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THE PROCESS OF CLINICAL DIAGNOSIS AND PREPARATION OF THE PATIENT FOR PSYCHODYNAMIC GROUP PSYCHOTHERAPY

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clinical diagnosis,
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Summary

This article deals with the issue of diagnosis and qualification of patients for group psychotherapy. Meticulously conducted diagnosis and appropriate preparation for the beginning of treatment in a group reduces the risk of sudden resignation, increases the effectiveness of therapeutic interventions, gives the patients a greater sense of security, especially in the initial period of therapy. It also enables therapists to predict the patient's functioning in relations. In the literature we can find information about disqualifying factors as well as features favoring and facilitating the use of group therapy, but in reality qualification decisions are rarely clear and simple. The first part of the article reflects on the dilemmas related to the qualification of patients with various additional difficulties and dysfunctions, often described as excluding from group therapy. Next, reference is made to the importance of the diagnosis of mentalizing processes and personality assessment as significant predictors of functioning in a therapeutic group. Finally, the importance of diagnosis for the description of the subjects' problems and their preparation for psychotherapy, which is crucial for further treatment, was considered.

Introduction

In this paper, I would like to address the process that precedes a patient's admission to psychotherapy, with a particular focus on psychodynamic group psychotherapy. This process involves identifying the patient's psychological problems, diagnosing their personality and mentalizing abilities, as well as developing their psychological understanding, their psychopathology, and qualifying and preparing them for group psychotherapy delivered in the psychodynamic modality. Acting as a diagnostician and qualifying psychologist for patients, and concurrently running group therapy in the day unit, I encounter a variety of problems and doubts related to the diagnosis and classification of patients. As part of the therapy and diagnosis team, we face dilemmas regarding the admission of patients in crisis, with substance use disorders, with experience of trauma, with cognitive deficits,

considering whether group psychotherapy will be an appropriate form of treatment for these individuals. Patients with complex problems, often meeting the criteria of at least several disorders, come or are referred to therapy.

For the purposes of this paper, I would like to adopt a definition of psychotherapy as a method of treatment for people with mental disorders [1]. In Norcross' broader view, psychotherapy is the conscious and intentional application of clinical methods and interpersonal attitudes derived from recognized principles of psychology to help people modify their behavior, cognitive processes, emotions and/or other personal characteristics in a course that those receiving therapy consider desirable [2].

Psychotherapy belongs to scientifically validated methods of treating mental disorders, and its effects are seen both during its course and after the interactions have ended [3].

Group therapy, practiced since the middle of the last century, is one form of psychotherapy. It is an effective and relatively inexpensive method of treating patients suffering from neurotic and personality disorders.

Studies confirm a reduction in the severity of neurotic symptoms and changes in personality in patients who have completed short-term psychodynamic group psychotherapy [4].

Regardless of the therapeutic approach preferred by group therapists, it seems important and necessary to have the correct diagnosis of a patient referred to the group, the initial conceptualization of their problems, and the right way to prepare for treatment, preventing early and sudden withdrawal, as well as enabling more effective use of therapy. As studies indicate, the qualification process reduces treatment dropouts [5]. The knowledge and clinical experience of consultants play an important role in the subsequent treatment process. Patients who are properly diagnosed and prepared benefit more effectively from the therapeutic process.

Psychological problems of the patient – diagnostic dilemmas

Psychological diagnosis preceding the psychotherapeutic process has both a descriptive, exploratory and therapeutic function. The diagnostician acquires data and integrates and compiles them to describe the patient's condition while explaining the sources of the condition and planning the most effective therapeutic measures [1].

The psychologist formulates a diagnosis for psychotherapy, during which they define the patient's psychological problem, reflecting on the appropriateness of an evidence-based group psychotherapy will be, examine the patient's goals, expectations and motivation for therapy, and determine the therapeutic interventions needed by the patient [6].

The examiner assesses the patient's symptoms, compares them with known ICD-11 or DSM-V classifications, and makes a nosological diagnosis. They also examine the severity of symptoms.

I would just like to point out some important dilemmas faced by the diagnostician and consider a few diagnostic doubts that sometimes arise in the team with which I work.

During the diagnostic process, the examiner assesses cognitive functions – attention processes, memory, learning abilities, and abstracting abilities. The patient's benefit from psychodynamic treatment requires at least basic cognitive performance. In various psy-

chiatric disorders, cognitive functions are impaired or there are dysfunctions of selective cognitive processes. For example, in depression, executive functions, attention, verbal learning, short-term memory and psychomotor abilities are impaired [7]. Furthermore, patients with OCD (obsessive-compulsive disorder) have deficits in executive functions, especially inhibitory and switching abilities [8].

Most psychiatric disorders are associated with a disruption of specific cognitive functions. The level of symptom severity and cognitive deficits are often critical in terms of the patient's ability to benefit from group psychotherapy. A patient with severe symptoms of depression or anxiety may require a longer preparation process, individual psychological support or pharmacological assistance before they are ready for group treatment.

The presence of neuropsychological problems does not disqualify any patient from an insight group psychotherapy. However, it is advisable to examine the extent to which executive functions, reflective abilities and other cognitive functions relevant to the therapy process are preserved.

A further important task at the stage of initial diagnosis is to differentiate people with mental disorders from healthy people experiencing temporary emotional difficulties or mental crises. Such people often do not require psychotherapy and can receive appropriate, tailored psychological help or crisis intervention at the consultation stage. It is important to have a broad experience and knowledge of both psychopathology and crisis issues to discern to what extent people with mental disorders experiencing periodic crises and difficulties require psychotherapeutic interventions, and to what extent they qualify for help or crisis support. An example would be a person in treatment for bipolar affective disorder, experiencing a grieving process after the death of a spouse. If this is the case, the process of diagnosis would involve differentiating the disruption of mental processes in the course of mental disorders from the reactions of healthy people (previously well adapted to a difficult, critical, emergency situation), in whom existing resources and problem-solving skills become insufficient [9].

An important issue is to make a proper differential diagnosis, which may appear prima facie to be more of a psychiatric domain than a psychological one but is of great importance for further treatment of the patient. An example of this difficulty is the differentiation of patients with PTSD (post-traumatic stress disorder) and borderline personality, despite the fact that these diagnoses are often treated as co-occurring, linked by similarities in underlying mechanisms and overlapping symptoms.

Borderline personality has been treated as a chronic form of PTSD integrated within the personality [10]. Patients with post-traumatic stress disorder are often diagnosed as having borderline personality in real-life healthcare settings, but studies show less effectiveness of psychotherapies recommended for patients with personality disorders against those with PTSD. Furthermore, BPD (borderline personality disorder) overlaps with other diagnoses in about 80%, and "pure" cases of the disorder account for 3% to 10% [10]. Contemporary research stresses the importance of differentiating these disorders. The differences between the two are related to self-image – more stable, though negative in PTSD (compared to BPD patients' self-image); relationships dominated by avoidance rather than (as in BPD) chaotic involvement. PTSD is marked by hypervigilance, reactive anger and difficulties in dealing with emotions, affecting the tendency to cope by abusing psychoactive drugs

or suicidal behavior. In contrast, in patients with borderline personality, impulsivity and acting-out tendencies predominate [11]. It is necessary to take into account the presence of a dissociation mechanism in PTSD, understood – according to trauma theory – as coping with traumatic experiences by separating a variety of experiences (sensory impressions, emotional experiences, cognitive experiences and self-image) [11]. Therapists' consideration of post-traumatic symptoms and adequate diagnosis influence the selection of an appropriate treatment method and thus increase the effectiveness of the therapy applied.

The recommendations of the American Psychological Association, supported by research, indicate the effectiveness of behavioral-cognitive methods in reducing post-traumatic symptoms. Contemporary psychodynamic models with proven effectiveness usually do not address PTSD symptoms [11]. On the other hand, the importance of interpersonal problems in traumatic experiences, the co-occurrence of PTSD with other disorders, and the lack of consideration of side effects associated with the processing of traumatic experiences are all emphasized in ongoing studies. There are also emerging studies indicating the effectiveness of interpersonal and psychodynamic methods in trauma therapy [12, 13]. Due to the inconclusive nature of the research findings, the decision to qualify a patient with PTSD for group therapy requires an individual assessment of the benefits and losses that may accrue to the patient from this form of treatment. A patient's admission to the group should be preceded by adequate preparation, identification of realistic goals and possible consideration of modifying the method and adapting it to the capabilities of the individual. The diagnosis of a substance use disorder is another diagnostic dilemma. It does not necessarily exclude the patient from group therapy, but it does require expanding the clinical diagnosis to include the depth of addiction mechanisms, the strength of motivation to change, the ability to control, and the readiness to tolerate frustration. As research indicates, a substance use disorder often co-occurs with personality disorders [14], and psychodynamic psychotherapy, including group therapy, is sometimes used to treat people with addiction problems [15]. Psychodynamic psychotherapy may provide an alternative treatment model to the commonly used behavioral-cognitive therapy approach to treating addicts. In psychodynamic group psychotherapy, the patient undertakes work on insights into their own emotions, unconscious conflicts, traumas, self-image, and relationships. Treatment is focused on the therapeutic work with personality. When deciding on the qualification of a patient with current operating mechanisms of addiction, it is important to take into account the patient's motivation for and readiness to enter therapy, ability to maintain abstinence and awareness of how they work. The parallel use of self-help groups can be helpful. Group psychotherapy can be preceded by supportive and psycho-educational work on the mechanisms of addiction.

The assessment of the patient's safety and risk of a suicide attempt is another issue addressed during the diagnostic process. Many patients presenting for treatment often or periodically have suicidal thoughts, hence the importance of assessing their severity and the risk of a suicide attempt – in other words, distinguishing thoughts from tendencies and actual intentions. In the classic view of the crisis, the diagnosis of presuicidal syndrome, described by Ringel, who found that most suicidal acts are committed in a very similar mental state, is associated with the assessment of the risk of attempting to take one's own life. This state is associated with the so-called situational, dynamic, interpersonal narrowing,

a narrowing of the area of values, the presence of suicidal fantasies, inhibited aggression and self-aggression [16]. A person at risk of suicide tends to have a tunnel vision of the world and self. The situation in which they find themselves seems to have no solution, and the problems only seem to pile up, attempts to cope bring a sense of remaining in the circle of the same problems and the impossibility of solving them. The picture of relationships is a picture of emptiness and loneliness, and often the only bond that the person clings to is severed, while simultaneously they lose their personal connection to all previously important values and goals. Suicide becomes the only possible way out of the cognitive tunnel.

Modern research identifies more precise criteria related to suicide risk. The distinction between acute suicidal affective disorder and suicidal crisis syndrome increases the predictive capabilities of the diagnostician. The acute suicidal affective disorder is considered when there is a dramatic increase in suicidal tendencies within hours or days, there is marked social alienation and/or estrangement from oneself, alienation is experienced as hopeless and impossible to change, and symptoms are accompanied by excessive agitation. Suicidal crisis syndrome is associated with a persistent or recurrent sense of entrapment and an urgent need to escape an unavoidable life situation; death seems the only escape. Other diagnostic criteria include affective symptoms, cognitive impairment, behavioral changes and/or social withdrawal [17]. The finding of acute suicidal affective disorder and suicidal crisis requires crisis intervention and is not a condition in which the patient would be amenable to insight-oriented group psychotherapy.

The above, as well as other diagnostic problems not mentioned here, often require in-depth reflection by the diagnostician and an extension of the diagnostic process to include additional tests to answer the question of whether group psychotherapy would be most appropriate for this patient at this time.

Diagnosis of the mentalizing processes

Mentalizing processes are fundamental in all therapeutic approaches, as well as in the domain of psychological assistance [18]. The diagnosis of the patient's ability to recognize, modulate and express their own emotional states and identify the mental states of others is an important preliminary step in the psychotherapy process. In the process of qualifying for group therapy, the examination of the ability to mentalize is a predictor of the patient's functioning in group relationships and determines the direction of therapeutic interventions.

Mentalizing is a multilevel mental process that is both conscious and unconscious. First, it is motivational – related to the willingness and motivation to mentalize, and second, it relates to the ability to recognize and understand one's own behavior and emotions as arising from mental processes and states. It also refers to the ability to reflect on similar processes in other people. Mentalized emotionality consists of recognizing, naming and differentiating emotional states, the ability to modulate them, and their emotional expression [18].

The process of mentalizing involves the ability to differentiate between internal and external reality and to create representations of one's own and others' mental states. It lays the foundation for more mature and complex defence mechanisms as it involves transforming the non-mental into the mental [19]. Mentalization plays an important role

in interpersonal relationships. On the one hand, it enables one to perceive and understand other people's perspectives and experiences, regardless of one's personal perspective; on the other hand, it provides an opportunity to make meaning and reflect behavior. Mentalizing can be considered in several dimensions, as an automatic or controlled process, affective and cognitive, related to the self and others. Other dimensions of mentalizing are related to orientation to the inside or outside of the mind, mentalizing in terms of time; mentalizing in terms of the content of mental states and mentalizing in narrower or broader terms (current state of mind versus relating to the autobiographical context) [20].

The examination of the ability to mentalize from a psychodynamic perspective can take place during an interview with the patient, and it is also possible to use standardized diagnostic tools.

In the diagnostic process, we examine to what extent the patient correctly recognizes their own emotional states, whether they are able to regulate them, whether they are capable of decentralization, in what dimensions (content of mental states, level of representation, object-self, time frame), and to what extent their mentalization processes take place.

Hypotheses about the processes of mentalization can be made based on the description of the patient's relationships, especially conflict situations between themselves and a loved one. We obtain information from the examined person on whether and how they address mental states, whether they recognize them in themselves and others, whether they include them in their understanding of themselves and people, whether reflection on mental states influences the regulation of their behavior, whether they are motivated to mentalize [19]. The diagnosis of mentalizing processes can be helpful in determining the level of personality disorders and helps select appropriate interventions for the patient's mentalizing abilities in the process of psychotherapy [19]. The correct identification of deficits and capacities in terms of mentalization processes will be an important guideline for the further stage of therapeutic work, providing important information for psychotherapists on determining the directions and goals of therapeutic interventions and adapting them to the capacities of a given patient and focusing on developing mentalization abilities in the patient in specific dimensions. This knowledge is also important for a better understanding of the patient's existence in group relationships and engaging in relationships with other people, as well as for coping with difficult experiences and experienced emotions.

Diagnosis of personality

The clinician should always determine the personality of the patient suffering from a variety of problems and take it into account in terms of treatment outcome. As an example, personality disorders co-occurring with depression, particularly borderline personality, adversely affect the outcome of treatment and lead to lower remission rates and increased relapse rates [21]. Thus, the diagnosis of personality serves to better plan therapy and select an appropriate method, enables the prediction of change, predicts acting-out behavior, and reduces the risk of premature treatment abandonment.

Personality is a pattern of relatively enduring ways of thinking, experiencing, motivating, behaving and forming relationships in a given person [22].

Referring only to a categorical description in the diagnosis seems insufficient and does little to expand the knowledge of the patient, especially from the perspective of further psychotherapeutic treatment. A nosological diagnosis made with the help of, for example, the DSM-5 Structured Clinical Interview for Personality Disorders identifies the category of personality disorder, but the behaviors and traits assigned to each category of disorder do not reflect the patient's actual existence. Furthermore, category-specific behaviors, such as avoidant behavior, shyness and withdrawal characteristic of avoidant personality, may also be associated with narcissistic or paranoid personality.

From the perspective of psychotherapy, it seems more helpful to describe the personality structure of the treated patient. In describing personality, we take into account the level of organization and type of personality, the flexibility with which personality traits manifest themselves in certain situations, and the degree of activation of traits that causes suffering and impedes existence. We also take into account adaptability to stressors and ethical values [22]. The description of personality structure reflects the level of integration versus dispersion of identity, object relations, defense mechanisms, reality check abilities, level of aggression and value system. By examining individual functions, it is possible to describe personality at particular levels or degrees of pathological organization – from normal through neurotic, borderline type to psychotic personality organization [23].

The structured interview, proposed by Kernberg, can be used to diagnose personality organization, for examining self-integration, object relations, defense mechanisms used, externalization versus internalization of problems, assessment of moral reasoning and aggressiveness. The interviewer encourages freedom of expression in terms of the reported difficulties, the course of symptoms, the patient's functioning in various situations and roles, and expectations of treatment. In a later stage, the diagnostician focuses on interpersonal relationships, social existence, desires and needs occurring in relationships, as well as self-perception and own characteristics. The examiner uses clarification and confrontation in areas of inconsistency and preliminary interpretations, observing the patient's reactions and the examiner's own emotional reactions to the patient [24]. An in-depth personality diagnosis gives the diagnostician, and at a later stage therapists, a lot of extremely valuable information about the patient, their functioning, representations of self and others, defense mechanisms and aggression. Thus, it makes it possible to anticipate, plan the direction of preparation and further work with the patient, as well as the proper selection of patients for the group.

Conceptualization of the patient's difficulties

The conceptualization of a patient's difficulties is a structured set of hypotheses explaining an individual's psychological, behavioral and interpersonal problems. It includes etiological, predisposing and sustaining factors and causal mechanisms formulated in psychological language, justified in the light of theory and collected empirical data, and forming the basis for therapeutic interventions. In interpreting the information obtained from the patient and their own observations, the psychologist relies on theoretical assump-

tions. The essence of conceptualization is its accuracy and the criterion of accuracy is its usefulness in therapeutic practice [25].

When creating hypotheses about the patient's problems, the examiner takes into account temperamental factors, related to the somatic state, physicality and biological equipment of the subject [26]. Modern psychodynamic models take into account non-dynamic factors in understanding the issues and thinking about the patient, and providing additional perspective [27]. These factors influence the formation and persistence of symptoms. Furthermore, the patient's functioning in various areas may involve an attempt to adapt to the patient's own neurobiological limitations [28].

In the next phase, the examiner performs a psychodynamic explanation of the underlying conflicts, the mechanisms of the patient's underlying problem and its relationship to the conflict areas [26]. The examiner makes hypotheses about the disturbances occurring during specific phases of psychosexual development. The examiner is also able to explain the patient's personality.

They also describe the patient's personality and mentalizing abilities, referring to the subject's identity, ability to perform reality checks, the nature of the relationship with the object, the type and configuration of defense mechanisms, the level of moral reasoning, and determines in dimensional terms the level of personality disorder – neurotic, higher borderline, lower borderline.

It also seems important to consider the patient's resources in the broadest sense.

At this stage, the examiner also answers the question about the most appropriate therapeutic interactions for the patient. They anticipate possible responses to the therapeutic situation – likely manifestations of transference, anticipated resistance, and projected responses to therapeutic interventions [26]. The examiner also makes a final clinical decision – whether group psychotherapy for a given patient, with their symptoms and problems and personality traits, will be an appropriate treatment method. Thus conceptualized, the picture of the respondent is a kind of "map" in the further therapeutic process.

Preparation for the therapy process

Patient preparation procedures serve to reduce the risk of a dropout, especially in the early stages of treatment [29]. Discussion of the diagnosis in a dialogue between the examiner and the diagnosed, on how the diagnostician understands the patient's problems, without formulating categorical conclusions, with an expression of curiosity about whether the patient agrees with the conclusions or sees the sources of their own difficulties in a different way than the examiner, is also part of the preparation for therapy. According to the psychodynamic concept, the diagnostician presents an understanding of the patient's problems in terms of development, indicating directions for possible further therapeutic work, delineating opportunities to work through developmental processes blocked in the past [30].

During the consultation that prepares the patient for the start of therapy, the psychologist introduces the patient to the therapeutic process and explains the importance of group standards (confidentiality, attendance, no contact outside sessions, no judging, etc.) and,

depending on the problems, establishes an additional contract with patients. They also discuss the role of therapists in the group, issues related to silence, and the importance of gradual exposure, and encourage questions about the group and treatment. A reduction in uncertainty and ambiguity at the beginning of psychotherapy increases patients' sense of security and facilitates their adaptation in the group.

Slightly more attentiveness is required for patients who are particularly at risk of dropping out of therapy early – those with deeper personality disorders, who are young, and who come in with a focused problem [31]. In the process of discussing the course of group treatment, the psychologist addresses aspects of ending and discontinuing treatment, contracting with the patient that they will discuss their decision to drop out of therapy in advance with the group. The examiner also addresses the patient's recurring relationship patterns, preparing the patient for the process of transference occurring in the group. Crises that may arise in the course of psychotherapy, as well as the specifics of emotions associated with the end-of-treatment phase, are also important topics [6].

The process preceding the patient's admission to therapy significantly affects the effectiveness of treatment. Pre-diagnosis allows for the proper selection of patients; due to the problems present and personality structure, it enables therapists to better understand patients and plan their therapy, and the preparation process results in patients adapting more quickly to therapy, interacting with greater ease and dropping out less often.

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