

**A mixed method Delphi study to determine professional consensus  
on the key elements of outpatient Psychodynamic Group  
Psychotherapy (PGP) for psychosis**

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## Abstract

Although psychodynamic group psychotherapy (PGP) has been offered to patients with psychosis for over a century there is little empirical evidence of its effectiveness. In part this has to do with the lack of a consistent and adequately robust definition of this intervention. The aims of this study were to develop a set of the core components of PGP for psychosis and to gain a deeper insight into the current methods of its delivery. A research design using a mixed methodology combining the Delphi method and the thematic analysis has been employed. 37 experts around the world were recruited to participate in three rounds to produce and rate statements that aimed to address the following areas in order to consolidate consensus of opinion: indications for treatment, the aims of therapy, therapy frame, therapeutic factors, assessment and preparatory sessions, the formulation of hypotheses, a general therapeutic approach throughout assessment and therapy, phase specific interventions and attitudes and qualities necessary for therapists conducting PGP for psychosis. 145 components were endorsed as important or essential for PGP for psychosis by more than 80% of the experts. The participants' comments on their rating decisions were then subjected to thematic analysis which highlighted further adaptations of PGP which should be applied to patients with psychosis: more active leadership, and more considered interpretation of unconscious dynamics and transference. Participants argued for the flexible application of PGP principles and stressed the importance of understanding psychosis as a response to overwhelming emotional experiences. Importantly, none of the participants considered PGP to be harmful to patients with psychosis, which warrants a review of the existing warnings against psychodynamic therapies for psychosis. The outcomes of this study could be

of value to clinical practice, the training and dissemination of PGP for psychosis, the development of a competency framework as well as for future research into its effectiveness.

## **Chapter One: Introduction**

### **Part One: Summary and background of the project**

Psychosis is a common and very debilitating psychiatric disorder affecting 500 000 people in the UK (Cooke et al., 2014) and 51 million people worldwide, roughly about 1% of the population (NICE, 2014). Psychosis has a significant impact at both individual and societal levels. It can place people at a higher risk of developing substance abuse and committing homicide or suicide (Nielsen & Large, 2010). Given such high prevalence rates and the negative effects of psychosis, the development of effective interventions for psychosis is of high priority.

Psychoanalytic psychotherapy has been offered to patients suffering from psychosis for over a century and has been proven effective by several studies (Bateman & Fonagy, 2009; Gabrovsek, 2009; Leichsenrung et al., 2015). Contemporary psychoanalysts argue that psychoanalysis and medical treatment should supplement each other and that combining psychopharmacology and psychotherapy significantly improves outcomes and helps to retain the improvement (Rosenbaum et al., 2013; Kennard, 2009; Hinshelwood, 2004). In addition, it would be expected that psychodynamic therapy would strengthen the benefits provided by supportive counselling as well as widening the choice of service users in the offered modalities of psychological intervention along with CBT, systemic and family interventions (Kennard, 2009). According to recent evidence, psychodynamically informed therapy may have a particular contribution to make for patients whose psychosis is associated with certain types of personality dysfunction and interpersonal difficulties, particularly where there is presence of trauma in the aetiology (Kingdon &

Turkington, 2005; Read et al., 2005).

Psychosocial dysfunction in psychosis is the primary concern of therapeutic engagement and interventions in psychodynamic psychotherapy. As these patients often have difficulty in reality testing<sup>1</sup>, lead isolated lives, and often have maladaptive relationships, group therapy can have certain advantages. Psychodynamic Group Psychotherapy (PGP) in this study is referred to as an investigative therapy which seeks to raise awareness of the group's dynamics and individual internal conflicts in order to improve interactions between group members, thus enabling group members to draw on this experience to improve their interpersonal relationships beyond the group.

Across Europe PGP for psychosis has a well-established place in mental health services. It is widely offered both privately and through national health systems. It is especially well established in Germany, Scandinavian and Eastern European countries. In addition, Scandinavian group analysts have developed well accredited manuals (Lajer & Valbak, 2005; Lorentzen, 2013) and pioneered some of the most recent research endeavours into the effectiveness of this treatment (Rosenbaum et al., personal communication). In the UK group therapy has been widely offered in therapeutic communities, inpatients and outpatient NHS settings (Kennard, 2009; Hinshelwood, 2004; Winship, 2009; Novakovic, 2013; Garland, 2013).

There is currently a limited body of empirical research into PGP for psychosis

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<sup>1</sup>Reality testing here is referred to as the individual's awareness of his or her limitations as they relate to biological, physiological, social or environmental realities. Reality testing ability allows the individual to distinguish between the internal and external world and between fantasy and reality.

despite this intervention being delivered worldwide for almost over a century now (Kennard, 2009; Leichsenring, 2013; Rosenbaum et al., 2013). The lack of evidence might be linked with the complexity of group psychotherapy research. Already in 1948 Kotkov et al. (as cited in Opalic, 1989) advocated the need to gather further information on the context of research into group psychotherapy including patient population, the role of the therapist, the method of conducting groups and how best to evaluate the research results. Sixty years later Blackmore et al. (2009) in a systematic literature review on the efficacy and effectiveness of PGP pointed out similar gaps in PGP research and revealed a lack of consistency and standardisation in the delivery of PGP, stating that the terminology used to describe PGP was often ill-defined.

The aim of this research was to address this very lack of a consistent model of PGP for psychosis through a mixed method research using the Delphi method and thematic analysis of the participants' comments on the most important components of PGP for psychosis. Additionally, the investigator has a specific professional interest in this area from running an outpatient PGP for people with psychosis in an NHS setting in the UK for six years. Although the investigator has received a formal training in individual psychoanalytic psychotherapy and been in personal analysis and a patient in a psychoanalytic group psychotherapy, she has no formal training in PGP. The investigator sought to improve her understanding of PGP through the study and to use it as an opportunity to critically reflect on her own clinical practice.

The purpose of this chapter is to review psychoanalytic contributions to the understanding of psychosis, to give a historical overview of the development of PGP

for psychosis, and to draw attention to the unique benefits of this intervention for patients with psychosis. The chapter will conclude with a review of the available literature on the effectiveness of PGP for people with psychosis.

## **Part Two: A Psychoanalytic Contribution to Understanding Psychosis**

An introduction into PGP for psychosis must begin with the psychoanalytic understanding of psychosis, with the application of PGP deriving from this concept of psychosis. Urlic (1999) adds that how one understands psychosis and group experiences will determine the therapist's role and approach. In the literature there are several thorough reviews of how various theoretical traditions in psychoanalysis contribute to an understanding of psychosis (Mace & Margison, 1997; Bell, 2003; Hinshelwood, 2004; Lucas, 2009). For the purpose of this study, the investigator will provide a brief overview of the fundamental concepts which have come to define the understanding and psychoanalytic treatment of psychosis up until present in the works of Freud, Klein, Bion, Fromm-Reichmann and Lacan. This chapter primarily focuses on the British School of psychoanalytic thought not only because it informs the investigator's training and way of thinking but also because it represents well elaborated and established understanding of psychosis and its treatment within psychoanalytic tradition. This selection limits the scope of this review as it omits other important psychoanalytic work done with these patients (Federn, Sullivan, Searles, Freeman, Feinsilver, Williams, de Masi, Arieti, Benedetti) and only briefly touches on the ideas of Lacan and authors from the USA.

While the term psychosis is most often applied to people who have received a psychiatric diagnosis of psychotic disorder (DSM-IV, ICD-10), in psychoanalytic theories psychosis is identified as a state of mind, in which the person relates to himself and the world around him in a great dissonance or a rift with consensual reason (Lucas, 2009). Psychoanalysis revolutionised our understanding of psychosis, enabling a shift from a previously held view of an hereditary-constitutional-degenerative disease of the brain to the consideration of it in terms of human development (Lucas, 2009).

A review of a psychoanalytic understanding of psychosis must begin with Freud's contribution. Freud's central point, namely that we should listen with care to the content of psychotic experiences rather than dismissing them merely as manifestations of underlying organic pathology, remains pertinent today. His ideas about psychosis first appeared in his analysis of Schreber's memoirs (Freud, 1911) where he developed his key concepts in relation to psychosis – projection, narcissism and delusional formation as pathological attempts at recovery. Laplanche and Pontalis (1973) summarise Freud's attitude to psychosis as a condition founded in a primary disturbance of the libidinal relation to reality where psychotic symptoms (delusions) are seen as attempts to restore the link with objects.

Projection was defined by Freud as a key mechanism of paranoia (as well as a defence mechanism) where the subject is searching for the source of unpleasurable experience in the external world. According to Freud, patients with paranoid psychosis project intolerable thoughts and feelings into external reality, thus ridding themselves of mental pain, and feel persecuted when these projections return in the

form of reproaches (Freud, 1896).

Hinshelwood (2004) refers to Freud's understanding of psychosis as a "two-phase view", where in the first stage, the person experiences some sort of psychic upheaval as a "world catastrophe" (mental breakdown, where the ego is overwhelmed by the external reality) and in the second stage, the world is reconstructed through the creation of the world of delusions and hallucinations (the ego reconstructs a new reality in accordance with the desires of the id).

Freud believed that patients with psychosis were not amenable to psychoanalytic treatment as their predominant mode of relating was narcissistic (psychic energy or libido directed at itself or part of itself) and thus they were unable to develop any neurotic transference and accept help from others (Freud, 1914; 1924). However, he urged psychoanalysts to continue research into underlying dynamics of psychosis as he believed that "scientifically based psychiatry is not possible without a sound knowledge of the deeper-lying unconscious processes in mental life" (Freud, 1916, p. 255).

Freud's ideas were influential in the development of PGP in the beginning of the 20<sup>th</sup> century, although Freud himself never saw groups as a medium for his psychoanalytic method (Freud, 1926, as cited in Behr & Hearst, 2005). His ideas were particularly taken forward in the context of group psychotherapy by psychoanalysts in the United States in the first half of the 20<sup>th</sup> century (Lazell, 1921; Wender, 1935; Silder, 1936).



It was Klein and her followers (Segal, Rosenfeld, Bion, Steiner) who introduced some of the most crucial concepts in a psychoanalytic understanding of psychosis and founded an analytic approach of working with psychosis. What seems to be clinically revolutionary in the works of Klein and her followers is the focus on the exploration of psychotic presentation rather than on the curative outcome process. Klein (1946) argued that when working with psychosis part of the therapist's task was to develop an understanding of the underlying dynamics operating within the patient's internal world.

Klein's understanding of psychosis is based on the developmental model which has its roots in object relations theory (Klein, 1946; 1952). This theory suggests that we are born in the relationship with an other; that the world of the infant in the first months of its life consists of either hostile and persecuting or gratifying parts of the real world (i.e., the mother's breast). Klein (1952) believed that as the infant is born with both libidinal and aggressive impulses, he thus has to protect himself from various persecuting anxieties by splitting good and bad, real and phantasy, and creating unrealistic perfect idealised 'good' objects and devalued 'bad' objects. Klein called this state of the infant's mind the 'paranoid-schizoid position'. As infantile development proceeds and the ego becomes more organised, the lessening of primitive splitting and projection leads to more integration in the perception of objects capable of being both 'good and bad'. This new integration of the object brings an awareness that the infant's destructive impulses have been directed against not only the 'bad' object but both 'good and bad' mother. This recognition is accompanied by painful feelings of guilt and remorse. According to Klein, this signifies the beginning of the infant's state of mind called the 'depressive position'.

It seems that the psychotic mind mainly operates from the paranoid-schizoid position by keeping the bad and good split off or under omnipotent control or by using other coping strategies to avoid the uncertainties and emotional strains of real life experiences. Klein (1946) thought that in these patients the ego particularly lacks the capacity to bear certain feelings, especially violent or envious feelings. She suggested that splitting these feelings off was a self-destructive process as well as a schizoid defence.

The concept of projective identification, introduced by Klein (1946), is very helpful in making sense of positive symptoms of patients suffering from psychosis. Klein describes projective identification as a process by which parts of the self are forcefully projected into an object and then reintegrated reinforcing the subject's feelings of inner persecution. Klein originally saw projective identification as a means for the infant to communicate with the mother, who by taking in the projections would become aware of the child's needs. This mode of communication turns into violent fragmentation in psychotic states and is used excessively in relation to persecutory anxiety.

Klein and her followers addressed Freud's therapeutic pessimism regarding psychoses and contributed to extending psychoanalytic technique to the treatment of patients with psychosis. Segal (1973) introduced the concept of manic defences, which she suggested arose to protect the individual from the experience of depressive anxiety, guilt and loss. In manic defences psychic reality and object relations are omnipotently denied. Manic defences are characterised by feelings of triumph, control and contempt (Segal, 1973). Furthermore, Segal (1973) found the capacity to

symbolise severely diminished in patients with psychosis, instead these patients resort to “symbolic equation”, in which the symbol is equated with the original object, giving rise to concrete thinking (Segal, 1957). However, Segal also saw a hopeful or redemptive aspect of symbolic equations, which had the potential to become symbolic formations through which the patient could learn to feel ambivalent towards his whole objects, experiencing sadness and loss (Joseph, 2009).

Rosenfeld (1954) disagreed with Freud's suggestion that no transference could occur in psychotic disorders. He argued that transference indeed occurred, but that it was of a concrete nature. Thus he considered these patients suitable for an analytic interpretative approach. Rosenfeld postulated that the psychotic patient was subject to a massive confusion of self and other to such a profound extent that ordinary splitting could not occur and that massive states of confusion in these patients were actually a defense against splitting (Rosenfeld, 1950). He wrote that good and bad, libidinal and aggressive impulses were so fused together that the infantile states of confusion became paranoid states of the adult. Rosenfeld, like Klein, postulates the existence of excessive projective identification in these confusional states, where psychotic patients remained identified with an internally persecuting super-ego object, thus constantly attacking their own selves, while projecting good or idealized qualities onto external objects.

Steiner (1993) introduced a concept of psychic retreats which described pathological organisations of the personality that offered protection from anxiety and pain. In psychosis such organisations represent a retreat to a delusional world in defiance of reality. The catastrophic nature of psychotic anxieties underlies “the desperate

dependence on the organisation, the loss of which implies the return of uncontrolled panic associated with experiences of fragmentation and disintegration of the patient's self and his world" (Steiner, 1993, p.64). Even though the patient may recognise that the retreat he has created is mad, he idealises his delusional world because of the protection it affords against psychotic ordeals of disintegration and annihilation, thus, as in Freud's theory, it has a restorative function. Steiner stated that where the psychotic process had not totally destroyed the patient's capacity to feel depression, useful analytic work was possible.

Bion (1954) made an outstanding contribution to the psychoanalytic understanding of psychosis through the development of his ideas on psychotic and non-psychotic parts of the personality. He viewed each person on a continuum basis, locating their functioning on a spectrum from projecting mental pain in psychotic states of mind to taking ownership of feelings in more neurotic states. He viewed a patient with psychosis as an individual who is dominated by a separate psychotic part that needs to be studied in its own right. Bion (1954) suggests that a separate psychotic part exists from early on in life, which attacks all the aspects of the mind that have to do with the registration of awareness of internal and external reality. The psychotic part of the personality is unable to evaluate emotional issues and, instead, functions as a muscular organ to fragment and evacuate troublesome feelings.

Bion (1954) proposed that every individual had a psychotic and non-psychotic part in his mind, which were in constant conflict with each other, opposing emotional and relational agendas. Bion (1957) thought that people suffering from psychosis negotiated the paranoid-schizoid position in a markedly different way from others,

due to a fragmentation of the psyche, resulting in the formation of the psychotic part of the personality. According to Bion, the psychotic part is preoccupied with an omnipotent control of relating to protect against the emotional impact associated with relating socially and intimately. The motivation of the psychotic part is to minimise the emotional impact of interpersonal reality, which is seen to be a source of dangerous, persecutory anxiety. The psychotic part of the mind relates to any good experience as dangerous, stupid, weak or humiliating. The ordinary misery of any relationship need is denied, misinterpreted, avoided, attacked or replaced by the extraordinary misery of delusional paranoid persecution and isolation. According to this model, psychosis is characterised by the prevalent presence of a psychotic part that actively opposes and interferes with non-psychotic functions of the mind. These non-psychotic functions are concerned with achieving and sustaining relationships with others and developmentally prepare us to tolerate the emotional challenges and dilemmas that we inevitably face in our lives.

Bion viewed hallucinations to be the result of a violent fragmentary projective processes as well as a muscular activity aimed at unburdening the psychic apparatus of accumulations of mental stimuli linked to an inability to tolerate frustration. He saw patients using delusions for constructive purposes and their attacks on thinking as a way to protect the ego from the development of painful meaning and any connection with reality (Bion, 1957). The end result in psychosis is that rather than developing any apparatus for thinking, the individual instead develops an apparatus for ridding the psyche of bad internal objects. Bion assumed that psychotic pathology reflected disordered thinking, when the patients used language as action. Bion proposed that schizophrenic language was a manifestation of disordered thinking and

that patients with psychosis could confuse omnipotent thoughts with actions.

According to Bion, there is always an underlying non-psychotic part capable of taking in and thinking. This means that even in the case of the most disturbed of patients one is still invited to seek an unaffected part of the patient with which to communicate. Bion viewed the task of the analyst as that of thinking and metabolising the feelings projected into him in order to help the patient reintegrate the disowned parts and feelings, in the same way that maternal containment and reverie would do so for the baby (Bion, 1962).

Kleinian ideas, particularly as taken forward by Bion, meant that a psychoanalytic treatment of psychosis was possible and effective and would be applied to the treatment of patients with psychosis also in groups (Bion, 1961). Object relations ideas are at the basis of Bion's theory on group dynamics and laid the foundation to the group-as-a-whole approach or Tavistock model taken up by various group psychotherapy schools across the world.

Lacan (1993) proposed that the mental structure of the psychotic came from foreclosure of the paternal signifier (the “no” the father uttered, which identified the mother as not belonging to the child, and the child as not belonging to the mother (“The Name Of The Father”)). Such a signifier does not become established in the mind of a patient with psychosis. As a consequence, this patient fails to inhabit any symbolic space (language) and does not enter the symbolic order. In this mechanism of foreclosure, which itself is a mechanism of psychosis, the repudiated content is not

hidden somewhere in the mind, but has simply been ejected, without remainder. The psychotic, then, not having entered the symbolic space, continues to live in the imaginary or narcissistic world of its union with the mother. The paternal signifier, having been ejected or foreclosed, can return, in various ways, in the form of hallucinations and delusions (Hurts, 2000).

Lacan was convinced that the primary signifier, once it has been foreclosed, could not be installed in the chain of signifiers that constitute language and the structure of the mind (Jan, 1990). It would remain forever outside of that chain, existing only in the real (the preverbal reality of the subject, characterised by a series of desired objects not clearly distinguished from the self (Jan, 1990)) and returning perhaps as hallucinations or delusions (Hurst, 2000). From a Lacanian point of view, what can be achieved with these patients in psychoanalytic treatment is the creation of a delusional metaphor that can serve a psychotic as a kind of substitute for the primary signifier (Hurts, 2000). The objective of treatment therefore would be more normal functioning, on the basis of a delusional metaphor that can create a kind of map for negotiating the narcissistic or imaginary world of psychotic experience (Lacan, 1977, as cited in Hurts, 2000; Redmond, 2013).

Lacan's ideas on groups ('cartel' as a work group) developed from the analytic work of Bion and Rickman where he saw a group as potential ground for the emergence of the subject (Mackie, 2016). Like Bion, Lacan believed that the emergence of the subject happened through the grasp of inter-subjective relations in the group where the dependence on the leader was challenged and responsibility for meaning and truth was shared. These ideas were taken up by Di Caccia at Antenne 110, Mish'olim

in Tel Aviv, Nonette at Clermont-Ferrand and at Le Courtil (Mackie, 2016).

In the USA in 1950s and 1960s a group of eminent psychiatrists who developed their approach to working with patients with psychosis at Chestnut Lodge (Fromm-Reichmann, Searles, Feinsilver, Sullivan) identified the roots of psychosis to be in early infancy, where the person is believed to have had a serious traumatic experience at a time when his ego and his ability to examine reality were not yet developed, which severely undermines the person's later abilities to cope with life's challenges (Fromm-Reichmann, 1939). Fromm-Reichmann (1939) believed that psychosis ensues when the person reaches his limit of endurance of psychic pain and escapes the unbearable reality of his present life through partial regression to early phases of personal development (autistic, delusional world of the infant). For these patients the analyst's attempts to understand and explore their isolated world represent a threat of being compelled to return to the frustrations of real life and experiences of psychic pain as well as revealing his inability to meet them (Fromm-Reichmann, 1939). Fromm-Reichmann believed that these patients always retain a dim insight into the delusionary nature of their world and long for human contact and understanding, but are terrified of the potential frustrations this contact might entail. She argued that classical analytic technique could not be applied to schizophrenia and introduced a concept of intensive psychotherapy which is to be distinguished from psychoanalysis (Fromm-Reichmann, 1950). She believed that these patients should be allowed not to use the couch and not be required to free associate. Analysts with these patients should refrain from transference interpretations in early stages of treatment. She saw the aim of the treatment as enabling patients to study and resolve their conflicts within a developmental perspective and subsequently change their self



and/or their object-representational world.

A follower of Fromm-Reichmann and her colleague from Chestnut Lodge, Harold Searles, also saw the aetiology of psychosis in a failure of mother-child symbiosis and maintained that the transference of symbiotic type was a necessary phase in every treatment. Searles made a particular contribution to the development of psychoanalytic treatment of psychosis during his time in Chestnut Lodge by further developing Bion's and Rosenfeld's ideas on countertransference. He believed that the analyst's emotions needed to become the subject of as precise and thorough investigations as were those of the patient himself/herself. These ideas were further developed at Austin Riggs Centre and Menninger Clinic where ideas of interpersonal analysis and ego psychology challenged the notion of psychoanalysis being hopeless in treating patients with psychosis. The treatment programmes in these psychoanalytic centres encompassed individual psychodynamic therapy, milieu and group psychotherapy and were further shaped into programmes for therapeutic communities.

### **Contemporary contributions to the psychoanalytic understanding of psychosis**

Following from Freud, psychoanalysts became more encouraged about the success of psychoanalysis in the treatment of psychosis, but varied in their views as to the exact focus of treatment, be it on encouraging the development of more mature defences, focusing on the interpretation of transference, improving the self and object-representational world, or developing alternative ways of understanding altogether. All the aforementioned thinkers agreed on a shift of focus in the treatment of psychotic patients from trying to cure them to trying to understand them.

Taken on its face value each symptom has little importance; seen as symbols and investigated in their inner meaning these symptoms throw a flood of light on the play of disturbing forces in the patient's life; and only when the psychosis is seen as the resultant of such forces, is it fully understood (Campbell, 1910, p. 19).

Contemporary psychoanalysts interested in the field of psychosis (Bell, Gonzalez de Chavez, Hinshelwood, Kennard, Martindale, Rosenbaum, Silver) all concur in the requirement of a search for meaning beyond the psychotic symptom, and view these attempts at research and understanding as much more therapeutic than simply focusing on a reduction of symptoms. They have moved away from Freud's original idea of psychosis conceptualised as an impairment of ego functions and regression to primary processes following the rupture between ego and external reality. This has been criticized for its focus on sexual frustration as the cause of the regression and a lack of consideration for the wider context of early interpersonal relationships.

One of the great achievements of the psychoanalytic tradition has been its inference of some order in the apparent chaos of people who are easy to dismiss as hopeless and incomprehensible, and consequently its offer of a way of understanding and helping the severely mentally ill. Psychodynamic therapists try to understand the metaphoric significance of the presenting problems and thus help convert raw anxiety into meaningful experience. A psychotic person's transference responses to the analyst and the group, and the analyst's countertransference each provide clues to understanding and containing anxieties.

Bell (2003), building on Bion, highlights that one of the crucial elements in

psychoanalytic thinking about psychosis is its insistence that psychotic processes are universal, rather than being restricted to those who have had manifest 'psychotic episodes'. Be it through dreams, in our infancy, as well as unconsciously underlying our everyday mental life, none of us are strangers to psychotic process. From this comes the view that the content of psychotic phenomena (such as ideas, voices or visions that are regarded by others as symptoms of psychosis) are always meaningful, and, furthermore, the concerns expressed through them are seen as no different from anyone else's concerns. Psychosis is not seen as expressing distinctive things, but rather as involving distinctive ways of expressing the same kinds of things, for example, the fears of abandonment.

In summary, the contemporary psychoanalytic approach to working with patients with psychosis, individually or in groups, necessitates an active attempt by the therapist to understand the patient as a person with conflicts, identity difficulties and emotional sadness and confusion, and to let the patient feel understood by the therapist.

### **Part Three: An Overview and History of PGP for Psychosis**

Psychodynamic group psychotherapy has characteristics that differentiate it from other psychotherapies. It has a combination of therapeutic elements that are specific to a group format that may favourably affect the experiences and behaviours of patients with schizophrenia. These groups try to help the members understand how long-term intra-psychic conflicts and maladaptive behaviours interfere with their lives, in the hope of lessening the impact of these difficulties and improving ego

functions. As Murray Cox (cited in Urlic, 1999) put it, the therapeutic group may reactivate the problem but also brings it back to where it started, to the family environment which exerts the crucial genetic and environmental influence.

According to Yalom (1985), the group represents a therapeutic factor in itself, where “more accurate perception of self and others result from the patient’s observation of direct interpersonal behaviour in the here-and-now situation. Group mirroring is probably the most specific phenomenon of group psychotherapy, differentiating it clearly from other psychotherapy modalities and it accounts for a large part of its specific therapeutic potentiality (Gonzalez de Chavez, 2006). Group mirroring is the intersubjective process of multiple, simultaneous, reciprocal and empathic mirroring reactions based on observation, examination, disclosure, reflection and mutual knowledge between group members (Chazan, 1993). Through feedback from others, self-observations and self-reflections patients become aware of their interpersonal behaviours and their maladaptive aspects and start appreciating the impact their behaviours have on others through hearing other group members’ opinions they have of them and the feelings they evoke in them. Yalom (1985) argues that the social microcosm of the group is bidirectional: not only outside behaviours manifest in the group, but behaviours learnt in the group eventually carry out to the patient’s life outside the group.

First mentioning of PGP for psychosis goes back to early 1920s when in the USA, Edward Lazell, a psychiatrist and follower of Freud and Jung, began offering group therapy in a form of group lectures to patients with Dementia Praecox. Lazell (1921) believed that lecturing his patients on the psychoanalytic ideas of the workings of the

mind was therapeutic as he argued that fear of death, the oedipus problem and the problem of sexual development were the common denominators of praecox. He argued that the advantages of the group method were many: patients did not feel alone or unique with their problem, and the fear of the analyst as an individual was removed. Even hard to reach patients retained the material from the lectures and many patients developed a positive transference, some even seeking further assistance.

Before the outbreak of the Second World War Louis Wender, also a follower of Freud in the USA, developed a methodology for small groups informed by psychoanalysis (Behr & Hearst, 2005). Wender moved away from the educational aspect of groups and utilized psychoanalytic principles in the handling of the group instead of the individual. He saw small group work as being effective mainly with neurotic and borderline patients but considered patients with psychosis unsuitable for these groups.

Around the same time in Bellevue Hospital in the US Paul Schilder, also Freud's follower, introduced his patients (after a period of individual analysis) to small groups of 6-7 where he attempted to give his patients a deeper insight into their problems via use of free association and interpretation of the resistance, transference and dreams (Pinney, 1978). Schilder is recognized by some authors as a pioneer of psychoanalytic group psychotherapy and his groups are seen as a precursor of the therapeutic community (Pinney, 1978). Schilder was the first to develop a group analytic technique where group members are encouraged to make interpretations to their fellow patients.

Following the Second World War, a group of eminent psychoanalysts (Harry Stack Sullivan, Frieda Fromm-Reichmann, Harold Searles) from Chestnut Lodge in the US promoted the application of psychoanalysis (individual and in groups) to the treatment of patients with psychosis in the form of intensive psychotherapy based on the enduring positive relationship with the patient. The study by Stanton and Schwartz (1954, cited in Mackie, 2016) looked at the therapeutic community aspect of the treatment offered at Chestnut Lodge and highlighted the deep effects the complex relationships between the staff and patients had on each other as well as the contribution of those to the overall treatment success. PGP and therapeutic community model was also applied in the Menninger Clinic and the Austin Bgriggs Centre.

After the Second World War the works of Irvin Yalom became influential in the field of group psychotherapy, which later became known worldwide as interpersonal group psychotherapy. Interpersonal group psychotherapy aims to provide a corrective emotional experience, in which group members are collectively encouraged to allow their adult thoughts and feelings to modify their earlier traumatic experiences (Yalom, 1985). This approach emphasises interpersonal learning where the group leader's participation is aimed at minimising the impact of transference tensions (Montgomery, 2002). Yalom and his followers identified specific group therapeutic factors and founded an area of research into the unique curative aspects of group psychotherapy (Yalom & Leszcz, 2005; Gozalez de Chavez et al, 2000).

After the Second World War, in the UK, the pioneers of PGP consistently referenced are Wilfred Bion and S.H. Foulkes who were using group therapy as an approach to

the treatment of soldier-patients in Northfield Military Hospital. Bion, a Kleinian analyst, went on to work at the Tavistock Clinic in London and founded group-as-a-whole approach or the Tavistock Model, in which the basis is the idea that a man is essentially a political (group) animal and that a person develops through the involvement in group life (Bion, 1961). Bion was preoccupied with hidden configurations of the group and its unconscious life, and observed a group as a whole rather than individuals in it. He observed that every group operates at two levels: the “work group” and the “basic assumption group”. Group members may strive towards completing the task of the group in a rational and orderly fashion but find themselves constantly undermined by an unconscious basic assumption, which he understood to be a primitive defensive response to the anxiety generated by the experience of being in the group. Bion describes three basic assumptions of dependency, fight or flight and pairing. He postulates that basic assumptions were clusters of defences against the psychotic anxieties present in all groups. Elucidation of these unconscious group processes provides group members with opportunities for profound self-understanding. In this tradition the task of the analyst is to interpret group phenomena in order to help the group function more effectively. Interpretations are made about and to the whole group, on the basis of the analyst’s understanding of projections from the group as a whole. The analyst refrains from relating to individual members as this is thought to support the basic assumption mode current in the group. This approach was particularly taken up by followers of Bion in the UK including Ezriel, Rickman, Sutherland, Turkey, Gosling, Resnik, Skolnick and others (Resnik, 1999).

During his time at Northfield Hospital, Foulkes, a psychoanalyst in the Freudian

tradition, instituted ward-based group therapy sessions and structured the wards like communities encouraging patients towards mutual support and cooperation in living. The whole community was seen as both the patient and as the instrument of treatment (Mackie, 2016). His followers, Bridger, Main and Jones further built on the idea of “hospital-as-a-whole” approach, which they implemented at Cassel Hospital and at Henderson Hospital where they worked on the development of a therapeutic community model (Mackie, 2016). Group therapy was integral to this model (Kennard, personal communication). When later working and teaching at the Maudsley Hospital, Foulkes's ideas on groups influenced Malcolm Pines and Robyn Skynner who also taught at the Institute of Group Analysis in London (Behr & Hearst, 2005).

According to Foulkes (1957), the development of a person as an individual is inseparable from the group from which he comes from. Foulkes described an individual's disturbances as the incompatibility between the individual and their original group (family). He believed that there is no such thing as an individual that exists apart from and outside the social (Foulkes, 1948). He believed that the “so-called inner processes” were internalised group dynamics. Foulkes thought that it was the impulse to communicate that was primary in the development of the mind. Thus, the process of communication itself is seen as the operational basis of therapy in the group and a disturbance of communication is considered to be at the roots of mental illness (Foulkes & Anthony, 1957, p.24). Foulkes broke away from the dyadic model of group therapy and introduced a model of analysis based on the notion of a communication network (group matrix), in which disturbances and normality were lodged in the group as a whole. The group is seen as a collective therapeutic agent



towards its members. These views on the theory and practice of group psychotherapy have had a wide influence in the UK and in Europe (Behr & Hearst, 2005). Foulkes's contemporary followers include Pines, Urlic, Canete, Restek-Petrovic amongst others.

Colleagues and the followers of Bion and Foulkes in the UK collaborated to further develop group psychotherapy in the therapeutic community, a model still strongly influential today in the treatment of patients with psychosis. Kennard (2004) states that the democratic aspect and the flattened hierarchy of this model encourage patients to take responsibility for their treatment and help reduce their dependency on professionals. Institutional therapeutic communities were actively developing during 1950s, 1960s and 1970s across the UK (Henderson Hospital, Cassel Hospital, Maudsley Hospital, Mill Hill Hospital). Through the series of patient and staff group meetings patients are taught to analyse current social tensions in order to understand the effect that their behaviours have on others; they learn how to relate more effectively to others and understand the obligations they have towards each other that could lead to closer relationships (Mackie, 2016). Therapeutic community model and group psychotherapy were further adopted by antipsychiatry movement in 1960s represented by Laign in England, Szasz in the USA and Foucault in France (Mackie, 2016). These analysts fought against the objectification of the mentally ill; they argued that madness was a product of society and advocated for psychosocial methods in psychiatric practice.

## **Part Four: Current trends in PGP for Psychosis**

Currently there is growing tendency to positive eclecticism in the provision of PGP for psychosis. Previously held concepts are emerging as problematic as practice of PGP for psychosis develops. Early psychoanalytic approaches seeking to create extreme regression in order to then reconstruct the psychic structure of the subject have caused many patients to deteriorate. Although some select patients have benefited from such an approach, the likelihood of conducting such treatment of the necessary intensity and length today became even smaller. Most therapists who now work with this approach agree that the objectives and the techniques used for treating patients with psychosis should be different from classic PGP used in the treatment of patients with minor disorders (Ruiz-Parra et al., 2010). They argue that the main objective of therapy should be to strengthen the functions of the self, especially reality testing, where a transference relation with the therapist is considered to be essential in order to establish and continue the treatment.

There are specific aspects of PGP and its modifications when applied to patients with psychosis that are being discussed in the contemporary literature (Schermer & Pines, 1999; Urlic, 2010; Ruiz-Parra et al., 2010; Restek-Petrovic et al., 2014a). These are:

- more active engagement of the group by the therapist rather than neutral stance of the therapist;
- focus on the here-and-now rather than there-and-then;
- avoiding interpretation of unconscious material, especially at the beginning of the treatment;

- the use of upward interpretations (interpreting primitive processes in terms of more mature ones);
- setting limits on free association (no monopolizing or cross talk rules);
- selective interpretation of transference;
- frequent detoxification of countertransference reactions;
- the creative use of metaphors to facilitate group communication and patients' self-expression;
- a supportive institutional context.

There are several detailed accounts of PGP for patients with psychosis in current literature and detailed descriptions of this approach (Chazan, 1993; Gabrovsek, 2006; Canete & Ezquerro, in print; Homberg, 2013; Koukis, 2009; Urlic, 2012; Restek-Petrovic et al., 2014; Aiello & Ahmad, 2014), some of which have been manualised (Lajer & Valbak, 2005; Ruiz-Parra et al., 2010). All reviewed accounts of PGP were in agreement that classical group psychoanalytic techniques required certain adaptations when applied to patients with psychosis, requiring more flexible application of PGP principles. Providing these supportive modifications are observed, PGP can be a meaningful and useful therapeutic intervention for patients with psychosis. The examples of these modifications are presented below.

### **Working with the transference**

In the UK, Canete and Ezquerro (personal communication) argue that in contrast to neurotic patients with whom analysis tends to emphasise the internal world, external reality must not be underestimated in the treatment of patients with psychosis. They

argue that transference interpretations tend to be perceived by patients with psychosis as an accusation that the problems they bring are not real or serious (but are only a product of their minds) which can intensify defensive reactions. They suggest that it is better for patients with psychosis to start working on the concrete level of their difficulties (Canete & Ezquerro, personal communication).

In Spain, Ruiz-Parra et al. (2010) argue that rather than focusing on the relationships between the group members and the therapist and the group it is more useful, and less threatening, to provide the patients with the possibility of discussing the difficulties found in their current interpersonal relationships outside of the group. This permits a certain emotional distancing that prevents the emotional tension levels of the patient and of the group from increasing to harmful levels. The here and now of the group should still be considered by the therapist and should inform the therapist's interventions rather than be interpreted.

In Italy, Homberg et al. (2013) introduced a group psychotherapy approach to treating patients with psychosis based on psychodynamic teachings of Fagioli (1972) known as "Teoria della nascita" (Human Birth Theory). Fagioli postulated that in mental illness the capability to recognize human reality was particularly lacking and that the psychotic patients' unconscious dynamics may even cause a total loss of contact with human reality. This inner black out automatically leads to a disturbed way of relating to others and to difficulties in knowing human reality. In group therapy Homberg et al. (2013) try to understand (and change) the patients' disturbed ways of relating with the therapist and the group. They hypothesise that improvement in the therapeutic relationship is caused by (partial) recovery of the libido capabilities

and will be followed by a general improvement in relating and by a reduction of clinical symptoms. These authors do not advocate working directly on the symptoms, but rather building the therapeutic relationship and then cautiously interpreting it, in order to modify it.

In the US, Semmelhack et al. (2009) advocate the group-as-a-whole approach as a helpful way of developing group cohesiveness in patients with psychosis and reducing levels of anxiety and depression in these patients. This model is defined as a deep psychological processing, where interpretations address processes operating outside the current awareness of the group. Unconscious dynamics are explored as they manifest in the here-and-now. One of the main goals is to increase the connectedness and cohesiveness of the group. The group-as-a-whole approach is considered useful in treatment of the severely mentally ill because most other environments contribute to these patients feeling isolated or by isolating them, not least because the members' isolation is part of their inner world as well as their relation to the external world (Semmelhack et al., 2009).

### **Interpretation and working with the unconscious**

Canete and Ezquerro (personal communication) propose a way of intervening in groups with patients with psychosis which they call "cumulative interpretation". They suggest that interpretations in these groups may have to be delivered gradually over weeks or even months, starting with a description of what is easily observable and accessible for the patient and only then moving into the less obvious meanings.

Ruiz-Parra et al. (2010) and Croatian analysts Restek-Petrovic et al. (2014) proposed not to make any references to unconscious aspects, particularly in the beginning of the treatment. They argued that to do so would distance the patient from their relationship with the real world and generate states of regression and serious emotional tension that favour psychotic decompensation.

In contrast, Resnik (1994) and Skolnick (1994), who worked around the world with patients with psychosis in groups, advocated an in-depth interpretative approach. They argued that patients with psychosis were able to gain much understanding in groups with the help of analysts who refrain from psychoanalytic jargon to convey more simply the meaning of the underlying unconscious phantasies. This approach to working in-depth with the unconscious of patients with psychosis was found to be controversial. Resnik (1994) highlights that the containment of the setting of the hospital and the family is necessary to assure the safety of the patient when one works in-depth with such patients, as when the delusion diminishes the depressive feelings, which were defended against, step in.

It is often argued that patients with psychosis have limitations on a symbolic (language) level and thus might struggle to make use of the group context where treatment is heavily reliant upon the members' verbal communication. Resnik (1994) suggests that there are various modes of communication in group which are equally meaningful and include gestures, stereotypes, mannerism, and pre-verbal expressions, which are all material for analytic study of the patients' and the group's internal dynamics. Stone (1998) also suggests looking at the language of action of patients with psychosis where absences and lateness in the group sessions can be

formulated as self-protective and self-stabilizing or as resistances.

Canete and Ezquerro (personal communication) highlight that in PGP patients with psychosis can make good use of metaphors to gain understanding without feeling overwhelmed by emotions that are too personal. Metaphor is able to reveal the depths before stirring the surface, which can help patients make links and facilitate understanding of their past and difficult realities, without them feeling too frightened or exposed (Canete & Ezquerro, personal communication). Importantly, words are not always used to carry emotional effects and to commutate meanings. Instead they can be used as ways of attacking emotional links between the group members (Hinshelwood, 2008).

In addition, when working with psychosis, therapists rely on their understanding of their countertransference reactions as a major source of communication with the patient as these patients heavily rely on the protective evacuative function of their projections. The therapist's capacity to examine the affects stirred up within the course of treatment and their ability to use these responses in their interventions becomes a central element in the carrying out the treatment (Stone, 1998; Urlic, 2010; Martindale, 2007).

### **Group processes**

In Denmark, Lajer and Valbak (2005) identified four phases of the group process: establishment, interaction, integration and termination. Although these phases tend to suggest the chronological order, the development of the group process is generally

considered to be uneven and can go back and forth. Several phases may be present in the group in the same session. Certain techniques are associated with particular phases by these authors (Appendix Two). In general, a more supportive approach is suggested in the early stages of group development, becoming more exploratory and insight-oriented in the later stages. Ruiz-Parra et al. (2010) and Urlic (1999) recommend that in the early stages of the group development, therapists should respond to a regressive relationship from group members in order for their childhood needs to be satisfied. In the later stages therapists should facilitate the patient's passage from a passive role to a relatively active one, assuming responsibility for one's life. Lajer and Valbak (2005) provide a detailed description and definition of the general therapeutic guidelines, specific therapeutic techniques and the therapist's tasks in PGP for psychosis (Appendices One, Three and Four).

### **Therapist's qualities and style**

Lajer and Valbak (2005) define the therapist's style when working with patients with psychosis as characterised by empathy, humour, transparency, activity and gratification (as opposed to neutrality, opacity, pending seclusion and frustrating position). Urlic (1999) adds that when working with patients with psychosis in groups, therapists must convey 'unpossessive' warmth, empathy, genuineness and must possess extensive experience. He adds that the role of the therapist depends on the group context and situation and that it develops as the group moves from one phase to another. Urlic (1999) argues that the level of the therapist's interference and activity should be carefully balanced in order not to leave the patients unprotected and overwhelmed by the lack of guidance and structure but also so as not to interfere with the individual and the group's realisation of their therapeutic potential.



## **Part Five: Unique advantages of PGP for patients with psychosis**

Experts argue that PGP has some distinct advantages over individual therapy for patients with psychosis (Urlic, 2012; Gonzalez De Chavez, 2009; Chazan, 1993; Restek-Petrovic et al., 2014). One of the advantages of group therapy with patients with psychosis is that, in contrast to individual therapy where patients are more directly exposed, a group setting can allow them to participate to the degree with which they feel comfortable. Being part of a group can address the psychotic patient's anxiety about being too close to others and being annihilated or devoured by others, or their fear that their rage is murderous (Pao, 1979), all of which is addressed by the group in offering these patients an opportunity to be engaged as little or as much as it is possible for them. Some authors (particularly during the 1970s and 1980s) argued that these patients should be spared from any highly expressed emotion that is generated by being in a group. To contradict this long held belief, recent research (Winship & Hardy, 2007 as cited in Winship, 2009) as well as clinical evidence show that these groups presented with very low violence rate (one incident per 40000 of hours of therapy), pointing to group therapy potentially being a safe and effective way of treating these patients despite such prior concerns.

Group therapy provides a therapeutic context with horizontality, neutrality and greater independence for the patients compared to individual or family therapies. The group facilitates the therapeutic relationship on a more realistic basis because the transferences are multiplied and diluted, thus correcting distortions and idealizations and decreasing symbiotic dependencies (Garcia-Cabeza & Gonzalez de Chavez, 2009; Urlic, 2010).

Urlic (2010) emphasises that the group becomes a container for unbearable feelings because it offers a specifically protected space for free exchange of feelings and thoughts and thus has a greater therapeutic potential. “The group” can offer better containment for the distressing psychotic falling apart type of experiences than can be provided by the individual therapist. Skolnick (1999), building on Bion, links psychosis with group processes and argues that group has a unique healing quality, where it becomes the container that protects its members from nameless dread and annihilation. Hinshelwood (1987; 2008) also introduced the idea of a group as an arena where unconscious conflicts of the individuals are dramatized and externalised. He viewed the group as a container required to contain the intolerable experiences of the individual members, where the focus of the analyst is on the organization of the group itself and the linkages that go on between the minds of the group members.

The group may serve as an auxiliary ego-structuring mechanism (Lavarenne et al., 2013) for its members who struggle with fragile ego boundaries as the group acts as a containing object by establishing firm boundaries and by mentalizing patients’ psychotic experiences. The group may become for these patients a solid object representation introjected by the patients themselves, which facilitates in turn their capacity to bear difficult feelings and to think. Over the time spent in the group patients improve their capacity to withstand relationships as the group, with its structure, is seen as a containing and thinking apparatus (Bion, 1962) which allows patients to bear the complex feelings that come up once they enter the realm of relationships with others.

According to Urlic (2012), PGP facilitates the expression of some degree of

regressive psychic functioning and allows a corrective emotional (symbiotic) experience to occur. Dependence on the group can often be more tolerable for the patients with psychosis whereas dependence on the therapist can be resented and denied (via envious rejections). Group patients are often more able to bear plain speaking from a fellow member than from a therapist (Chazan, 1993; Canete & Ezquerro, 2006).

The group is not perceived as an authority figure in a delusional system which divides the world into “us” and “them”, the therapist becomes part of “them” and resistance develops. Since group members are perceived as “us”, the patient is more likely to come to accept their observations concerning reality distortions (Chazan, 1993, p.168).

Kanas (1999) suggested that for many psychotic patients group therapy was their primary socializing experience and that patients should be encouraged to look at each other and relate interpersonally in the here-and-now. Chazan (1993, 1999) adds that PGP allows these patients to address issues of loneliness, emotional dependence and a sense of ineffectiveness by helping them to communicate better by developing common language, by using the group as a workshop for interpersonal relating. It also helps to improve reality testing by patients' experiences being mirrored in others. Kelman (1963) stresses that the context of group therapy allows patients to share experiences and directly meet other patients with disorders similar to theirs. This can help free them from the experiences of uniqueness, acquiring a more realistic view of themselves and gaining greater insight into their own problems.

Koukis (2009) argues that the group illuminates the dialogic and social nature of the mind, thus helping patients to gradually attribute their voices to themselves rather than external sources. In the group a large number of interpersonal and transpersonal

relationships allows for triangular or oedipal situations to emerge between analyst, group and the patient where patients become more familiar with these dynamic and are less afraid of them.

Finally, the group offers a particular structure in which each member can feel himself to be not only a patient but also to have an important role in others' treatment. In symbolic terms, when the patient can exist as a part of the providing breast, as well as feeling himself to be a needy infant, there is a mitigation of envy and hostile destructiveness (Canete & Ezquerro, 2006). For patients with psychosis this is a valuable therapeutic factor in its own right as it promotes a sense of confidence and well-being when they realise that, besides their problems, they have something to give to others.

## **Part Six: Literature Review on Efficacy and Effectiveness of PGP for Psychosis**

Psychodynamic interventions for people with schizophrenia, both group and individual, have been a controversial issue among many researchers (Coons, 1957; Roback, 1972; Kanas, 1986; Mueser & Berenbaum, 1990; Scott & Dixon, 1995; Mojtabai et al., 1998; Paley & Shapiro, 2002; Tarrier et al., 2002; Kennard, 2009; Hinshelwood, 2004; Willick, 2001) ranging from being considered an effective treatment for chronic schizophrenia to issuing a moratorium on using individual psychodynamic intervention for patients with psychosis. Clinical guidelines in the UK (NICE, 2014) and in in the USA (PORT, 2002) do not recommend psychodynamic interventions with psychotic populations based on the lack of evidence available regarding its clinical effectiveness and efficacy. This

recommendation has been widely debated and contested by several authors and researchers (Gottdiener & Haslam, 2003; Rosenbaum et al., 2013).

Such a climate of scepticism towards the contributions of psychoanalytic thinking to the treatment of psychoses continues. Although psychoanalytic treatment does not have a vast body of empirical evidence compared with medical and pharmacological treatment or other psychological interventions, like CBT, Shedler (2010) argued that existing empirical evidence which supported the use of psychodynamic treatments and therapy processes was often underappreciated. Additionally, it is rarely acknowledged that other therapeutic modalities are effective if they use unacknowledged psychodynamic elements and that the outcomes focused on symptom reduction are often unable to reflect the benefits derived from psychodynamic treatment. The goal of psychodynamic treatment goes far and beyond acute symptom alleviation fostering in addition inner capacities and resources which enable patients to live life with a greater sense of meaning, freedom and possibility. Such goals pose challenges to the development of appropriate outcome measures (Shedler, 2010; Rosenbaum, 2014).

There are further challenges which confound the issues of research into the effectiveness of PGP:

- longer treatment and follow-ups in psychodynamic research make it harder to offer large statistical numbers (Shedler, 2010);
- the 'ambiguity' of the concept of psychosis (Gabrovsek, 2009);
- heterogeneity of the patients (Hummelen, 1994; Bentall, 1988);

- issues around the theory and conceptualization of the complexity of groups (Scheidlinger et al., 1997; Opalic, 1990);
- the great variation in types of groups and the unavoidable uniqueness of each of them (Dies & Mackenzie, 1983).

Encouragingly, recent studies have begun to accumulate and provide data that PGP can be an effective intervention for a number of disorders, including depression, personality disorder and anxiety states (Robinson et al., 1990; Budman et al., 1998; Bateman & Fonagy, 2008). However, robust research into the effectiveness of PGP for psychosis is still very scarce. In a commonly cited review of empirical evidence of PGP for schizophrenia, Kanas (1986) concluded that psychodynamic (insight-oriented) group psychotherapy was not only ineffective but possibly harmful with this subject population. More recent reviews of existing studies on group psychotherapy (Burlingame et al., 2003; Kösters et al., 2006; Blackmore et al., 2009; Segredou et al., 2014; Orfanos et al., 2015) and on psychosocial interventions in schizophrenia (Paley & Shapiro, 2002; Mojtabai et al., 1998; Scott & Dixon, 1995) point towards an overall effectiveness of group psychotherapy while also highlighting the limitations of the methodologies of such studies. Sadly, these reviews fail to identify a single RCT study of the effectiveness of psychodynamic group psychotherapy for patients with psychosis and highlight the need for further studies in this area (Appendices Six and Seven).

### **Aim of the literature review**

Following the much debated issue of the clinical benefits of PGP for patients with

psychosis, the aim of this review is to collect and assess the most recent evidence for the effectiveness of PGP as a treatment for patients with schizophrenia and other psychosis, however scarce it is.

### **Methodology for the literature review**

A thorough literature review was carried out to achieve the aims set out above. A comprehensive literature search was conducted through the e-databases including Medline, PsycArticles, PsycInfo, PEP and CINAHL in November 2011 and reviewed again in November 2014. Studies were selected if their results were published in English with evaluation of PGP that included a control or comparison group or pre-post data. As no proper randomised control study of the effectiveness of PGP with psychotic patients was identified, so called observational studies<sup>2</sup> were also selected in order to maximise the number of studies included. Reference lists from included studies and identified reviews were followed up and contact was made with the on-line membership group of The International Society for the Psychological Treatments of the Schizophrenias and other Psychoses (ISPS) to ensure that all up to date research was included.

In his review Kanas (1986) included the studies on psychodynamic group psychotherapy undertaken prior to 1986. Thus the present review focused on more recent studies carried out since 1986 up to and including 2014. Search terms and its outcomes are reflected in Table 1.

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<sup>2</sup>Observational studies involve the direct observation of individuals in the therapy setting and include measuring scales of observed behaviors. In observational studies the assignment of subjects to groups is observed rather than manipulated (e.g., through randomization) by the investigator. This is a particular common research in the areas where ethical issues of access to treatment pose difficulties to RCT studies (Carlson & Morrison, 2008).

**Table 1:** Overview of the search strategy

Search #	Search terms	Limiters / Expanders	Results
S1	“schizophren* or psychosis or psychotic”	Limiters - Publication Year from: 1986-2014; English; Age Groups: Adulthood (18 years & older); Exclude Dissertations; Exclude Book Reviews; Exclude Non-Article Content; Exclude duplicate MEDLINE records	101899
S2	S1 AND “psychodynamic group therapy”		10
S3	S1 AND “psychoanalytic group therapy”		6
S4	S1 AND “dynamic group therapy”		1
S5	S1 AND “psychodynamic group psychotherapy”		5
S6	S1 AND “psychoanalytic group psychotherapy”		7
S7	S1 AND “dynamic group psychotherapy”		4
S8	S1 AND “group analysis”		201
S9 <sup>3</sup>	S1 AND “group therapy”		437
S10	S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9		610

The primary inclusion criteria was that the studies had to be on psychodynamic and psychoanalytic group intervention with a population of adult patients with schizophrenia or other psychosis. Studies were excluded if the intervention was defined other than psychodynamic (cognitive behavioural therapy, psychoeducation etc.) and not group oriented (individual or family therapy). Studies were excluded if the subject population did not have a diagnosis of schizophrenia (bipolar, comorbid or personality disorders; family members or carers) or if they were theoretical papers,

<sup>3</sup>The term “group therapy” was used to widen the search due to the already mentioned lack of clarity and description of the theoretic orientation of the group therapy in the titles and abstracts of the studies. The initial search which did not include term “group therapy” missed several papers which were identified through following up the reference lists of the identified reviews.



dissertations, comments, reply records or duplicates.

Titles and some abstracts from the resulting 610 records were then screened according to the inclusion/exclusion criteria stated previously, which led to the identification of 23 relevant records. Out of the 23 studies identified, a further 11 studies were excluded following a screening of the full text of the articles, since they were reviews of reviews, theoretical discussions or case studies. As a result, 12 studies were included in the review below (Appendix Five).

To synthesize evidence data from the studies selected for this review, the investigator followed both the Guidance for Undertaking Reviews in Health Care (CRD, 2009) and Wardlaw's advice on writing systematic reviews (Wardlaw, 2010).

### **Summary of the content of the selected studies**

The studies varied in the clarity of the approach description. Seven studies included in this review addressed PGP (Gonzalez de Chavez et al., 2000; Garcia-Cabeza & Gonzalez de Chavez, 2009; Sigman & Hassan, 2006; Pesek et al., 2010; Pesek et al., 2011; Restek-Petrovic et al., 2014a, 2014b), three studies addressed psychoanalytically oriented group psychotherapy (Wode-Helgodt et al., 1988; Isbell et al., 1992; Johnson et al., 2008), one study addressed PGP within the existential tradition (Opalic, 1989) and one study specified the group-as-a-whole or Tavistock model (Sammelhack et al., 2009).

The subject population in all studies mainly consisted of patients diagnosed with

schizophrenia or schizoaffective disorder. Patients in all studies received medication. Only four studies used comparison groups (Gonzalez de Chavez et al., 2000; Johnson et al., 2008; Opalic, 1989; Restek-Petrovic et al., 2014b) and one study used random allocation to different treatment conditions (Johnson et al., 2008). Most studies used a convenience sample, recruiting patients from existing groups only or included those patients who were motivated to participate. The length of treatments varied from 5 to over 300 sessions with varied frequency. The studies also varied in the description of the experience and training level of their therapists. All the studies used varied, often not validated, outcome measures and overall concluded on the efficacy of PGP (not always statistically significant) with the exception of one study (Wode-Helgodt et al., 1988) where half of the patients improved regardless of whether they received PGP or not. A summary of these studies' characteristics is presented in Appendix Five.

### **Selected studies' aims**

The studies reviewed varied in their aims. Eight studies focused on the evaluation of the efficacy of long term PGP (Wode-Helgodt et al., 1988; Isbell et al., 1992; Sigman & Hassan, 2006; Pesek et al., 2010; Pesek et al., 2011; Opalic, 1989; Restek-Petrovic et al., 2014b; Semmelhack et al., 2009), three studies looked at the therapeutic factors of PGP for patients with schizophrenia (Gonzalez de Chavez et al, 2000; Garcia-Cabeza & Gonzalez de Chavez, 2009; Restek-Petrovic et al., 2014a), and one study looked at the evaluation of the patients' baseline characteristics in the impact on effectiveness of PGP and group CBT comparatively (Johnson et al., 2008).

The aim of the studies which addressed group therapeutic factors in PGP for

psychosis was to learn preferential evaluations of therapeutic factors in order to establish similarities and differences with regard to the stage of therapy, duration of therapy, therapy setting and patients' sociodemographic characteristics. These latter studies represent a new era in group psychotherapy research and seek to evaluate the significance of therapeutic group factors for different patient groups and try to assist in selecting patients for whom PGP would be the most beneficial intervention (Restek-Petrovic et al., 2014a).

Studies focusing on the evaluation of social functioning and interpersonal relationships (Restek-Petrovic et al., 2014b) also represent a shift in the symptom reduction medical paradigm of the assessment of the recovery process and recognize that patients with psychosis have most difficulties in the area of interpersonal relationship. These studies include social functioning as a variable in the recovery process as a patient's recovery requires reintegration and resocialization (Slade, 2009).

### **Quality of studies reviewed**

The absence of control groups in most of the reviewed studies emerges as the main methodological shortcoming. The three studies which did use a control group either did not state whether randomisation was applied (Opalic, 1989), or selected patients on the basis of either their suitability for the group (Restek-Petrovic et al., 2014b) or accepted those who agreed to participate in the study (Semmelheck et al., 2009). To be able to provide reliable evidence for the effectiveness of the treatment it is necessary to provide a randomly selected control group in order to account for spontaneous recovery and the fluctuating nature of psychotic illness (McPherson et

al., 2005). The issue of randomisation has ethical complications linked to the denial of treatment or prolonging the wait. However, without adequate control groups it is impossible to establish whether post therapy changes were associated with specific or non-specific aspects of PGP, thus severely diminishing the value of positive findings in the reviewed studies.

### **Establishing the diagnosis and selection of the participants**

Nine out of twelve studies referred to the use of the DSM-IV (APA, 1994) or ICD-10 as diagnostic tools for selecting patients. Three studies referred to the psychotic or schizophrenic nature of their subjects' disorders, but did not use standard diagnostic tools. Only Isbell et al. (1992) described the heterogeneous nature of the psychotic disorders and reflected on the complexity of the condition and difficulties in the precision of the diagnosis, which would affect the transferability and generalisability of findings.

The issue of the patients' assessment of suitability for group treatment adds another dimension to selection bias (Valbak et al., 2003; Johnson et al., 2008). Often to be included into PGP patients have to undergo extended consultations to assess their suitability for the group. For example, Restek-Petrovic et al. (2014a) reported the following criteria for admission to PGP: a) sufficient cognitive and introspective abilities, at least minimal motivation for change, and partial insight into their difficulties, as well as the ability to tolerate anxiety; b) any patients affected by a neurological disorder were excluded, as were acutely psychotic (particularly paranoid) patients, patients with comorbid addictions, those with excessive destructive experiences in the primary family and patients with low comprehension

skills. The lack of randomisation combined with a selective criteria of accepting patients into group treatment also represents a severe limitation for the generalisation of these studies' findings.

### **Sample sizes of the reviewed studies**

A major weakness of all studies is the small number of subjects, which in most cases led to the inability to establish any valid statistical conclusions and raised concerns over the selection bias itself (Isbell et al., 1992; Sigman & Hassan, 2006). Thus the studies' samples might not reflect the heterogeneity of the psychotic population and adversely affect the generalisability of the results.

### **Treatment and treatment duration**

In order to select studies for this review a broad operational criteria has been used, adapted from Blackmore et al. (2009), which states that therapy has to have been delivered in groups by an interpretative or analytic procedures. This potentially creates omissions in the proposed search strategy as some studies might have delivered PGP but failed to state this explicitly. The treatment interventions were not standardised in all of the studies and contained confounding issues. The declared style of intervention in most studies lacked clarity and often did not take into consideration the training background of the therapists involved, also making it impossible to account for the quality and consistency of the effectiveness of the intervention delivered.

The length of treatment varied considerably, ranging from a few sessions to hundreds

of sessions. Nine studies commented on longer PGP treatment being more effective but could not support this with statistical data (Sigman & Hassan, 2006; Isbell et al., 2010; Restek-Petrovic et al., 2014a, 2014b) due to the absence of a control group. Most studies did not account for the significant differences in the length of treatment among their subjects and their implications on the outcomes of each study. As all studies report positive outcomes of their treatments and 9 out of 12 studies are of long-term duration with varied intensity, it is difficult to state whether the duration or intensity of treatment is most relevant to the outcomes. Eleven of the studies did not account for the drop-outs and their implications.

A highly important finding was mentioned by Pesek et al. (2010; 2011) where the best outcomes were observed for those patients who attended the group for three to five years. It was speculated that patients who stayed in the groups for longer struggled to separate from the group and move on to social settings outside of the group. Their finding of the negative correlation between social interaction and the time spent in a long term PGP suggests that there maybe an optimum time at which the patients should leave the group.

### **Outcome measures and statistics**

As schizophrenia and psychotic illnesses in general are characterised by chronic nature and severe overall functioning impairment, choosing appropriate treatment outcome measures is highly important. It has only relatively recently been established that recovery should be understood as being much broader than simple symptom alleviation (Slade, 2009). Recovery in the view of the schizophrenic patients may mean the continued presence of the symptoms but without their

debilitating impact (Slade, 2009). Such newly informed perspectives on recovery were reflected in the outcome measures chosen in the recent studies reviewed, which included further holistic measures such as quality of life scale, working alliance inventory and the assessments of social functioning (Johnson et al., 2008; Pesek et al., 2010; Restek-Petrovic et al., 2014b). Only five studies successfully combined symptom and overall functioning evaluation outcome measures (Opalic, 1989; Wode-Helgott et al., 1988; Johnson et al., 2008; Pesek et al., 2010, 2011), where researchers used a combination of validated outcome measures for both symptomatic and social/group functioning as well as interviewing participants about their personal experiences to inform the interpretation of its findings.

As most of the studies did not use a control group, the inclusion of pre- and post-treatment comparisons might have inflated any estimated effectiveness and provides no control for spontaneous remission. Ten studies commented on the low statistical validity of their outcomes due to the small samples used, thus necessitating future studies to employ larger samples and stronger statistical designs. Johnson et al. (2008) were able to statistically support their conclusion that patients with schizophrenia were more likely to benefit from group treatment if they had a higher level of insight, lower autistic preoccupations and lower social functioning. They also concluded that there was no statistically significant difference between benefits received by patients from PGP or group CBT. Opalic (1989) discovered statistically significant group psychotherapy effects on the patients with psychosis, where patients with psychosis reported greater understanding and trust among people, adopted a more realistic attitude towards their illness, and felt a sense of greater internal and social freedom as well as potential and significant change in the negative

view of their individual position in the society. Wode-Helgodt et al. (1988) discovered a statistically significant reduction in the amount of medication taken and the number of days on psychiatric ward, but none of the employed evaluation instruments revealed any difference in the improvements between PGP patients and the control group. The researchers speculated that the initial differences between PGP patients and control group patients may have concealed a slight positive effect of therapy.

Restek-Petrovic et al. (2014b) showed that patients from PGP had four times fewer hospitalisations during the duration of treatment than patients from the control group and that twice as many patients from PGP group turned to their psychiatrists for help, possibly indicating an increased potential to experience hope in treatment outcomes and thus a greater therapeutic alliance. Semmelhack et al. (2009) concluded that the decrease in anxiety levels and the increase in sense of connectedness and reduced isolation were statistically significant after 10 weeks of PGP compared to the control group. They proposed that such reduction in the level of anxiety might be linked with the reduced sense of isolation and an increased sense of connectedness. The rest of the studies reported that the observed improvements were not statistically significant, which diminishes the validity of their conclusions about overall PGP effectiveness.

### **Follow-up**

Only Wode-Helgodt et al. (1988) carried out a follow-up evaluation two years after the completion of PGP, but the dropout rate among the control patients was so large that it was difficult to say anything about differences between them and the PGP patients. The rest of the reviewed studies did not collect the follow-up data, thus



leaving the issue of the retention of the treatment gains unsettled. All of the studies but one failed to state information on attrition rates. This might have to do with the overall long duration and open-endedness of PGP, but it can deceptively inflate positive findings.

### **Limitations of the literature review**

It is widely acknowledged that user involvement in the systematic review process is important, most notably to ensure that the review findings are credible and useful. Although the author acknowledges that it is very important that patients understand and are involved in systematic reviews as they have a big influence on the development of health and social care services, lack of time sadly did not allow for this involvement. Thus this study is limited by the lack of patient perspective.

### **Summary of the outcomes of the literature review**

All but one reviewed studies concluded on overall effectiveness of PGP for psychosis and, notably, none of them mentioned any deterioration or negative outcomes among patients with psychosis receiving PGP, thus challenging the ideas about the harmfulness of PGP for patients with psychosis. The studies highlighted that medium to long term PGP lead to the improvement in social functioning, better adherence to medical treatment, improved quality of life, reduced stigmatization, increased hope in one's recovery and potential, an increased sense of connectedness, decreased isolation, decreased anxiety, improved insight and greater self-understanding. These promising findings need to be considered along with the methodological limitations discussed, which at present prevents the provision of conclusive evidence in regards

to the effectiveness of PGP for patients with schizophrenia. As such further research is warranted.

## **Part Seven: Summary**

This chapter detailed an overview of the psychoanalytic understanding of psychosis and its application to PGP, followed by an historical overview of the developments in PGP for psychosis with a specific focus on current trends and the unique advantages of this treatment. Finally, a thorough review of the existing literature on the effectiveness of PGP for psychosis was presented. Its conclusion was to testify to the overall effectiveness of PGP while pointing out the methodological limitations of the reviewed studies, the most significant of which is a lack of consistency and any standardisation of the PGP treatment delivered.

There are a variety of approaches and schools of thought regarding the delivery and conceptual underpinnings of PGP, but the degree of consensus and disagreement about what these intrinsic components would be has yet to be established. In order to be confident that people with psychosis receive appropriate and effective PGP, its content and delivery need clarification. The lack of robust research in this area should be addressed once it is commonly agreed what is to be understood by PGP for psychosis and which exact elements would be evaluated.

In this study the Delphi method was adopted to try to establish what an international group of experts in PGP for psychosis viewed as the intrinsic components of this treatment and to investigate their opinions on the best ways of delivering PGP to patients with psychosis. The methodology will be discussed in the next chapter.

## **Chapter Two: Methodology**

### **Part One: Introduction**

There is much debate in the literature concerning which elements of PGP should be modified and which elements should be retained when this treatment is offered to patients with psychosis. Reviewed authors varied in their views on issues such as patient suitability for treatment, application of technique (interpretation of the unconscious material and work with the transference), the therapeutic stance of the therapist (more directive versus more neutral) etc. The purpose of the present study was to try to develop a set of intrinsic components of PGP for psychosis by drawing on the expertise and knowledge of professionals currently practicing PGP for psychosis worldwide.

This chapter explains the methods used to investigate the aims of the study. Firstly, a mixed methodology is described and the rationale for its use is explained. Secondly, the distinctive features of the Delphi method and thematic analysis are described sequentially, the rationale for their employment is explained and their strengths and limitations are further examined.

The Delphi process was applied to elicit and quantify the opinions of experienced psychodynamic group psychotherapists working around the world with people with psychosis in both inpatient and outpatient settings, delivering medium to long term PGP. A method of thematic analysis was then employed to achieve additional aims for this study, which were a) to identify areas of theoretical and clinical tension through any lack of consensus among the participants and through analysis of their comments with a view to extend any knowledge and initiation of new ways of

thinking about PGP; b) to gain a greater insight and better understanding of the current ways of the delivery of PGP for psychosis through an in-depth thematic analysis of the participants' comments.

After which, this study is described with a detailed account of the data collection method through three distinct rounds of Delphi method. The recruitment procedure is outlined in detail with any limitations and their relevancy for actions taken. Accordingly, the process of thematic analysis of the collected comments is explored. The phases in thematic analysis employed to analyse the comments are explained and illustrated by examples of the investigator's analytic thought process. Any strategies employed to enhance the quality of this study are also elaborated. Finally, a self-reflective statement includes the investigator's background and any assumptions that may have influenced the conduct of the study.

## **Part Two: An Overview of Mixed Method Methodology**

In order to achieve the listed aims a mixed method design was adopted. According to Creswell et al. (2003), a mixed method research design may be defined as the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially and then integrated at one or more stages in the process of research. In this study an attempt was made, using both forms of data, to gain a deeper understanding into how PGP is delivered to patients with psychosis in current clinical practice.

The underlying epistemological position of the investigator in the application of a mixed method study was that of critical realism (Willig, 2008), that is the investigator believed there to be an objective reality and which could be

scientifically studied. The investigator recognizes that any observation is fallible and is bound to contain an element of error and that every theory is potentially revisable. A critical realism position thus emphasizes the importance of multiple measures and observations, each of which may possess different types of error, and thus the combination of which may bring about a better grasp on the subject under investigation (Hansen et al., 2005; Creswell et al., 2010). This position entails the belief that the data collected provides information about the world, about how things really are with the acknowledgement that the data the researcher gathers may not provide a direct access to this reality. When this epistemological stance is employed, it is important to design methods of data collection which facilitate true and undistorted representations (Willig, 2008).

Hansen et al. (2005) argue that qualitative and quantitative methods could be combined to use results from one method to elaborate on results from the other method and to better understand the research problems by converging numeric trends from quantitative data and specific detail from qualitative data. This can help to overcome the tension between a positivist world view that privileges objective observations and precise measurements and the constructed social realities obtained through interpretations of subjective experiences (Bazeley, 2002).

The Delphi method was used as a quantitative method to identify which components of PGP for psychosis achieved endorsement by the majority of expert participants, whereas qualitative data gathered in the form of expert comments on their rating decisions was used to identify areas of clinical and theoretical discussion in the delivery of PGP, as well as to clarify and explain why and how PGP is delivered to patients with psychosis in current practice.

It should be pointed out that the quantitative data was given priority over qualitative comments in this mixed method study and thus priority was distributed unequally between the two methods. Although such mixed methodology does not neatly fit into any one of the four types of mixed method study outlined by Hansen et al. (2005), it could be described as a concurrent design with priority given to the quantitative data of the Delphi method and any qualitative comments analysed through thematic analysis to further explore, explain and elaborate on the set of key components of PGP that the study identified. The data analysis was carried out separately and more in accordance with a sequential type of the mixed method study, and thus the mixed method design employed might be better described as a multiphase design (Creswell et al., 2010).

Data collected through both methods was independently analysed and any integration of findings took place during the interpretation and discussion of the results. Another important clarification is that the qualitative data used in this mixed method study was not intended to increase the validity of Delphi findings, but rather to contextualise the Delphi findings, develop further understandings and provide illustrate any application of PGP recommended for psychosis. Thus no data triangulation was either intended or attempted in this study.

### **The benefits and disadvantages of an applied mixed method study**

The primary advantage of the mixed method design is that multiple methods may be used in a single research study to take advantage of the representativeness and generalizability of quantitative findings and the in-depth contextual nature of qualitative findings (Greene & Caracelli, 2003, as cited in Hanson et al., 2003).

Mixed method study helps not only identify the set of key components but to explain and discuss issues around its implementation. Simply using the Delphi method would have been insufficient to capture the complexity of the research subject and to address the controversies and multiple perspectives around an application of PGP to patients with psychosis that the literature review revealed.

Some researchers argue that mixed method studies are already problematic at a philosophical and methodological level, where a postpositivist deductive paradigm is incompatible with a naturalistic inductive paradigm and thus mixed method study could be seen as unattainable (Smith, 1983, as cited in Hanson et al., 2005). According to Bryman (1988, as cited in Bazeley, 2002), mixed method studies carry a risk of corruption of both qualitative and quantitative methods if careful consideration is not given to the particular assumptions or rules and expectations regarding their conduct. Bazeley (2002) highlights issues with sampling in mixed method studies which affect the generalisability of findings. In this study, overrepresentation of participants from group analytic background and the lack of representatives from other regions (USA, South America) makes it difficult to realistically extrapolate the findings on the overall population of group psychoanalytic psychotherapists. Future studies should make specific efforts to invite participants from other theoretical psychoanalytic backgrounds and other regions globally to share their clinical experience and theoretical positions, once some primary parameters have been established by this study.

## **Part Three: The Delphi Method**

### **Rationale for selecting The Delphi method in this study**

There are many ways to research issues linked to group communication with the establishment of group consensus including brainstorming or a nominal group technique. Using the Delphi method in this study seems to be more appropriate as the logistical aspects of this study entails contacting people around the world to employ their expertise in identifying various components of PGP for psychosis as essential or not essential. The Delphi method enables the collection of opinions without needing to bring participants together physically, unlike the techniques of brainstorming or a nominal group technique. By using successive questionnaires, opinions are considered in a non-adversarial manner, with the current status of the group's collective opinion being repeatedly fed back. This informs the group members of the current status of their collective opinion and helps to identify items that participants may have missed or considered unimportant providing participants with an opportunity to change their opinions (Mckenna, 1994 as cited in Hasson et al., 2000; Adler & Ziglio, 1996).

According to Adler and Ziglio (1996) Delphi represents a reliable and creative method to explore ideas. According to Helmer (1977), Delphi represents a useful communication device among a group of experts and thus facilitates the formation of a group judgement. McKillip (1987) argues that the success of the Delphi method lies in its use of experts, utilizing their knowledge, combining it and redistributing it, which opens up doors and forces for new thought processes to emerge (McKillip, 1987).



## **Delphi definition**

Fowels (1978) states that the word Delphi refers to the city in ancient Greece where for a thousand years of recorded history people came to consult the prophetess Pythia. Her words were taken to reveal the rules of the Gods. Pythia's function was to tell the divine purpose in a normative way in order to shape coming events. Kaplan et al. (1950) referred to the “principle of oracle” as a “non-falsifiable prediction”, a statement that does not have the property of being “true” or “false”.

The first application of the Delphi method is traced by Linstone and Turoff (2002) to defence research in the early 1950's with the objective to obtain the most reliable consensus of opinion of a group of experts by a series of intensive questionnaires interspersed with controlled opinion feedback (Linstone & Taruff, 2002). The alternative method of handling this problem at the time would have involved a very extensive and costly data-collection process and the programming and execution of computer models of a size almost prohibitive on the computers available in the early fifties. The original justifications for the first Delphi study are still valid for many Delphi applications today, when accurate data is unavailable or expensive to obtain, or evaluation models require subjective inputs to the point where they become the dominating parameters.

In this study, the Delphi method is defined and applied according to Hasson et al. (2000), as a group facilitation technique and an iterative multistage process that seeks to obtain consensus on the opinions of “experts” through a series of structured questionnaires (rounds), which are completed by the participants anonymously. As part of the process, the responses from each questionnaire are fed back in a

summarised form to the participants. Although there is considerable variation in how the method is applied, the Delphi method has its own distinct characteristics which are listed in Appendix Eight.

Qualitative and/or quantitative questions can be asked of the 'experts' and the information is then analysed and fed back to each person, via further questions, and their responses are analysed and fed back, and so on, until the goal is reached, which is when a consensus is reached that offers synthesis and clarity on the question. In the Delphi method 'experts' do not directly interact with one another, so as to avoid the social processes and "contaminations" that can happen in group situations. Instead, the goal of the Delphi process is to systematically facilitate communication of information via several stages of the researcher asking questions, undertaking analysis, providing feedback, and asking further questions. Because the study involves 'experts' it is assumed that some reasonable quality information will be inputted, and because it is an iterative system, it is assumed that good quality knowledge will evolve.

Usually the Delphi method undergoes several distinct phases. Initially the subject under discussion is thoroughly explored, where each expert contributes additional information, pertinent to the issue. The next phases involve the process of reaching an understanding of how the group views the issue. If there is significant disagreement, then that disagreement is explored to bring out the underlying reasons for the differences and possibility to evaluate them. The study process is considered to be complete when all previously gathered information has been analysed and the evaluations have been fed back for consideration (Appendix Nine).

### **Strengths and limitations of the Delphi method**

According to Cuhls (2003), some disadvantages of Delphi studies are that they are complex procedures and require significant resources. Iqbal and Pipon-Young (2009) also highlight that the Delphi method commonly suffers from a lack of guidance and agreed standards regarding interpretation and analysis of results, a universally agreed definition of consensus, and a limited generalisation potential as the information comes from a selected group of participants and may not be representative. The high level of commitment required from participants is also a significant drawback. Gunaydin in his PhD on Delphi Method adds the issues of format bias and ambiguity (the format of the questionnaire or particular questions may be culturally, linguistically or theoretically unsuitable for potential participants) and manipulation of Delphi (the response can be altered by the investigator and research panel in the hope of moving the next round responses in a desired direction).

According to Gunaydin, the outcome of a Delphi method is nothing but opinion and the results of the Delphi method are only as valid as the opinions of the experts who made up the participants. Additionally, the epistemology of evidence-based medicine categorizes expert opinion as the lowest form of medical evidence as experts are constrained by cognitive biases and personal values. Tonelli (1999) argues that assignment of expert opinion to the evidentiary ladder represents an epistemic error. He asserts that rather than the lowest form of empirical evidence, expert opinion could be viewed as the highest form of clinical experience and judgement. Finally, a controversial debate rages over the issue of the term “expert” and how to identify adequately a professional as an expert (Strauss & Zeigler,

1975). However, Tonelli (1999) and Woolf (2000) highlight that both evidence and opinion have their limitation (i.e. methodologically flawed clinical research) and urge expert opinions be included when developing clinical guidelines as without such input, guidelines will lack clinical relevance and credibility.

Although there is a danger with agreement in that it may stifle conflict and debate, the employment of the qualitative data and analysis in this study was intended to encourage and explore views that might represent more radical opinions compared with the overall agreement and generate debate and alternative views. It was also hoped that participants of this Delphi study would use their participation as an opportunity to reflect on their ways of practicing and thinking, that they will ask self-reflective questions and be able to review their ways of thinking and practicing, partly as the result of participation in this project.

The major factor influencing the choice of method used in this study was the significant advantage that the Delphi method offers as an exercise in group communication among a panel of geographically dispersed experts (Adler & Ziglio, 1996). The method responds to the demand for improved communications among larger, diverse and/or geographically dispersed groups which cannot be satisfied by other available techniques. This allows for the expression of a broad range of views on which to base analysis. Besides this, there are other considerable advantages of this method. Linstone and Turoff (2002) stress that the Delphi method's ability to offer its participants an opportunity to interact with the group at their own convenience, the capacity to handle large groups, and to structure communication. They argue that the Delphi process through written communication does tend to distance participants from feelings provoked by personal interaction and thus can

minimizes psychological effects, such as conformity to the dominant view or other social pressures; therefore it is conducive to independent thinking and the gradual formulation of reliable judgements. Iqbal and Pipon-Young (2009) also add that iteration enables participants to review, re-evaluate and revise all their previous statements in light of comments made by their peers, which can be enhancing not only in terms of the validity of the outcomes of the findings but also in terms of enhancing one's clinical practice in a reflective way.

### **The identification and selection of the participants**

The Delphi method generally employs a purposive sampling technique<sup>4</sup> in the process of the recruitment of participants. The participants in Delphi studies are not selected randomly, so representativeness is not assured. Rather, they are selected for a purpose, to apply their knowledge to a certain problem on the basis of criteria, which are developed from the nature of the problem under investigation. Researchers must also decide how to conceptualise and define "expertise". The method may be undermined if the participants are recruited who lack specialist knowledge, qualification and proven track record in the field (Kennedy et al., 2001). Individuals who might provide a minority or differing perspective should be actively recruited to the panel (Linstone & Turoff, 2002).

In this study, the commitment of participants to complete the Delphi process is related to their interest and involvement with the questions being examined.

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<sup>4</sup> Purposive sampling - a form of non-probability sampling in which decisions concerning the individuals to be included in the sample are taken by the researcher, based upon a variety of criteria which may include specialist knowledge of the research issue, or capacity and willingness to participate in the research (Oliver, cited in Jupp, 2006).

Therefore, a fine balance must be struck in selecting experts who will be relatively impartial so that the information obtained reflects current knowledge and/or perceptions, yet also have interest in the research topic. Thus the technique can be exposed to both researcher and subject bias. Additionally, as the participants know the group's responses, they may change their views in line with what others are saying. However, this is also perceived as an advantage of Delphi in that this is what brings participants towards a group consensus (Hasson et al., 2000).

The number of participants depends very much on the topic area as well as the time and resources at the researcher's disposal. Although Delphi surveys have been conducted with as few as seven and as many as 1000 participants, Linstone and Turoff (2002) recommend recruiting between 10 and 50 participants and Hasson et al. (2000) between 15 and 60 participants. As in all surveys, the sample needs to be large enough to draw conclusions, therefore the number of answers per statement has to be high enough. The sample mix should comprise as diverse representation of the group of experts as possible and lobbying should be avoided.

### **Delphi data analysis**

According to Hasson et al. (2000) the level of consensus need not be universally agreed upon by the Delphi researchers. In defining the level of consensus consideration should be given to the sample numbers, the aim of the research and available resources. McKenna (1994) drawing on Loughlin and Moore's work (1979) suggests that consensus should be equated with 51% agreement amongst respondents, Sumsion (1998) recommends 70%, while Green et al. (1999) opted for

80% (as cited in Hasson et al., 2000). Graham and Milne (2003) used 65.5% and above agreement amongst respondents.

Morrison and Barratt (2010) in their Delphi study trying to establish what a group of experts in CBT for psychosis viewed as important components used 80% agreement as the indicator of the component to be considered as essential and 70-79% of agreement as an indicator for the component to be re-rated in the second round, whereas all the components which reached less than 70% agreement were excluded and considered non-essential. Similarly, in an unpublished study by Kongara and Summers (personal communication, August, 2013) employing Delphi method to identify key components of individual psychodynamic psychotherapy for psychosis 80% agreement was used to define the key components and all the components which reached less than 80% of agreement were re-rated in the second round.

## **Part Four: Thematic Analysis**

### **Definition of Thematic Analysis**

The method of thematic analysis is intended to uncover certain themes or patterns of meaning across the entire dataset. “A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the dataset” (Braun & Clarke, 2006, p.82). Thematic analysis provides a flexible and useful research tool due to its theoretical freedom, which can deliver a rich, detailed and complex account of the data.

### **The rationale for use of Thematic Analysis**

Thematic analysis was chosen as the method of analysis here in order to identify, analyse and report patterns (themes) within the collected data. Thematic analysis does not require detailed theoretical and technological knowledge of approaches such as discourse analysis or grounded theory, and it can offer a more accessible form of analysis (Braun & Clarke, 2006). Moreover, thematic analysis is not wedded to any pre-existing theoretical framework, and can therefore be used within different theoretical frameworks, and be used to do different things within them.

Thematic analysis was chosen as a way of making sense of the qualitative data that this research seeks to bring forth as it is a flexible approach which can be used by a novice researcher and is a relatively quick and easy method to learn. It is a useful method for working within a participatory research paradigm and can usefully summarize the key findings of a large body of data. It also allows for any similarities and differences across the data set to be highlighted and enables further insights into the data to be generated (Braun & Clarke, 2012), which was one of the original aims of this study.

### **The epistemological position**

The thematic analysis in this study was carried out from an epistemological position of critical realism, where the ways individuals make meaning of their experience is acknowledged (the experts come from different theoretical traditions of group psychoanalytic therapy) and also the ways the broader social context impinges on those meanings, while still retaining focus on the material and other limits of



'reality' (Braun & Clarke, 2006). The assumptions underpinning this thematic analysis were that the participating experts were representatives of different theoretical traditions and that their opinions were respected and valued by other representatives of their traditions. It was also assumed that experts understood that their ratings and comments were anonymous and thus could speak freely about their ideas. Participants' comments were theorized in a straightforward way, unlike in a constructionist approach where there is a focus on the motivations and individual psychology of the participants dependant on sociocultural contexts. A critical realism approach was chosen over a constructivism approach as the investigator herself is an exponent in the field of PGP for psychosis and hence was mindful of the unintentional and unconscious bias she might have had in interpreting constructions of others.

### **The strengths and limitations of thematic analysis**

Thematic analysis is often criticised for a lack of clarity and insufficient detail in its application. In this chapter a highly detailed account of the initial coding, themes development and themes revision will be presented in an attempt to improve the transparency of the analytic process undertaken by the investigator.

In providing a set of ideas derived from a review of the literature as well as from the personal clinical experience of conducting PGP groups with patients with psychosis, the investigator attempted to reflect on her own theoretical position and acknowledged that the themes emerging, although grounded in the data through a very detailed coding, were also the result of the active engagement with the data which came from both the theoretical and clinical experience of the investigator. As

Ely et al. (1997) argue “if themes ‘reside’ anywhere, they reside in our heads from our thinking about our data and creating links as we understand them” (p.206).

## **Part Five: Procedure of the current study**

A Delphi longitudinal design over three rounds in the form of self-rated questionnaires was employed. The initial questionnaire was developed with the help of the research panel in the first round and distributed to the participants in the second round. In the third round the questionnaire based on the evaluation of the results of the second round was distributed to all participants from the second round with a request to re-rate the items which did not reach the set out level of consensus and to comment on their rating decisions. The Delphi method used in this project followed the procedure outlined by Langlands et al. (2008) and Morrison and Barratt (2010). Similar Delphi techniques have been used in other research projects in the area of treatment for psychosis (Burns et al., 2000; Fiander & Burns, 1998; Marshall et al., 2004; Langlands et al., 2008; Morrison & Barratt, 2010). The analysis of the collected data also followed the previous studies' approach using the following software programmes IBM SPSS Statistics 21 for Delphi results and MAXQDA (software designed for managing qualitative data) for thematic analysis.

### **Section One: Participants**

The participants who were invited to take part in the Delphi method were experts in the field of PGP for psychosis (ie, group analysts and psychodynamic group psychotherapists with extensive training in PGP and extensive experience in conducting these groups with people with psychosis) and some of them also

significantly contributed to the area of research in PGP for psychosis.

58 eligible participants were invited to participate. Each of them was sent information and consent forms via email (Appendices Ten and Eleven). As a whole, these participants were representative of the European region and various theoretical backgrounds. Out of those invited, 15 did not respond to the invitation, 6 declined to participate due to a lack of time or other commitments, and 37 returned signed consent forms.

The following inclusion and exclusion criteria were applied to selected participants.

Inclusion Criteria:

1. two or more years of experience of conducting outpatient medium to long term PGP groups with patients with psychosis;
2. published on the subject of PGP for psychosis or participated in the research projects in the field;
3. have been delegates to IGA, ISPS or other relevant conferences.

Exclusion Criteria:

1. retired or not in practice for more than 5 years;
2. not able to speak English to the level of comprehending the questionnaire fully.

The experts who participated in the Delphi procedure were identified by a three step procedure. Firstly, the research panel members independently recommended known experts in the field for the study. Secondly, a lengthy and extensive search was carried out to identify potential experts from every world region by contacting relevant international organisations and associations, professional organisations and training institutions. Thirdly, following email communication with the experts who have previously been identified, new experts were referred to the study. All referrers and organisations contacted were sent inclusion and exclusion criterion for future referral of eligible participants. The followed recruitment process of eligible participants was intended to give as vast as possible geographical and theoretical background coverage.

These participants were recruited mainly with the help of ISPS International and its branches across the world, IGA (Institute of Group Analysis) and the personal contacts of the investigator and members of the research panel. The individuals who were willing to participate were asked to email their consent to the investigator and follow the link to the online questionnaire where they were asked to anonymously rate a set of statements deemed pertinent to PGP for psychosis.

The group of participants selected for the research represented mainly European regions (e.g., UK, Spain, Italy, Denmark, Germany, Spain, Croatia, Switzerland), different levels of expertise (manual authors, principle research investigators, supervisors, therapists), diverse theoretical schools of group psychoanalytic thinking (integrative psychodynamic, group analysis, group-as-a-whole approach, school of Fagioli), working in private and public sector, and working in different therapeutic settings (co-therapy, various duration and frequency of the sessions).

Two groups of participants were involved: 37 respondents to the questionnaire who were referred to as “participants” and five experts who were referred to as the “research panel”. The research panel members contributed to the development of the questionnaires and the interpretation of subsequent data but did not take part in responding to the questionnaire. It was deemed impractical to involve participants in the first round of the development of the questionnaire as it required an investment of time and resources beyond the scope of this project to collect the feedback from originally estimated 40-60 experts on both minor and major changes in the statements list and re-email the amended questionnaire, wait for further feedback and re-email again until all participants felt that it was ready for rating.

In the first round of compiling the set of statements five UK based experts in the field of psychoanalysis, PGP and psychosis were originally approached to participate on the panel of experts who would moderate, comment and revise the initial set of statements and originally they agreed to participate. However, all the aforementioned experts but one withdrew their participation when they were contacted by the investigator with the invitation to review the original set of statements due to the lack of time and other commitments. The recruitment of a new group of panel experts significantly held back the research time frame. A new group of experts was approached and included representatives from group-as-a-whole approach, group analysis, integrative PGP and PGP grounded in object relations theory. These panellists were representatives of both UK and European regions.

For the recruitment of the participants a purposive sampling method was employed. This procedure meant that all participants held senior positions in their respective organisations and had either published or specialised in the area of offering PGP to

people with psychosis. In addition, the experts collectively represented mainly the European region and wide range of psychoanalytic theoretical backgrounds in group work and various practice settings. This approach was intended to ensure that the key aspects of PGP for psychosis identified were more likely to reflect the most important and most widely applied aspects of the intervention in various countries.

While experts were invited to participate from across the world, no experts from South America and few from North America were either identified or responded, thus leaving out centres with significant practice and research expertise on psychoanalytic practice, which posed a significant limitation to this study. Consequently, caution should be applied when recommending the key components identified as gold standards of PGP for psychosis globally. Nonetheless, the key components identified in this study reflect some of the international context, based on which, with the help of future research, a definition and a model of PGP for psychosis could be developed. These findings may also contribute to more coordinated international research and an identification of gaps in the theoretical and practical applications of PGP for psychosis.

## **Section Two: Procedure of the Delphi method**

### **Round One (February-June 2014)**

Before the first round five manuals were identified which described PGP and these were consulted in depth when developing a set of statements for the Delphi study: by Gonzalez de Chavez (integrative psychodynamic), by Valbak and Lajer (psychodynamic for patients with psychosis), by Ruiz-Parra et al. (interpersonal

psychodynamic for patients with psychosis), by Garland (generic psychodynamic), and by Lorenzen (psychoanalytic for patients with anxiety and depression). Recently developed clinical guidelines for group psychotherapy by Bernard et al. (2008) have also been incorporated. With assistance from Bent Rosenbaum the manual by Valbak and Lajer (2005) was translated into English and laid a foundation for the development of the set of key components for the Delphi method.

The first round was the most time consuming round in this study. In this round a set of statements was compiled based on the reviewed manuals and clinical guidelines, a detailed literature review, consultation with relevant experts and the personal experience of the investigator in running an outpatient PGP group for psychosis within UK NHS setting. Also, statements from a current Delphi study on the key components of individual psychodynamic psychotherapy for psychosis conducted by Kongara and Summers (personal communication) were used to ensure that components which are relevant to both group and individual psychodynamic therapy for psychosis were included.

The initial set of statements included 436 components which were reviewed by the investigator, research panellists, David Kennard and Aleksandra Novakovich and reduced to a revised set of 187 statements in total (Appendix Seventeen). The reviewers suggested taking a more focused approach, to modify the structure of the sectors and helped to identify duplicates as well as assured readability and relevance of the questions. This consultation was carried out through emails, Skype and personal communication, where each review of the set of statements consisted of the expert panellists suggesting changes and the investigator making those changes and resending the modified set of statements for further comments. Throughout this

consultation, many additions, deletions, and modifications were suggested by the panel experts, and the consultation process was ceased when all five members of the research panel felt that the list adequately represented the full range of essential components required to successfully implement PGP for psychosis.

The final version of the set of statements was kindly edited and proofread by one of the research panellists and it was reviewed for ambiguities and understanding to the best of the abilities of the research panellists and the investigator. An external psychologist, whose native language is not English, was approached to participate in the pilot study in order to determine a timeframe for responding to the questionnaire and to verify the readability of the questions for an audience for whom English may also not be their first language.

Although most Delphi studies start in the first round with an open ended question, it was not deemed possible in this case as the time constraints and busy life schedules of the research panel members made starting from scratch and asking all five panellists to come up with a list of key components an impossible task to accomplish. Thus the investigator took it upon herself to review the literature and the existing manuals and compile the initial set of statements describing both generic and specific aspects of this intervention. It was considered to be more practical and efficient to ask the research panellists to brainstorm based on an already drafted set of components.

The research panel also proposed including one open ended question in the questionnaire in the second round as it was felt that it could usefully encourage participants to think of potentially missed important components or alternative ways



of formulating the already included statements.

### **Round Two (June 2014 – October 2014)**

In round two identified experts across the world were invited to rate the set of statements finalized by the panel in the first round. This set of statements was constructed and formatted to an online Google G Drive (Appendix Seventeen). The selected participants were e-mailed a link to the online version and asked to complete the questionnaire by rating the importance of each item, with regard to PGP for psychosis, on a Likert rating scale of 1-5 (1 - essential; 2 - important; 3 - do not know/depends; 4 - unimportant; and 5 - should not be included). The results from the questionnaire were automatically entered into an anonymous database. Once the questionnaire had been distributed to the identified individuals and organisations, follow-up emails and reminders were sent to encourage further participation. As the distribution of the questionnaire in round two started very close to the summer break of most analysts, it was agreed by the investigator and the research panel to send out reminders after the break with an additional deadline of four weeks (Appendix Thirteen). Regular contact and a flexible deadline as well as individualised emails and acknowledgements of participation were employed to increase the response rate of prospective participants.

The research panel members were consulted on their opinion about the cut off points for the inclusion/exclusion of the statements into the third round of the Delphi study having provided them with a brief overview of the literature on the analysis of the Delphi data (Appendix Twelve). It has been agreed that following the studies by Morrison and Barratt (2010) and by Langlands et al. (2008), the following cut-off

points were to be implemented:

1. If at least 80% or above of experts rated an item as essential or important as an ingredient of PGP for psychosis, it was included as an essential component.
2. If 70-79% of experts rated an item essential or very important, investigator asked all experts to rerate that item in the third round and comment on their thinking behind their rerating decision.
3. Any statements that did not meet the above two conditions were excluded from the list of essential components of PGP for psychosis.

### **Round Three (November 2014 – February 2015)**

In round three a questionnaire was constructed from the data gathered from the round two. A descriptive data analysis of the participants' responses using SPSS Statistics 21 was undertaken, based on which the second questionnaire was constructed. The purpose of this round was to invite the participants to consider their ratings in the light of the group response and decide whether they wanted to change any of their responses (Appendix Thirteen). It is commonly suggested to feedback percentages and provide individual round scores for every item to all participants in the third round. This provides visual means for the participants of assessing diversity of responses (Iqbal & Pison-Young, 2009).

In this round participants were asked to review the selected key components they had rated in round two in the light of the summarised data of the ratings. The participants

were sent a questionnaire of the same format as in the previous round but incorporating only those items that 70-79% of experts had rated as essential or important. They were asked to rerate these items and comment on their ratings and the rationale behind them. It was hoped that a stimulating discussion and debate would be generated in this round around the most controversial elements of the PGP for psychosis, like the use of interpretation of the unconscious material, incorporation of the transference and the extent to which the technique is supportive or exploratory.

In this third round it was hoped that when participants were presented with new information or ideas in a non-threatening way (as they are in the Delphi technique due to its anonymity), they may see things from a different point of view and they have the opportunity to adjust their views accordingly. One of the purposes of this round was to identify areas where participants may have diverse views and opinions and encourage them to reflect on the areas which potentially were less defined in the comments.

### **Section Three: Procedure of the Thematic Analysis**

All participants were asked to comment on their re-rating decisions in the third round as well as provide comments on whether any important components were missed in the set of statements provided in the second round. These comments were often clarifications of their thoughts or justifications of their rating decisions. Sadly, no clinical illustrations were provided in these comments, which might had to do with the length of the set of statements participants were required to rerate. Both additional comments from the second round and the comments for every rerated

statement in the third round were treated as a dataset for further qualitative analysis. A thematic analysis as it is described by Braun and Clarke (2006, 2012) was applied as a method of analysis. Through focusing on meaning that emerged across the dataset, thematic analysis made it possible for an inexperienced in a qualitative research investigator to discover and make sense of collective and shared meanings and opinions.

The thematic analysis was driven by a set of following questions:

- How do experts around the world see PGP being adjusted/adapted when delivered to patients with psychosis?
- What are the areas of disagreement in the delivery and conceptualisation of PGP for psychosis?
- What are the issues which need further research and exploration in the delivery and conceptualisation of PGP for psychosis?

The themes were identified using a “bottom up” inductive form of analysis (Frith & Gleeson, 2004) and were strongly linked to the data. The data was coded without trying to fit it into a pre-existing coding frame, or the investigator’s analytic preconceptions.

### **Phases of the Thematic Analysis**

It is important to reiterate that prior to engaging with data collection and data analysis the investigator carried out an extensive literature review on the subject and already possessed four years of clinical experience of conducting a PGP group with

patients with psychosis as well as have had a personal analysis with a Kleinian analyst. The investigator was mindful of some of her preconceptions stemming from her background and experience and their impact on her analysis of the data. These preconceptions included the following ideas and opinions: a more supportive than exploratory approach was helpful for patients with psychosis. A more supportive approach to PGP, according to the investigator, involved a more active than neutral therapist's stance, focused rather than free floating group discussion, a cautious interpretation of the unconscious material and limited free association, both group-as-a-whole and individual interpretations implemented, positive transference not to be interpreted, focus on the here-and-now rather than there-and-then interventions, the use of metaphors and PGP delivered within a wider therapeutic programme or supportive institutional context.

### **Phase One of Thematic Analysis**

In order to familiarize herself with the data, the investigator read the whole data set in an active way by making initial comments. The chronological description of the analysis undertaken can be found in Appendix Fourteen. Having read and familiarized herself with the data, the investigator generated an initial list of ideas about what is in the data and what is interesting about it (Braun & Clarke, 2006). These initial ideas included the following:

- Patients are to be enabled and psychosis should not be viewed as a symptom but a way of creatively adjusting to difficult experiences.
- Being aware of patronizing and stigmatising in how therapists approach

whatever techniques they use.

- The ideas of continuum, fluctuation and dynamic processes in using techniques and interventions, based on where the patients are at and not on what should be done.
- The idea of psychosis as a dynamic condition as well as the group as a dynamic process where there are points when the group/individual is fragile and when more supportive interventions are appropriate and times when greater recovery and more exploratory interventions are possible. It is not a dichotomy but dynamic situation, like between the psychotic and non-psychotic part or the depressive and paranoid-schizoid positions, in which it is never possible to maintain one 100% and one inevitably fluctuates between the two.
- The issue should be not about whether a supportive or interpretative approach is more useful, but what is helpful when considering the specific mind state of the group and the individual. The idea is of psychotherapy being an art rather than a science as well as the key components of PGP being guidelines rather than rules or prescriptions.
- The issues of frame, therapeutic factors and therapist's requirements.
- The impact of the current group dynamics and stages of therapy.

## Phase Two of Thematic Analysis

The entire dataset was re-read and initial codes were generated. MAXQDA software was used during this process. Initial coding of the entire dataset was attempted, where codes identified a feature of data that appeared interesting and meaningful to the investigator in relation to the research aims. The initial coding was very much data driven and equal attention was given to each data item. Initially a very descriptive approach was applied, where coding was carried out for as many potential patterns as possible (Box 1). The first round of coding resulted in 244 codes which in some instances were paraphrases but aimed, as systematically as possible, to reflect what is in the data set. This approach to coding was utilised to ensure that the investigator's subjective influence on the analysis of the dataset was minimised as the investigator herself conducted PGP for patients with psychosis as part of her job and is aware of the existing debates on the limitations and advantages of PGP in application to patients with psychosis. An initial detailed coding of the data set had the aim of minimising any unintentional bias which may have highlighted certain themes, neglecting those which the investigator might potentially disagree with or find irrelevant as a result of the influence of her own knowledge and experience.

**Box 1:** Example illustrating the first and second phases of the analysis of participants comments on rerating two statements in the second round

Codes	Comment about rerated statements	Clusters/initial themes and additional comments
Unconscious	<p><b>5. PGP should aim to help patients gain an understanding of conscious and unconscious factors contributing to the formation and maintenance of their symptoms.</b></p> <p>P1: I think for people experiencing psychosis the unconscious may already be conscious, but experienced</p>	Cautions work with the unconscious (or

<p>might already be conscious</p> <p>Avoid emphasis on symptom</p> <p>Cautious interpretation of the unconscious</p> <p>Case by case approach</p> <p>Psychosis is a valid response to life experience</p> <p>Limited role of insight in recovery</p> <p>Stages of group development</p> <p>Cautious work with the unconscious</p> <p>Working with unconscious is an integral part of PGP</p>	<p>as coming from outside the self - as a voice or delusion.</p> <p>P5: I do not totally agree with the emphasis of symptoms. It is often as important to see the non-psychotic conscious and unconscious factors contributing to grip of life. - And to see in PGP how the other group members succeed.</p> <p>P6: Either on conscious or on unconscious levels psychotic symptoms are prevailingly understood the therapist should be always very cautious whether to enter into explanations regarding possible causative elements of the disorder and its symptoms. It depends mostly of the therapist's assessment of the actual level of patient's ego strength.</p> <p>P11: group therapy should explore the persons framework of their experience (psychosis is NOT a 'symptom', its a valid response to life experiences) ....without a pre-conceived notion of the outcome of the exploration</p> <p>P14: the insight /understanding does not seem to be necessary for improvement, at least not in all cases BUT the conductor must NOT explain feared unconscious material too early</p> <p>P22: Truly valuable</p>	<p>all knowledge or experience is bearable)</p> <p>Psychosis as an adaptation</p> <p>Cautious work with the unconscious. Therapeutic relationship. Maybe the role of CT?</p> <p>Human dilemmas vs pathologising</p> <p>Therapeutic relationship (without memory and desire)</p> <p>Cautious work with the unconscious</p> <p>Stages of the group (conflicting recommendations on working with unconscious dynamics or flexibility?)</p>
<p>Stages of group development</p> <p>Case by case approach</p> <p>Intervention should be flexible and enabling</p> <p>Case by case approach</p> <p>Interventions depend on the stages of the group dynamics</p> <p>Case by case approach</p>	<p><b>24. Therapists should focus on here-and-now interactions rather than the there-and-then dimension of patients' relationships.</b></p> <p>P4: Depends on the dynamics, group composition, situation and momento of the group</p> <p>P6: It is not an either or situation. It depends on the content of the patient's contribution, on how accessible the connections are and on how beneficial it would be for patient. If the therapist judge that connecting the here-and-now with the there-and-then would be an enabling experience for the patient and the group, then the connection should be made available to the patient and the group.</p> <p>P14: This should be the case in the beginning of therapy, in the advances stage there and then should also be considered</p> <p>P20: but not dogmatically, if the patient is open to linking past and present</p> <p>P22: I think we should address whatever appears to be meaningful and important for the patients</p> <p>See earlier. Here-and-now interactions form a basis for future orientation.</p> <p>The sharing of then and there is a significant here and</p>	<p>Group dynamics are linked with various interventions</p> <p>Flexibility of the application of PGP</p> <p>The stress on meaning and not on symptom relief</p>



<p>Interventions promoting understanding/meaning</p> <p>Group therapeutic factors</p> <p>Case by case approach</p> <p>Benefits of here-and-now</p> <p>Interventions depend on the stages of the group dynamics</p> <p>Case by case approach</p>	<p>now experience, as well as helping understanding.</p> <p>P26: Yes, immediate witnessing of any group process makes interactions, statements, and behaviour explicit, understandable, trustful.</p> <p>P15: The focus should be where the person is</p> <p>P19: But it is a sign of trust when patients start to talk about their family members and how these relations have developed (there-and-then), since it takes several, sometimes many sessions before psychotic patients dare to disclose such personal matters in the group (although only on the explicit, verbal level). And sometimes a patient, having told his history, may need at first support and/or clarifying of his feelings by the therapists before the therapists intervene on the here-and-now interactions of the group.</p>	<p>Not either/or approach</p> <p>Learning in the group</p> <p>Development of group dynamics</p> <p>Time required for change to take place</p> <p>Therapy is an art not a science. Therapeutic relationship is a guide</p>
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### Phase Three of Thematic Analysis

In this phase the development of the code clusters and initial themes began where the codes from the first two phases could be organised into meaningful groups and patterns. All relevant coded data extracts were collated for a particular cluster or pattern. It was noted that experts responded and commented on different aspects of PGP, which reflected the variety in the ways of practicing PGP but also individual characteristics and interests of the individual therapists. This highlighted that therapy was a highly subjective experience both for the patient and the therapist. Some of the elements people focused on were also diverse and contradictory.

For example, the cluster of ideas of PGP as a way of developing meaning with the patient of their predicament rather than focusing on the symptom elimination or imposing therapist's ideas on where they should be heading in the areas of work,

hobbies, relationships. The investigator's thinking process in drawing together all coded comments for this cluster was along these lines: "What can be a sense of purpose for one is not necessarily so for another. Rather than filling in the empty space with something or encouraging the patient to do something, the purpose of any intervention should be a step towards the development of meaning of one's situation and experience. Maybe, depending on where the person is and at what stage the group dynamics and development are, the trust and therapeutic alliance should follow. What is meaningful now, might not be meaningful later or before. Also any ideas of condescending, patronising, not enabling approach to the understanding of psychosis as an illness might fit here as well".

At this point supervision was sought to look at the dataset and to see whether the emerging ideas were grounded in the data. Supervision was also sought to ensure that the investigator was not simply picking out themes and ideas which were of interest to her subjectively due to her own clinical experience and training background. Additionally, an independent psychoanalytically trained clinical psychologist with a limited amount of experience of working with patients with psychosis was asked to audit the code system. Her codes were very similar to the final coding system (Appendix Fifteen).

Examples of other initial clusters:

1. Therapeutic goals
2. Therapist's factors
3. Relationships inside and outside the group

4. Interpreting, understanding vs encouragement (maintaining analytic attitude)
5. Psychosis as an adaptation (creative adapting to painful internal world and relations)
6. PGP and other settings
7. Group therapeutic factors
8. Application of the interventions should be flexible (applying the model flexibly in response to the group's and the client's individual needs and context)
9. Enabling the grief process
10. Human dilemmas vs pathologising
11. Cautious work with unconscious communication
12. Co-therapy and supervision
13. Therapeutic frame
14. Supportive aspect of PGP (flexible tension between exploratory and more structured active supportive approach)

The Box 2 provides examples of codes and participants comments which informed the formation of two out of the above clusters.

**Box 2:** Examples of two clusters, its codes, and relevant participants' comments

Cluster	Codes	Participants' comments
Therapeutic Frame	<p data-bbox="448 365 608 398">Co-therapy</p> <p data-bbox="448 674 608 763">Individual treatment and PGP</p> <p data-bbox="448 965 608 1032">Optimal size of the group</p> <p data-bbox="448 1413 608 1480">Preparatory sessions</p>	<p data-bbox="639 365 1345 432">P5: I think it can be helpful for therapist to get different point of observation</p> <p data-bbox="639 443 1345 600">P21: And it strengthens the frame, because, in the case of absence of one therapist, the group can - SHOULD - be run by the other therapist. In addition, two therapists, even of the same sex, allow more easily a helpful transference of a parental pair</p> <p data-bbox="639 566 1345 600">P26: it may also make the transference more complex</p> <p data-bbox="639 645 1345 678">P3: Do not combine with individual treatments</p> <p data-bbox="639 689 1345 745">P5: PGP can be helpful to patients without any prior experience of psychological therapy</p> <p data-bbox="639 757 1345 813">P26: Sometimes one therapy can be an obstacle in another, the transference is often split so it can be a problem-centred</p> <p data-bbox="639 824 1345 880">P15: The treatments should support each other. Combination with family therapy is also helpful.</p> <p data-bbox="639 925 1345 958">P5: 10-12 members are possible</p> <p data-bbox="639 969 1345 1093">P12: Groups should include 6-8 members. The group size should not be too daunting for most anxious patients but should not be too big in order to provide individual patients with special care when necessary</p> <p data-bbox="639 1104 1345 1137">P18: 8-12</p> <p data-bbox="639 1149 1345 1294">P22: According to my experience, it depends on setting and type of the group. The number, accordingly, could be even up to double. It depends on the style of work, whether it is a person-focused approach or group-focused approach (in that case the group might be bigger)</p> <p data-bbox="639 1339 1345 1429">P7: In the preparatory sessions therapists should raise potential difficulties the patient might face in continuing with treatment and encourage them to discuss these issues in the group sessions</p> <p data-bbox="639 1473 1345 1597">P12: 3-5 probatory sessions in the group could be helpful for patients to decide whether they would like to continue with the treatment or not. number of the probatory sessions should be clarified as a group rule.</p>
Application of the interventions should be flexible	<p data-bbox="448 1612 608 1769">Interventions depend on the theoretical approach of the therapist</p> <p data-bbox="448 1814 608 1971">Interventions depend on the group dynamics and its phase</p>	<p data-bbox="639 1612 1345 1747">P22: This would result from a particular stance taken by the therapist, for example therapist from group-as-a-whole background would not make individual interpretations in the group.</p> <p data-bbox="639 1814 1345 1948">P12: Whether therapists need to communicate their hope to patients about the potential helpfulness of PGP depends on the phase of the group process and possible crisis in supporting group by its members.</p> <p data-bbox="639 1960 1345 2016">P4: Using there-and-then or here-and-now interventions depends on the group dynamics, composition and momento of the group.</p> <p data-bbox="639 2027 1345 2049">P22: Here-and-now interventions should be predominantly at the</p>

	Interventions should be enabling	<p>beginning of the therapy, in the advanced stages there-and-then interpretations should be considered.</p> <p>The idea that therapists should help patients to learn from past mistakes is too education. Learning from experience is always very truthful and impressive, nevertheless “most expensive”.</p>
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#### **Phase Four of Thematic Analysis**

Following the development of the initial themes, the entire dataset and the code system were reread and reviewed to make sure that the codes and emerging patterns reflected the content and meaning of the relevant data abstracts. It was ensured that the identified themes reflected the entire dataset and that meaningful patterns were not missed. In this round the investigator started looking for the the function of code clusters. Majority of the code clusters seem to be grouped around the following themes: what PGP is, how it is delivered, how it is modified when it is delivered to patients with psychosis and how psychosis is understood by PGP practitioners.

#### **Phase Five of Thematic Analysis**

During this phase the code clusters were developed into final themes and the finalizing, defining and naming of the themes took place followed by detailed description of these themes. The findings from the thematic analysis presented in the next chapter were intended to present a complex descriptive account of the data inserting extracts from participants’ comments to highlight and illustrate the themes. It is hoped that the presented account of findings in the next chapter will provide a useful summary of a large body of participants’ comments and offer a “thick description” of the entire data set (Braun & Clarke, 2006).

Four main themes were developed, where the dominant theme was “PGP requires certain supportive modifications when applied to patients with psychosis”. Other themes, although reflective of dataset overall, seem to carry less significance and less engagement from the participants. The prevalence of the themes was determined by counting the number of different participants who articulated the topic/theme and each individual occurrence of the theme across the entire dataset. The key themes were elaborated upon in most detail by the participants.

Although overall analysis of the data remained predominantly on a summarising and descriptive level, some arguments about existing controversial aspects around application of PGP to patients with psychosis were made and illustrations from the data were presented to support the analytic claims made. It is also hoped that the analysis produced generated further insight into the current modifications of PGP for psychosis and to the underpinning of the understanding of psychosis in the current psychoanalytic tradition.

#### **Section Four: Quality assurance**

It could be argued that certain views and preconceptions of a problem were imposed upon the respondent group in this study by asking them to rate an already designed set of statements. Additionally, the Delphi method is often criticised for an assumption that it can be a surrogate for all other communication in a given situation. In the attempt to overcome this, all participants were asked in the second round to provide additional comments if they felt that they wanted to make contributions of other perspectives related to the problem. In the third round they were also asked to comment on the rerating decisions.

For example, in the second round participants commented that the questionnaire had a strong object relations bias and that other theoretical traditions such as Lacan should be considered. Several participants highlighted the importance of regular supervision due to the nature of “toxic and thought blocking projective identifications”. Several participants mentioned issues of patients' suitability for PGP (“PGP seems to be more feasible with stabilized patients and not first-onset psychosis” and the “suitability of patients with negative symptoms needing to be addressed”). One participant commented that issues of therapeutic frame were not sufficiently reflected, whereas another participants pointed out that the statements about the frame should be presented as an optimal way of functioning rather than rigid rules and expectations. Participants commented that open-ended therapy should be avoided to avoid ambiguity and uncertainty. One participant commented that some of the questions contained more than one statement which made it hard to rate these questions. All of these comments represent the limitations of the current study but also an opportunity to be considered and addressed in the future research and development of the working model of the key components of PGP.

The comments from the third round were systematically analysed and represented an additional way for participants to communicate their views and perspectives. These comments were also used to uncover potential disagreements or extreme positions on any of the listed aspects of the PGP, which will be discussed in great detail in the next chapter. Although it could be argued that participants could have been asked in the first round to comment on the rating decision of each of 187 to gain further in-depth insights on components of PGP which achieved consensus on being included or excluded, it could not be asked of participants to make detailed comments on

every component as it was a highly demanding task in itself to rate 187 statements.

When coding and developing themes, the preconceptions of the investigator were outlined from the outset and cross-coding of a fragment of a dataset by an independent researcher was employed (Appendix Fifteen) to ensure that the codes and the emerging themes were not unduly influenced by the pre-existing notions and ideas of the investigator. It might be argued that in this detailed description some depth and complexity was lost, but a rich overall description was maintained. As the aim of the analysis was to investigate the various ideas and opinions on how PGP should be implemented, the rich overall description was given a priority in the presentation of the findings. Braun and Clarke (2012) also assert that the investigator cannot free themselves from their theoretical and epistemological commitments and that the prevalence of the themes which highlighted the required modification to PGP was of greater interest to the investigator and thus was observed more frequently in the dataset.

Finally, supervision was sought to look at the dataset and to see whether the emerging ideas were grounded in the data in order to ensure that the researcher was not simply picking out themes and ideas which were of interest to her subjectively due to her own clinical experience and training background. Participants comments were provided in the next chapter to further ground the analytical claims in the data and to allow the readers to make a judgement about the appropriateness of the investigator's interpretations.



## **Section Five: Ethics**

Careful consideration has been given to the protection of the anonymity of the participants through employment of an anonymous database for the collection of their responses to the survey. Anonymous participation was hoped to avoid peer pressure in forming the opinions about the subject under investigation. All participants were emailed an information participation sheet which explained the process of the study in detail (Appendix Eleven). All participants were explained that their participation was voluntarily and that they could terminate their participation at any point. No harm was anticipated to come from participation either for the investigator or the participants as participants were asked to reflect on technical aspects of their PGP practice.

Ethical approval for all aspects of the methodology was granted by the Essex University Research Ethics Committee in December 2013.

## **Section Six: Limitations of the Study Procedure**

This procedure was extremely time consuming, which necessarily led to several limitations which might have been avoided had a team of researchers been working on it. Firstly, the already described difficulty in recruiting a more representative sample of participants representative of the regions globally and representative of the various approaches to PGP. Secondly, as participants were given a set of ready compiled statements, there was only limited space for them to make their own contributions to the content and format of the statements. For example, the Delphi questionnaire could have benefitted from including a brief survey of the views of the

participants on what psychosis consists of, and the use or not of diagnostic tools, such as DSM-IV (or ICD-10), and in addition the selection of people for the groups they ran – both their diagnostic category, and the level of disturbance. Last but not the least, involvement of the people with psychosis who have had experience of PGP in the consultation process of the questionnaire development and interpretation of the analysis of the results could have greatly enhanced the meaning, significance and the relevance of this study.

### **Section Six: Self-Reflective Statement**

This project has been both emotionally and professionally challenging for the investigator as the investigator herself has been running a PGP group for patients with psychosis for several years. It has been a trying task to keep reflecting on personal biases in the development of the questionnaire and in the interpretation of the collected data. The process of engaging the experts has been the most demanding task as the investigator had to bear long silences to the invitation emails and bear the frustration of sending reminder emails. What the investigator found helpful in this waiting process was being able to observe the parallels between the struggles in the therapeutic engagement of the patients with psychosis, which requires delicate, thoughtfully paced work from the therapist and the similar engagement difficulties with consequent demands on the investigator in the recruitment of the participants. The countertransference feelings of frustration with slow pace of change in improvement of the patients seemed to seep through the investigator's experience of carrying out the research project over the past four years. Using supervision and personal reflections both in analysis and with colleagues helped to bear those experiences and persevere with the project. As the result, the hard work of the

investigator and of the participants paid off with greater understanding of the difficult work PGP therapists have to do with patients with psychosis.

## **Part Six: Summary**

The current research project adopted a mixed method research design, combining a Delphi study and thematic analysis in order to identify and investigate the key components of PGP for psychosis. The current study aimed to recruit a purposive sampling of highly experienced PGP practitioners from around the world, which was achieved with limited success. A Delphi questionnaire was the main method of data collection. Despite best efforts only some theoretical schools of PGP and regions globally were represented by participants. Although methodology applied had significant limitations, strategies to improve its validity are elaborated upon in the quality assurance section. Finally, a self-reflective statement described the researcher's background, expectations and encountered difficulties in the research process.

## **Chapter Three: Results and data analysis**

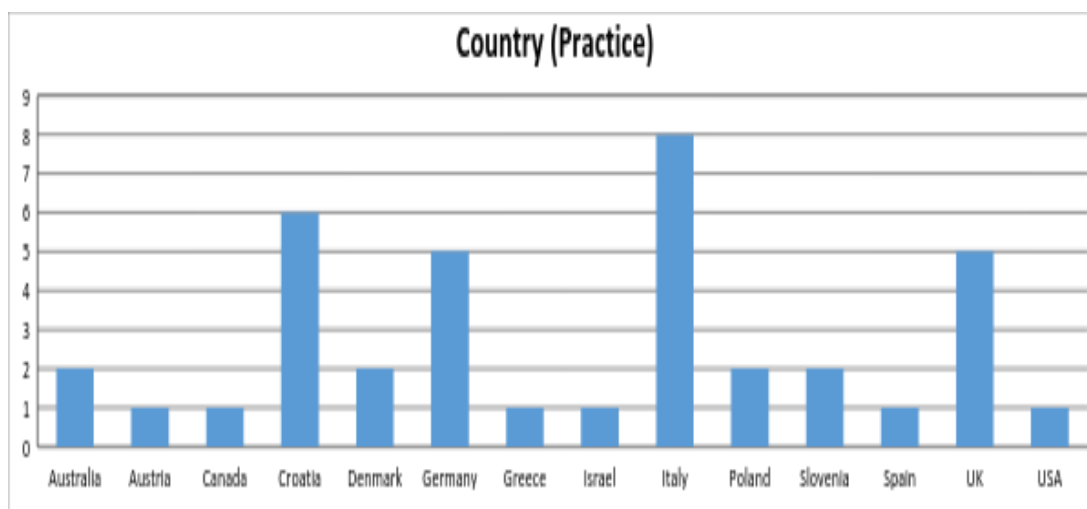
### **Part One: Introduction**

This chapter presents the findings of the study. It begins with the description of the participants demographics, followed by the sequential presentation of the findings from the Delphi study and thematic analysis. These findings include the results from the three rounds of the Delphi study, which led to the endorsement of 145 key components and the exclusion of 35 components with 7 items not having reached predetermined level of consensus. Thematic analysis resulted in the identification of four core themes from the participants comments, which further elaborated psychodynamic aspects of PGP, its essential elements, required modifications when offered to patients with psychosis and overarching understanding of psychosis as a response to difficult life experience.

### **Part Two: Participants Demographics**

Initially 58 experts who met the inclusion criteria were invited, via email, to take part. 37 participants responded to the survey (64% response rate). This sample was largely representative of the European region, demonstrating a good geographic spread in the region. Unfortunately no participants were recruited from Asia, Latin or South America. One participant came from the USA, one from Canada, one from Australia, and one from New Zealand (Figure 2). Overall, the participants' demographics are proportionally representative of the original invitation list, with the exception of the aforementioned geographic regions. As only a few participants were recruited from some countries, participants' geographic locations of practice were referred to as UK, Europe and Other, to preserve their confidentiality when

illustrating findings with the quotations from their comments.



**Figure 2:** Participants and the Countries where they practice

There was a good representation of highly experienced group psychotherapists, where the average number of years of experience offering PGP to patients with psychosis was 16 years, with the longest time practicing being 40 years. The shortest time being 5 years.

There was also a good representation of theoretical schools with a predominance of group analysis (22), but also a good representation of the Tavistock model or group-as-a-whole approach (7), the psychoanalytic school of Fagioli (4) and some experts from the interpersonal (2), self-psychology (1), and Lacanian approaches (2).

These expert participants came from a variety of practicing contexts, including the private (9) and national health settings (23), practicing in both settings (6), as well as inpatient (7) and outpatient (6) or both (25) care units. Most experts came from national health care setting, which might be both specific to the participants' countries as well as reflective of the costs of the provision of PGP.

The participating experts generally offered group treatment on a weekly basis for 90 minutes duration. More experienced therapists tended to practice alone, however the majority of participants preferred practicing with a co-facilitator.

### Part Three: Results from the Delphi Survey

Survey responses from 37 participants in the second round were recorded in an anonymous database and analysed by obtaining group percentages. 109 items emerged as key components in the second round. 34 items were excluded and 44 items required rerating in the third round (Table 2, Table 3, Table 4).

**Table 2:** Items which were excluded from the list of key components of PGP for psychosis.

Questions rated as key components by less than 70% of participants	Round excluded
<b>Indications for Therapy</b>	
1.PGP can be helpful without adjunctive medication.	1
2.Patients with predominant positive symptoms can benefit from shorter term PGP of 6-12 months duration.	1
3.Patients with long standing negative symptoms and lacking adequate support systems should be offered long-term or open ended PGP.	2
4.Patients need to be able to adhere to the PGP frame, sit through the entire session and be able to cope with not having constant attention paid to them.	1
5.PGP groups should consist of patients with similar ego functioning levels.	1
6.Patients who are actively suicidal or who are acutely overwhelmed with psychotic symptoms should not be offered PGP.	1
<b>Therapy Aims</b>	
7.PGP should aim to help patients gain an understanding of conscious and unconscious factors contributing to the formation and maintenance of their symptoms.	2
<b>Therapy Frame</b>	
8.Homework, including practice assignments, agreed between sessions activities, thought diaries and monitoring procedures are not employed in PGP for patients with psychosis.	2
9.In the initial group sessions the rules of PGP should be discussed in detail to clarify any questions or doubts patients have and should be reviewed every time a new member joins the group.	1
10.If patients cannot tolerate this length of session, therapists may reduce the length of the session with mutual agreement within the group.	1
11.If a patient is unable to attend, an empty chair should be kept in the PGP session.	1
12.Individual sessions are possible at the request of group members, but	1

patients are encouraged to talk about the individual sessions with the group.	
13. Therapists should not take other roles in relation to the patients in the group (psychiatrist, social worker or nurse).	1
<b>Therapeutic Factors</b>	
14. Altruism (growing self-esteem by offering help to others) is one of the key therapeutic factors in PGP for psychosis.	1
15. Catharsis (allowing oneself to express feelings which are difficult for the patient to express) is one of the key therapeutic factors in PGP for psychosis.	1
16. Existential awareness (accepting responsibility for life decisions) is one of the key therapeutic factors in PGP for psychosis.	1
17. Guidance (receiving advice, nurturing support and assistance) is one of the key therapeutic factors in PGP for psychosis.	1
18. Family re-enactment (identifying and changing dysfunctional patterns or roles one played in the family of origin) is one of the key therapeutic factors in PGP for psychosis.	1
19. Identification (observing and imitating more adaptive attitudes of other group members and therapists) is one of the key therapeutic factors in PGP for psychosis.	1
<b>Assessment and Preparatory Sessions</b>	
20. Before assessment, therapists should read all information available in discharge letters, and patient records from previous or current therapists and request more information if necessary.	1
21. It is important to speak in depth about the recent psychotic episode in order to assess the patient's insight as well as their capacity to link their symptoms with their emotional conflicts.	1
22. Towards the end of the preparatory sessions, therapists should provide a summary of the patient's history, their difficulties and strengths, including the agreed therapeutic goals. This summary should be shared in writing with the patient and other professionals involved in the patient's care.	1
<b>Formulation of Hypothesis</b>	
23. Following the initial individual sessions with each group member, therapists should formulate a set of hypotheses regarding the patient's level of functioning, coping mechanisms and strengths.	1
24. These hypotheses should cover the patient's potential transference onto the group.	1
25. These hypotheses should cover factors influencing the therapeutic alliance	1
<b>General Therapy Approach throughout Assessment and Therapy</b>	
26. Therapists will aim to reflect on only group-as-a-whole processes.	1
27. Although positive transference should be fostered, transference should not be analysed, but should be kept in the therapist's mind as a guide to individual and group dynamics.	1
28. Resistances and transferences should not be analysed unless they interfere with the therapeutic process.	1
29. The method of free association should be avoided.	1
30. Therapists should avoid 'uncovering' interpretations which seek to overcome defences and increase depth of insight and mutative inner change.	1
31. PGP should offer patients opportunities to practise what they learn within the sessions (ego training in action).	1
<b>Engagement Phase Specific Interventions</b>	
32. Therapists should start by focusing on the issues that are already conscious for the patient and the group, such as symptoms and common concerns of group members	1

33. Interpretations of group and individual unconscious processes should be avoided, but therapists should use this information to reach deeper understanding of what is happening in the group.	1
<b>Interpersonal Phase Specific Interventions</b>	
34. Patients need to be helped to recognise their symptoms and to come to terms with their illness through learning new ways of coping from each other. This will help them connect with their experience in a more realistic and meaningful way.	1
<b>Therapists' Qualities and Attitudes</b>	
35. Therapists may help patients define their and the group's reality by giving advice.	1

In the third round, the 37 participants from the second round were sent a revised questionnaire of the same format as in the second round but containing only items that 70-79% of experts had rated as very important or important in the previous round. All expert participants were asked to rerate these items (n=44). Twenty eight participants responded in the third round, which resulted in additional 36 statements being included and three statements being excluded. Seven statements remained in a grey area of the consensus with 70-80% reaching agreement (Table 3).

**Table 3:** Items which did not gain consensus on being included or excluded.

Question	Overall Consensus
<b>General Therapy Approach throughout Assessment and Therapy</b>	
1. Therapists should focus on here-and-now interactions rather than the there-and-then dimension of patients' relationships.	76.9%
2. Therapists should aim to help patients learn from past mistakes and failures by helping to see these in the context of patient's illness and their consequent lack of opportunities.	76.9%
3. Therapists should aim to help patients learn from past mistakes and failures by helping to see these in the context of patient's illness and their consequent lack of opportunities.	71,00%
<b>Engagement Phase Specific Interventions</b>	
4. The focus of interventions is on the here-and-now.	76.9%
5. Identification with therapists is not discouraged: therapists take on active, teaching and modelling roles so that patients learn new ways of relating.	76.9%



<b>Termination Phase Specific Interventions</b>	
6.A few months prior to ending, therapists with the help of other group members should summarise the improvement they have witnessed and the aspects that need further work.	76.9%
<b>Therapists' Qualities and Attitudes</b>	
7.Conducting PGP groups for psychosis on one's own should be avoided as it poses significant risk and difficulty to both patients and therapists.	76.9%

A total of 145 items were included as key components of PGP for psychosis agreed by 80% and above of expert participants (Table 4).

**Table 4:** Items which were included in the list of key components of PGP for psychosis.

Statements rated as important by >80% of participants	Round included
<b>Indications for Therapy</b>	
1. There is good reason to offer PGP to patients with psychosis as it helps them form and maintain rewarding relationships with other people.	1
2. PGP (with appropriate supportive modifications) may be offered to patients with psychosis, at various stages of onset and for many therapeutic purposes.	1
3. PGP is an important contribution, alongside medication, rehabilitation and individual therapy and should be offered as part of integrated treatment.	1
4. PGP can be helpful after a period of individual psychological therapy.	1
5. PGP can be helpfully combined with medication.	1
6. PGP can be helpfully combined with individual therapy.	2
7. PGP (with appropriate supportive modifications) can be helpful to patients at early stages of psychosis.	2
8. PGP can be helpful to patients with psychosis without any prior experience of psychological therapy.	2
<b>Therapy Aims</b>	
9. PGP should aim to improve quality of life.	1
10. PGP should help patients reinstate hope in their lives, occupations and relationships.	1
11. PGP should aim to help patients discover the defences that prevent them from recognising their potential and help patients to gradually replace these defences with more constructive and active ways of engaging with their lives.	1
12. PGP should aim to help patients find ways to manage their emotions and to tolerate reality.	1
13. PGP should aim to help patients be more aware of their own mental states.	1
14. PGP should aim to help patients become more aware of the mental states of other people.	1
15. PGP should aim to help patients learn about the ways they relate to each other in the group and to people outside of the group.	1
16. PGP should aim to strengthen patients' egos through the experience of their capacity to build relationships inside and outside of the group.	1
17. PGP should help patients improve social and interpersonal skills through	1

discussions and experience of interacting with others during the sessions.	
18.PGP should aim to help patients acknowledge and come to terms with the losses or changes in their life due to their illness.	2
19.PGP should aim to prevent relapses.	2
<b>Therapy Frame</b>	
20.Therapists must ensure that the setting is kept constant, but if some change is required, they should be clear with the patients about the circumstances in which the therapy arrangements might change.	1
21.Each PGP session should last between 60 and 90 minutes if patients can tolerate it.	1
22.Frequency of the PGP sessions should be at least once weekly.	1
23.PGP should be continued for at least one year, but preferably for three years or be open-ended.	1
24.Members of the group should be contracted to confidentiality and to not disclosing information about other patients outside of the group.	1
25.Socialising outside of the group, although not encouraged, is not banned. However, members are encouraged to discuss their encounters in the group.	1
26.If patients happen to relapse while in therapy, this should not be an indication for early termination of therapy.	1
27.PGP sessions should not have a pre-determined structure or agenda. PGP sessions are based on a free flowing exchange of members' emotions and thoughts.	2
28.PGP groups should include 6-8 members. The group size should be not too daunting for most anxious patients but should not be too big in order to provide individual patients with special care when necessary.	2
29.Therapists should liaise with other health professionals involved in patients' care and discuss the outcomes of these liaisons with their patients.	2
<b>Therapeutic Factors</b>	
30.Instillation of hope (being able to observe and remain in contact with other group members who improved and overcame very similar problems) is one of the key therapeutic factors in PGP for psychosis.	1
31.Cohesiveness (a feeling of togetherness experienced by the group members, valuing the group) is one of the key therapeutic factors in PGP for psychosis.	1
32.Interpersonal learning input (patients learn about themselves through feedback from others) is one of the key therapeutic factors in PGP for psychosis.	1
33.Interpersonal learning output (practising to interact in a more adaptive manner) is one of the key therapeutic factors in PGP for psychosis.	2
34.Universality (a feeling of having problems similar to others, feeling not alone) is one of the key therapeutic factors in PGP for psychosis.	1
35.Self-understanding (insight into one's feelings, thoughts and attitudes and into one's relationships with other people) is one of the key therapeutic factors in PGP for psychosis.	1
<b>Assessment and Preparatory Sessions</b>	
36.During the assessment and preparatory sessions it is important to build a therapeutic alliance and create an atmosphere where disclosure and reflection feels safe.	1
37.In preparatory sessions, the patient should be invited to talk about themselves, describe their problems and their experience of past therapies.	2
38.Goals of therapy and the patient's expectations should be explored and agreed. Therapists may clarify with the patient if the goals are outside the scope of therapy.	2
39.In the preparatory sessions therapists should raise potential difficulties the patient might face in continuing with treatment and encourage them to discuss these issues in the group sessions.	2

40. Therapists should discuss with the patient issues of privacy and risk and level of responsibility should be agreed upon.	2
41. Information shared with other professionals should be provided in a sensitive and patient-friendly manner. A copy of the correspondence, whenever possible, should be given to the patient	2
42. Therapists should attempt to gain an understanding of the emotional meaning to the patient of daily life events with a focus on interactions and interpersonal relationships.	1
43. Therapists should decide if the group available would match the patient's needs and level of functioning.	1
44. Where relevant, drug and alcohol use need to be discussed with the patient. It should be considered whether the patient should address their addiction before joining the group.	1
45. An emphasis on shared responsibility in therapy is important, making it clear that the patient must also be prepared to do some work in order to make progress.	1
46. If therapists feel that the patient's or other people's safety could be compromised, they need to agree with the patient that they can contact other professionals involved in the patient's care.	1
47. The patient's attitude towards medication should be explored and the position of therapists should be clarified.	1
48. Therapists should check whether the patient has understood the information provided and if they found it relevant to their concerns.	1
49. Any information given to the patient regarding the treatment should be clear and consistent.	1
50. The patient should be informed about possible concurrent treatment modalities: medication, family support, individual therapy and how these treatment modalities may relate to PGP.	1
51. The patient should be informed about how far information will be shared between therapists and other members of the treatment team, including the therapist's supervision arrangements.	1
52. During the preparatory sessions, therapists should provide all the necessary information about the group, its rules and aims (including a print-out version).	2
53. Patients need to be warned that recovery is possible but that they may need to get actively involved in the process and that it may be some time before they can experience any changes.	1
<b>Formulation of Hypothesis</b>	
54. The formulation will be informed by the therapists' assessment of the transference and counter transference.	2
55. Aspects of the formulation should be shared with the patient when therapists judge this a helpful intervention.	2
56. The therapist should discuss these hypotheses in supervision.	2
57. This formulation, based on observations of the initial interaction with the patient, will be further elaborated and reviewed to incorporate new information gathered in the group sessions. Therapists will decide how and when to feed this back to the patient.	2
58. These hypotheses should cover any suicidal or violent impulses.	1
59. The formulation should consider the patient's non-psychotic as well as their psychotic functioning.	1
60. The formulation should cover the patient's degree of awareness of the illness.	1
61. The formulation should consider unconscious as well as conscious aspects.	2
<b>General Therapy Approach throughout Assessment and Therapy</b>	
62. Therapists will use an ordinary conversational style to offer patients an opportunity to discuss anything they choose.	1
63. The general therapeutic approach is active, supportive and focused on helping	1

patients to test reality and build relationships.	
64. Therapists should not restrict themselves to remaining emotionally neutral. They should make themselves available as a “container” for the patient.	1
65. Therapists have to look on the non-psychotic part of the patient or the group as an ally that will help the group contain and work through the psychotic elements that appear in the interaction.	1
66. Therapists must support the patients' and the group's non-psychotic functioning by keeping things simple and highly consistent.	1
67. Therapists must maintain a flexible position concerning the methods and content of therapy.	1
68. PGP should focus on developing and maintaining the therapeutic alliance throughout therapy.	1
69. Defences must be understood, respected, maintained and at times even enhanced by therapists as they have the function of protecting the patient from contact with difficult feelings.	2
70. PGP should support the patients to regain a sense of purpose in their life by resuming studies/work etc.	2
71. In PGP, patients should be assisted in reality testing and in challenging their own beliefs through identification with therapists and other group members.	2
72. PGP should help group members manage their difficulties and support them during crises.	1
73. Therapists will aim to reflect on the patients' individual verbal and non-verbal communications.	1
74. Therapists will aim to reflect on both individual and group-as-a-whole dynamics.	1
75. Therapists should be mindful of the transference content in the patient's communications (towards therapist, other members or the group as a whole).	1
76. The therapist's responses to patients' verbal and non-verbal communications should be guided by his/her understanding of the individuals' and the group's history as well as the here-and-now situation.	1
77. Patients may need explanations which are careful, slow, detailed and repeated in order to reduce anxiety and mistrust.	1
78. Therapists should find the balance between delving into barely accessible emotional material, on one hand, and on the other, conveying that they do not want to tear the patient/s out of a state of emotional security.	1
79. Therapists will always be alert to the possibility of the patients or the group reverting to a psychotic state, and will be prepared to return to a more supportive approach if this is indicated.	1
80. Therapists should deal with expressions of aggressive impulses as soon as they are manifested by helping patients to explore their feelings and link them with other feelings that acted as a trigger (loss, abandonment, envy or jealousy).	1
81. Negative transference must be explored to avoid frustration as much as possible and to allow patients to express their feelings rather than act them out.	1
82. Therapists should be mindful that powerful countertransference feelings may develop and they should work on them in supervision in order not to become disengaged and unempathetic.	1
83. Use of metaphors can facilitate group communication and exploration, and can help patients gain greater understanding of their behaviours as well as helping to accommodate emotionally loaded conflicts and experiences.	1
84. Therapists might use humour with caution to manage intensity of feelings and to bring humanness and lightness to individual and group experiences.	1
85. Therapists should maintain a non-judgemental stance and should help the group to avoid polarized positions.	1
86. Interpretations should take into consideration patients' vulnerabilities and should	1

aim at keeping anxiety at a manageable level.	
87. Interpretations of unconscious material will be offered only when and if the patient is judged able to make use of these without resorting to psychotic defences.	1
88. Therapists should offer ego-supportive interpretations which access and reinforce the individual's strengths and healthy defence mechanisms.	1
89. PGP should provide opportunities for the group members to receive corrective emotional experiences.	1
90. Therapists should aim to help patients develop internal structure by adhering to the therapy frame.	1
91. Therapists should help patients manage their feelings by helping them to stay with painful emotions rather than rush away from them.	1
92. Therapists should help patients explore their own thoughts (instead of ignoring them) by building links between patients' experiences and thoughts.	1
93. Therapists should help patients develop more coherent narratives by organising in a more articulate way the confusing and disconnected associations in the group.	1
94. Therapists should aim at facilitating dialogue and discussion amongst group members.	1
95. Therapists should offer observations and comments on group processes in the here and now to foster the group's ability to reflect on its own processes.	1
96. Experiences of suicide attempts, self-harm or harm to others need to be discussed and explored in the group.	1
97. If therapists feel that a patient in the group is at risk, they should act to keep the patient safe.	1
98. The impact of breaks and holidays on the group should be explored through attending to patients' phantasies and worries. Care provision during the breaks needs to be agreed with other professionals involved in the patients' care.	1
<b>Engagement Phase Specific Interventions</b>	
99. Therapists should foster and reinforce interactions between group members.	2
100. Therapists need to communicate their hope to patients about the potential helpfulness of PGP.	2
101. Therapists should aim to create an enabling and supportive culture and to establish cohesion.	1
102. Therapists should make the framework and rules clear to allay anxiety.	1
103. Therapists must be reliable and consistent and contribute actively to the establishment of positive transference.	1
104. Therapists work on offering a corrective emotional experience by assuming an empathic, understanding and non-judgemental attitude.	1
105. It is important to allow time for this stage before moving on, as it takes time to establish basic trust and confidence in therapists and the group.	1
<b>Interpersonal Phase Specific Interventions</b>	
106. Once basic trust has been established, patients are encouraged to explore their differences while their feelings of safety are closely monitored.	1
107. Therapists should aim to help patients consolidate their sense of trust, to tame their fears and to increase their interactions within and outside the group.	1
108. It is important to help patients find ways of expressing their angry feelings in more constructive ways, so they do not feel the need to suppress these feelings or feel persecuted by them.	1
109. Therapists should help patients find words for expressing dangerous feelings so they can understand them and work on them rather than act them out or transform them into persecutory delusions/hallucinations.	1
110. Patients are encouraged to actively engage in problem solving so that they can gain more control over their lives.	2

111. Therapists should help patients to establish connections within the group (and outside the group) by watching others, listening to others and talking to each other, rather than merely imagining what others think. Learning to check their assumptions will help them to stay in touch with reality.	2
112. Patients should be helped to recognise the vulnerabilities and limitations imposed by their illness and to learn to react more assertively to other people's responses to their illness. Any sense of stigmatisation needs to be openly discussed.	1
113. Therapists should support patients' growing sense of self-awareness and awareness of other people's feelings through encouraging patients to actively ask questions, check their assumptions and express feelings and thoughts about their interactions with others constructively.	1
114. The PGP focus may now shift towards more long-standing problems and unhelpful relational patterns by looking at their impact on current relationships and functioning, both within and outside the group.	2
115. Individual symptomatic difficulties of the patients should be elaborated from a perspective that links them with the relationships with others.	2
116. Therapists should continue helping patients to improve their ability to build relationships inside and outside of the group in order to enable them to seek support and help outside the group when the group finishes.	2
<b>Termination Phase Specific Interventions</b>	
117. In medium and long term duration PGP groups termination should be communicated at least three months in advance.	2
118. A few months prior to ending, therapists with the help of other group members should summarise the improvement they have witnessed and the aspects that need further work.	2
119. Passivity of group members needs to be explored and challenged so patients learn to take more control of their lives.	2
120. Therapists should openly accept patients' criticism of PGP and explore patients' expectations which were not fulfilled.	1
121. Therapists should reflect with patients on the positive things they got out of PGP.	1
122. Therapists should comment on the creative and life-affirming aspects of the patient's and the group's functioning selves.	1
123. Therapists should support patients in containing feelings about loss and hope at the same time.	1
124. Therapists should help patients to say good bye and to think about what they learnt from others and what others learnt from them. Patients are encouraged to use what they have learnt to meet new friends and keep active once they leave the group.	1
125. If a patient wants to shorten the termination stage, therapists must explore the reasons to break the agreement to have a planned ending.	1
126. Both the group and the patient who is leaving should be helped to talk about their phantasies and worries about leaving the group and the plans they have after they leave the group.	1
127. Therapists should always offer a follow-up opportunity for patients leaving the group.	2
<b>Therapists' Qualities and Attitudes</b>	
128. Therapists should be able to access their own humanness, which also includes the ability to 'metabolize' and process their own psychotic-like experiences.	2
129. Therapists must have a capacity to tolerate and accommodate intense unspoken and unconscious conflicts.	1
130. Therapists must be active listeners and maintain analytic attitude.	1
131. Therapists must accept playing a modelling role and fostering a culture of tolerance, reflection and calmness. This attitude could help patients to feel safe enough to express their feelings.	1

132. Therapists must be patient, empathic and non-judgemental in their style. They should find a language that is acceptable and not hurtful for the patients.	1
133. Therapists must be able to maintain a balance between activity and inactivity (active observation).	1
134. Therapists must be able to respect a slow pace of change and be able to recognize and acknowledge small steps in patients' development.	1
135. Therapists need to be active, ensuring that silent periods are short so the levels of frustration, anxiety and ambiguity are low.	1
136. Therapists need to be honest and transparent about their attitudes, opinions and concrete information about themselves, ensuring that their work or safety are not compromised by these disclosures.	1
137. Therapists should be able and willing to reflect on their own responses to the patients, including their potential for negative responses, e.g. aggression, power struggles, guilt etc.	1
138. Therapists should be able to exhibit considerable awareness of countertransference reactions, even more than when working with other kinds of patients.	1
139. Therapists should aim to maintain realistic hope for patients, being mindful of the possibility of pessimism or over-ambition.	1
140. Therapists need to make their verbal interventions clear, simple and focused. They should check with group members whether their words have been understood if group members look puzzled or confused about the intervention.	1
141. When crisis is imminent, therapists should advise and guide patients in a concrete way as to how they should tackle the problems while being mindful of their own countertransference and the need to contain their own anxiety.	1
142. Therapists have to bear feelings of frustration, apparent meaninglessness and the laborious work that is required to help these patients make progress.	1
143. Therapists should be supported by supervision arrangements. This will enhance their reflective capacity and help them contain and process their patients' intense projections.	1
144. Therapists should be in supervision with a supervisor who is skilled in group therapy specifically with psychotic patients.	1
145. Conducting the group with a co-therapist can offer greater containment, consistency, stability and model effective ways of relating to these patients as well as offer support for therapists.	2

Overall, the set of statements designed for this study received a high level of consensus with 78% of the initial statements achieving consensus amongst the participants for consideration as essential components. The excluded statements are those which highlight the need for flexibility in the application of the PGP according to the individual circumstances of the group and its members. It is important to note that the phase specific interventions received more unanimous consensus compared to the generic interventions, which might mean that had these generic interventions been linked more specifically to the phases of the group dynamics, they might have

received higher consensus amongst the participants. For example, a method of free association, interpretation of dreams and uncovering interpretations are commonly avoided in PGP for psychosis in the earlier stages of the group dynamics. Maybe if they were amongst the interventions of the interpersonal phase, they might have received a stronger endorsement.

#### **Part Four: Results from the Thematic Analysis**

Comments made by 38 participants about the whole questionnaire in the second round and comments about rerating decisions made by 28 participants in the third round were compiled into a dataset which was submitted to thematic analysis. The following four themes were developed using the process of thematic analysis:

1. *PGP as a therapeutic technique which aims to understand the meanings behind experiences of patients with psychosis: “PGP offers a potential for healing and growth by helping individuals develop unique understanding of their experiences in a process of building relationships with other group members and the therapist”.*

This theme highlighted the main purpose of PGP being the search for the meaning of psychotic experiences. The theme included reflections on the role of interpersonal dynamics and interactions within the group as a media of the process of understanding. It also reflects on the group and its interpersonal dynamics as a curative factor and highlights other therapeutic factors of the group.

2. *Essential elements of PGP: “Exploration of unconscious dynamics are indispensable in order to remain in the psychodynamic frame”.* This theme contained comments on working with unconscious dynamics, transference and countertransference and the growing interface between PGP and other therapies in



the treatment of patients with psychosis.

3. *Supportive modifications of PGP when applied to patients with psychosis: “Patients with psychosis can benefit from PGP providing it has an important supportive component”*. This theme included participants’ ideas on required modifications to classical PGP technique for it to be safe and effective with patients with psychosis highlighting issues concerning setting, frame, exploratory stance, working with unconscious dynamics, using transference and countertransference and supervision requirements.

4. *Understanding psychosis from PGP perspective: “Psychosis is NOT a symptom, it is a valid response to life experiences”*. This theme included participants’ ideas around the nature of psychosis which underlined their approach to delivery of PGP.

***Theme One: PGP as a therapeutic technique which aims to understand the meanings behind experiences of patients with psychosis: “PGP offers potential for healing and growth via helping individuals develop unique understanding of their experiences in a process of building relationships with other group members and the therapist”***.

In this study PGP was defined as an investigative therapy which seeks to raise awareness of the group’s dynamics and individual internal conflicts in order to improve interactions between group members, thus enabling group members to draw on this experience to improve their interpersonal relationships beyond the group. This definition of PGP was developed through multiple discussions and group emails with the research panel members and received unanimous agreement. Participants acknowledged that belonging to various theoretical schools and coming from various training backgrounds could affect the way therapists apply the technique and respond

to their patients.

Participants were in agreement that what was specific and particular about the PGP for patients with psychosis was an attempt to understand and help patients find meaning in their psychotic experiences to help them reduce the distressing and debilitating impact of these experiences.

*“An aim of group therapy could be to explore the impact of the individuals experiences, what has been learnt, what the individuals understanding of this has been, what frameworks are available for understanding this that makes sense to the person etc. Where the objective is 'to prevent relapse' this devalues and dismisses the experience as "bad or undesirable" in some way. It would be more constructive to 'aim' to understand... Group therapy should explore the person's framework of their experience” (Other, Psychodynamic).*

All participants viewed group dynamics and a focus on interactions or relationships inside and outside of the group as intrinsic principles of PGP. The meaning of patients' experiences is developed through the analysis of the group dynamics and interpersonal relationships in the group. Participants argued that focus on interactions and group dynamics as a therapeutic technique had particular value for patients suffering from psychosis.

*“Fostering and reinforcing interactions between group members is a constant aim, nevertheless difficult to reach.... Immediate witnessing of any group process makes interactions, statements, and behaviour explicit, understandable, trustful” (Europe,*

*Group Analysis*).

Participants commented on group process and dynamics, particularly on the development and evolution of patterns of relationships among group members. Participants emphasised that in their attempt to develop meanings of patients' experiences therapists should strive for a balance that allows for therapeutic progress but at a pace that participants can tolerate in order not to encourage further regression and activation of primitive defences and the psychotic part of the individual and the group. Participants called for specific attention to be paid to the non-psychotic part of the patient and the group and therapy being a fluid dance/relationship of dipping in and out of psychotic states towards greater tolerance of psychic pain through the development of emotional meanings of the patients' experiences. Participants argued that interventions should depend on where the patient/group was at. Participants agreed that PGP should enable patients to get in contact with difficult feelings, trying to move toward more adaptive defences, but that therapists needed to be careful so as not to underestimate the patient's capacities. The therapist should be flexible regarding individual patients and their capacity to bear anxiety and understand unconscious material.

*"The patient has also the right to their beliefs and the therapist has to respect this right enough when offering challenging interventions"* (Europe, *Psychoanalyst*).

"The focus should be on what emerges in the group and what is important for the patients in order to work on the relations" (Europe, *Psychodynamic & Self Psychology*).

Working with and analysing group dynamics ties closely with a psychoanalytic way of addressing the specific origins and determinants of a rift in the social interaction and identity of a person as the most dominant in psychosis (Ginkel & Conway, 2009). This psychosocial dysfunction in psychosis is the primary concern of therapeutic engagement and intervention in PGP and is addressed through various group mechanisms, particularly with the use of mirroring phenomena.

*“The psychic disorder of psychotic type tends to isolate a patient, i.e. a person with psychotic regression is often tending to withdraw from his/her group(s). PGP sometimes represents the only way of contacting with others, besides some family member” (Europe, Group Analysis).*

*“It is well known that what one patient says has much more probability to exert an impact on another patient that is in crisis than the intervention of the therapist” (Europe, Group Analysis).*

The key advantage of group therapy is that the group and relationships in the group become therapeutic vehicles where key psychodynamic principles of attention to unconscious and transference/countertransference dynamics remain of paramount importance. Participants commented on the helpfulness of sharing and receiving comments from other members about symptomatic difficulties, *“as a way of experiencing helpful relationships here and now, even when symptoms are not perceived at once as having to do with relationships” (Other, Psychoanalyst).* Participants also commented that individual difficulties elaborated within the group from a perspective which links them to the relationships with others can be helpful as peer support but also enriches one’s ability to integrate the knowledge and

understanding as *“isolated knowledge of individual symptoms does not lead very far”* (Europe, Group Analysis).

The most fundamental aspects of group treatment in group analytic psychotherapy are the social process and the context of the group, which must be considered alongside a variety of psychodynamic formulations. Participants argued that in PGP therapists should foster and reinforce interactions between group members with the focus on here-and-now processes in the group where immediate witnessing of any group process makes interactions, statements, and behaviour explicit, understandable and trustworthy.

The participants agreed that only some therapeutic group factors were important when PGP is offered to patients with psychosis: the instillation of hope, cohesiveness, interpersonal learning input, universality and self-understanding reached high levels of consensus among our participants in being considered as core components of PGP for psychosis. Those which received the strongest endorsement were: “universality” (94.7%), “instillation of hope” (92.1%), “interpersonal learning output” (92.1%) and “self-understanding” (89.5%). Altruism, catharsis, existential awareness, guidance, family re-enactment and identification were identified by participants as not key in PGP for patients, with psychosis with “family re-enactment” (50%) receiving the least endorsement.

The outcomes of this study both differ from and support the outcomes of studies where the importance of the therapeutic factors was rated from the patients’ point of

view (Gonzalez de Chavez et al., 2000; Restek-Petrovic et al., 2014a). In this study, participating therapists, similarly to patients in the previous studies, rated the factor of instillation of hope highly, which might have to do with the group setting being a unique environment where the patients observe and remain in contact with the progress of other members. This could be of great benefit for the patient in feeling optimistic about their own capacity for change.

Participants highlighted that insight alone was not sufficient in the treatment of psychotic patients for recovery to be achieved, whereas group cohesiveness was rated highly in its importance by the participants, just as it was rated by patients in the previous studies. According to Bernard et al. (2008), mechanism of cohesion (member's sense of belonging, acceptance, commitment and allegiance to their group (Bloch & Crouch, 1985)) is the most central therapeutic factor of group psychotherapy. In general, the therapeutic relationship is considered to be a mechanism that operates across all therapies and is a major contributor to the change and improvement (Wampold, 2001).

It is interesting to note that despite a therapeutic factor of self-understanding having achieved a high endorsement by the participants in this study, an item which did not reach high consensus was the aim of gaining an understanding of conscious and unconscious factors, contributing to the formation and continuation of patients' symptoms. This outcome might be related to recent debate arising in the literature on whether insight is sufficient for patients to achieve recovery (Lysaker et al., 2009). It might also accord with the current observations on the tendency to overvalue unconscious dynamics at the expense of taking into account conscious experiences

and what is happening in the external world (Canete & Ezquerro, personal communication).

*“Danger of neglecting conscious dynamics and what is happening in the external reality. Don’t forget there is sick in the world not only in the patients” (Other, Psychodynamic).*

When trying to understand patients' experiences, participants highlighted that it is important to take into account what is happening in patients' lives outside the group and how this affects them.

*“But it seems especially important for psychodynamic therapists (who are trained to detect the unconscious conflicts/ structural deficits) not to neglect the CONSCIOUS material, since this can lead to formerly undiscovered unconscious conflicts/structures” (Europe, Group Analysis).*

The issue of insight and understanding will be further elaborated in the discussion chapter of this manuscript.

***Theme Two: Essential Elements of PGP: “Exploration of unconscious dynamics are indispensable in order to remain in the psychodynamic frame”.***

Participants emphasised that for the group therapy to have a particular psychodynamic focus it has to involve working with the unconscious, being attentive to transference and countertransference dynamics between the group, individual members and the therapist as key components of the intervention. They also placed

specific emphasis on the supervision requirements. These components also reflect specific psychodynamic/psychoanalytic techniques which were identified in the recently designed list of competencies required to deliver effective psychoanalytic/psychodynamic therapy (Lemma et al, 2008) as well as in the guidelines for practising PGP (Bernard et al., 2008).

*“Explorations of the unconscious dynamics (mainly, the interpretation of dreams), indispensable in order to remain in the psychodynamic without slipping into psychoeducation” (Europe, Fagiolian Psychoanalyst).*

Interestingly, the more prescriptive statements on how to handle transference and countertransference in PGP were excluded by participants from the set of key components (i.e., “Resistances and transference should not be analysed unless they interfere with the therapeutic process”, “Although positive transference should be fostered, transference should not be analysed, but should be kept in the therapist’s mind as a guide to individual and group dynamics”). Similarly, more orthodox approaches to working with unconscious dynamics were not supported by participants, leading to exclusion from the set of key components of PGP for psychosis (i.e., “The method of free association should be avoided”, “Therapists should avoid uncovering interpretations which seek to overcome defences; and increase depth of insight and mutative inner change”).

Although participants highlighted the specific elements of PGP which distinguish it from other therapeutic modalities, they also pointed out that developing bridges



between various therapeutic modalities and how various approaches can be usefully combined. Participants commented on the growing recognition among experts in the psychodynamic modality of other therapeutic modalities (i.e., CBT) and suggested that these modalities can usefully enrich each other's practices.

*“Certain homework, as mentioned above (although a technique of behavioural therapy), can be helpful if eg several participants often cannot remember what happened in most recent session/s - in this case we would suggest the participants writing down what happened in the latest group session... Behavioural therapy, including CBT, has started to include some psychodynamic principles (although sometimes under new names), also the importance of a good therapeutic relationship. And psychodynamic approaches/ PGP should not be afraid to consider the addition of scientifically proven techniques from other methods, as long as they seem helpful and do not disturb psychodynamic principles” (Europe, Group Analysis).*

Many participants commented on the qualities and attributes of the therapists required to practice psychoanalytically and included personal analysis of the group therapist as key, particularly in their ability to face their own psychotic like experiences and while being able to contain and metabolize very primitive and powerful emotions projected by their patients.

*“Therapists should be able to access their own humanness. Therapist should keep in mind that their humanity and sanity is an important therapeutic factor. I think it is*

*really difficult to be a group therapist for a person who thinks that human mind is psychotic by its nature” (Europe, Psychodynamic Integrative).*

Participants highlighted that working with psychotic patients in the group required the therapist to pay particular attention to countertransference and the toxic feelings projected into them, the containment of which can only be supported by regular supervision. It is often highlighted in the literature that management of countertransference in group settings is considered more difficult than in individual therapy because of the multiple and shared transferences directed towards the therapist as well as because of the public nature of the work (Bernard et al., 2008, p.496).

Participants argued that therapists should be in regular, and ideally specialised supervision arrangement with a supervisor who is knowledgeable about group work and psychotic processes as *“the nature of internal containment of toxic and thought blocking projective identifications by therapists means that the period of time these mental states are experienced should be minimized to avoid risk to the therapist of emotional stress and damage” (UK, Group Analysis).* Conducting group psychotherapy with psychotic patients is a challenge not only to a therapeutic technique, but to the “reflective space” (Hinshelwood, 1994), the countertransference and the self of the therapist. Further challenge comes from the intense dispersal of projective identifications in the group. *“The supervision in itself is an important part of the process. That is the right place to discuss all hypotheses occurred to the therapist, and also the more “In-statu-nascendi” hypotheses, that is hypotheses helped by different counter-transference experiences” (Europe, Psychoanalysis).*

Additionally, participants advocated co-facilitation and stressed the importance of co-facilitators exchanging experiences and thoughts in order to protect the processes of thinking and meaningful reflection from powerful projections of the group members. Co-facilitation was also highlighted by the participants as strengthening the frame and assisting with the development of helpful transference.

“If PGP for psychosis is run by a female and a male therapist to enable transference to both mother and father. Two therapists, even of the same sex, allow more easily a helpful transference of a parental pair” (Europe, Group Analysis).

***Theme Three: Supportive modifications of PGP when applied to patients with psychosis: “Patients with psychosis can benefit from PGP providing it has an important supportive component”***

Similarly to recently published clinical and theoretical papers (Aiello & Ahmad, 2014; Gonzalez de Chavez, 2009; Urlic, 2010; Ruiz-Parra et al. 2010; Lajer & Valbak, 2005; Canete & Ezquerro, in print; Restek-Petrovic et al, 2014a), participants in this study unanimously felt that certain adaptations to group analytic/psychodynamic technique were required when working with patients with psychosis. Participants commented on the necessity of the interventions being of a more supportive rather than exploratory nature and argued for a more active and facilitative approach towards the interactions between patients. According to participants, these adaptations seem to be particularly important in the early stages of group development and with patients with more fragile ego states. The more advanced the group is in its development and the more resilient patients capabilities in bearing emotional pain are, the more interpretative and less directive interventions

by the therapists should be, which is much closer to the classical group psychodynamic/analytic technique.

One participant argued that for PGP to be helpful to patients with psychosis it has to *“have an important supportive component and a thorough risk assessment has to be done before placing such a patient in a group. An extended individual assessment may help with adherence to therapy. Also a crisis intervention plan has to be agreed with the patient before placing him/her in a PGP. Progress needs to be monitored and good communication with the other professionals involved in the care of the patient is important. Providing all this is in place, I think these patients could benefit from PGP”* (UK, Group Analysis).

In terms of the specific adaptations to the technique of PGP, participants commented on applying more directive leadership and focusing on containment as well as interpreting. Although all participants highlighted the importance of assessing every case and every group on an individual basis and highlighted dangers of generalisations, they promoted a more encouraging and directive style of leadership when offering PGP to patients with psychosis.

*“Interactions are one of the basic principles. In PGP with patients with psychosis more reinforcement is needed than in PGP consisting of neurotic patients”* (Europe, Group Analysis).

*“The degree of active encouragement and identification should be decided considering the capacities of the group members”* (Europe, Group Analyst).

However, participants also highlighted that being directive should not be confused with educational, prescriptive, concretely supportive or assuming an expert or teacher style approach (which, according to participants, are more CBT style interventions). Participants stressed that therapists should avoid teacher like or “let me show you how to do it in a better way” approaches as they felt that it would interfere with patients connecting to their unconscious inner worlds and would disempower them in their ability to develop meanings and ownership of their experiences. They pointed that therapists should “*clarify rather than teach behaviours*” (Europe, Group Analysis).

Some participants specifically commented on taking risks with more exploratory challenging interventions with these patients only when the setting in which PGP is delivered is containing enough for any potential regressions and relapses of these patients. While stressing the importance of it being delivered as part of a wider therapeutic care programme (Kennard, 2009; Canete & Ezquerro, personal communication).

*“But sometimes (in severely chronic cases) therapists should think about powerful, but risky interpretations which could lead to a relapse in order to provoke a change, BUT ONLY IF the patient’s continued participation in PGP and other (social psychiatric) almost daily therapies and close communication between the carers seem guaranteed” (Europe, Group Analysis).*

Participants argued that the type and level of intervention should depend on the needs

of the individual. Interventions should depend on an assessment of the basic personality structure and the specific vulnerabilities of the members (potential difficulties with treatment could be discussed in preparatory sessions), on the assessment of the actual level of the patient's ego strengths and the patient's containing capacity. There is a need to be sensitive to this so as not to push the patient too hard or too fast.

*“Depends on the person... when the difficult areas come up and how safe the person feels at the time. Depends on dynamics, group composition, situation and momento of the group” (UK, Group Analysis).*

Participants commented on supportive interventions being more commonly used in the earlier stages of group development or when new members join the group, whereas uncovering interventions are more commonly used in the later stages.

*“Focus on here-and-now interventions should be the case in the beginning of therapy, in the advances stage there and then should also be considered” (Europe, Group Analysis).*

These comments support the general approach to PGP for patients with psychosis in the literature (Pines & Schermer, 1999). Although the literature reviewed often advocated against the use of free associations, analysis of transference and interpretation of unconscious material, participants in this study emphasised a much more flexible approach towards those recommendations. They stressed that the

assessment of the patient's and the group's ego strengths, vulnerabilities and level of functioning, as well as what is important and meaningful, should be the main guide for how supportive or uncovering the interventions should be. Participants cautioned against interpreting unconscious dynamics early in the group development as the existing symptoms and patterns of relating were in place to protect patients' fragile egos from coping with overwhelming painful meanings.

*“Either on conscious or on unconscious levels psychotic symptoms are prevailingly understood the therapist should be always very cautious whether to enter into explanations regarding possible causative elements of the disorder and its symptoms. It depends mostly of the therapist's assessment of the actual level of patient's ego strength” (Europe, Group Analysis).*

*“We are treating PSYCHOTIC patients! So, be careful with probatory interpretations of Unconscious material in the prep session and even later in the group! The patient must have developed enough trust in the therapeutic relationship/group coherence, he must be able to bear your (therapists') intervention tackling his unconsciousness and should be shortly before discovering it by himself” (Europe, Group Analysis).*

Additionally, an issue of patient suitability for PGP was mentioned by some participants. Although the statement that PGP can be offered to patients at various stages of the onset of their illness and for various therapeutic purposes reached high consensus, participants also raised caution in offering PGP to patients with negative symptoms, to patients who are acutely psychotic or who have unaddressed addiction

issues. One of the participants wondered whether PGP was more suitable for “stabilized patients” with residual positive symptoms and with an explicit need to work on interpersonal relationships.

Participants commented that, from a psychoanalytic perspective, it is vital to have a frame for working with psychotic patients. One participant felt that frame issues were not sufficiently reflected in the survey: “*a highly important symbol, the frame, was hardly mentioned in this Delphi Study*” (Europe, Group Analysis). It is hard to underestimate the containing and holding function of the frame in working with patients with psychosis. If the therapist and the group setting is consistent and reliable, patients feel safer to act out and work through their distressing internal relational dynamics. In their comments, participants highlighted the following frame issues: patient selection, the size of the group, preparatory and probatory (trial) sessions, confidentiality, cross-professional communication, co-therapy, duration of treatment, combination with individual therapy, responses to changes in the setting, flexibility of the structure and the role of follow-up sessions.

A large number of participants’ comments were about suggested modifications to the frame of PGP. It was highlighted that consistency of the frame was of utmost importance. However, participants felt that the frame should be presented as an optimal way of functioning rather than rigid rules or expectations formulated by therapists. Participants suggested that the number of patients to be included in a PGP group depended on the theoretical approach of the therapist (group-as-a-whole approach can be applied to bigger groups), setting and type of the group, and could



include between 8 and 12 patients. One participants stressed that the group size should be not too daunting for most anxious patients but should not be too big in order to provide individual patients with special care when necessary (UK, Group Analysis).

Participants felt that preparatory sessions were useful for helping patients engage better with PGP but that their structure should be adjusted to the patient's needs and level of functioning. One participant felt that the way patients engage in preparatory sessions could be approached from the assessment point of view and might indicate whether PGP could be appropriate for them or not. Another participant suggested the idea of "probatory group sessions", where new patients entering the group could be offered 3-5 group sessions where they could have an experience of group therapy and decide whether they wanted to continue or not.

Participants felt that some structure to the sessions was useful as it helped to balance anxiety in the group and *"to structure the non-structured parts of patients' external and internal spaces, but it should be flexible enough to help even the most unusual experiences to take a form of dialogue"* (Europe, Psychoanalyst). Participants felt that opening and closing rounds in the group sessions could be useful with an opening questions of what was important in the previous session to help all patients say something or to reactivate the unfinished agenda and the message from the previous session if the therapist felt that it was worthwhile and important to enter the conscious consideration of the members.

Although majority of participants felt that both individual and group psychodynamic psychotherapy could be helpful for patients with psychosis, some cautioned against offering both individual and group therapy at the same time as they felt that *“one therapy can be an obstacle in another; the transference is often split”* (Europe, Group Analysis). They advised for therapists to be careful about the ambivalence present in patient’s split off internal world when recommending combinations of therapies. However, when these issues are carefully thought about combination of PGP with family therapy was considered helpful.

All participants who provided comments in the third round argued that longer term therapy should be offered to these patients (over two years) as *“significant changes correlate with duration time of participation”* (Europe, Group Analysis). Although majority of participants argued that PGP therapy should be offered open-ended to these patients, one participant warned against this *“in order to reduce ambiguity and uncertainty”* (Other, Interpersonal Psychoanalysis and Self Psychology). All participants agreed that termination should be communicated to the patients well in advance (at least three months in advance) as time is required for *“metabolisation”* (Europe, Group Analysis), particularly for patients with psychosis who struggle with adjusting to change. Participants suggested that termination, like other events in the group (new members joining, therapists leaving etc) should be explored from the position of the meaning of communicated emotions (eg., fears, sorrow), fantasies and thoughts. Although the idea of follow-ups was generally supported by the participants as it could be used as *“a symbol (for ongoing support/ongoing relations with the group) which increases patients’ hope/confidence”* (Europe, Group Analysis), one participant cautioned against it as it might compromise work on ending for patients

who become very dependent on the group.

Importantly, one of the lowest consensus levels among the participants was reached on whether PGP can be helpful without adjunctive medication, which suggests that participants felt that medication was an important part of a complex approach to the treatment of patients with psychosis. Additionally, participants spoke about the importance of delivering PGP within a multidisciplinary or community setting. They highlighted that not only does this allow for the creation of an important containing and holding environment for the patient but also for an important supportive setting for patients to practice new ways of relating to themselves and others outside of the group. This way of delivering PGP also helps various therapeutic modalities and approaches to complement each other and avoid situations of undoing each other's work or acting out splitting dynamics of individual patients. This containing environment also allows for PGP to work at times on deeper exploratory levels.

*“Psychiatrists, psychologists, and when necessary other professionals should liaise in order to better understand conditions of a patient and to organise help” (Europe, Group Analysis).*

Although overall participants agreed on the need for sensitive and respectful information sharing between the health professionals involved in the patient's care, they advocated the patient's involvement in this process. They argued that information sharing should be patient-friendly, foster confidentiality, avoid unconscious material and in general should contain only what seems really important

or helpful to be discussed with other health professionals, otherwise “this could lead to less frankness, less spontaneity of the group members” (Europe, Group Analysis).

**Theme Four: Understanding psychosis from PGP perspective: “Psychosis is NOT a symptom, it is a valid response to life experiences”**

This theme had a very passionate and engaging representation in the dataset. Participants insisted that when delivering PGP, psychosis should not to be viewed solely as an illness without taking the person who suffers it into account. According to the participants, when delivering PGP to patients with psychosis professionals should maintain an understanding of psychosis as a response to overwhelming emotional experiences (Martindale, 2007; Rosenbaum et al., 2013; Bell, 2003; Bentall, 1993). Participants felt that understanding psychosis as an illness was unhelpful, stigmatising and even damaging.

*“The alienation of patients often is treatment conducted: seeing the psychosis, especially as a life-long fate. Then the word “negative symptoms” is, in fact misleading: the negative symptoms can be a symptom of treatment system, not only that of the patient” (Europe, Psychoanalyst).*

*“Group therapy should explore the person’s framework of their experience (psychosis is NOT a ‘symptom’, it is a valid response to life experiences) ....without a pre-conceived notion of the outcome of the exploration” (Other, Psychodynamic).*

Participants stressed that only seeing PGP as an illness when offering therapy can be

demotivating, disempowering and even risks intervening with the recovery process of the patients. Their responses to the statement “whether PGP should aim to help patients acknowledge and come to terms with the losses or changes in their life due to their illness” divided in the following ways:

*“I strongly disagree because the question suggests a kind of resignation towards the limits imposed by a permanent disability. We know, instead, that psychosis are always treatable and sometimes even with amazing results. The idea of immovable limits and changes due to patients’ illness would demotivate them” (Europe, Fagiolian Psychoanalyst).*

*“Therapy should help patients find their way towards recovery, not come to terms with “illness”, which is a rather biased and potentially harmful concept of psychotic condition. That doesn't mean that therapy shouldn't help patients acknowledge the complexity of the situation, as well as reality factors” (Other, Psychoanalyst).*

Recently it has been advocated to use extreme caution in making a diagnosis of schizophrenia as it can generate stigma and unwarranted pessimism (Cooke et al., 2015). The British Psychological Society (Cooke et al., 2015) argued that continuous medicalisation of people’s natural and normal responses, even though with at times distressing consequences, often misses the relational context and the social roots of many such problems. As an alternative to labelling and diagnosing an approach of ‘collaborative formulation’ was suggested which explores the personal meaning of the events, relationships and social circumstances of someone’s life, and of their

current experiences or distress (Cooke et al., 2015; Bentall, 1993; 1998). Unlike an alienating nature of diagnosis, this approach is based on the assumption that however extreme and unusual the nature of one's presenting difficulties at some level they are meaningful and sense can be made of them. The task of PGP, according to participants, is to help people develop understanding and meaning from their experiences with the help of group therapy members and the therapist.

*“Exploring current 'adaptations' may well reveal the external circumstances or experiences as the source of pain/distress ... to practice how to interact in a more 'adaptive manner' is fine as long as this goes hand in hand with looking at the external experiences as well. Another way of saying this is that there is far more value in exploring what is sick in the world and how we can better cope with this than there is in helping people who are rightly affected by this to 'adapt' to a sick world. The outcome may be the same but the emphasis is very different - the 'sickness' is not solely located in the patient and group therapy needs to reflect this” (Other, Psychodynamic Psychotherapist).*

Participants spoke about the importance of bearing in mind that behind symptoms and experiences there are individuals with their life stories and experiences. Participant stressed their disagreement with the focus on symptoms in PGP.

*“I do not totally agree with the emphasis of symptoms. It is often as important to see the non-psychotic conscious and unconscious factors contributing to grip of life and to see in PGP how the other group members succeed” (Europe, Psychoanalyst).*

*“Grief and loss for some may be issues they may wish to focus on, however for others "psychosis" may be a positive vehicle for healing and growth - again , assumptions or value judgements about the individual experience is not helpful, and may even be counterproductive as without extreme sensitivity and awareness the individual's unique understanding and potential for healing and growth can be 'overruled' by the 'clinical' paradigm of (for example in this question) 'loss' and 'illness' and in previous questions 'symptoms'” (Other, Psychodynamic).*

Participants stressed the move away from the focus on the problem and the symptoms to the development of meaning of patient's and group's experiences and helping patients understand what their experiences are about. According to one of the participants, this search for meaning should be underpinned by a sense of dilemmas being generally human and not exclusively pathological.

### **Part Five: Summary**

Thirty seven experts participated in the study worldwide and endorsed 145 components as the key elements of PGP for psychosis. The excluded 35 components highlighted the need for flexibility and individual assessment of each group and its members' circumstances. The seven items which did not gain the predetermined consensus level gave focus to areas of debate and of future research and will be further explored in the discussion chapter. The themes identified in the participants' comments deepened insight into the areas of conceptualisation, application and modifications of PGP when applied to patients with psychosis. The identified themes

reflected participants' understanding of PGP as a therapeutic intervention aimed to understand patients' experiences where a focus in the conceptualisation of psychosis has shifted from the symptoms to the understanding of psychosis as a response to overwhelming life experiences. The themes identified also included participants' elaborations on the essential elements of PGP and its modifications when it is applied to patients with psychosis.

Although the above results are of practical importance to the development of the standard for PGP for psychosis, at this point they only can be considered as an initial stage in a research programme where this set of statements will need further development to become a more practically applicable set of criteria and where the statements can be further refined and evaluated. Illustrating these essential ingredients of PGP for psychosis with clinical vignettes and accounts provided by experienced PGP clinicians might also assist in the future development of a PGP for psychosis manual or a set of clinical guidelines which would be helpful in the training, standardisation and future research of PGP for psychosis.



## **Chapter Four: Discussion**

### **Part One: Introduction**

To the best knowledge of the investigator, this is the first study that attempts to achieve expert consensus regarding the key components of PGP for psychosis. In consolidating opinion, a high degree of consensus was obtained on a wide range of items regarding indications for treatment, therapy aims, therapy frame, therapeutic factors, assessment and preparatory sessions, formulation of hypothesis, a general therapy approach throughout assessment and therapy, phase specific interventions and the therapists' qualities and attitudes. The set of 145 key components of PGP for psychosis endorsed by expert participants as the result of this study closely reflects the existing set of competencies for psychodynamic work (Lemma et al., 2008) and the guidelines for practicing psychodynamic group psychotherapy (Bernard et al., 2008). This is an important outcome of this study as the devised set of key components received a high consensus amongst the participating experts as well as reinforced the existing competencies and guidelines.

Both the literature and experts' opinions highlight the following unique aspects of PGP when delivered to patients with psychosis: the intention of understanding and deriving meaning from psychotic presentations, viewed rather as ways of coping with unbearable mental pain and difficult life experiences. The development of the meaning and understanding of presenting difficulties is achieved through the analysis of interpersonal group dynamics pointing out group as one of the key curative factors. Additionally the reviewed literature and the carried out Delphi study highlighted significant modifications required for PGP as a technique when applied

to patients with psychosis. Detailed accounts of PGP for psychosis in the literature and the analysis of experts' comments identified that a significant part of the communication in these groups is carried out through the intense toxic projections of the patients, which poses specific requirements to the analyst's training and qualities and particularly the need for specialist supervision. Participants also stressed that when working with unconscious dynamics and the transference in a PGP setting with patients with psychosis, a careful balance between supportive and exploratory approaches should be observed depending on the individual's and the group's levels of functioning.

This chapter presents a discussion of the above outcomes in relation to the existing literature followed by an overview of the strengths and limitations of this study. The chapter concludes with the summary of the study's outcomes, implications and recommendations for future research.

## **Part Two: “Psychosis is NOT a symptom, it is a valid response to life experiences”**

In line with the recently published report “Understanding Psychosis and Schizophrenia” (BPS, 2014), participants in this study pointed out the aspects of a diagnostic label of psychosis as being unhelpful at times; they stressed the dangers of seeing psychosis as only an illness in delivering PGP, which can be demotivating, disempowering and can even intervene with the recovery process of patients. Participants and the literature called for the efforts in treatment to be spent on understanding the presentation rather than on labelling it.

The BPS Report (2014) promotes the idea that psychosis can be understood and treated in the same way as other psychological problems – an idea which has long been promoted by psychoanalytic psychotherapists and supported by the participants in this study. Participants in this study, in agreement with the BPS Report (2014), stress that whilst medical treatment is important, people with psychosis also need to be helped to make sense of their experiences. The Report suggests that these problems are often a reaction to trauma or adversity of some kind which impacts on the way we experience and interpret the world and that these patients should be helped to make sense of their experience with the help of psychological therapies and not just given medication.

The Report highlights that although thinking of psychosis as an illness can have some advantages, for example, it provides a framework for offering help (time off work, benefits, and access to services) or not feeling alone. Timely recognition and diagnosis of serious mental illness can lead to appropriate and lifesaving treatment. Furthermore, some people may find being given a diagnosis meaningful, supportive and something which gives them hope. In other ways thinking in terms of illness can be unhelpful. People who received this diagnosis often felt stigmatized, disempowered and excluded from mainstream society. Additionally, giving diagnosis can divert attention from the possible meaning or positive aspects that the experiences might have for the person.

Psychotic symptoms are more and more understood as reflecting a person's real life experiences (Rhodes & Jakes, 2004). Recent research findings on the psychogenic nature of psychosis highlight the importance of the search for meaning promoted by PGP for the recovery and increased wellbeing of patients with psychosis. Read et al.

(2005) found strong support for the theory that early childhood trauma, such as abuse and neglect, could lead to the development of psychosis in later life. Recent research also shows support for the 'traumagenic neurodevelopmental' model of psychosis, which suggests that the anomalies of the brain so often associated with biological causes of schizophrenia can be caused by adverse life events, especially those occurring in early childhood (Read et al., 2005).

Bentall (1993) challenged the concept of schizophrenia and advocated for treatment modalities working towards making psychotic behaviour more comprehensible and thus more obviously related to ordinary behaviours and experiences. He gives examples of hallucinations which often accompany ordinary experiences such as post-bereavement, solitude and the twilight periods between sleep and wakefulness etc (Bentall & Slade, 1988). He goes on to argue that delusions may often reflect an individual's life experiences such as powerlessness and victimization (Bentall, 1993). The concept of 'schizophrenia' has been criticized for its dubious utility both in terms of predicting symptoms (construct validity) and in terms of predicting outcome (predictive validity) (Bentall & Slade, 1988). Additionally, the term 'schizophrenia' encompasses too diverse or heterogeneous a group of people to be a meaningful concept (Benning, 2007).

The debate on the role and nature of insight in contemporary psychotherapy literature also highlights the shift in approach from labelling to understanding. Lysaker et al. (2009) argued that where traditionally insight was understood as patients considering themselves ill or their experiences to be signs of being unwell, a synthesized view of insight as a process of personally making sense within one's own personal narrative of experiences and losses may offer a range of clinical insights, revealing how there

might be different paths to recovery. In recent decades, the psychoanalytic concept of insight has also evolved, whereas it previously referred to awareness of unconscious processes, is now considered to be the patient's awareness of changes experienced (Garcia-Cabeza & Gonzalez de Chavez, 2009). Lysaker et al. (2009) and Mak and Wu (2006) suggest that to be meaningful, insight needs to be an element of a larger personal understanding of one's life and go beyond awareness of illness.

*The development of personal meanings of experiences linked to illness are catalysts for the recovery process, with changes in self-understanding paving the way for reduction in symptoms and improvement in function (Lysaker et al., 2009, p.117).*

According to the outcomes of the studies by Gonzales de Chavez et al. (2000) and the outcomes of this study, self-understanding is considered by the patients and by the therapists to be the one of the most valuable therapeutic factors in long-term PGP with outpatients with psychosis where patients are already in the advanced stages of their treatment. Additionally, participants in this study highlight that group therapy represents a unique context where meanings of patients' experiences could be developed with the help of analysis of interpersonal group dynamics and the mirroring function realized by other group members as well as the containing attitude of the therapist.

*Group psychotherapy introduces many factors that help self-knowledge: the multiple mirror reactions are used to draw the patients out of their isolation and singularity. It provides them with insight on the subject or psychopathological character of the psychotic experiences of the other group members and helps them to accept and admit the subjective character of the psychotic experiences of the other group members and helps them to accept and admit the subjective character of their own disorders, thus encouraging self-knowledge and change (Garcia-Cabeza & Gonzalez de Chavez, 2009 p.141-142).*

### **Part Three: PGP as a search for meaning**

Participants in this study highlighted the nature of psychodynamic understanding of psychosis where psychosis is viewed as an adaptation to be understood rather than an illness to be eliminated. Psychoanalytic theories have always pointed out aspects of adaptation and coping in psychosis and the danger of eliminating symptoms and exposing patients to unbearable mental pain which psychosis was used as coping or defence mechanism (Bell, 2003). Participants in this study stressed the move away in PGP for psychosis from the focus on symptom elimination to the process of understanding and developing meanings of patients' experiences in order to reduce the distressing impact of disturbing and frightening feelings (see Theme One in the Results Chapter).

The psychoanalytic understanding of psychosis is very different from a medical paradigm and underpins the practice and delivery of PGP to these patients. The psychoanalytic approach offers a unique way of grappling with psychotic processes and primitive mental mechanisms, bringing an attitude where meaning is given a priority (Steiner, 2013) and based on the general assumption that psychological phenomena are amenable to understanding (Segal, 2013). Already Freud (1923) pointed out that “even the apparently most obscure and arbitrary mental phenomena invariably have a meaning and a causation...” (p. 1979). Urlic (2010) adds that “the psychodynamic culture opens up possibilities of deeper and more complex understanding of the psychic functioning of the patient, and enlarges the containing capacity for the patient’s most overwhelming symptoms” (p. 11). The healing quality of being understood has been highlighted frequently in the psychotherapy literature.

There is an ongoing debate in the literature about the curative power of interpretation as a conveyor of insight versus interpretation as a conveyor of certain emotions and positive kinds of interrelatedness which leaves the patient with a feeling of being understood, not necessarily on a verbal or cognitive level (Stone, 1983).

PGP helps these patients with major deficit in symbol formation to connect words or thoughts with (unconscious) emotions and ideas that have become dissociated or fragmented. This process may be understood as creating a space for reflection and consensual validation or development of metacognitive capacity (Lysaker, 2010 as cited in Rosenbaum et al., 2013). Rosenbaum et al. (2013) add that the essential idea of supportive psychodynamic psychotherapy is that there should be a gradual build-up of empathic collaboration in meaning-making that becomes increasingly internalised by the patient and which may be crucial to reducing the patient's anxiety and distrust in relationships in the long term.

Working psychoanalytically with patients with psychosis, individually or in groups, helps therapists to make sense of the chaotic presentation of chronic psychosis and offers a patient a space to reflect freely on their experience as well as derive meaning from overwhelming and distressing experiences (Martindale, 2007; Lucas, 2008; Rosenbaum et al., 2013). In psychodynamic therapy with supportive modifications the therapist's task is to actively attempt to understand the patient as a person with conflicts, identity difficulties and emotional sadness and confusion, and to let the patient feel that the therapist understands them (Fromm-Reichmann, 1959 as cited in Rosenbaum et al., 2013).

From a psychodynamic perspective, both in literature and in this study, psychosis is thought of as a response to unbearable affects and circumstances and it is to be expected that those very affects will frequently emerge in the therapeutic setting, not unusually within therapists themselves (countertransference). Therapists will often have to struggle within themselves with difficult feelings such as significant anxiety, loneliness, hostility and also frustration from a lack of improvement (Fromm-Reichmann, 1959). Being aware of these internal processes may help the therapist to listen to and clarify the meaningful connections between these feelings and the problems that provoked or maintain the patient's psychosis – connections that otherwise may be easily overlooked and disregarded (Rosenbaum et al., 2013).

Participants in this study, in agreement with the literature (Gabrovsek, 2009), highlighted the crucial importance of paying attention to powerful countertransference reactions evoked in the facilitators of groups with psychotic patients as one of the sources of powerful communication by the patients (see Theme Two in the Results Chapter). Participants highlighted the important role of supervision for group facilitators to help them contain and reflect on powerful emotional responses and group dynamics. It is often argued in the literature that management of countertransference in the group setting is considered more difficult than in individual therapy because of the multiple and shared transferences directed towards the therapist and because of the public nature of the work (Bernard et al., 2008). “The therapist should appreciate that containing and working through destructive forces (in the group, in the context of the group, or in the group leader) holds the possibility for creative growth and therapeutic change” (Nitsun, 1996 as cited in Bernard et al., 2008, p.496). It is highly important for the therapists to attend



to their emotional reactions in supervision and to persist in exploring their roots in an ongoing way to help distinguish whether these reactions emerge from the therapist's internal world or are induced by patients' projections.

Although co-facilitation was not unanimously endorsed by the participants as a preferred method of conducting PGP groups with psychotic populations, it was highlighted that co-facilitation offers additional space for the reflection and can help therapists share the burden of toxic projections by the patients. The hope is that at least one of the therapists will be able to maintain their capacity to think when the other therapist's thinking is under attack by powerful projections. Participants and the literature stressed some specific competencies that are required for the therapists in order to work within PGP model with patients with psychosis including extensive training and personal analysis, flexibility, humility and ability to withstand and bear internal storms (see Theme Two in the Results Chapter). One of the participants argued that *"herapists should be able to access their own humanness. Therapist should keep in mind that their humanity and sanity are important therapeutic factors. I think it is really difficult to be a group therapist for a person who thinks that human mind is psychotic by its nature"* (Europe, Group Analysis).

#### **Part Four: Group and interpersonal dynamics as agents of change**

According to psychoanalytic thinking, the roots of psychosis are in disturbances in early relationships. These psychotic experiences are ways of adapting and coping with the resulting mental pain (Symington, 2013). Foulkes (1975) argued that individuals as social beings and a group represented a unique media or environment

for the emotional healing to take place. Foulkes referred to the healing process in groups as “ego training in action” (Foulkes, 1975, p.112) where the group works as a therapeutic and social environment that helps build ego strengths of its members. Participants in this study stressed that *“PGP offers a potential for healing and growth via helping individuals develop unique understanding of their experiences in a process of building relationships with other group members and the therapist” (Other, Psychodynamic Psychotherapist).*

Group analysis places great emphasis on the potential evolution of the group into a therapeutic process in which treatment is “of, by, and for the group” (Foulkes, 1964; 1975). For example, through a process of mutual mirroring the group itself becomes a curative agent. A skilled and empathic group therapist can facilitate significant inter-member communication and help the members to support each other and to reflect on their own and each other’s behaviours. To that extent, the members can internalise some of the leadership functions and the group itself can become a curative agent (Schermer & Pines, 1999). Additionally, the group aspect of the psychotherapeutic treatment was recently empirically explored in the systematic review and meta-analysis of group treatments for patients with schizophrenia by Orfanos et al. (2015), which highlighted that the impact of group mechanism on negative symptoms and social functioning deficits appears to be non-specific and shared across a wide range of psychotherapeutic treatments delivered in a group setting.

Participants in this study pointed out the following unique benefits of PGP for psychosis highlighting the group aspect of the intervention being a therapeutic factor

in itself (see Theme One in the Results Chapter):

- Participation to the degree patients feel comfortable
- Improvement in reality testing via mirroring patient's experiences in others
- Being accepted as an equal
- Desingularization and loss of sense of uniqueness
- Feeling competent and meaningful in being able to help others and have something important to offer
- Dilution of the transference
- Corrective emotional experience
- Workshop for interpersonal relationships

The therapeutic potential of PGP described by the participants reflects the identified specific therapeutic qualities of PGP for psychosis described in the literature (Chazan, 1993; Gonzalez de Chavez, 2006; Canete & Ezquerro, personal communication). However, there is an ongoing debate in the literature on whether group therapists have over-emphasized group-specific mechanisms of action (Bernard et al., 2008). On one hand, Horwitz (1977) noted that some group writers and clinicians "anthropomorphize" the group so that it becomes the patient, leading the therapist to focus solely on group-level interventions at the expense of individual members. On the other hand, the recent guidelines for group psychotherapy argue that participating in a therapeutic venue comprised of multiple therapeutic relationships produces therapeutic factors that are unique to the group format

including interpersonal learning, altruism and cohesion (Bernard et al., 2008). Additionally to this discussion in the literature it is important to note that participants in this study excluded the component “Therapists will aim to reflect on only group-as-a-whole processes” from the key components of PGP for psychosis and advocated a balance of individual and group-as-a-whole interventions.

Among the specific therapeutic elements of group psychotherapy many authors distinguish context, dynamics, mirroring, content, matrix and group therapeutic factors. All of these elements are subject to mutual influences and modifications as the group therapeutic process and its different stages advance (Gonzalez de Chavez, 1997). Corsini and Rosenberg (1955) classified the essential mechanisms for therapeutic success in group psychotherapy, following which Yalom (1985) identified group therapeutic factors and defined them as series of therapeutic action mechanisms which generally exist in group therapy and which help bring about change in the patients, thus contributing to the therapeutic process (Gonzalez de Chavez et al., 2000).

From the studies of the importance of various group therapeutic factors as evaluated by the patients with psychosis the instillation of hope, universality and self-understanding were identified as the most valuable, whereas identification – as the least valuable (Garcia-Cabeza & Gonzalez de Chavez, 2009). Recent research has also established that certain factors are more important for the patients at different stages of group and individual development (Restek-Petrovic et al., 2014a). For example, catharsis and family re-enactment become more important for patients who have spent longer time in the group. Also self-understanding is valued more by outpatients than by inpatients with psychosis and is generally attributed to later

stages of patients' therapeutic journeys (Garcia-Cabeza & Gonzalez de Chavez, 2009). These findings are particularly revolutionary in helping therapists choose which strategies to use in their work depending on the life stage of the group and ego strengths of the individual members.

The outcomes of this study showed that the instillation of hope, cohesiveness, interpersonal learning input, universality and self-understanding reached high levels of consensus among the participating therapists in being considered key components of PGP for psychosis with “universality”, “instillation of hope”, “interpersonal learning output” and “self-understanding” having received the strongest endorsement. Altruism, catharsis, existential awareness, guidance, family re-enactment and identification were identified by participating therapists as not sufficiently important for PGP for psychosis with “family re-enactment” receiving the lowest level of endorsement.

These outcomes both confirm and differ from previous studies where patients were asked to rate the importance of the therapeutic factors. Both therapists and patients evaluated the instillation of hope, self-understanding and universality as the most important therapeutic factors and the identification as the least important. Recently strong evidence has emerged that many people diagnosed with schizophrenia recover over time with many experiencing symptom remission, attainment of psychosocial milestones and regaining the sense of wellbeing (Lieberman et al., 2002 as cited in Lysaker, 2009), which helps patients remain connected to the hope for potential recovery throughout their PGP treatment. It seems important that the hope is held not

only by patients but also by clinicians as it can often feel as if no progress is being achieved when working with these patients.

The low rating given for the importance of “identification” might relate to what Restek-Petrovic et al. (2014a) state regarding imitative behaviour carrying the risk of loss of self-identity and individuality. It might also have to do with patients’ fears of being engulfed by the group. From the participants’ perspective identification could be at times confused with teaching and thus being disempowering, a possibility which has been heavily debated by participants in this study. As such this therapeutic factor was excluded (see Theme Three in the Results Chapter). Therapists also seem to view the therapeutic potential of the group differently from the patients, in giving interpersonal learning more importance, which might have to do with the group mirroring phenomena being particularly highlighted by the participants from a group analytic background, who comprised the majority of the participants in this study.

The research results by Restek-Petrovic et al. (2014a) established that longer participation in the group was associated with a greater perceived importance of “catharsis” factor, which authors linked with the longer time required for patients to develop trust in the containing capability of the group to freely verbalise their emotions. Also, “family re-enactment” was perceived as more important by patients who participated in the group over a long period of time. Authors suggested that, as most patients with psychosis have dissatisfying experiences in their families of origin, using the group for working through those experiences in transference also requires time. Therefore, the high evaluation of this factor might imply some degree of insight into actualisation of early patterns of interaction within the secure

conditions of the psychotherapy group. This, in turn, might lead to the development of more mature object relations and results in overall improvement of social functioning (Restek-Petrovic et al., 2014).

According to Yalom and Leszcz (2005), group therapy resembles a family in many aspects (authoritative or caring parental figures, sibling dynamics, strong emotions, hostile and competitive feelings as well as feelings of solidarity, companionship, belonging and loving). They argue that resolving transference problems with the therapist and with other members of the group means simultaneously resolving “unfinished business of the past”. If the therapy is successful, a patient will experiment with a new sort of behaviour and will modify the family roles they had in the past, repeated experience of different aspects of their family roles and relationships might help to change internalised object representations (Restek-Petrovic et al., 2014a). In contrast to the findings from the patient evaluation research, “family re-enactment” was evaluated as important by the least number of participating experts and thus was excluded from the list of key components of PGP for psychosis. This outcome could be thought about in relation to the idea of “the group as the particles of the mind” (Hinshelwood, 2008) rather than the idea of the group as family organisation of individuals. Hinshelwood (2008) proposes to conceptualise group dynamics as a process where individual members are locked into specific mental functions of the group/mind and not just a social/family role which can give a greater understanding of the group dynamics than viewing the group as a resemblance of the family.

These findings can be particularly helpful for group therapists when choosing which

strategies to use in their work depending on the life stage of the group.

### **Part Five: Required adaptations to PGP when offering it to patients with psychosis**

All reviewed accounts of PGP in the literature and the outcomes of this study concluded that classic PGP techniques required certain adaptations when they were applied to patients with psychosis. These modifications were discussed at length in the introduction chapter and in the results chapter as part of the analysis of Theme Three. The discussion below will mainly focus on the modifications which raised the most debates in the literature and among the participants and which commonly have not reached consensus thus suggesting the need for further research.

Significant modifications were suggested by the participants in this study in the following areas: a more supportive approach, active leadership, cautious work with unconscious dynamics and transference, and specific supervision requirements. Although the application of a traditional interpretative (uncovering) approach to patients with psychosis is not recommended in the literature (Goldstein, 1998), participants in this study erred on the side of more inclusivity rather than restrictions in application of a more interpretative approach as well as advocating for a more flexible application of PGP principles. However, participants did advise caution when working with unconscious dynamics and transference. *«Either on conscious or on unconscious levels psychotic symptoms are prevailingly understood the therapist should be always very cautious whether to enter into explanations regarding possible causative elements of the disorder and its symptoms. It depends mostly on the therapist's assessment of the actual level of patient's ego strenght» (Europe,*



*Group Analysis*).

These recommendations seem to reflect Bion's idea of the dialectic co-existence of psychotic and non-psychotic parts in the minds of the group and individual (Bion, 1957). Bion defined psychotic functioning as the relative presence of an active psychotic structure and process of mind. This psychotic part of mind actively opposes and interferes with non-psychotic functions of the mind, which are concerned with achieving and sustaining engagement in relationships across the range of social life – family, social, sexual, professional. The non-psychotic part is developmentally prepared to tolerate and negotiate the emotional challenges and dilemmas which inevitably accompany the social nature of our lives (Ginkel & Conway, 2009). The psychotic part, on the other hand, is characterised by its preoccupation with relating omnipotently and safeguarding against the emotional impact associated with relating intimately. The motivation of a psychotic part of mind is to minimize the vulnerability of interpersonal reality and avoid conflictual and painful thoughts and feelings (Ginkel & Conway, 2009).

Participants argued for it to be borne in mind that patients and groups operate from both non-psychotic and psychotic parts (see Theme Four in the Results Chapter). Participants spoke about taking risks and not underestimating the capacities of the patient. They advised assessing the ego strengths of the individual and the group and basing how interventions should be applied on the prevalence of either psychotic or non-psychotic parts (see Theme Three in the Results Chapter). Participants suggested that the less the patient's and/or group's mind is dominated by the presence of psychotic parts, the more interpretative, explorative and challenging the approach

taken with the patients could be. Rosenbaum et al. (2013) argue, that even in situations where the patient still has major psychotic symptoms, the therapist needs to trust in the existence of some normally functioning aspects of patient's personality (Bion, 1957), and support these more sane parts in a consistent and straightforward manner. "The therapist's aim is to help the patient expand the sane attitudes and thoughts and diminish the psychotic functioning" (Rosenbaum et al., 2013 p.313).

One of the most commonly suggested adaptations of PGP in the literature and by the participants was the introduction of a more supportive approach (see Theme Three in the Results Chapter). Lakeman (2006) explored in depth the issues of adapting psychotherapy to psychosis and changing its continuum from being supportive to a more exploratory/expressive range. He described supportive therapy as being intended to prevent relapses, make positive efforts to minimise anxiety and enhance self-esteem. Supportive techniques may include empathic communication, encouragement, advice, guidance, problem solving and the conveyance of positive regard. Whereas exploratory therapy may seek to bring about personal change or entail deeper reflection, it makes more demand on the person who may need to tolerate greater anxiety and require greater meta-cognitive capacity. Goldstein (1998) suggests that for "...psychotic patients, to whom intense transference can be clearly disruptive... supportive intervention predominate over insight-oriented ones". Lakeman (2006) proposes that when one is in doubt over whether to err on the side of supportive or exploratory intervention, one needs to ask oneself the following questions: what does the patient ask for and need, and what is their present capacity to endure the therapeutic process? Generically speaking, Lakeman (2006) proposes using a more supportive approach when a patient is actively psychotic and is in need

of feeling some understanding and hope and a connection with others. When patients do reach a point of anchorage when acute phase of psychosis subsides, explorations of underlying dynamics of their experiences could be more possible. Schermer and Pines (1999) suggest that it is useful to promote a “moderate degree of regression and its attendant anxiety in order to influence, if not the psychotic core self, the psychotic defences and distortions reflective of primitivized object relations” (p. 27).

Overall the participants in this study agreed with the above approach and argued that working with the unconscious requires a careful assessment of the patient’s ability to bear the mental pain of meanings of their experiences. *“The patient must have developed enough trust in the therapeutic relationship/group coherence to be able to bear the therapist’s interventions tackling his/her unconsciousness” (Europe, Group Analysis)*. Participants differed in their opinions on how supportive or how interpretative approach should be and made comments such as *“Focusing on the lack of opportunities is a supportive intervention, which strengthens the self-esteem but which can lead away from learning by mistakes”* and *“checking assumptions must be connected with patients’ emotions (or it would be pure CBT), is a task within PGP (which prepares to check assumptions later in outer reality) with the help of therapists’ explanations of verbal and nonverbal interactions in the group/the ways how members relate to each other (including cautious interpretations of transference and countertransference, mostly done in the form of questions - similar to MBT)”*. This question of delicate balance seems to require further exploration and research as some participants varied in their comments between how exploratory or how supportive interpretations of unconscious dynamics should be for patients with psychosis.

Working with dreams is considered one of the key aspects of exploratory work, however participants were unable to reach sufficient consensus on whether working with dreams was a key component of PGP for psychosis, which seems to reflect the debate highlighted above about the delicate balance which therapists need to observe on the continuum of supportive and more exploratory work when PGP is delivered to patients with psychosis. Participants commented that the balance between the interpreting and restraining from interpreting unconscious material, particularly interpretation of dreams, should be carefully observed. One of the participants suggested that these interpretations should nevertheless be made, even if with caution, as *“they are indispensable to remain in the psychodynamic frame without slipping into psychoeducation”* (Europe, Psychoanalytic School of Fagioli). Another participant commented that *“dreams, like metaphors, facilitate working towards understanding, but without threatening the defences that psychotic patients may have against the unbearable meaning of their experience... dreams can certainly be treated as any other material brought to the session. In that sense, the decision to whether or not you make interpretations about the material of the dream will depend on the group's capacity to process the material and see what they can make of it”* (UK, Group Analysis).

According to Restek-Petrovic et al. (2013), working with dreams with psychotic patients can be very productive, however it requires the group's state of mind to be monitored thoroughly and interpreting unconscious content of the dream with great caution. When dreams are incoherent, confused, with frightening affects, a supportive approach and containment in the group is considered the primary approach. The approach used when analysing dreams in groups of psychotic patients

is often a combination of interpretative and more formative, depending on the actual situation in the group and the stability and the level of regression of group members (Urlic, 2012). Restek-Petrovic et al. (2013) argue that “in the developed, long-term group process of psychotic patients, the expression and analysis of dreams that engages the entire group can significantly affect progress at the level of individual members and a group as a whole” (p.303). Working with dreams in the group can assist with verbalising powerful emotions from the dream, successfully containing these and supporting those sharing their dreams. In analysing their dreams, patients open up their inner worlds to the group, through which they conduct analytic work on themselves as well as strengthen the cohesions and the identity of the group (Restek-Petrovic et al., 2013).

Some participants highlighted active leadership as another supportive modification to PGP indicated for patients with psychosis. However, overall the participants erred on the side of caution regarding the promotion of identification with the therapist, another component that did not reach sufficient consensus. The comments from the participants highlighted the particular importance of differentiating between supportive and teaching styles. The opinions ranged from open discouragement of identification with the therapist, to considering it being helpful but not turned into the aim of the therapy process, through to encouragement of identification with the therapist in the early stages of the group development. The question participants particularly grappled with was how to offer supportive exploratory work but not slip into teaching? Several participants commented on the importance of the identification with the therapist not being turned into the role of the teacher. The aim of the PGP intervention, according to the participants, was to “clarify” feelings and

experiences rather than to “teach” them. One of the participants suggested that the identification with other patients was more helpful in patients’ learning. Participants raised the issue of the impact of the therapeutic approach and felt that some theoretical schools of PGP, such as the group-as-a-whole approach should avoid using active leadership altogether.

The adaptations described should also be viewed from the point of view of a context in which PGP is delivered to patients with psychosis. There is a big difference in the ego strengths and functioning as well as the frame and setting in which inpatient and outpatient groups for patients with psychosis are delivered (Novakovich, personal communication). Inpatient groups are typically of much shorter duration, less constant membership and with more acute presentations, thus therapeutic goals are necessarily limited (Urlic, 2012). Outpatient groups, particularly at the later stage of development, can be approached from a much more exploratory approach and the role of the facilitator can shift from being an active leader to a conductor who intervenes only when the group is at an impasse (Urlic, 2012; Garcia-Cabeza & Gonzalez de Chavez, 2009).

Many participants, in agreement with the recommendations in the literature (Restek-Petrovic et al, 2014a; Urlic, 2012), commented on a preference for supportive techniques at the early stages of group development or when new members join the group rather than uncovering or exploratory (see Theme Two in the Results Chapter). Chazan (1993) argues that in PGP for psychosis the therapist may have to work hard to facilitate group interaction and group work, particularly in the early stages and after regression. Chazan (1993) also suggests that although patients may seem to

require individual attention in the group, it is best not to provide it, and to employ therapist energies toward building the group instead. Interestingly, the statement that only group-as-a-whole interventions should be applied in PGP for patients with psychosis received a very low level of support (21.1%) from the participating experts, which might be attributed to several factors. One of those being the idea that these interventions can be experienced as annihilating for these patients (Schermer & Pines, 1999), and another being the small representation of group-as-a-whole therapists among the participating experts. It could be an important topic for a more focal clinical research: to identify whether these interventions are not supported because of the patients' clinical needs or because of the theoretical tradition of the group facilitators.

The majority of the participants, although without full consensus, were in agreement with the recommendations from the literature that therapists should focus on here-and-now interventions rather than there-and-then dimensions of patients' relationships (76.9% agreement). However, participants strongly feel that the focus on here-and-now interactions should not be rigid or dogmatic, but should take into account individual and group dynamics and address whatever appears to be meaningful and important for the patients. For example, participants proposed that a focus on here-and-now might be more useful in the engagement stages of the group development where a basic level of trust has not yet been established. Some participants stress that references to there-and-then interactions by the patient can be seen as a sign of developing trust from the patient to the group since it takes several, sometimes many sessions before psychotic patients dare to disclose such personal matters (experiences of growing up, relationships with family members). Other

participants felt that in the earlier stages of group development these disclosures need to be supported by the therapists through clarification of the feelings brought up and experiences before intervening on the here-and-now level. The role and function of these interventions hopefully can be explored in the future research.

Majority of the participants were supportive of the idea of offering PGP to patients with various psychotic presentations. Only one participant mentioned the following selection guidelines: *“PGP seems more feasible with “stabilized patients, not first-onset psychosis. Best candidates are those with: no acute positive symptoms, and low to moderate negative symptoms; no addiction problems on the foreground; a relatively good awareness of their illness; residual positive symptoms and an explicit need to work on interpersonal relationships” (Other, Interpersonal Psychoanalysis and Self Psychology)*. In the literature it is commonly suggested that significant substance misuse, lack of motivation for change, lack of cognitive and introspective abilities, lack of insight into one’s illness and low tolerance to anxiety could be relative contraindications for being offered PGP (Restek-Petrovic et al., 2014; Rosenbaum et al., 2013). All participants argued for longer duration of the treatment which is an important information to be considered by the health services in the current climate of austerity and drive for efficiency. The impact of the duration of PGP on its efficacy needs to be explored in future studies.

## **Part Six: The Efficacy of PGP**

Although efficacy of PGP for psychosis has not been directly addressed in this study, some of the findings both from the literature review and from the study itself can



point to some tentative conclusions. Both the reviewed PGP accounts in the literature and the participants' comments from this study point towards PGP being useful and feasible for patients with psychosis. The literature reviewed highlights that patients presenting with psychosis, inclusive of negative symptomatology, over time make good use of PGP groups where they engage through regular attendance, express emotions, make connections, build relationships and reflect within the group on their personal experience of mental illness (Urlic, 2012; Homeberg et al., 2013; Restek-Petrovic et al., 2014a; Ailello & Ahmad, 2014; Canete & Ezquerro, personal communication). At times even a reduced dose of medication combined with group psychotherapy treatment brought about positive outcomes (Kapur, 1999). All clinical material presented in the reviewed literature concluded that PGP could help individuals affected by most severe forms of psychosis to make sense of their experience and make positive use of the reflective PGP setting.

Some recent research findings show that group psychotherapy with psychotic patients can be as effective as individual psychotherapy (Gonzalez de Chavez, 2009). The main findings in the research literature report patients becoming more hopeful, overcoming their isolation, coping with stigma, improving social relations and gaining better self-knowledge as the result of group interventions.

*Being together with fellow patients who understand what is like to have a psychotic illness, as well as being accepted by the group therapists in a safe and containing therapeutic environment, enabled many of these patients to improve social skills and personal autonomy (Canete & Ezquerro, personal communication).*

Understanding and supporting one another in a group context helps patients to improve their self-esteem and feel more hopeful about having meaningful

relationships with other people (Canete & Ezquerro, personal communication). These clinical claims have also been supported by the recent meta-analysis of various group psychotherapeutic treatments for patients with schizophrenia (Orfanos et al., 2015), which claimed that group psychotherapeutic treatments can improve negative symptoms and social functioning deficits in the treatment of schizophrenia.

Although no single RCT study of efficacy of PGP for psychosis has been identified, Rosenbaum et al. (2013) argued that in the absence of RCT evidence about the efficacy of psychodynamic therapy, we should take account of the non-RCT evidence that does exist. These authors argue that respect for patient choice and satisfaction, along with an evidence based approach, support making supportive psychodynamic psychotherapy available as a treatment option in services for psychosis. Rosenbaum et al. (2013) argued that psychodynamic therapy combined a number of ingredients for which there was evidence of effectiveness, such as attachment theory and mentalizing. In addition, recent results from the Danish National Schizophrenia Project have strengthened the evidence for the effectiveness of psychodynamic treatment in psychosis (Rosenbaum, 2012). The results showed that symptom and functional improvement significantly favoured supportive psychodynamic psychotherapy in combination with treatment as usual over treatment as usual alone.

The results of the present Delphi study and the thematic analysis of the participants' comments highlight that overall experts who deliver PGP to patients with psychosis believe that, with certain supportive modifications, PGP is an effective therapeutic modality and is particularly equipped through its group therapeutic context to address interpersonal and social aspects of these patients' difficulties. The statements in the

reviewed literature on the dangerousness of psychodynamic interventions overall for patients with psychosis, which were referred to previously, have evidently not been supported by the findings of this study. Not a single participant commented on the unsuitability of PGP for patients with psychosis. Also the indications for the patient selection for PGP, according to the survey, should err on the side of inclusivity. This could be linked to the debate about psychosis being a complex and heterogeneous condition and also highlight the usefulness of PGP to patients with various types of psychosis and at various stages of illness. However, participants did stress the necessity of supportive modifications to classical PGP as well as of being mindful of the level of functioning of individual patients and the group as a whole when making more uncovering and exploratory interventions and interpreting transferences and defences.

### **Part Seven: Psychoanalytic and other therapy approaches**

NICE guidelines do not recommend psychodynamic psychotherapy (group or individual) as a choice of treatment for patients with psychosis, but strongly advocate Cognitive Behavioural Therapy (NICE, 2014). These approaches have little in common; however recent research proposes that they can be used in an integrated way (Garrett & Turkington, 2011). Participants in this study commented on the growing recognition among experts and in the recent literature between the psychodynamic modality and other therapeutic modalities, for example CBT, and suggested that such modalities can usefully enrich each other's practices. Participants stated that *"Behavioural therapy, including CBT, has started to include some psychodynamic principles (although sometimes under new names), also the importance of a good therapeutic relationship. And psychodynamic approaches/ PGP*

*should not be afraid to consider the addition of scientifically proven techniques from other methods, as long as they seem helpful and do not disturb psychodynamic principles” (Europe, Group Analysis).*

Garrett and Turkington (2011) believe that the reason why psychoanalytic approaches showed limited growth in their application to treatment of psychosis was not because their ideas were irrelevant but because “psychodynamic technique has paid too much attention to the interpretation of unconscious mental processes underlying the psychosis, and too little attention to the conscious experience of the psychotic symptom perceived as an event in the outside world” (Garrett & Turkington, 2011, p 2-3). According to the authors, psychoanalysis has much to offer to treatment of patients with psychosis in addition to CBT: it promotes empathy, contributes to the timing of CBT interventions and is extremely useful in understanding the meaning of hallucinations and delusions, stressors and trauma, and how self-esteem is regulated. They argue that before the unconscious meaning of the psychotic symptoms can be psychodynamically interpreted to a person, “thing presentations” of mental life must first be returned within the boundary of the self, and CBT provides the technical means for this. Garrett and Turkington (2011) argue that CBT provides a massive reinforcement of the patient’s observing ego, which allows the patient to consider alternative explanations for his experience. Once CBT has helped re-establish connections between psychotic experience and internal emotional life, a psychodynamic perspective becomes increasingly important. The authors argue that the integrated model will enrich the practice of both CBT and psychodynamic therapists.

According to Martindale (2015), a psychodynamic approach to understanding of psychosis can be very helpful for therapists applying CBT to patients with psychosis. In addition to further expanding the role of delusions and other symptoms as defences from overwhelming experiences, he argues that CBT therapists need to learn to understand the difficult negative feelings which arise when working with these patients as countertransferential. Psychodynamic thinking can help the therapist not only to understand these feelings but also to bear considerable discomfort and prevent the temptation to adopt a quick solution or get-out that may mirror the psychotic attempt to avoid mental pain. CBT therapists can benefit from understanding delusion as a construct and unconscious attempt to prevent disturbing and painful issues from overwhelming the mind. A premature attempt to understand, change or get behind the delusion, which can happen when CBT techniques are applied, threatens the very purpose of delusion as it could lead back to the past painful experiences (Bell, 2003; Rosenbaum et al., 2013).

According to Rosenbaum et al. (2012), there are benefits of offering psychodynamic therapy as it has the potential to meet different needs compared to CBT. One advantage of psychodynamic therapies, and particularly of PGP, is that they attend to relationship issues and specifically to the patient-therapist and patient-group relationships. These are important aspects of any treatment success, including compliance with medical treatment often burdened by disabling side-effects. The flexibility of psychodynamic therapies allows therapy to adapt to the individual and their stage of recovery and provide an opportunity for exploration as and when patients are able to use this (Rosenbaum et al., 2013).

According to Rosenbaum et al. (2012), supportive psychodynamic therapy has the advantage of focusing simultaneously and systematically on three areas:

- Difficulties with tolerating, understanding and dealing with emotional experience
- Difficulties with mentalizing linked to the development of self-agency, and a coherent sense of self and life history
- Difficulties with forming emotional bonds and maintaining interpersonal relationships.

Together, these difficulties contribute to considerable distress, social withdrawal and problems in functioning in various areas of life. Following Borneo, Rosenbaum et al. (2013) argue that if there is more than one effective form of therapy then there is an additional important argument for making available more than one approach, particularly when patients express a wish for choice or don't want to be restricted to any single model.

### **Part Eight: Strengths and limitations of the study**

A three round electronically based Delphi technique was successfully used to develop a working set of key components describing contemporary PGP for psychosis, which may prove useful for future research, clinical practice and training. Thematic analysis applied to participants' comments on their rating decisions allowed for important technical considerations of application of PGP to patients with psychosis to be investigated, providing further clarifications and meaning to

the identified set of core components of PGP. It also allowed areas with a lack of consensus to be identified and highlighted issues for further research.

Whilst the sample of experts was small (37 participants), this is not necessarily a problem for a study of this nature. Rowe and Wright (2001) suggest that the use of a small sample with the Delphi method is appropriate when the study aim is to generate new information on a topic that is generally understood but not specifically defined. Through the Delphi method, participants were able to give a considered and anonymous response to the research question whilst being offered the opportunity to review peer responses in the latter rounds, allowing a natural evolution and development to the understanding and substantiation of the concept. It is hoped that this may provide the basis of the beginnings of a knowledge base that both informs therapeutic interventions in PGP and provides a basis for more extensive clinically relevant research of effectiveness of PGP for psychosis (Roos & Wearden, 2009).

One of limitations of the Delphi technique is that the set of statements describing PGP for psychosis developed here can only reflect the opinions of the participants who were approached and participated; other “experts” may have influenced the development of the definition of PGP for psychosis in a dissimilar way. Unfortunately none of the experts from Latin America, US or Russia were recruited, which excluded representation from regions that have strong psychodynamic traditions in their own right. The investigator contacted the president of ISPS US Brian Kohler and a leading expert in working with psychosis Anna-Louise Silver (US) to try to seek their help with the recruitment of suitable participants, but received either no reply or no further contacts. Brian Martindale, the president of ISPS UK, emailed an encouraging and supportive invitation to participate in this

study to all members of ISPS International across the world, but this brought only a very marginal increase in participation. Several professional bodies in Latin America in the psychoanalytic and group analytic fields were contacted without success. Additionally, as the process of recruitment of the eligible participants heavily relied on personal recommendations and referrals, this inevitably affected the overall representativeness of the selected participants from an international milieu of group psychotherapists, presenting a limitation for this study.

Another limitation was a drop out in the third round of the Delphi study where only 75% of all participants responded and provided their comments. Almost half of the participants (48%) who commented on their rating decisions were representatives of the group analysis tradition and thus it is difficult to generalise those comments to other theoretical traditions of PGP. It is possible that the length of the set of statements was a deterring aspect for potential participants to engage with it meaningfully, though seemed necessary at the time to secure a richness in responses and considerations.

The seven items which did not reach consensus on either being included or excluded from the key components of PGP for psychosis might be viewed as an outcome of an incomplete Delphi study. It might have been helpful to carry out an additional round of re-rating for the participants to have another opportunity to rate and comment on their thoughts regarding these items. This idea was not pursued by the investigator in favour of the ethical completion of the project as all participants were contracted at the outset to participate in two rounds of rating of a lengthy survey and thus the additional demand on their time did not seem possible.



The majority of the comments about the survey were positive and complementary with the exception of few comments. One participant expressed their concern at the object-relations bias of the questionnaire:

*“This questionnaire is too long. I assume it is designed for the beginner therapist and so I find it irritating in its object relations bias” (Other, Lacanian).*

This might have to do with the investigator’s contribution to the selection of the set of statements which was derived from systematically reviewed literature and available manuals. The investigator’s training and personal analysis were conducted by Kleinian analysts. However every effort was made to ensure that other schools were represented and the research panel involved members from the Foulkesian, Freudian and interpersonal psychoanalytic theoretical traditions. The set of statements could also be improved by a small survey of participants' understanding of psychosis and their approach to the selection and suitability of patients for PGP groups.

*“Some questions have more than one statement, therefore, is it difficult to answer, as the response to one statement may be different to the response to the second statement” (UK, Group Analysis).*

The issues of the clarity and generalisation of the statements raised by the participants will have to be addressed in the future research. This might be addressed with the help of clarifying clinical vignettes which could not be included in the set of statements due to its volume, but can be addressed in the manual type document in the future. It is also notable that participants did not use clinical

material to illustrate their rating decisions, which again might have to do with the volume of statements participants were required to engage with.

Many participants commented on how valuable they found their participation as it allowed them a chance to reflect on the challenging work they did with very complex patients. They also found the set of statements reflected well the interventions they delivered to their patients, as well as perceived it to be an important area of research for the future of PGP.

*“Congratulations for the questionnaire, accurate and complete, and for the opportunity you gave me to reflect on our demanding and fascinating job” (Italy, Psychoanalytic School of Fagioli).*

*“Very useful and thorough set of questions” (Croatia, Group Analysis).*

*“Thanks for having me involved in this research, which represents a unique and rare occasion of incentive and exchange for a fascinating and complicated job as ours. A very nice opportunity” (Italy, Psychoanalytic School of Fagioli).*

A significant limitation of this study is the absence of the service user involvement due to the lack of the resources. Experts by experience could have contributed greatly to the evaluation of the literature and in the development of the themes as their personal experience of the group therapy could have greatly contributed to the understanding how PGP contributed or not to their recovery journey. If this study were to be followed up, it will be important to seek these contribution.

Finally, although the resultant set of core components clarifies PGP as a therapeutic intervention, it is hard to imagine its usefulness without further refinement and illustration of these core components through clinical material. It is hoped that this study will be built upon not only in the direction of improving the representation of participants in the sample, but also to further refine the set of statements into a working model, even a manual, hopefully without it becoming too prescriptive.

### **Part Nine: Implications and contributions of this study**

This work is the first of its kind seeking to develop an initial set of key criteria of PGP for psychosis employing the help of international experts. The 145 components of PGP for psychosis endorsed by the international experts in PGP represent an empirically derived set of components necessary for effectively treating patients with psychosis using PGP. With some further refinement and development this set of core components could be helpful in ensuring that people with psychosis receive effective PGP and the therapists who deliver it have relevant competencies. It is hoped that some recommendations on the delivery of PGP for psychosis will be drawn from the findings of this study. These recommendations should ensure greater adherence to the defined PGP model in practice, facilitate the development of a competency framework for group therapists and be of value in relation to the training and dissemination of PGP for psychosis. In addition, this study could be the first step in standardising the intervention which in the future could be evaluated for its effectiveness in clinical trials. The resultant set of core components can be used to clarify a concept (theory and practice) of PGP for psychosis. Moreover, if further refined and developed, this framework might influence clinical practice by defining

and integrating the main components that can guide clinicians to safe and effective application of PGP to patients with psychosis.

## **Part Ten: Summary and Future Research Directions**

PGP has a long history of being offered to patients with psychosis, however to date there is little empirical evidence of its effectiveness. Controversial opinions exist on whether PGP is helpful for patients with psychosis. In part, formal research into the effectiveness of PGP for psychosis was hindered by the variance of the theories and technical applications of psychodynamic concepts. The literature reviewed that did contain empirical evidence however scarce points towards required some modifications to PGP when offered to patients with psychosis. Specifically this involves a more supportive approach, active leadership, more considered work with unconscious dynamics and transference, and specific supervision requirements which focuses particularly on the therapist's countertransference.

The aim of this study has been to determine the extent of expert consensus on the essential principals and technical elements of PGP for psychosis and to develop an empirically based model of core components of PGP for psychosis. The fact that 145 items were endorsed as being important or essential for PGP for psychosis by more than 80% of the expert participants highlights how much commonality rather than differences of opinions exists amongst varied practitioners. This set of key components of PGP for psychosis reflects the already existing guidelines and competencies for PGP, yet what distinguishes them from the information that is provided in the reviewed literature and treatment manuals, is endorsement by a large

number of experts.

Overall it has been agreed by the experts that the recommended modifications found in the literature should be applied when PGP is offered to patients with psychosis. The items which were not included underline the participants' argument for a flexible application of psychodynamic principles. Participants stressed the importance of an individual assessment of the functioning of the group and its members and particular attention be given to both psychotic and non-psychotic parts of the mind state of the group and its members. They advocated against any rigid recommendations to avoid further uncovering work as well as the application of too directive leadership as they feared it could undermine the non-psychotic part of the group and its members. Participants highlighted the unique benefit of PGP for patients with psychosis in helping patients develop meaning for their distressing experiences through their relationships with others and based on the therapist's belief that psychosis represents a meaningful response to distressing emotional experiences.

One of the strengths of this study was that the participants were able to submit comments on the overall survey and on every statement they related. This enabled the investigator not only to draw on the participants' experiences through their consensus ratings but also gain a deeper understanding of some of the issues already raised in the literature from the clinical experience of the participants. One limitation of this study is that it remains unknown whether the endorsed components would be applicable to PGP approaches delivered in other parts of the world like Latin and North America, Asia and Russia, from where the investigator failed to recruit participants. The comments analysed represent the views of participants

predominately from the group analytic theoretical background and so might not be representative of other PGP theoretical traditions (group-as-a-whole, interpersonal, ego psychology, Lacanian approaches). Future work would need to refine and further develop this set of statements into a practical framework or a manual which could be used to inform clinical practice, assist in training of PGP practitioners and contribute to further evaluation research of PGP for psychosis. Significant resources might be required for future studies to address these limitations.

It is hoped that the outcomes of this study will contribute to the ongoing debate about required modifications when PGP is delivered to patients with psychosis. Critically, none of the participating experts or reviewed studies provided evidence of PGP being harmful to patients with psychosis. This set of core components of PGP for psychosis formed as the result of this study may influence clinical practice by defining the main components that can guide clinicians to safe and effective application of PGP to patients with psychosis. Hopefully, the outcomes of this study will encourage future investigation of the effectiveness of PGP for psychosis and contribute a widening of the choice of psychological interventions offered to people with psychosis. While these outcomes are important for psychiatry in general, they are not without significance for patients with psychosis as beneficiaries of a more defined, safe and effective treatment.

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## Appendices

### **Appendix One: Attitudes of the PGP Therapist Required to Facilitate an Appropriate Group Therapeutic Setting (Ruiz-Parra et al., 2010)**

- To be shown to be active in directive, but passing to a position of the inactivity when the group interacts productively
- Encourage the interaction of the patients and communication within the group
- Favour that the analysis of the questions is performed within the group itself, avoiding rigid interaction directed towards it
- Make “diplomatic” and supportive comments
- Adapt the interventions of the therapist and of the group members to make them more accessible to all the members
- Make clear, specific and consistent interventions.
- Never indicate unconscious aspects
- Provide the structure or focalize to the patients in the subject if irrelevant aspects are discussed and cannot be focalized, are disorganized or inactive
- Repeat the important statements. Make oral summaries. Clarify and give cohesion to the subject, manifesting the points in common and differences
- Connect the current subject with the subjects of the past in the group
- Link what is individual and outside of the group with the here and now of the group
- Change the subject or suggest a change of it if the setting is not safe. Discourage new subjects at the end of the session to avoid the patient leaving the group in an anxious state
- Give his/her own opinion when necessary

## **Appendix Two: Phases of Group Process in PGP for Psychosis and Associated Therapeutic Techniques (Lajer & Valbak, 2005)**

### Stage One: Group Establishment

The goal of this stage is to establish the group's culture. The techniques is to make the framework and rules clear to allay anxiety. The therapist must be predictable and contribute actively to the establishment of positive transference. The therapist must actively promote individual's attempts to relate to other group members. Development of the reality testing is an important task during this stage. This applies to both knowledge and management of symptoms, treatment and everyday situations. The temporal focus is mostly on the here-and-now. Therapist works on offering a corrective emotional experience by assuming empathic, accepting, understanding and predictable, reliable style. It is important to allow time for the first stage before moving onto the second stage as it takes time to establish basic trust and confidence in the therapist.

### Stage Two: Interaction

The goals of this stage are to continue building trust, to tame fears further, to improve interactions within the group and outside the group, to get patients to recognise, accept and cope with diagnosis and symptoms in a broader sense, and begin more consciously to create meaning and coherence of the self, time and relationships. The technique at this stage is to help patients to establish connection within the group (and outside the group) by watching others, listening to others and talking to each other, rather than to imagine what others think – practising reality testing. It is very important to identify angry feelings and make them permissible and turn them into something constructive for the patients. During this stage it becomes more possible to establish links between here-and-now, past and future.

### Stage Three: Integration and Autonomy

At this stage there is more recognition of individual differences and similarities. Patients gradually start accepting more complex emotions in other people and are less likely to just distinguish between good and bad. Patients start testing expression of more dangerous feelings, like aggressive feelings. For psychotic patients this stage can take place only after a long time members have been in the group. They learn to accept the limitations their illness entails and confront stigma. Therapist needs to bear in mind that despite the developing ability to bear feelings, patients are still fragile and are prone to fragmentation/fragility. The goal of this stage is to continue improve patients' ability to build relationships inside and outside of the group so it is possible for patients to seek support and help outside the group when the group finishes.

### **Appendix Three: General Therapy Guidelines for PGP for Psychosis (Lajer & Valbak, 2005)**

- Positive transference is important and should not be interpreted, but used as a tool.
- Therapist must be open and honest to the patient all the time
- Therapist must make themselves available as both container and acting “Ego”
- Therapist can move from being teacher, role model and identification figure to be reality corrective, at times gratifying and other times gently frustrating. The rate depends on the patient’s condition and character structure, the phase of therapy and the strength of therapy alliance.
- Negative transference does take place, but not to be interpreted.
- Defence has a purpose which must be understood and respected. The defence does not need to be attacked but met respectfully and possibly empathically positively interpreted.
- Anxiety levels should be kept low.
- The key focus should be on building relationship
- The therapist must maintain a flexible position concerning the methods and content of therapy
- Patients and therapist must find/maintain optimal distance
- The therapist must create a “sustaining environment”
- The therapist must make themselves available as a “container” for the patient
- The therapist must let themselves be used as a helping “Ego” for the patient
- The therapist must restrain from interpreting until the therapeutic alliance is securely established
- The therapist must maintain respect for the patient’s need to be sick

## **Appendix Four: The Therapist's Tasks in PGP for Psychosis (Lajer & Valbak, 2005)**

1. The therapist must be an active listener.
2. The therapist must be culture-creating, be a model for the culture of the group where individual differences and feelings are allowed and welcomed. The therapist may show his own reactions with body and face in a clear yet soothing way. The therapist must be curious and enquiring towards distinctions between I and the group, past, present and future, outside and inside, between process and content, between insight and corrective emotional experience.
3. The therapist must be anxiolytic in its style by explaining, repeating and translating to minimise hurtful experiences. The therapist must be more visible in more regressed groups and less visible in better functioning groups. The therapist must have an enhanced empathic understanding using a positive formulation to allay anxiety in the group and increase empathy.
4. The therapist must have ego-building and exploratory function in the group: 1. to increase the ability to accommodate affect by verbalising the affect and maintaining attention to it. 2. to help patients better know their anxiety, what triggers it and what it entails. 3. to increase their ability to discover what worries them. 4. to increase their ability to see and understand their inner conflicts and related anxiety or grief. 5. demonstrate group processes and help the group members to see what is constructive and what is destructive for the. 6. Help them to understand their contributions to group processes and the impact they have on each other.
5. The therapist as an administrator protecting the frame. Therapist must maintain boundaries of the group in setting up rules about attendance, cancellations, breaks, space and duration of the meetings, contacts outside of the group between group members and with the therapist. The framework should be clear to all group members. Rules of the behaviour in the group.
6. The therapist should be able to gradually move from providing structure to supporting the established/existing structure (including time, depth and reciprocity). When patients jump from one topic to another, the therapist must intervene to maintain the topic and create context of the conversation. The therapist must allow for some fluctuation to analyse the defence structure, but also be mindful of the patients' tendency to fragmentation.
7. The therapist must help patients to connect with each other starting from the preparation sessions where a new group member is informed about other group member's age and gender. Patients' interest in each other is stimulated and supported in the group. Similarities and differences, subgroups must be to some extent accepted, but therapist has to avoid anyone being excluded. Therapist might ask patients relate directly to each other rather than talking to the therapist. Group members must be encouraged and supported to make comments and opinions so that they are aware that their participation matters to others. Therapist needs to highlight common feelings and problems to develop affinity and communication.
8. The therapist must identify the theme of the group by observing, listening and asking questions in order to understand what it is. Sometimes it could be useful to bring a theme from a previous session. The therapist must stick to the theme until it is sufficiently explored and majority of group members spoke about it and exchanged

advice.

9. The therapist must handle the affections in the group to avoid the destructive power of those often causing blinding effect. The therapist must identify, verbalise and tolerate those affections. Using humour can be useful. Working with affections, therapist must be aware of the countertransference, “pairing”, scapegoat function and separation anxiety.

10. The therapist must promote problem solving. Therapy should aim at improving patients' everyday life. They can often give each other important information and even advice about everyday life issues. This strengthens self-confidence and the confidence of the group members. Demystifying and removing misconceptions are important elements of problem solving.

11. The therapist must promote insight and self-esteem by helping patients to create context by reminding them about sides to themselves which they currently forgot about, to remember feelings of others, to establish patient's own understanding of their reactions and feelings. Self-awareness is often accompanied by severe anxiety and stress and can lead to psychosis. Fear and grief must be accommodated and detoxified. The sensation of patients' history is brought up rarely by the therapist to help focus and here-and-now situation. Help reduce the excessive attention to themselves and their mental activity by getting the group to discuss the pros and cons of the philosophy of self-sufficiency versus philosophy of acceptance of needs and dependency. Explore member's responses to others. Their expectations of other's responses to themselves and how they relate to their responses.

### Appendix Five: Characteristics of primary studies included in the systematic literature review

Study	Study design	Setting	Participants	Intervention (treatment conditions)	Treatment duration	Outcome measures
Garcia-Cabeza & Gonzalez de Chavez, 2009	Evaluative study of therapeutic factors and their relationship to insight, no control group and no pre-post data	Mixed gender outpatients	17 patients diagnosed with Schizophrenia	Psychodynamically oriented group therapy delivered once weekly for 90-120 minutes	Patients who attended the group for at least one year were included, the mean number of months in therapy was 24.6 (s.d.=7.8)	Global Assessment of Functioning; Sociodemographic questionnaire; Brief Psychiatric Rating Scale; Insight evaluated via SAI-E and Scale of Camarillo; Yalom Q-sort Questionnaire
Wode-Helgodt et al, 1988	Evaluative study of the impact of long term PGP on patients with psychosis with a control group and pre and post data and two year follow-up	Mixed gender outpatients	12 patients with acute psychosis and schizophrenia in a group treatment, 12 patients matched for diagnosis, age and sex, but not for the time elapsed since the last psychotic episode	Psychoanalytically oriented group therapy co-facilitated for 1.5 hour once weekly	Two years	Rorschach Test; Defence Mechanism Test; Katz Adjustment Scales; Self-evaluation test; Post Therapy Semi-structured Interviews with patients and their relatives; Follow-Up Questionnaire
Semmelhack et al, 2009	Evaluative study of the impact of group-as-a-whole approach on patients with psychosis with a control group	Mixed gender inpatients form long term	11 patients in PGP (3 with paranoid schizophrenia, 4 with schizoaffective disorder, 2 with psychotic depression	Weekly one hour sessions of group-as-a-whole approach with deep psychological processing; Control group received	10 weeks	Beck Depression Inventory; Beck Anxiety Inventory; Group Attitude Scale

		care setting	and 2 with bipolar disorder) 12 patients in control group matched for diagnosis, age and gender	medication and attended activity groups		
Restek-Petrovic et al, 2014b	Evaluative study with a control group of the impact of PGP on the social functioning of patients with psychosis with the post data only	Mixed gender outpatients	30 patients in PGP and 30 patients in TAU 20 patients diagnosed with schizophrenia 6 with schizoaffective disorder 2 with delusional disorder 2 with psychotic depression	Psychodynamic group psychotherapy once weekly; TAU – occasional check-ups with a psychiatrist, receiving medication and no psychotherapy	Two years	Non-standardised: patient self-assessment and therapist assessment instruments of the following areas: overall social functioning, working functioning, communication and romantic relationships. Recording of number of hospitalisations
Opalic, 1989	Comparative study of evaluation of the effectiveness of PGP among neurotic and psychotic patients with pre-post data and a control group	Mixed gender outpatients	26 neurotic patients and 24 psychotic patients as part of the experimental group and 50 outpatients who came for psychiatric check-ups only as part of the control group	Psychodynamic group psychotherapy within existential tradition	Several months weekly, exact duration not reported	The Semantic Differential, Kotchen's Test, MMPI
Restek-Petrovic et al, 2014a	Comparative study of evaluation of therapeutic	Mixed Gender	57 patients with long standing diagnosis of	Psychodynamic group psychotherapy	Ongoing long-term slow-open groups, weekly one hour sessions	Yalom's Therapeutic Factors Questionnaire

	factors based on the duration of patients' participation in the group, the phase of group development and patients' sociodemographic characteristics. No control group and no pre-post data	outpatients	schizophrenia (31), schizoaffective disorder (10), acute psychotic disorder (12), delusional disorder (2) and bipolar disorder with psychotic features (2). Only regular patients were included			
Isbell et al 1992	Single case of intervention effectiveness evaluation using videotapes of the middle stage of treatment	Mixed gender outpatients	7 patients with long histories of symptoms of schizophrenia or schizoaffective disorder	Psychodynamically oriented group psychotherapy	Ongoing group with stable membership, 2.5 years long at the time of the evaluation, weekly sessions	Group Environment Scale (GES) not validated for therapeutic groups, applied by independent raters to the sessions videotapes; retrospective GES ratings by the therapist; interviews with subjects
González de Chávez et al 2000	Comparative study of evaluation of therapeutic factors, no control group and no pre-post data	Mixed-gender inpatients and outpatients	32 patients diagnosed with schizophrenia: 21 inpatients and 11 outpatients	Psychodynamically oriented group psychotherapy with slightly different therapeutic objectives for inpatients (stabilisation and desingularization) and outpatients (insight into ones condition and relationships)	Inpatients: 5-24 sessions 3 times per week Outpatients: 30 – 264 weekly sessions	Validated: Yalom Card (Q) sort test (Yalom 1985)
Sigman & Hassan 2006	Single case of intervention effectiveness with vague pre-post data, no control	Mixed-gender outpatients	8 patients, 4 with schizophrenia and 4 with schizoaffective	Psychodynamic group psychotherapy	2.5 years – over 7 years weekly sessions	Not validated: therapists recorded and classified behaviours



	group	nts	disorder			in the group
Johnson et al 2008	Comparative study of the evaluation of the patients' baseline characteristics in the effectiveness of the group therapy	Mixed gender outpatients	58 patients with schizophrenia and treatment-resistant hallucinations	Subjects randomly assigned to receive either group cognitive behavioural therapy or supportive psychodynamic counselling with primary goal to improve social integration	12 weekly sessions in both treatment types	Validated: Positive and negative syndrome scale (PANSS); Beck cognitive insight scale (BCIS); Social functioning scale (SFS); Working alliance inventory adapted for group (WAI-G); Psychosocial treatment compliance subscale (PTCS)
Pesek et al, 2010	Evaluative study of long term PGP with patients with psychosis	Mixed - gender outpatients	32 patients with diagnosis of schizophrenia or schizoaffective disorder; from original 47 16 were excluded (6 dropped out after four sessions or less; 7 were lost to follow-up, 3 refused to participate)	Psychoanalytic group therapy inclusive of psychoeducative and cognitive techniques	50% of patients spent 0-2 years and 11 months in a group; 34% spent 3 to 5 years and 11 months; 16% spent over 6 years. The groups were of ongoing open-ended nature run over the period of ten years with fortnightly sessions	Validated and not validated: Drug Attitude Inventory (DAI-10); World Health Organisation Quality of Life (BREF); Clinical Global Impression Scale (CGI) and therapist recorded level of participation in the group and patients self-rated level of importance of the group to their life
Pesek et al, 2011	Evaluative study of the outcomes of long term PGP on physical activity and	Mixed-gender outpatients	32 patients with diagnosis of schizophrenia or	Psychoanalytic group therapy inclusive of psychoeducative and	The groups were of ongoing open-ended nature run over the period of ten years with fortnightly sessions	Validated and not validated: Drug Attitude Inventory

	medical treatment of patients with psychosis	nts	schizoaffective disorder; from original 47 16 were excluded (6 dropped out after four sessions or less; 7 were lost to follow-up, 3 refused to participate)	cognitive techniques		(DAI-10); World health Organisation Quality of Life (BREF); Clinical Global Impression Scale (CGI) Physical activity questionnaire
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### Appendix Six: Characteristics of the Systematic and Meta Reviews of Psychosocial Interventions for Psychosis

Author, year	Title	Patient Group	Intervention	Number of studies included	Setting	Years covered by the review	Identified studies on PGP for patients with schizophrenia or other psychosis
<b>Kanas 1986</b>	Group therapy with schizophrenia: a review of controlled studies	Patients with schizophrenia	Different orientations, duration and context of group psychotherapy	43 controlled studies	Inpatients and outpatients	1950-1986	Coons, 1957; Semon & Goldstein, 1957; Roback, 1972; MacDonald et al, 1964; Pattison et al, 1967; Kanas et al, 1980
<b>Mueser &amp; Berenbaum 1990</b>	Psychodynamic treatment of schizophrenia: is there a future?	Patients with schizophrenia	Predominantly individual psychodynamic psychotherapy	Not systematic search: 4 RCT studies 2 naturalistic follow-up studies	Inpatients and outpatients	1966-1988	None reported
<b>Scott &amp; Dixon 1995</b>	Psychological interventions for schizophrenia	Patients with schizophrenia	Individual and group psychodynamic and supportive psychotherapies, psychosocial skills training	18 reviews (4 on group psychotherapy) and 13 additional primary studies not included in the reviews (5 on group psychotherapy)	Inpatients and outpatients	1966-1993	Kanas, 1986 (review)

<b>Mojtabai et al. 1998</b>	Role of psychosocial treatments in management of schizophrenia: a meta-analytic review of controlled outcome studies	Patients with schizophrenia	Various individual and group psychosocial treatments (ranging from traditional psychotherapy modalities to community treatments)	106 primary studies	Inpatients and outpatients	1974-1994 PSYCHLIT  1966-1994 MEDLINE	None reported
<b>Huxley et al. 2000</b>	Psychosocial treatment in schizophrenia: a review of the past 20 years	Patients with schizophrenia	Group, family and individual therapy of different orientation	70 studies: 26 on group therapy, including 5 on social skills training, 8 on social and independent living skills training and 13 on miscellaneous group therapies	Inpatients and outpatients	1980-2000	Wode-Helgodt et al, 1988
<b>Burlingame et al. 2003</b>	The differential effectiveness of group psychotherapy: a meta-analytic perspective	Patients with a variety of mental health diagnosis	Group psychotherapies of various theoretical orientation	111 experimental and quasi-experimental studies, out of which 15 were of psychodynamic orientation and 3 included patients with psychotic and thought disorder	Inpatients and outpatients	1983-2003	None reported
<b>Penn et al. 2005</b>	Psychosocial treatment for first-episode psychosis: a research update	Patients with first episode schizophrenia or early psychosis	Various types of individual, group and family psychosocial interventions	3 quasi-experimental studies on group therapy, 14 multielement treatment programme studies, 8 individual therapy studies, 5 family therapy studies	Inpatients and outpatients	1983-2004	None reported
<b>Kösters et al. 2006</b>	A meta-analytic review of the effectiveness of inpatient group psychotherapy	Patients with a variety of mental health diagnosis	Group psychotherapy of various theoretic orientation	80 studies (one of which of psychodynamic orientation)	Inpatients	1980-2004	None reported

<b>Blackmore et al. 2009</b>	A systematic review of the efficacy and clinical effectiveness of group analysis and analytic/dynamic group psychotherapy	Patients with a variety of mental health diagnosis	Psychodynamic /psychoanalytic group psychotherapy	37 primary studies and 23 reviews	Inpatients and outpatients	2001-2008	De Chavez, 2000; Sigman & Hassan, 2006
<b>Segredou et al. 2014</b>	A systematic review of evidence of group psychosocial interventions for adults with schizophrenia and bipolar illness	Patients with schizophrenia and bipolar affective disorder	Various types of group psychosocial interventions	23 studies concerning patients with schizophrenia and 5 studies concerning patients with bipolar affective disorder	Inpatients and outpatients	1986-2006	None reported

## Appendix Seven: Conclusions of the Systematic and Meta Reviews of Psychosocial Interventions for Psychosis

Author, year	Studies' conclusions in relation to the efficacy or effectiveness of PGP
<b>Kanas 1986</b>	Group therapy was judged to be an effective modality of treatment for schizophrenics in 67% of inpatient studies. It was especially useful in groups lasting from more than 3 months. Therapy groups were effective for schizophrenics in 80% of the outpatient studies. Interaction-oriented approaches were more effective than insight oriented approaches, which were found to be harmful for some schizophrenics
<b>Mueser &amp; Berenbaum 1990</b>	All studies failed to find any beneficial effect of psychodynamic treatment, but have serious methodological limitations which limits the conclusions. Too emotionally intense therapy maybe harmful at least to some schizophrenics. The evidence that psychodynamic treatment worsens the outcome of schizophrenia is indirect and debatable; the data supporting the efficacy of this treatment are even less convincing. Since the psychodynamic treatment has not been demonstrated to be effective, a moratorium on the use of the psychodynamic treatments for schizophrenia is proposed.
<b>Scott &amp; Dixon 1995</b>	The relatively few RCT available have severe methodological limitations, which sharply limits their value. Reality-oriented approaches appear to be superior to psychodynamic, but further research is needed to identify and evaluate the disorder specific models that target specific deficits and disabilities in schizophrenia. There appears to be no evidence for the efficacy of psychodynamic (group or individual) therapy for patients with schizophrenia.
<b>Mojtabai et al. 1998</b>	Studies reporting on the effects of group therapy produced the smallest effect sizes. No evidence is reported that psychodynamic therapies are harmful, nor that they are superior to other interventions. Combined psychosocial and somatic treatments maintained their relative advantage over somatic treatments alone in the follow-up studies. Combined interventions consistently produced lower relapse frequencies than somatic treatments alone. There is evidence that psychosocial interventions are more effective in the more chronic stages of schizophrenic illness.
<b>Huxley et al. 2000</b>	Less structured discussion focused therapies have yielded mixed results. Some demonstrated positive treatment effects for symptoms and social functioning, whereas others reported no benefits.
<b>Burlingame et al. 2003</b>	The review argues that the average recipient of the group treatment is better of than 72% of untreated controls. The clients in homogeneous groups outperform those in in groups with mixed symptoms. Regrettably, there was no improvement with thought disorder patients. However the value of these results is limited by the small sample sizes.
<b>Penn et al. 2005</b>	Adjunctive psychosocial interventions for patients experiencing early psychosis are beneficial across a variety domains and can assist with symptomatic and functional recovery. Unlike individual therapy, group treatment for first-episode psychosis does not appear to have been examined for efficacy in randomized, controlled trials.
<b>Kösters et al. 2006</b>	Beneficial effects were found for inpatient group therapy in controlled studies as well as in the studies with pre-post data. Differences in the homogeneity of patient improvement effect size were found across different diagnostic categories. Greater improvement was exhibited in mood disorder patients when compared to mixed, psychosomatic, PTSD and schizophrenic patients.
<b>Blackmore</b>	The studies examined, including earlier reviews, consistently support the use of group psychotherapy as an effective approach, across diverse conditions,

<b>et al. 2009</b>	participant groups and settings. The number of empirical studies, in particular of high quality RCTs, is small. The methodological quality of the studies identified was variable. Unpublished outcome measures with unknown psychometric properties were too often used, and the variety of the outcome measures made it impossible to conduct meta-analysis. The terminology used to describe the therapeutic interventions was often ill-defined. These problems presented significant methodological challenges to the review.
<b>Segredou et al., 2014</b>	The therapeutic approach in the majority of the studies was along the lines of CBT and psychoeducation. All studies reported improvement in at least one parameter. Most of them reported improvement in skills and overall functioning. No single study of PGP meeting the selection criteria was identified.

### **Appendix Eight: Characteristics of Delphi Method (Iqbal & Pipon-Young, 2009)**

- it uses a group of participants specially selected for their particular expertise on a topic
- it is often conducted across of two or more sequential questionnaires known as “rounds”
- it often employs an initial 'idea generation' stage in which participants are asked to identify the range of salient issues
- it collates ideas from round one to construct the survey instrument distributed in subsequent rounds
- it has an evaluation phase (third or further rounds) where participants are provided with the analysis of the responses from the previous round and are asked to evaluate their original responses
- it is interested in the formation or exploration of consensus, often defined as the number of participants agreeing with each other on questionnaire items.



## **Appendix Nine: Common Steps in the Delphi method (Fowles, 1978)**

1. Formation of a team to undertake and monitor a delphi on a given subject.
2. Selection of one or more panels to participate in the exercise. Customarily, the panelists are experts in the area to be investigated.
3. Development of the first round Delphi questionnaire
4. Testing the questionnaire for proper wording (e.g., ambiguities, vagueness)
5. Transmission of the first questionnaire to the panellists
6. Analysis of the first round responses
7. Preparation of the second round questionnaires (and possible testing)
8. Transmission of the second round questionnaires to the panellists
9. Analysis of the second round responses (steps 7 to 9 reiterated as long as desired or necessary to achieve stability in the results)
10. Preparation of a report by the analysis team to present the conclusions of the exercise

## Appendix Ten: Round One Participants Email Invitation

Dear colleague,

As an experienced practitioner in the field of offering Psychodynamic/Psychoanalytic Group Psychotherapy (PGP) to patients with psychosis you are being invited to take part in a research study on key elements of PGP for psychosis. This project is part of my doctorate qualification in counselling psychology at the University of Essex (supervised by Dr XX and Dr XX) and I chose this project because I believe that it is no longer possible for psychodynamic interventions to continue being competitive with other therapies without sufficient evidence base.

It is hoped that this study will identify core components of contemporary PGP for psychosis and will help to consolidate the currently accepted modifications to PGP in its delivery for psychosis. It could be that with some additional work from training and regulatory bodies these core elements could form the underpinnings of a competency framework. The identified core components may contribute to greater standardisation and adherence in the delivery of PGP for psychosis. Identifying key components of PGP for psychosis may also have important implications for the selection of staff for training.

Your participation will involve two rounds of rating a web based set of key elements/components deemed as pertinent to PGP for psychosis by the research panel which included myself and five experts: XX, XX, XX, XX and XX.

Members of Expert Research Panel (ERP) have been consulted throughout the development of the inventory of the components of PGP for psychosis. The principle investigator is very grateful to the contributions of XX (Europe), XX (UK), XX (Europe), XX (Europe) and XX (UK) for the time they invested in the development and review of the initial questionnaire for this study as well as the consultation and discussion of the results following the data collected from two rounds of the Delphi study. These are the leading psychoanalytic group psychotherapists with a vast experience of developing and delivering PGP to patients with psychosis who published widely on the subject.

In this study, you will be asked to participate in rating statements that address significant elements of PGP for psychosis in order to consolidate consensus of opinion.

Before taking part in this study please consult the attached information sheet for more details about the project. If you are willing to take part, please follow the link below to the online version of the Delphi questionnaire where you will be asked to rate whether you agree that a particular aspect as being pertinent to PGP for psychosis on a 5-item Likert rating scale (strongly agree, agree, neither agree not disagree, disagree, strongly disagree). The results from all completed questionnaires will be recorded in an anonymous database and will be statistically analysed.

[https://docs.google.com/forms/d/1eMnj11yPgvupp0GEod7FHGwEyNe6kMc8-nmIhSmA2UM/viewform?c=0&w=1&usp=mail\\_form\\_link](https://docs.google.com/forms/d/1eMnj11yPgvupp0GEod7FHGwEyNe6kMc8-nmIhSmA2UM/viewform?c=0&w=1&usp=mail_form_link)

If you have any questions or would like to discuss this research project further, you are welcome to contact me on the phone number or email address provided below.

**Please respond to this email if you are happy to participate. By responding to this email you confirm that:**

- 1. You have read and understood the information sheet for the above study and have had the opportunity to ask questions.**
- 2. You understand that your participation is voluntary and that you are free to withdraw at any time, without giving reason.**

Thank you very much for taking time to consider your participation in this important for the future of PGP for psychosis project.

Sincerely yours,

Natalia Solovieva  
Chartered Counselling Psychologist  
Psychodynamic Psychotherapist

e-mail: [nsolovieva@yahoo.com](mailto:nsolovieva@yahoo.com)

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## **Appendix Eleven: Information Sheet**

### **Key Elements of Psychodynamic Group Psychotherapy for Psychosis: Delphi Study**

#### **BACKGROUND**

There is currently limited body of empirical research into Psychodynamic Group Psychotherapy for psychosis despite this intervention being successfully delivered worldwide for almost over a century now. This research aims to use an international Delphi method to try to establish the key components and elements of contemporary Psychodynamic Group Psychotherapy (PGP) for psychosis recruiting the participation of worldwide experts in this area. The lack of research in the area of PGP for psychosis has been widely identified in the literature and presently, some clinical guidelines do not recommend psychodynamic interventions with psychotic populations based on the lack of evidence available regarding its clinical effectiveness and efficacy. This recommendation has been widely debated and contested by several authors and researchers. Internationally there is sufficient clinical consensus regarding its usefulness.

#### **PURPOSE**

It is hoped that this study will identify core components of contemporary PGP for psychosis and will help to consolidate the currently accepted modifications to PGP in its delivery for psychosis. The results of this study may prove useful to professionals responsible for provision or training in PGP for psychosis. It could be that with some additional work from training and regulatory bodies these core elements could form the underpinnings of a competency framework. The identified core components may contribute to greater standardisation and adherence in the delivery of PGP for psychosis. The outcomes of this study can also lay foundation for further research as the key components will help to define PGP. Identifying the key components of PGP for psychosis may also have important implications for the selection of staff for training.

#### **WHAT WILL HAPPEN**

In this study, you will be asked to participate in rating statements that address significant elements of PGP for psychosis in order to consolidate consensus of opinion. Eligible experts like yourself will be approached worldwide and will have to have been practicing PGP for over two years, have analytic training background (irrespective of theoretic orientation) and/or widely written on issues of PGP in application to psychosis.

The Delphi questionnaire will be formatted to online web page and the link will be emailed to all the participants, where the participants will be asked to rate whether they agree that a particular aspect as being pertinent to PGP for psychosis on a 5-item Likert rating scale (strongly agree, agree, neither agree not disagree, disagree, strongly disagree). The results will be recorded in the anonymous database and analysed to obtain group percentages.

The study will consist of two rounds. In the first round of this study, you will be asked to rate whether you agree that a particular component is pertinent to PGP for psychosis on a 5-item Likert rating scale (strongly agree, agree, neither agree not

disagree, disagree, strongly disagree). The results will be recorded in the anonymous database and analysed to obtain group percentages. Your answers together with the answers of other experts from across the world will be statistically analysed and the statements which will obtain the ratings of “strongly agree” or “agree” amongst at least 80% of participants will be selected. In the second round a list of statements which have not received “strongly agree” or “agree” ratings will be emailed to you again. You will be asked to re-rate these statements based on the knowledge that those statements have not received a majority agreement on their pertinence to PGP for psychosis. As part of the re-rating process in the second round you will also be asked to comment on your re-rating decisions.

#### TIME COMMITMENT

In the first round, rating the web based questionnaire typically takes about 90 minutes. In the second round, re-rating should take much less time as it is envisaged that a lot of the statements will receive agreement on their pertinence from the majority of the participants in the first round. It is envisaged that re-rating and commenting in the second round should take up to 40 minutes.

#### PARTICIPANTS' RIGHTS

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/destroyed. You have the right to omit or refuse to answer or respond to any question that is asked of you. You have the right to have your questions about the procedures answered. If you have any questions as a result of reading this information sheet, you should ask the researcher before the study begins.

#### BENEFITS AND RISKS

There are no known risks to the prospective participants in this study. The results of this study may prove useful to professionals responsible for provision or training in PGP for psychosis. While spending time to think about the key elements of this intervention, clinicians might have an opportunity to reflect on their practice and apply these new reflections and insights to their practice.

#### CONFIDENTIALITY/ANONYMITY

The rating data collected does not contain any personal information about you. All ratings will be stored in the anonymised database, so that even the researcher will not know whose data the particular ratings represent. All data will be destroyed 5 years after the completion of the study.

#### FOR FURTHER INFORMATION

If you have any questions about this study, please do not hesitate to contact the researcher using the contact details provided above. Mr Scott and Dr McPherson also will be glad to answer your questions about this study at any time. The outcomes of this study are hope to be published in the peer reviewed journals.

## **Appendix Twelve: Round Two Data Analysis Email for Research Panel Discussion**

Dear research panel members

Thank you so much for all your contributions in getting this research project under way. We have now completed the first round of data collection from 37 participants worldwide and I was wondering whether you would be kind enough to give me your thoughts on selecting the statements for the second round.

According to Hasson et al (2000) the level of consensus is not universally agreed upon by the delphi researchers. In defining the level of consensus consideration should be given to the sample numbers, aim of the research and resources. “McKenna (1994) drawing on Loughlin & Moore's work (1979) suggests that consensus should be equated with 51% agreement amongst respondents, Sumsion (1998) recommends 70%, while Green et al (1999) opted for 80%” (Hasson et al, 2000). Graham & Milne (2003) in their use of delphi technique to define in what areas training programme in clinical psychology should be improved used 65.5% and above agreement amongst respondents in selecting the priority areas for the training for improvement.

Morrison and Barratt (2010) in their delphi study trying to establish what group of experts in CBT for psychosis view as important components used 80% agreement as the indicator of the component to be considered as essential and 70-70% of agreement as an indicator for the component to be re-rated in the second round, whereas all the components which reached less than 70% agreement were excluded and considered non-essential.

In the unpublished study by Kongara and Summers (personal communication) employing delphi method to identify key components of individual psychodynamic psychotherapy for psychosis 80% agreement was used to define the key components and all the component which reached less than 80% of agreement were re-rated in the second round (out of original 139 statements 46 were selected to be re-rated in the second round).

In our study 37 participants worldwide took part. Out of 187 statements 109 reached consensus among 80% and above of all the participants. 78 statements reached consensus among 79% or less of participants.

I have two questions, which I would appreciate your comments on:

1. What are your thoughts about taking 80% and above of consensus as a cut off point for statements to be included into the set of key components of PGP for psychosis.
2. Do you feel that all remaining 78 statements should be re-rated like in Kongara's study or should we have a bottom cut off point like in Morrison and Barratt study (this does not have to be 70%, it could be 50% as some of the studies claim the consensus to start at 51%)? I was wondering about more meaningful engagement of participants in the second round if the set of statements to be re-rated is manageable as I was thinking about asking the participants to comment qualitatively on their decision to keep or change the rating of every component in the second round. If we were to ask this of the participants, it would be very hard to engage meaningfully with 73 statements to re-rate and comment on.

Please see the attached document with 78 statements which reached less than 80%

agreement with statements highlighted in orange which seemed to be excluded from their importance to PGP by the majority.

I would like to send out invitations to participants for the second round at the end of this week and would very much appreciate your feedback.

Look forward to hearing from you.

Best wishes

Natalia Solovieva

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Psychodynamic Psychotherapist

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## Appendix Thirteen: Round Two Participants Email Invitation

Dear colleagues,

Thank you so much to all of you for your kind participation in the first round of the Delphi project regarding the key aspects of psychodynamic group psychotherapy for psychosis.

I am sorry it took much longer than expected for us to collect the data and analyse it following the first round. We tried our best to ensure as wide representation as possible and delayed the completion of the first round until the end of October 2014 as some of you requested more time to ensure your participation.

We are very pleased to let you know that 37 group analysts and psychotherapists participated from across the world to date. Your participation in this study is very valuable and we hope that you will be able to participate in the second round of this study.

We would like to briefly share with you the results of the first round which we hope you will hold in mind as you take part in the second round.

The original set of statements in the first round contained 187 components to be rated and several questions regarding demographic informations about the participants.

Out of 187 statements:

109 reached agreement where 80% and above of the participants gave it ratings “agree” or “strongly agree”

44 reached agreement where 70-80% of the participants gave it ratings “agree” or “strongly agree”

34 reached agreement where less than 70% of the participants gave it ratings “agree” or “strongly agree”

Majority of the statement which did not reach 80% agreement seem to be about general and phase specific interventions.

Following the recent Delphi studies, in our questionnaire for the second round we have included only 44 statements which reached agreement by 70-80% of the



participants. We excluded the statements which were rated as “agree” or “strongly agree” by less than 70% of the participants.

Please see the three documents attached to this email which reflect these results. In the two documents with the statements which did not reach 80% agreement you can also see the percentages across the scale for every statement.

Please refer to the document “upd\_consent70-80%.docx” attached to this email while completing the second round.

In the second round we are inviting you to reconsider your previous rating of the included 44 statements in light of the group percentages for these statements. If you disagree with the majority response to a particular statement, we would appreciate if you can please comment on the position you take in the comments box given below each statement.

Please find the questionnaire link for the second round below:

[https://docs.google.com/forms/d/1QkpVRBOCF4XJgS8eLU4VoJOTHb6OzSmFAsalTowETfE/viewform?c=0&w=1&usp=mail\\_form\\_link](https://docs.google.com/forms/d/1QkpVRBOCF4XJgS8eLU4VoJOTHb6OzSmFAsalTowETfE/viewform?c=0&w=1&usp=mail_form_link)

**We are planning to close second round data collection in three weeks time, possibly by the 10<sup>th</sup> of December. I hope very much that you will be able to complete the questionnaire by then. Please let us know if this time frame does not work for you for whatever reason.**

Thank you very much again for your participation in this important for the future of PGP for psychosis project.

Sincerely yours,

Natalia Solovieva

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Psychodynamic Psychotherapist

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## Appendix Fourteen: Week by week timetable of the study

Delphi Rounds	Weeks	Dates	Delphi Activities
Round One	Weeks 1-4	01/10/13 - 31/10/13	Literature review of available studies and articles on PGP for psychosis
	Weeks 5-8	01/11/2013 - 30/11/2013	Contacting potential research panel members identified through personal contacts of the investigator and the literature to obtain their initial agreement for the participation. Beginning the translation of the manual by Valbak & Lajer (2005)
	Weeks 9-20	01/12/2013 - 28/02/2014	Completing the translation of the manual by Valbak & Lajer (2005) with the help from Bent Rosenbaum. Compiling the first set of statements describing the pertinent components of PGP for psychosis. Based on the identified manuals and reviewed literature. The initial set of 436 statements compiled and sent out to research panel for review. Consultations with David Kennard and Aleksandra Novakovic.
	Weeks 21 – 25	01/03/2014 - 31/03/2014	The initial responses, feedback and recommendations from the research panel and consultants are collated and interpreted by the investigator. A new draft of 260 statements is developed.
	Weeks 25 – 33	01/04/2014 - 31/05/2014	A revised draft is emailed to research panel members with a request to check for further duplicates, ensure that all important components are included and to check for readability. Following another round of collation and interpretation of responses from the research panel further 60 statements are excluded as being incorrect or duplicate and 16 new statements added. A revised draft is again emailed to the research panel for the final review.
	Weeks 34 – 38	01/06/2014 - 30/06/2014	Final comments from the research panel are collated and interpreted. Further 30 statements are excluded as duplicates or ambiguous statements and further 15 statements are amended.
	Week 39-40	01/07/2014 - 14/07/2014	Email addresses of prospective participants are obtained and invitations are sent out. Informed consents to participate in the study of the first 12 participants were obtained.
	Weeks 40-42	14/07/2014 - 31/07/2014	Further networking and recruitment. 12 completed questionnaires received
	Weeks 43-44	01/08/2014 - 31/08/2014	Summer break
	Weeks 45-51	01/09/2014 -	Reminder emails were sent and further recruitment with the help of ISPS president undertaken

		10/10/2014	
	Weeks 52-54	10/10/2014 - 31/10/2014	Statistical and descriptive analysis of the data received from 37 participants was analysed and selection of statements for rerating was undertaken. A new survey was developed.
	Week 55	10/11/14	Emails to participate in the second round were sent
	Week 57	01/12/14 – 08/01/15	The email reminder was sent to all participants to complete the second round questionnaire
	Week 58-65	08/01/15 - 31/01/15	Collection of all data from round three was completed. Descriptive data analysis using ISPS Statistics 21. Beginning of qualitative analysis. First read of the entire data set, developing the initial ideas, observations and thoughts
	Week 66-70	01/02/15 - 28/02/15	Continuation of thematic analysis. Second read of the dataset and detailed coding
	Week 71-75	01/03/15 – 30/03/15	Third read and the review of codes and potential themes as part of the thematic analysis
	Week 76 – 80	01/04/15 – 30/04/15	Finalizing, defining and naming themes. Producing a report on the outcomes of the thematic analysis

## Appendix Fifteen: Cross-coding of a fragment of a data set by an independent researcher

Raw data set (Round 1)	Codes	Themes
<p>Are there any other components which you feel are pertinent to PGP for psychosis which might have been omitted in this set of statements?</p> <p>No thanks everything was very well covered</p>	FC (Fully covered)	No Theme
<p>It is important that expert clinical supervision is available soon after the group session, preferably the same day. The nature of internal containment of toxic and thought blocking projective identifications by therapists means that the period of time that these mental states are experienced should be minimised to avoid risk to the therapist of emotional stress and damage.</p>	S (Supervision)	Therapist containment
<p>There are no areas on this form for comments specifically from the position of clinical supervisor of this work. The questions are framed in such a way that comment can be made from this perspective, which is a good thing.</p>	S (Supervision)	Therapist containment
<p>PGP seems more feasible with ""stabilized patients"", not first-onset psychosis). Best candidates are those with : no acute positive symptoms, and low to moderate negative symptoms; no addiction problems on the foreground; a relatively good awareness of their illness; residual positive symptoms and an explicit need to work on interpersonal relationships.</p>	PE	Patients Eligibility
<p>Open-ended groups are to be avoid, in order to reduce ambiguity and uncertainty. Long-term is an absolute necessity (at least 2 years).</p>		
<p>Frame is to be presented as an optimal way of functioning (and reasons to do so are to be explained to the group) rather than rigid rules or expectations formulated by therapists.</p>	GS	Group Stability
<p>Avoid interruptions (""cigarette breaks"" ) during sessions.</p>	TS	Technical Specification
<p>If a patient drop out of the group, most of the time, it is not a good idea to include a new patient, especially if the group is ongoing for several months. Trust and security issues are too great with these patients, and group cohesion takes months to build.</p>	GS	Group Stability
<p>If one therapist is to be absent for a week or two only, it is often more constructive to pursue the sessions with the other therapist alone to maintain continuity, but not for more than 2 consecutive weeks (to avoid splitting, and pressure on the therapist's containing capacities).</p>		
<p>Debriefing after each session, where therapists talk about the group process and each patient, helps a lot to mentalize what are often implicit processes and progress.</p>	GS/TS	Group Stability/ Technical Specification
<p>If needed, supervision with a therapist who is familiar with</p>		

<p>psychotic processes is essential, but it doesn't really matters if the supervisor knows a great deal about group therapy."</p>		
<p>Other theoretical approaches also need to be considered such as Lacan</p>		Therapist containment
<p>No</p>	S (Supervision)	Theoretical Specification
<p>Some questions have more than one statement, therefore, is it difficult to answer, as the response to one statement may be different to the response to the second statement.</p>	TS (Theory)	No theme
<p>no</p>	FC (Fully covered)	No theme
<p>no</p>	FC (Fully covered)	No theme
<p>Congratulations for the questionnaire, accurate and complete, and for the opportunity you gave me to reflect on our demanding and fascinating job. The only comment I would make is related to the not many explorations of the unconscious dynamics (mainly, interpretation of dreams), indispensable in order to remain in the psychodynamic without slipping into psychoeducation.</p>	FC (Fully covered) FC (Fully covered) TS (Theory)	No theme Theoretical Specification
<p>Thank you and good luck with your work.</p>		
<p>THE PROBLEMS WITH PATIENTS WITH NEGATIVE SYMPTOMS</p>	FC (Fully covered)	No theme
<p>In this set of statements you should add the psychiatrist's knowledge of psychopathology, his attitude to relating to the patient as well as his personal human integrity, which are preliminary to be a psychotherapist.</p>	TS	Technical Specification
<p>Therapists practice using different frames and goals in a variety of settings-- generalizations are problematic</p>	TS	Technical Specification
<p>Shared sense of dilemmas being generally human, not exclusively pathologic, seems important duration of treatment should not be limited in outpatient care with psychotic. significant changes correlate with duration time of participation.</p>	TS	Technical Specification
<p>severe psychotic symptoms can be delt in group treatment if underlying anxieties can be adressed (12)</p>	GS/TS	Group Stability/ Technical Specification
<p>no comb. indiv. reatment</p>	TS	Technical Specification

<p>advise is not a key element of analytic group therapy.</p> <p>Yes: 1. It makes sense, if PGP for psychosis is run by a female AND a male therapist to enable transference to both mother and father.</p> <p>2. For putting a group together, it seems important to apply the Noah's Ark Principle: I.e. there should at least be TWO group members who share the same important distinguishing FEATURE! (E.g. at least two group members suffering from bipolar disorder, at least two pensioners, at least two male group members etc.)</p> <p>And I would like to mention that health care reality often forces the therapists to make compromises! (As I know from several colleagues.) For example: Since some national health care systems do not pay supervisions (and the institutional/personal budget might be too low for monthly supervisions) or due to the lack of fitting supervisors in RURAL areas, the PGP for psychosis therapists may have to accept supervisions e.g. only every three months and seek additional help through e.g. collegially intervisions with other psychotherapists (even if some of these colleagues have a different approach).</p> <p>This questionnaire is too long. I assume it is designed for the beginner therapist and so I find it irritating in its object relations bias.</p> <p>I coined the notion of 'corrective symbiotic experience', thinking on especially first phase of psychotherapeutic relationship, but thinking on its resolution when occasion appears. The dilution of transference of that intensity through the group setting is often adequate.</p> <p>no</p>	<p>TS</p> <p>TS</p> <p>TS</p> <p>TS (Theory)/TS</p> <p>S (Supervision)</p> <p>TS (theory)</p> <p>TS (theory)/ TS</p>	<p>Technical Specification</p> <p>Technical Specification</p> <p>Technical Specification</p> <p>Theoretical Specification /Technical Specification</p> <p>Therapist Containment</p> <p>Theoretical Specification</p> <p>Theoretical Specification / Technical Specification</p>
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## Appendix Sixteen: Statements which received $\geq 80\%$ consensus from the expert participants

Statements rated as important by $\geq 80\%$ of participants	Round included	Consensus
<b>Indications for Therapy</b>		
1. There is good reason to offer PGP to patients with psychosis as it helps them form and maintain rewarding relationships with other people.	1	89.5%
2. PGP (with appropriate supportive modifications) may be offered to patients with psychosis, at various stages of onset and for many therapeutic purposes.	1	92.1%
3. PGP is an important contribution, alongside medication, rehabilitation and individual therapy and should be offered as part of integrated treatment.	1	92.1%
4. PGP can be helpful after a period of individual psychological therapy.	1	84.2%
5. PGP can be helpfully combined with medication.	1	94.8%
6. PGP can be helpfully combined with individual therapy.	2	84.6%
7. PGP (with appropriate supportive modifications) can be helpful to patients at early stages of psychosis.	2	88.5%
8. PGP can be helpful to patients with psychosis without any prior experience of psychological therapy.	2	88.5%
<b>Therapy Aims</b>		
9. PGP should aim to improve quality of life.	1	86.9%
10. PGP should help patients reinstate hope in their lives, occupations and relationships.	1	100%
11. PGP should aim to help patients discover the defences that prevent them from recognising their potential and help patients to gradually replace these defences with more constructive and active ways of engaging with their lives.	1	81.6%
12. PGP should aim to help patients find ways to manage their emotions and to tolerate reality.	1	86.9%
13. PGP should aim to help patients be more aware of their own mental states.	1	92.1%
14. PGP should aim to help patients become more aware of the mental states of other people.	1	86.8%
15. PGP should aim to help patients learn about the ways they relate to each other in the group and to people outside of the group.	1	97.4%
16. PGP should aim to strengthen patients' egos through the experience of their capacity to build relationships inside and outside of the group.	1	92.1%
17. PGP should help patients improve social and interpersonal skills through discussions and experience of interacting with others during the sessions.	1	86.8%
18. PGP should aim to help patients acknowledge and come to terms with the losses or changes in their life due to their illness.	2	81%
19. PGP should aim to prevent relapses.	2	92.2%
<b>Therapy Frame</b>		

20. Therapists must ensure that the setting is kept constant, but if some change is required, they should be clear with the patients about the circumstances in which the therapy arrangements might change.	1	94.8%
21. Each PGP session should last between 60 and 90 minutes if patients can tolerate it.	1	84.2%
22. Frequency of the PGP sessions should be at least once weekly.	1	89.5%
23. PGP should be continued for at least one year, but preferably for three years or be open-ended.	1	89.5%
24. Members of the group should be contracted to confidentiality and to not disclosing information about other patients outside of the group.	1	100%
25. Socialising outside of the group, although not encouraged, is not banned. However, members are encouraged to discuss their encounters in the group.	1	92.1%
26. If patients happen to relapse while in therapy, this should not be an indication for early termination of therapy.	1	94.7%
27. PGP sessions should not have a pre-determined structure or agenda. PGP sessions are based on a free flowing exchange of members' emotions and thoughts.	2	84.6%
28. PGP groups should include 6-8 members. The group size should be not too daunting for most anxious patients but should not be too big in order to provide individual patients with special care when necessary.	2	84.6%
29. Therapists should liaise with other health professionals involved in patients' care and discuss the outcomes of these liaisons with their patients.	2	84.5%
<b>Therapeutic Factors</b>		
30. Instillation of hope (being able to observe and remain in contact with other group members who improved and overcame very similar problems) is one of the key therapeutic factors in PGP for psychosis.	1	92.1%
31. Cohesiveness (a feeling of togetherness experienced by the group members, valuing the group) is one of the key therapeutic factors in PGP for psychosis.	1	84.2%
32. Interpersonal learning input (patients learn about themselves through feedback from others) is one of the key therapeutic factors in PGP for psychosis.	1	84.2%
33. Interpersonal learning output (practising to interact in a more adaptive manner) is one of the key therapeutic factors in PGP for psychosis.	2	92.1%
34. Universality (a feeling of having problems similar to others, feeling not alone) is one of the key therapeutic factors in PGP for psychosis.	1	94.7%
35. Self-understanding (insight into one's feelings, thoughts and attitudes and into one's relationships with other people) is one of the key therapeutic factors in PGP for psychosis.	1	89.5%
<b>Assessment and Preparatory Sessions</b>		
36. During the assessment and preparatory sessions it is important to build a therapeutic alliance and create an atmosphere where disclosure and reflection feels safe.	1	94.7%
37. In preparatory sessions, the patient should be invited to talk about themselves, describe their problems and their experience of past therapies.	2	84.6%
38. Goals of therapy and the patient's expectations should be explored and agreed. Therapists may clarify with the patient if the goals are outside the scope of therapy.	2	96.1%
39. In the preparatory sessions therapists should raise potential difficulties the patient might face in continuing with treatment and encourage them to discuss these issues in the group sessions.	2	84.6%



40. Therapists should discuss with the patient issues of privacy and risk and level of responsibility should be agreed upon.	2	100%
41. Information shared with other professionals should be provided in a sensitive and patient-friendly manner. A copy of the correspondence, whenever possible, should be given to the patient	2	88.4%
42. Therapists should attempt to gain an understanding of the emotional meaning to the patient of daily life events with a focus on interactions and interpersonal relationships.	1	89.5%
43. Therapists should decide if the group available would match the patient's needs and level of functioning.	1	89.5%
44. Where relevant, drug and alcohol use need to be discussed with the patient. It should be considered whether the patient should address their addiction before joining the group.	1	86.8%
45. An emphasis on shared responsibility in therapy is important, making it clear that the patient must also be prepared to do some work in order to make progress.	1	89.5%
46. If therapists feel that the patient's or other people's safety could be compromised, they need to agree with the patient that they can contact other professionals involved in the patient's care.	1	89.5%
47. The patient's attitude towards medication should be explored and the position of therapists should be clarified.	1	86.2%
48. Therapists should check whether the patient has understood the information provided and if they found it relevant to their concerns.	1	86.9%
49. Any information given to the patient regarding the treatment should be clear and consistent.	1	97.4%
50. The patient should be informed about possible concurrent treatment modalities: medication, family support, individual therapy and how these treatment modalities may relate to PGP.	1	81.5%
51. The patient should be informed about how far information will be shared between therapists and other members of the treatment team, including the therapist's supervision arrangements.	1	84.2%
52. During the preparatory sessions, therapists should provide all the necessary information about the group, its rules and aims (including a print-out version).	2	92.4%
53. Patients need to be warned that recovery is possible but that they may need to get actively involved in the process and that it may be some time before they can experience any changes.	1	81.5%
<b>Formulation of Hypothesis</b>		
54. The formulation will be informed by the therapists' assessment of the transference and counter transference.	2	84.6%
55. Aspects of the formulation should be shared with the patient when therapists judge this a helpful intervention.	2	84.6%
56. The therapist should discuss these hypotheses in supervision.	2	100%
57. This formulation, based on observations of the initial interaction with the patient, will be further elaborated and reviewed to incorporate new information gathered in the group sessions. Therapists will decide how and when to feed this back to the patient.	2	96.2%
58. These hypotheses should cover any suicidal or violent impulses.	1	86.8%
59. The formulation should consider the patient's non-psychotic as well as their psychotic functioning.	1	84.2%
60. The formulation should cover the patient's degree of awareness of the illness.	1	86.9%

61.The formulation should consider unconscious as well as conscious aspects.	2	88.4%
<b>General Therapy Approach throughout Assessment and Therapy</b>		
62.Therapists will use an ordinary conversational style to offer patients an opportunity to discuss anything they choose.	1	86.8%
63.The general therapeutic approach is active, supportive and focused on helping patients to test reality and build relationships.	1	81.6%
64.Therapists should not restrict themselves to remaining emotionally neutral. They should make themselves available as a “container” for the patient.	1	97.4%
65.Therapists have to look on the non-psychotic part of the patient or the group as an ally that will help the group contain and work through the psychotic elements that appear in the interaction.	1	92.1%
66.Therapists must support the patients' and the group's non-psychotic functioning by keeping things simple and highly consistent.	1	92.1%
67.Therapists must maintain a flexible position concerning the methods and content of therapy.	1	89.5%
68.PGP should focus on developing and maintaining the therapeutic alliance throughout therapy.	1	89.5%
69.Defences must be understood, respected, maintained and at times even enhanced by therapists as they have the function of protecting the patient from contact with difficult feelings.	2	84.7%
70.PGP should support the patients to regain a sense of purpose in their life by resuming studies/work etc.	2	92.3%
71.In PGP, patients should be assisted in reality testing and in challenging their own beliefs through identification with therapists and other group members.	2	84.6%
72.PGP should help group members manage their difficulties and support them during crises.	1	94.7%
73.Therapists will aim to reflect on the patients' individual verbal and non-verbal communications.	1	94.7%
74.Therapists will aim to reflect on both individual and group-as-a-whole dynamics.	1	84.2%
75.Therapists should be mindful of the transference content in the patient's communications (towards therapist, other members or the group as a whole).	1	97.4%
76.The therapist's responses to patients' verbal and non-verbal communications should be guided by his/her understanding of the individuals' and the group's history as well as the here-and-now situation.	1	89.5%
77.Patients may need explanations which are careful, slow, detailed and repeated in order to reduce anxiety and mistrust.	1	86.8%
78.Therapists should find the balance between delving into barely accessible emotional material, on one hand, and on the other, conveying that they do not want to tear the patient/s out of a state of emotional security.	1	81.6%
79.Therapists will always be alert to the possibility of the patients or the group reverting to a psychotic state, and will be prepared to return to a more supportive approach if this is indicated.	1	86.9%
80.Therapists should deal with expressions of aggressive impulses as soon as they are manifested by helping patients to explore their feelings and link them with other feelings that acted as a trigger (loss, abandonment, envy or jealousy).	1	94.8%
81.Negative transference must be explored to avoid frustration as much as possible and to allow patients to express their feelings rather than act them out.	1	94.8%
82.Therapists should be mindful that powerful countertransference feelings may develop and they should work on them in supervision in order not to become disengaged and unempathetic.	1	97.4%

83.Use of metaphors can facilitate group communication and exploration, and can help patients gain greater understanding of their behaviours as well as helping to accommodate emotionally loaded conflicts and experiences.	1	84.2%
84.Therapists might use humour with caution to manage intensity of feelings and to bring humanness and lightness to individual and group experiences.	1	94.7%
85.Therapists should maintain a non-judgemental stance and should help the group to avoid polarized positions.	1	92.1%
86.Interpretations should take into consideration patients' vulnerabilities and should aim at keeping anxiety at a manageable level.	1	97.4%
87.Interpretations of unconscious material will be offered only when and if the patient is judged able to make use of these without resorting to psychotic defences.	1	84.2%
88.Therapists should offer ego-supportive interpretations which access and reinforce the individual's strengths and healthy defence mechanisms.	1	84.2%
89.PGP should provide opportunities for the group members to receive corrective emotional experiences.	1	86.8%
90.Therapists should aim to help patients develop internal structure by adhering to the therapy frame.	1	84.2%
91.Therapists should help patients manage their feelings by helping them to stay with painful emotions rather than rush away from them.	1	92.1%
92. Therapists should help patients explore their own thoughts (instead of ignoring them) by building links between patients' experiences and thoughts.	1	100%
93. Therapists should help patients develop more coherent narratives by organising in a more articulate way the confusing and disconnected associations in the group.	1	81.6%
94.Therapists should aim at facilitating dialogue and discussion amongst group members.	1	81.6%
95.Therapists should offer observations and comments on group processes in the here and now to foster the group's ability to reflect on its own processes.	1	86.8%
96.Experiences of suicide attempts, self-harm or harm to others need to be discussed and explored in the group.	1	81.6%
97.If therapists feel that a patient in the group is at risk, they should act to keep the patient safe.	1	100%
98.The impact of breaks and holidays on the group should be explored through attending to patients' phantasies and worries. Care provision during the breaks needs to be agreed with other professionals involved in the patients' care.	1	100%
<b>Engagement Phase Specific Interventions</b>		
99.Therapists should foster and reinforce interactions between group members.	2	96.2%
100.Therapists need to communicate their hope to patients about the potential helpfulness of PGP.	2	92.4%
101.Therapists should aim to create an enabling and supportive culture and to establish cohesion.	1	84.2%
102.Therapists should make the framework and rules clear to allay anxiety.	1	89.5%
103.Therapists must be reliable and consistent and contribute actively to the establishment of positive transference.	1	92.1%
104.Therapists work on offering a corrective emotional experience by assuming an empathic, understanding and non-judgemental attitude.	1	86.8%
105. It is important to allow time for this stage before moving on, as it takes time to establish basic trust and confidence in therapists and the group.	1	92.1%
<b>Interpersonal Phase Specific Interventions</b>		

106.Once basic trust has been established, patients are encouraged to explore their differences while their feelings of safety are closely monitored.	1	94.7%
107.Therapists should aim to help patients consolidate their sense of trust, to tame their fears and to increase their interactions within and outside the group.	1	86.8%
108.It is important to help patients find ways of expressing their angry feelings in more constructive ways, so they do not feel the need to suppress these feelings or feel persecuted by them.	1	92.1%
109.Therapists should help patients find words for expressing dangerous feelings so they can understand them and work on them rather than act them out or transform them into persecutory delusions/hallucinations.	1	94.7%
110.Patients are encouraged to actively engage in problem solving so that they can gain more control over their lives.	2	92.3%
111.Therapists should help patients to establish connections within the group (and outside the group) by watching others, listening to others and talking to each other, rather than merely imagining what others think. Learning to check their assumptions will help them to stay in touch with reality.	2	92.3%
112.Patients should be helped to recognise the vulnerabilities and limitations imposed by their illness and to learn to react more assertively to other people's responses to their illness. Any sense of stigmatisation needs to be openly discussed.	1	81.6%
113.Therapists should support patients' growing sense of self-awareness and awareness of other people's feelings through encouraging patients to actively ask questions, check their assumptions and express feelings and thoughts about their interactions with others constructively.	1	86.8%
114.The PGP focus may now shift towards more long-standing problems and unhelpful relational patterns by looking at their impact on current relationships and functioning, both within and outside the group.	2	88.5%
115.Individual symptomatic difficulties of the patients should be elaborated from a perspective that links them with the relationships with others.	2	84.6%
116.Therapists should continue helping patients to improve their ability to build relationships inside and outside of the group in order to enable them to seek support and help outside the group when the group finishes.	2	91.3%
<b>Termination Phase Specific Interventions</b>		
117.In medium and long term duration PGP groups termination should be communicated at least three months in advance.	2	88.5%
118.A few months prior to ending, therapists with the help of other group members should summarise the improvement they have witnessed and the aspects that need further work.	2	88.5%
119.Passivity of group members needs to be explored and challenged so patients learn to take more control of their lives.	2	88.5%
120.Therapists should openly accept patients' criticism of PGP and explore patients' expectations which were not fulfilled.	1	94.8%
121.Therapists should reflect with patients on the positive things they got out of PGP.	1	86.8%
122.Therapists should comment on the creative and life-affirming aspects of the patient's and the group's functioning selves.	1	86.8%
123.Therapists should support patients in containing feelings about loss and hope at the same time.	1	89.4%
124.Therapists should help patients to say good bye and to think about what they learnt from others and what others learnt from them. Patients are encouraged to use what they have learnt to meet new friends and keep active once they leave the group.	1	81.6%
125.If a patient wants to shorten the termination stage, therapists must explore the reasons to break the agreement to have a planned ending.	1	94.7%
126.Both the group and the patient who is leaving should be helped to talk about their phantasies and worries about leaving the group and the plans they have	1	94.7%

after they leave the group.		
127.Therapists should always offer a follow-up opportunity for patients leaving the group.	2	96.2%
<b>Therapists' Qualities and Attitudes</b>		
128.Therapists should be able to access their own humanness, which also includes the ability to 'metabolize' and process their own psychotic-like experiences.	2	92.3%
129.Therapists must have a capacity to tolerate and accommodate intense unspoken and unconscious conflicts.	1	97.4%
130.Therapists must be active listeners and maintain analytic attitude.	1	92.1%
131.Therapists must accept playing a modelling role and fostering a culture of tolerance, reflection and calmness. This attitude could help patients to feel safe enough to express their feelings.	1	92.1%
132.Therapists must be patient, empathic and non-judgemental in their style. They should find a language that is acceptable and not hurtful for the patients.	1	94.8%
133.Therapists must be able to maintain a balance between activity and inactivity (active observation).	1	89.5%
134.Therapists must be able to respect a slow pace of change and be able to recognize and acknowledge small steps in patients' development.	1	94.7%
135.Therapists need to be active, ensuring that silent periods are short so the levels of frustration, anxiety and ambiguity are low.	1	86.8%
136.Therapists need to be honest and transparent about their attitudes, opinions and concrete information about themselves, ensuring that their work or safety are not compromised by these disclosures.	1	92.2%
137.Therapists should be able and willing to reflect on their own responses to the patients, including their potential for negative responses, e.g. aggression, power struggles, guilt etc.	1	89.5%
138.Therapists should be able to exhibit considerable awareness of countertransference reactions, even more than when working with other kinds of patients.	1	92.1%
139.Therapists should aim to maintain realistic hope for patients, being mindful of the possibility of pessimism or over-ambition.	1	100%
140.Therapists need to make their verbal interventions clear, simple and focused. They should check with group members whether their words have been understood if group members look puzzled or confused about the intervention.	1	92.1%
141.When crisis is imminent, therapists should advise and guide patients in a concrete way as to how they should tackle the problems while being mindful of their own countertransference and the need to contain their own anxiety.	1	86.8%
142.Therapists have to bear feelings of frustration, apparent meaninglessness and the laborious work that is required to help these patients make progress.	1	97.4%
143. Therapists should be supported by supervision arrangements. This will enhance their reflective capacity and help them contain and process their patients' intense projections.	1	89.5%
144.Therapists should be in supervision with a supervisor who is skilled in group therapy specifically with psychotic patients.	1	81.5%
145.Conducting the group with a co-therapist can offer greater containment, consistency, stability and model effective ways of relating to these patients as well as offer support for therapists.	2	96.20%



### Statements that received 70% - 80% consensus from the expert participants

Question	Strongly agree	Agree	Neither agree/nor disagree	Disagree	Strongly disagree	Overall Consensus
<b>General Therapy Approach throughout Assessment and Therapy</b>						
1. Therapists should focus on here-and-now interactions rather than the there-and-then dimension of patients' relationships.	42.3% (11)	34.6% (9)	19.2% (5)	3.8% (1)	0% (0)	76.9%
2. Therapists should aim to help patients learn from past mistakes and failures by helping to see these in the context of patient's illness and their consequent lack of opportunities.	26.9% (7)	50% (13)	11.5% (3)	3.8% (1)	3.8% (1)	76.9%
3. Dreams should not be interpreted but used as metaphors, helping the patient and the group to explore the meaning at a level that does not feel exposing or persecutory.	42.1% (16)	28.9% (11)	10.5% (4)	7.9% (3)	10.5% (4)	71%
<b>Engagement Phase Specific Interventions</b>						
4. The focus of interventions is on the here-and-now.	50% (13)	26.9% (7)	15.4% (4)	3.8% (1)	0% (0)	76.9%
5. Identification with therapists is not discouraged; therapists take on active, teaching and modelling roles so that patients learn new ways of relating.	23.1% (6)	53.8% (14)	15.4% (4)	3.8% (1)	3.8% (1)	76.9%
<b>Termination Phase Specific Interventions</b>						
6. A few months prior to ending, therapists with the help of other group members should summarise the improvement they have witnessed and the aspects that need further work.	26.9% (7)	50% (13)	23.1% (6)	0% (0)	0% (0)	76.9%
<b>Therapists' Qualities and Attitudes</b>						
7. Conducting PGP groups for psychosis on one's own should be avoided as it poses significant risk and difficulty to both patients and therapists.	47.4% (18)	28.9% (11)	15.8% (6)	5.3% (2)	0% (0)	76.3%

### Statements which were excluded from the list of key components of PGP for psychosis

Questions rated as key components by less than 70% of participants	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Consensus
<b>Indications for Therapy</b>						
1.PGP can be helpful without adjunctive medication.	23.7% (9)	18.4% (7)	26.3% (10)	21.1%(8)	7.9%(3)	42.1%
2.Patients with predominant positive symptoms can benefit from shorter term PGP of 6-12 months duration.	13.2% (5)	31.6% (12)	34.2% (13)	21.1%(8)	0%(0)	44.8%
3.Patients with long standing negative symptoms and lacking adequate support systems should be offered long-term or open ended PGP.	34.8 % (8)	34.8% (8)	21.7% (5)	8.7% (2)	0% (0)	69.6%
4.Patients need to be able to adhere to the PGP frame, sit through the entire session and be able to cope with not having constant attention paid to them.	13.2% (5)	34.2% (13)	31.6% (12)	18.4%(7)	0%(0)	47.4%
5.PGP groups should consist of patients with similar ego functioning levels.	15.8% (6)	34.2% (13)	15.8% (6)	34.2%(13)	0%(0)	50%
6.Patients who are actively suicidal or who are acutely overwhelmed with psychotic symptoms should not be offered PGP.	26.3% (10)	26.3% (10)	26.3% (10)	15.8%(6)	5.3%(2)	52.6%
<b>Therapy Aims</b>						
7.PGP should aim to help patients gain an understanding of conscious and unconscious factors contributing to the formation and maintenance of their symptoms.	61.5% (16)	7.7% (2)	23.1% (6)	3.8%(1)	0%(0)	69.2%
<b>Therapy Frame</b>						
8.Homework, including practice assignments, agreed between sessions activities, thought diaries and monitoring procedures are not employed in PGP for patients with psychosis.	42.3% (11)	26.9% (7)	23.1% (6)	7.7%(2)	0%(0)	69.2%
9.In the initial group sessions the rules of PGP should be discussed in detail to clarify any questions or doubts patients have and should be reviewed every time a new member joins the group.	28.9% (11)	28.9% (11)	21.1% (8)	13.2%(5)	7.9%(3)	57.8%
10.If patients cannot tolerate this length of session, therapists may reduce the length of the session with mutual agreement within the group.	39.5% (15)	23.7% (9)	13.2% (5)	18.4%(7)	5.3%(2)	63.2%
11.If a patient is unable to attend, an empty chair should be kept in the PGP session.	44.7% (17)	13.2% (5)	28.9% (11)	7.9%(3)	5.3%(2)	57.9%



12.Individual sessions are possible at the request of group members, but patients are encouraged to talk about the individual sessions with the group.	31.6% (12)	34.2% (13)	15.8% (6)	13.2%(5)	5.3%(2)	65.8%
13.Therapists should not take other roles in relation to the patients in the group (psychiatrist, social worker or nurse).	23.7% (9)	44.7% (17)	26.3% (10)	5.3%(2)	0%(0)	68.4%
<b>Therapeutic Factors</b>						
14.Altruism (growing self-esteem by offering help to others) is one of the key therapeutic factors in PGP for psychosis.	28.9% (11)	28.9% (11)	28.9% (11)	10.5%(4)	0%(0)	57.8%
15.Catharsis (allowing oneself to express feelings which are difficult for the patient to express) is one of the key therapeutic factors in PGP for psychosis.	26.3% (10)	28.9% (11)	31.6% (12)	13.2%(5)	0%(0)	55.2%
16.Existential awareness (accepting responsibility for life decisions) is one of the key therapeutic factors in PGP for psychosis.	28.9% (11)	39.5% (15)	26.3% (10)	5.3%(2)	0%(0)	68.4%
17.Guidance (receiving advice, nurturing support and assistance) is one of the key therapeutic factors in PGP for psychosis.	26.3% (10)	26.3% (10)	28.9% (11)	18.4%(7)	0%(0)	52.6%
18.Family re-enactment (identifying and changing dysfunctional patterns or roles one played in the family of origin) is one of the key therapeutic factors in PGP for psychosis.	28.9% (11)	21.1% (8)	31.6% (12)	18.4%(7)	0%(0)	50%
19.Identification (observing and imitating more adaptive attitudes of other group members and therapists) is one of the key therapeutic factors in PGP for psychosis.	34.2% (13)	28.9% (11)	15.8% (6)	18.4%(7)	2.6%(1)	63.1%
<b>Assessment and Preparatory Sessions</b>						
20.Before assessment, therapists should read all information available in discharge letters, and patient records from previous or current therapists and request more information if necessary.	36.8% (14)	28.9% (11)	23.7% (9)	5.3%(2)	5.3%(2)	65.7%
21.It is important to speak in depth about the recent psychotic episode in order to assess the patient's insight as well as their capacity to link their symptoms with their emotional conflicts.	26.3% (10)	31.6% (12)	28.9% (11)	7.9%(3)	5.3%(2)	57.9%
22.Towards the end of the preparatory sessions, therapists should provide a summary of the patient's history, their difficulties and strengths, including the agreed therapeutic goals. This summary should be shared in writing with the patient and other professionals involved in the patient's care.	15.8% (6)	15.8% (6)	36.8% (14)	23.7%(9)	5.3%(2)	31.6%
<b>Formulation of Hypothesis</b>						
23.Following the initial individual sessions with each group member, therapists should formulate a set of hypotheses regarding the patient's level of	31.6% (12)	36.8% (14)	18.4% (7)	10.5%(4)	0%(0)	68.4%

functioning, coping mechanisms and strengths.						
24.These hypotheses should cover the patient's potential transference onto the group.	26.3% (10)	39.5% (15)	26.3% (10)	7.9%(3)	0%(0)	68.5%
25.These hypotheses should cover factors influencing the therapeutic alliance	26.3% (10)	39.5% (15)	26.3% (10)	6.9%(3)	0%(0)	65.8%
<b>General Therapy Approach throughout Assessment and Therapy</b>						
26.Therapists will aim to reflect on only group-as-a-whole processes.	15.8% (6)	5.3% (2)	21.1% (8)	39.5%(15)	18.4%(6)	21.1%
27.Although positive transference should be fostered, transference should not be analysed, but should be kept in the therapist's mind as a guide to individual and group dynamics.	36.8% (14)	26.3% (10)	21.1% (8)	7.9%(3)	5.3%(2)	63.1%
28.Resistances and transferences should not be analysed unless they interfere with the therapeutic process.	36.8% (14)	26.3% (10)	21.1% (8)	7.9%(3)	7.9%(3)	63.1%
29.The method of free association should be avoided.	21.1% (8)	26.3% (10)	21.1% (8)	28.9%(11)	2.6%(1)	47.4%
30.Therapists should avoid 'uncovering' interpretations which seek to overcome defences and increase depth of insight and mutative inner change.	26.3% (10)	26.3% (10)	28.9% (11)	18.4%(7)	0%(0)	52.6%
31.PGP should offer patients opportunities to practise what they learn within the sessions (ego training in action).	42.1% (16)	18.4% (7)	28.9% (11)	7.9%(3)	0%(0)	60.5%
<b>Engagement Phase Specific Interventions</b>						
32.Therapists should start by focusing on the issues that are already conscious for the patient and the group, such as symptoms and common concerns of group members	31.6% (12)	34.2% (13)	18.4% (7)	13.2%(8)	0%(0)	65.8%
33.Interpretations of group and individual unconscious processes should be avoided, but therapists should use this information to reach deeper understanding of what is happening in the group.	28.9% (11)	28.9% (11)	21.1% (8)	13.2%(5)	7.9%(3)	57.8%
<b>Interpersonal Phase Specific Interventions</b>						
34.Patients need to be helped to recognise their symptoms and to come to terms with their illness through learning new ways of coping from each other. This will help them connect with their experience in a more realistic and meaningful way.	42.1% (16)	23.7% (9)	28.9% (11)	5.3%(2)	0%(0)	65.8%
<b>Therapists' Qualities and Attitudes</b>						
35.Therapists may help patients define their and the group's reality by giving advice.	15.8% (6)	23.7% (9)	36.8% (14)	21.1%(8)	2.6%(1)	39.5%



















37. **37. Individual sessions are possible at the request of group members, but patients are encouraged to talk about the individual sessions with the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

38. **38. Members of the group should be contracted to confidentiality and to not disclosing information about other patients outside of the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

39. **39. Socialising outside of the group, although not encouraged, is not banned. However, members are encouraged to discuss their encounters in the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

40. **40. Therapists should not take other roles in relation to the patients in the group (psychiatrist, social worker or nurse).**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

41. **41. Therapists should liaise with other health professionals involved in patients' care and discuss the outcomes of these liaisons with their patients.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

42. **42. If patients happen to relapse while in therapy, this should not be an indication for early termination of therapy.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

## Therapeutic Factors

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49. **49. Catharsis (allowing oneself to express feelings which are difficult for the patient to express) is one of the key therapeutic factors in PGP for psychosis.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

50. **50. Self-understanding (insight into one's feelings, thoughts and attitudes and into one's relationships with other people) is one of the key therapeutic factors in PGP for psychosis.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

51. **51. Existential awareness (accepting responsibility for life decisions) is one of the key therapeutic factors in PGP for psychosis.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

52. **52. Guidance (receiving advice, nurturing support and assistance) is one of the key therapeutic factors in PGP for psychosis.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

53. **53. Family re-enactment (identifying and changing dysfunctional patterns or roles one played in the family of origin) is one of the key therapeutic factors in PGP for psychosis.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

54. **54. Identification (observing and imitating more adaptive attitudes of other group members and therapists) is one of the key therapeutic factors in PGP for psychosis.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

## Assessment and Preparatory Sessions

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61. **61. Therapists should decide if the group available would match the patient's needs and level of functioning.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

62. **62. In the preparatory sessions therapists should raise potential difficulties the patient might face in continuing with treatment and encourage them to discuss these issues in the group sessions.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

63. **63. Where relevant, drug and alcohol use need to be discussed with the patient. It should be considered whether the patient should address their addiction before joining the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

64. **64. Patients need to be warned that recovery is possible but that they may need to get actively involved in the process and that it may be some time before they can experience any changes.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

65. **65. An emphasis on shared responsibility in therapy is important, making it clear that the patient must also be prepared to do some work in order to make progress.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

66. **66. Therapists should discuss with the patient issues of privacy and risk and level of responsibility should be agreed upon.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree











90. **90. Therapists should focus on here-and-now interactions rather than the there-and-then dimension of patients' relationships.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

91. **91. Therapists have to look on the non-psychotic part of the patient or the group as an ally that will help the group contain and work through the psychotic elements that appear in the interaction.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

92. **92. Therapists must support the patients' and the group's non-psychotic functioning by keeping things simple and highly consistent.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

93. **93. Defences must be understood, respected, maintained and at times even enhanced by therapists as they have the function of protecting the patient from contact with difficult feelings.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

94. **94. Therapists must maintain a flexible position concerning the methods and content of therapy.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

95. **95. PGP should focus on developing and maintaining the therapeutic alliance throughout therapy.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree





108. **108. Therapists should deal with expressions of aggressive impulses as soon as they are manifested by helping patients to explore their feelings and link them with other feelings that acted as a trigger (loss, abandonment, envy or jealousy).**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

109. **109. Negative transference must be explored to avoid frustration as much as possible and to allow patients to express their feelings rather than act them out.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

110. **110. Therapists should be mindful that powerful countertransference feelings may develop and they should work on them in supervision in order not to become disengaged and unempathetic.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

111. **111. Dreams should not be interpreted but used as metaphors, helping the patient and the group to explore the meaning at a level that does not feel exposing or persecutory.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

112. **112. The method of free association should be avoided.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

113. **113. Use of metaphors can facilitate group communication and exploration, and can help patients gain greater understanding of their behaviours as well as helping to accommodate emotionally loaded conflicts and experiences.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree











138. **138. Interpretations of group and individual unconscious processes should be avoided, but therapists should use this information to reach deeper understanding of what is happening in the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

139. **139. Identification with therapists is not discouraged: therapists take on active, teaching and modelling roles so that patients learn new ways of relating.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

140. **140. Therapists must be reliable and consistent and contribute actively to the establishment of positive transference.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

141. **141. The focus of interventions is on the here-and-now.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

142. **142. Therapists work on offering a corrective emotional experience by assuming an empathic, understanding and non-judgemental attitude.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

143. **143. It is important to allow time for this stage before moving on, as it takes time to establish basic trust and confidence in therapists and the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

## Interpersonal Phase Specific Interventions

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## Termination Phase Specific Interventions

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156. **156. In medium and long term duration PGP groups termination should be communicated at least three months in advance.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

157. **157. Therapists should openly accept patients' criticism of PGP and explore patients' expectations which were not fulfilled.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

158. **158. Therapists should reflect with patients on the positive things they got out of PGP.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

159. **159. Therapists should comment on the creative and life-affirming aspects of the patient's and the group's functioning selves.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

160. **160. A few months prior to ending, therapists with the help of other group members should summarise the improvement they have witnessed and the aspects that need further work.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

161. **161. Passivity of group members needs to be explored and challenged so patients learn to take more control of their lives.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

162. **162. Therapists should support patients in containing feelings about loss and hope at the same time.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

163. **163. Therapists should help patients to say good bye and to think about what they learnt from others and what others learnt from them. Patients are encouraged to use what they have learnt to meet new friends and keep active once they leave the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

164. **164. If a patient wants to shorten the termination stage, therapists must explore the reasons to break the agreement to have a planned ending.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

165. **165. Both the group and the patient who is leaving should be helped to talk about their phantasies and worries about leaving the group and the plans they have after they leave the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

166. **166. Before a patient leaves the group, a risk assessment and care package should be put in place either by group therapists or by other professionals involved in the patient's care.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

167. **167. Therapists should always offer a follow-up opportunity for patients leaving the group.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

## Therapists' Qualities and Attitudes

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174. **174. Therapists need to be active, ensuring that silent periods are short so the levels of frustration, anxiety and ambiguity are low.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

175. **175. Therapists need to be honest and transparent about their attitudes, opinions and concrete information about themselves, ensuring that their work or safety are not compromised by these disclosures.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

176. **176. Therapists should be able and willing to reflect on their own responses to the patients, including their potential for negative responses, e.g. aggression, power struggles, guilt etc.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

177. **177. Therapists should be able to exhibit considerable awareness of countertransference reactions, even more than when working with other kinds of patients.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

178. **178. Therapists should aim to maintain realistic hope for patients, being mindful of the possibility of pessimism or over-ambition.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

179. **179. Therapists need to make their verbal interventions clear, simple and focused. They should check with group members whether their words have been understood if group members look puzzled or confused about the intervention.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

180. **180. Therapists may help patients define their and the group's reality by giving advice.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

181. **181. When crisis is imminent, therapists should advise and guide patients in a concrete way as to how they should tackle the problems while being mindful of their own countertransference and the need to contain their own anxiety.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

182. **182. Therapists have to bear feelings of frustration, apparent meaninglessness and the laborious work that is required to help these patients make progress.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

183. **183. Therapists should be able to access their own humanness, which also includes the ability to 'metabolize' and process their own psychotic-like experiences.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

184. **184. Therapists should be supported by supervision arrangements. This will enhance their reflective capacity and help them contain and process their patients' intense projections.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

185. **185. Therapists should be in supervision with a supervisor who is skilled in group therapy specifically with psychotic patients.**

*Mark only one oval.*

	1	2	3	4	5	
Strongly disagree	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Strongly agree

186. **186. Conducting the group with a co-therapist can offer greater containment, consistency, stability and model effective ways of relating to these patients as well as offer support for therapists.**

*Mark only one oval.*

1      2      3      4      5

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Strongly disagree                  Strongly agree

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187. **187. Conducting PGP groups for psychosis on one's own should be avoided as it poses significant risk and difficulty to both patients and therapists.**

*Mark only one oval.*

1      2      3      4      5

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Strongly disagree                  Strongly agree

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## Final Comments

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188. **188. Are there any other components which you feel are pertinent to PGP for psychosis which might have been omitted in this set of statements?**

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## Participant Information

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Please enter the answers to the following questions in the boxes underneath the questions.

189. **189. What country do you currently practice in?**

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190. **190. What is your training background?**

(for example, "Group Analysis" (Foulkes), "Group-as-a-whole psychoanalytic approach" (Bion), "Psychoanalytic/psychodynamic" (object relations and self-psychology). "Interpersonal Psychodynamic" (Yalom) etc.)

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191. **191. In what healthcare settings do you provide PGP for psychosis?**

(for example, private sector, public sector (national health system), inpatient setting, outpatients setting etc.)

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192. **192. Please enter the number of years you have been practicing PGP for psychosis**

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193. **193. What is the frequency and duration of therapy that you offer when practicing PGP for psychosis**

(for example, once weekly, twice weekly, fortnightly, 60 minute sessions, 90 minute sessions etc.)

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194. **194. How do you normally conduct your groups?**

(for example, on your own, with a co-therapist, with a participant observer, with a trainee etc.)

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**Thank you very much for your time and participation**

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