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Long-term group psychotherapy of schizophrenia in the private practice setting: description of two year's experience

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Analysis of literature indicated that tong-term outpatient supportive psychotherapy of schizophrenia in the private practice setting is a neglected topic. The general rules of psychotherapy of schizophrenia are briefly summarised. The theoretical presumptions of the developed method of 90-minute, monthly sessions, psychodynamic, supportive slow-open, long-term psychotherapy for 6-8 patients, conducted in the private practice setting are described. Analysis of the results after the first and the second year of therapy indicates that an elaborated method may be useful and valuable. However, further observations and studies are needed.

Key words: psychotherapy of schizophrenia, long-term outpatient group psychotherapy, case study

Introduction

Determining the optimal therapeutic modality and implementing it for patients with schizophrenia still remains a challenge in psychiatry. The treatment and the prevention of recurrence in schizophrenia come up against many difficulties from both the perspectives of the patient, as well as the therapist. Examples of the difficulties incurred are economic limitations, time constraints, as well as the lack of readiness to accept certain difficulties connected with the defined methods of treatment. Schizophrenia affects persons who are in different life situations, and their treatment should take into consideration these differences. At the present time, the psychotherapy of schizophrenia in Poland is mainly being done in the hospital and daily unit setting. To a very limited degree, it is available in the outpatient setting in the National Health Service (NHS). A new phenomenon is the development of private psychiatric practices, in which patients pay in full the cost of treatment. It needs some studies, because on the Medline database and in the Polish literature, there is a lack of data pertaining to the utilisation of group psychotherapy in schizophrenia in the private practice setting. Moreover, this kind of treatment is not even mentioned in a comprehensive review of literature on psychosocial treatments of schizophrenia [1], as well as in a modern monograph on group psychotherapy of schizophrenia [2]. It is noteworthy that outpa-

tient group therapy of schizophrenia is discussed in this book, however its setting is not clarified [3]. The described above, lack of publications on group psychotherapy in private practice setting can mean that the there is no paper on this topic because it is being recognised that there are no differences between the treatment of schizophrenia in group psychotherapy in the private setting in comparison to the treatment provided in the NHS. However, it can also mean that group psychotherapy of schizophrenia is not being often performed or utilised in the private practice setting.

Even though addressing the entire problematic entity of work in the individual private practice setting goes beyond the ramifications of this article, it seems that the differences between private practice and the conditions in the NHS are notable, at least in Poland. For example, the conditions in a private practice help in maintaining confidentiality during treatment, which helps well functioning working individuals in deciding to continue psychotherapy. Yet, the fact of full payments for the session by oneself can cause the patient to decrease the frequency of visits, or even discourage the patient from taking advantage of additional visits during situations of worsened psychological states. It seems that in the event that the doctor would not be available, the patient who is taken care of under the NHS has a greater ease and an advantage of finding and attaining care during emergency states, than the patient treated in a private practice setting. It is easier to turn for help to a hospital clinic, which is considered a primary place of such therapy, than to an alternative therapist previously appointed by the main private consulting therapist in case of absence. Just as it would seem, there exists a great divide between the dominant therapeutic strategies applied to treat patients with schizophrenia in the NHS and those used in private practice. As much as the possibilities of psychosocial interventions are maximally used in NHS, so much so individual therapy is dominant in private practice. If the facts written about here occur, to some even degree, in other countries, it is worthwhile to present Polish experiences with group psychotherapy of schizophrenic patients in the private practice setting in English.

The goal of this paper is the presentation of long-term supportive group psychotherapy of well functioning patients with schizophrenia. This article will describe two years of therapy, and it is a modified version of the report after the first year that was published in Polish [4]. The inspirations, theoretical basis, method, and the participants in therapy, as well as the results of the questionnaires which were filled out by the patients after the first and second years of therapy will be presented.

Inspirations

The idea to form the group resulted from the conviction that the existing data supports the following facts:

– Essential psychological problems connected with schizophrenia appear in patients' social relations, and discussing these concerns in an individualised setting is not enough for this group of patients.
– Many patients with good remissions drop out of treatment due to an almost uni-

versal tendency to deny the diagnosis of schizophrenia after a long and successful remission.
– The best way to adapt to the consequences of schizophrenia is to learn from the experiences of other individuals touched by this disease.
– A group therapy available in daily units, outpatient clinics and patient's clubs in the NHS is focused on patients with more severe problems in functioning in society. They do not fulfil specific needs of relatively well functioning patients.

The limitations of the NHS described above were confirmed by the experiences of several schizophrenic patients that I met in private practice. This inclined me to propose the time unlimited group psychotherapy for the relatively well functioning patients. It has been expected that it would be useful in such therapeutic goals as:

- reaching and maintaining a realistic idea of one's illness and its consequences, including compliance to medication,
- training of interpersonal skills focused on functioning in normal competitive professional situations and in intimate personal relationships,
- satisfying the need for sharing one's problems connected with the disease.

Theoretical basis

The theoretical concept of group therapy presented below is a synthesis of a general knowledge of schizophrenia as well as of psychodynamic psychotherapy, cognitive behavioural therapy, and in particular group analysis. This approach was applied due to the lack of generally accepted rules of group analysis of schizophrenia. There were only few publications dealing with this topic, when the project was elaborated [2, 5, 6]. [The first comprehensive chapter on group analytic treatment of schizophrenia [12] was published and available a little later. In addition, meaningful, commonly accepted conclusion regarding the long-term, supportive group psychotherapy of schizophrenia is missing. In a great mass of advice by the American Psychiatric Association [7] there is lack of specific directions involving the ways of conducting this type of therapy, even though it is noted that "supportive groups can be helpful in helping patients in teaching them how to deal with their symptoms, develop relations with other people in controlled conditions, and in developing a therapeutic relationship with a group in therapy (p. 28)." In the advice given by other experts [8], the only idea mentioned is the psychoeducation of outpatients.

In this situation it is reasonable to describe in this paper presumptions underlying group therapy presented in the study. It has been accepted that in group therapy, one should respect the general rules of the psychotherapy of schizophrenia formulated by Gabbard [9]:

1. The main focus should be on building a relationship.
2. The therapist must maintain a flexible stance regarding the mode and content of therapy.
3. The therapist and the patient must find and maintain an optimal distance in their relationship in order to proceed psychotherapy.

4. The therapist must create a holding environment.
5. The therapist must serve as a “container” for the patient.
6. The therapist must serve as an auxiliary ego for the patient.
7. The therapist must be genuine and open with the patient.
8. The therapist should postpone interpretation until the therapeutic alliance is solid
9. The therapist must maintain respect for the patient’s need to be ill.

While working on the described form of psychotherapy, the following general theoretical presumptions dealing with schizophrenia were accepted:

- Schizophrenia is a disease whose occurrence and course is influenced by biological, psychological, and social factors.
- Schizophrenia and schizoaffective disorders are diseases that often have a recurrent course and need lifetime therapy.
- Upholding an internal psychological equilibrium lowers the risk of decompensation.
- In understanding the internal problems of patients with schizophrenia, deficits in personality have a greater meaning than internal psychological conflicts; therefore, psychotherapy should be directed toward the improvement of adapting the patient to his/her own internal psychological construct as well as external situations.
- The long-term relationship with the therapist and the group can increase the feeling of safety for the patient and in part can satisfy his need for personal ties.
- The therapist can understand the interpersonal relations and group processes in more complex (psychodynamic) terms, but due to the patients vulnerability should focus his or her interventions on realistic problems and relations.
- The possibility of an individual contact with the therapist and a stable relationship with him can constitute a “secure base”. It can be understood as a realistic, and an essential ingredient of the described method of a long-term therapeutic procedure.
- In comparison with the psychotherapy of neurotic disorders, the main goal of group psychotherapy in schizophrenia is not to gain the kind of symptomatic improvement which shall allow the end of therapy, but rather the kind of improvement that will maintain remission. Although, the possibility of ending therapy remains in those specific cases which are very promising in their course.
- The optimal time of introducing group psychotherapy is the phase in which positive symptoms are controlled by pharmacological treatment, since patients with severe symptoms are not able to integrate compounded information flowing from the participants in the group [see 9].
- The frequency of sessions of group outpatient psychotherapy of schizophrenia ranges from the most commonly mention in the literature, 1 week [e.g. 9], to every 2 weeks or once a month [10]. In long-term time unlimited, supportive group psychotherapy of patients who recognise their illness as a lifetime condition, monthly sessions seem to be a frequency that can be acceptable by patients and helpful for them.

Methods

- Slow open group: time unlimited, with possibility to stop by each of the participants at any time, as well as with the possibility of a new patient inclusion, upon the agreement of the group participants.
- Number of participants: 8-10 persons.
- Setting: a private practice office setting in a tenant building in the centre of Warsaw.
- Frequency of meetings: 1/month.
- Time of session: 90 minute group session + 30-60 minutes for pharmacological prescriptions.
- The possibility of individual visits between sessions - when needed.
- Cost: fee for the session, after the session in which the patient took part [resigned from taking up the so-called contracted fee which includes taking fees for sessions in which the patient did not participate in order to minimise the repressive behaviours of taking part in a group, which touches upon essential interpersonal problems].

Inclusion criteria

- at least one experienced episode of schizophrenia or schizoaffective disorder,
- a stable therapeutic relationship in individual therapy,
- goals of beginning group therapy by the patient are discussed with him/her and accepted by him/her,
- a relative remission (the ability of functioning independently in social situations),
- at least some insight into the disease

The therapist: – a psychiatrist, qualified psychotherapist and group analyst

The way of leading the group in therapy

- gives the initiative over to the group [accepts the subject which is taken up by the group],
- answers questions, gives explanations,
- clarifies issues dealing with the topics which are initiated by the group,
- introduces topics only when it is necessary (e.g., when a patient is withdrawn and the group did not present interest in him or her and when the patient in a crisis that is known to the therapist from the phone call).

The way of leading the group is shaped by the therapist's training in group analysis as well as in cognitive behavioural therapy. The group analytic approach implies respect to the group processes understood in terms of object relations as a therapeutic tool, that is helpful in increasing the interpersonal skills of the patients. The group is also considered as an important psychosocial support for its participants. The cognitive-behavioural approach implies psychoeducative responses to the needs expressed by the group members and the emphasis on development of coping skills. Sessions are not structured beforehand; planned and prepared discussions are not held, and there is

no psychodrama or role-playing. On the other hand, answers to all varieties of ques-

Tabela 1

Characteristics of the participants in the group

Patient/ Gender	Age	First episode	Hospitali-sations + daily units	Recurrences	Last episode	In the group since:	Symptoms during the study period	Education/ Employment	Family situation
1.(f)	30	1992	0	1	1996	04.99	-	Master's Degree in Nutritional Tech/ shop t salesperson	Single, living with parents
2.(f)	25	1995	1+1	0	1995	04.99	-	Student /Secretary	Single, alone
3.(m)	59	1996	2	1	1997	04.99	-	Architect/working in profession	Married/ with 2 children
4.(m)	32	1991	0+1	0	1997	04.99	-	Engineer/in the course of his studies for master degree/working in his field	Separated /has a child out of wedlock
5.(m)	34	1991	2+2	1	1996	04.99	Stress-related paranoid ideations	Architect /working in profession	Single, alone
6.(m)	30	1993	2	2	1999	12.99	Postschizophrenic depression	MA in administration /working in profession	Divorced /one child
7.(m)	23	1999	0	0	1999	03.00	-	Student	Single, lives with parents

tions are given to patients - there is no analysis or interpretations of the fact of asking questions, which is typical in the psychotherapy of anxiety disorders.

Participants

From the beginning of the group therapy in April 1999 to the moment of carrying out the study, the following individuals participated in group sessions:

1. Female, 31 years old, living with parents, Master's Degree in Nutritional Technology. First episode of schizophrenia was experienced during her last years of study in 1992, not treated. Second episode was in 1996, and from December of that year she has been under the care of the author. This episode was successfully treated with risperidone and individual psychotherapy. In December of 1997, she undertook employment, which required working 3 different shifts, and it was too stressful for her. After three months prodromal symptoms appeared. However, she has been successfully working as a seller in a shop since that time. As a result of resistant hyperprolactinemia risperidone was substituted with success by olanzapine in August of 1998. In the spring of 2000, she was given the opportunity of discontinuing the neuroleptic treatment, but after about six weeks prodromal symptoms appeared, which were relieved by re-introducing olanzapine again.

2. Female, 29 years old, living alone, working, and paying for her studies. First episode in the fall of 1998. From January 1999, she has been under the care of the author and treated with olanzapine and fluoxetine. Full remission, yet complains of less motivation for different kinds of activity in comparison to the time before her illness.

3. Male, 60 years old, married with two children, architect. First episode in 1996, second in 1997, hospitalised both times, treated by the author in outpatient office since September 1997, first with risperidone + clomipramine, and from November of 1998 with olanzapine. From December 1999, full remission. He worked in his field for a few months, but his contract was not extended. During the last year he has been supervising the building of his own house.

4. Male, 34 years old, living with parents, has an unwed child, completed licencing studies and is paying for continuing education to obtain his Master's degree, and working as a seller since November of 1999. First episode of schizophrenia in the winter of 1997, treated in the daily unit, and later in the outpatient clinic with perphenazine with a limited improvement. Under the care of the author since October 1997. After changing the pharmacological treatment to risperidone in a dose of 4mg/d, full remission was attained in 4 weeks. In Septmeber of 1998 as a result of continuing sleepiness and increased liver enzymes, AST & ALT, the pharmacological treatment is changed to olanzapine. From December of 1998, fluoxetine is added, after which depressive symptoms disappeared.

5. Male, 35 years old, alone, parents living outside of the country, keeps in touch with his sister and his parent's family, architect. Ill since 1991, two hospitalisations

(1991 & 1996), two times in the daily unit (1991 and 1996). Consulted by the author in July of 1996, and referred to the hospital and treated as an outpatient after finishing his treatment in the daily unit in the winter of 1996. In 1997, he completed his studies and began work in his profession. With success he is working in a recognised architectural group, slowly but systematically advancing. He has had prodromal symptoms during situations of strong stress at work, or during trials to decrease the dosage of neuroleptic by himself. Pharmacological treatment with sulpirid and from December of 1999 with olanzapine.

Joined the group

6. Male, 31 years old, Master‘s Degree in administration, living since September of 1999 with his parents.

First episode and hospitalisation in 1993. In 1995, he completed his studies, married, and changed his place of residence. In 1998, his daughter was born. In January 1999, his second episode began, and he was hospitalised. After being released in September of 1999, he has been under the care of the author, and since December 1999 he has been in the group. He was released after a marked improvement on risperidone. Yet, a substantial improvement in mood and activity began in February of 2000 after the addition of clomipramine [fluoxetine, which was tried earlier, was ineffective]. From March of 2001, he has a position, which is equivalent to the educational level, which he holds.

7. Male, 24 years old, student, living with parents. First episode in the fall of 1999. Treated by the author since November of 1999 with risperidone, with certain constant negative symptoms continuing. He joined the group in March 2000. After the switch from risperidone to olanzapine, the negative symptoms were alleviated. From the fall of 2000 the patient is successfully continuing with his studies.

Left the group

8. Male, 23 years old, living with parents. Electrical technician. First episode during the spring of 1998 during his obligatory army service. Treated as an ambulatory outpatient by the author since the fall of 1998. Full remission after treatment with risperidone. He undertook work in his profession. He took part in two of the first meetings (April, May). In June he went on vacation out of the country with his parents, where he discontinued the medication, and treatment. He came back in September of 1999 and was referred to the daily unit. After several months of therapy in the daily unit and the outpatient clinic, the patient is working in a security guard agency after remission.

9. Female, 36 years old, married with two children, basic education. Schizoaffective disorder. First episode in 1990. Hospitalised in 1990 and 1993. Fifth recurrence in November of 1996. From that time, the patient is under the care of the author. A small degree of improvement with perphenazine, clomipramine, as well as carbamazepine. In March of 1997 a worsening state, after which perphenazine is substituted by risperidone. In March of 1999 a change from risperidone to olanzapine as a result

of hyperprolactinemia. In the course of therapy there were several worsening states as a result of the individual patient's discontinuing the medication, after a long period of remission. In 1999, the patient took up work for several months. In January of 2000 the patient resigned from taking part in the group after she decided that the group isn't of any benefit to her. In the summer of 2000, without consulting the doctor, she discontinued the neuroleptic, after which she had a recurrence of psychosis, which was treated several months in the daily unit and only a decrease in the severity of symptoms was attained. In the spring of 2001 she stated her wish of returning to the group, for which she received agreement from the group. She took part in the March meeting and did not come to any of the meetings following this.

Frequency

In individual session, 5-8 patients took part.

In the first year: 3 patients had not missed any sessions, 2 had only missed one session. During the second year: 2 patients had not missed any sessions, 4 had missed one session, and one patient had missed 6 sessions.

The main topics of therapy

During the first few sessions, the participants exchanged their experiences about the symptoms of the disease as well as the treatments for the disease. In the next period, they were interested in the trials of finding a job by specific individuals in the group, a change in the chosen field of study by one participant, as well as the effect of the disease on personal relationships. Topics which were discussed in the beginning repeated themselves as new participants came to be introduced into the group. In the second year of therapy, the focus of the group concentrated on questions regarding functioning in one's profession. Interest in full remission appeared several times, the problem of psychotic symptoms from the past kept returning, being described with a growing distance.

The typical course of the session

The conductor comes to the room and welcomes participants and gives initiative to the group. Usually someone starts to share his or her recent experiences or problems with others. The therapists intervenes when there are problems in communication or addresses patients who are withdrawn, apparently suffering or those who revealed earlier some problems to the therapist by phone or during an individual session and are not able to start to speak about them. It is noteworthy that the course of sessions changed during the course of therapy. That reflects gradual development of bonds with the group. At the very beginning there were very limited spontaneous communication among patients and the therapist was much more active, posing introductory questions, encouraging patients activity, than later. During the third year, the patients usually spontaneously start to ask themselves about events in period of time between sessions. More

recently, some interpretations of personal problems come from the group members. E.g., patient No 9 after two years remission after the first episode insisted on tapering and withdrawing of the medication. Unfortunately several weeks later he relapsed with dominant symptoms of disorganisation and with some delusions of reference. He visited the therapist in the period between group sessions, restarted the medication, and significantly improved soon. During the session he described the decompensation. However, he underestimated its meaning and was not critical to factors which could trigger psychosis. He revealed that after stopping medication he abused alcohol several times during parties, was overactive as a student offering his help to many colleagues and eventually had not time to sleep enough for several weeks. The group confronted the patient with his abnormal activity after finishing medication. One patient said that in this way he wanted to prove himself that he was strong. Other patient responded to the therapist question: How do you understand experiences of the patient during psychosis? – "They were grandiose, perhaps you have low self-esteem and psychotic experiences fulfilled his wishes of being powerful and very important".

Questionnaire survey after the first year

With an aim to gain better orientation as to the effectiveness of the method of therapy described, a questionnaire was sent to the participants after one year with questions regarding the evaluation of group therapy by them, as well as a short questionnaire for filling out as a self-rating of changes which they observed in themselves during their participation in the therapy described. In the questionnaire, their responses were chosen on a five-point scale (significant improvement, some improvement, without change, some worsening, significant worsening). Answers were obtained from all of the participants in the group therapy, including two persons which resigned from therapy, one of which unfortunately misunderstood the instructions and evaluated the psychotherapy which she had gone through during her treatment in the daily unit.

Self-evaluation of mental state

In the group of seven persons taking part in therapy, no one reported a worsened state in any of the parameters evaluated. One person, rarely taking part in the meetings, did not notice any changes; but during the entire time under observation, she was in remission with sporadic prodromal symptoms occurring. On the other hand, the majority of patients acknowledged that in comparison to the start of group therapy:

- symptoms of disease resolved completely (4 persons), significantly diminished (1 person)
- general mood had significant improvement (4) or had some improvement (1)
- ability of being competent in the home/at work had significant improvement (3) or had some improvement (1)
- interpersonal contacts had significant improvement (2) or had some improvement (1)
- the feeling of safety had significant improvement (3) or had some improvement (2)
- the faith in one's own potential ability had significant improvement (1) or had some

improvement (3)

The person who resigned from continuing therapy after taking part in group therapy for one year stated that she had no symptoms of disease and a significant improvement in all of the parameters which were evaluated. The other patient which took part in the first two sessions, did not understand the instructions correctly as to filling out the questionnaire, and during the vacation period he had independently discontinued his medication, broke off all contacts with his doctor and had a return of psychosis after a few weeks. Next, he had been treated in the inpatient department, which had allowed for full remission. He was not interested in returning to group therapy because, according to him, therapy does not bring him any benefits.

Evaluation of group psychotherapy

Expectations from group psychotherapy before starting therapy

- "Improvement in general mood and return to normal."
- "Difficult to define, but rather not great expectations. I prefer individual therapy since it is difficult for me to share my own problems with a greater number of people."
- "Conversations on the subjects of fighting the symptoms of disease, stress factors, and remission of disease, depression, and remission of schizophrenia."
- "I would most of all like to find friends in a new group of people."
- "I wanted to compare the experiences of others with my own experiences, and to see how others deal with this similar situation."
- "Increase my mood."

The majority of participants concluded that their expectations were either fulfilled completely or in part by group therapy.

Fears in regards to group psychotherapy before its beginning

- Two persons did not have any fears, while the rest of the group had fears regarding the problem of: contact with one another, confidentiality, reaching understanding between themselves and acceptance.
- From the answers given to different questions, the result is that these fears were not proven to be true.

Comparison of group psychotherapy with individual psychotherapy

Among advantages of group psychotherapy in comparison to individual therapy, the following were mentioned:

- the possibility of meeting individuals with similar problems and the sharing of experiences in how the problems were conquered
- lesser intensity and smaller emotional dose

However, 4 persons did not mention any disadvantages, and the remainder paid attention to:

Table 2

Results of PANSS examination and self-rating after the second year of therapy

Patient	PANSS score (minimum = no symptoms = 30; maximum = 210 points)	Self-rating of symptom severity (no symptoms, mild, moderate, serious or severe)	Self-rating of current state in comparison with premorbid period (premorbid state = 100%)				
			General well-being	Performance at work and everyday activities	Interpersonal relationships	Feeling of safety	One's own abilities
1	31	mild	80%	40%	30%	150%	60%
2	30	mild	80%	50%	80%	50%	50%
3	30	No symptoms	200%	150%	150%	200%	150%
4	30	No symptoms	85%	80%	90%	90%	80%
5	30	mild	90%	90%	90%	80%	80%
6	30	No symptoms	100%	100%	50%	100%	75%
7	30	No symptoms	100%	95%	95%	100%	95%

- a smaller amount of time for one person
- less confrontation with one's own problems

The person who resigned from participation in group therapy supported his decision by saying, "I don't like to listen about diseases and I don't like to meet with people who are ill."

The examination after two years

After two years of therapy, a study using the Positive and Negative Syndrome Scale [PANSS], a scale of patient evaluation of the worsening of symptoms as well as a patient evaluation of the actual state of health in comparison to the period before the occurrence of disease was performed. The results of PANSS and self-ratings are presented in Table 2. Below are presented the answers to the remaining questions.

Advantages obtained during the second year

- A more positive way of looking at one's own person, a greater chance of developing contacts with others, not only with patients, but also with persons whom I knew before.
- I met people with similar problems, and we were witnesses to getting out of another deadlock.
- My general mood has improved greatly and is now very good, a great calm, happiness from life and general satisfaction, lack of stress, and lack of disease symptoms has followed.
- I had the opportunity to compare my psychological condition with that of others, and to share my fears, as well as consult on subjects of coping in various difficult situations.
- I liked coming to these meetings. The contact with other people who have similar problems allowed me to become more conscious of my state.
- Communication which is more at ease and open, a greater psychological "ease", a greater internal calm, becoming more familiar with the disease, a greater tolerance for stress.
- I met people with problems similar to my own.

Unfulfilled expectations during the second year of therapy

- It gives me too few reasons to be happy with myself.
- I still lack confidence in myself and have low self-esteem in regards to my own undertakings, but before the explosion of my disease I didn't have this either.
- It fulfilled all of my expectations.
- I didn't have any expectations, which were not fulfilled.
- I didn't have any specific expectations.
- We certainly did not touch upon the delicate matter of internal religious experience, which was a dominant aspect of my psychosis.
- My expectations were fulfilled.

Expectations for the year ahead

- To approach these meetings with less stress.
- I hope that thanks to these meetings I will be less egocentric, maybe I will learn to listen.
- To maintain a good mood, to not have any signs of disease recurrence, to be happy with life, to open up to the group-sincere statements.
- The same as up to this time-the possibility of listening to other persons who have similar problems.
- No concrete or specific (expectations).
- Contact which will be even more at ease in the group, I hope to become more emotionally close with people sharing this same misfortune.
- I would like to bring up the topics: is this disease genetically determined; and should we admit to the disease to people we do not know well.

Discussion

The presented results have serious limitations because they are subjective opinions, more so as a result of the lack of anonymity. The following facts are an indirect testimony to the actual good psychological state of the patients: continuing participation in the group, successful functioning in society, lack of worrisome signals from the family or close friends, those of whom were active during the period of decompensation. It is noteworthy that all but one patient had no symptoms in PANSS, and in this one patient had only three mild symptoms one minimal. The fact of systematic participation in therapy by the majority of patients, under the full consciousness of the possibility of resigning from therapy, while still holding onto their individual contact with the therapist, is testimony to the positive attitude toward therapy. Group psychotherapy is an essential part of the therapeutic effects used for persons who participate. The positive changes which are observed should be understood as the result of complex treatment, effects of which are based on pharmacotherapy (it is worthwhile to notice, that everyone was treated with atypical neuroleptics), as well as the relationship with the therapist, who is readily available (patients have the unlimited possibility of consultations by telephone and additional individual sessions which are called for, and which they take advantage of occasionally-it is worthwhile to mention that they do not abuse the possibility of consultation over the telephone).

The applied style is in agreement with the views presented in literature [1, 2,3, 5, 6, 7, 8, 9, 10, 11, 12], including elements of outpatient group psychotherapy of psychoses elaborated from the group analytic [Foulkesian- Foulkes was a founder of the group analysis] perspective [3]:

1. Improvement of ego functions.
2. The attenuation and dissolution of the transference to the therapist.
3. The enhancement of the insight within the basic frame of the therapy relationship.
4. The transmission and application of what is learned in the group of everyday life

situations.

5. The support of healthy parts of the ego.

It has been accepted that the most beneficial solution is unlimited long-term supportive group psychotherapy with a rather small frequency of sessions. This solution is connected to the belief that psychological deficits have a greater meaning than do problems, which result from the intra-psychological conflicts in schizophrenia, because deficits cause serious difficulty in the ability to tolerate unpleasant feelings, which are an inseparable element of insight psychotherapy. From the observations of the author, patients during the period after remission of positive symptoms show a marked resistance to analysis of these symptoms and they frequently and even directly refuse work that requires recalling these experiences. This type of stance is understandable in the context of deficits which are present, and which are the cause of difficulty in tolerating certain problems, which patients do not always have to have as an essential meaning in their future lives. For example, in one patient, strong symptoms appeared several years ago in the context of a failed relationship with a man. In individual therapy she refused to analyse this problem, trying to find other ways of fulfilling her needs for personal ties, she even seriously considered entering a convent, and later she became involved with the lives of her family, in this helping her sister to bring up her sister's children. An essential element in the psychotic experiences of another patient was also due to a failed romantic relationship. Attempts at analysing this problem led to the worsening of the patient's mood, who had made attempts at making new acquaintances and he discusses these experiences during the course of his infrequent individual therapeutic sessions. The problem of intimate relations slowly, and more frequently is signalised by other persons in the group during the sessions.

A fundamental strategy relies upon the flexible ability to follow the problems, which are taken up by the patients, and strengthening their positive experiences in relation to the group and the therapist. This is based on the conviction that there is a small chance of attaining fast and serious changes in the way of experiencing and functioning in those with schizophrenia as well as acknowledging the possibility of gradual and slow modification in personality. In the case of preparedness of certain patients for insight psychotherapy, they have the possibility to increase the frequency of their individual sessions. However, it did not take place. From my observation, it seems that a forced intensive program for the entire group can be destructive for the group as well as for many of its participants, who are not completely prepared to confront their limitations.

Conclusions

- The experiences described here suggest that for some socially well-functioning individuals with schizophrenia, the long-term supportive group psychotherapy can be a helpful element in treatment, and possible in an ambulatory setting, in that in a private practice.
- The relatively short period of observation, as well as the simple study tools used which could be more precise cause that the work has an introductory character,

needing verification during a longer period of time and with the implementation of more precise study methods.

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