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Katarzyna Kotlarska, Paweł Smyk, Irena Najbar

THE DAY THERAPY AND REHABILITATION PSYCHIATRIC WARD AT THE BABIŃSKI UNIVERSITY HOSPITAL IN KRAKOW

Dr. Józef Babiński University Hospital in Krakow

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Summary

The article presents the therapy programme of the Day Therapy and Rehabilitation Treatment Unit, which is a part of the Babiński University Hospital in Krakow. The basic ideas of the clinical work of the ward, its structure, and the profile of admitted patients are presented. The described day care ward stands out from other psychiatric rehabilitation facilities, thanks to having a psychotherapeutic attitude, rather than using a strictly medical model, which results in an individual and group psychotherapy offer addressed to all patients. The therapeutic approach is adopted taking into account three directions in treatment: from interpretation to intersubjectivity, from intrapsychic to interpersonal attitude, and from the psychology of one person to the psychology of two people or even a network of people. The article describes the eclectic therapy and rehabilitation model used in the ward, the process of qualifying patients for treatment, as well as the variety of therapeutic activities. Several elements of the therapy programme have been presented: the model of psychiatric rehabilitation based on the principles of the therapeutic community, the model of individual and group psychotherapy, the multitude of other group activities, including occupational therapy, psychoeducation, and social skills training, as well as including the mentalization approach in the therapeutic process.

The article presents the Day Therapy and Rehabilitation Psychiatric Ward, which is part of the Babiński University Hospital. Founded in 1976, it was initially located on Limanowskiego Street in Cracow and together with the Club of Non-Professional Artists was the first institution in Cracow providing day psychiatric care. In 2000, the ward was moved to the Babiński University Hospital and since October 2016 up to the present day, it has been based in the building located on the outskirts of the Hospital – the so-called 'Little White House.' For over 40 years of its activity, the ward has evolved and undergone several changes in the concepts lying behind psychiatric rehabilitation, working methods and the profile of admitted patients, to become today's ward of psychiatric rehabilitation with a psychotherapeutic approach, addressed primarily to patients in early disease stages. This article aims to present working methods adopted by the ward, with particular emphasis on the applied therapeutic model.

The basic idea behind the working methods of the described ward is a departure from a typical medical treatment model which is focused mainly on pharmacological treatment, in favour of psychotherapy and other therapeutic interventions (described later in the text), with special emphasis on the therapeutic community, proven to be a highly effective approach. The ward works in close cooperation with other Hospital units, primarily locked wards, providing patients with access to psychiatric rehabilitation on a daily basis. Moreover, the ward's unique location – within the hospital but off the beaten track, in the middle of nature – makes the ward a place where therapeutic, recovery-oriented ideas can come to fruition. The location of the ward – right at the exit from the hospital – symbolises the aim of the ward staff to support patients in their socialization and self-empowerment process and to help them return to functioning in the world outside psychiatric institutions.

Practical implementation of integration ideas in the therapeutic team

One of the distinctive features of the ward is its integrative psychotherapeutic approach applied by all its staff. The ward employs two medical doctors (in the past, three physicians worked in the ward), three psychologists, two nurses, and one occupational therapist. Working together, the staff have tested how different trends in psychotherapy can complement each other. All psychologists and physicians have specialist training in psychotherapy. However, they represent different approaches, *i.e.* cognitive-behavioural, psychodynamic, humanistic, systemic, and integrative therapy. This conglomeration of various theoretical approaches, ways of understanding disorder mechanisms and interaction methods, does not cause disputes within the team but rather provides a platform for dialogue and contributes to an atmosphere of openness and mutual learning.

Recently, the psychotherapeutic world displays the trend to integrate various therapeutic approaches, which results from noticing the limitations of applying and adhering to only one approach [1]. One example of such a trend is an attempt undertaken by Paul Wachtel [2] to synthesise psychoanalysis and a cognitive-behavioural approach. The experience gained over several years of our ward's work shows that parallel integration of various therapeutic approaches coupled with the integration of different forms of psychotherapy [3] may also bring benefits, both to patients and therapists. Weekly staff meetings and regular supervision allow the team members to exchange ideas, talk about patients' problems and share individual theoretical perspectives, which broadens the understanding of patients' issues, enables the staff to develop a more holistic picture of the patients' difficulties, often facilitates breaking the impasse in therapy and allows therapists to enhance their skills.

Working in a team, particularly a team that aims to implement the integration idea, it is necessary to communicate diagnoses and clinical hypotheses in a precise and clear way. However, despite a lot of experience gained by working as an interdisciplinary team combining different

approaches, the intricacies characteristic to each therapeutic school are still best known only to those therapists that specialise in them. This certainly slows down the communication as it is not possible to describe one's observations using only specialist terminology. Nevertheless, the discussions on patients' issues which adopt various theoretical viewpoints may lead to more comprehensive solutions of both theoretical and practical nature. And although therapists talk in different ways, ultimately they all talk about the same patient. The perspective of a different approach can also encourage others to revise their knowledge and search for new sources, remaining faithful to the understanding of their therapeutic school and theoretical principles. The differences in the conceptualization of patients' problems are a natural phenomenon in the ward. Tensions and disputes that sometimes occur, may be an opportunity to take a deeper look at the problems. To give a specific example, let us consider a situation where a psychoanalytic therapist is one of the supervisory staff on a trip to a museum organized for patients. In our understanding, such situations do not have to undermine the psychotherapy setting and can be discussed at therapeutic sessions. Based on our observations, however, most tensions that occur in the ward, do not relate to theoretical foundations for the understanding of patients' problems but are rather part of group processes that include also our personnel.

Research on the effectiveness of psychotherapy [4] shows that the success of different psychotherapeutic techniques depends on the type of disorder, *e.g.* for some affective and anxiety disorders, cognitive-behavioural therapy brings better results than psychodynamic therapy. Thanks to the differences between therapeutic techniques used by our team members, it is possible to effectively adjust the type of therapy to individual needs of the patient, including individual psychotherapy and where necessary cognitive training, family consultations, and other forms of therapeutic interventions. Such individually tailored psychiatric rehabilitation is indeed possible thanks to combining different approaches to psychotherapy.

Mentalization

Taking into account specialist education of individual members of our therapeutic team and aiming to optimize the therapeutic approach tailored to the patient rather than professed theory, we are convinced that 'how therapists do what they do' is more important than 'what they do.' Regardless of theoretical orientation and clinical experience, the ward's therapeutic team aims to support mentalization in patients [5]. The interventions performed by our therapists focus on this very process, hence, it has become more consistent and firm in the therapeutic community. Mentalization can bring ward patients a lot of benefits. First of all, some somatic and emotional states are transformed into ideas that can be verbalized and communicated, which ability seems crucial in the psychotherapeutic process. Additionally, understanding mental states of other people facilitates interpersonal relationships, increases understanding of social situations and helps to notice mechanisms behind

conflicts. In our work, it is also important to intentionally counteract the process, often involuntary, of blocking mentalization, which occurs in the therapeutic community. It is assumed that both patients and all members of the therapeutic team should mentalize because sustaining a mentalizing stance is one of the best ways to achieve therapy goals. An attitude of curiosity and not-knowing that is characteristic of mentalization is also helpful in learning how to better tolerate ambiguity and uncertainty.

Basing on the assumptions of Allen, Fonagy and Bateman [5], the ward staff facilitate mentalization by:

- cultivating an attitude of inquisitiveness, curiosity and 'not-knowing',
- providing patients with the experience of security, thanks to which they feel safe to explore their own and other people's mental states,
- maintaining the right level of patients' emotional involvement,
- applying reflective techniques, adjusted to the patient's capacity to mentalize,
- using uncomplicated but precise interventions,
- maintaining a balance between engaging patients in exploring mental states of others and their own mental states,
- encouraging patients to look at interactions with others and their own experience from different perspectives,
- recognizing the importance of patients' experience before suggesting a different viewpoint,
- undermining the accuracy of unjustified assumptions made by the patient regarding attitudes, feelings, and beliefs of the therapeutic team,
- revealing a therapist's thoughts so that patients can correct a distorted image of the therapist; admitting defeat in the mentalization process and striving to understand the conflict.

The process of admission to the ward

The ward has capacity for 25 patients. The initial part of the therapeutic process consists of a diagnosis on multiple levels, which already begins on admission to the ward. The patient undergoes appropriate therapeutic interventions, adequate to the diagnosis and their individual needs. The main goal of the therapy and rehabilitation program is not only to obtain remission of the disease symptoms but also to develop the motivation to undergo further treatment, to prevent relapses, to increase the patient's resources enabling them to cope with the disease, to develop social competence, to enhance healthy areas of functioning and to restore the ability to perform multiple social roles. In order to achieve these goals, it is crucial that the ward patients are properly selected.

The therapeutic treatment offered by our ward is aimed at patients with mental disorders which, according to ICD-10 classification of mental and behavioural disorders [6], include: organic mental disorders, schizophrenia, schizotypal and delusional disorders, mood disorders, mental retardation, and holistic developmental disorders. The mere fact that the patient has been diagnosed with one of the above disorders, does not mean that they will be eligible for the therapy offered by our ward. We should keep in mind that a newly admitted patient joins a therapeutic community, which is considered one of the most important therapeutic tools. Our observations show that the most effective selection of the patients to such therapeutic community is based on the optimal difference in the level of disorder and social functioning. If the difference is too big, for example, patients experiencing the first episodes of the disease, with good social functioning, will be placed in the same group with deeply disturbed patients suffering from chronic diseases, it may lower the motivation for therapy in the better-functioning patients, due to losing hope for improvement. On the other hand, too little difference in the level of functioning and the type of disorder may deprive patients of the benefits that can be brought by diversity and sharing experience of different stages of recovery. These observations are confirmed by the literature. Analysing the effectiveness of group therapy, Yalom [7] noted that some degree of incompatibility in the therapeutic group stimulates dissonance, which in turn facilitates changes.

Another important criterion for ward admission is the patient's motivation for treatment. Qualifying the patient for treatment during the first meeting, the therapist is not only able to recognize the patient's level of motivation but also to enhance it by introducing some parts of motivational dialogue. At this stage, it is also important to verbalize therapy goals as it can stimulate patients to think about actual changes they can introduce in their lives. How much the patient will be engaged in therapy activities, in some cases depends on the very first meeting with a therapist. Research shows [8] that the patient's engagement in therapy, and hence its effectiveness, depends to some extent on the patient's personality traits, personality disorders underlying the reported problem as well as the patient's expectations of the therapy outcome. It is of crucial importance to acknowledge these factors while qualifying patients for admission to the ward because, based on our experience, the patient's involvement in a therapeutic community, work of the ward and therapeutic activities, largely impact the effectiveness of these interactions. Without internal motivation and commitment, psychiatric rehabilitation will not bring the expected results, and the goals set by the patient will not be achieved.

The literature [9] also draws attention to the importance of negative selection of day ward patients so that those to whom our therapeutic offer is not suited, are not admitted to the ward. For instance, addiction is not treated in our ward and thus patients who abuse alcohol, drugs, or other psychoactive substances, do not qualify to be treated here. During the stay in the ward, abstinence is strictly required. Also, functioning as a day ward, we cannot treat patients who exhibit strong suicidal

tendencies and patients who are in active, unstable psychosis. Such cases are admitted to locked wards. Moreover, due to the specific nature of therapeutic interactions, the ward's offer is not addressed to patients with a very low level of functioning, *e.g.* with a diagnosis of significant or deep mental retardation or significant cognitive impairments. Apart from the above-mentioned explicit exclusions, there are patients with diagnoses which may give rise to doubts whether or not they should be admitted to the ward. In such cases, great importance is attached to their motivation and adaptability to the ward conditions.

Therapeutic community

The work in our ward is based on the concept of a therapeutic community, according to which functioning within the community and the quality of relationships established by patients reflect their social functioning in a general sense and difficulties they encounter in everyday life. As early as in 1953, Jones [10] pointed out the therapeutic value of community participation. He emphasized that open communication, engaging the patient in the healing process, making decisions and encouraging discussion about interpersonal conflicts were of crucial therapeutic importance. Since then, mental health care has undergone significant changes, but assumptions for therapeutic community and community-based therapy can still be considered valuable and highly effective [11].

In our ward, therapeutic community meetings take place every morning and are led by two patients who, in a given week, perform the functions of the leader and deputy of the ward. During those meetings, the community discusses current problems of the ward, solves formal issues, etc. The staff also provide proper conditions for the patients to submit their suggestions, ideas and share their thoughts. Moreover, each ward patient is required to perform various functions in the community, such as daily kitchen and garden duties, the function of a chronicler and treasurer, and at the end of their stay in the ward – the role of the community leader and deputy. This way, patients develop constructive social behaviour and strengthen their sense of responsibility for the group. Apart from the therapeutic community meetings and functions that the patients perform, all other social interactions and spontaneous discussions are considered to be therapeutic opportunities of significant therapeutic value.

It is important for the functioning of the ward that the therapeutic community is developed both by patients and the ward personnel. Everyone participates in community meetings and everyone has an equal right to raise issues that are important to them. Such approach emphasises the role patients play in shaping the ward environment and deciding, for example, on the rules applied in the ward, which, if needed, are modified at community meetings. Patients also have a voice in scheduling activities. When some activities are criticized by a significant proportion of patients or patients show

little interest in them, the issue is discussed with the entire community and, if necessary, such activities are modified or replaced by other activities.

The role of a medical doctor in the therapeutic community and physician-patient relationship supporting the patients' own initiative are characteristic therapeutic factors in the ward. Unlike in other wards (particularly the locked ones), in our day ward, it is not the physician that reaches out to the patient but the patient that has to make recovery-oriented efforts and plan their appointments with the physician. Physicians are part of the therapeutic community, on the same terms as other members of the therapeutic team, and participate in therapy activities.

The functioning of the therapeutic community and the participation of the whole therapeutic team in the therapeutic community is based on the assumption that the therapeutic relationship is one of the most important healing factors [12]. Non-specific therapeutic factors which are effective in psychotherapy can also be used in psychiatric rehabilitation. By creating, together with patients, an atmosphere of understanding, acceptance and commitment, it is possible not only to reduce disorder symptoms but also to stimulate personal and social development. Gelso and Hayes [13] point out that a good, supportive relationship between the therapeutic team and the patient can have a very positive impact on the effectiveness of other therapeutic interactions and the other way round – therapeutic actions will not bring the intended results if the therapeutic relationship is not good enough.

Therapeutic group activities trigger strong factors of change, for example, social pressure from the group encourages patients not only to participate in therapy activities but also to be actively involved. These factors, referred to as 'social microcosms' [7], stimulate interpersonal learning, *i.e.* learning through observation and imitation in situations where patients have the opportunity to see similarities in mental difficulties they experience (universalism) or through the need to help others (altruism). These processes are considered to be strong healing factors in the therapeutic community. The day treatment program implemented in the ward also supports the therapeutic community's fundamental principles, described by Rapoport [14] as democratization, liberalism, attachment to the community, and reality confrontation.

Individual and group psychotherapy

The ward conducts group psychotherapy for two groups of patients. Each group has sessions twice a week at a fixed time. Patients are assigned to groups after the first week in the ward, based on the level of functioning and their diagnosis, so that difficulties and issues experienced by group members were as similar as possible. The group process runs on various levels, giving the patients an opportunity to exchange information, express difficult emotions in a safe way, share their experience and thoughts, and get feedback from other group members. By participating in these sessions, patients learn to recognize and express their emotions and needs, they have an opportunity to be aware of and

modify their relationship style, and by taking a closer look at their symptoms together with other group members, they develop more effective ways of dealing with their disorders. Due to the high patient turnover in the ward, the psychotherapy groups are open, which requires constant adaptation of group therapy techniques and goals to new patients. This – as noted by Yalom [7] – does not determine the effectiveness of therapeutic interactions and does not rule out the possibility of forming the group process.

Group psychotherapy in our ward is conducted by psychologists who rotate every four months, leading in turns psychotherapy and psychoeducation groups. This rotation benefits patients as it teaches them adaptation to changes. The patients also benefit from different quality that each therapist brings to the group by introducing such variables as: their own style of leading the group, different theoretical approaches as well as different personalities. From a therapist's perspective, a 4-month break from leading a group (conducting psychoeducation classes instead), which occurs every 8 months, prevents burnout and allows them to conduct group psychotherapy with new energy, enthusiasm and solicitude towards patients. However, this model of work involves a certain risk of disturbing the therapeutic process and thus slowing down the healing process for some patients, which especially applies to those with the most difficulties in developing trust and openness in therapy. Despite these drawbacks, our experience has shown that the benefits of introducing rotational changes into therapeutic work outweigh the risks that such changes entail.

One of the characteristic features of the described ward is the fact that all patients have access to individual psychotherapy or individual support. In other words, every patient admitted to the ward is provided with individual care tailored to their needs. In most cases, face-to-face therapy sessions take place once a week. Depending on the patient's abilities and motivation, individual therapy consists in supporting and maintaining the patient's participation in everyday life and developing independence, both during the time of worsening symptoms and after the symptoms disappear. The therapy also focuses on increasing the awareness of the patient's own emotions and personality issues. Moreover, this form of treatment gives patients the opportunity to understand the psychological basis of their disorders and to discover their own resources. In most cases, individual therapy is short-term (patients are admitted to the ward for 16 weeks). However, in some cases (therapeutically justified), the patient is admitted to the ward for a consecutive period of time so that his/her therapy can be continued. In many cases, individual meetings in the ward are the therapeutic 'first step' for patients who, after being discharged from the ward, are encouraged to undergo outpatient therapy.

Another feature that distinguishes our ward from other such facilities is engaging all the team members in individual work with patients. Depending on personal characteristics, the type of disorder, and the patient's abilities, typical individual psychotherapy is not always necessary or advisable. Despite this, the vast majority of patients benefit from non-specific therapeutic factors such

as: awareness of being under individual care, knowledge who they can contact in case of a crisis, a weekly appointment (on a specific day and at a specific time) with the therapist, establishing a therapeutic relationship – all these factors build a sense of security and trust in patients, necessary for the healing process [15]. Therefore, each team member in our ward has at least one patient under care. Psychotherapists (psychologists and physicians) conduct individual psychotherapy ranging from insight to supportive therapy, while nurses, occupational therapists, and interns conduct one-to-one supportive meetings, keeping the same therapeutic setting as psychotherapists. Thanks to this organization of work, each patient benefits from individual care, and each team member can develop a psychotherapeutic perspective on the patient, moving away from purely psychiatric thinking.

The combination of individual and group psychotherapy also works well in our ward. Patients participate in both types of therapy, which are offered either in a form of polytherapy (individual therapy and group therapy are conducted by two different therapists) or combination therapy (one therapist conducts individual and group therapy). This division results mainly from the ward's organizational potential, however, each of these interventions brings a positive outcome. To be effective, polytherapy requires an open and respectful relationship between the individual therapist and the group therapist [7], which in our day ward is achieved thanks to the close cooperation of all the therapists. Both in polytherapy and combination therapy, group therapy accelerates and enriches the process of individual psychotherapy, and vice versa – individual psychotherapy, especially when focused on 'here and now', facilitates deeper involvement in the group process.

In addition to psychotherapeutic interventions, it is also possible to hold family consultations in our ward. Such meetings aim to foster cooperation between the patient, the patient's family, and the therapeutic team. Family consultations help to find a common area of understanding and to gain additional information about the patient and their environment, which facilitates progress in the therapeutic process. The meetings are held based on the principles of the systems theory, allowing the therapist to learn about the patient's family system, relationships within this system, ways in which family members communicate, their attitude to mental illness, ways of dealing with it and factors hindering the patient's treatment and rehabilitation process.

The ward structure

Splitting is a natural phenomenon in a therapeutic team which treats patients with severe mental illnesses or deep personality disorders. In order to reduce misunderstandings and conflicts resulting for example from the sole fact of working with such patients, it is important to have a clear and stable ward structure, which would be understandable and respected by all the staff. Knowing who is to make a certain decision proves to be useful and practical. The model developed by our ward assumes that it is the patient's individual therapist who has a key voice in the patient's case but who

can always consult with the rest of the team. The team's weekly clinical meetings provide a safe space for discussion. Within this framework, the patient's individual therapist talks about their observations from the last week and gets additional information from reports on therapeutic activities – group therapy, psychoeducation, arts-and-crafts occupational therapy, and the drug training course, which are presented at the meeting by individual team members. This form of meetings makes it easier to see the patient in multiple dimensions.

People diagnosed with mental illness obviously require pharmacological treatment. Some patients are admitted to our day ward immediately after being discharged from inpatient wards and need only slight changes in their medication. Other patients, however, come from mental health outpatient clinics in order to intensify therapeutic interactions and thus avoid hospitalization. In such cases, significant pharmacological changes may be necessary. Hence, each patient is permanently assigned to a psychiatrist. A team consisting of a physician and an individual therapist constitutes the basic decision-making unit which provides a platform for frequent discussion on the patient's condition and further therapeutic plans.

Other therapeutic interventions supporting treatment

As said before, psychiatric rehabilitation in the described ward is based on therapeutic community principles, with an emphasis on psychotherapeutic rather than clinical approach to the patient. At the same time, other therapeutic interactions are implemented so that the selection of activities is diverse, interesting and tailored to the needs of each patient. In addition to psychotherapy, patients participate in various organized group activities as well as work therapy and play therapy, which not only have a therapeutic effect in itself but also activate patients and strengthens their involvement.

In addition to group psychotherapy, group activities organized in our ward include: psychoeducation classes, 'life story', weekly summary, and social skills training. All patients admitted to the ward participate in these activities. Psychoeducation classes are a series of meetings held by a psychologist or a psychiatrist once a week. The classes cover various topics such as: symptoms, causes and treatment of mental diseases, and recurrence prevention, placing particular emphasis on schizophrenia and affective diseases, ways of coping with the disease, a healthy lifestyle, legal and social issues of patients. The aim of the classes is to provide patients with information that will help maintain and consolidate the effects of their treatment.

'Life Story' is an activity that also takes place once a week. During these meetings, one of the patients (usually at the end of their stay in the ward) presents their life story to the entire therapeutic community. The aim of this type of activity is to create an opportunity for each patient to look at the timeline of their lives and present their experience and interests, as well as to overcome stage fright

and difficulties in talking about themselves. These activities facilitate building trust in the therapeutic community and help patients get to know one another.

Working with patients, the ward therapeutic staff pay special attention to preparing patients to find a job, become independent, and function outside psychiatric institutions. The weekly summary and social skills training are the activities that focus on achieving these goals. The weekly summary is a group session held every Friday, during which patients collectively summarize the entire week of therapeutic work, reviewing their individual therapeutic goals and evaluating the treatment progress. The patients also get support to make a constructive plan for the weekend – these plans are reviewed later at a community meeting on Monday. Such activities teach time management and also sensitize the observing ego of each patient by recognizing how events and experiences can affect emotional states and physical well-being.

The social skills training, on the other hand, is aimed to improve the patients' ability to cope with everyday life, enhancing their social and practical skills. The topics and issues that social skills training groups cover are often the subject of in-depth analysis at a later session of the psychotherapeutic group. Our ward holds the following training sessions for multiple groups of patients: culinary, budgeting, pharmacology, and problem-solving training.

In addition to organized group activities, a strong emphasis is put on occupational therapy carried out in various forms. Two workshops are available for the ward patients – occupational and artistic. The occupational therapy is aimed at all patients. It is a form of treatment and self-improvement that is achieved through specific activities, occupations, and works, which may have educational and therapeutic values [16]. As a therapeutic measure, occupational therapy can affect the patient's overall mental and physical well-being. It can also enhance teamwork skills and strengthen social competences. Manufacturing, handicraft, and physical activities – when properly selected, can have a calming, stimulating, and rehabilitative effect on the patient.

The occupational therapy carried out in our ward includes also art therapy – practical activities in the art workshop as well as regular group classes 'Encounter with Art' aimed at developing creative expression in patients. In addition to art therapy, every two weeks patients, under the care of the ward therapists, visit museums or art galleries, experiencing art in person. Art therapy, by developing creativity and supporting patients' resources, helps them to better understand themselves, to enhance their quality of life and to cope with problems and conflicts [17]. As part of the occupational therapy, patients have an opportunity to participate in pottery workshops, gym, and audiovisual presentations on gardens delivered by the Interdisciplinary Occupational Therapy Centre operating in the Babiński University Hospital. Moreover, gardening classes are conducted, during which patients cultivate the ward garden under the supervision of a qualified gardener.

The holistic approach to the patient adopted by the ward staff results in including physical activity and elements of relaxation and play in the rehabilitation process. Physical activity – carried out both in the form of gardening and morning gymnastics, in which patients participate every day, complements psychotherapeutic interactions, supports the patients' mental and somatic health, and increases their energy and motivation for therapy. Similarly, activities that are seemingly playful such as playing charades, help strengthen group ties, overcome social anxiety, reduce tension and teach patients active rest. What is more, play encourages laughter, which – as shown in the literature [18] – provides stress relief, helps cope with mental difficulties, strengthens the respiratory and circulatory systems, and modulates functioning of the immune system.

Recapitulation

To sum up, it should be emphasised that the ward staff adopt the holistic approach to the patient and the healing process, the approach which is implemented both through the variety of therapeutic interactions offered to patients and through a multidimensional approach to understanding difficulties they experience.

The presented operating model for our ward, due to the need to constantly monitor the functioning of the therapeutic community, is still a 'maturing' project, modified and improved on a daily basis. This also applies to the mind frame of the ward staff, whose members benefit not only from the opportunity to discuss their theoretical orientation and enter the dispute between various theoretical conceptualizations (which may be developmental in itself) but also benefit from a 'safety-valve' in the form of individual and group supervision. The staff members enhance their professional qualifications by participating in various trainings, aimed at integrating the wisdom of approaches – the ones that are similar to their school of thought with those that are different.

The rich, varied treatment program presented in this article may evoke the feeling of a cacophonous mosaic, which may confuse treatment participants, who may be unable to see the measurable benefits resulting in the improved mental condition. There could also be a legitimate concern about the therapeutic team – one can say that led by narcissistic temptations, they create an excess therapeutic program to satisfy their own needs. The authors cannot fully exclude some elements of such a risk. However, due to the extensive structure of the treatment model, the authors do their best to minimize this risk and provide patients with a platform for effective and efficient therapeutic efforts, assessed not only by clinical scales but above all by the ability to serve social roles, to better understand oneself and the outside world, and to achieve more effective emotional economy.

Without depreciating the medical model prevailing in psychiatry, the authors notice its limitations in the individual development. Therefore, they propose complementing therapeutic

interactions with interactions that result in building a sense of agency, managing the patient's own resources, and reducing the patient's dependency on psychiatric institutions – which, not so long ago, was not always a standard goal in day therapy.

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E-mail address: ka.kotlarska@gmail.com