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THERAPEUTIC ASPECTS OF A PSYCHIATRIC WARD

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stationary psychiatric ward
therapy
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 one of the general psychiatric departments of the Babiński University Hospital in Kraków. 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

In the current model of psychiatric treatment in Poland, general psychiatric stationary wards play an important role. They are a fundamental element of 48 psychiatric hospitals, as well as the core of psychiatric departments in general hospitals, totalling 155 [1]. Out of more than 200,000 annual stationary psychiatric hospitalizations in Poland, a large proportion, *i.e.* more than 50 % [2], take place in general psychiatric wards. The present article highlights the opportunities offered by a psychotherapy-oriented general psychiatric ward. This form of treatment during the initial phase of the illness or during its exacerbation allows further treatment based on a variety of open institutions of community psychiatry [3]. Equally important for treatment is the parallel working through of psycho-pathological disorders of the therapeutic relationship within the transference/countertransference field [4,5].

Our reflection on the therapeutic potential of a closed ward is also in line with the Safewards

movement[1]. For instance, they overlap when it comes to the function of the therapeutic community, which is supposed to create a safer environment for treatment at the ward [6]. Similar processes took place in treatment in the UK just after the war: "The [therapeutic] community (...) had to learn this fact before the full force of the energy could be released in self-cure. What applied to the small community of the training wing may well apply to the community at large; and further insight may be needed before whole-hearted backing can be obtained for those who attempt in this way to deal with deep-seated springs of national morale." [7, p. 33] First, we will discuss ways of communicating in the team. The treatment objectives at stationary wards will then be presented, followed by the assumptions, policies and organizational solutions that apply to the ward. We would also provide practical examples.

Communication in the therapeutic team

The team mainly consists of 38 employees, mainly nurses with completed higher education and specialization in psychiatry. The physicians are interested in psychotherapy or have completed therapeutic training. Some are certified psychotherapists. The psychologists are educated psychotherapists (after psychotherapeutic or/and family therapy courses). An occupational therapist and a social worker play an important role, as well. The exchange of information takes place in writing in the form of change-of-shift reports and orally at the morning briefing. In addition, once every two weeks supervision of the patient and his or her family takes place in the presence of the therapeutic team. The family support group is supervised once per month. Additional psychotherapy group supervisions are organized according to the experience and needs of the facilitators. Informal conversations among staff about patients with an intravision are also important.

It can be assumed with great probability that the way in which the therapists communicate, or the "on-call room atmosphere", directly translates into communication between the therapists and patients [8, 9]. Just like in the family: how parents communicate with each other translates into communication with children. This is why such importance is attached to the quality of communication within the team.

After three years of project work, turbulent discussions and lengthy briefings, the team's internal contract has been created. Each professional group undertook to provide additional therapeutic activities. Nurses ran training sessions every day, physicians conducted psychoeducation, psychologists ran psychotherapy and a support group for the hospitalized patients' families, while the social worker ran a support group for patients [see: Appendix 1]. Lacking a fitness instructor, patients themselves undertook to

1 Safewards is a model of operation of closed wards, providing practical guidance to improve patient and staff safety by reducing conflicts and forced interactions. More information can be found on www.safewards.net/pl/

carry out their early-morning exercises, and all these classes were added to the schedule. The occupational therapist organized additional cultural events. One of these events was a cruise on the Vistula attended by the patients of the closed ward. Of course, patients who required maintaining safety procedures remained "at home" and did not participate in that trip. Also, this was in the "pre-COVID era" and at that time passes functioned normally. Such a therapeutic program required an additional work effort. The reward for it was increased satisfaction and safety for both patients and staff, with the use of physical coercive means at the ward significantly reduced.

Closed ward objectives

As soon as a safe treatment framework is provided for in the treatment of deep mental disorders, it is essential to understand the area and content of the mental substance that the patient evacuates (gets rid of). With a favourable treatment course, reflections on these substances can help to develop frozen areas of personality or suppressed processes of mental maturation. The diagnosis and treatment in a closed ward are intended to give direction to patient development. The very symptoms of the illness provide important information about both the deficit aspects of the patient's mental health and the way in which they are to be treated. A closed ward allowing for a 24/7 stay in acute phases of decompensation is expected to ensure:

1. safety
2. the possibility to express and describe the experiences of the illness
3. unfreezing and revitalizing resources to guide patient development

1. A stationary ward as a shelter and a place for the restoration of healthy internal structures from an individual and social perspective

Disturbed thinking and lack of control over what happens in your mind causes patients' fears of the greatest possible intensity. Experiencing fear is true both of the patient and of society as a whole, the latter being concerned with the instability of the person and the unpredictability of their behaviour. As the person who, in a crisis, can threaten him or herself and the surrounding environment in the event of behaviour control loss or activation of alloaggressive and destructive behaviour, legal regulations are intended to ensure the safety of a person [10]. Statistically, destructive behaviour is generally the domain of those who are healthy, while the sick are responsible for a small proportion of destructive behaviour in relation to others or the surrounding environment [11, 12].

Creating a sense of security as a reflection of the patient's internal need to achieve a stable foundation for an unstable structure is one of the fundamental elements of the treatment of deep mental crises. Patient experience shows that ambivalent feelings toward psychiatric hospitalization are often still present even at the point of discharge from the ward, with a yearning for a sense of safety as its important element [13]. This is perfectly illustrated by a patient's words: "I came to my senses here. I feel safe here (…) It's about me being safe. The staff made me feel safe and feel better." [14, p. 17] The quotations cited above from the statements of patients draw attention to the metaphorical meaning of "being admitted to a hospital/ward" as to "being received" in an emotional experience of being adopted into a foster family, which is accompanied by uncertainty, fear, but also a desire to be "wrapped in a warm blanket in someone's arms" [15, p. 102]. The structure of the ward, which provides a "hold", consistency and a clear goal of recovery, can be the only sense of stability for patients. It also provides an opportunity to be guided, but with the option of negotiating an escape into one's own space [16].

2. The ward as a place to evacuate deep unconscious feelings

Mental disorders trigger contact with intense emotions, which can be called proto-emotions [4]. Many authors consider that without a structural framework, once already spilt in decompensation, "mental jelly" cannot be reabsorbed or healed. Architectural and social structures are needed to support recovery after a deeper splitting of one's personality all the way down to its deep, unconscious layers [17]. Otherwise, some mental content may remain lost, dissociated and inaccessible via memory [18]. The mental wound then remains unhealed, and the scars of the soul do not allow posttraumatic growth which we are seeking as a response to a deep mental crisis [19]. "Therapeutic heroism" [20] refers to the possibility of the therapist to contain emotions from deep levels, within the framework of a therapeutic bond. Not everyone has such time possibilities or professional resources. Thus, to counterbalance the romantic attitude to treatment, it is important to create a structural framework for the treatment of deep mental disorders. This requires a balance between concrete and matrix thinking [21] and architectural imagination. The architecture of closed wards should, at least in part, reflect the internal architecture of the wounded worlds, while at the same time pointing to the order and future organization created in the therapeutic process. In short, the architecture of the treatment site should contain the hope of healing the sick soul [22].

From a patient's perspective, the basic element of expressing (and hearing) one's experience is the quality of the relationship and the way of communicating with the medical staff. Patients particularly value the opportunity to be heard with attention and interest. The previously discussed element of ensuring patient safety is also present in the patient – medical personnel communication. For example, a free space for expressing self-harm thoughts is an important function of suicidal prevention [23]. When patients openly describe their experiences to the personnel, there is a higher chance that they will be remembered and

understood. Thanks to a smooth transfer of information in the ward, such as in change-of-shift reports, this information becomes important and should reach all members of the therapeutic team [24].

3. The ward as the place to awaken health resources (recovery)

In the world of modern psychiatry, the concept of recovery is becoming increasingly important [25]. It assumes a significant impact and responsibility of the patient for his or her health. It emphasizes the importance of the healthy parts of the "I", their discovery and development. In most cases, this idea is also possible to be used in the ward, in the acute phase of the illness. This stage of treatment is a potential opportunity not only to manage acute psychotic symptoms or extreme mood fluctuations but also to discover the causes of the current crisis, to build a therapeutic alliance and a motivation to continue treatment. In other words, the stay on a stationary ward can be the beginning or a stage of a road where the patient will not only be the recipient of benefits but the person who actively co-decides on his or her fate. In this way, one can avoid the feeling of being a person who is ill "in an entirety". A part or even several components may be ill. However, despite the illness, the patient has a passion, interests, and fortes. These resources, in the context of a psychiatric ward, can be discovered both in a therapeutic relationship and in relationships with other patients. This also creates conditions for patients to feel the gratifying feeling of helping others, providing support or sharing their experience. One particular exchange – between the doorman who was a patient in charge of the ward doors and the patients' rights agent – became legendary in "6A". "You are a patient and you are holding the keys to the ward in your hand. Why is that?" "Because this is a closed ward" responded the patient/doorman. We are very grateful to all those who have supervised the ward for understanding, for example, the therapeutic expressions of how the patient-staff community functioned at the Babiński Hospital.

The concept of recovery implies not only a paradigm shift in the treatment of schizophrenic patients but also new organizational and therapeutic solutions [26-28]. Reflections on this area have appeared also in the Polish reality, both at the theoretical level [29, 30] and at the level of proposals for organizational solutions [31]. The recovery concept has important implications for the work of the therapeutic team. It helps to create a therapeutic identity for the team and to work out common views on the treatment, while leaving space for disputes and lasting controversy. Two basic methods are described below: individual contact and therapeutic community. Due to the limitations of this text, other forms of therapeutic work, as set out in the Appendix (Appendix 1), will be described separately.

4. Individual therapeutic contact with the patient in the general psychiatric ward

The link between the ward reality, which a patient with deep perception disorders receives as a

"matrix" [32] or at least as an organization providing both care and repression, is the physician [doctor, therapist, member of the therapeutic team – we use these words that are synonymous interchangeably]. Individual contact is a golden thread that connects the patient with reality, by immersing in changes of psychotic processes. The contact is massively perceived as significant, the scale of meanings is extremely variable in scope, and changes in the patients' perception of this relationship occur sometimes in fractions of a second [33]. Contact is the most important tool allowing the patient to enter the treatment program and benefit from it. In deep mental crises, the therapist becomes a mirror for the patient, in which the latter has the opportunity to see reality [34, 35]. In this sense, supportive psychotherapy is specifically aimed at encouraging the patient to gradually leave the world of internal chaos [36]. It is worth noting that this process is extremely difficult for the patient and requires a lot of trust. With time, the patient realizes that reality is not threatening. As Garry Prouty stated [36], real-world messages over time create a web of contact, a non-psychotic "anti-matrix" that strengthens the patient's efforts. They therefore allow to look at one's own crisis from a different perspective and then develop a conceptualization of the illness. This usually takes place in several steps:

a. The patient begins to be able to take the perspective of the other person (of the psychologist/therapist). He or she also understands that his or her behaviour/way of thinking may have been disturbing to someone. This is an important moment which is proof of the ability to look on the outside and to build the foundations for the conceptualization of one's own crisis. Recognizing the perspective of others (usually persons close and important to the patient) is often an expression of the patient's willingness to partake in discourse. The perspective of others is a symbol of the patient's own perspective: in such mental conditions, as an external view, not the patient's view, it creates the conditions for a safe ("not-mine") working through of the crisis. (*They could think I was crazy but I just wanted them to go away, I wanted to scare them. If I had just left then, I wouldn't have ended up here; rather than that, I'd have quietly gone back home.*)

b. The patient creates a preliminary conceptualization of the mental crisis, internalizing some elements that were previously experienced as "not-mine". This usually happens in parallel with building a sense of safety and a therapeutic alliance. Such working conceptualizations are often simple and relate to isolated difficulties rather than to the process of the illness. (*Something is really happening to me. I can't deal with the stress, everything upsets me*). This is often the stage at which the patient is ready to negotiate further treatment and rehabilitation in open conditions.

c. The patient builds a more or less elaborate concept of his or her mental crisis. As far as the resources (individual and social) allow, he or she internalizes the illness as part of his or her life in a non-threatening way. This creates a chance to experience an impact on his or her own life and treatment.

Individual psychological work with a patient in a psychiatric ward is largely based on building and strengthening a therapeutic alliance, accompanying the patient at all stages of building awareness of his or her own crisis and its origin, deepening the understanding of his or her own emotions and coping with others, as well as leaving room for seeking support from others (personnel, patients). In view of the specific nature of the effects (relatively short-term care in a deep mental crisis), the therapist should be aware of the limitations and important role that he or she plays: the role of the person who is responsible for preparing the patient for an informed and voluntary continuation of self-work, in a form adapted to his or her abilities and needs. The process described above, often seen with patients in deep mental crises, illustrates the role of therapeutic supportive contact and (perhaps above all) of the patient's resources to recover from the crisis. The principles described above will be elucidated using a specific example.

Working with a patient – an example

A patient, aged 26, hospitalized due to exacerbation of symptoms in schizophrenia. On admission and during the first week after arrival in the ward, he remains in a strong fear caused by a number of psychotic experiences (mainly of persecutory, religious, and nihilistic content). The anxiety leads to an extreme withdrawal and reluctance to establish contact. When asked if he wanted to talk, he runs away but comes back in a while to suggest a conversation in the dining room. In the course of the conversation, he communicates through psychotic content. The patient chooses the dining room on the ground floor of the ward, a noisy and chaotic place (reflecting his internal world), as the place to talk. After the meetings are moved to an office, he focuses on accessing the internet to view a certain religious portal. Each subsequent meeting is longer, with the patient providing an opportunity to reflect on his words. The patient is tense when he arrives for one of the next meetings. He sits down and for the first time, he waits for my reaction. He asks if there are cameras in the room and if I have access to the internet. I let him find out for himself that there is no network connection. For the first time, the patient is testing a certain reality, calming down significantly, spontaneously starting to talk about his interests in philosophy and writing poems. I encourage him to continue to write them in the ward, which he then does meticulously throughout his stay.

The patient does not ask about my understanding of his symptoms but increasingly gives me space to speak. The less psychotic content there is in his experiences, the more helplessness and uncertainty transpires, in which the desire hides to be taken care of in a comprehensive way. At the same time, in his ambivalence, he splits away anger and casts it outside, onto "others": "I'm going to sue all psychiatry." In psychotic content, religious-nihilistic delusions dominate at that time, concerning the approaching end of life ("The age of Christ is coming, I cannot do anything about it, it all makes no sense.")

The patient refers to earlier statements, combines them with each other, initially in a superficial manner, using his own meaning codes (words, associations). Despite the still present delusional content, a visible change happens in the patient: organization of the experience, curiosity, space sharing. This allows for a gradual planning of further rehabilitation interventions, towards which the patient shows mistrust. The possibility of direct continuation of the interventions, preceded by gradual preparation (visit to the rehabilitation ward, localization proximity) convinces him to give it a try. During the last meetings, the patient gives me a gift – he brings a box of tea he got from his mother and his personal history. He talks about his early experience of his father's death. During this story, he does not mention the prospect of his own death even once, which was probably the result of looking at himself in reality and in separation from the father's object, with whom psychotic proximity was identified only with death.

5. Therapeutic community

a. An example of the course of a weekly community meeting in the ward:

The community meeting was inaugurated in a timely manner by the ward president. Almost everyone was present. Once the meeting had started, one of the patients wanted to leave but was encouraged by the staff to stay. The first point on the agenda was for patients admitted to the ward within the last week to introduce themselves. One patient, who despite having been hospitalized for a while had not yet attended community meetings, introduced himself. The president then evaluated the functions performed by patients during the past week, while asking them to self-evaluate. He asked for at least one person who had performed a given function to evaluate how well he or she had been able to perform the task and what difficulties he or she had had. The next point on the agenda was a reading of the events of the previous week by the "chronicler", *i.e.* the person recording current events. The chronicle was detailed. At the end, less appropriately, he described the trip of one patient to dental surgery to remove a wisdom tooth as an important event in the life of the ward. Next, the people who had organized sports tournaments over the weekend gave out the diplomas to applause for the winners. The president discussed the therapeutic activities that had taken place over the previous week. Patients who partook in them described their experiences. They started to spontaneously praise the ward's occupational class and the therapist who runs the activities (applause again). Several patients wanted to leave the meeting but others encouraged them to stay. The president began taking submissions for performing various functions in the ward the following week and the patients hardly needed encouraging to sign up. There were more applicants for most of the functions than there were spots available. The patient who had failed to organize a literary event in the previous week, despite having undertaken to do so, applied again and assured that this time the event would be taking place. The next item on the agenda was the patients reporting free motions concerning the functioning of the ward. The first one to speak was

the president himself by encouraging everyone to respect the common areas in terms of cleanliness, airing of rooms and toilets, and taking care of the equipment in the ward. Afterwards, there were many who were willing to submit their motions. Patients petitioned for a room renovation or, for example, encouraged other patients to follow the principles of separating trash and recyclables. After the free motions, the president asked the patients who would leave the ward in the coming days to say goodbye. Patients took turns thanking the staff and other patients for their stay and care, and briefly described their plans, those related to further treatment but often also to their life in general. After the goodbyes, the president held elections for the new president and vice-president of the ward for the following week. The patients almost unanimously chose the president, while the other candidate received two votes. There were four candidates for the vice-president's post. The votes were fairly evenly distributed but in the end the vice-president was also successfully elected. The current president thanked everyone for their presence and closed the meeting.

b. Meeting dynamics:

The meeting began in silence. The president seemed to give a clear structure to the meeting, while staying very calm. During a few consecutive points on the agenda, the atmosphere was drowsy, a sense of "fog" was felt through which patients had wade to engage in specific statements. Thanks to the structure provided by the president and his ability to find space for other people's emotions' utterances even if they were not a propos the current point of the meeting, a certain climate of regression was felt. One could feel like in a school roll call. Patients were willing to speak and the community reacted, showing interest. Following the school metaphor, a group of patients formed which one could call "classroom rebels". However, the form of their contesting the sense of gathering was, paradoxically, strong involvement in events, signing up for multiple functions, ironic applause and submitting proposals. One could detect their fear of being rejected by the community, and their "clowning around" was a sort of desire to remain in the group. It is possible that the fear also had to do with the (completely verbally absent) psychotic background, which the president was happy to block as he structured the reality of the meeting. Patients who were currently in a worse mental form appeared frozen with the abundance of events. Then they became gradually more and more animated, up to the point of wanting to leave the room. When they were stopped by the staff, the tension would subside. Returning to the meeting, one of these patients sat down next to a member of the staff and remained there until the end. Paradoxically, the partially ironic involvement of several patients had a positive impact on the dispersing of the dense psychotic fog from the beginning of the meeting, and their actions engaged other patients to join the community.

The community was manic, at the limit of irritability. The chaos was organized by missionary delusions present in the structure of this community. The structuring role of the president with strong team support (in the form of engaged, but rather silent, presence) indicates the type of regression in the community, centred on one person [7]. Boundaries were poorly marked because a large number of patients were still in

broadcasting phases. The community channelled by a large proportion of tension, not completely organized by the gradually healing delusions of the members of this community.

Summary – therapeutic activities in the closed ward

Understanding the relationship between the internal structures of the "I" which creates the conditions for a normal internal life that is going on, we see that the role of the closed ward is not just to simply remove symptoms of the disorder. The symptoms must be understood to start deeper recovery processes. The role of the closed ward is to recognize the resources of the patient as well as the internal and external hindrances in development, which result in a mental crisis. Initiating the recovery processes which stem from patient resources not only leads to a simple disappearance of symptoms but, after stabilization, to directing the patient's life development. The social measures taken and the parallel accompanying psychotherapy are intended to enable the implementation of renewed or newly acquired life skills also outside the closed ward community. For this to happen, a continuity of treatment and care is necessary, as are a specified time perspective and knowledge of the tools that will be used in the subsequent phases of recovery, both in the closed ward and outside of it. The first and the most fundamental of these tools is the continuity of treatment and communication with the patient and about the patient between the professionals involved in treatment, assistance and care. Due to their specific characteristics, other therapeutic tools in the closed ward will be discussed in detail in separate articles.

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APPENDIX 1. Schedule of therapeutic activities in the ward

FIRST AND LAST NAME.....

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
OCCUPATIONAL THERAPY CENTER in the ward				
MORNING GYMNASTICS 07:00 am - 07:45 am	MORNING GYMNASTICS 07:00 am - 07:45 am	MORNING GYMNASTICS 07:00 am - 07:45 am	MORNING GYMNASTICS 07:00 am - 07:45 am	MORNING GYMNASTICS 07:00 am - 07:45 am
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		COMMUNITY MEETING 10:00 am - 11:00 am		
PSYCHOSOCIAL SUPPORT GROUP 02:00 pm - 03:00 pm	MUSIC THERAPY 01:30 pm - 03:00 pm	RELAXATION 01:45 pm - 02:45 pm	GROUP PSYCHOTHERAPY 01:15 pm - 02:30 pm	PSYCHO-EDUCATION 01:30 pm - 02:30 pm
MEMORY TRAINING 03:45 pm - 04:15 pm	MEMORY TRAINING 03:45 pm - 04:15 pm	MEMORY TRAINING 03:45 pm - 04:15 pm	MEMORY TRAINING 03:45 pm - 04:15 pm	MEMORY TRAINING 03:45 pm - 04:15 pm
MEDICATION TRAINING ORGANIZING MEDICATIONS BY ONESELF 08:00 pm - 08:30 pm	MEDICATION TRAINING ORGANIZING MEDICATIONS BY ONESELF 08:00 pm - 08:30 pm	MEDICATION TRAINING ORGANIZING MEDICATIONS BY ONESELF 08:00 pm - 08:30 pm	MEDICATION TRAINING ORGANIZING MEDICATIONS BY ONESELF 08:00 pm - 08:30 pm	MEDICATION TRAINING ORGANIZING MEDICATIONS BY ONESELF 08:00 pm - 08:30 pm