Archives of Psychiatry and Psychotherapy, 2009 ; 3 : 17–25

Understanding and treatment of people suffering from schizophrenia in Kraków

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Summary

The authors described the idea of a psychosocial approach in treating people suffering from schizophrenia, which is based on Manfred Bleuler's and Antoni Kępiński's concepts, and which is crucial in their thinking about the causes and the course of schizophrenia. This approach refers to the idea of a bond and solidarity. It creates comprehensive, integrated models of treatment, rehabilitation and supports the individual throughout the long years of living with the illness. Therapeutic relationship, self-activity of patients and the role of the group are fundamental in therapeutic programmes at every phase of the treatment. A community psychiatry model implemented in Kraków consists of 11 institutions, which form a network of mental health centres open for patients and their families. To illustrate the programme, the authors describe activities that intensify the psychotherapeutic experience; therapeutic camps, dramatherapy, employment and the anti-stigma programme.

schizophrenia / community treatment programme

Pro memoriam Professor Antoni Kępiński

INTRODUCTION

Community psychiatry views the illness and the help offered to patients in the light of their biographies and in a wider social context. Its objective is to provide help in the patient's place of residence and this help is offered by a number of people who are members of local communities. This approach refers to the idea of bond and solidarity. It allows to create comprehensive, integrated modes of treatment and rehabilitation and supports an individual throughout the long years of living with the illness. It focuses on the severely, chronically ill, while keeping in sight those who are ill for shorter periods and not so severely. It reconciles medical and social aspects. It takes care of treatment, accommodation, work and leisure. It embraces various kinds of treatment and care, depending on the specific needs of patients. It increases patients' empowerment, so they can, as much as possible, help themselves [1].

Antoni Kępiński [2, 3] similarly to Manfed Bleuler [4, 5] stresses this tradition of thought about schizophrenia which emphasizes *what is common,* and not particular. Such understanding of schizophrenia effects in therapeutic recommendations: they think that a stable relationship with another person, inclusion in a community a patient accepts, constant activation of his/her healthy resources and mobilization of hidden developmental possibilities make up the effect directed at the core of the illness, because it

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fosters the harmonization of internal splitting. Therefore our task is to introduce the patients suffering from schizophrenia to a "common space". And because our attention has moved from "a psychotic episode" to "the course of life with schizophrenia", and "the course of life with schizophrenia" has moved from institutions to communities, we inherited the task of creating not only "a therapeutic community with the patient in an institution" while in an acute psychotic state, but also a "common space" through the years of joint living outside of the hospital.

UNDERSTANDING SCHIZOPHRENIA

Bleuler in his essay on schizophrenia wrote that his fundamental experience was the recognition that the important influences that positively affect personality development in each of us and later, throughout lifetime, support the 'sense of the self', are those influences which also prove helpful to people suffering from schizophrenia. Those methods of exerting influence are efficient which are active at puberty; for instance, they work with our children. Therefore, one can say that the task is rather clearly defined; it is enough to act in the spirit of Bleuler and Kępiński, as many social psychiatrists say nowadays. We admit that this message is in accord with our thinking and we cannot find anything more valuable or sensible in our work with patients suffering from schizophrenia.

Patients suffering from schizophrenia tend not to inhabit the common space. Because they do not satisfactorily participate in the life of their community, they are deprived of social experience and of the social energy which we are accustomed to tap from contacts with other people. Gradually, the deficit of what is common becomes larger and the empty space and an unlived life make them helpless in confrontation, rivalry and competition, depriving them of the values and benefits that stem from participation in a community.

This is why the motivation to participate in community life becomes subdued. As we suppose, a strong source of this motivation arises exactly from the sense of belonging to a group, one's interest in others and in the world, as well as social competence needed to explore the world. People suffering from schizophrenia lack all these things and this phenomenon is reinforced by the illness as such, by the treatment and by the stigmatisation in the environment. While the appearances of communication are kept up, there exists an abyss between what is experienced internally and what is expressed externally. Long before the onset of the illness, the protective function of the *self* is stronger than its expressive function and the man withdraws like a snail into its shell. The process of enabling patients to express themselves and to regain their own activeness proceeds from arousing interest through increasing competence to a growing sense of belonging to a group. We can say that our philosophy of work is:

1. Understanding schizophrenia as a specific kind of development.
2. Acting in the spirit of Bleuler and Kępiński, assuming that persons with schizophrenia are aided by anything that aids our own children to develop.
3. Endowing psychotic experiences with meaning.
4. Enriching the patient's social experience with reflection stemming from psychotherapy.
5. Integrating individual therapy and cooperation with the family in overcoming the illness, often throughout the patient's lifetime.
6. Supporting the patient's own motivation and his/her bond with the group.
7. Considering many dimensions of life and therapy: work, accommodation, leisure activities.
8. Integrating pharmacotherapy, psychotherapy and rehabilitation.
9 Integrating education and research into one programme.
10. Building up the therapeutic imprinting of the experience of being together in young members of our team.

THERAPEUTIC RELATIONSHIP

When an acute psychotic crisis is over, a variety of therapies are offered based on the pa-

tient-therapist relationship. It should protect the patient from the harms of the healthcare system and the excessive interference of the activating social field. Depending on individual needs, the relationship may last even a lifetime, throughout the years of living with the illness. This relationship does not automatically ensure autonomy, but if the system of supervision is properly constructed it may prove to be a safety valve. In such a case, the essence of supervision is to continuously reflect on the feelings of the person suffering from schizophrenia in contact with the therapist. What feelings are they? First, the patient feels dependent and helpless; he/she would like to resist but is actually afraid to do so because the therapist has at his/her disposal various instruments of power. Second, the patient hopes, in spite of all the limitations in these circumstances, that he/she may be understood, accepted, loved and at the same time is afraid that this may be unattainable.

FREEDOM OR SELF-ACTIVITY OF THE PATIENT AS AN OBJECTIVE OF THE THERAPY IN THE COMMUNITY PROGRAMME

From the clinical perspective, a person suffering from schizophrenia has little chance to break all ties with healthcare institutions and therefore should experience as much autonomy and independence as possible - in the relationship with the therapist, in contact with healthcare institutions and in contact with his/her social environment.

An opportunity to achieve this objective arises within such therapeutic programmes that value freedom or, using a less lofty term, self-activity of patients as much as their health. So the patient's freedom must be one of the objectives of therapy. In practice, every phase of therapy and every form of therapy can be, and ought to be, scrutinized in this respect. This way one achieves continuity: initially the patient is maximally dependent on the therapist/institutions as they take over almost all the functions of the patient's *ego*, then intermediate phases follow, and lastly the patient regains control over the functions of his/her *ego* and, appropriately to the circumstances, a proper distance to therapists and healthcare institutions [1, 2, 6].

The problem of freedom is not addressed by those therapeutic programmes that are targeted at removing symptoms (e.g. biological treatment programmes) as well as by psychosocial programmes based chiefly on a behavioural and educational approach, which focus on social training, behavioural correction and adaptation. We opt for a third solution, where freedom and activity of the *self* also belong to the objectives of therapy. From this perspective we can describe the therapeutic system that is implemented by the Community Psychiatry Unit of the Medical College of the Jagiellonian University and by the Association for the Development of Community Psychiatry and Care in Kraków.

COMMUNITY TREATMENT PROGRAMME (CTP)

An integrated community treatment programme (CTP) for people suffering from schizophrenia has been running for the last 30 years at the Psychiatry Department in Kraków, Poland. Its aims were to integrate treatment, psychotherapy and rehabilitation for patients and their families and to reach improvement in psychopathology, psychological and social competence. Three generations of psychiatrists, inspired by the ideas of late Professor Antoni Kępiński, have built a system of open psychiatry in Kraków, which is available - with no limitations - to every person who has had schizophrenia. The programme is implemented by one therapeutic team at various centres in Kraków and is based on a common concept of the illness and philosophy of treatment.

The subsequent elements of the programme are interlinked to form a continuity. It begins with the maximum dependence of a patient from institutions and therapists, and goes through intermediate phases to the phase in which the patient achieves relative independence and starts to be active and self-reliant to the greatest possible extent. The programme is implemented within the network of community centres (NCC) run by the same one team. This assures the continuity of care for each individual and allows 'person-oriented' thera-

py to be implemented within one programme. The creation of such a system is a result of concerted cooperation of many institutions and associations in our city (Fig. 1).

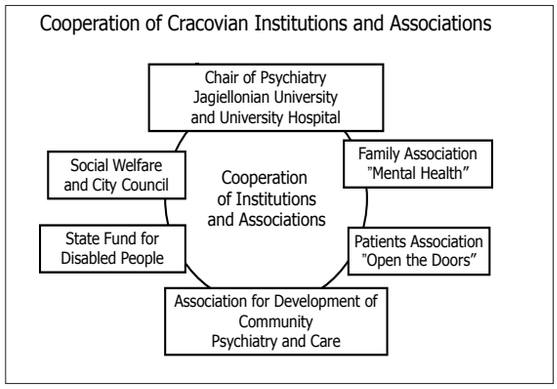

Figure 1. Cooperating institutions and associations

A significant part in the development of the programme was played by independent, non-governmental associations of families and patients, which conduct their own self-help and educational programmes with our assistance. At the same time the NGO formed by our professionals, the "Association for Development of Community Psychiatry and Care", is in charge of organising the occupational programme and running social firms in our community.

The Network of Community Centres (NCC) consists of: the Community Psychiatry Unit at the Chair of Psychiatry whose tasks include research and education, a day treatment centre with a psychotherapeutic profile, a day rehabilitation centre, an outpatient clinic, a family unit, a therapeutic hostel, occupational therapy workshops, a day centre and social firms (Fig. 2).

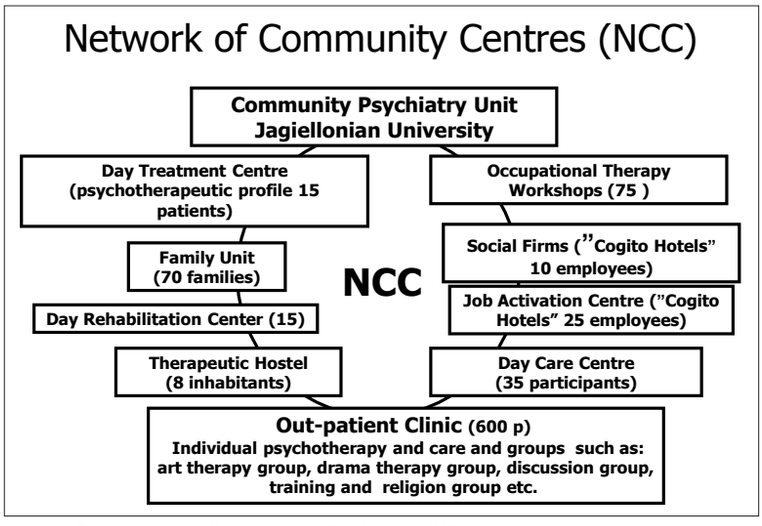

Figure 2. Network of Community Centres (NCC)

The subsequent components of the system correspond with various kinds of therapy, from psychotherapy and rehabilitation to self-help and employment on the free labour market. The degree of autonomy is reflected in the language. And so in outpatient treatment we have patients, in occupational therapy workshops, day care centres and therapeutic camps – participants, in the therapeutic hostel are residents; in the therapeutic theatre "Psyche" – actors, in the organization of former patients "Open the Doors" – members and educators, in the magazine "Dla nas" ("For Us"), which voices the opinions of patients and professionals – editors, in the special workplaces for professional activation and in the social firms (e.g. the hotel and restaurant "U Pana Cogito") - employees. The variety of roles is inscribed in the treatment programme.

The entire process of therapy, from the in-patient ward to the "U Pana Cogito" social firms, can be perceived as a process of gradual increase in a patient's own activity by utilizing the social field of the group and the emotional assimilation of the experience. In other words, therapists, therapeutic institutions and systems can either stimulate and support the process or block and hinder it. The same process can be described as a passage from a passive therapeutic environment, which is mainly to protect and support, to an active therapeutic environment, where significant therapeutic factors are present: structure, involvement, negotiations and creation of active therapeutic fields [7, 8].

Therapeutic community – the role of the group

Our treatment programme is based on working in small groups and on forming bonds within the group. The first group a patient meets is a group in his/her hospital ward. It is a place where bonds with the whole community of the ward are formed, with other patients and therapists. This is also a place where the first deeper relationship is formed, the one with the therapist managing the case;

this relationship may survive many years and serves as a basis for all the therapeutic measures and the patient's activity.

Therefore in the day ward (15 outpatients) we have a family-like atmosphere. Every day the therapeutic community meets to identify problems and discuss them. These meetings build up a culture of open communication and personal responsibility, which Penelope Campling called a 'culture of enquiry' [9]. Permanent elements of the programme include negotiations concerning pharmacotherapy, patients' own initiatives regarding individually planned treatment steps and activities undertaken by the patients' board. Since the patients are involved in the process of treatment from the very beginning, they gain a sense of capability to control both their therapy and the organisational matters in the hospital ward. The therapists' intention is that joint meetings should foster the development of a good community and provide, in an active therapeutic field, successful corrective emotional experience and social competence [9, 10].

This phase of treatment (following a psychotic crisis or preventing it) is taking place in a relatively strong field of group relationships. Support by individual therapists is required, as well as their close cooperation with family therapists. The family unit has the same location as the day ward. Family therapists and individual therapists from the day ward together visit the patients at home, conduct educational or diagnostic sessions and for 25 years have run a conjoint group for a few patients and their families. Family therapists devote one whole day for work at the day ward and hold all the meetings under the motto 'My family today and tomorrow'. The family and cooperation with the family play a pivotal role in living a life with schizophrenia as they affect the course of the illness. In Poland, nearly 80% patients live with their generational or procreational families.

For a patient, a group he/she meets when attending a form of outpatient therapy or at workplace may become the main reference point in life. We suppose there are such situations and such forms of activity which add to the "poetic density" of the common therapeutic space. Especially, they spur the motivation and activity or they create room (space) for expression. One example here are psychotherapeutic camps [11], which we have been running for 25 years now, the therapeutic theatre [12], or activities such as spreading the idea of open psychiatry in education and TV productions, preparing and coordinating the Polish nationwide campaign of the "Schizophrenia – Open the Doors" programme and organising "The Day of Solidarity with People Suffering from Schizophrenia". All these efforts are undertaken together with self-help organisations of the patients and their families and are intended to reintegrate the patient into professional life, without which he/she cannot be fully reintegrated into social life. A special part here is played by the social firms, the restaurant and the hotel "U Pana Cogito" (Fig. 3).

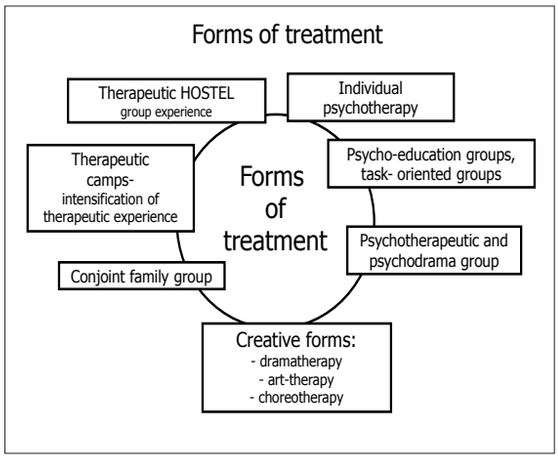

Figure 3. Forms of treatment

So, the same common goals may be achieved in various contexts. Generally our strategy consists of an appropriate, dynamic assessment of the illness and the treatment process: a good diagnosis should take into account that the illness progresses in phases and to evaluate what and in which form should be beneficial for whom and at which moment of treatment. The goal must be identified in a joint discussion and the participants should be aware of the therapeutic process. The involvement and participation of the patient are indispensable. One should also consider the patient's expectations and demystify the treatment process because treatment is to be done with the patient and not for the patient.

To illustrate our programme we chose activities that intensified the psychotherapeutic experience; therapeutic camps, dramatherapy, employment and the anti-stigma programme.

Therapeutic camps

At present we organize 4 camps per year: a hiking, horseback riding, mountain hiking and a skiing one. The description below illustrates a mountain hiking camp, where various kinds of activities, beginning with morning physical exercising and including joint preparation of meals, trips, everyday community meeting, dance parties etc. make up a day programme.

After many years of experience we perceive these camps as a great opportunity to build social bonds and increase patients' social competencies, thus having the possibility of influencing the essence of schizophrenic disturbances. Task oriented work, social training in a natural environment coupled with the use of various behavioural techniques and the inspiring creative atmosphere serve this goal well.

Despite the fact, that in our description of the camp as a method of therapy, stress is put on the behavioural side of it (goals and training), the therapeutic work is still taking place. First of all, each patient has his own individual therapist to talk to, during the camp daily community meetings concern mostly what the patients think and what they are going through. It seems any work the participants and therapists perform that is focused on a sport or task activity can be more effective if connected with the reflection on it and on the relations in the group. Sometimes the main subject in group discussions is the following future events, sometimes the undergone illness, sometimes it is just about co-operation in preparing meals. "The emphasis was always put on helping campers use individual and group initiative" says Weisman [13]. This statement is close to our personal views and our work is structured around this idea.

The increased influence of such experience as compared to other forms of therapy is also specific to a therapeutic camp. The whole individual is addressed at physical, emotional and intellectual levels through the deepening of personal relationships, group interactions and physical activities (skiing, riding, climbing, walking, swimming). The most important task for the team is to retain an 'optimal level' of intensity while keeping in mind that it remains different for each patient. If the team succeeds in this task the improvement of the patient's social competencies becomes apparent [11].

Drama therapy

The theatre group, as a part of the treatment system, is also based on the ideas of a therapeutic community. It is a task-oriented group: its task is to create a performance and to perform it in front of an audience. As for the theatrical aspect of the task, a professional guide here is the director; however, working together for about 3 years in order to prepare a play requires cooperation, negotiations and mutual help. The theatre group forms a therapeutic community which works on itself and for itself, also outside the limitations of time and space assigned for the meetings. During rehearsals, the director is the key person, teaching the actors how to play and encouraging them to experiment. Drama therapy intensifies the processes that normally occur in any therapeutic community. It engages the patient/actor in relationships at the level of cooperation with other fellow actors, in relationships between actors as performers of roles and in relationships of the presented personages [9, 12]. In this way, the feelings and behaviours of the group members are strongly intensified. The actors, in order to create a spectacle together, need to acquire a sense of safety and an ability to communicate openly. This space of intensified emotions is expressed and reflected on in the group [9]. The theatre group consists of about 25 people: patients diagnosed with schizophrenia and two or three therapists who perform with the patients. The group is led by a professional director, recently accompanied by a dance therapist. The meetings take place once a week for about 3 hours. Before spectacles for the public, additional rehearsals are held during weekends. The latest productions are *Tristan and Iseult,* and *A Midsummer Night's Dream.*

How can a patient, a person who underwent a psychotic crisis and suffers from a variety of disorders, adapt to a role and play it? The patients who join the theatre group fall into two categories, those with a dominant, developed negative syndrome, overcome by the sense of vacuousness and helplessness; and those who maintain good contact with people and who are emotionally alive but periodically experience intensified hallucinations and anxiety. Either subgroup has the same needs in theatrical therapy: encouragement, stimulation, inspiration and requirements posed to its members against the background of a strong sense of safety. The director who leads our theatre group works with the patients just as he would work with professional actors. In this way, he invokes the patients' hidden capabilities and talents and expresses his respect towards them, he does not give the poor patients a lenient treatment. Such an approach changes their role from the one of a patient into the role of an actor. The relation with the director, a professional leading a group of patients/actors, is of vital importance in the therapeutic process.

The next factor that allows the patients to strengthen their identities during the meetings of the group is the reality of the staged play. The reality of the spectacle is an intermediary reality, in the sense that, within it, the patients/actors can display their feelings and fears. They can experiment with new behaviours, they speak about the feelings of the characters they play and therefore, indirectly, about their own feelings. In this manner, they learn about themselves and others [14], and during regular rehearsals they consolidate their knowledge. Therefore the theatre group becomes an area of both psychotherapy and social training. It appears that such a combination produces more lasting results, which can subsequently be of use in everyday life.

Employment and education and their role in our anti-stigma programme

The main difficulty that resulted from the changes of the political system in Poland was the exclusion of mentally ill people from the labour market. Before the change 80% of the mentally ill people in Poland were employed. At present only 20% of them are.

The enterprise named Cogito Hotels is an undertaking based on similar models of European social firms that are managed by people who have undergone mental crises. The assumption behind such a form of activity is to act against stigmatisation of mentally ill people, giving them equal opportunities to participate in social life. The hotels provide services for tourists and organize training courses and meetings for institutions and individual clients. The hotels are a showcase project of cooperation between nongovernmental, local initiatives and governmental organisations.

Cogito Hotels are two pretty buildings with 14 rooms, a restaurant and a conference room, which are known for their friendly atmosphere. They are located close to Wawel Castle and the Market Square. This social firm has been operating since its opening, as one of the many hotels in Kraków and a part of the local hotel infrastructure. Nowadays it employs 25 people suffering from schizophrenia and seven healthy ones. In 2005 Cogito Hotels received over 2000 guests from 23 countries from all over the world, as well as 2000 inhabitants of Kraków who celebrated various family events in the restaurant. Cogito Hotels became valuable for the local community both as a social firm and as a centre of education. We try to evaluate and propagate the benefits derived from this project by employees and other people who are educated about mentally ill people and their problems, be it in an "invisible way" or in an organised way. Education in an "invisible way" means using contacts with neighbours, hotels managers and tourist who spend time in our hotel. On the other hand, Cogito Hotels, with their conference centre, developed a wide educational programme for medical students, social workers, family doctors, journalists, teachers and local authorities. We also run vocational training for 160 clients in such areas as the hotel business, catering or bicycle mechanics. Training courses for family members concentrate on solving problems and self-aid groups. During workshops, conferences and presentations, our clients and the hotel employees share their experience of illness and

work. They participate in media campaigns, speaking about their subjective experience of illness and stigma, about coping, hope and the potential for personal development.

Cogito Hotels are a social firm, but at the same time they symbolise the patients' empowerment and the dialogue between the community and individual-oriented psychiatry. This is a dialogue that stems from schizophrenia but overcomes the illness and social exclusion. [15].

The Day of Solidarity with People Suffering from Schizophrenia in Poland

This event is celebrated in every city all over Poland and organised in cooperation with local communities. During the Day of Solidarity with People Suffering from Schizophrenia there are ritual events that are held in every city; for example people going through symbolic doors at the same time in all the involved cities. The main consolidating idea is that of a good community. This event is a festival of every local community. It is celebrated on a popular street in each city's centre. The cafés and restaurants hold exhibitions of works by patients/artists and invite participants to poetry-reading sessions in the evening. The idea of solidarity is deeply rooted in the experience of Poles; it evokes images of attachment and bond. The experience of solidarity was the most important experience of the Polish nation: Solidarity proved victorious and opened up vistas of hope.

CONCLUSIONS

Therapists who work with patients suffering from schizophrenia and want to follow Manfred Bleuler and Antoni Kępiński must be able to adopt two perspectives. On the one hand, they have to be able to immerse themselves in the inner world of a patient, to accompany him/her in the illness, to accept the existent situation and to attempt to understand it. They need to make sense of experiences, to make order in the inner chaos only by their presence, which is not characterised by quick action, and by their care, which has nothing to do with the whole machinery of social engineering. On the other hand, they have to be sensitive to those phenomena that constitute the real experience of our patients and their families. They are: homelessness, unemployment, daily emptiness, loneliness, poverty in the world of consumerism, mercenary attitudes, social niches destroyed by the ever present market. They also include: lack or deterioration of social and familial bonds, sometimes even hostility and rejection, stigma, common lack of knowledge about the illness and treatment, the burden on the family and the fatigue resulting from the task of daily care for the patient, as well as burnt-out therapeutic teams. We encounter these phenomena in our community therapy every day. The outcome of the struggle with the illness depends on the skill of particular therapists, therapeutic teams and institutions, and on the extent to which they can integrate these two perspectives in a coherent action in the spirit of Antoni Kępiński and Manfred Bleuler. If they, let me repeat, can create a common space. And this is what we consider crucial in psychosocial treatment of schizophrenia.

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