Group psychotherapy with adolescents

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List of abbreviations

TAU – Treatment as usual

PDT – Psychodynamic therapy

IPT – Interpersonal psychotherapy

IPT-A – Interpersonal psychotherapy for adolescents

MBT – Mentalization-based treatment

MBT-A – Mentalization-based treatment for adolescents

MBT-G – Mentalization-based treatment in groups

BPD – Borderline personality disorder

CBT – Cognitive behavioural therapy

CBGT – Cognitive behavioural group therapy

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Summary

Title: Group psychotherapy with adolescents

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Group psychotherapy with adolescents encompasses treatment of several individuals between 12 and 19 years old at one time. The advantages of this modality include convenience, ongoing assessment, psychoeducation, social comparison and support, natural surrounding, engagement, and motivation. Psychodynamic group psychotherapy centres on the idea that behaviour and emotional responses originate in the internal world, and its focus is on intrapsychic problems and the patient's past. Interpersonal psychotherapy targets problem areas within the patient's current interpersonal relationships and is focused on the here-and-now. Mentalization-based group psychotherapy facilitates the development of mentalization by evoking reflection and understanding of oneself and their relationships with others. Cognitive behavioural group psychotherapy is based on the idea that thoughts, actions, and feelings are interconnected. The goal of this model is teaching the patients strategies to cope with and restructure distorted thoughts. Many studies support the efficacy of group psychotherapy as comparable to individual psychotherapy. However, there is need for further research on which modalities or combination therapies are the most effective. This paper also presents several vignettes lead as psychodynamic group therapy.

Key words: group psychotherapy, adolescents, psychodynamic group psychotherapy, interpersonal group psychotherapy, cognitive behavioural group psychotherapy, mentalization-based group psychotherapy

Sažetak

Naslov: Grupna psihoterapija s adolescentima

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Grupna psihoterapija s adolescentima obuhvaća liječenje više osoba u dobi od 12 do 19 godina u isto vrijeme. Prednosti ovog modaliteta uključuju praktičnost, stalnu procjenu, psihoedukaciju, socijalnu usporedbu i podršku, prirodno okruženje, angažman i motivaciju. Psihodinamska grupna psihoterapija se usredotočuje na ideju da ponašanje i emocionalne reakcije potječu iz unutarnjeg svijeta, a fokus je na intrapsihičkim problemima i pacijentovoj prošlosti. Interpersonalna psihoterapija cilja na problematična područja unutar pacijentovih trenutnih međuljudskih odnosa i usmjerena je na ovdje-i-sada. Grupna psihoterapija temeljena na mentalizaciji potiče razvoj mentalizacije izazivanjem refleksije i razumijevanja sebe i svojih odnosa s drugima. Kognitivno-bihevioralna grupna psihoterapija temelji se na ideji da su misli, radnje i osjećaji međusobno povezani. Cilj ovog modela je podučavanje pacijenata o strategijama za suočavanje s iskrivljenim mislima i njihovo restrukturiranje. Mnoge studije podupiru učinkovitost grupne psihoterapije kao usporedive s individualnom psihoterapijom. Međutim, postoji potreba za daljnjim istraživanjem o tome koji su modaliteti ili kombinirane terapije najučinkovitije. U radu je također prikazano nekoliko vinjeta vođenih kao psihodinamska grupa.

Ključne riječi: grupna psihoterapija, adolescenti, psihodinamska grupna psihoterapija, interpersonalna grupna psihoterapija, kognitivno-bihevioralna grupna psihoterapija, grupna psihoterapija temeljena na mentalizaciji

1. Introduction

Group psychotherapy is defined as treatment of several people within groups ran by a therapist with a co-therapist (1). It treats the individual within the context of a group with its members actively participating (2).

Group therapy has multiple purposes, including corrective, developmental, educative, preventive, recreational, and therapeutic functions (3).

Group treatments have several distinct advantages for both clinicians and patients. It is convenient as one therapist can treat a number of adolescents at one time. The group modality presents opportunities to directly observe the members' emotional and behavioural reactions and interactions with peers, which helps the therapist direct their ongoing conceptualization of the patient and monitor their progress. Within groups, there is also increased emphasis on psychoeducation. According to social comparison theory, change occurs more readily if one has models for social comparison. Group members gain new information from others with similar problems, increased motivation to adapt to their challenges, and it helps normalize what makes individuals feel different or alone. Group therapy offers opportunities for members to experiment with new behaviours and implement new skills. As many adolescents starting psychotherapy are unfamiliar with psychological interventions and their roles in affecting change, the group environment may help by encouraging active participation as this is modelled by the therapist and other members (4).

In practice, adolescence is divided into two groups. The pubertal group (ages 12-15) is marked by an increase in instinctual behaviour and distancing from parents. Self

reflection is harder and these group require more active leadership (5). The techniques therapists use with this group are a combination of activities, play, drawing, psychodrama, and discussion periods (6).

Adolescence in the narrow sense begins from at the age of 16 and lasts until the age of 19. The main questions in this group surround identity. Psychodynamic and analytic therapeutic models are used most often, as verbal psychotherapy is most efficient. If possible, these groups should be heterogeneous, and the therapeutic team should be a male-female pairing (5, 6).

In the past five years most of the research published about group psychotherapy with adolescents included four psychotherapeutic modalities – psychodynamic psychotherapy, interpersonal psychotherapy, cognitive behavioural psychotherapy, and mentalization-based therapy, which I will describe in this thesis.

2. Psychodynamic group psychotherapy

Psychodynamic psychotherapy with adolescents takes on a psychoanalytic approach whilst integrating ideas from other disciplines such as developmental psychology, attachment theory, and neuroscience (7). Within this framework, the approaches of Freud, Foulkes, Bion, and Kohut have been adapted to the group model (6).

The central idea behind psychodynamic psychotherapy is that behaviour and emotional responses have an inherent meaning and are rooted in the internal world that has been built up from the earliest experiences and relationships (8).

The goals of group psychoanalytic psychotherapy are improving mentalization abilities and promoting interpersonal interactions in a safe and controlled environment (9).

The group format is of particular value for individuals with interpersonal problems as it brings their difficulties to the surface in a way individual therapy may not have (10). Group psychotherapy is also particularly useful for adolescents because of their natural need to be with their peers (5).

Analytic group psychotherapy is indicated for neurotic adolescents, anxious and inhibited children, adolescents with narcissistic problems, those with eating disorders, and depression. Contraindications include severe behavioural disorders, significant exhibitionism tendencies, severe narcissism, significant ego lability, psychotic disorders in early treatment phases, and trauma caused by physical and sexual abuse (5).

In group-analytic psychotherapy the individual is being treated within the context of the group with the active participation of the group. The group as a whole is a network of individual mental processes, the psychological medium in which they communicate and

interact. There is a system of interactions which is a therapist's primary basis for orientation, interpretation, and confrontation. This orientation shows on which levels their interventions are most useful, but the whole process is occurring for the benefit of individual members (2).

It is proposed that confrontation, empathy, and interpretation are the therapeutic triad underlying the approach of interactional psychodynamic group psychotherapy and that all three stem from a common source. Confrontation promotes the verbal expression of thoughts and feelings, while empathy involves the process of incorporating the other person's feelings and thoughts. Interpretation occurs when there has been sufficient empathic confrontation and clarification to uncover and understand the underlying internal conflicts and resistance (6, 11).

The role of the group therapist, aside from the managerial duties, is to establish a therapeutic alliance appropriate to the age level of the patients. They orient the group to the main goal of understanding and solving painful thoughts and behaviours, maintain members' awareness of their behaviour with each other, and remind them to share their thoughts and feelings, and to offer suggestions about how to deal with these problems (6).

With adolescents, the therapist tries to take on an emotional role model midway between the adolescent and the parent. It is recommended to "assume the attitude of controlled curiosity and sophisticated ignorance, especially in the early stages of the group" (6). The therapist is expected to be flexible and stay aware of their counter transference (5).

Watzke et al (11) compared the therapeutic action, style, and content in cognitive behavioural and psychodynamic group therapy. They found that psychodynamic group therapists use more interpretative and confrontative interventions. Their focus is on intrapsychic problems. In regard to group dynamics, they aim to understand the group's interactions, and put more emphasis on transference and an individual's past (11).

When leading group psychotherapy with adolescents, the therapist must intervene more commonly than with adults. The interventions are more active and are commanded by authenticity, spontaneity, and reflectivity. The therapist has to learn how to balance confrontation and support, how to lead the group members from acting out to self reflection (5).

There are a variety of therapeutic factors working during group psychotherapy. These include the adolescents seeing they are not alone or unique in their problems (universality); the group as a place where verbalization of emotions is encouraged and transference dominates; the group as a container of anxiety; learning the balance between establishing and respecting boundaries; the group as a passing space; and the group as a space where the adolescents can experience altruism (5).

Abbass et al analysed the efficacy of short-term psychodynamic therapy models in adolescents. They found moderate to large effects in almost all outcome categories (general psychopathology, somatic complaints, anxiety, mood, personality conditions), and small gains for interpersonal problems only in follow-up (12).

3. Interpersonal group psychotherapy

Interpersonal psychotherapy (IPT) can significantly improve quality of life and functioning in adolescents. It is a structured, time-limited, high contact, dynamically informed psychotherapy focused on the here-and-now (13, 14).

IPT is based on the premise that depression is inextricably intertwined with the patients' interpersonal relationships. The goals of IPT include decreasing depressive symptomatology and improving interpersonal functioning by enhancing communication skills and solving problematic situations (15, 16).

Interpersonal psychotherapy for adolescents (IPT-A) is designed as a 12-week-long treatment, with sessions occurring once a week. It is divided into three phases, the initial, middle, and termination phases. In the initial phase the diagnosis is confirmed, and the therapist educates the patient about the illness, explores the patient's important interpersonal relationships, and identifies the problem area. During the middle phase, the therapist identifies specific strategies to combat and improve the patient's interpersonal difficulties. In the termination phase the focus is on clarifying the warning symptoms of future depressive episodes, emphasizing successful strategies used, and fostering their generalization to future situations (15).

The main approaches for achieving these goals are identification of one or two problem areas as the focus of treatment and emphasizing interpersonal problems in current relationships. The four problem areas serve to help focus the treatment on a specific condition of interpersonal functioning that has the potential for change and improvement, and which might then translate to other situations. The problem areas include: (1) grief; (2) interpersonal disputes with friends, parents, siblings, and teachers;

(3) role transitions such as changing schools, entering puberty, becoming sexually active, birth of another sibling, becoming a parent, illness of a parent; (4) interpersonal deficits such as difficulties in initiating and maintaining relationships and communicating their feelings (17).

If the onset of depression is connected with the death of a loved one, the problem area targeted in IPT is grief. The goal is to facilitate the mourning process, which starts with reviewing the adolescent's relationship with the deceased. The therapist should provide reassurance about the adolescent's feelings and link present behaviours to feelings about the loss. They should work on improving the adolescent's communication skills and instruct them on developing other supportive relationships. The last step of the IPT strategy is the adolescent's reintegration into their social environment, during which the therapist assists them in considering ways to meet people and evaluating new social contacts (18).

If an adolescent describes their depressive symptoms as arising with conflict within an important relationship, the problem area is interpersonal role dispute. It occurs when the expectations within significant relationships are discordant, which causes feelings of helplessness in adolescents. The therapist's goal is helping the adolescent with the definition and resolution of conflict. If the dispute has reached the dissolution stage and the adolescent has decided to terminate the relationship, then the focus becomes mourning the loss of the relationship. The strategies employed by the therapist are exploring the dispute, identifying its patterns, analysing the adolescent's decisions in the dispute, and increasing communication skills. Sometimes successful resolution of the

conflictual relationship occurs with restructuring the expectations of the relationship into ones more realistic (19).

Role transitions encompass life changes and turning points such as between childhood and puberty, high school to university, student to worker, couple to parenthood, married to widowed etc. Some of these transitions are normative and predictable, allowing for psychological and physical preparation, while some events like sudden death, illness, or unexpected changes in family structure, can be more unsettling and harder to accept. Therapists' goals for this problem area include helping the adolescents relinquish old and accept new roles. They educate the adolescent about the transition and review their feelings and expectations of new roles. They also assess and work on new social skills with the adolescent, helping them establish social support for their new role (20).

The last problem area covers interpersonal deficits. These are social and communication impairments which harm the development of interpersonal relationships and include problems with initiating and maintaining relationships, inability expressing feelings verbally, and difficulties in relaying information and establishing communication. This becomes the focus of IPT if adolescent's depression presents with or is a result of interpersonal deficits. In this case the therapist attempts to diminish social isolation and instructs the adolescent in improving their relationships. The interpersonal deficits may also be evident in group therapy between members, which gives the therapist the opportunity to analyse their communication and facilitate practicing new social skills and the development of better relationships (21).

Rossello et al evaluated the relative efficacy of CBT and IPT delivered in group and individual formats. Analysis of their results did not reveal significant differences between individual and group formats, but the results suggested that CBT produced greater decreases than IPT in depressive symptoms, as well as in other measures of outcome (e.g. improved self-concept). Despite this difference in outcome, there is evidence for the efficacy of both interventions at posttreatment (22).

O'Shea et al compared the long-term effects of group and individual interpersonal psychotherapy. They found significant improvements in depression, anxiety, internalizing problems, and functioning, which were maintained at the 12-month follow up. There were no notable outcome differences between the group and individual applications (23).

4. Mentalization-based group psychotherapy

“[Mentalizing] is defined here as the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons” (24).

Mentalization is not seen as a learned skill, but a high-level mental function that mostly occurs subconsciously. It is a combination of the individual’s internal world, which may be adopted as the reflective part of their self, and the purposeful and the representational aspects of the self. These provide the individual the capacity to differentiate inner from outer reality, intrapersonal processes from interpersonal communications, and what is self from what is not (25).

Mentalization-based treatment (MBT) was originally designed to treat borderline personality disorder (BPD) in adults. It is rooted in psychodynamic theory, attachment theory, and neurobiology (26).

The most commonly seen personality disorder in clinical practice is BPD. It is a complex mental disorder characterized by a pervasive pattern of instability in mood and affect, interpersonal relationships, self-image, and impulse control. It is associated with severe functional impairment, significant treatment utilization, and a high rate of mortality by suicide (27).

Borderline patients are vulnerable to shift to nonmentalizing modes in states of emotional arousal, resulting in panic responses and impulsive behaviour. This is caused by a neurochemical switch which triggers fight and flight and freeze mechanisms in

emotionally charged states. That is why this therapeutic model is based on facilitating the development of mentalization in patients (24). Interventions provoking mentalization in group psychotherapy are focused on evoking thoughts, reflection, and understanding of oneself and one's relationship with others (9).

Treatments shown to be effective with borderline personality disorder have a high level of structure, consistent and reliable implementation, theoretical coherence, flexibility, individualized approach to care, good integration with other available services, and take into account the problem of constructive relationships (28).

The therapeutic model of mentalization-based psychotherapy intended for BPD consists of both individual and group sessions, which are linked together through meetings of the therapy team. In group sessions the focus is on consideration of others' mental states and emphasis on appropriate affect expression through understanding of personal and others' motivations. Patients are asked to examine their understanding of others' behaviour as well as question their own. There is no specific stress on skill acquisition, but rather an emphasis on the interpersonal processes. MBT offers group therapy to understand oneself in relation to others (25).

Psychoeducational group sessions attempt to increase understanding of mentalizing and emotional regulation, while group therapy sessions are more process-focused and aimed at facilitating interpersonal mentalization (29).

Problems and conflict arising in therapy represent a dynamic within the relationship that needs exploring in the context of other relationships. Aside from the efforts to improve

mentalization, a significant aspect of therapy is the activity of pinpointing what belongs to whom (25).

The therapist leading mentalization-based psychotherapy groups should be a flexible, reflective, communicative individual who is clear about personal and interpersonal boundaries, and who can tolerate the emotional impacts personality disordered-patients have on oneself. They should manage internal and external conflict without becoming over-involved and should be comfortable with working in a multi-disciplinary group (30).

Griffiths et al compared the efficacy of introductory mentalization based treatment in the adolescent population (MBT-Ai) with treatment as usual (TAU) with TAU alone over 12 weeks on reduction of self-harm and crisis presentations. They found a significant reduction of self-reported self-harm and emergency department presentation for self-harm in both groups. However, there were no differences between MBT-Ai with TAU and TAU groups. Social anxiety and emotional regulation improved, and borderline personality features decreased over time in both groups as well, but similarly, the differences between groups were insignificant (29).

Beck et al observed the efficacy of mentalization-based treatment in groups (MBT-G) for adolescent BPD compared to TAU (standard clinical care). They delivered the intervention as a 1-year program formed by three components: MBT-Introduction, MBT-Group, and MBT-Parents. Their results showed no superiority for either therapy method (26).

Bo et al evaluated the outcomes of adolescents with BPD who participated in MBT-G for 1 year. The majority of participants exhibited improvement in borderline

symptomatology, depressive features, self-harm, peer-attachment, parent-attachment, mentalizing, and general psychopathology (31).

MBT-A is a promising treatment possibility. However, it is unknown which MBT modality (individual, group, family), or combination thereof, is the most effective, nor how long or intensive therapy should be in order to confer benefit (29).

5. Cognitive behavioural group psychotherapy

Cognitive behavioural therapy (CBT) is based on the notion that thoughts, actions, and feelings are closely interconnected. This therapeutic model tries to identify the thoughts and actions that influence depressive feelings. The goals of CBT are to reduce depressive symptomatology, shorten the duration of depressive episodes, teach alternative ways of preventing depressive feelings, and increase a person's sense of control over their life (16).

Cognitive therapy conceptualizes psychological difficulties through five elements. These include interpersonal or environmental context and an individual's physiology, emotional functioning, behavior, and cognition. These features create a dynamic and complex system of interactions (32).

CBT can be used for a variety of presenting problems experienced by adolescents, including depression, anxiety, anger and aggression, eating disorders, and more (4).

The general aims of CBT are identification and restructuring of irrational or distorted beliefs related to the self, others, and their environment that produce emotional distress and maladaptive behaviours. These goals are maintained for each participant when CBT is delivered in a group format. Additionally, support, peer modeling, a sense of commonality, and an environment in which participants can practice the variety of the skills acquired, all contribute to the beneficial aspects of group therapy (4).

The cognitive behavioural model assumes that an individual's interpretation of an experience affects their reaction to that situation. Distorted thoughts will lead to exaggerated emotional reactions and irrational behavioral responses. Cognitive

behavioural group therapy (CBGT) consists of two primary elements, cognition and behaviours. The various levels of cognition can be described by schemata and automatic thoughts (4).

Schemata are collections of the most basic beliefs individuals hold that affect and distort their interpretation of incoming information. In essence, schemata are the lenses through which one perceives oneself and others, their interactions, the world, and their environment. They develop early in life, are reinforced over repeated learning experiences, and are usually fully integrated by adolescence. Automatic thoughts are situationally specific, spontaneous thoughts or images that come up in people's minds during a shift in mood. These simple, easy to identify thoughts usually cause immediate emotional or behavioral reactions (32).

The focus of cognitive behavioural therapists is on the individual's information-processing systems in order to better identify their automatic thoughts that maintain and perpetuate maladaptive cognitive schemata (32).

Some of the behavioral strategies integrated by CBT are modeling, contingency management, and exposure exercises. Cognitive strategies include problem solving skills, coping techniques, and restructuring distorted thoughts into ones more proactive and positive (33).

Clarke et al examined the effects of acute and maintenance group CBT for depressed adolescents. Of the acute-phase interventions, the skills taught included mood monitoring, improving social skills, increasing pleasant activities, decreasing anxiety, improving communication, and conflict resolution. The booster sessions aimed to

address continued self-monitoring of behaviours and situations, pervasive lifestyle changes designed to cope with future stressful events, and high levels of social support, which are three factors affecting the maintenance of treatment gains. They found that the acute CBT groups lead to higher depression recovery rates than the waitlist group and had greater reduction in self-reported depressive symptomatology. The booster sessions didn't affect the rate of recurrence on follow-up but seemed to accelerate recovery among participants still struggling with depression at the end of the acute phase. The results support the growing evidence that group cognitive behavioural therapy is an effective intervention for adolescents with depression (34).

Rossello et al evaluated the relative efficacy of CBT and IPT delivered in group and individual formats. Analysis of their results did not reveal significant differences between individual and group formats, but the results suggested that CBT produced greater decreases than IPT in depressive symptoms, as well as in other measures of outcome (e.g. improved self-concept). They proposed multiple reasons for this difference in efficacy, one of which accounted that CBT is more structured and usually appears to offer faster symptom relief (22).

7. Clinical vignettes

I have observed many sessions of my mentor's adolescent group psychotherapy and am including some clinical vignettes below. The therapeutic modality of this group is psychoanalytic psychotherapy, and the mentor is a licenced group analyst. The group is held once a week within the day hospital and consists of eight adolescents, heterogeneous by gender. It has been run in this framework for years. The longest time members have spent in this group is about a year, while some members for a few months. This is a slow-open group. Most adolescents have depression, anxiety, poor self-image, suicidal ideation, and female members also have a history of more frequent self-harm, as well as symptoms of eating disorders.

Clinical vignette 1

EM speaks about being bothered by how her grandmother is talking to everyone about her diagnoses and mental health. When asked how she deals with it, EM replies that she usually keeps everything inside and doesn't say anything. Sometimes she "explodes" and insults her or starts a fight. She is very angry that her grandmother keeps doing this and doesn't know what to do.

The group members don't have any advice for her but are inspired by her opening up.

A expresses how she never fights with her family, because she feels like she must keep everyone calm. When asked why, she says she feels like everyone else's feelings are her responsibility. NI asks if they help her, A answers that they don't. She talks about always "emptying her cup" and spending her energy on her friends, but never "filling it". She expresses having no hope in changing, because she is afraid that if she does, something bad will happen, and that she will lose all her friends. NI tells her that if they

were good friends, they wouldn't leave her, but A just replies she thinks she is not good enough to deserve anything better. Upon further prompting, she says that if she can't help anyone, she wants to hurt herself.

EL talks about being a people pleaser and changing her attitudes depending on the person she is with. She thinks she doesn't have a sense of her real self and that she doesn't have a personality. When asked if she feels like that with everyone, she replies that maybe sometimes when she's with her boyfriend she feels more like her real self, but when he's not around, she can't. When asked why, she proposes that she maybe doesn't feel safe enough with people, or she's afraid she will lose them if she has different stances than they do. NI asks her to give an example of it, but EL can't think of one.

EL then asks the group members how she can change this. She expresses being hopeful, but impatient, to change, and explains how she will research everything and write it all down. Because she feels she is different with different people, she sometimes feels like she has two people in her head controlling her every move. She asks the group again how they changed this.

In response, M expresses that she used to be a people pleaser when she'd just started high school. She had a lot of friends and adjusted her personality to fit them. She says she changed this when she realized that she didn't actually like them, so she started to stand by her principles and found better friends and is much happier since.

EL asks how that happened and how she realized this. M tried to explain further, and EL replies how she doesn't know how to do this but that she wants to.

Clinical vignette 2

EM came to the group with a problem – her friends are telling her she should change her attitudes. She explains that every time she has a different opinion, they have a fight. N tells her she should find new friends.

EM says everyone tells her she is rude even though she is just being honest. She feels like her best friends are manipulating her. When asked for an example, she quotes her friend: “If you don’t give me 10 kuna, you’re awful and won’t have friends.” She expresses that she thinks she is horrible, that no one likes her, and like she only causes problems for people.

Because she feels like she has to justify herself to people, she told her friends about her mental illness and now they are constantly asking her about her diagnoses and medications. EM says she is very frustrated because they don’t stop even though she tells them she doesn’t want to talk about it anymore.

Other members of the group say they don’t have this problem, because they don’t talk about these issues with their friends. T and NI don’t talk about it at all. NE talks about mental health when someone else starts the topic. F speaks about it, but only with a friend she’d met in group therapy.

EM complains that everyone copies homework from her, and the therapist asked the rest of the group what they would do. Everyone agreed they would let people copy their homework, except for K – he says it’s their problem, he would only let those that were nice to him.

EM expressed that she feels like nothing and no one with people outside of the group, and the therapist asks everyone how they feel within the group. F says she feels comfortable because she feels like no one is judging her there. NE agrees. When the rest don't reply, he asks what they have learned today. NI: "That we don't have to talk about our problems with everyone." F: "That we need to stand up for ourselves." T: (humorously) "That we should let people copy our homework."

Clinical vignette 3

This session the main therapist is absent, and the group is led by the co-therapist (CT). She asks the group what they talked about during the last session and if anyone wants to talk more about that or has anything happened that someone wants to talk about. No one but EM respond, saying that she has no motivation to speak today.

Long silence – Co-therapist: How do you feel in this silence?

- EM: Calm, comfortable. No judgement.
- CT: How do the rest of you feel in this silence?
- F: Same as EM.
- CT: You feel comfortable?
- F: Yes.
- CT: How about you, NE?
- NE: Likewise.
- CT: What is the difference between comfortable and uncomfortable silence?
- Pause
- CT: Do you have any situations in which there is uncomfortable silence?

- EM: Yes. When it is very quiet at home, when everyone in my family is quiet, then I know it's because of me and I feel very uncomfortable, and I spend more time in my room and feel more depressed.
- CT: But how do you know it's about you?
- EM: Because they spend more time with me, ask more questions, come to my room more often, they worry more about me.
- CT: How do you handle that silence?
- EM: I spend more time in my room. And when there is uncomfortable silence at school, I try to start conversations with people.
- CT: Hmm. NE, how do you handle uncomfortable silence?
- NE stays silent
- CT: Are you like EM, do you try to start conversations?
- NE: Yes, I try to start to talk.
- CT: When is silence uncomfortable for you?
- NE (murmuring): When I'm with a girl.
- CT: With a girl?
- NE: Yes.
- CT: And what do you do then?
- NE: I try to get information, I try to break the silence.
- At further questioning by CT, most members agree that uncomfortable silence is when they ask a question and everyone is silent, when the head is empty, when people are having a bad day etc.; comfortable silence is when you're with

someone you’re close to (F), when you’re alone, when you’re doing something (T) etc.

- EM spoke about feeling lonely in silence because she has no one to talk to.
- T also mentioned silence can be when you’re quiet but listening to music.
- EB: talked about different types of silences, said that you should break silence with humour
- CT: Do you have any jokers in your class?
- EM and EB both said they’re the jokers
- CT: What kind of humour do you have?
- NI: Sarcasm
- T: And insults (humorously)
- NI: No, you don’t have any humour.
- T: Like that. (laughs)
- CT: What is your humour like, F?
- F: Well, I don’t know. (pauses) Dry and uninteresting. I don’t think I have a sense of humour.
- EM: I think you do.

Comments

The vignettes show intrapsychic conflicts of rejection, misunderstanding, narcissistic feelings of depression, emptiness, and shame, as well as the inability to communicate with other people and peers, problems with parents or interpersonal problems. This is an already more developed group with better group cohesion (35). The group oscillates in every session between states of block and disorganization, and occasionally reaches the level of an organized group, with intensive mutual empathy and reciprocal exchange

(5, 36). In some vignettes the therapist's activities and interventions are more present. They connect individual sessions with each other by asking questions like "What did we talk about last week?", as well as create better cohesion within the group with questions such as "And what do the others think and feel about what the group member said now?"

8. Conclusion

Group psychotherapy with adolescents is an empirically proven psychotherapeutic method in the treatment of various mental disorders in adolescents. Depending on the therapist's education it can roughly be divided into psychodynamic, interpersonal, mentalization-based, as well as cognitive behavioural group psychotherapy. It is important that a therapist is educated in a particular theoretical direction. The most common theoretical foundations of group psychotherapy with adolescents are presented in the introductory part. Individual clinical vignettes of the psychoanalytic group of adolescents are presented at the end of the paper. In the vignettes we can notice subconscious intrapsychic conflicts of adolescents (e.g., adolescent's narcissistic position, deep depressive feelings, poor self-image), as well as interpersonal problems. The topics of self-destruction and processing negative emotions are also included in the sessions. We can also observe concepts of the group as a whole, such as group cohesion, mutual empathy, and oscillations between states of disorganization and organization of the group (2, 5, 35, 36).

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11. Biography

Katja Kočnar was born 18.07.1997 in Zagreb, Croatia. She finished primary and high school in Slovenia where she grew up, before coming to Zagreb to study medicine. She loves music and plays two instruments. She has aspired to a career in which she could help people and the field of psychiatry has always held a special interest.