the function of the group as a platform for communication. It is necessary to find a common language and to learn how to participate in the group dialogue. Psychotic patients as compared to others often have more severe communication deficits. In the group I conduct development in this respect has been notable. Initially, each patient used to produce their narrative paying no attention to communication with others. This can be also interpreted as a regressive state, where the time for "feeding" is equitably shared, but group members are interested neither in others nor in mutual communication. In groups comprised of patients differing in disorder severity, the participants often communicate at least for the sake of social norms, even at the initial stage of the group process.

In group settings, the participants' symptoms can be comprehended in interpersonal terms. Particularly important may be the emergence of symptoms during the session, as it allows to discuss them in the context of the group situation. The patients discover they are not the only ones who experience symptoms of this type. This is obviously important also in groups of patients with no previous experience of psychosis. However, having a psychotic episode and being hospitalized in a psychiatric department can be often seen as stigmatizing, so it is of particular importance for the patient to hear that he is not alone in such a situation.

Interestingly, in the group I conduct, where all the participants have experienced a psychiatric hospitalization – they reported in unison that they had "never thought anybody else could have similar experiences." I believe this suggests they had survived their hospitalization in isolation protecting them from the feeling they "had something in common" with their co-patients.

One of the group members at the first session expressed his need for reflecting on his psychotic experience as follows:

> *I wanted to come to a group of people who also had the experience of psychosis because since the onset of my illness I have always believed it shows through and that I must be on the alert so as not to spill it out. And here I see that all of you are normal, and nothing shows you might be ill…*

Moreover, other universal group experiences such as the members' equality, assuming responsibility or discovering their importance to others, fulfill an especially important function in the light of the frequently depreciating family environment, where the patient's "illness" denotes taking their importance or responsibility away.

Specific factors

It follows from the analytic theoretical rationale presented at the beginning that in psychotic patients, closeness often leads to disorganized thinking. Experiences with individual therapy of psychotic patients indicate that focusing the therapist's attention on the patient results in a flood of chaotic feelings to the extent completely blocking any contact. If the focus of attention is on another person, the same patients are able to recognize and empathetically respond to the situation, taking the position of "the third party" [21]. I was astonished that patients very difficult in individual contacts presented their high functioning in the group. The

mother-child dyadic relation with the therapist means that the latter is expected to perceive the patient's inarticulate "cry" [22]. Reports on individual therapies of psychotic patients show how therapists develop an internal language with the patient, the same as in the mother-infant relationship [19]. Group relationships impose the use of adult language on the group members.

If we assume that containing in the therapy of psychotic patients is important, then – according to Garland [23] – any group is characterized by greater stability and ability to contain than the individual therapist. The group continues to exist for each group member irrespective of their actual attendance at the group sessions during a given week – the group remains on the members' minds and unites them.

The group offers a very special structure, where every group member not only feels to be a patient but also fulfills an important role in the treatment of others. Using Klein's terminology, we can say that a patient in a group, by feeding others, becomes a part of the group's breast, and not only (as in individual therapy) a hungry child. The feeling that one has the ability to feed, mitigates envy towards the feeding object [23].

Hopper [24] proposed ten arguments for the treatment of "difficult patients" in group settings. In his opinion, "difficult" patients are those who experience annihilation anxiety and fears associated with their sense of fragmentation. Sometimes, they present with encapsulation of their traumatic experience and with dissociative symptoms. This pertains to patients "at the psychotic level" who frequently use psychotic experiences as their defenses.

1. The group provides a containing environment that creates a good "environmental mother".
2. The group becomes a transitional object that helps an individual to individuate and separate from the archaic, negative maternal object.
3. The group provides opportunities for safe play, that is, for trying on and taking off various gloves of identity without serious consequences.
4. The group provides opportunities for realistic feedback from people who are heterogeneous in their social and personal qualities.
5. The group provides opportunities for negotiations of personal and social boundaries both between oneself and others and within oneself, and in this connection to understand the difference between psychic and social facts.
6. The group offers opportunities for benign mirroring.
7. The group offers protection and shielding from tough but necessary confrontations. Although scapegoating occurs, the therapist can usually reclaim projected parts.
8. The group provides intimacy with males and females but in general, the intimacy is more diffuse and, therefore, less frightening to the vulnerable patients, who usually suffer from a degree of confusion in their gender identity.
9. The group offers opportunities for altruism, that is, patients can simultaneously both help and be helped, and this greater degree of symmetry and independence of patients and the group conductor provides opportunities for reparation and forgiveness, and for moderating the experience of destructive envy and rage.
10. Face-to-face interactions with peers and the therapist are especially suitable for anxieties associated with shame, which is more than merely an archaic form of guilt.

Group therapy process

What does the course of psychotic patients' group treatment from Kleinian psychoanalysts' perspective look like? According to this school, psychosis presents a threat to the patient's relationship with the symbiotic mother resulting in his unconscious looking for another mother. The group becomes a substitute mother, containing the patients' primitive anger against the "bad breast". Their anger may be directed not at the self or delusional figures but rather at the group whose role it is to endure and contain these feelings. These parts of the self that have not submitted to integration yet can be then situated by the group members in each other, in the therapist, and in the group as a whole. In the safe atmosphere, re-introjection of these contents in a less toxic form ensues, as well as their development towards a depressive position allowing to experience oneself and others as whole objects [25].

An important part of therapeutic work is to analyze projective mechanisms frequently underpinning the development of productive symptoms.

The therapist's comments during one of the sessions:

> *"You say it is money that precludes your moving out of your parents' house – because it is perhaps easier to talk about money than about emotional difficulties. Likewise, Mr. T. talks about strict religious requirements because it is easier to refer to external prohibiting rules than to one's own difficulties in starting relationships and coping with sexual impulses. I am talking about this also because you have mentioned psychosis – both of you have experienced at that time a situation where your internal experiences were located outside."* A female group participant brakes into the conversation: *"I have just thought how readily I used to obey my mother who never let me go to a party so that I would not come home late at night. It was easier for me to think she forbade me to go, even though I really knew it was my own difficulty with going out, and that if I had put my foot down, she would probably have let me go."*

Modifications of therapeutic work in psychotic patient groups

In many publications, the necessity of psychoanalytic therapy modification in the treatment of psychotic patients is emphasized. In individual therapy, these modifications are referred to as "parameters". Eissler [26] postulated a more active role of the analyst, reduction of regression, and incomplete transference analysis. According to Kernberg [27], in the therapy of patients with more severe disorders therapists should focus on the current reality rather than on the past, should begin their analysis with negative transference first, to deal subsequently with idealization, should devote more time to such phenomena as "acting out", and reduce the number of sessions to 1-2 a week. It seems worthwhile to note that this results in moving away from the classical psychoanalytic therapy, which is conducted 4-5 times a week, and to a great extent resemble the modifications concerning therapy provided to other kinds of patients in the settings of sessions held once or twice weekly.

Recommendations on modifications of the classical group analytic therapy for psychotic patients proposed in the literature will be discussed in more detail in what follows, since on the

grounds of my experience with conducting group therapy, I cannot fully agree with them. It is important that I am referring here to the ”golden standard” of the analytic group – an outpatient, semi-open, and long-term group (the proposed modifications apply to this type of group). I do not deal here with groups run in day wards or in community self-help centers, where contacts between the patients/participants outside group sessions are obvious. In this situation, the therapy is modified, but not due to the specificity of psychotic patients but because of external conditions – the need to intensify interactions due to a short stay in the day ward or the use of other forms of interaction in both structures.

1st recommendation:

In groups of psychotic patients, it is important to foster interpersonal relations between participants, even if they express “escapist” tendencies [28]. In practice, this means that verbal exchanges concerning general issues should not be interpreted as the participants’ trying to avoid their personal problems, but rather as a development of their abilities to initiate contacts with others, and as creating a common space where mutual exchange can take place.

Comment:

This recommendation seems to pertain to forms of therapy more structured than the classical group analysis. In the analytic group, we do not deal exclusively with the defensive function of conversations on general issues, but also, and perhaps first and foremost, with unconscious contents of narratives.

In the group I conduct, a recurring topic of discussions among participants was the attitude of the external world towards the mentally ill. This topic seems to fulfill different functions at various stages of the group process. While it served initially to unite the group and increase its cohesion (“we all share similar experiences”), in crisis situations in the group it re-emerged as the “basic assumption” of fight-flight proposed by Bion [2]. Sometimes, it was an unconscious description of the participant’s family situation with the division: “I against the rest of the family”, or a representation of a dissociated internal world.

In my view, the recommendation for non-interpretation of discussing general issues in psychotic patient groups is unwarranted. Like in other patient groups, it is important to recognize and name the actual meaning of the conversation – the group’s common denominator.

2nd recommendation:

It is recommended that interpretations concerning the group as a whole should be used with caution or even totally avoided [28]. This recommendation is due to the concern that descriptions referring to the group as a whole might be easily included into psychotic beliefs about a lack of boundaries between minds, and thus may lead to symbiotic regression. Moreover, interpretations lacking any explanation of how the therapist arrived at such a conclusion become magical sounding formulas about “group” thinking or experiences.

Comment:

In my opinion, this recommendation seems valid for most groups, not only “psychotic” ones. Therapeutic groups for people with personality disorders often comprise borderline patients, for whom interpretations that join the participants’ minds into a single “group” mind may be incomprehensible and increasing their sense of threat. Interpretations in which the therapist explicitly points to these patient narratives that have led him to the conclusion presented in the interpretation seem to be more advantageous not only in groups of psychotic patients. The therapist’s revealing his way of thinking may be beneficial for patients who

represent low levels of mentalization accompanied by symbolization difficulties. These characteristics are not limited to psychotic individuals and pertain also to borderline patients. I believe that this way of working does not exclude the application of typical Foulkesian interpretations to the group as a whole.

In groups where participants strive for a dyadic relation, individual interpretations inevitably change therapy "through the group" into "therapy in the group" or "against the background of the group". As compared to "personality disorder" groups, the group I have conducted has displayed, particularly in the initial stage, much stronger tendencies to use individual interpretations to continue the dialogue with the therapist, changing the group settings into individual "feeding", with each participant awaiting their turn. My refusal to enter any dyadic relationship resulted in the ironic term "ask the expert" coined by the group as a comment to regressive questions addressed directly to the therapist (e.g. "how do you think, what should I do?")

An example of such an interpretation to a group as a whole, including the contribution of individual members, may be a fragment from a group session:

> *At the beginning of the session, patient R. tells the story of a conflict with an accidental person on the street: "my dog attacked a crow and this guy crushed me terribly, I think he wanted to provoke me to fight." Next, patient A. tells two stories – how badly she was treated by an employee at her office and by her friend. Patient M. turns on in chaos: "I've done a lot of things wrong in my life, now I try to apologize to people, even if I do not manage to do it in person, it is in my mind or in my prayers." After a moment of silence, the intervention of the therapist: "I feel that you are talking today about situations in which you face difficult situations where other people are aggressive towards you, as in the case of Mr. R. or Mrs. A., but it is difficult to think that this aggression is on their side, it is difficult to feel anger and you stay with feeling that you are not right and you have to apologize, as did M."*

This intervention stimulates further conversation about the difficulties in experiencing feelings of anger and work with the psychotic sensations of the patient M. It was also possible to discuss their anger at the situation in the ambulatory clinic – constant changes of physicians and change of the place where the group takes place. The result of this group work is the patient's exit from chaos and mastering psychotic experiences during the session.

3rd recommendation:

In psychotic patient groups, the therapist should cope with an attack at a scapegoated member of the group in a different way than in other types of groups. Classical interpretations of scapegoating in terms of anger at the therapist are regarded as too threatening for psychotic patient groups. In their case, it seems sufficient to show the mechanism of projection that allows for re-introjection of persecutory contents. This recommendation is based on the assumption that the groups in question tend to get stuck at an early stage free from the separation-individuation conflict. According to Agazarian and Peters [29], psychotic patients do not attain the stage of rebellion against the leader and so it is more realistic to aim at helping them enter into meaningful dialogue with others. The group may be unable to cope with their anger at the therapist.

Comment:

I have the impression that this recommendation is due to the fact that group therapy of psychotic patients is often run in hospital settings or in other facilities within a predetermined limited timeframe. The participants of the long-term group I am conducting are engrossed in the problems of separation-individuation and have become independent from their parents and therapists.

4th recommendation:

In the treatment of psychotic patients, better outcomes are achieved if individual and group therapies are combined.

Comment:

In my opinion, combination therapy is associated with the risk of increasing dissociative mechanisms, and that may be particularly unfavorable in psychotic patients. The choice of such treatment may be a sign of projective identification, where in the therapist's perception his psychotic patient is a perpetually unfed infant or a sign of the therapist's fear of the patient's internal world and of the need for support from another person.

The modification I use in my group in the case of patients who continue their individual therapy at the time of their joining the group is that their combination therapy can be accepted only in the first few months of their group membership. This facilitates their entry into the group and coping with difficult emotions. On the other hand, an evident change follows their individual therapy termination – increases can be seen both in the group importance and in their work intensity during group therapy sessions.

5th recommendation:

In the case of psychotic patients, the abstinence principle (including no socializing and no contacts outside the group) is frequently renounced, or "flexible group boundaries" are postulated [30].

Comment:

I wonder whether permissibility of contacts outside the group as well as other deviations from the regular group settings (seen by group leaders as "flexibility") might perhaps not be the therapists' projective identification with the disorganized world of psychotic patients, where it is difficult to establish and maintain boundaries.

Group therapy structure

Group therapy with psychotic patients must be long-term. The group I conduct is semi-open, new group members are included at a slow pace so as to enable the group to peacefully discuss the change. According to Garland [23], who conducts long-term group therapy of psychotic patients, they should not expect their treatment to take less than 3-4 years. The group therapist should have an active leadership style, should like this type of work and this type of patients. The group should be supported by other forms of therapy and rehabilitation making up a whole treatment system, preferably with the possibility of hospitalization. Regrettably, the latter postulate may be currently difficult to fulfill in Poland – the provision of long-term group therapy seems to be often unfeasible in view of the unstable working conditions under the National Health Fund (NHF) schemes.

One of the difficulties in running outpatient groups within the NHF is the requirement for a certain number of people to be present at the session so that the benefit can be settled. Analytical groups have developed their theory and practice in relation to the so-called ”small group”, traditionally counting up to 8 people. Just because someone did not come to the session does not mean that he is ”missing” in the group. The symbolic expression of his presence is an empty chair. Patients say that, even absent, they were thinking about the group. The constant fear of therapists that there will not be enough patients at the session leads to the enlargement of groups beyond the limit of the analytical group – a group is formed which in psychotherapy is referred to as a ”medium” group in which both group process and techniques are different than in a small group. In this sense, some of the above modifications can be understood as resulting not from the specifics of psychotic patients, but from treatment within the health care system. If the group is too large, we can treat it as a ”group experience” (such as a therapeutic community) for a patient undergoing individual therapy.

Under the circumstances, it seems important for those who conduct groups in private practice centers or consulting rooms to develop a system of support from other structures providing treatment and support to people with the experience of psychosis.

The group I conduct has moved from an NHF-financed outpatient clinic via a private therapeutic center to a private consulting room. The first transfer has definitely decreased the group sense of security, not only due to the practical troublesomeness of paying for therapy sessions but also due to the group members' permanent belief about the instability of NHF-financed treatment (e.g. frequent changes of attending physicians). While initially only one participant decided to discontinue group therapy explaining his decision by his recently started individual psychotherapy, two other participants failed to come to our sessions at the private center. An evidence of the participants' relationship needs seems to be the fact that a couple started dating, and in further consequence, one more participant left the group. Thus, after the crisis of changing their place of residence, the group has been reconstructing itself largely from scratch. As my supervisory experiences suggest, any change of settings is difficult for various groups, but in psychotic patient groups the site of therapy serves a particular role related to a very primary level and to their sense of security associated with the maternal environment.

Due to the change of settings in the course of therapy, I decided the fees for group sessions should be below the market price. Such a practice of accounting for financial abilities of some groups or individual patients becomes more and more popular. There are e.g. less expensive groups for youth, old age pensioners, etc.

After the group reconstruction at the private center, the participants' session attendance and their informing about anticipated absences have considerably improved. The participants expressed their satisfaction with the “non-hospital” settings.

The subsequent change from the private center to my consultation room was not followed by an evident crisis, perhaps due to the close proximity of the two sites, or to the fact that some participants had previously been individually consulted at the latter site. I wonder whether therapists who reject any possibility of providing cash-based psychotherapy to psychotic patients are not in collusion with these patients' feeling they have no resources. It seems that, just like it is the case with other patients, also in this case charging for therapy sessions moves the therapist-patient relation closer to a partnership model. The question arises: do we accept this type of relationship with psychotic patients?

Countertransference in the therapy of psychotic patients

As a physician and psychotherapist, I have been treating psychotic patients for many years. I have a feeling it is the conducting of group therapy that has led me to an internal change as well as to the belief that psychosis is a "life event", but not a catastrophe, and that psychotic symptoms should be understood in the same way as neurotic symptoms.

It was difficult for me to specify the nature of this change. A description of supervision conducted by Michael Eigen [31] has been helpful in this respect. Treating psychotic patients is frequently considered as a rewarding experience. I think this is associated with the clarity of the therapist-patient relationship. Namely, the therapist is not subject to the unpleasant feelings of being envious of his patients. The contract is clear: I am healthy, the patient is sick. This idea is supported by the biomedical model of mental illness assuming that psychotic patients have brain lesions. I think it might be sometimes difficult for us to answer the question in what respects we would like to be similar to our patient. We are the ones who pull the patient "upwards", to health. In my opinion, the turning point in the therapy of psychotic patients consists in a change of the therapist's approach, from his role of a person who rescues or uplifts the patient, pulling him towards a better (our) life, to the therapist's genuine interest in his patient's internal world. I do not mean any spectacular psychotic experiences but rather our discovering the wealth of their world of thoughts and feelings, just like it is the case with other types of patients.

Supervision seems to be of particular importance when working with psychotic patient groups, since as a triangulation process, it prevents the development of a dyadic relationship. For me, a group supervision shared with other therapists who work with personality disorder groups turned out to be most important. In this way, my group of psychotic patients and its participants have become included in the sphere of common understanding.

Homo- or heterogeneous groups?

The approach I am proposing to treat patient groups on a similar basis as personality groups leads to further questions. Is the difference between neuroticism and psychoticism quantitative or qualitative? The stance of Danielle Quindoz [32], who coined the notion of heterogeneous patients manifesting both neurotic and psychotic characteristics, is close to my way of thinking. Heterogeneous patients are capable of using psychic mechanisms of the neurotic type (e.g. symbolization) but they resort also to psychotic mechanisms such as denial, projection, projective identification, dissociation. They have difficulties in integrating mature and rather primitive mechanisms, which may result in their fear of madness. They tend to cut off their psychotic aspect at the price of impoverishing their identity and maintaining their sense of existence. I believe when often meeting such patients; we list them under the broad borderline diagnostic category and include them in personality disorder groups. Participating in a common group with patients who have psychotic experiences, they could perhaps benefit from this opportunity to explore their own psychotic components [25].

Interesting is the discussion concerning purposefulness of creating homogeneous groups for patients with the experience of trauma. In this case, the participants' shared experiences are believed to give them a sense of being understood and help them more readily accept

interpretations offered by other group members. Moreover, it is a reversal of the traumatic situation, where the traumatized person was usually alone. Participation in a group of people similarly traumatized is experienced as a restoration of the family, homecoming, regaining a sense of belonging. On the other hand, the commonality of experiences may stimulate the patients' tendencies to compare themselves with others and to enter a competition of suffering, stimulate idealization-devaluation, and increase the risk of acting-in in the form of re-enacting the trauma. Thus, e.g. Judith Herman [33] suggests that homogeneous groups are recommended at the initial stage after the traumatic experience, when the process of mourning should be completed in safe circumstances, while in later stages – when the participants' task is to rebuild relationships – heterogeneous groups should be formed, involving patients with different types of trauma.

These issues are not discussed as regards psychotic patient groups, as if such patients obviously could not be included in "personality disorder" groups. Homogeneous grouping of psychotic patients seems to lead to similar phenomena as in the case of homogeneous post-traumatic groups – on the one hand, building group cohesion, but on the other hand, possibly producing a "shared misfortune group" [34], with the recurring theme of being misunderstood by "others". The question may be raised to what extent therapists who create such a group give the stigmatizing message that people with the experience of psychosis are "different" and, therefore, should have "their own" group. This approach, or frankly speaking, the therapists' fear of psychosis may lead them to modify therapeutic techniques toward more structured sessions. This is corroborated by recommendations proposed by Kanas [35] who claims that psychotic patients should participate in homogeneous groups, since mixed groups increase their psychotic regression. Another argument is that in homogeneous groups specific techniques can be used, e.g. focusing on strategies of psychotic symptoms management. A common phenomenon seen also in other countries is that treatment of such patients is assigned to less experienced therapists, which may result in their need for supporting themselves with specific techniques.

If we assume that homogeneity of psychotic patient groups is not beneficial, then the question arises: how to include persons with the experience of psychosis into groups of other types so as to avoid them feeling different and ensure that they can talk freely about their experiences. In the group I conduct, I once began talking about the possibility of including persons who never had any psychotic experiences. The group members agreed that for the time being psychosis was not a predominating subject matter during our sessions and decided that membership of other persons would be possible provided they had had some other significant or traumatic life experiences resulting e.g. in their psychiatric hospitalization. However, the arrival of a new participant with no experience of psychosis, but after psychiatric hospitalization and with traits of narcissistic and histrionic personality had unexpected consequences. His severe personality disorder scared the remaining therapy participants, they considered him to be much sicker than themselves. One can wonder whether his presenting behavior and the contents of his narrative, i.e. his openly expressed need to be the focus of the group's attention as well as his total lack of interest in problems of others were perhaps acting as a malicious reflection of the needs of other group members. After months of therapeutic work, they have begun to cope with these needs, to recognize the value of feeding others or of the position of the third.

Thus, my experience gained from conducting a group of psychotic patients has convinced me that it is the level of the disorder severity or ego strength that are pivotal in building a group, and not the presence or absence of psychotic symptoms. Experiences with including into the group borderline patients periodically undergoing psychotic disorganization have shown that such patients with hypochondriac or obsessive symptoms are able to empathize with the loss of the observing ego in psychosis. They can see that in periods of their symptoms aggravation they too are incapable of recognizing the unreality of their fears about their imagined illness or of rejecting magical thinking in their obsessive behaviors.

Conclusions

Analytic group therapy is an appropriate method of treatment for psychotic patients. It can be used in very different structures. It is important to ensure safety – a fixed place, time, and continuity of group work.

In my opinion, persons with the experience of psychosis should be included into analytic groups in the same way same as other patients, on the Noah's ark principle. Inclusion criteria should be the same as for "neurotic" patients or patients with a personality disorder. Obviously, the therapist must be convinced that patients with psychotic symptoms are able to benefit from psychotherapy, and besides, he or she must have clinical skills required when working with psychotic symptoms. The consequence of such an understanding would be the disappearance of the division into "neurotic" and "psychotic" departments.

My work with the analytic group of psychotic patients has convinced me that this form of therapy is effective, and at the same time has shown how difficult it is to overcome the barrier of exclusion.

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