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Group therapy of patients with schizophrenia – own experience

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The paper discusses selected theoretical elements and own experience from group therapy of patients with schizophrenia conducted at hospital division.

Key words: schizophrenia, group therapy, psychoanalysis

Since December 1996, the Division F9 for persons aged between 18 and 35 years with a diagnosis of schizophrenia has been functioning in the 3rd Psychiatry Department at the Institute of Psychiatry and Neurology in Warsaw. Work in the Division is founded on combining pharmacotherapy (which is the basis of treatment) with supportive individual psychotherapy, group psychotherapy and psychoeducation. In the therapeutic and educational program realized in the Division the patients' families are also included.

The program of group work taking place in the Division, among some other forms, includes group therapy whose name was agreed upon as "drama". The way in which the therapist interprets the clinical material provided by these workshops is based on the psychoanalytic theory referring to schizophrenic psychoses. The aim of this paper is to present both the methods applied in the groups and certain conclusions that, in the opinion of the therapist, issue from these activities. The conclusions refer to group work with patients suffering from schizophrenia.

Selected elements of psychoanalytic theory of schizophrenic psychoses

Discussing the issues connected with understanding of schizophrenic psychoses within the psychoanalytic theory, I wish to limit the discourse only to those elements, which, in my opinion, may be helpful in interpretation of clinical material, presented below. The theory developed by M. Klein assumes that the sources of psychoses go back to the early childhood of the future patients (the first months of their lives). A special importance is ascribed to fears of persecution [5] that a child experiences at this

phase of development, and to specific defense mechanisms like splitting of the object and impulses, idealization, negation of the internal and external reality, repression of emotions. Most of these phenomena are later present in schizophrenia.

According to M. Klein [1980], a child's ego lacks cohesion. In her approach, in the early development there occur alternative tendencies towards integration and towards disintegration of ego. They are connected with constitutionally conditioned, lesser or greater ability of the early ego to tolerate fear. These fluctuations between integration and disintegration are characteristic of the first months of life.

In this period the child must disperse fear of persecution and in consequence the anxiety of being annihilated, which is of psychotic intensity, and to cope with aggressive impulses experienced as threatening the existence of ego and the object with which it is related. To do this, a child's ego must develop primary defensive mechanisms. The destructive impulses experienced by a child are partly projected outwards and partly bound within the ego. However, these mechanisms are not fully effective, and the fear of being destroyed from within perseveres. M. Klein [1980] believes that under the pressure of this threat, the incoherent early ego is inclined to fall into pieces, to get fragmented and disintegrate. "This falling to pieces appears to underlie states of disintegration in schizophrenics." [5]. She suggests that the primary anxiety of being annihilated by the destructive forces within together with the ego's specific response of falling into pieces or getting split may play the main role in schizophrenic processes.

A similar process may also regard the object with which the child is related. In fantasy, the infant turns its oral-sadistic impulses to the frustrating object. Then it feels that the object is attacked by the fantasies and put in bits. Bion's works [1957] confirmed Klein's theses referring to the importance of ego's early fragmentation. Klein described these processes as issuing from destructive forces within the organism while Bion believed that these destructive impulses were evoked by defensive reasons and aimed to destroy this part of personality, which was responsible for awareness of reality. According to Bion, sadistic fantasy leads to splitting of objects into particularly minute bits and to a simultaneous, equally minute splitting of these parts of the personality which could bring the awareness of reality so much hated by the psychotic personalities [1]. Thus, splitting of the internal and external object is accompanied by splitting within the ego. If the object is perceived as fragmented, ego is endangered with splitting in relation to the internalized fragments of the object. This process is of a fantastic nature, but the importance of these childish fantasies is great, because it leads to feelings and relations, and later to thinking processes which are split from one another.

Bion claims that in the case of psychotic personalities there occurs splitting of objects and all this part of personality, which is responsible for awareness of the internal and external reality. After Freud, he emphasizes the importance of this part of consciousness, which is connected with sense experiences and which starts functioning in response to the reality principle.

As the features of a psychotic personality he regards: significant prevalence of destructive impulses, hatred towards the internal as well as external reality, which

includes everything that leads to becoming aware of its existence, dominating anxiety of being annihilated, and a specific formation of relations with the object, characterized by their suddenness and immaturity.

Disintegration of this part of personality, which is responsible for awareness of reality, is particularly important. Fragments that occur in result of this process are later projected towards external objects. Bion [1996] described the nature of "bizarre objects" with which a psychotic person is surrounded. They include real objects (e.g., a radio or TV set) as well as the detached and expelled from personality functions that could give awareness of reality to the psychotic person. In the patient's fantasy there takes place a process through which a real object (e.g., a radio set) is engulfed by the projected part of the ego (e.g., concerned with awareness of what the patient sees). Then the radio is felt to be watching the patient. "The object [...] swells up, so to speak, and suffuses and controls the piece of personality that engulfs it: to that extent the particle of personality has become a thing" [1].

According to Bion, withdrawal of a psychotic patient from reality is an illusion, and it arises from splitting off and projection of a part of personality towards external objects. For the patient, however, the force of this omnipotent fantasy is so great that in his/her experience it becomes a fact, and the patient behaves as if his/her senses and their awareness were fragmented and separated. Nevertheless, apart from the psychotic part of personality, in schizophrenic patients we also find a non-psychotic part of personality, hidden under the domination of the former. In this sense a psychotic patient's ego in not totally withdrawn from reality.

Another aspect of psychotic persons' perception of reality is described by Searles [1966] in his work on schizophrenic communication. Among numerous clinical instances of deformed images and ways of communication of these patients, he describes a patient for whom similar objects were identical. For this woman, her glasses and her stockings were impossible to distinguish; the same regarded two physicians in the hospital whose common features made her believe them to be identical.

Searles [1966] describes also a patient suffering from chronic paranoid schizophrenia who perceived persons not as whole figures, but as "anatomic and psychological fragments of persons, controlled, through holes in their heads, by obscurely described entities with omnipotent power". This kind of experiences can also be seen in clinical material presented below.

Summarizing his views, Bion [1996] claims that fragmentation of ego and expulsion of its parts both into and about its objects is the basic feature of the psychotic personality of schizophrenic patients, and takes place at the outset of a patient's life. It also leads to destruction of thinking processes. "The consequences for the patient are that he now moves, not in a world of dreams, but in a world of objects which are ordinarily the furniture of dreams" [1]. The patient's "sense impressions appear to have suffered mutilation" [1], in other words, to be highly deformed. "Bizarre objects as well as thought disturbances close to ideographic thought lead to confusing real objects with primitive ideas [1].

The phenomena described above of fragmentation, creation of "bizarre objects", deformation of perception of reality as well as thought disturbances in which impres-

sions are hard to distinguish from the primitive ideographic thinking, are present in the clinical material discussed below.

Goals, methods and the course of activities

The name of the described groups, namely "drama" is a conventional description, which reflects the origin of techniques dominating in their course. These techniques have been taken from the drama that is one of the methods of work applied by teachers in didactic and educational work with children and adolescents. The name might be associated with psychodrama – this requires explanation that the discussed activities neither use assumptions nor apply techniques of psychodrama.

The aim of the activities is to prevent isolation of patients, to include them in interactions with other persons and to provide them with social experiences. To this extent, the goals of the "drama" coincide with numerous goals of the remaining activities conducted in the Division. Another aim assumed while designing the activities is to include the symbolic sphere and fantasies of the patients in the range of therapeutic influence in the treatment program.

Due to these assumptions, in the course of activities we can also distinguish two groups of techniques. The first group includes various kinds of exercises taken from drama as a method of work with children. The second one comprises exercises based on projective and symbolic material acquired from the patients. Patients' thoughts and emotions experienced on the basis of both these groups of techniques are comprehensively discussed with the patients during the therapy.

A "drama" lasts for 1.5 hours. The leading function is performed by a physician. Two nurses (always the same) take part in the activities as group members. The therapist plans the therapy and conducts it in a directive way, not taking part in execution of particular tasks. He takes an active role in the part of activities devoted to discussion after every task executed by the participants. The subject of the activities as well as particular exercises are planned on the day before the activities and on the day of the activities, depending on what experiences are – in the opinion of the therapeutic team – dominating in the group and what the group's needs are. Therefore, the activities are not run in accord with a previously designed plan. They are adjusted to the present situation in the Division regarded as a therapeutic community. When the team decides whether the subject requiring work consists in the patient's making relationship with one another, the problems of aggressiveness, dependence, resistance, ideas concerning the illness and treatment (help), lack of contacts between patients or just having fun – plans are made of the activities during which the given, selected problem or question may be opened, experienced and worked through.

Most patients taking part in the activities are persons in the period after an acute psychotic episode (state of partial clinical remission), though sometimes presently psychotic persons are also admitted. The group is of an open character. Participation in the activities is obligatory for persons hospitalized in the Division. Exceptions are admitted for actually acute patients.

After each workshop, the therapeutic team discusses its course. The activities are not supervised by a person from outside the Division.

A distinction between psychoanalytic understanding of the problems as well as the patient's psychopathology, and the application of psychoanalytical methods was made while designing the activities. This problem requires broader discussion, for it might seem that there is a contradiction between the theoretical psychoanalytic assumptions and the way of leading the group originating from educational methods. According to Łapiński [1980]: "Psychoanalysis finds double application in group psychotherapy. Firstly, psychoanalytic assumptions can facilitate understanding of psychopathology, the problems of a patient and those of the psychotherapeutic process, which he undergoes in the group. Secondly, particular methods or systems of psychoanalytic group psychotherapy can be considered as applications of psychoanalysis [...]" [4]. Our activities are founded on the former of these possibilities. We recognize that deeply disturbed persons like schizophrenic patients require rather directive methods, methods that induce them to be active, protect them from social isolation, break their apathy and inertia. Therefore, we decided to choose methods that invest a clear structure in the therapeutic situation, and require active leadership. Activities conducted in this way provide the patients with certain experiences which, in turn, are understood by the person conducting them on the basis of the psychoanalytic theory. Using an analogy, we could explain that, e.g., a theatrical performance or any other product of human activity is not "psychoanalytic", that is, created with the use of a psychoanalytic technique, but it can be submitted to such an interpretation, often revealing the depth of meanings and messages inaccessible in any other way.

This means that understanding of the patients' messages and behaviors as well as their ways of experiencing refers to the psychoanalytic theory. On the other hand, the activities themselves serve as a source of the patients' experiences and are discussed with them.

Drama exercises seem to have numerous advantages in regard to patients with serious difficulties in communication – they are relatively simple (they can be used for children). Besides, they represent certain "parts" of social situations; they are situations that are simplified and reduced to a certain purposefully selected dimension. They do not make the patient face so complete an exposure as a "full" social situation does, e.g., while exercising definite social behaviors occurring in life. The discussed activities do not include, for instance, performing psychodramatic scenes or definite task situations like in rehabilitation programs. The patient's experiences are limited to certain elements of relations. This makes possible the patient's deeper emotional involvement in the exercise with relatively lesser extent of isolation and affective-cognitive withdrawal from the situation.

It should be emphasized that these activities constitute an integral part of the therapeutic procedure applied to the patients in the Division. First of all, drama exercises and especially introductory exercises, being relatively simple, enable the patients to get acquainted with the group work techniques in the simplest version. Therefore, they facilitate participation in activities and acceptance of social exposition without excessive fear of failure (e.g., anxiety that "I can never do this"). This "getting acquainted"

with the methods of work in a group is acquired by the participants gradually during all activities in the Division. On the other hand, the patients' constant participation in various group activities in the Division, conducted by various therapists, provides them with always-new experience and develops better tolerance of being active in social situations. This decreases concentration on the technical aspect of exercises (diminishes anxiety of being negatively evaluated and of failure). It also enables the patients to better communicate with their own experiences.

A decision was made of using drama exercises and working on the basis of the patients' experiences arising during the group therapy. The discussion after each activity, whatever it was, is an effort aimed at opening and more active exploration of these experiences. This is an attempt at combining the corrective influence of exercises (experiences that each patient gains from participation in them) with the element of understanding and supporting messages addressed to the patient.

Another, equally important though not mentioned in the name, element of the activities is based on the use of projective material. It comprises various kinds of associations and comparisons that the patients are asked for while the strictly structured form of conducting and progress of activities is preserved. Great importance is attached to the work on the patients' understanding themselves in relation to other persons (also in the transference to the therapist) as well as to their understanding of social situations. It is these contents which are acquired on the basis of the patients' projections that are extensively used for this aim.

Perception and understanding of projective material by the patients is fairly diversified, but it is usually good enough to make it possible to distinguish, e.g., comparison and translate it to emotional or experiential content. In schizophrenic patients, numerous thinking processes are characterized by the presence of the primary process, i.e., the primitive way of mental functioning. Discussion aimed at the patient's ability to communicate and way of experiencing himself as well as his relations with others, completed with clarification and sometimes interpretation allows for understanding information hidden in the verbal communicate and addressed to the surroundings, and for structuring the meanings of these messages. For instance, introducing distinctions between: present, past, future; I – the other; I am – I would like to be (ego ideal – real ego). Discussion creates a chance for the therapist to have insight into the emotions experienced by the patient, his perception of his present situation, way of experiencing relations with others, ways of communication, expectations of others, his perception of his own difficulties. On the other hand, for the patient this mode of communication also creates a chance of expressing his experiences in a much fuller and true form. The patient who feels that his hidden communicate can be understood and received by a selected member of the group (to whom it is addressed), or by the therapist, is able to experience understanding and sense of relation on a more comprehensive and "truer" level.

Combination of the above mentioned ways of work with exercises that provide the patients with a chance of non-verbal communication of their experiences opens possibilities of expression even to more inhibited patients and to those who are more withdrawn from contact which their environment.

Clinical illustration

The therapy the course of which I wish to describe took place after a six months' period of conducting "drama" workshops in the division. During the two discussed workshops, which took place at a week interval, after the initial part aimed at overcoming the patients' isolation and involving them in the activity, they were asked to take part in the following tasks.

1. One of the participants stands up and can make a few steps within the circle. Each member of the group is to answer the question what this person looks like (what is this person's occupation, what is his/her position, etc.)
2. The exercising person (all group members, taking turns) selects two other persons from among those present, and answers the question concerning similarities and differences between these two persons.

During the first exercise, the attention is focussed on the attempt to understand on the basis of what elements the patients suffering from schizophrenia construct associations that constitute for them the foundation for assessment of reality and their functioning in it. Each group participant, after having expressed his/her association concerning the person moving in the center, was asked to explain on what basis he/she ascribed the observed person to the given occupation (on what basis the conclusion was formed).

The pronouncements revealed that the patients taking part in the activities perceived others in a fairly peculiar way. Most often it was some element (a moustache, hair, a garment, posture) that was "cut out" of the whole and decided about the association. The pronouncements of participants regarding the same person standing in the middle indicated how each of them perceived only a fragment of the whole. During the discussion, this part, as it were, "swelled up", grew, and became so large that it constituted the whole object (as if it obscured the whole figure and decided itself about the reception of meaning of the whole person). It could be discerned that such a split fragment was the only one perceived by patients and it determined the meaning of what they saw – it constituted the basis for associations (e.g., associations concerning the occupation of a given person). It was easier to recognize, because the patients, person after person, "cut" one and the same object, and it was visible how, in each case, a different split part of this object "swelled up" and determined it as a whole. The association of the therapist referred to fragmentation and his inability to see (perceive) the whole. For instance, the patient perceived only the moustache in the object, this moustache became the whole of the object and this evoked certain associations and fantasies, and then reference to the object issuing from these associations. The great variety of these associations regarding the same person was what the patients themselves indicated during the final discussion. In conclusion some patients also revealed the "symbolic equation" characteristic of schizophrenic persons, i.e., identity of a symbol with the symbolized object (concreteness of thinking). For example, the patient who once heard that he resembled a priest revealed in the discussion that he had learned from therapy that „he could be a good priest". The patient who had heard that he looked like a footballer expressed an analogous opinion.

During the second workshop, it was also observed that most patients performed "cutting" and fragmentation of objects. They found two identical elements in two persons, and on this basis their selection was not so much of similarity as of identity. The selection of the indicated fragment was performed in various ways. Some patients chose an external feature (e.g., hair), others were directed by a fragmentary and insignificant feature departed from essential similarity (e.g., being interested in motorcycles). Some patients referred to the experience of impact of the compared persons on their own sensations (e.g., "I blush at the sight of both these persons"). At the initial phase of treatment, on the basis of association connecting two persons, one patient selected the experience that "I know what they feel". It seems that these persons represented her split and negated depressive part. Another patient conceived two compared persons in a whole; she did not refer to fragments of the objects, but in her pronouncement she deprived them of human features. Objects perceived in this way became a place into which the patient projected helplessness and weakness, and which she perceived as weak (not threatening) objects devoid of aggressiveness.

At a certain moment of the activities, one of the patients responded with severe anxiety and tension. He revealed that one of the persons whom he wanted to choose himself was selected for comparison. One person of whom he had thought was selected in a couple with another patient whom he would not choose. He announced that "they were not similar at all". When this patient selected a couple in accord with his perception of these persons, it turned out that for him the selected persons were identical – they did not differ in any respect. They differed only when they moved (in the speed of walking).

One patient compared herself with another one, being guided by the feeling that "we think the same".

Two autistic patients suffering from chronic schizophrenia with domination of negative symptoms also took part in the activities. The opinion received from one of them revealed that all group members were alike for her; they did not possess any individual features and were fused into a friendly, not dangerous, benevolent but not individualized mass.

Another of the chronically ill patients, neglected, always dressed in a dull and untidy way, revealed her perception of others as "moving empty clothes" devoid of life. For her other persons were inanimate garments, sometimes their being alive was manifested in some functional aspects. Experiences of this kind were described by Mahler [cit. after Pao, 1979] as "maintenance mechanisms". They include de-animation, de-vitalization and de-differentiation, and their aim is to establish an archaic form of contact with a primitive, de-differentiated, global environment.

Discussion

It seems that this exercise unveils phenomena described by M. Klein, W. Bion, and other analytic authors mentioned above. It refers us to the phenomena of deformation and fragmentation of objects perceived by persons with a diagnosis of schizophrenia. In the patients' declarations we can also find various parts and stages of formation of

"bizarre objects" described by Bion.

This description is also concordant with, e.g., clinical psychological examinations of schizophrenic persons, for instance with projection tests (Rorschach's test, pictogram). These tests, while conducted even with persons who do not manifest acute symptoms, reveal characteristic features of perceiving and analyzing. Both in the relapse of an illness and during remission, these tests indicate formal thinking disturbances, inadequacy of associations, symbolic thinking, thinking slips, over-generalizations, and contaminations. The described pronouncements of the patients are particularly close to unjustified generalizations on the basis of inessential features and similarities.

On the basis of this experience I can better understand difficulties encountered by persons realizing rehabilitation and training programs for patients with the diagnosis of schizophrenia. If we assume that while training an "ordinary" social situation, these patients experience so great a deformation of reality as it was described above regarding a highly simplified situation, it is easier to understand the long period as well as the amount of work on the part of the instructors conducting the activities required to teach patients to realize successfully even the (apparently) simple tasks.

It is essential to consider the question to what extent the discussed approach, which is interesting from the cognitive point of view, is also therapeutic. To answer this question I wish to refer to the work by Jakubczyk and Żechowski [1997] devoted to a "transitional reality". According to these authors a psychiatric division, especially a division in which psychotherapy is conducted, should be a place where a patient acquires new emotional experiences of a potentially corrective character. However, in order to enable the patient to acquire these experiences, there must occur contact between the reality perceived by the patient and the corrective (healthy) reality created by the personnel. In the case of psychotic patients whose perception of reality is highly deformed and who are withdrawn from the common reality to the world of individual and psychotic reality, it is a particularly difficult task. These two realities may become incompatible [cit. after 2]. The author suggests introducing in the therapy a "transitional reality" that could be accepted both by patients and therapists. One of its aims is to enable the patient to recognize that his/her understanding of reality is one of possibilities and not a certainty, and to ensure that this recognition is achieved without the therapist's rejecting the patient's way of experiencing. Apart from enabling the patient to accept that there may exist a reality different than his own, this approach is characterized by communication with the patient in his/her own language (using the concepts which the patient understands in his/her own way) as well as confrontation of the two realities on a common plane. Jakubczyk and Żechowski emphasize the importance of the fact that "In the therapeutic work with psychotic patients the personnel must enter the patients' reality, and then leave it without suffering any harm" [2].

The clinical experience of group therapy described above is also a description of this very "transitional reality" in which:

1. Communication is possible between the patients and the personnel in the area of perception of the world experienced by psychotic patients with the therapists' simultaneous structuring and dealing with the objects that are discovered there.
2. The patients' experiencing (sometimes hard to tolerate emotionally) of another way

of perceiving the world is possible. This experience is the one, which the patients most often refer to during the final discussion at the end of the activities. It evokes great emotions and is felt very strongly.

3. Creation of "transitional reality" is, in this case, executed "from the psychotic point of view"; the starting point does not consist here in presupposed constructs and views adopted by personnel in their perception of the world. The activities start with the patients' deformed images which, during discussion, are transferred from the psychotic side towards the common reality that is shared with others, differentiated and structured.
4. It becomes possible to understand a patient on a more primary level. It is doubtless subjectively perceived by patients.
5. The patients become able to reveal this kind of primary, fragmented and deformed images. On the one hand, it shows their feeling of safety, on the other, it opens a chance of therapeutic work in the area which is usually inaccessible.
6. In my opinion, the "transitional reality" created during a large number of activities conducted within the frames of a therapeutic programme is, to a certain extent, generalized and extended to the whole environment of the Division (therapeutic community).

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