Archives of Psychiatry and Psychotherapy, 2011 ; 1 : 71–80

Towards psychotherapy-oriented community psychiatry – 30 years of experiences in Kraków

Pro memoriam Professor Antoni Kępiński

Andrzej Cechnicki

Summary: The author describes a treatment and rehabilitation programme integrating persons suffering from schizophrenia and their families into Kraków life, which was inspired by the thought of Antoni Kępiński for more than 30 years. The essence of this programme, described as "Live, treat oneself, reside and work in the local community", is the psychotherapeutic approach implemented in a community context. It has been recognized and in 2007 was awarded the Pro Publico Bono prize for best citizenry work.

schizophrenia, person-oriented psychiatry

MOTTO: "Ethos" is, among other things, a place where a living creature "settled down", a place "it domesticated", their natural place of stay, where they feel safe and does not find it necessary to hide. A man, as all living creatures, continues to search for his "ethos" − a place of settlement and a circle of familiarity. J. Tischner [1]

In this description of psychotherapy-oriented community psychiatry I will use the example of a comprehensive "Schizophrenia Treatment and Rehabilitation Programme" implemented in Kraków, which is a solution to which I and many of my colleagues have devoted all our professional lives. Therefore, they have become co-authors of this work, which could have been created only on the basis of close relationships in our therapeutic team and intellectual community of our environment. It seems to us that over the years we have preserved basic values and standards we associated with this approach, even when we enter new areas of conflict created by economics, and the "budget" [2], which seems to be the defining word above all. Undoubtedly, thinking and acting within the budget means some progress. It introduces transparency. One knows the available means, knows what can be planned and managed. All of us have become small economists. This is not a mistake, because we have become realistic, we've stopped dreaming and complaining. The budget has only one disadvantage: every year it is smaller and smaller! How should we approach that issue? Discussions on this topic lead us, whether we want it to or not, to the central question of the necessities. Since, year after year, the funds at our disposal are decreasing, what is absolutely necessary? The practical dimension of this problem is manifested in the following solutions: should we employ a doctor or a psychologist? Naturally, a doctor, since a doctor can also take duty shifts. Should we employ a nurse or an ergotherapist? Naturally, a nurse, since provision of good care is by no means more important than therapeutic classes, etc etc. If this process continues, we may end up again having the two professional groups which have always been necessary, that is doctors and nurses. In the end, the necessary approach will turn out to be the medical

Andrzej Cechnicki: Community Psychiatry Unit, Chair of Psychiatry, Jagiellonian University Medical College, Society for the Development of Psychiatry and Community Care, Kraków, Poland. Correspondence address: Andrzej Cechnicki, Community Psychiatry Unit, Jagiellonian University Medical College, Society for the Development of Psychiatry and Community Care, 2/8 Sikorskiego Sq., 31-115 Kraków, Poland. E- mail: mzcechni@cyf-kr.edu.pl

approach. We, who were formed by the tradition of Antoni Kępiński, when faced with a question of "necessity", refer to the very essence, the specifics of psychiatry, that is the medical-social approach. In this case we need to consider the following elements as necessary:

- Developing relations with the patient and family,
- Sensitivity of perception and reflection,
- Building a feeling of safety, trust and security,
- Carefully discovering the relations between the disease and biography,
- Efforts to find and prepare an individual path of return from the disease to life,
- All of the above must happen in an environment which provides time and space for changes, which a man cannot make in the period of three months.

Consequently, this "extra", endangered by reduction, far from the biological core of our profession, is what is really necessary. Certainly, now is the moment to realise again what the values and norms of our profession are. Therefore, today we must undertake a critical assessment of, and counteract the tendencies to:

- Reducing the complexity of psychiatric theory and practice and focus on the biological aspect.
- Aggressive promotion of the efficiency rule, which contributes to reducing everything to what is measureable.
- Creating an atmosphere of hurrying which poses a threat to the psychiatric treatment culture.
- Limiting the activity of psychiatric clinics and hospitals to what is curable and promising, which results in removing the chronically ill from the scope of their responsibility.

On psychotherapy-oriented community psychiatry in Kraków

When we think about the roots of psychotherapy-oriented community psychiatry, we come back to the intellectual and spiritual heritage of Antoni Kępiński [3, 4].

Antoni Kępiński, similarly to Manfed Bleuler [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 development possibilities make up the effect directed at the core of the illness, because it fosters the harmonization of internal splitting. Therefore our task is to introduce the patients suffering from schizophrenia to "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 hospital.

The development of an integrated system and programme, treatment and rehabilitation for persons suffering from schizophrenia and their families has more than 30 years of tradition with the Kraków Chair of Psychiatry [3, 6, 7]. Three generations of psychiatrists inspired by the thought of Antoni Kępiński have created, over a period of years, a network of interconnected community institutions. This system has a diversified therapeutic programme, oriented towards the needs of the ill person, available without any limitations to such a person and their family. In 1976, a team of therapists who had previously worked at a closed ward of "first episode" treatment, made 200 house calls in order to understand better their own patients and their families. Understanding, and thereby also treatment, has gained a broader family context and was soon to extend to a number of aspects of living with this disease. The first step involved the establishment of day-patient psychotherapeutic groups, a combined family group, which for thirty three years meets every Wednesday, gathering patients and their families [8, 9, 10]. Also the hostel and therapeutic camps [11, 12] can boast of a comparative history – more than thirty years of tradition. The round-the-clock ward stopped to be the only place where the disease is treated, and the assistance for many patients has been extended to

their entire life. It has been a consistently implemented task and the vision consistently followed by community psychiatry based on the reformation movement from 1970s. Many members of our team are lucky to have worked on it from its very beginning. The final aim was to create an integrated, comprehensive programme of treatment for persons suffering from schizophrenia and their families and a network of multi-functional centres, which form one system enabling programme implementation. Today it comprises 12 institutions, 60 therapists – doctors, psychologists, educators, occupational therapists, nurses, physicians, a priest, a theatre director, a painter and social workers, as well as 43 beneficiaries (former patients) employed in various elements of the system, but connected by common understanding of psychosis, tasks – also of educational and research nature – and supervision. Treatment coordination and continuity is secured by the university Community Psychiatry Unit and by the Management Board of the Society for the Development of Psychiatry and Community care, associated with the former by personal unions. Recently, apart from the entire model [6, 7], its theoretical assumptions and phenomena accompanying its development [2, 15, 16, 17, 18, 19], the following issues were described: the importance of individual and group psychotherapy [20, 21], social training [22], day ward [23], the importance of cooperation with families [24] the role of theatre-therapy and the healing theatre [25, 26, 27, 28], the issue of rehabilitation and professional integration in a broad scope, as well as counteracting exclusion from social life [29, 30, 31, 32, 33], to list just a few examples which illustrate the complexity of the phenomenon which is the construction of such a treatment system and programme.

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.

The essence of such psychotherapy-oriented community psychiatry is the use of four factors which have a major importance for obtaining favourable changes [34, 35, 36, 38, 39, 40].

1. Explanation – means extending the understanding of the problem and its significant internal and external conditions
2. Getting by – active assistance in fighting the problem, both by support and active provision of social competencies
3. Problem updates and resource activation – to activate new models of experiencing and acting, alternative solutions, it is necessary to actively search for resources at all stages of therapy
4. Good, positive, stable over time – i.e. ensuring continuity – therapeutic relationship is the best documented element of effective therapy

Eventually, a significant aspect of a person-oriented treatment programme are activities which aim to restore the due place of the persons suffering from schizophrenia in their local communities, including them to the broadest extent possible to the social life and counteracting stigmatization and exclusion [30, 31, 32, 36].

Treatment model – cooperation of institutions, centres and therapeutic teams

In order to create a custom-made psychosis treatment and rehabilitation programme, we established cooperation of institutions from the field of science, education and treatment: on one hand we have the university centres of the Chair of Psychiatry of the Medical College, the University Psychiatric Hospital for Adults, which comprises two day wards, and a non-public "Medinorm" unit providing care to day patients, while on the other hand we have social security structures and institutions promoting employment financed by the State Fund for the Disabled Peo-

ple. We have managed to develop close cooperation of three non-governmental organisations: of Patients, Families and Professionals, ensuring integration, continuous care and control of quality of services provided within the system. This multi-lateral perspective, frequently referred to as trialogue, is reinforced by close cooperation

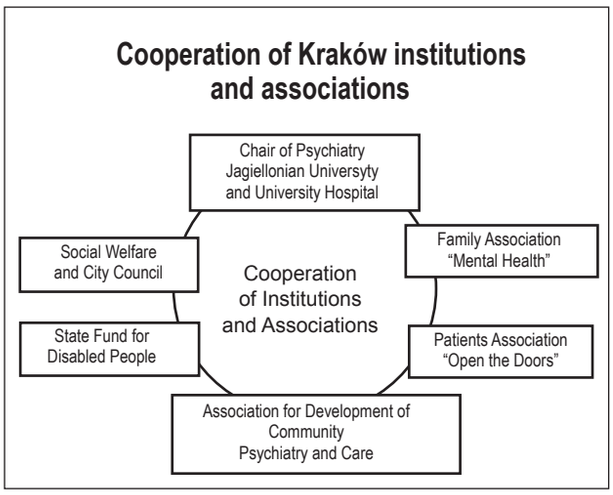

Figure 1. Cooperating institutions and associations

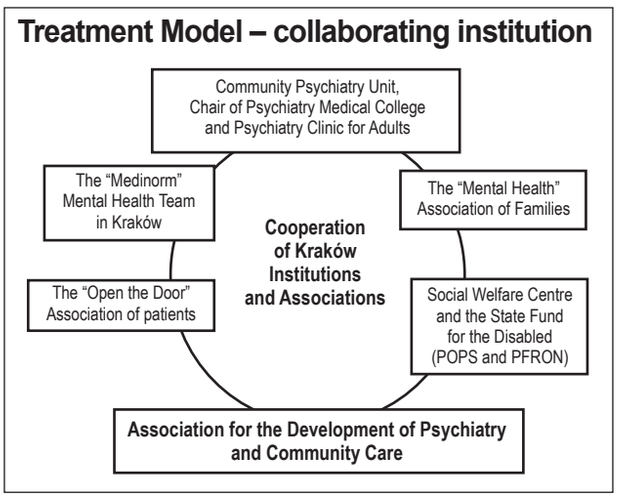

Figure 2. Community model of schizophrenia treatment in Kraków – collaborating institutions

with the local government at the level of a commune (Fig. 1 and 2).

On the basis of this institutional collaboration, we have built an entire system of closely cooperating community institutions combined into a common network, located in the city centre and thus easily accessible and open to all patients (Fig. 3 and 4).

The Community Psychiatry Unit at the Chair of Psychiatry in cooperation with the Society for the Development of Psychiatry and Community Care developed a treatment and rehabilitation programme for persons suffering from schizophrenia, including those with recurring and less favourable medical history, which gives them a chance for professional rehabilitation and participation in the social life. The city map includes several addresses well-known to all patients and their families. They are: A Psychotherapeutic and Rehabilitation Day Wards, Family Unit, a Therapeutic Hostel (protected flat), group flats, Outpatient Clinic from Psychosis Therapy and Rehabilitation, Occupational Therapy Workshop, Job Activation Centre and a Social Company "U Pana Cogito Hotels and Restaurant", Community Self-Assistance House, Senior Centre. All those centres have a "family atmosphere" irrespectively of the fact whether they are financed

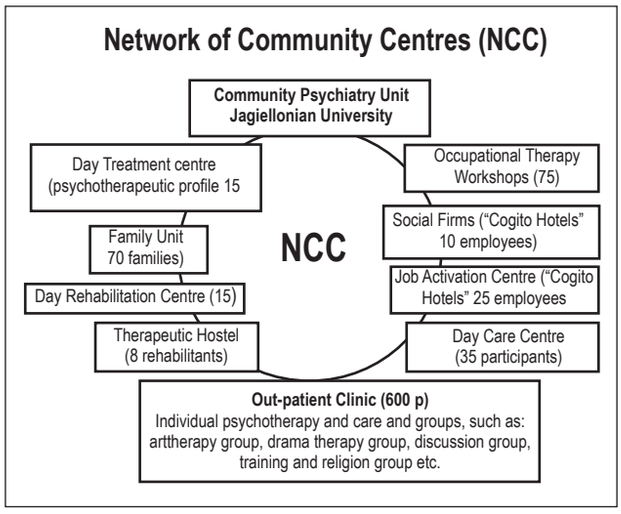

Figure 3. Network of Community Centres (NCC)

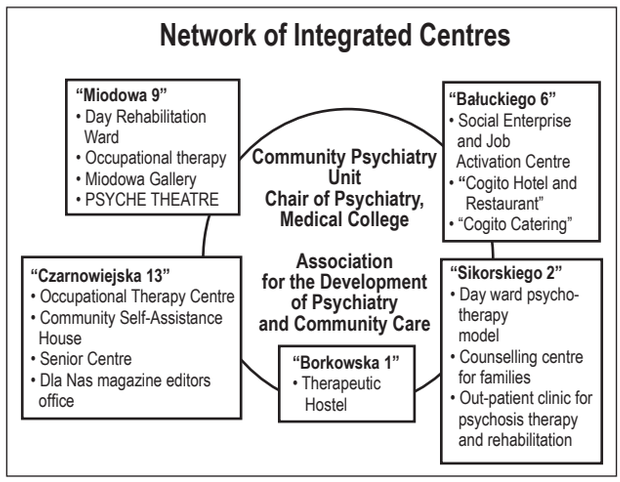

Figure 4. Network of centres integrated in the system of asistance for patients with schizophrenia in Kraków

by the health fund, welfare institutions or the state fund for rehabilitation. Teams working in those centres and patients treated there cooperate closely with each other. Treatment and rehabilitation is free of charge. The selection of a centre where the patient will continue the treatment depends on the arrangements between the therapeutic team, the patient and his family. This is how we create space for psychiatry oriented towards a person and their needs [34, 35, 36, 37, 41], we create the culture of common life, cooperation, negotiations and agreements, inclusion of therapists and care providers into the responsibility for the fate shared with the ill persons and their family.

When a patient leaves a psychiatric ward, he is not the only one who needs assistance to continue the treatment: it is necessary to include the families into the cooperation. Many ill persons will require training and education to regain their lost job, live independently or with little support of their care takers. Most patients need assistance and support in organising their free time. Therefore, the rehabilitation programme includes various areas of treatment and assistance (Fig. 5).

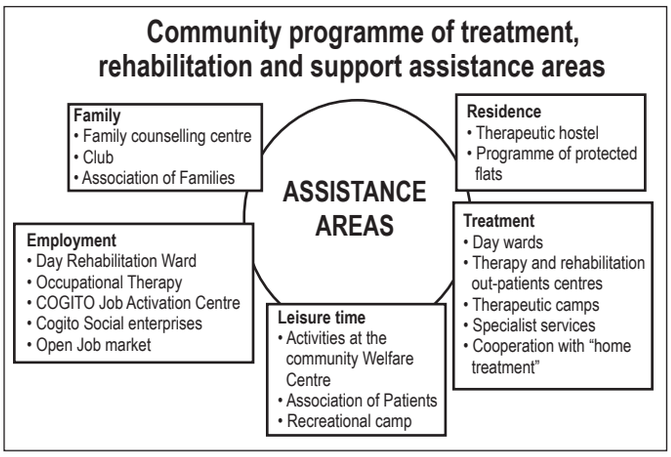

Figure 5. Community treatment, rehabilitation and support programme – assistance areas

Apart from stability, accessibility and experience of the therapeutic team, the diversity of therapeutic offer guarantees that the treatment and psychotherapy, rehabilitation and support will be properly directed on various stages of the disease and will form a mutually supplementing programme which meets both the needs of a patient and their family. This allows for gaining fuller knowledge on the disease and ways of dealing with crisis situations, preventing relapses, acquiring broader social competences and life skills which enable increased independence, co-responsibility and true pursuit of partnership in recognition of the huge own contribution of patients and their families into the treatment process (Fig.6).

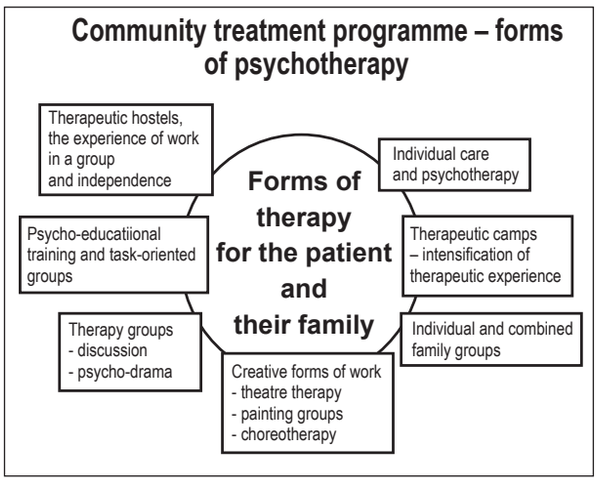

Figure 6. Community programme – forms of therapeutic work with the patient and family

The process which enables patients to express themselves and regain their own activeness takes place by stimulating their curiosity, increasing competence and building the sense of belonging to a group. Undoubtedly, everything starts with motivation, when we obtain a patient for cooperation and when we lose in this common activity. Our entire treatment programme is built on work in small groups and building bonds in the group. We believe that some forms of activity result in specific tightening of the "common space", they particularly stimulate own motivation, own activeness or they create space for expression. They include psychotherapeutic camps we have been organising for years, as well as common activities, such as: Saving the day ward and hospital administration from privatization, promoting the idea of open psychiatry, running joint educational activities, making TV films, publishing *Dla Nas* journal, therapeutic theatre, "Miodowa" Gallery, Programme of Solidarity with Mentally Ill and "Cogito hotels", with their philosophy or doing tasks and facing one's fate directly, numerous ideas and projects and

hope spreading all over Poland. While establishing a custom-made treatment and rehabilitation programme which meets the requirements and capacities of a patient, we rely on several basic rules:

1. **Integration**, which involves comprehensive application of biological treatment, psychotherapeutic and psychosocial impacts.
2. **Pursuit of partnership:** at every stage it is necessary to refer to *cooperat*ion on the basis of the assumption that one cannot treat and rehabilitate a patient without his active *participation* and *assistance provided to the entire family*.
3. **Versatility** of impacts on order to introduce favourable changes to various areas of professional, family, social and civic life.
4. **Optimum stimulation** which assumes that both excessive and insufficient stimulation, i.e. the shortage of stimuli, monotony of events, are harmful for the patient.
5. **Gradation of difficulty, "step by step":** This principle is applied to all forms of impact in connection with impairment of adaptation capacity, and in particular social adaptation in all patients with mental disorders.
6. **Repeatability of impact:** Results from the necessity to strengthen the acquired skills and the need to prevent relapses.

Following the discharge from an in-patient ward, in an day ward or in various out-patient groups patients come across the focus on "education", not only psycho-education aimed to widen the knowledge on the disease, treatment and preventing a relapse, but also broadly understood professional education, with the increasing importance of the "social competencies training" and the therapists attention focused on the "social network" with its roots in the local environment (Fig. 7).

Social competencies trainings must take into account individual capacities and start with low level of requirements providing at the same time significant assistance of therapists, and then gradually decrease the therapists' role and transfer the training experiences into natural life situations, job training, etc. Along with the development of social psychiatry, many treatment programmes started to put more emphasis on education and not on treatment – they focus on developing skills and training, and not on integrating the "I" processes, on therapeutic environment with its roots in the society, and not a hospital with its specific culture.

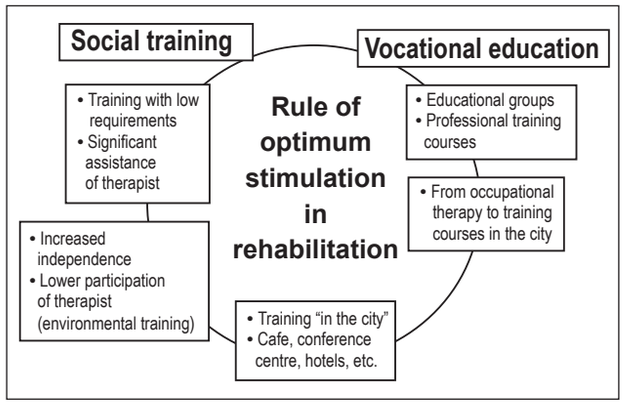

Figure 7. The principle of optimum stimulation in rehabilitation

Autonomy-oriented therapeutic programmes

From the clinical perspective, which is our point of view, the aim is to cause that a patient suffering from schizophrenia, who has little chance of breaking, once and for all, relationships with treatment institutions, could have the experience of the biggest "autonomy" and "independence" in relations with a therapist/ treatment institutions/ as well as with social environment. A chance to obtain those goals appears within those therapeutic programmes for which the category of "freedom" – or to use more common words – patient's "own activity" is equally important as the category of "health". Consequently, patient's freedom must also be the objective of therapy.

Practically speaking, each phase of the therapy and each of its forms may and should be analysed from this perspective. In this way we obtain a continuum, starting from the maximum dependence of the patient on therapist/institution/system and the therapist/institution taking over almost all functions of the patient's Ego – through intermediate stages – to a situation where the patient is in control over Ego functions, obtains the optimum distance to therapists and treatment institutions for a specific situation. Therefore, in this case, the *differentia specifica*, the differentiating category, is the approach to the phenomena of "freedom", "own activity" as well as "closeness and distance" from two interweaving perspectives: that of a patient and

that of a therapist. Patients suffering from schizophrenia frequently long for "freedom" or even find it in their own schizophrenic world, breaking relations with social reality and life situation in which they exist. At the moment of hospitalisation, they articulate the problem of "freedom". In the most basic way: they experience the dependence they want to object, but they are usually afraid to enforce their objection, because the therapist/institution/system have at their disposal the entire clearly exposed apparatus of power. The problem of "freedom" is disregarded both in therapy programmes targeted at removing the symptoms (e.g. in the biological treatment programmes), as well as in psycho-social-biological programmes with dominance of behavioural-educational approach, where the emphasis is put only on social training, behaviour adjustment and adaptation. We are in favour of the third perspective in which "freedom" – own activity of "I" is also an objective of therapy.

Subsequent elements of the system correspond to various organisational forms, from psychotherapeutic and rehabilitation ones to self-aid and organisation of employment on the open job market. The degree of autonomy is included in the language. On day wards we have „patients" at Occupational Therapy Workshop, at the Community Self-Assistance House and therapy camps we have "participants", in a therapeutic hostel we have "residents", in the "Psyche"-treating theatre we have actors, in the ex-patient organization "Open the Door" we have the Association members, educators, in the "Dla Nas" magazine which is a Forum for Patients and Professionals we have journalists, in the area of professional integration – in ZAZ and Social Company, i.e. "U Pana Cogito Hotels and Restaurant" we have employees. The diversity of roles is assumed by the treatment programme.

The entire process of therapy, from an in-patient ward to social enterprises, "U Pana Cogito Hotels and Restaurant" one may see the issue of gradual increase of the "I" activity through the use of the social area of a group and emotional assimilation of new experiences. In other words, therapists, therapy institutions and therapy systems may stimulate and support this process, or block and hinder it. This path may be also described as a passage from "passive" therapeutic environment which provides mostly "protection" and "support" to the "active" therapeutic environment in which the significant therapeutic factors become the structure, inclusion, creating an active therapeutic area, negotiations [38, 39, 40].

However, the systemic solutions are not a substitute for free choice each therapist has to face and which is manifested in the relationship with a patient from the very beginning of the treatment process. Either we take the patient's freedom away together with his illness, or the purpose of therapy is also – apart decreasing or removing symptoms – to maintain the "freedom" of patients as a basic value which enriches their lives and gives it meaning.

TWO CASE STUDIES

Community psychiatry involves years of treatment and community support. A symbol of this life-long struggle with the disease is the philosophy of "U Pana Cogito Hotels" and the "Programme of Solidarity with the Mentally Ill". With the use of those two examples, I would like to introduce the idea and practice of community psychiatry.

"U Pana Cogito Hotels" as a work place and centre of education on person-oriented psychiatry

Social companies "U Pana Cogito" Hotels are model projects which combine a lot of important, diverse elements of a stigmatization prevention programme. As the Job Activity Centre (one part) and a social enterprise (second part) they belong to one of many Kraków's hotels and form an integral part of the city hotel infrastructure. They employed 25 persons suffering from schizophrenia and 8 healthy employees. The project coordinator is the Society for the Development of Psychiatry and Community Care. In 2005, "U Pana Cogito Hotels" hosted 2,500 guests from 43 countries from all over the world (occupancy 76%), while another 2,000 inhabitants of Kraków visited the hotel while participating in various forms of family events organized at the hotel restaurant. We try to identify, assess and promote the benefits stemming from the project from the employees and other

groups of people who are educated in this "invisible way" about schizophrenia and the capacities and talents of people suffering from this disease. "U Pana Cogito Hotels", operating as a social enterprise, has become a significant culture-creating institution for the local community of the district and Kraków. This image is strengthened by the fact that apart from providing accommodation for tourists, the Society and the Community Psychiatry Unit of the Medical College run an extensive educational programme at the Conference Room of "U Pana Cogito Hotels". The participants of seminars and training which take place there, another 2,000 per year, are medicine students, social workers, family physicians, journalists, teachers and representatives of local self-government. The hotels, visited by numerous study groups from abroad and the media, promote knowledge about mental diseases, people suffering from them, person-oriented psychiatry, have become a showcase for this sensitive face of the city, basing on the tradition of Kępiński and Tischner.

"U Pana Cogito Hotels" are social enterprises, culture-building institutions, but they also have a symbolic dimension. What is the meaning of this symbol? In Poland they symbolise the process of regaining patients' influence on their own life, strengthening them in the process of healing. They build the culture of dialog between the local community and need-oriented psychiatry. They create a dialogue devoted to schizophrenia, overcoming diseases and facilitation of social integration.

Programme against Stigmatization and Exclusion – "Let's Open the Door"; Programme of Solidarity with the Mentally Ill

The most important event in the social, political and media campaign for the persons suffering from schizophrenia in Poland are the annual Days of Solidarity with the Mentally Ill organized within the programme Against Stigmatization and Exclusion "Let's Open the Door". They have taken place since 2000 in all large cities all over the country in cooperation with local community. Both the broader social-cultural aspect of this event, as well as its educational meaning are of importance. In order to make the "Let's Open the Door" Programme credible, apart from educational activities, it had to include positive examples of treatment and overcoming the disease. Therefore, apart from education of selected groups in Poland, the activities also included promotion of positive examples of treatment and overcoming the disease. In our country, at the current stage of unfinished reform of psychiatric care, the association of education performed via the Programme with promotion of valuable activities of community psychiatry was a necessary condition for credibility of the programme itself.

The main uniting idea was the idea of a "good community". The events are a holiday for the local community. The favourite street in a city, a frequently visited one, invites everyone for a common feast. Cafes, restaurants, present exhibitions of patients' and artists' works, they organize poetry evenings and theatre performances. We award the prize "An entrepreneur with a face" to businessmen who create the biggest number of workplaces for our patients in a given year. The symbolism of "Solidarity" is strongly rooted in the experiences which refer to interpersonal bonds, to the most important experience of our nation, in which human solidarity was the victorious power and opened space for hope.

Social psychiatry is common education. The media here has a huge role to play. Educational films (10 commandments of community psychiatry – about getting better, work, family, faith, to community psychiatry itself) made together with our patients by a Kraków's local public TV station, tell the story of a difficult experience of this disease, searching for the sense of psychotic episodes, regaining influence on the course of therapy and its "co-authorship". They also tell about the social reception of schizophrenia, they point that the diagnosis often sounds "like a verdict, as a lost fate, being pushed into the abyss". By uncovering their face, resignation from anonymity, taking up the public mission, participation in the "Open the Door" programme, running common, countrywide education and showing the path to therapeutic dialogue, they show the huge potential hidden in the postulated "treatment co-authorship". They are like Arnild Lauveng's books – a message of hope, of a won battle with schizophrenia [41].

THE IMPORTANT ELEMENTS OF PSYCHO-SOCIAL TREATMENT OF SCHIZOPHRENIA

The basic rule of treatment and rehabilitation in social psychiatry involves the inclusion of the entire surrounding world into cooperation. This pertains to the family, partners, persons living with the patient, work environment, but also taking into account the person's situation, e.g. the unemployment that has affected our patient. Therefore, social psychiatry takes into account more than just brains and a single person, but the entire social micro-system.

Therapists who work with patients suffering from schizophrenia and want to follow Manfred Bleuler and Antoni Kępinski 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, the stigma, the 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.

In recognition of this programme inspired by Antoni Kępiński, integrating people suffering from schizophrenia into Kraków life; for writing with them "a common life story" and not only "a medical history"; for the programme we called "Live, treat, reside and work in a local community", our organisations were awarded the Pro Publico Bono prize for the best civic work of 2007.

REFERENCES

1. Tischner J. Myślenie według wartości. Kraków: Społeczny Instytut Wydawniczy Znak; 1982: 399.
2. Cechnicki A. Refleksja nad psychiatrią społeczną w krakowskiej Klinice – przeszłość i teraźniejszość. Dialog. 2001; 11: 97–100.
3. Kępiński A. Schizofrenia. Kraków: Wydawnictwo Literackie; 1972.
4. Kępiński A. Poznanie chorego. Kraków: PZWL; 1978.
5. Bleuler M. Schizophrenie als besondere Entwicklung. In: Doerner K, editor. Neue Praxis braucht neue Theorie. Guttersloh: Verlag Jakob van Hoddis. 1986
6. Barbaro B, Cechnicki A, Zawadzka K, Zadęcki J. Model terapii i rehabilitacji w schizofrenii. Psychoterapia. 1979; (28): 6–10.
7. Cechnicki A, Bielańska A. A community treatment programme for people in Krakow suffering from schizophrenia. In: Therapeutic Communities for Psychosis. London and New York: Routledge. 2008.
8. Zawadzka K, Cechnicki A, Barbaro B. Die Rolle des Haubensuches im Betreungsmodel von Familien schizophreniekranke Patienten in Kraków, Psychiatrische Praxis. 1988; 15: 30–33.
9. Zadęcki J, Cechnicki A, Drozdowski P, Kurgan A, Zawadzka K. Terapia bifokalna w leczeniu schizofrenii. Bilans dwuletnich doświadczeń z grup rodzinnych, Psychoterapia. 1979; 28: 21–29.
10. Bogacz J, Cechnicki A. Gesellschaftliches Leben und die Welt der Bedeutungen, in: Zeitschrift fur systemische Therapie und Beratung. Marburger MICS. 2007; 1: 5–9.
11. Barbaro B, Cechnicki A, Konieczko B, Ostrowska I, Zadęcki J, Zawadzka K. Hostel jako forma pozaszpitalnej terapii chorych na schizofrenię. Psychoterapia. 1979; 28: 32–37.
12. Zadęcki J, Cechnicki A. Uwagi w sprawie mieszkań terapeutycznych (hosteli) w Polsce. Doświadczenia krakowskie, Biuletyn Instytutu Psychiatrii. 1985; 1–2.
13. Cechnicki A, Datka J, Hanik B, Hodura E, Zadęcki J, Zawadzka K. Obóz leczniczo-rehabilitacyjny dla chorych na schizofrenię, Psychoterapia. 1979; 28: 38–42.
14. Cechnicki A, Bielańska A, Walczewski K, Therapeutic camp as a part of an integrated community programme for schizophrenic patients. In: Therapeutic Communities - The Interna-

tional Journal for Therapeutic and Supportive Organizations. 1999; 2(20): 103–117.

15. Zadęcki J, Cechnicki A. Problematyka wartości w schizofrenii, Zdrowie Psychiczne. 1983; 1: 57–62.
16. Cechnicki A. Uwagi o modelu podatności na zranienie w schizofrenii, Psychoterapia. 1990; 3: 39–48.
17. Cechnicki A. Wybrane aspekty leczenia schizofrenii. Psychoterapia, 1992; 2: 27–37.
18. Cechnicki A. Co jest istotne w psychospołecznym leczeniu schizofrenii, In: Schizofrenia. Różne konteksty, różne terapie. Kraków: Biblioteka Psychiatrii Polskiej. 2000; 37–47.
19. Barbaro B, Cechnicki A, Możliwość ograniczenia hospitalizacji psychiatrycznej z perspektywy psychiatrii społecznej". Psychiatria Polska. 1992; 1-2: 155–159.
20. Bielańska A. Psychoterapia indywidualna osób z diagnozą schizofrenii, Psychoterapia. 2006; 3(138): 75–86.
21. Bielańska A, Cechnicki A. Psychoterapia grupowa w leczeniu schizofrenii, in: Schizofrenia. Różne konteksty, różne terapie. Kraków: Biblioteka Psychiatrii Polskiej. 2004. p. 139–150.
22. Cechnicki A, Bielańska A, Drożdżowicz L. Rola treningu społecznych umiejętności w systemie leczenia chorych na schizofrenię. Psychoterapia. 1986; 4: 17–28.
23. Cechnicki A. Dziesięć lat oddziału dziennego dla chorych na schizofrenię – opis programu terapeutycznego. Psychoterapia. 1992; 2: 3–17.
24. Barbaro B, Ostoja-Zawadzka K, Cechnicki A. Możesz pomóc. Poradnik dla rodzin pacjentów chorych na schizofrenię i zaburzenia schizotypowe. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2005.
25. Bielańska A, Cechnicki A, Rogoż K. Dramaterapia, jako forma rehabilitacji chorych na schizofrenię. Doświadczenia własne, Psychoterapia. 1986; 4: 25–30.
26. Cechnicki A, Bielańska A, Budzyna-Dawidowski P. Drama Therapy as a Means of Rehabilitation for Schizophrenic Patients: Our Impressions. Am J Psychother. 1991; 4: 566–575.
27. Bielańska A, Cechnicki A, Drama Therapy in a Community Treatment Programme. In: Gale J, et al, editors. Therapeutic Communities for Psychosis. London: Routledge; 2008. p. 223–24.
28. Bielańska A. Teatr, który leczy. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2002.
29. Cechnicki A, Kaszyński H. Programy rehabilitacji zawodowej i pracy dla osób chorych na schizofrenię – rozwiązania krakowskie. Postępy Psychiatrii i Neurologii. 2000; 9: 427–434.
30. Cechnicki A. Pozytywna kampania edukacyjna. Bilans czterech lat polskiego programu „Schizofrenia – Otwórzcie Drzwi", in: Schizofrenia. Różne konteksty, różne terapie. Kraków: Biblioteka Psychiatrii Polskiej. 2000: 157–169.
31. Cechnicki A, Bielańska A. Przeciwdziałanie wykluczeniu i marginalizacji osób chorujących psychicznie. In: Duda M, Gulla B, editors. Przeciw wykluczeniu społecznemu, Kraków: Wydawnictwo Naukowe PAT; 2008. p. 99–121.
32. Cechnicki A, Kaszyński H. Przyszłość pracy dla osób chorych psychicznie. In: Cechnicki A, Bomba J, editors. Schizofrenia: różne konteksty, różne terapie. Kraków: Biblioteka Psychiatrii Polskiej; 2004. p. 3.
33. Kaszyński H, Cechnicki A. Integracja zawodowa osób chorujących psychicznie w Polsce w perspektywie uchwalenia Narodowego Programu Ochrony Zdrowia Psychicznego, Psychiatria po Dyplomie. 2007; Wydanie specjalne: 36–41.
34. Cullberg J. Therapie der Psychosen. Ein interdisziplinaeren Ansatz. Bonn: Psychiatrie –Verlag. 2008.
35. Ciompi, L. Wie koennen wir die Schizophrenen besser behandeln? Eine Synthese neuer Krankheits- und Therapiekonzepte, Der Nervenarzt. 1981; 52: 506–515.
36. Amering M, Krausz M, Katschnig. Hoffnung Macht Sinn. Wien: Facultas Verlags; 2008.
37. Alanen Y. Schizofrenia. Jej przyczyny i leczenie dostosowane do potrzeb. Warszawa: Instytut Psychiatrii i Neurologii; 2000.
38. Gunderson JG. Functions of milieu therapy. Psychotherapy of Schizophrenia. Proceedings of the 6th International Symposium on the Psychotherapy of Schizophrenia, Lausanne; 1978.
39. Gunderson, JG, Carroll A. Klinische probleme im Lichte empirischer Forschung. In Stierlin H, Wynne LC, Wirsching M, editors. Psychotherapie und Sozialtherapie der Schizophrenie. Berlin: Springer-Verlag; 1985.
40. Washburn S, Conrad M. Organization of the therapeutic milieu in the partial hospital. In: Luber RF, editor. Partial Hospitalization. A Current Perspective. New York: Plenum Press; 1979.
41. Lauveng A. Byłam po drugiej stronie lustra. Wygrana walka ze schizofrenią. Sopot: Smak Słowa; 2008.