View metadata, citation and similar papers at core.ac.uk brought to you by CORE

Coll. Antropol. **33** (2009) 3: 879–887
Original scientific paper

Aggression in Group Psychoanalytic Psychotherapy: Questionnaire Development (GA-Ag)

Slavica Pavlović and Mirela Vlastelica

Private Psychiatric Practice, Split, Croatia

A B S T R A C T

The aim of this study is developing of a questionnaire that observes aggression in group psychoanalytic psychotherapy and examines its factor structure. The questionnaire comprised of 160 statements in five-point Likert-type scale was developed through analysis of the content of aggressive communication among patients during group sessions. The questionnaire was applied on 253 patients that attended 40 small therapy groups in 9 cities in Croatia. All 20 group analysts are trained in the Institute for Group Analysis Zagreb. The patients were selected based on indications for group analysis. Two parallel questionnaire forms were designed of 80 items that were isolated through assessment of item discrimination and principal components analysis limited to five factors. A new, reliable and valid questionnaire that can be employed in group psychotherapy has been developed. The following has been isolated through factor analysis: 1. Difficulty in communication, 2. Distrust in the group therapist and the group, 3. Withdrawal from relationships and communication, 4. Low containing capacity, and 5. Mutual lack of understanding. This questionnaire can measure the level of difficulty in communication, distrust in the therapist and the group, passive aggression, containing capacity, lack of understanding among group participants and in the group as a whole.

Key words: *group psychotherapy, psychoanalytic psychotherapy, aggression, questionnaires*

Introduction

Group psychoanalytic psychotherapy[1–3] with the theoretical background in psychoanalysis is first and foremost intended for curing of adult neurotic patients, even though group analysis principles are also employed in working with the groups of patients with PTSD and psychoses. A therapist – group conductor and 6 to 8 patients are seated in a circle trying to establish as good communication as possible. Ninety minute sessions are held on once or twice a week basis over several years. Withdrawal or reduction of symptoms and better communication with others are the therapeutic aims of group analysis that are achieved through analysis of the unconscious content of manifest communications and interactions (free floating discussion) that are treated as free associations in psychoanalysis. By revealing the unconscious meaning of communication (though translation from the unconscious to conscious), the instinctive drives, that were tied up in symptoms and conflicts by then, are released. »In Psychoanalytic theory aggression and/or aggressiveness are hypothetical force or principle imagined to actuate a range of acts and feelings«[4]. Group situation by its nature activates and reactivates high tensions and strong conflicts. They are accompanied by aggressive affects, reactions, thoughts, fantasies, dreams, feelings, memories, and acting-outs. At the same time related object relations are also reactivated[1–3,5–8] along with the aggressive affects and emotions. As the aggressiveness has surfaced then, it becomes accessible to direct observation and monitoring[5], so that dealing with it directly becomes possible.

Kernberg[5] defines an affect as an instinctive, constitutionally and genetically defined aspect of behavior and reaction, which is structured through object relationships. It has a specific cognitive superstructure, defined facial expression pattern, subjective pleasant or unpleasant experience, and muscle-neurovegetative pattern of discharge and relief. The intensity, rhythm and the threshold for activating an affect are defined by neurophysiologic disposition[5,8,9].

Received for publication April 4, 2007

Developmentally speaking, early affects are primitive and appear in first two-three years of life. Thus they are intense, global and diffuse, and their cognitive aspects are not clearly differentiated. Emotions or feelings are complex affects which are combination of primitive, but cognitively processed affects. Along with other factors, object relations may structure and organize affects, especially those that appear during »peak« affect state[5]. Experiences in such states are stored in implicit memory structures and take part in creation of intrapsychic world of object relations. In this manner they define the dynamics of the unconscious, Kernberg points out[5]. Those affects that are connected with the pleasant are organized around libido, for which basic affect is the sexual excitement. Those connected with the unpleasant are organized around aggression, for which basic affect is rage that is in the root of hate, envy, anger, and irritability[8,9] in forms that vary. Strong and primitive, internalized aggressive and sexual object relations are repressed together with the related affects, and become part of id. Id contents connect with one another and integrate into a positive or negative emotional quality of condensation and displacement mechanism. In such a manner, affects become alarms or representation of both instinct and object relationships, and are in the center of each gratifying or frustrating experience[5]. Interaction of libido and aggressive impulses through internalized pleasant object relationships leads to a successful neutralization and sublimation of aggressive impulses and affects, i.e. to modification of psychological, experiential and/or communicative aspect. Facial affect expression has communicative and social function, and bears special importance in (group) psychoanalytical psychotherapeutic process and transference. It allows the therapist and other group members to empathize and to emotionally respond to experiences of other group members[8]. Affective states in transference re-enact important patient's object relationships from the past, i.e. when certain aggressive affects are activated in transference, frustrating object relationships, impulses and desires are activated simultaneously. They are also accompanied by patient's unconscious effort to reactivate object relationship »here and now« if it was pleasant, or to break away from it if it was painful[5–8,11].

Consequently, points of fixation and the patient's authentic traumatic experiences occur due to dealing with the patient's aggressive affects in transference directly. Analysis and working through these conflicts result in neutralization of related primitive and strong aggressive affective states, by which the tied up instinctive energy is released at the same time. Instead of making symptoms, the released energy can then be used for more mature and productive purposes that enrich personality. Orgel[12] says on the matter: »the analysis of aggression plays a determinative role in the ….lives of analysands, and vitally affects the health and creativity…«.

Group therapy situation works as a trigger that activates group members' vulnerable points which have been formed during traumatic experiences in their lives. It stimulates different aspects of regressive behavior and related affects and emotions, intrapsychic and interpersonal anxieties, fears, tensions, and conflicts. However, it is also an environment where autism, aggression and destructiveness, which are inseparable segments of neurosis, start to transform into their healthier forms[2]. These changes are possible in sufficiently empathic groups that have a good holding[10], adequate caring and good containing capacity[6]. »Self development through subjective interaction«[11] allows corrective emotional experience through which patients learn to communicate in a more mature manner. Their capacity to show and process their aggressive impulses, affects and emotions in a more mature, constructive, creative and socially adequate manner is increased. The result of all these processes is an increased patient's ability to better adjust to people and situations in reality; a better quality of life.

While outcome and process studies are widespread in practice in many psychotherapeutic disciplines, they are rare in psychoanalysis and psychoanalytical psychotherapies, even in group analysis. They are accompanied by many methodological dilemmas, controversy and limitations[13,14]. One of the major difficulties facing psychodynamic psychotherapy researchers is the relative lack of developed instruments to assess both the characteristics of patients in terms of their psychodynamic difficulties and to monitor change from a psychodynamic point of view which is beyond behavior and symptom change. No study of psychotherapy process and/or outcome is better than the instrumentation that has been utilized[15]. Thus, group analysis has yet to »digest« evidence on its efficacy[16]. Carter points out that empirical research with standardized measures required to examine 'does it work and if so for whom?' are lacking. There are numerous satisfactory outcome questionnaires designed to observe changes in symptoms that occur because of psychotherapy, Beutler and Clarkin point out[13]. However, they remind, there are only few instruments designated for evaluation of changes in interpersonal behavior patterns and hardly any instrument that can examine character and structural changes caused by psychotherapy. Empirical evidence on therapeutic changes in aggressive patterns of behavior and reaction is also insufficient. One of the reasons is a lack of adequate and analytically sensitive measuring instruments. Having reviewed the literature and data bases posted on the Internet (Medline, PsyINFO), a similar instrument has not been found. In this study, the aim is to create a new »GA-Ag« (Group-analysis-Aggression) Questionnaire which should allow observing of the dynamics of aggressive impulses and affects in group-analytical psychotherapy.

Methods

Development of questionnaire

The questionnaire was developed in three phases. In the first phase, the content of aggressive interaction and communication within the group was examined: affects feelings, thoughts, reactions, fantasies, and dreams. Patients' statements were noted down after sessions. Based

on these records, 26 items with yes or no responses were drafted. The questionnaire was applied on a group of 7 patients in three turns: after the 9th, 72nd, and 148th session.

In the second phase, the questionnaire was expanded to include 45 statements with yes or no answers and employed in 10 small groups totaling 68 patients and 7 therapists. The therapists were of different genders, different formal education and different level of formal training in group analysis. The questionnaire was again employed in the same groups after 15 months of therapy[17].

Having used the experience gained in previous two phases, in the third phase 160 statements related to patients' feelings and reactions during group therapy were constructed and selected. Responses were presented in Likert-type scale and grouped in the following categories: 1-never, 2-rarely, 3-sometimes, 4-often, and 5-very often. Materials with invitations for voluntary participation in the study were sent to 48 addresses; i.e. to all group analysts who are members of the Institute for Group Analysis Zagreb in Croatia. The material contained standardized instructions for therapists and patients. Data gathered from patients were: age, gender, formal education, professional occupation, employment and marital status, previous group or individual psychotherapeutic experience, membership duration in the current group. Data collected from therapists were: gender, formal education, level of training/experience in group analysis, type of group composition, frequency of session's weekly, private/state setting. As instructed, those therapists who agreed to participate in the study employed questionnaires with their patients after their group sessions. Of 400 questionnaires sent, two hundred and fifty three (63%) returned; were properly filled, contained requested information and were included in data processing.

Sample

There were 253 patients examined, of which 41% were male. The average age of patients was 36; the age ranged from 28 to 57 years. There were 15% of patients who were ≥28 of age, 46% from 29 to 38 years, 30% from 39 to 48, and 9% of patients who were from 49 to 57. There were 50% married patients, 39% singles and 11% divorced. University degree had 45% of patients, and 55% of patients had high school and elementary school education. There were 72% of patients who were employed. There were 9% of patients of medical professional background, 18% of administrative, 25% of social studies, 24% of technical, 20% of service industry background, and 4% of patients were students. An average duration of group therapy was 28.79±11, 50 months; there were 26% of patients who were in group treatment up to 6 months, 37% from 7 to 24 months, 18% from 25 to 48, and 19% of those who were in a group for more than 49 months. Prior to joining group therapy, 28% of patients did not attend individual therapy, while 72% did as it follows: up to 6 months 29% of patients, from 7 to 24 months 29%, over 25 months 14% of patients. There were 83% of patients who did not have previous group experience, while 17% had in some other groups with an average duration of 15.69 months (up to 12 months 11% of patients, from 13 to 24 months 3%, and over 25 months 2% of patients). Furthermore, the research included 12 group analysis trainees (5%) who have been completing their practical training in groups with patients and 95% of patients whose DSM-IV diagnoses were as following: 8% of patients with F30; 36% with F40; 17% with F43.1; 26% with F50-F60 and 8% of patients with F20.

Therapists: Examined groups were conducted by 20 therapists (including two authors of this study); 7 men, (27% of patients had male therapist) and 13 women. Their basic professional occupation was as following: there were 15 psychiatrists who had 78% of patients, 3 psychologists (16% of patients), 1 defectologist (2% of patients), and 1 medical doctor (4% of patients). There were 7 group analysis trainers who conducted 19 groups (46% of patients), 6 group analysts conducted 9 groups (26% of patients) and 7 group-analysis trainees conducted 12 groups (28% of patients).

Groups: There were 40 groups examined with an average of 6, 33 patients per a group. There were 38 slow-open groups (90% of patients) and 2 closed groups of patients with PTSD. Once a week sessions were conducted with 34 groups (79% of patients), and twice a week sessions with 6 groups. There were 31 groups with the neurotic disorder patients (76% of patients), 4 groups with PTSD patients (14%), 4 groups with psychotic patients (7%) and 1 homogenous group of borderline-narcissistic patients (3%). There were 2 inpatient groups (6% of patients), 10 outpatient groups (26%) and 28 groups were conducted in private practice (68%). There was 1 group from Dubrovnik (1%), 2 from K. Kambelovac (4%), 1 from Osijek (4%), 6 from Pula (15%), 1 from Šibenik (2%), 1 from Trogir (2%), 7 from Zagreb (16%), 4 from Zadar (10%) and 17 from Split (46%).

Questionnaire validation

The content analysis excluded Items that contained double negation and those items that were unclear to patients either in content or form (18 items).

Since responses provided to 85 items grouped around the ultimately negative, a control scale of socially desirable answers was created. The selection for the scale required a change only in the criterion related to response distribution. Items for which more than 60% of patients selected the response 1-never and which met the remaining criteria, were included in the control scale comprised of 20 items.

For the purpose of practical application, two questionnaires were designed. Isolated basic and control scale items were organized and classified in an irregular sequence in two parallel questionnaire forms, GA-Ag1 and GA-Ag2 which represented final version of the scale for observation of aggression in group analysis-psychotherapy.

Time required for filling in and questionnaire rating is 10 to 15 minutes per a questionnaire. The overall questionnaire result is obtained objectively by summing up the scores for all selected responses. Maximum score, in-

TABLE 1
FINAL VERSION OF QUESTIONNAIRE ON AGGRESSION IN GROUP ANALYSIS: GA-Ag1

No.	Question*
1	It irritates me when everybody speaks at the same time in the group
2	It irritates me when the therapist laughs**
3	It makes me angry when a group member feels sorry for himself/herself
4	It is tiring to listen other group members talking for the sake of talking
5	Group members who get insulted easily, annoy me
6	Nervous group members irritate me
7	I have an impression that the other group members are jealous of the attention I get from the opposite sex
8	I am annoyed with group members who incline to argue with others
9	Those who play smart in the group make me angry
10	I irritate some group members very much
11	The therapist does not like me
12	When group provokes me I get furious
13	Helplessness of other group members scares me
14	It irritates me that I can not provoke the therapist
15	Group members who do not show their emotions scare me
16	It annoys me when we loose time in the group
17	It crosses my mind sometimes that some group members should be excluded from the group
18	Those who start from “Adam and Eve” irritate me
19	Those who need to be told same thing over and over again annoy me
20	The therapist has his/her favorites in the group
21	Group members who can understand everything upset me
22	It makes me angry when I feel other group members do not understand me
23	There are subjects I do not want to talk about
24	Some group member are such that they make me talk to them with great caution
25	I am content when I see that the therapist has a hard time
26	From time to time it happened to me that I did not know what the group wanted from me
27	The group members’ anger gets to me easily
28	When I am attacked I want to defend myself, but I do not know how
29	It upsets me when somebody cries in the group
30	I am annoyed with those group members who talk only to the therapist
31	It irritates me when somebody does not see he/she is hurting others in the group
32	I do not feel comfortable showing my anger in the group
33	Therapist’s nonchalance makes me angry
34	Silence at session makes me feel uneasy
35	It annoys me when somebody changes the subject of discussion in the group
36	It happens that I say something during the session, and only later on I understand I hurt somebody
37	I get scared when I can not tell the difference between my feelings and someone else’s from the group
38	Group thinks I underestimate the therapist
39	It makes me angry when I feel helpless
40	When a group member hurts me, I withdraw and I am silent

* The scale for each item ranged from 1 – never to 5 – very often
** Control scale items

cluding the control scale, is 200 points; minimal score is 40. Maximum number of points in control scale is 50; minimal is 10 points.

Statistical analysis

Statistica 7, software application (StatSoft. Inc. Tulsa, USA) was utilized for data processing. Item discrimination was estimated through analysis of response distribution for each item and in item-total correlation. Those items for which a normal distribution significantly deviated in relation to response 1-never, and for which total percentage of response to 1-never, and 5-very often was frequently over 30% (85 items), were excluded. Items with the item-total correlation less than 0.3 were excluded (11 items) with the exception of 2 items that were less than 0.27. Items with Alpha if item deleted over

TABLE 2
FINAL VERSION OF QUESTIONNAIRE ON AGGRESSION IN GROUP ANALYSIS: GA-Ag2

No.	Question*
1	I envy new group members; their start is easier**
2	Group members who always blame others for everything irritate me
3	I am annoyed with those group members who hide their true feel
4	It disturbs me when somebody interrupts those who are talking
5	Overly sensitive group members irritate me because you can not tell them anything
6	I think the therapist is cold and uninterested
7	I am irritated by those who are always nice and considerate
8	It makes me angry if the group does not understand me
9	I find it tiring when I have to be careful about when and how I say something to somebody
10	I feel the therapist does not care enough for the group
11	I am irritated by those group members who always say the same thing
12	I do not like when somebody acts as if he/she was a child
13	Those who talk much but do not say anything make me angry
14	I feel the therapist handles the group with difficulty
15	I am embarrassed by my rage
16	I feel helpless when I am attacked in the group
17	I feel I do not get enough support in the group
18	I do not say what I think because it seems to me that would be boring to others
19	The group uses me
20	I am irritated by those who act as if the therapist was only theirs
21	Those group members who do not let anybody come closer make me angry
22	I have difficult time controlling my anger with some group members
23	Therapist's calmness irritates me
24	When I am angry with somebody, I am quiet
25	I felt on the edge to burst into rage
26	I am afraid when the therapist is in a bad mood
27	It happens to me that something in the group upsets me, but I do not understand what
28	I was intimidated by certain things that happened at session
29	I am told I also act the same as those who I find annoying
30	The therapist has disappointed me
31	I am annoyed by those group members who attack the group, but keep coming back
32	It borders me that certain group members argue about everything they are told
33	If group members hurt me, I hesitate to let them know that
34	It makes me angry when somebody does not see he/she is hurting others in the group
35	I think the therapist has no tact
36	I am overcome with rage when the group does not understand me
37	It makes me angry when somebody keeps asking for help, but throws away all assistance offered
38	I hesitate to burst into rage in the group
39	I have a feeling the group wants to get rid of me
40	It happens to me I can not endure silence and then I have to say something

* The scale for each item ranged from 1 – never to 5 – very often
** Control scale items

0.9745 (16 items) were excluded, with the exception of 4 items of 0.9746.

Factor analysis isolated 5 factors. Items with factor saturation less than 0.3 (76 items) and items with less then 0.27 (3 items) were excluded from the matrix which was constructed by means of Varimax – Kaiser Rotation method.

A new matrix comprised of all selected items and all 4 selection criteria was created. Those matrix items that met the minimum of 3 out 4 criteria were included in the final selection. This is how 60 items were isolated from the basic scale.

Results

Reliability analysis showed that the questionnaire's Cronbach Alpha is 0.975; i.e. homogeneity of the ques-

tionnaire is high. Reliability analysis of each factor showed good internal consistency of factors 1–4.

Cronbach Alpha is: 1.factor 0.879, 2.factor 0.790, 3.factor 0.821, 4.factor 0.751 and acceptable reliability of 5.factor where Cronbach Alpha is 0.643.

Factor analysis showed multidimensionality of aggression measured by the questionnaire, so that five independent and very clean factors with the dominance of Factor 1 were isolated. Factor 1 covers 21.2% of variance, Factor 2 covers 5.2%, Factor 3 covers 3.4%, Factor 4 covers 2.9% and Factor 5 covers 2.5% of variance.

Factor 1 – Difficulty in communication: In accordance with the selection criteria, of 40 isolated items 28 have been kept in the final questionnaire version. The content of Factor 1 is related to anger and irritability (aggression) which appear when other group members are not able and ready to communicate, to open emotionally and participate in relationships in an authentic manner. It also applies to situations when a special caution and effort have to be made to communicate with others.

Factor 2 – Distrust in the therapist and the group: Thirty one items were isolated. Upon the completion of the selection process, 17 have been kept. Factor 2 content shows how much group members can afford to be critical and demanding (aggressive) towards the group and the therapist; what their impression is of the therapist's interest in the group, his/her tactfulness, his/her emotional capacity and competence. A strong tendency of providing socially desirable responses is the consequence of a specific loyalty and a developed positive transference towards group psychotherapy and the therapist. The content and the distribution of item responses are directed towards negation of aggressive feelings. This has created a necessity to employ a control scale in which 16 of seventeen Factor 2 items have been included.

Factor 3 – Withdrawal from communication: Twenty six items were isolated and 12 selected. Factor 3 content points at withdrawal, passivization, and inhibition in communication which shows fear from one's aggressive instincts and loosing of control over them.

Factor 4 – Low containing capacity: Thirty three items were isolated and 14 selected. Factor 4 content points at contamination by other group members' aggressive feelings, group tensions and low capacity to contain them.

Factor 5 – Mutual lack of understanding: Thirty two items were isolated and 9 kept. Factor 5 content shows inability to understand other peoples' behavior and simultaneous anger and irritability a group member feels when it seems as if others did not understand him/her. Item: It makes me angry if the group does not understand me, is saturated by Factor 1 and Factor 5 almost in the same degree 0.334 and 0.332. The result is logical if one bears in mind that Factor 1 points at difficulties in communication and Factor 5 at mutual lack of understanding. Misunderstanding provokes anger that creates difficulties in communication.

Discussion

The study shows the development of the questionnaire on aggression in group-analytical psychotherapy with good psychometric characteristics.

During group-analysis treatment general level of aggressiveness and tensions diminishes individually and in the group as a whole. In our opinion it is of special importance that the developed questionnaire offers possibility to evaluate these changes from a psychodynamic point of view, considering that the content of items is related to intrapsychic and interpersonal tensions in patients during sessions. Furthermore, it is possible to obtain information on certain motives that stimulate aggressive experiences and reactions.

High degree of reliability of data obtained by this questionnaire is important to its validity, which has been also tested by factor analysis. Reasons for such a high degree of homogenous sample are: a) high number of items – 160; b) homogeneous sample of patients who were included in group analysis based on the inclusion criteria (interviews); c) items have been created based on authentic formulations made by patients; d) experienced practitioners, group analysis trainers, have taken part in creating and selecting the items.

Factor analysis has confirmed theoretical-psychoanalytical and group-analysis interpretations according to which aggressiveness, tension and frustration in a group have different aspects and origins. The dynamics of aggressive impulses in a group is complex, manifold determining phenomenon[1,5–9].

Since communication is the basis of group psychotherapy process, the obtained result is not surprising as aggression in a group is mostly tied up with difficulty in communication and misunderstanding. Those group members who can not disclose emotionally, are in resistance and avoid communication and authentic participation in the group work (Factor 1), other group members tolerate with difficulty[1–3,6,7]. The importance of a careful and good selection of patients for a group, in which evaluation of capacity for communication is of special importance, has been confirmed[1–3,7]. Troublesome communication in a group very much frustrates group members and works as the strongest trigger that reactivates the inner object world and experiences tied up in aggressive affects[1,2]. Thus exists one of the most important tasks for a group therapist, and that is to work on creating preconditions for a meaningful communication that he/she has to facilitate, make possible and easier[1–3,7,9]. Mature groups and patients will develop a more mature communication and will be more tolerant of difficulties others have in communicating.

A significant importance of a group conductor and his/her position has also been confirmed. His/her role is to serve the group for the purpose of its development and growth (Factor 2). A group becomes a group exactly because it has a group conductor. Small group therapy setting stimulates regression with those group members who are already in one. In such and atmosphere the need

TABLE 3
QUESTIONNAIRE'S FACTOR STRUCTURE
GA-Ag1

Item	Factors				
	1.	2.	3.	4.	5.
1	0.555				
2*		0.572			
3	0.416				
4	0.607				
5	0.561				
6	0.569				
7		0.26			
8	0.428				
9	0.599				
10					0.632
11		0.394			
12				0.398	
13				0.435	
14		0.465			
15	0.342				
16	0.411				
17	0.309				
18	0.515				
19	0.618				
20		0.466			
21	0.41				
22					0.385
23			0.369		
24			0.346		
25		0.369			
26					0.48
27				0.5	
28			0.593		
29				0.355	
30	0.431				
31				0.357	
32			0.607		
33		0.671			
34				0.296	
35	555				
36					0.354
37				0.415	
38		0.611			
39			0.432		
40			0.603		

*Control scale items

TABLE 4
QUESTIONNAIRE'S FACTOR STRUCTURE
GA-Ag2

Item	Factors				
	1	2	3	4	5
1*		0.27			
2	0.473				
3	0.628				
4	0.579				
5	0.55				
6		0.69			
7					0.384
8	0,334				0.332
9	0.478				
10		0.56			
11	0.61				
12	0.502				
13	0.58				
14		0.591			
15			0.514		
16			0.543		
17		0.441			
18			0.602		
19		0.389			
20	0.569				
21	0.436				
22					0.466
23		0.544			
24			0.582		
25				0.591	
26				0.426	
27				0,.24	
28				0.513	
29					0.588
30		0.693			
31	0.559				
32	0.534				
33			0.639		
34				0.476	
35		0.68			
36				0.402	
37	0.632				
38			0.528		
39					0.415
40				0.426	

* Control scale items

for a positive and protective parental figure in the group is extremely strong, especially in a young, newly formed group[1–3], and with more regressive patients. Due to patients' dependence on the conductor, group/patients will keep the therapist from their own aggressive attacks and criticism. Only after group/patients resolve their dependence on the therapist, they will be able to be critical, see him/her more realistically, and will have capacity to work »on his/her own« in the presence of the therapist. The scale of the socially desirable responses can also provide data on a degree to which group/patients are dependent on the therapist and the group.

Factor 3[1,5,6,8] shows that aggression in a group can very strongly and convincingly appear in a passive form: though withdrawal, silence and inhibited behavior. Such a behavior presents a special problem for the group since

it breaks communication and makes it impossible, which in turn, increases group tensions and aggression in it. Passive forms of aggression towards the group and within the group are present to a higher extent in group's early phases. As group develops, the group and the members learn how to articulate and verbalize all their feelings, the aggressive ones as well.

The capacity to absorb, metabolize and respond to other person's feelings is known as containing capacity[6] in the theory of psychoanalysis. Factor 4 confirms that neurotics, the most common group members, have small capacity for someone else's problems because their own neurotic conflicts prevail. While the containing capacity is low in young groups, it increases proportionally to group's growth so that in terminal phases of group work it is much higher than in the beginning. Mutual lack of understanding in a group provokes aggressive feelings (according to Factor 5) leading to a risk of acting out[7]. This underlines therapist's responsibility and his/her skill to create preconditions for a meaningful communication and mutual understanding.

It is expected that higher score in the questionnaire will be achieved by those patients and groups whose group situation stimulates higher degree of aggression. Namely, the patients who have more difficulty in communication, are more distrustful of the therapist and the group, incline to withdraw from the relationship and communication, hence have smaller containing capacity. They are also more likely to misunderstand in group communication. Likewise, it is expected that lower score in the control scale will point at those patients and groups who are more dependent on the therapist and the group, and therefore strongly idealize the therapist and deny their own aggressive impulses.

The disadvantage of this study is a high reliability of questionnaire results that has been conditioned by high number of items. An effort has been made to resolve this issue by creating shorter version of questionnaire.

In further work it is necessary to employ factor analysis in parallel questionnaire forms, test its reliability, discrimination, and criteria validity in relation to standardized personality questionnaires. Of a special importance for clinical practice would be to establish whether the questionnaire discriminates patients in accordance with indications for group analysis: age, gender, marital status, formal education, professional occupation, DSM-IV diagnosis, prior experience in psychotherapy-preparation for the group, duration of group treatment. It is necessary to establish whether the questionnaire results can be brought in relation to therapists' characteristics (gender, formal education, professional therapy experience) and to peculiarities of the group (session frequency, private or state setting, homogeneous or heterogeneous group composition, closed or slow-open groups).

This research is continuation of previous studies of the two authors. Previous researches, facilitated on smaller samples of groups, included the following: the assessment of the analytic group treatment efficiency according to Yalom's classification[18], patients' ranking of therapeutic factors in group analysis[19], group members' assessment of their conductor[20], and changes of defense mechanisms and personality profile during group analytic treatment[21].

Even though this questionnaire has been originally designed for application in group psychoanalytical psychotherapy so that its employment follows peculiarities and specific qualities of psychoanalytical theory and therapy, we think it would be useful to explore the possibilities of its application in groups that are conducted with different agenda and in line with other theoretical and technical concepts.

Acknowledgements

The authors wish to thank all colleagues who participated in the study: dr. Anton Sanda, dr. Britvić Dolores, dr. Brkljačić Đurđica, prof. Čajo Najda, dr. Dedić Helena, dr. Jeličić Jadranka, dr. Josić Dragan, dr. Katavić Zdenko, dr. Kezić Slobodanka, dr. Luetić Anđelka, dr. Marković Hrvoje, dr. Matijević Veljko, dr. Marčinko Helena, prof. Miolović Gabrijela, dr. Perinčić Robert, dr. Stojanović Milivoj, prof.dr. Urlić Ivan, prof. Veronika Dina and Motovun group.

REFERENCES

1.KLAIN E, Grupna analiza. In Croat. (Medicinska naklada, Zagreb, 1996). — 2. FOULKES SH, Therapeutic group analysis (Allen and Unwin, London, 1964). — 3. YALOM ID, The theory and practice of group psychotherapy (Basic Books, New York, 1994). — 4. RYCROFT C, A critical dictionary of psychoanalysis (Penguin Books, London, 1993). — 5. KERNBERG OF, Aggression in personality disorders and perversions (Yale University Press, New Haven and London, 1992). — 6. BION WR, Second thoughts: selected papers on psychoanalysis (Heinmann, London, 1967). — 7. NITSUN M, The anti-group (Routledge, London, 1996). — 8. KERNBERG OF, Aggression and transference in severe personality disorders. Available from: URL: http://www.toddlertime.com/dx/borderline/bpd-kernberg.htm — 9. SCHMIDT-HELLERAU C, Int J Psychoanal, 83 (2002) 1269. — 10. WINNICOTT DW, Playing and reality (Tavistock, London, 1971). — 11. BROWN D, Self development through subjective interaction. In: BROWN D, ZINKIN L (Eds) The psyche and the social world (Routledge, London, 1994). — 12. ORGEL S, Psychoanal Q, 71 (2002), 419. — 13. BEUTLER EL, CLARKIN J, Future research directions. In: BEUTLER EL, CRAGO M (Eds) Psychotherapy research (American Psychological Association, Washington, 1991). — 14. MILLER EN, LUBORSKY L, BARBER PJ, DOCHERTY PJ, Psychodynamic treatment research (Basic Books, New York, 1993). — 15. FONAGY P, An open door review of outcome studies in psychoanalysis, 2nd rev ed (International Psychoanalytical Association, 2002). — 16. CARTER D, Group Analysis, 35 (2002) 119. — 17. PAVLOVIĆ S, TOCILJ-ŠIMUNKOVIĆ G, URLIĆ I, Group analysis and elaboration of aggression. In: Bridging – the risks we take. (11th European Symposium in Group Analysis, Budapest, 1999). — 18. VLASTELICA M, URLIĆ I, PAVLOVIĆ S, Coll Antropol, 25 (2001) 227. — 19. VLASTELICA M, PAVLOVIĆ S, URLIĆ I, Coll Antropol, 27 (2003) 779. — 20. VLASTELICA M, URLIĆ I, Coll Antropol, 28 (2004) 183. — 21. VLASTELICA M, JURČEVIĆ S, ZEMUNIK T, Coll Antropol, 29 (2005) 551.

M. Vlastelica

Private Psychiatric Practice, Vukasovićeva 10, 21000 Split, Croatia
e-mail: mirelavlastelica@yahoo.com

RAZVOJ UPITNIKA O AGRESIJI U GRUPNO-ANALITIČKOJ PSIHOTERAPIJI

S A Ž E T A K

Cilj ove studije je razvoj upitnika za praćenje agresivnosti u grupnoj psihoanalitičkoj psihoterapiji i ispitivanje njegove faktorske strukture. Analizom sadržaja agresivnih komunikacija pacijenata tijekom grupnih seansi stvoren je upitnik s 160 tvrdnji Likertove skale od 5 stupnjeva. Primijenjen je na 253 pacijenata iz 40 malih terapijskih grupa u 9 gradova u Hrvatskoj. Svih 20 grupnih terapeuta je educirano prema programu Instituta za grupnu analizu Zagreb, dok su pacijenti za grupe odabrani prema indikacijama za grupnu analizu. Odabir čestica (itema) za finalnu verziju upitnika napravljen je analizom sadržaja, distribucije odgovora, procjenom unutarnje konzistencije upitnika, pouzdanošću i faktorskom analizom. Procjenom diskriminativnosti čestica (itema) i analizom komponenata limitiranih na 5 faktora izdvojeno je 80 tvrdnji od kojih su formirane dvije paralelne forme upitnika. Faktorskom analizom izdvojeni su faktori: 1. Poteškoće komunikacije; 2. Nepovjerenje prema voditelju i grupi; 3. Povlačenje iz odnosa i komunikacije; 4. Nizak »containing capacity« i 5. Uzajamno nerazumijevanje. Razvijen je novi pouzdani instrument za procjenu agresivnosti u grupnoj psihoanalitičkoj psihoterapiji.