Psychiatria Danubina, 2019; Vol. 31, Suppl. 2, pp S185-189 *Conference paper*

CHANGES IN THE LONG-TERM PSYCHODYNAMIC GROUP PSYCHOTHERAPY IN FAMILY MEMBERS OF PERSONS WITH PSYCHOTIC DISORDERS

Majda Grah[1,2], Branka Restek-Petrović[1,3,4], Slobodanka Kezić[1], Silvana Jelavić[1] & Tea Lukačić[1]

[1]*Psychiatric Hospital "Sveti Ivan", Zagreb, Croatia*
[2]*Zagreb University of Applied Health Sciences, Zagreb, Croatia*
[3]*Medical Faculty, Josip Juraj Strossmayer University of Osijek, Osijek, Croatia*
[4]*Faculty of Dental Medicine and Health, Josip Juraj Strossmayer University of Osijek, Osijek, Croatia*

SUMMARY

Background: *The experience gained in working with psychotic persons as well as the findings from the literature have pointed to the need for systematic inclusion of the families of affected individuals, facilitating the creation of partnership within treatment, and to the need for a better understanding of family dynamics that reflects on the psychological conditions of the patients.*

Aim: *The aim of this paper is to explore the changes in self-esteem and loneliness of group members during the therapeutic process and whether the use of more mature defence mechanisms is the answer to the treatment of group psychotherapy.*

Subjects and methods: *We followed three groups of 30 members (18 women and 12 men). At the beginning of inclusion in group psychodynamic psychotherapy and after 18 months of psychotherapy, members completed the following questionnaires: Rosenberg Self-esteem Scale, short version of UCLA Loneliness Scale (ULS-7) and Lifestyle Questionnaire (LSI).*

Results: *The research results show a statistically significant increase in self-esteem, a significant reduction in loneliness, and significantly reduced use of defence mechanisms after 18 months of group psychotherapy.*

Conclusion: *Research findings confirmed positive changes in family members who gradually feel better and safer, with less anxiety and fear, all positively reflecting on the family atmosphere, the ability to accept and understand the sick member, as well as his better quality of recovery.*

Key words: *defence mechanisms - family members - group psychodynamic psychotherapy - loneliness - psychotic patients - self-esteem*

* * * * *

INTRODUCTION

Psychological analysis of every problem, regardless of whether it is in an individual, group or family context, is the subject of psychiatrists interest and therapeutic programs aimed at helping families understand, resolve and overcome difficulties with their family members with schizophrenia and other psychotic disorders. Over the last thirty years, there has been a resurgence of interest for psychology and psychotherapy in psychosis, including the involvement of family members in the therapeutic process. The strategy of improving emotional climate in schizophrenic patients' families comes from Great Britain, where Vaughn and Leff noted a higher rate of relapse in patients returning to families with stronger emotional expression (more intense EE) (Vaughn & Leff 1976). Furthermore, McFarlane emphasizes that the expression of emotions in families with children has been growing over the years as a result of concern and need for the protection of a sick member. In families whose children only have prodromes, there is much greater warmth, with less rejection, hyperprotection and need for fusion than is the case with families of children with overt disease. This also explains McFarlane's hypothesis that the EE intensity increases with the length of prodrome prolongation (McFarlane 2002).

In an effort to develop an improved and more advanced psychosocial treatment for schizophrenic patients treated in hospital, the beginnings of multifamily therapeutic models were initiated in the 60s (Laqueur et al. 1964, Detre et al. 1961). Studies that followed their efficacy ensued (Hogarty et al. 1974, Hogarty et al. 1979, Hudson 1975, Cheek et al. 1968, Goldstein et al. 1978). Proven clinical efficacy of multi-family groups led to a gradual development of different models (Thorsen et al. 2006, Restek-Petrović et al. 2011).

Today they are based on the principles of cognitive-behavioral therapy with a psycho-educational approach. Within these multi-family groups, patients and family members are provided with the possibility of alliances with an educated and empathic professional, the possibility of informing about schizophrenia, the possibility of familiarizing with the treatment guidelines and the practical resolution of problems caused by the disease, as well as a better early recognition of possible relapse (Restek-Petrović et al. 2011). During the first months of the overt appearance of the disorder, the family is very often in crisis, which can lead to further deterioration of relationships and problems inside the family. That is the time when families are generally more willing and open to psychoeducation and family treatments.

Psychoeducation as an early intervention for the family endeavors to bring the mental illness of the sick member closer to the rest of the family, and emphasizes the importance of supporting families in the continuity of treatment (Martindale 2009).

In few multi-family models, a psychodynamic or group analytical principle was applied to understand family dynamics and choice of therapeutic interventions. Foulkes considered that family psychotherapy was important and that family group psychotherapy and group analysis were generally complementary when working with psychotic, especially with schizophrenic, patients, where the relationship between families in the horizontal and the vertical sense is easily observable (Foulkes 1975). Rachel Chazan was working with multi-family groups that worked on analytical principles. By monitoring her work, she noted three dimensions of dynamics within such groups (Chazan 2001).

The first dimension is dynamics within each pair in the group. This encompasses the view of a single partner on his mate, how the husband feels about his spouse experience of herself and vice versa, and how they feel about each other. The second dimension covers the entire range of relationships that develop between couples, between individual and some couple, groups and couple, groups and individual, and relationships within the group. The third dimension is the dynamic that takes place between the group and the therapist. It is the task of the therapist to facilitate the smooth running of these processes.

The aforementioned findings contribute to understanding the influence of the environment on the development, course and prognosis of psychotic disorders, especially those of schizophrenic type. The biopsychosocial approach to the treatment of these disorders brought closer the collaborative concept in which the family, patient, and physician play leading roles in improving psychosocial rehabilitation (Thorsen et al. 2006). The ultimate goal of a multifamily group model intended to treat the whole family of the patient suffering from schizophrenia and other psychotic disorders is to provide total symptomatic recovery and achieve the best possible and complete participation of patients in their daily life and community in general (McFarlane 2002). Such an approach includes family members as partners in treatment and psychosocial rehabilitation of the patient, and its main goal is for the family and their diseased member to develop individual skills to recognize symptoms and sensitivity to notice them.

The experience gained in working with psychotic persons, as well as the knowledge from the literature. have pointed to the need for systematic inclusion of the families of the diseased, facilitating the creation of a partnership in the treatment and the need for a better familiarity with the family dynamics reflecting on the psychological conditions of patients. The perceived low self-esteem and high level of loneliness in family members of the diseased suffering from psychotic disorders, as well as the lack of research in this area, raised the question of whether during the psychotherapy process self-esteem could be improved, loneliness reduced and the defence mechanisms affected.

The Aim

The aim of this paper was to investigate changes in self-esteem and loneliness of group members during the therapeutic process and whether the use of more mature defence mechanisms is the response to the treatment of group psychotherapy.

SUBJECTS AND METHODS

During the 18-month period, 30 members of the families of patients with psychotic disorder were followed, and were included in the three Psychotherapeutic Psychodynamic Groups of the semi-open type led within the Early Intervention Program of the First Episode of Psychotic Disorders (RIPEPP) at the Sveti Ivan Psychiatric Hospital in Zagreb, Croatia. Groups were open-ended, and they continued after 18 months.

Each group consisted of ten members. The work of psychotherapeutic groups for family members is based on psychodynamically oriented group psychotherapy, led by psychiatrists, group analysts. The members of the group are the parents with whom the patients suffering from psychotic disorders are living and who showed in the indicative interview the motivation for working in the group. These include families whose children have been ill for up to five years at longest from the onset of overt symptoms of the disorder. Family members were involved in group psychodynamic psychotherapy that took place once in two weeks for 90 minutes. The sample consisted of 18 women and 12 men, of whom 3 were divorced, 3 widows, and the rest in marital or partnership relationships. The average age of all participants was M=58 years (SD=5.21; median =57.5), with the lowest age being 48 and the highest 70 years. Men and women on average were of similar age (women M=57.4 years; SD=5.14; men M=58.9; SD=5.14).

As a measure of self-esteem, Rosenberg's personal self-esteem scale (1965) was chosen. The scale is a one-factor structure, and consists of 10 statements that question self-esteem, 5 of which are positively and 5 are negatively formulated. Responses are recorded on a 5-degree Likert type scale, and the overall score is formed as a linear combination of results in all the particles (a possible range of results is 10 to 50). The instrument proved to be a reliable measure of self-esteem (Cronbach alpha coefficient of internal consistency of 0.47 to 0.89; Lacković-Grgin 1994).

A short version of UCLA Loneliness Scale (ULS-7) contains 7 particles relevant to loneliness. Responses are also recorded on a Likert type scale from 1 to 5, while the total result forms as a sum of results in all the particles. The scale is a one-factor structure, Cronbach alpha confidence coefficients range from 0.83 to 0.85 while possible range of 7 to 35 (Lacković-Grgin et al. 2002).

Kellerman's Lifestyle Questionnaire (LSI) measures eight dimensions of defence mechanisms: reaction formation, denial, regression, repression, compensation,

projection, intellectualization and displacement. The questionnaire consists of 92 particles answered by "yes" or "no". The overall score is defined as the sum of the positive responses to the individual defence dimension, which is then transformed into percentages. The instrument showed acceptable metric characteristics (Conte & Apter 1995). Group members completed these questionnaires when included into the group psychotherapy and after 18 months.

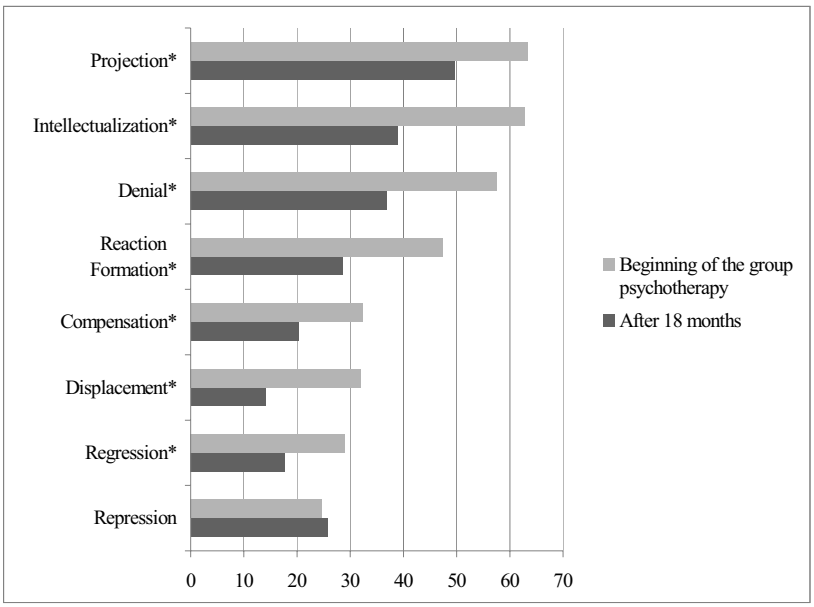
RESULTS

The data analysis was performed in SPSS 23 for statistical analysis. Differences in self-esteem and loneliness, as well as the results on the dimensions of individual defence mechanisms in the first and second measurements, were verified by the nonparametric test the Wilcoxon Signed Rank Test for dependent samples.

In the first measurements most participants on the self-esteem scale achieve the result around the theoretical average of the scale (M=30.1, SD=2.8) while in the second measurement the average result is higher (M=37.1, SD=5.7) at the significance level $p<0.05$. After 18 months of group psychotherapy, our participants reported a significant increase in self-esteem experience. There was also a reduction in the feeling of loneliness. At the beginning of psychotherapy the average score on the UCLA scale of loneliness is M=19.9 (SD=6.8), which is approximately half the range of the overall scale. In the second measurement, most participants report reduced feelings of loneliness (M=15.3, SD=5.9). This difference was statistically significant at the significance level of $p<0.05$. After 18 months group members of group psychotherapy reported significantly less experience of loneliness and increased self-esteem. The results are shown in more detail in Table 1.

Table 1. Mean (M), standard deviation (SD), z-value (z) and p-value (p) of Wilcoxon Signed Rank Test for measures of Rosenberg self-esteem scale, loneliness scale (UCLA-7), and Life Style Index (LSI) in group of parents (N=30)

	Beginning of psychotherapy		After 18 months			
	M	SD	M	SD	Z	p
Projection	63.3	21.1	49.6	17.4	-4.10	0.000*
Intellectualization	62.8	11.1	38.9	20.8	-2.67	0.008*
Denial	57.6	20.7	36.9	18.3	-3.34	0.001*
Reaction Formation	47.3	23.6	28.5	13.3	-4.00	0.000*
Compensation	32.3	16.6	20.3	16.9	-2.67	0.008*
Displacement	32.0	16.1	14.1	11.5	-3.61	0.000*
Regression	29.0	13.8	17.7	10.2	-2.91	0.004*
Repression	24.7	14.1	25.7	16.1	-0.58	0.546
Self-esteem	30.1	2.8	37.1	5.7	-2.64	0.008*
Loneliness	19.9	6.8	15.3	5.9	-2.97	0.003*



* significant difference at $p<0.05$ Wilcoxon Signed Rank Test

Figure 1. Mean values (M) for defence mechanism dimensions of Life Style Inventory at the beginning of group psychotherapy and after 18 months, N=30

Life Style Index results are expressed in percentages. The ranking of defence mechanisms by frequency of use in the first measurement shows that projection, intellectualization and denial are most commonly used, followed by reactive formation, compensation, displacement, regression and repression. One of the possible ways to interpret the results suggests that values greater than 60 may indicate a high level of defence (Lamovec et al. 1990). On the dimensions of projection and intellectualization in the first measurement, the participants achieve a relatively high score above 60, while the result is the smallest on the size of the repression, which is also the only defence mechanism whose frequency of use has not decreased in the second measurement. The second measurement shows a statistically significantly lower score on almost all defence mechanisms dimensions (except for repression). Also, in a second measurement, none of the results exceeds 60. According to this criterion, our participants at the beginning of group psychotherapy show greater defensiveness, which is especially seen on the dimensions of projection and intellectualization, while after 18 months of psychotherapy the defence no longer exceeds 60. The second measurement shows a statistically significantly lower score on almost all defence dimensions (except for repression). The data are graphically shown in Figure 1.

DISCUSSION

The low level of self-esteem and loneliness of family members at the beginning of treatment can be attributed to stress caused by the outbreak of acute psychotic episode, changed behavior of the diseased individual in the family setting, delay in meeting the normative age requirements, stigmatization carried by the fact of mental illness and contact with psychiatric service, but also the pathological primary constellations of family relationships (expressed interdependence, symbiotic pattern of relationships, hyperprotectivity and such) (Restek-Petrović et al. 2018). Family members often accentuate their emotional reactions to the illnesses of a child as a leading problem during psychotherapy that leaves them away from quality communication and discourages them in trying to exchange feelings (Grah et al. 2012). As shown in Table 1. and Figure 1., Rosemary's self-esteem scale in the first measurement average results were statistically significantly lower compared to the second measurement. The average results of UCLA scale loneliness in the first measurement were statistically significantly higher as compared to the second measurement. This confirms a significantly lower experience of loneliness and increased self-esteem of group members after 18 months of group psychotherapy. During psychotherapy, family members express their feelings, discover their roots, and understand them both in themselves and in their surroundings. It is assumed that such a dynamics of the therapeutic process gradually returns a feeling of self-esteem and reduces the feeling of loneliness.

Within the family with a member affected with a psychotic disorder, there are frequent difficulties in communication that encourage a continued use of regressive defence mechanisms, such as projection and denial, with the help of which separation from their unaccteptable parts and negation of clear signs of disease inside the family fail to perceive the upcoming relapses. It all makes it possible to relate pathological relationship with a dynamics that favors the further development of distrust inside the family. During this study in the Questionnaire of Lifestyle, significantly less use was made of 7 out of 8 dimensions of defence mechanisms compared to the first measurement 18 months earlier.

All in all, the most commonly used defence mechanisms were projection, intellectualization and denial. Projection, intellectualization and denial, then reactive formation, compensation, displacement and regression were significantly less frequently used after 18 months compared to the beginning of the therapy. Repression, as one of the most powerful defence mechanisms, was the least commonly used, and its frequency of use did not change significantly after 18 months of therapy.

At the beginning of the therapy, expressed loneliness and low self-esteem are probably due to feelings of guilt caused by a psychotic disorder of the diseased member, as well as feelings of shame and fear because of the present illness. During psychotherapy, family members gradually feel better and safer, with less anxiety and fear, all positively reflecting on family atmosphere as well as the ability to accept and understand the sick member and his better quality of recovery. Family members are enabled to work with their own content in the context of similar experiences of others, in a safe framework where they can experientially meet the changes (Grah et al. 2012). In the therapeutic process, they succeed in expressing their feelings, getting acquainted with their roots and understanding them, both in themselves and in their surroundings. This gradually returns a feeling of self-esteem and reduces the feeling of loneliness. Family members gradually have less and less need to use defence mechanisms, especially those more regressive, because they feel better and safer, with fewer anxieties and fears they initially were distinctly defending in different ways.

It is essential to set aside some limitations of this research. First of all, this is the absence of a control group why it is not possible the obtained positive effects unequivocally attribute to participation in group psychotherapy. Also, a relatively small sample was used, which renders generalization of the obtained results impossible. In addition, the potential impact of some variables, such as the mental condition of the parent or the role of the therapist, was not taken into account (due to the small number of examinees no comparison was made between the three groups of parents led by different therapists).

CONCLUSION

Results of the research suggest significant positive changes in family members involved in group psychotherapy: after 18 months of therapy, parents reported significantly greater self-esteem, reduced loneliness, and significantly reduced use of investigated defence mechanisms.

Given the observed changes during the 18 months of the therapeutic process it is possible to conclude that these are probably associated with the participation of group members in group psychodynamic psychotherapy. For even more complete results further research is needed.

Acknowledgements: None.

Conflict of interest: None to declare.

Contribution of individual authors:

Majda Grah: concept and composition of paper, theoretical explanations, literure choice;

Branka Restek-Petrović: theoretical explanations, corrections of paper;

Slobodanka Kezić: literature searches and analysis;

Silvana Jelavić: literature searches and analysis;

Tea Lukačić: literature searches and statistical analysis.

References

1. *Allen RL, Oshagan H. The UCLA Loneliness Scale: Invariance of social structural characteristics. Personality and Individual Differences 1995;19:185-195*
2. *Birchwood M, Tarrier N. Psychological Management of Schizophrenia. Chichester: Wiley, 1994*
3. *Conte HR & Apter A: The Life Style Index: A self report measure of ego defences. In H. R. Conte & R. Plutchik (Eds.): Ego defenses: Theory and measurement, 179-201. Oxford, England: John Wiley & Sons, 1995*
4. *Chazan R: The Group as Therapist. London: Yassica Kingsley, 2001*
5. *Cheek FE, Laucius J, Mahnoke M, Beck R: A behaviour modification training programme for parents of convalescent schizophrenics. U: Rubin R, ur. Advances in Behaviour Therapy. New York: Academic Press; 1968, str. 137-144*
6. *Detre T, Sayer J, Norton A, i sur. An experimental approach to the treatment of the acutely ill psychiatric patient in the general hospital. Connecticut Medicine 1961; 25:613-9*
7. *Goldstein MJ, Rodnick EH, Evans JR, May PR, Steinberg MR: Drug and family therapy in the aftercare of acute schizophrenia. Archives of General Psychiatry 1978; 35:1169-77*
8. *Grah M, Restek-Petrović B, Mihanović M, Kezić S, Bogović A, Jelavić S. Primjena grupne analize u psihoterapijskom radu s članovima obitelji pacijenata oboljelih od psihotičnih poremećaja. Soc Psihijat 2012; 40:169-176.*
9. *Hogarty G, Goldberg S, Schooler NR, Urlich RF and EPICS Collaborative Study Group. Drug and sociotherapy in the aftercare of schizophrenic patients. II: Two year relapse rates. Arch Gen Psychiatry 1974; 31:603-8.*
10. *Hogarty G, Schooler NR, Urlich RF, Mussare F, Ferro P, Herron E: Fluphenazine and social therapy in the aftercare of schizophrenic patients. Arch Gen Psychiatry 1979; 36:1283-4*
11. *Hudson B. A behaviour modification project with chronic schizophrenics in the community. Behaviour Research and Therapy 1975; 13:339-41.*
12. *Jackson C, Knolt C, Skeate A, Birchwood M. The trauma of first episode psychosis: the role of cognitive mediation. Australian and New Zealand Journal of Psychiatry 2004; 38: 327-333.*
13. *Kezić S, Grah M, Restek–Petrović B, Mihanović M, Moro Lj: Kontratransferne reakcije u radu s članovima obitelji bolesnika oboljelih od psihotičnog poremećaja – specifičnosti razvoja grupne dinamike. Soc Psihijat 2008; 36: 202-207.*
14. *Lacković-Grgin K. Samopoimanje mladih. Zagreb: Naklada Slap, 1994.*
15. *Lacković-Grgin K, Penezić Z, Nekić M. Kratka verzija UCLA skale usamljenosti. U: Lacković-Grgin K, Proroković A, Ćubela V, Penezić Z (ur). Zbirka Psihologijskih skala i upitnika, Zadar: Filozofski fakultet, 2002, 77-78.*
16. *Lamovec T, Bele-Potočnik Š, Boban D. Upitnikm životnog stila i odbrambeni mehanizmi. Informacija. Ljubljana: Centar za psihodijagnostička sredstva, 1990.*
17. *Laqueur HP, LaBurt HA, Morong E. Multiple family therapy. In: Masserman J, ed. Current psychiatric therapies, vol. 4. New York: Grune&Stratton, 1964.*
18. *Martindale BV. The rehabilitation of psychoanalysis and the family in psychosis: recovering from blaming. Psychiatr Danub 2009; 21 Suppl 1: 51-60.*
19. *McFarlane WR. Multifamily groups in the tretmant of Severe Psychotic Disorders. New York: Guilford Press, 2002*
20. *Restek-Petrović B, Orešković-Krezler N, Bogović A, Mihanović M, Grah M, Prskalo V. Kvaliteta života osoba oboljelih od shizofrenije liječenih dugotrajnom psihodinamskom grupnom psihoterapijom. Soc Psihijat 2012; 40:29-37*
21. *Restek Petrović B, Mihanović M, Grah M, Bogović A, Molnar S, Grošić V i sur. Early intervention in psychosis: A comprehensive hospital outpatient programme for the first episodes during the critical period of illness. European Psychiatray 2008; 23Suppl 2: 140.*
22. *Restek-Petrović B, Mihanović M, Grah M i sur. Koncept rane intervencije u prevenciji i liječenju psihotičnih poremećaja. Medix 2011; 97Supl:1-9.*
23. *Restek-Petrović B, Mayer N, Grah M. Psychodynamic Group Psychotherapy in the Early Intervention Program for Patients with Psychosis (RIPEPP). Psychiatr Danub 2018; 30(Suppl 4):198-202.*
24. *Rosenberg M. Society and the adolescent self-image. Princeton, NY: Princeton University Press, 1965.*
25. *Thorsen GRB, Gronnestad T, Oxnevad AL. Family and Multi-Family Work with Psychosis. London: Routledge, 2006, str. 6-7.*
26. *Vaughn CE, Leff JP. The measurment of expressed emotion in the families of psychiatric patients. Br J Clin Soc Psychol 1976; 15:157-65.*

Correspondence:
Majda Grah, MD
Psychiatric Hospital "Sveti Ivan"
Jankomir 11, pp68, HR-10 090 Zagreb, Croatia
E-mail: majda.grah@ pbsvi.hr