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Basurto-IGPP. A manual-directed approach of integrative group psychotherapy in psychosis

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A manual on Integrative Group Psychotherapy for outpatients with schizophrenia and other psychoses (Basurto-PGIP) is presented. The model takes into account group specific therapeutic factors. It integrates influences from other integrative psychotherapeutic models, interpersonal group therapy, group analysis and recent developments in cognitive behavioural therapy for psychotic symptoms. The manual is structured in levels of different complexity that can be applied in a progressive manner. The intervention tries to adapt to patients features, therapists ability and training, and centres resources. It can be applied in two possible settings: a short term closed group and a long term open group. Advantages and disadvantages of the model are described.

Key words:
Integrative Group Therapy. Psychosis.

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Basurto-PGIP. Un abordaje manualizado de Psicoterapia Grupal Integradora en Psicosis.

Se presenta un manual sobre psicoterapia grupal integradora para pacientes ambulatorios con esquizofrenia y otras psicosis que denominamos Basurto-PGIP. El modelo tiene en cuenta los factores terapéuticos específicamente grupales. Integra influencias provenientes de otros modelos de psicoterapia integradora, de la terapia grupal interpersonal, del análisis grupal y de los recientes desarrollos de la terapia cognitivo-conductual de los síntomas psicóticos. El manual se estructura en distintos niveles de complejidad que pueden ser aplicados de forma progresiva. La intervención trata de adaptarse a las características de los pacientes, las capacidades y la formación de los terapeutas, y los recursos de los centros. La aplicación es posible en dos encuadres: un grupo cerrado de duración limitada y un grupo abierto de duración prolongada. Se describen además las ventajas e inconvenientes del modelo.

Palabras clave:
Psicoterapia Grupal Integradora. Psicosis.

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INTRODUCTION

Schizophrenia is a health problem affecting from 4 to 7 persons out of every 1,000.[1] It generally begins for the first time in the early stages of life and often follows a chronic course.[2] Those affected have a variable degree of discapacity. On many occasions, it prevents them from taking responsibility for their own care and social, academic, work, financial and residential needs.[3]

General panorama in the treatment of schizophrenia

Antipsychotic medication is a practically indispensable therapeutic tool.[4-7] However, probably only a minority of patients can manage successfully with an approach that only includes drug treatment and brief hospitalizations.[8] The efficacy of first and second generation antipsychotics is clear in regards to the positive symptoms.[9,10] However, this provides less control on the negative symptoms and disorganization.[10-12] Studies on effectivity confirm a complex and pessimistic panorama.13 In most cases, at least one psychotherapy intervention that complements the drug treatment is necessary.[4-7,15,16]

Role of psychotherapy in the treatment of schizophrenia

There is evidence on the efficacy of some psychotherapy interventions. Family interventions in several sessions[17] and psychoeducation ones[18] have demonstrated their efficacy in the presentation of relapses. Behavioral therapy,[14] therapy oriented towards drug compliance[14] and psychoeducational interventions[14,18] are beneficial for maintenance of drug compliance. Cognitive-behavioral therapy of the psychotic symptoms is effective in reducing the severity of the positive symptoms.[19] Psychoanalytic psychotherapy and psychoanalysis have been shown to be insufficient in order to recommend their routine use in the treatment of schizophrenia,[20] although their principles could help the clinicians to understand the experience of the patients and their interpersonal relations.[6]

Two group interventions have demonstrated their efficacy: training in social skills and integrative psychological therapy (IPT). The former has a moderate positive effect on the acquisition of social skills and their generalization to more extensive settings as well as on negative symptoms.[21] The IPT has a moderate positive effect on neurocognition, positive and negative symptoms and psychosocial functioning.[22]

The role of group psychotherapy

Public health services are faced with the need to provide adequate and quality psychotherapy care to a growing number of users. The response to this demand depends on aspects such as the complexity of the intervention, its duration and costs. For this reason, great interest has been generated in the development of effective short duration or group psychotherapy models.[23] A group intervention in the treatment of schizophrenia could be cost-efficient, permitting adequate management of the health care resources.

There has been speculation on the added advantages offered by group treatment of psychosis versus individual treatment. The group context is more realistic. It offers experiences of real socialization and their stimulation. It favors greater independence of the patient, who is seen to be less dependent on the therapist. The help can come from the rest of the members and not only from the therapist and the patient can even help the other patients. The relationship with the therapeutic team is established on more realistic bases. The therapy group can act as a reference group for its members.[24-29]

The group provides the patients the possibility of observation, examination, reflection and knowledge about the others, and on oneself through others (mirror reaction). The patient can observe the similarities and differences, that which is mutual and that which is individualized. The patient can cognitively decentralize, observe him or herself from outside, with other keys, from the perspective of the others.[26,28]

Given the interpersonal nature of the group, the patients can share coping strategies of the symptoms, compare reality of their experiences directly or indirectly, receive support and give support altruistically to the others, improve their skills to relate with others and decrease the feeling of isolation through the universalization phenomena. The group offers no behavioral models.[29] In the group, the interactions are multiple and cover multiple approaches, this favoring insight and interpersonal learning.[28]

The therapeutic relationship is substituted in the group by a new concept, group cohesion.[29] This will be established naturally, given the need of the individuals who are in the group to belong.[30] It contains the sum of the relationships in different directions and on different levels. It includes both conscious and unconscious components of the relationship, and not only on the interpersonal level, but also that of the relationship with the group as a whole. The relational tendency is established positively as a whole for the majority of the individuals of the group. Thus, while the individuals may have problems on one of the levels of relationship, they can maintain a productive relationship on another level, which may be therapeutic by itself and maintain the individual in the therapy, allowing for the intervention of the other therapeutic factors.

This does not mean that there are no problems on the level of group cohesiveness. The nature of the disease that these patients have tends to favor their having relationship problems. This can be translated in the first stages of the group into problems to establish group cohesiveness and in the advanced stages into problems to establish relationships of mutuality and reciprocity. However, given the greater number of levels of relationship and the inclusion of qualitatively different levels (such as the relationship of the individual member in the group as a whole), the possibilities of establishing a predominantly therapeutic link in the group increase.

The group exercises a multiplying action of its therapeutic effects through all the pathways described

Another one of the characteristics of group psychotherapy is its flexibility, it being possible to apply different theoretical approaches within the group framework. The current tendency is towards the integration of the different approaches, the needs of the patient and his/her clinical condition predominating over the theoretical framework of intervention.[24]

Principal models of group psychotherapy in schizophrenia

In general, group psychotherapy models in schizophrenia can be classified into those that focus on the approach to the patients themselves and those that are aimed at their family (including the patients in the group or not).

The immense majority of the multi-familial group interventions for relatives of the patients with schizophrenia use a psychoeducative model to which they sometimes add elements obtained from the behavioral modification.[31-33]

In relationship to the group therapy oriented towards the patients themselves, we could classify them into three groups: group therapy based on behavior and cognitive-behavioral modification techniques, group therapy having dynamic orientation and integrative group therapy. The first group of the three have been developed the most.

Group therapy based on the learning and cognitive theories have been developing secondarily to the appearance of individual treatments that followed this model. The most outstanding exception has been the development of training programs in social skills and integrative psychotherapy, which are group inherent.

Cognitive-behavioral therapies of schizophrenia are divided into:

- that those are based on the acquisition of knowledge and development of skills for the patient to improve their functioning and/or recognize and compensate their incapacities or deficits, and
- those that work for the modification, decrease or overcoming of the psychotic symptoms

The psychoeducative interventions are in the first group. Furthermore, interventions aimed at rehabilitating deficits in different areas have been designed:

- Social skills: initially the technique of token economy in institutional settings was used, although training programs in social skills were rapidly developed. Of these, the best known and most widespread is the program of modules for training in social and independent living skills of the University of California of Los Angeles (UCLA).[34]
- Neuropsychological deficits: several types of structured therapies have been developed for this purpose, such as cognitive remediation, cognitive improvement therapy, training in cognitive adaptation, and neuropsychological educational approach to rehabilitation (NEAR).[35] Only Cognitive Improvement Therapy[36-40] is considered as a form of group therapy. In the rest of the programs, most of the interventions are performed or could be performed individually.
- Mixed interventions (they deal with both types of deficits): the best known one is Integrative Psychology Therapy (IPT).[41,42]

We found cognitive-behavioral therapies of the psychotic symptoms in the second group.[43-49] Even though there are differences between them, there is still a flow of constant influence between them.

Dynamic group therapies include group interventions of very different types. Some have contrasting elements among them. We have been able to distinguish three types of approaches: psychoanalytic, group analysis and of the group as a whole, and the interpersonal ones.[50]

In this field, a tendency to positive eclecticism and a review of some previous problematic concepts in regards to the treatment of psychoses prevails. The first psychoanalytic approaches sought to obtain extreme regression in order to then reconstruct the psychic structure of the subject. This attitude caused many patients to become worse regarding their disease. Although some selected patients could benefit from such an approach, the likelihood of conducting such an intense, lasting and costly treatment was small.

Currently, most of the therapists who work with this approach agree that the objectives and the techniques used should be different from those used in the treatment of patients with minor disorders. The therapy should be oriented towards objectives or be focal. It avoids the interpretation and analyses of childhood experiences or of development. The main objective is to strengthen the functions of the self, especially the reality test. Finally, transferential relation with the therapist is considered to be essential in order to establish and continue the treatment.[51]

In regards to psychoanalytic group therapy, there are interventions based on the theory of the object relations52 and on self-psychology.[53] Regarding group analysis, we stress authors such as Sandison[54] and Urlic,[51] who have adapted the conceptualizations of Foulkes[55-58] to the treatment of psychotic patients. Malawista & Malawista[59] and Johnson et al.[60] work with concepts related to the group-as-a-whole, a concept developed fundamentally by Bion.[61] García Badaracco[62] have proposed a model of treatment in therapeutic community for the serious mental disorders based on the psychoanalytic concepts.

Yalom,[29,63,64] the principal author of Interpersonal Group Therapy, made many proposals that are currently commonly accepted by the group therapists, whatever their orientation. He was the one who described the group therapy factors and who oriented towards the use of an approach in the here and now in the group. His contribu-

tions to the therapy of in-patients have been more controversial.[65]

The interpersonal approach is focused on the analysis of interpersonal interactions of the group members, understanding them as a reflection of the interpersonal relationships that the patients have in the real world, in order to restructure them and, in this way, improve the functioning of the patients. In this way, the quality of life of the patients improves and the stress caused by altered interpersonal relationships decreases.

There are variable degrees of integration in almost all of the previous models. However, the principal approach of integrative group therapy specifically defined as such is that proposed by Kanas.[66-68] It includes the influences of different models. It brings together structure, safety and coping with the symptoms from the psychoeducative approach. From the dynamic approach, it brings together open discussion and selection of material by the patients and from the interpersonal approach, the work in the here and now, decrease of withdrawal and improvement of interpersonal interaction from the interpersonal approach.

Limitations of the current approaches

The current approaches in the psychotherapy treatment of schizophrenia have some advantages, but also some limitations. Generically, we understand that a psychotherapeutic intervention is more beneficial if it is effective, is well-accepted by the subjects receiving it, it is in a group or is time limited, its learning is relatively easy and it can be performed by professionals with different levels of psychotherapy capabilities.

Psychoeducative group therapy is an interesting option since it complies with almost all the criteria indicated. However, there is still no clear evidence on its efficacy. In spite of the fact that there is evidence that the psychoeducative interventions in schizophrenia are effective in the prevention of relapses, the only meta-analysis performed 18 combines individual psychoeducative interventions with group and family ones to reach these results. Our own review shows contradictory results when only the group interventions are analyzed.[69] Some disadvantages of the psychoeducative approach lie in the fact that little attention is given to interpersonal needs, it does not make it possible to make corrections on the disadaptive interactions produced in the here and now, and it is possible that it will not cover subjects that have special importance for the group members.[67]

Social skills training has been a widely used intervention in recent years. However, its use tends to be confined to highly structured settings such as rehabilitation units, day hospitals or residential settings. It is an effective, manualized and standardized intervention that is relatively easy to learn and is well defined, that apparently could be used in community settings, but that requires a degree of organization and space and material needs that limit its outpatient utility. It has been hypothesized that the modular structure facilitates individualization of the treatments. It has been hypothesis that the modular structure facilitates individualization of the treatment. It is suggested that only the modules oriented towards the deficient areas of each patient be applied. However, in practice, it is difficult to achieve the existence of a sufficient number of different modules open at one time. This problem probably will not exist in specific units with a large volume of patients.

Integrative psychological therapy, in spite of being an effective intervention and of its clear advantages, has the same problems as social skills training have. Furthermore, it requires a higher degree of psychotherapeutic training. The complete program may have special utility to obtain an improvement in functioning in the subgroup of patients with greater neuropsychological deterioration. The initial subprograms could be difficult for the most reserved patients to accept.

In spite of the demonstrated efficacy of individual cognitive-behavioral therapy of these psychotic symptoms, the same cannot be said about its group variant,[23] which presently does not seem to take advantage of the added therapeutic potential of the group. It often continues to be a mere reply to the individual interventions but in group format.

The pure dynamic approach may favor regression and be more anxiogenic, and thus, worsened the psychotic symptoms. The interpersonal approach hardly deals with the psychotic symptoms and may be anxiogenic.[67]

Integrative group therapy has clear theoretical advantages over other approaches. However, it has a limited approach to psychotic symptoms and, in the most advanced stages of the group, places emphases on the here and now which may sometimes be excessively and anxiogenic for the patients.

Manualization and its interests

Manualization of a psychotherapy intervention has four objectives: facilitate its investigation, permit its reproducibility, train new therapists and spread the model. This process has received criticisms and praise.[70,71] It may not reflect the real practice of the model and may even simplify it. However, as it facilitates investigation, it makes it possible to verify the model's efficacy and the learning and dissemination of effective treatment models.

Objective

The objective of the present work is to present an integrative group psychotherapy model for the follow-up of patients with schizophrenia and related disorders that attempts to take into consideration the limitations of other models and to present its manualization.[69]

MATERIAL AND METHODS

Model sources

Own

Since its creation in the year 1973, the Psychiatry Service of the Hospital de Basurto under the direction of Jose Guimón, has been a pioneer in our country for the introduction of group models of treatment of mental disorders in public health settings.[72-76] Thirty-seven years later, it is still developing an intensive group activity that includes interventions in different settings for different psychiatric disorders.[77]

In 1983, the Consorcio de Uribe Costa, currently a mental health center, in which multifamily groups of intervention in serious mental diseases were carried out, was founded.[78]

Both centers, together with the Psychiatry Service of the Hospital de Cruces, Clínica AMSA of Bilbao, Department of Psychiatry of the University of the Basque Country, Hospital del Mar of Barcelona, University Hospital of Geneva and the OMIE Foundation, make up a combination of institutions having a continuous and fruitful interrelation that has served as an international reference over the last 37 years in the development, training, investigation and application of group interventions in serious mental disorders, on the different levels of intervention (psychiatric hospitalization, day hospital, out-patient groups) with a clear evolution towards an integrative approach.[79]

In this dominant *zeitgeist* in which, in the middle 1980's, Eguiluz et al. initiated a series of outpatient groups for the treatment of schizophrenia[80-86] which, although were initially designed as psychoeducational groups, finally underwent profound modifications due to their training and experience in dynamic group psychotherapy, assimilation of the innovations that were occurring in this area and mutual influence between models that were being developed with this purpose both in the same Hospital de Basurto and in the Mental Health Site of Uribe Kosta. The evolution continued with the work of revising the model carried out by the Hospital de Basurto group, with the introduction of new contributions, its theoretical structuring, application of the model in different settings (day hospital) and formats (time limited groups) and finally the manualization of the interventions.[69]

From others

The model includes some interesting contributions of group analysis, as the concept of group matrix,[55-58,87] reflections on the mirror phenomena after Foulkes,[26,28,88] or those developed by Urlic on the technique variations of group analysis in its applications to psychotic patients.[51]

It also assimilates some ingredients of the interpersonal group therapy of Yalom.[29] It adheres to his model of group therapy factors, although granting greater weight to some in detriment to others.

The integrative group psychotherapy model of Kanas[66-68] and other integrative developments, such as those proposed by Gonzalez de Chavez[25-28] are assimilated, although differences are established from them.

We also include the ideas of Mc Kenzie on the stages and organization of the time-limited groups and on the social roles.[89-91]

Finally, our group has tried to integrate some of the proposals made in recent years from the different authors who work with the cognitive model on psychotic symptoms.[43-49,92]

Elaboration of the manual

The declared purpose of this project is to make a manual of the group psychotherapy model that we have been using in recent years. In fact, this is an intermediate objective, given that the final objective was to have a tool that could be scientifically evaluated and used in a public setting of mental health. We are aware that quality psychotherapy care in a situation of high pressure care is only possible, given that the resources are limited, by using interventions that comply with the following requirements: be relatively easy to learn by the health care professionals, be flexible when applied by the staff with different degrees of psychotherapy experience, have a time limitation and/or be applied in groups, require few material and economic resources, and not be applicable only to a small subgroup of patients. Thus, the participants of the project made the design of the manual considering all the above factors. We decided to structure the manual into a hierarchy of progressive complexity levels. We simplified the model as much as possible, first describing a basic level of group intervention, of short duration and early to learn and apply. After we added progressively more complete levels to it, that can be incorporated or not to the specific group that is aimed to be carried out.

The model has evolved over the years and has been assimilating new theoretical and technical knowledge in the treatment of psychoses. An effort has been made to present these incorporations didactically integrated into the most general model, so that the professionals familiarized with them can apply them on the basic model respecting their structure.

RESULTS: BASURTO-IGPP MANUAL - INTEGRATIVE GROUP PSYCHOTHERAPY IN PSYCHOSIS (IGPP)

The Integrative Group Psychotherapy in Psychosis (IGPP) is an intervention that attempts to adapt the capacities and training of the therapists and the resources of the centers to the characteristics of the patients. That is why it has been designed to be conducted within two possible settings (time limited group and open group having long duration) and on three levels of complexity (a basic level, an intermediate one and another advanced). In the intermediate level, contributions are incorporated from the cognitive-behavioral therapy of the psychotic symptoms and from the interpersonal therapy. On the advanced level, some come from group analysis.

We will begin by describing the time-limited group in its most basic level. After, we will describe the second and third level interventions, which can be incorporated either isolatedly or combined with the basic structure. Finally, the long duration open group. The open groups are designed as variants of the time-limited group, adding elements of differentiation in relationship to the phenomena that invariably will occur on the passage through the time-limited group to the open one. The middle and advanced level interventions also can be integrated on the basic structure of the long duration open group. In fact, it is in this type of group in which it is possible to most extensively incorporate second level interventions, since the smaller time pressure makes it possible to extend the work on the symptomatic questions and the interpersonal difficulties.

An alternative model to that of time limited single groups or open groups is the performance of groups limited in sequential time. In these groups, the patients are invited to participate in several time-limited groups, each one with defined objectives, which follow one after another.

Time Limited Group. Basic level

This is a closed group (with no incorporations during the treatment) that initiates with 12 patients so that, in case of possible drop-outs, it ends up ideally with 8 or 9. It is conducted in 20 sessions, 1 per week, of 1 hour's duration each. It can be lead or directed by one therapist, although two therapists would be better than one. It is a homogeneous group, that includes patients diagnosed of schizophrenia, schizophreniform disorder, schizoaffective disorder and some group A personality disorders. Patients with mental retardation, dementia, delusion, memory disorder, active drug dependence, marked antisocial traits or high aggressive or suicide risk are excluded. Priority is given to the most intensive devices (day hospital, hospitalization) if they are indicated. The patients are required to make a commitment to attend and to maintain confidentiality regarding the identity and information provided by the participants.

Each group session owes its sequential structure to the integrative group model of Kanas,[66,67] which is modified according to the needs. In each session, the patients *choose a subject* related with their needs as affected subjects; *they discuss things related to the subject,* elaborating it with non-threatening, constructive introspection (sometimes the discussion already provides some clarification and improves contact with reality) and finally, they *share coping strategies for the problems found* in the group. The subjects are chosen by the patients themselves, although the therapist may rule some out, depending on their adequacy. In a type-session, one or two subjects generally appear. The inclusion of more subjects generally indicates excessively superficial work. In our model, the coping strategy phase is sometimes shown to be unnecessary, when the elaboration in group of a problem presented by one or several patients is seen to be a sufficient objective (for example, when universalization phenomena occur that favor cohesion and decreases isolation, at the beginning of the group).

The patients are encouraged to prioritize their principal concerns and they are not limited by predefined subjects. The only conditions are that the subjects cover their needs as affected subjects (table 1) and do not generate an excessive emotional tension level. Those subjects related with rage and aggression, sexual orientation and identity[67] and those in which immovable polarization of the members (politics, religious, etc.) could be expected[86] are avoided. Reference is never made to unconscious aspects. To do so would distant the patient from their relationship with the real world and general states of regression and serious emotional tension, that favors psychotic decompensation. A reconstructive approach is also not used. The purpose is to learn to be more aware of and manage aspects of the current situation. The retrospective is always put into contact with the present.

The attitude of the therapist (table 2) is well defined and is a fundamental ingredient of the therapy. His/her principal functions are to favor an active participation setting by the patients to work on their own problems and create a safe setting.

Table 1	Typical subjects

Auditory hallucinations
Persecutory and referential delusions
Disorganized thinking
Affective inadequacy
Medicine taking. Adverse effects and attitudes about it
Family relationship problems
Social adaptation, academic and occupational problems
Feelings of isolation, depression and hopelessness
Fears regarding relapses and hospital admissions
Relationship with health care system
Concern about normality of thoughts and decisions.
Stigmatization
Others

Table 2	Attitude of the therapist

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. Favor communication within the group
Favor 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

Contacts outside of the group will not be forbidden, but they should be known to all the group members and the therapist(s) (restitution to the group).

There are 4 stages in the group: the initial phase or engagement, differentiation, interpersonal work and termination.[89-91] Each stage can be analyzed from the point of view of their characteristics, duration, phenomena that occur during it, the therapeutic factors that are operating, strengths and problems presented by the different individuals in relationship to the social role they adopt, the differentiated attitude that the therapist has to maintain during it and, finally, the areas of work and subjects covered (table 3). The stages will overlap, and their duration is orientative. Passage from one stage to another is facilitated or delayed depending on the group objectives, and the tendency to return to previous stages as a resistance mechanism is discouraged. The subjects belonging to each stage are abided by and it is recommended against using those of other stages or of releading the group towards subjects of the current stage. However, if the group suffers significant tension, transitory passage to a safer stage as a protection mechanism is tolerated. In our model, in the interpersonal phase, and on the contrary to what occurs in the other approaches,[27,29,67,91] we tend to prioritize the work on the interpersonal problems that are occurring at that time in the natural setting of the patient, outside of the group. In this way, we avoid analyzing the interpersonal problems that are seen among the members, in the here and now of the group, which would be more in agreement with the orthodox interpersonal approach.[29,64,93] This attitude has been shown to be less threatening for the most fragile members of the group.

MacKenzie[91] reviewed the literature and observed the descriptions on the performance of 4 types of differentiated social roles in the groups: sociable, structural, divergent and cautionary. In the initial phase, the patients who adhere to a social role have an important role in the creation of a group environment of support and in the establishment of group cohesiveness. Those that are ascribed to a structural role complement the action of the former, helping to identify problems and to establish a work ethics. The members who ascribed to the divergent role are those who have the most influence in mobilizing the group in the passage from the first stage of the group to the second, since they feel more comfortable expressing different opinions. Their principal risk is that they encourage the presence of emotions such as rage, anger or fury, or they emotionally overburden the group. They may end up acquiring the role of scapegoat. It should always be kept in mind that the differentiation will be limited and that the transition of symptomatic subjects to interpersonal ones should only be done gradually. The therapist, as a transferential figure, has a power that allows him/her to reinforce the interventions that orient the group in this direction and avoid reinforcing others in the contrary sense. In the interpersonal stage, the patients with a structural role can have problems to include the emotional aspects, and for patients with a cautionary role, inclusion of a combined analysis of the difficulties may be a difficult task, given that the level of complexity and active participation in the group necessarily increases. The patients with a cautionary role have fewer problems with the termination stage and are a model for other patients. Vicarious learning frequently occurs in these patients and it is noticed how, in spite of their apparent withdrawal, they have maintained their attention to the group process and have benefited from it.

Table 3 Stages of the limited duration groups

	INITIAL PHASE or COMMITMENT	DIFFERENTIATION PHASE	INTERPERSONAL PHASE	TERMINATION PHASE
Duration	6 sesiones	6 sesiones	6 sesiones	2 sesiones
Subjects	Symptoms. Common subjects	Symptoms at the beginning. Interpersonal aspects at the end. Differences (limited differentiation).	Interpersonal subjects. Symptoms reviewed in light of the interpersonal	Termination. Achievements. Fears regarding the future. Independence.
Objectives	Create a safe and supportive setting. Establish cohesion. Learn the dynamics of the interventions. Learn that the members of the group are the principal agents of change. Work on the symptoms.	Create a safe place where the expression of differences is accepted. Favor greater independence of the patient regarding the therapist and that the patients become responsible of the group itself. Continue to work on the symptoms.	Work on the symptoms, including their interpersonal aspects. Analyses and resolution of problematic interpersonal patterns.	Obtain a realistic view of their future together with certain sensation of capacity to cope with it
Therapeutic factors	Cohesion. Universalization. Installation of hope. Altruism.	Transition of factors from the first phase to that of the third one.	Mirror reaction. Vicarious learning. Interpersonal learning.	Existential factors
Specific interventions of the therapist	Interventions aimed at the group as a whole ("the group..."). Summaries that give coherence to the subject. Reinforcement of the interaction.	Reinforcement of the classification of the differences end of the interventions that are assimilated to the objectives. Control the level of tension supported by the patients. Inhibit the expression of anger and rage.	Favor the analyses of the current extra group interpersonal difficulties. Encourage an environment of respect. Control the level of tension.	Facilitate and semi-structure termination if necessary

Contributions from cognitive-behavior therapy of the psychotic symptoms

Even though the basic intervention model implies routine work on the symptoms, in which we have included many of the contributions made by Kanas[67] in regards to it, the recent developments of the cognitive-behavioral therapy focused on the psychotic symptoms can be incorporated by an assimilative integration of the concepts and techniques proposed on the original basic model.

The ABC model of cognitive therapy is considered again for the functional analysis of hallucinations. Hallucination would be the activating event (A) or background of the feelings associated with it (B of *belief*), and in turn these have consequences (C) that are predominately emotional or behavioral. At the same time, hallucination occurs under certain conditions (environmental or internal triggers). Knowing this sequence makes it possible to approach the symptom form different levels of intervention, for example, the hallucination can be modulated by acting on its triggers, or the emotional and behavioral consequences can be modified, reformulating the belief on the hallucination.[48]

In this sense, the group situation can be useful, since the beliefs associated to delusion and their consequences can be contrasted in the group.

Initially, we favor the use of strategies used by the patients themselves and manifested in the groups to lessen

the hallucinations or their repercussion (modification strategies of sensory input, of increase of activity, reduction of stressful social activity, etc.). These authors have reclassified these strategies, assigning them a dual function, the previously indicated one and the improvement of the sensation of control, that opens up a space for the analysis of the beliefs associated to the hallucinations.

On the other hand, the patients associate a meaning to the hallucinations on which we can focus in the group interaction. For example, the patients may have beliefs on how obedient they must be in regards to the hallucinations and what happens if they do so or not. They frequently consider that they have to obey them because if they do not something terrible would happen, since they generally also have associated beliefs on the omnipotent power of the hallucinations. Frequently, these beliefs do not agree with the experience of the patient and have scarce internal consistency. Furthermore, the use of control strategies on the hallucinations is a first step to criticize their power, since the patients themselves may control their presence, grade and intensity in some cases and up to a certain point.[48] Other beliefs associated to hallucinations that may be of interest have been described, such as the beliefs regarding the identity of the hallucinations and their purpose.

Once again, the ABC model may be a useful framework for the functional analyses of the delusion. The delusion may be a belief (B) associated to an activating event (A), that results in some consequences (C) that may be cognitive (believes associated to the delusion), emotional or behavioral. In this sense, both the beliefs associated to the delusion as well as the emotional and behavioral consequences of it, whether immediate or in the middle term, may work to reduce the emotional malaise.

Some new pathways to approach the situation of the delusional patient, such as challenging the evidence that supports the belief or the consistency of the system of delusional beliefs, are defined. Sometimes the delusion may be reclassified as an understandable response in order to give meaning to the experience.[48]

The new developments of cognitive-behavioral therapy on delusion stress the need to generate adequate commitment with the patient to be able to approach the delusional ideas.[45] In the case of the group, group cohesiveness, that substitutes individual therapeutic commitment, may be a safe base from which to analyze this subject. Furthermore, functional analysis of delusion and intervention on it may be done not only by direct elaboration of the problem of the patient by the group but also through vicarious learning.

The group, through the experiences of its members, makes it possible to see the delusion from a longitudinal prospective. Frequently, there are patients in the group who have a delusional experience and may serve as a reference of prestige on it.

Contributions from the group analytic perspective

The therapists who have worked previously from the group analytic model with neurotic patients should know that group psychotherapy with psychotics requires some technical modifications regarding the initial model.[51] Briefly, we will indicate that free flow of discussion is avoided, given that when the discussion is structured, it prevents access to unconscious material and disorganization of the group. On the other hand, the group analytic precondition of analyses by the group of material produced by the group is respected. In the group of neurotic patients, this material would include actions and interactions of their members and the analysis of dynamic processes of the group. In the group of psychotic patients, the group has the responsibility of analyzing their own material. However, this analysis does not reach the same depth. It is understood that there are still two levels of contents (manifest and latent), but the group only works on the manifest level. The therapist is the private support of the work of interpretation from the manifest level to the latent one. He/she does not verbalize elements on the latent level in the group nor favor, and even avoids, their analysis. This sense that this has is to avoid shifting the purpose of orientation to reality, to avoid the presence of anguish that is unmanageable by the patients and avoid regression, which is associated to worsening of the psychopathology.

For the therapists who have not previously worked with the group analytic model, some concepts of group analyses have special utility as they are applied to groups with psychotic patients. A basic characteristic of the interpretation of the relationships between individual and group is derived from the concept of the group matrix, with a practical sense directly applicable to the groups in question:[55-58] communication of the individual patient is observed through the response of the group as a whole, as if it has come from the group through the mouths of the individual person. This communication speaks to us about the individual him/herself, but also of the group, and these two levels of interpretation are always present. On the other hand, any event in the group potentially involves all the group and each one of its members. The event would be part of a *gestalt* (configuration) of which it is the figure, while the background is manifested in the rest of the group.

With regards to the role of the therapist, it should be mentioned that in the beginning, the patient will establish a regressive relationship, and will expect their childhood needs to be satisfied. The therapist should facilitate the patient's passage from a passive role to a relatively active one, which includes aspects of reality and assumption of personal res-

ponsibility in relationship to the patient's own destiny and that of the group. The therapist will undergo a partial transformation from the role of leader to that of conductor.[51] An excessive degree of interference of the therapist will interfere with the individual and the group as a whole for the development of all their therapeutic potential. On the other hand, it is assumed that the least interference possible is that which does not entail leaving the patients somewhat unprotected. The therapist must permanently be alternating in the choice between carrying out a function of support or a function of analysis,[51] potentially more anxiogenic for the patients, but with a greater association to change of dysfunctional patterns of them.

Modified contributions from interpersonal therapy

It seems undeniable that psychoses include an interpersonal dimension that can be treated and that the changes produced in its problematic aspects have a positive repercussion for the patient (improving the prognosis of the disease, adaption to life changes produced by it, quality of life, etc.).

In the classical interpersonal group therapy, the therapist would orient the group towards the work regarding that which is occurring at the moment in the room where the group therapy is taking place, that is, the here and now of the group. Specifically, the focus of the therapy would be the interpersonal interactions between the group members and between these and the therapist or the group as a whole. The contents and form (fundamentally the latter), of these would be attended to. The reason for such an attitude would be because in this way the group would show its maximum power and effectiveness.64 However, the affective intensity in the here and now of the group, of their own negative affects (and sometimes even the positive ones) towards the rest of the members or of the others towards them, and of their hidden motivations would likely be excessive for many of the patients with schizophrenia and related disorders. It could have repercussions on their fragile self, facilitating the emergence of symptoms or dropouts from the group under poor conditions. On the other hand, the analyses by the group of the motivations and the affects associated to the interpersonal behaviors would probably have the same effect.

In their clinical experience, it has been demonstrated that 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, and to share and mutually analyze them. In fact, the patients frequently continue linking interpersonal difficulties with the symptoms, even in the interpersonal stage, which implies a double distance, as it avoids speaking about the difficulties in interactions with the others and the problems themselves. This permits a certain emotional distancing that prevents the emotional tension levels of the patient and of the group from increasing to harmful levels. It also permits the resolution of interpersonal problems in the space outside of the group, providing the patient a safe forum in which these can be understood and where their elaboration can be facilitated.

This does not mean in any way that the here and now of the group is not considered. The therapist will perform a private and permanent work of an evaluation and analysis of the interpersonal interactions that occur in the group with several meanings: having a more extensive view of the difficulties that the patient has in the most extensive social context, warning about the attempts of the patients to avoid confronting their interpersonal difficulties outside of the group, given that it is almost inevitable that the patient will reproduce his/her usual roles in the group; prevent the problems that may arise in the group produced by distorted patterns of interaction; and intervene, at the pertinent time, from the knowledge of the group process in benefit of the patient or of the group as a whole.

On certain occasions, however, it is advisable to relate the discussion generated regarding the interpersonal difficulties outside of the group with the group process and with the here and now of the group. Frequently, the patterns of interaction characteristic of an individual become clearer for the rest of the members than for the individual involved in group situations. Thus, if the adequate moment is chosen, these members can throw light on the individual immersed in a pattern of interpersonal interactions within a supportive setting, thus facilitating the solution of an interpersonal problem outside of the group itself.

For the interpersonal line, therapy is a *corrective emotional experience*, a term introduced by Alexander.[94] Therapeutic work would imply an alternate sequence where affect would first be experienced and expressed and then would be analyzed and understood.[29,63,64] Both the psychoanalysis and interpersonal therapy have tried to provide multiple responses to why, in the interaction between two individuals, the performance by one of them of an interpersonal behavioral pattern evokes a complementary role in the other individual that tends to reinforce the behavior of the former, in a type of self-reinforcing loop. This is frequently an unconscious process for the members involved.

In this sense, the corrective emotional experience would imply the rupture of this loop. The disadaptive interpersonal pattern of a certain patient (that includes cognitive, emotional and behavioral elements that are interrelated) does not recruit the other in the complementary role and in this way loses its value. This is the fertile area where the new more effective interpersonal patterns arise.

In our experience, the change in the patterns sometimes occurs or is reinforced through the cooperative analysis of the dysfunctional pattern and the definition of new patterns, but on other occasions, it is not associated to this analysis but rather occurs as a learning experience. Some authors have called attention on this and other alternative ways to produce changes in the patients.[95]

Long-duration open group

The limited time groups could be especially useful and sufficient for some patients, as those who have a more benign course of their disease and a more adequate support system. However, for some more serious patients, with continued positive symptoms, persistent damage in their level of organization or a relevant negative symptom, especially if they lack adequate support systems, passage to a longer duration open group could be preferable.

The open group is divided into two large stages. The initial stage, or forming of the group, that would include a sequence of three substages similar to the first three stages of the closed group (table 4), although less defined in time, and the stage that corresponds with the already constituted group. In the latter, a dynamics is generated in the group that makes it possible to analyze the problems in interpersonal relationships or elaborate individual symptomatic difficulties from the perspective that links them in the relationship with the other and that permits a greater emotional approach to them. In the initial moments of this stage, when the group is learning how to function on this level and until the full functioning mentioned is established, which we have called initial interpersonal stage.

In the group that is already made up, depending on a series of relevant events, the dynamics and contents will be changing. Thus, the group will be placed in different positions, which will show the makeup of the stages described (table 5):

- After vacation periods, with the incorporation of new members, as resistance to the differences in the interpersonal work with difficult subjects, etc., the group will make reference to symptomatic and mutual subjects, which will give it cohesion, that we will call cohesive or commitment position.
- At other times, the group is within what we call the transition or differentiation position, which will assimilate the initial transition stage in its characteristics.
- When the adequate conditions are available, they will be situated in the interpersonal position. This position always occurs at the beginning of the group that is already constituted and is the most developed position. A climate of tolerance and safety in the group must be made clear for its reproduction.

Table 4 Open group stages

Short duration closed group	Long duration open group	
Initial stage or of commitment	Initial differential stage	Initial stage
Differentiation stage	Initial interpersonal stage	
Interpersonal stage	Constituted group	Constituted group
Departure stage		

Table 5 Positions in the Open Group

Initial group	Already constituted group
Initial or commitment stage	Cohesive or commitment position
Differentiation stage	Transition or differentiation position
Interpersonal stage	Interpersonal position

The therapist will have to evaluate what position the group is in at each point in time and evaluate if it is necessary and adequate for each moment or if, on the contrary, it hinders the therapeutic process. In the first case, he/she will allow the group to transitorily maintain such a position. In the second case, the therapist will facilitate the change of position.

The incorporation of a new member generally detains the group and facilitates its change to a cohesive position. It is uncommon for the communication to be more difficult and for the subject or the therapists to have a more active attitude, similar to that at the beginning of the group. Excessive concern should not be given to whether this is transitory. A group that has adequate functioning generally has great capacity to rapidly take up its usual dynamics again. It is advisable to actively include the new member without too much pressure. At the end of his/her first session, the new member will be questioned about how he/he has felt and his/her interventions will be reinforced. It is also adequate to protect the new member from excessive premature exposition. Some patients, due to the anguish of this situation of uncertainty caused by initiating a group experience, begin to indiscriminately go into profound self-revelations without having been able to create a situation of confidence towards the group in their mental space.

An attempt will be made to work on the departure of a patient from the groups as much as possible several months before this is to occur (in the groups that we have been conducting, we attempt to allow at least two months for this, a period which would include four to eight group sessions) in order to permit the patient to prepare him or herself regarding what it means to leave the group. On some occasions in which a patient has abruptly decided to leave the group, we have proposed that they attend at least one more session in order to be able to prepare the departure with greater elaboration.

DISCUSSION

Differentiating traits of the model

The Basurto- IGPP model maintains, above all in its most basic level, many points in common with other integrative group approaches. However, it has some notable differences:

- It is designed on progressive levels of complexity to facilitate its performance by different types of professionals.
- It defines a methodology for the performance of time-limited groups and long-duration open groups.
- It maintains a more flexible sequential structure depending on the subjects discussed by the patients.
- It includes some contributions of the group analytic model and of the cognitive behavioral therapy of the psychotic symptoms.
- It only uses the analyses in the here and now of the interactions of the group members in a very restricted way, thus generating less anxiogenic climates in the group.

Advantages and disadvantages

Advantages

Our group psychotherapy model has some of the advantages previously attributed to other integrative group psychotherapy models such as that it permits the patients to deal with their own problems related with the disease in a more personalized way, work can be done on the symptoms and the interpersonal difficulties can be dealt with. It is an approach that minimizes the anxiety generated by the old dynamic approaches and does not favor the regression of the patients. It focuses on the current problems of the patients and the ways to resolve them or tolerate them with the help of the group.

As it is a group model that considers the specific group therapy factors, it makes it possible to attenuate some of the problems attributed to the individual treatment of the psychotic patients, such as problems in the therapeutic relationship or limited insight.

It can be introduced flexibly depending on the type of professional, his/her psychotherapy training, type of patients it is aimed at and the resources of the center.

Disadvantages

The principal limitations of the model proposed come from two different sources: those that depend on the therapist and those that depend on the patient. Resistance of the mental health care professionals to carry out group interventions under situations in which they would be indicated has been found. The reasons for this resistance are varied and may go from lack of training in group psychotherapy to institutional resistances, including the fears and fantasies of the therapist him/herself. Four solutions that are not mutually exclusive have been shown to be useful: learning in co-conduction with more experienced therapists, external supervision, progression in the degree of group structuring and technical complexity of it and group experiential learning of the therapist.

The model may have limited utility in those patients with intense neuropsychological involvement. More specific interventions, as certain models of integrated psychological therapy, or the implementation of some of the different models of cognitive remediation would be indicated. However, they are not excluding interventions. In this case, a combined sequential intervention would be necessary

Patients with comorbidity with active substance dependence, this being a significant number of patients with psychoses, would not benefit from our intervention. In this case, focusing much of the interventions on consumption itself would be unavoidable so that specific psychotherapies for dual pathology would be indicated. However, those patients who have milder forms of substance abuse disorders would benefit from our intervention.

Another limitation of our model is that it does not permit treatment in patients who, due to their own characteristics, would not be well assimilated into the out-patient group format: patients with marked violent or suicidal tendencies, with extreme exacerbation of the positive symptoms in situations of minimum social interaction or with a comorbid diagnosis of antisocial personality.

The future of the model

The extensive clinical experience of these 25 years has oriented us to believe that patients who have been treated

according to the general model of the IGPP have better evolution, with greater treatment compliance, more stable regimes of antipsychotic medication, better tolerability to the side effects, development of effective strategy in prevention of relapses and decrease of the number of hospitalizations, with greater capacity for social interaction and better quality of life. However, at present, this is only a clinical impression. We consider that it may be an easy to implement in outpatient sites. We are aware of the need to evaluate the efficacy of the model. For this reason, we have established the first experience of evaluation of the model through a clinical trial that compares the intervention proposed with the usual treatment.[69]

CONCLUSIONS

The Basurto- IGPP model is a type of manualized integrative group therapy that tries to accumulate the advantages of the previous models of this type and adds some proposals of other models that have not been previously included.

We consider that it is a model that could be relatively easy to apply and that it has utility in the outpatient treatment of psychotic patients who do not require high intensity resources, of day hospital type.

The model has been designed for application by different types of professionals with different types of training. In its most basic level, it could be performed by mental health nursing specialist, or by a psychologist or psychiatrist with limited experience in group psychotherapy

However, it would be recommendable for the professionals who develop the intervention to acquire some basic knowledge on group psychotherapy.[29,61,64,96] On the other hand, the fact that the therapist with at least a brief personal experience of group sensitization will facilitate his/her capacity to recognize and understand the powerful forces that move in the group, the fears and expectations of the patients regarding it as well as the deviations from the expectable dynamics.

Group supervision of several professionals who direct groups of this type is another tool that we consider to be useful, above all in the first groups conducted by each professional.

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