PSYCHOTERAPIA 1 (204) 2023
PAGES: 53–66
DOI: 10.12740/PT/165798

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THERAPEUTIC ASPECTS OF A PSYCHIATRIC WARD. PART II

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stationary psychiatric ward
personal therapeutic program
recovery

Summary

The isolational aspect of psychiatric care determines scientific and theoretical reflections on therapeutic work with patients in deep mental crises. Current changes in this area imply the need to share not only advances in the global rehabilitation of patients, but also effective practices of therapeutic interactions with patients treated in general psychiatric stationary wards. Issues regarding the treatment of patients in deep mental crises are still relatively rare in literature, in particular in the context of the role of teamwork and its therapeutic potential. Attention to these elements of stationary treatment therefore appears to be of paramount importance in the understanding of the treatment process. The article presents a team model of therapeutic work at the general psychiatric department of the Babinski University Hospital in Cracow. The theoretical assumptions underlying the department's work are presented. Some therapeutic techniques are illustrated with elements of clinical practice. A reflection on the further directions of therapeutic work in residential psychiatric care is presented.

Introduction

This article is a continuation of the earlier work titled "Therapeutic Aspects of a Psychiatric Ward" [1]. This time, we want to focus on additional therapeutic tools. They serve to broaden the field of collaboration from which both the patient and the doctor can benefit together. Key to this collaboration is establishing a thread of agreement with the patient – formal, emotional, existential, or based on the roles of both patient and doctor. Equally essential to treatment is the parallel exploration of psychopathological phenomena and therapeutic relationship disturbances within the transference-countertransference field [2, 3]. The functioning of the treatment team is based on harmonizing views and approaches. During the formation of the described therapeutic work style in the general psychiatric admission ward, we were inspired by the concept of the "common mind," as described by Christopher Bollas [4]. The operationalization of this Bollasian shared thinking is the

adopted therapeutic work style, the organization of the daily schedule, and the weekly rhythm according to a plan – a plan discussed and described on the activity board accessible to all members of the therapeutic ward community. The Personal Therapeutic Program (Appendix 1) functions to organize the patient's daily and weekly schedule, providing information and harmonization, reassuring the patient about their participation in the life of the ward.

General psychiatric wards at the Dr. J. Babiński Clinical Hospital in Krakow present different models of work organization. However, all of them operate in an acute care mode, serving a designated group of patients divided by region and, in some cases, by gender. The described ward is a male general psychiatric ward for the Krowodrza district of Krakow. In terms of staff-to-bed ratio (up to 42 patients on the ward), it conforms to the standards of other wards in this hospital. A common theme of teamwork is the psychotherapeutic concept from the realms of psychoanalytic, psychodynamic, and systemic approaches. Part of the team is trained in the psychodynamic approach, and the ward director is certified as a supervisor by the Polish Psychiatric Association.

In the previous work, theoretical references, treatment goals, assumptions, principles, and organizational solutions of the inpatient ward were discussed. The role of the therapeutic community and individual treatment program was elaborated upon with practical examples. It was emphasized that in a regional, diagnostically heterogeneous inpatient ward that constantly admits new patients in a state of acute mental illness, a more challenging goal beyond providing structure and safety was set: building a therapeutic alliance and the even more difficult task of motivating patients for further therapy and activating resources for recovery, considering that this is just the beginning of the journey. Continuity of treatment and care is needed, along with a specific time perspective and familiarity with tools that will be used in subsequent phases of recovery, both within and outside the closed ward. This part of the work will discuss patient-doctor interactions, forms of psychotherapeutic work, and psychosocial interventions.

Personal therapeutic program

The program is presented to the patient in the first days of their stay. Together with the patient, the scope of their involvement is determined based on the schedule. This schedule is also posted in the corridor near the entrance to the ward. Any changes and modifications to the personal therapeutic program are made in real-time.

Without connecting the patient's personal life goals to the therapy in the ward, it will be difficult for them to grasp the meaning of occupational therapy, talk therapies, or even relaxation.

Anna Bielańska, in her critical review of psychotherapy methods for individuals with schizophrenia-related issues, emphasizes the necessity of using various theoretical approaches effectively in clinical practice [5]. Short-term health benefits related to symptom improvement should align with a recovery strategy focused on building a satisfying life beyond the hospital setting [6].

The personal therapeutic program consists of morning physical exercises, medical visits, occupational therapy, talk therapies (support groups, psychoeducation, and psychothera-

pies of various schools and methods), and skill training. Each professional group includes conducting specific modules of the personal therapeutic program as part of its duties.

Medical visits (ward round)

Medical visits occur in three modes:

1. Individual discussions to assess treatment progress: pace of recovery, degree of symptomatic remission, and degree of adherence to the personal therapeutic program. The discussion with the patient also evaluates the degree of conceptualization of recovery resources and their practical significance in reality outside the closed ward. One of the first recovery resources is critical self-awareness.
2. On community days, bedside visits focus on health status and identifying specific roles within the ward community that are appropriate to the patient's resources. Patients are also encouraged to take on these roles.
3. Individual visits with attending physicians occur at the end of the week and serve to summarize treatment progress. The implementation of the personal therapeutic program is jointly evaluated: attendance, usefulness of activities, and benefits gained from different types of therapies – occupational, talk, and functions undertaken within the therapeutic community. The effectiveness of pharmacotherapy and future treatment plans are also assessed in collaboration with the patient. Detailed discussions of current and potential side effects of medications are crucial for building patient trust in the therapeutic alliance and for legal reasons [7-9].

Occupational therapy (using the example of a pottery workshop)

The activities are centered in the occupational therapy studio, filled with creations from generations of patients treated here. The walls are adorned with paintings, drawings, as well as rugs, and shelves hold sculptures made from paper mâché, origami animals, matchstick houses, and so on. The studio serves as a meeting place for group activities under the guidance of a therapist. It is designed in the style of a rural cottage. The intention was for participants to temporarily move into a non-hospital, idyllic dimension. The interior greets participants with the inscription of a Polish proverb: "It's not saints who make pots," (meaning that one can learn anything with a bit of practice) and the walls are adorned with painted rural flowers – hollyhocks, poppies, and cornflowers. On the opposite wall, a landscape appears, leading to a cottage with a fence made of clay pots and a rooster.

Patients enjoy working with clay, which is a very versatile material: soft, malleable, and easy to work with. We sometimes discuss its origin as a sedimentary rock and its natural connection to humans, which has an almost atavistic dimension. Clay has been with humanity since prehistoric times; it has always been present. Someone once picked up this thought and declared that the first human was shaped from clay. And so, we continue in this manual transformation, even beginners can create something impressive. Sessions are conducted in small groups of 6–7 people. Patients experience the transformative power of engaging with craftsmanship and art. Perhaps this is how the words of the ceramics master, Bolesław Książek, gain strength: "Life is beautiful because you can do ceramics" [10, p. 71].

Psychosocial support group

During the psychosocial support group session, it is customary for the therapist to begin by asking one of the patients to come forward with their own problem, and for the other group members to assist in solving it. This assistance involves sharing their own experiences in overcoming similar difficulties, providing emotional support, exchanging useful information, and seeking common solutions. Often, during the analysis of someone's problem and life difficulties, an image emerges of an isolated, hurt, rejected individual who feels very lonely due to mental illness, fearing others and avoiding them.

Clinical vignette: Since the sessions have an open character, it is necessary to inform everyone each time about their purpose and function. The group work principles are recalled: respectful communication, not talking over each other, being mindful of words, treating presented topics seriously, maintaining therapeutic confidentiality, silencing phones, not wandering around, etc. After addressing the technical aspects of the meeting, the pivotal moment arrives – the selection of the meeting's topic. The person wanting to present their problem is asked to describe it, and the other participants, drawing on their own experiences and resources, help solve the problem. An important element of the whole process is providing emotional support, based on both empathy and attempts at understanding. However, healthy criticism should not be avoided.

An example situation: Mr. Andrzej, a patient who is regaining his psychological balance on the ward and preparing for further therapy in a dual diagnosis treatment center, asked the gathered group for help, expressing his concerns about leaving the hospital and waiting time for the dual diagnosis treatment ward. "What can I do to avoid relapsing?" – a simple but fear-tinged question was raised. A silence fell, which, considering that a significant percentage of patients on the ward have dual diagnoses, seemed ominous. This silence was broken by Mr. Janek's voice. His statement surprised many people in the room. Hitherto uninvolved, quiet, unassuming, and calm, he retreated into his distant past in his story. He talked about his youth when he was heavily addicted to both alcohol and drugs and tried to fight these addictions. He talked about his stays in rehabilitation centers, the difficulties associated with them, but also about what helped him. "It was very difficult, sometimes it seemed hopeless, but I managed. I worked, I was in a relationship, other people helped me, my determination, and faith gave me strength. I managed to stay away from drugs, but alcohol caught up with me," he concluded with sadness in his voice. This statement was very authentic and sincere. Among us are those who succeeded and achieved life successes to the best of their abilities, while others are still struggling. Mr. Janek's words were very personal, and although they touched on a difficult topic, they carried a moving dose of enthusiasm and belief in the "possibility of the impossible," the belief that even after stumbling again in his life, he will manage to stand up once more.

Mr. Darek, who has been on the ward for a while, has been relatively uninvolved in the activities, isolating himself, more focused on his internal experiences and thoughts. He expressed his opinion with a trembling, emotional voice: "I am very sick, I have many problems, my life situation is on the brink of collapse. I might lose my family, my job, everything that is most important to me. I had to slow down. Before coming to the hospital, I took all the herbs and other substances and burned them in front of my

wife. I told her there's no going back to them, and I'll return home after breaking this avalanche." He cried.

Such statements evoke emotions while making participants in the group aware of the heavy psychological burden and accompanying suffering. The act of revealing and articulating these difficulties conquers the often natural fear of exposing oneself and opening up in front of a large group of essentially unknown people. Both personal statements activated the group and, riding the wave of emotional arousal, triggered numerous comments and questions: Why did this happen? What could have been the triggering factor? Attempts at explanations were made, which often overshadowed previously present good advice, didactic but dry instructions.

During the discussion and attempts to analyze the discussed topics, Mr. Andrzej was not forgotten. Group members addressed him directly, and he himself, perhaps encouraged by the earlier statements and the interest of the whole group, without hesitation, presented and described the origin of his current problem, explained his life situation, and voiced concerns about his future. His painfully sincere confession concerned the beginnings of his drug addiction, a life that lay in ruins, unsuccessful stays in rehabilitation centers, uncontrollable aggression that landed him behind bars and made him homeless. Stories of life at the bottom – street fights, thefts, beatings, all accompanied by drugs – ruined his health and, as he stated himself, "I miraculously go on, but under my skull, there's only emptiness."

A remarkable moment occurred when Mr. Andrzej, with emotion, said: "Listen, the most beautiful moment of my life was three months when I wasn't using drugs, when I was clean. I miss that time. I would like to experience something like that again, but I'm afraid I'm not strong enough to endure the worst moments of withdrawal." Younger patients listened to his story with an extraordinary focus, without the often present cheerfulness, casualness, and verbal negativity. Someone just muttered quietly to someone else: "Listen, listen to what will be left of you." This is probably related to a special bond that forms between people who share similar difficulties, the same denominator. This bond is forged when one person says to another, "I know what you're talking about, I know how you feel, I've been there, I understand you." Such understanding gives the strength to speak.

Group psychotherapy

Group therapy is intended for patients who have experienced a psychotic crisis. Individuals in acute psychosis do not qualify for these sessions, but some exceptions are possible: "In constructing the group, the level of disorder or ego strength is most important, not the presence or absence of psychotic symptoms [11]." When selecting participants for the sessions, we draw on the knowledge of the entire ward staff. Melanie Klein emphasizes the importance of an appropriate setting when working with psychotic patients. Additionally, within the mentioned theory, it is important that significant others are supportive or at least neutral toward the therapy [12]. This also applies to the staff members on the ward. To maintain a safe framework for group psychotherapy, sessions are held at a fixed time and place, lasting 75 minutes.

Group psychotherapy in a general psychiatric inpatient unit is often the first contact a patient has with psychotherapy itself. The theoretical premise is on the border between

insight-oriented work and supporting the patient's resources. Sessions are led by two therapists. There is a reflecting team present, drawn from the systemic therapy approach and adapted by us [13]. The reflecting team, present in the background, only speaks at the end, offering concise comments on the course of the session. One, two, or three therapists present a new perspective on the session and provide positive reinforcement for the processes occurring in therapy.

A difference from the classical Andersenian concept is the way information is conveyed by the reflecting team— it is not a conversation among team members about patients, but a brief statement directed at the patients. After this, the patients have the space to respond to the reflecting team's words and report their perception of the sessions. Beyond the circle, there is another therapist — an observer, referred to by patients as a chronicler. At the beginning of the meeting, this observer introduces themselves, and their role is explained to the patients. They do not speak throughout the session but take notes. This function is valuable when discussing the sessions after the group ends, allowing for a more distant and objective view of certain processes.

To illustrate this, we would like to present a short clinical fragment. There is a rule that no one else can join after all the individuals have introduced themselves. Just as the last of the patients finished introducing themselves, a late patient entered, explaining, apologizing, and asking if they had made it in time. In our opinion, at that moment, excluding them from the session would have been more cruel than caring. The patient remained in the session, and the question was redirected to the group, asking their thoughts and feelings about it. We do not know if this was the most correct reaction, but we do know that this session was one of the more constructive ones in a while. Any expectations placed on the group in the therapy for psychotic patients can hinder or even impede the healing process. The phrase "without memory and without expectations, desires" is very relevant here [14].

Nine patients and four staff members participated in the described group, including two psychotherapists and two members of the reflecting team. The meeting took place before the observer function was introduced.

At the beginning of the session, one of the authors informed the patients about her three-month absence and bid them farewell. At that time, the rule of locking the therapeutic room's door from the inside was still in place. This was always agreed upon with the group. When asked for consent to lock the door, Mr. J. objected. The group supported his position. According to the patients' decision, the door remained open. While discussing the remaining rules, patients clearly emphasized the need for confidentiality and mutual respect. Transitioning to the part where patients had space to express their emotions, a long silence ensued. This silence was interpreted in the context of the open door, as well as the temporary absence of the group therapist due to mandatory training. In response to this, the group spoke a lot about the difficulties of opening up to other people in their everyday lives and in the ward's realities, where the lack of trust and stability becomes a problem. The difficulty posed by the high turnover of patients in the general psychiatric unit was discussed. Almost every day, new individuals are admitted to the hospital, and those with whom relationships have been formed are discharged. Against this backdrop, the group posed the question of whether it is worth engaging in such relationships at all.

Another perspective in the discussion was presented by Mr. P., who said he felt better here than in the rehabilitation unit, where stays are long, resulting in fewer changes among patients. He pointed out the external stability in the general psychiatric unit provided by closed doors, medications, and restraints. However, he admitted that the rotation in this place bothers him. Then patients openly discussed the problems they see related to their illness in the context of interpersonal relationships and the stigma of psychiatric treatment. It was difficult to deepen this thread: the lack of trust was emphasized, which more practically demonstrated the essence of the problem raised in the session.

Patients referred to the daily functioning of the ward, talked about the tendency to form small subgroups where closeness is easier to achieve, and where they search for similarities among themselves. After these words, we realized that this process also takes place within the group. When one patient talked about problems with their parents, two others mentioned having a similar situation. Again, when another participant talked about relationships with neighbors, several others indicated that they were familiar with this issue from their own experience. Throughout most of the session, patients were more willing to address anxiety rather than psychosis, which is closely related to the fact that the group was in the process of getting to know each other. From our observations, it is clear that psychotic symptoms become a topic that can be explored when there is greater closeness and trust among patients; this is a later stage of group formation. This is directly related to the dynamics of changes on the ward and the composition of each group, as the group remains open.

After the reflecting team's statement, when there is time for participants' summaries and reflections, patients spoke most openly. Each patient spoke in a way that seemed as if they were introducing themselves at the end. This behavior can be understood in two ways: either as a form of resistance or as a desire to share more about themselves with the group. In this specific case, we lean toward thinking of the group's behavior as a result of the work during the session to build trust and closeness among participants. This reflection is confirmed by the fact that this process was sustained in subsequent sessions, and the topics were directly continued.

Music therapy

Music therapy sessions in the ward are conducted in a receptive group setting. Patients listen to pieces of music and then discuss them. The sessions take place once a week at a fixed time and last for one and a half hours. The group size varies and can sometimes be quite large (around 20 people). The group is also heterogeneous in terms of participants' symptoms, so organizing the meeting in a way that involves as many people as possible is crucial.

Due to the extended duration of the sessions, patients who participate in them are often those whose mental state has improved, who feel stronger, and who are willing to engage in the work proposed during music therapy. However, there are cases when patients with psychotic symptoms also manage to endure the sessions, making an effort to organize their thoughts and feelings while expressing themselves. It is more challenging for patients with heightened anxiety to participate fully.

For such a diverse group, musical diversity is important. The sessions are led by a psychologist, so defining the psychological goals of this therapy form is also crucial. Ultimately, the session leader decides on a series of sessions with thematic character. The pieces are selected with Polish lyrics, and they are chosen in a way to activate emotions while also triggering reflection. The thematic cycle begins with general themes like "Life," "Human," "Who am I?," "Home," and progresses toward various emotions and psychological states, such as "Happiness," "Hope," "Pain and Anger," "Freedom," "Faith," "Love," "Struggle," "Different Values," and "Time for Change."

At the beginning of the sessions, the leader presents how the sessions will proceed. Following this introduction, some patients may choose to opt out of participation. The leader emphasizes that participants should strive to talk about all their feelings, including the negative ones. The subsequent stages include participants introducing themselves by name and listening to a calm-toned piece for a few minutes. During this time, patients can relax and focus on their breathing. The group does not discuss the first piece. For pieces with lyrics in Polish, patients attempt to name their feelings. Usually, starting from the second piece, they also relate to the content, and the number of actively participating individuals gradually increases. They begin to react to each other, engage in discussions, support one another when someone expresses sadness, guilt, or sorrow. They also share in the joy when someone talks about joyful matters. Encouraged by memories that reinforce their emotions, they start searching for positive memories in their lives. During these sessions, they either correct their communication methods or gain confirmation that they are handling their relationships well.

Toward the end of the sessions, the leader usually asks about a topic that has not been previously mentioned but is gradually revealed through the pieces. Participants who may not have spoken during the sessions but have been present throughout are asked about their current emotions and their overall impression of the sessions. Often, they also mention the atmosphere of the sessions—favorable to a sense of safety, openness, and with elements of humor. It is evident that they leave the sessions feeling more relaxed and continue conversations in the hallway. If a participant experiences negative emotions during the sessions and the therapy does not help in calming them, the leader engages in an individual conversation with them after the music therapy session.

In addition to themed sessions, music therapy is also conducted based on songs chosen by the patients themselves and songs from different countries with varying cultures. When patients select their own songs, the group also discusses emotions, and then the participant who chose the song speaks about their emotions and what makes the chosen song meaningful to them.

During music therapy with songs from different parts of the world, patients discuss their own emotions but are also encouraged to talk about how the music characterizes the nation it originates from. The journey within oneself is thus replaced by a journey to different parts of the world.

Psychoeducation

Psychoeducation takes place once a week at a fixed time. These sessions are conducted thematically, following a schedule that is consistently available to patients on the bulletin board. The cycle of sessions comprises seven meetings, covering topics such as mental health, symptoms of mental disorders, schizophrenia and psychosis, mood disorders, addictions, treatment methods, and legal aspects in psychiatry. The topic of mental health and mental hygiene is led by a psychologist, while sessions on other topics are led by doctors.

Brief description of sample psychoeducation session conducted in the ward:

The vice-chairman of the community prepared a flipchart, while the chairman made rounds in the rooms to ensure that everyone who could participate in the sessions had already arrived. The arrangement of chairs was oval to create a seminar-like atmosphere, emphasizing that each participant's contribution would add value to the sessions. The meeting began with an open question from the facilitator about addiction-related issues. Patients without diagnoses related to addiction were the most eager to speak.

The aim of the sessions was to analyze patients' experiences in order to determine common characteristics of addictions and to understand the impact of addictions on mental health, physical health, and social situations. To give structure to the discussion and facilitate participation, a large schematic figure was drawn on the flipchart: the head in one color, the rest of the body in another color, and smaller figures around it in a third color. These three colors represented the three aspects in which addiction issues were examined: psychological, physical, and social.

While alcohol addiction was the most frequently discussed addiction, patients were encouraged to find analogies to other addictive substances and behavioral addictions. Each aspect was discussed in terms of the consequences of addiction, harm, and difficulties in recognizing them during active phases of the disorder. The facilitator provided a kind of translation, continuously transforming patients' sporadic observations and experiences into universal rules, mechanisms, and consequences of addictions.

Despite the original plan, the structure of the sessions was not rigid, and the topics were discussed rather sporadically. However, the primary goal remained to relate to patients' voices and their lived experiences. The session ended with a time for questions from patients directed toward the facilitator, focusing on pharmacotherapy for addictions and the effectiveness of treatment in therapeutic detox units. In these discussions, more patients became active, particularly those who were soon to undergo such treatment.

According to literature and the experience of each facilitator, the cycles of psychoeducational meetings are not considered independent forms of therapy. Instead, they are seen as part of a complex clinical intervention that, in synergy with pharmacotherapy and psychotherapy, aims to enhance the effectiveness of treating mental disorders [15, 16]. These interventions consist of various elements, all aimed at providing practical value to patients. Among other things, they provide patients with an understanding of their conditions, teach them problem-solving, communication skills, and assertiveness [17].

Statistically, as evidenced by studies in German-speaking countries, psychoeducation is more commonly conducted in groups that are more homogeneous in terms of patient diagnoses [18]. However, due to the focus on psychotherapeutic aspects of psychoeducation

[19] and the limited possibilities of a closed ward for organizing such sessions, all patients being treated in the ward at a given time participate in these sessions.

The effectiveness of psychoeducational interventions is enhanced when conducted in conjunction with family psychoeducation [20], which is made possible in Ward OP5 through the functioning family support group. It is worth noting that, beyond the psychoeducation goals of improving treatment efficacy and patient functioning, these sessions, conducted regularly, also serve as valuable sources of information for evaluating patients' health status, treatment responses, their ability to function in a group, and cognitive capabilities [21]. Each session in the psychoeducation cycle is discussed the following day during the morning medical briefing.

Sessions conducted by nursing staff

Patients have the opportunity to participate in nursing training sessions such as:

1. **Activation Training**
   As part of this training, patients are encouraged to perform their morning routines (bathing, brushing teeth, shaving, changing into clean clothes). Together with the facilitator, they tidy up their lockers and make their beds. The staff makes every effort to ensure that this type of activity is not experienced as repressive or invasive of patients' intimacy. The balance between patients' self-activity and staff assistance depends on the symptomatic presentation. Patient reluctance to participate in the training can stem from various factors. In cases of heightened negative symptoms (e.g., in the course of schizophrenia), therapists negotiate with the patient to encourage independent actions.

2. **Memory Training (Teleexpress)**
   In the afternoon hours, patients watch selected news broadcasts together with nursing staff. After the program, they recall the information presented. They share their interests and knowledge about the world. The aim of the training is to reinforce immediate memory, foster interest in the external world, and promote communal activity within the ward community.

3. **Medication Training**
   In the individual therapeutic plan of the ward, nursing training is utilized to enhance the independence of patients and their proficiency in using psychotropic medications. The main goal is to achieve a situation where the patient is capable of active and sustained collaboration with the staff, including adhering to prescriptions. Medication training covers four topics:

   — information about the actions of psychotropic medications and the benefits associated with them,
   — teaching self-sufficiency in safe and correct medication administration,
   — skills in recognizing side effects and strategies to counteract them,
   — competence in negotiating with the physician regarding treatment-related matters.

Patients with chronic mental illnesses often face challenges in maintaining personal hygiene, establishing and maintaining relationships, and engaging with the external world (including other people) after the acute symptoms of the illness have subsided. In the initial phase, patients are encouraged to participate in memory and activation training. Only after some time do they engage in medication training. It is important to remember that what might be easy for us can be incredibly difficult for the patient, given their lack of practice over the years, accompanied by anxiety and low self-esteem. The patient and therapist must work together to overcome these barriers. It's quite common for patients to perceive the assigned tasks as unnatural, too simple, or artificial. In each of these cases, patients should be patiently encouraged to complete the given task. Sometimes, patients may become fatigued by repetitive exercises. In such cases, they should be encouraged by highlighting the progress they have made each time. Each patient should have the time to overcome one difficulty threshold and move on to the next.

It should be noted that for patients with schizophrenia, thought disorders, anxieties, complexes, difficulties in concentrating, and a tendency toward isolation, these training sessions are very challenging. After a certain stage, which is individual for each patient, these sessions become a well-liked, effective, and efficient rehabilitation method. During the sessions, specific boards and assessment cards (e.g., for external appearance) are used to discuss the trained skills.

Contact with families

Working with families goes beyond obtaining information during the initial, so-called objective interview upon admission. The involvement of families in formulating both immediate and distant treatment goals is particularly important. We use family interviews, family consultations, and supervision (conducted by experienced supervisors who are not part of the daily ward staff) in more complex situations that require deeper consideration. For families dealing with chronic issues, a Support Group for Families has been established [21]. Working with families is an extensive topic that would require a separate discussion beyond the scope of this text. This work was previously carried out by the team of the legendary "C" Ward at the Department of Psychiatry of the Jagiellonian University Medical College, with some modifications described by Rostworowska and Opoczyńska-Morasiewicz [22].

Conclusions

Therapeutic treatment in a focused closed ward involves the patient's participation and understanding of the healing process in its multiple aspects.

The essence of therapeutic work in a closed ward is to ground the patient in the reality of life beyond the ward. Therapeutic goals should align with the patient's life goals.

The daily schedule and repetitive exercises require the use of specific tools and their collective discussion and documentation in a concise form.

Outside the ward

It is not always possible for the patient to continue the comprehensive therapeutic process started in the ward. Some patients benefit from the opportunity to continue treatment through the Day Psychiatric Rehabilitation Ward, with which we collaborate closely. This unit is also based on a psychotherapeutic approach to the process of healing from mental illness [23].

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Appendix 1. **Schedule of therapeutic activities in the ward**

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
OCCUPATIONAL THERAPY CENTER in the ward				
Morning Gymnastics 7:15–7:30	**Morning Gymnastics** 7:15–7:30	**Morning Gymnastics** 7:15–7:30	**Morning Gymnastics** 7:15–7:30	**Morning Gymnastics** 7:15–7:30
Activation Training Morning routine Making beds Tidying cabinets 7:00–7:45	**Activation Training** Morning routine Making beds Tidying cabinets 7:00–7:45	**Activation Training** – Morning routine – Making beds – Tidying cabinets 7:00–7:45	**Activation Training** – Morning routine – Making beds – Tidying cabinets 7:00–7:45	**Activation Training** – Morning routine – Making beds – Tidying cabinets 7:00–7:45
Art Workshop	**Fitness Room**	**Community Meeting** 10:00–11:00		**Pottery Workshop** **Floral Workshop**
Music Therapy	**Physical Exercises**	**Gardening Activities**	**Dance Therapy**	**Physical Exercises**
Psychosocial Support Group 14:00–14:45	**Group Psychotherapy** 13:00–14:15	**Social Communication** 13:00–13:45	**Music Therapy** 14:00–14:45	**Psychoeducation** 13:30–14:30
Medication Training Organizing medications by oneself 20:00–20:30	**Medication Training** Organizing medications by oneself 20:00–20:30	**Medication Training** Organizing medications by oneself 20:00–20:00	**Medication Training** Organizing medications by oneself 20:00–20:30	**Medication Training** Organizing medications by oneself 20:00–20:30

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