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## FROM FAMILY THERAPY WITH PSYCHOTIC PATIENTS TO COUPLES THERAPY. 30 YEARS OF PRACTICE AT THE DEPARTMENT OF FAMILY THERAPY AND PSYCHOSOMATICS<sup>1</sup>

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**family therapy  
couples therapy  
systemic approach**

### Summary

*The article presents the 30-year history and activities of the Department of Family Therapy and Psychosomatics in Krakow. Founded in 1993, the center stems from the psychotherapeutic tradition of Krakow psychiatry, initiated by Antoni Kepiński. Initially focused on working with families of psychotic patients, it gradually evolved towards couple therapy.*

*The team currently consists of psychiatrists and psychologists with psychotherapeutic experience. The Department combines clinical practice with scientific research and didactic activities, providing internships for psychotherapists. The therapeutic approach evolved from psychoeducation through strategic and structural methods to dialogical, narrative, and constructionist approaches, with strong influences from the Milan school.*

*Over the years, the patient profile has changed – couples now dominate, often with personality disorders in one partner, which has required integrating systemic approaches with psychodynamic ones. The Department also provides consultations for psychiatric wards and conducts research on therapeutic processes. The center played a pioneering role in training psychotherapists in Poland, publishing the first Polish family therapy textbook.*

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<sup>1)</sup> This article is an adaptation of the chapter: Furgał M, Gdowska K, Borcsa M. Ein Beispiel aus Polen: Familientherapie, Paartherapie und systemische Konsultationen – die Abteilung für Familientherapie an der Psychiatrischen Klinik für Erwachsene der Universität Krakau. In: Borcsa M, Wilms B, eds. Systemische Therapie: Anwendungsbereiche in der psychiatrisch-psychotherapeutischen Versorgung. Stuttgart: Verlag W. Kohlhammer; 2024, 279–293.

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*Currently, it struggles with systemic problems – long patient waiting lists and low valuation of family therapy in the healthcare system, which threatens the availability of this form of help in public healthcare. Despite these challenges, the team aims to maintain a high quality of care and participate in developing standards for the field of family therapy in Poland.*

## Introduction

Systemic family therapy has been developing in Poland since the late 1980s. It is the only therapeutic approach in the country that has evolved in parallel with its development in Europe. Earlier, traditional therapeutic approaches were eliminated from the public sphere due to the dominance of communist ideology in politics and social life. Family therapy developed in parallel in Kraków and Warsaw, the latter based at the Clinic of Child and Adolescent Psychiatry of the Institute of Psychiatry and Neurology. Somewhat later, the development of systemic psychotherapeutic practice took place at the Wielkopolska Society for Systemic Therapy in Poznań<sup>2</sup>, in collaboration with the Saarländische Gesellschaft für Systemische Therapie.

At the Kraków Psychiatric Clinic<sup>3</sup>, psychotherapy has been a subject of great interest for many decades. Even during the period of communist rule, when psychotherapy was called into question, various forms of therapeutic intervention continued to develop actively. The first psychotherapy group began operating on the initiative of Antoni Kępiński in the second half of the 1950s. It was a mixed group for patients with mood disorders, psychoses, and neuroses, both inpatients and outpatients. At that time, such groups (therapeutic communities) were established in an organized manner within psychiatric wards [1, 2], as well as within external, outpatient structures accessible to patients with neurotic disorders or personality disorders. This was a pioneering endeavour in Poland. Kraków remains an important center for psychotherapy to this day, and psychiatry practiced at the Kraków Psychiatric Clinic has always been treated as a psychosocial discipline, in contrast to the biomedical approach dominant in other centers.

At the Kraków Psychiatric Clinic, family therapy developed in parallel within two co-existing centers. The Department of Family Therapy, which we describe here, operated within the Adult Psychiatric Clinic under the leadership of Professor Bogdan de Barbaro. The second was the Child and Adolescent Psychiatric Clinic, established and run for many years by Professor Maria Orwid. Both centers always collaborated and learned from one another, drawing on international contacts, holding joint seminars and conducting mutual peer supervision.

Of great significance for the establishment of family therapy in the practice of the Kraków Psychiatric Clinic was the 1990 congress of the International Family Therapy As-

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<sup>2)</sup> The founder of this organization and its long-serving director was the late Dr. Jerzy Jakubowski.

<sup>3)</sup> This name, though often used informally, combines two organizations with personal links – the Department of Psychiatry at the Jagiellonian University and the psychiatric wards and clinics of the University Hospital

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sociation (IFTA) held in Kraków<sup>4</sup> and the establishment in 1998 of the Scientific Section of Family Therapy within the Polish Psychiatric Association.

### **The history of the Family Therapy Unit**

The Department of Family Therapy has been operating as an outpatient clinic within the Department of Psychiatry at Jagiellonian University and the University Hospital since 1993. Since 2016, it has been known as the Department of Family Therapy and Psychosomatics, reflecting the expansion of its research focus. However, the history of the Department began before its formal establishment. The origins of work with families date back to the time when the head of the department was the aforementioned Antoni Kępiński, who, in his publications as early as the 1970s [3], highlighted the importance of the family environment in the treatment of psychoses.

A distinctive feature of the Kraków center was its focus on psychosocial factors in working with patients with schizophrenia. One area of focus was the social integration of patients and social rehabilitation in the broadest sense; another was working with their families. The beginnings of research on the relationship between family functioning and schizophrenia were linked to the discovery of the role of emotional expression in the course of the illness [4, 5], although discussions regarding the role of the family environment in the genesis and course of schizophrenia had emerged much earlier. The concepts of researchers such as Frieda Fromm-Reichmann, Robert Liberman, and Murray Bowen were considered. In clinical practice, structured psychoeducation for the families of patients with schizophrenia-spectrum psychoses was introduced as a routine procedure in the treatment of hospitalized patients, following the prior organization of various forms of support for families.

The family therapy clinic of the psychosis ward served as the foundation for what would later become the Family Therapy Department. Its team worked closely with the ward and provided support to patients hospitalized there. Over time, as the number of patients transitioning to outpatient care grew, family consultations and psychoeducation began to evolve into increasingly long-term processes. The first and, at that time, only guide in Poland for families of patients with schizophrenia, *Możesz pomóc (You Can Help)*, edited by Bogdan de Barbaro and Krystyna Ostoja-Zawadzka, was published [6].

The outpatient clinic team began exploring opportunities to learn about family therapy. In 1984, its founder and long-time director, Bogdan de Barbaro, went on a fellowship to Stony Brook University, where he had the opportunity to establish many contacts and participate in conferences on family therapy. Four years later, he completed a one-year training program in family therapy led by Lyman Wynne, while also practicing at the Uni-

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<sup>4)</sup> Among those attending the congress were: Tom Andersen, Gianfranco Cecchin, Mory Elkaïm, Lyman Wynne, Helm Stierlin and Satu Stierlin, Don Bloch, Florence Kaslow, Klaus G. Deissler and Yrjö O. Alanen. The congress was organized by one of the founders of IFTA – Maria Orwid.

versity of Rochester Medical Center (New York). Upon his return, he organized a series of self-study seminars that allowed for the integration of the experiences of well-established teams engaged in family psychoeducation with the practice of the family therapy team at the Child and Adolescent Psychiatry Clinic. Other team members pursued their education through internships and workshops, including at the Palo Alto Mental Research Institute.

In 1993, the team gained the status of an independent Family Therapy Department, comprising Krystyna Ostoja-Zawadzka, Lucyna Drożdżowicz, Ilona Kołbik, and Przemysław Budzyna-Dawidowski, under the leadership of Bogdan de Barbaro. The establishment of this unit at the University was facilitated by the emergence in Poland of a specialization in family medicine, which, in addition to drawing on experience in somatic medicine, required support from researchers studying the socio-psychological structure of the family system.

The new political reality opened up opportunities for more intensive contacts with foreign centers. The network of relationships that was being built enabled participation in the global mainstream of family therapy. The Family Therapy Department became a member of the European Family Therapy Association. Over the years, the center was visited by individuals significant to the development of family therapy, who conducted seminars and training sessions<sup>5</sup>. With each such visit, team members gathered and integrated new theories and therapeutic experiences. To this day, one can find threads in the team's work inspired by those meetings.

### **The Family Therapy and Psychosomatics Department Team**

The team currently consists of three psychiatrists who are also psychotherapists, as well as three psychologists who are psychotherapists. Two of these individuals are experienced psychotherapy supervisors. At the same time, some team members are employed at the Faculty of Medicine of the Jagiellonian University Medical College. In addition to family and couples therapy, their responsibilities include conducting research and teaching. Most of this involves teaching psychiatry. Organizational support is provided by a secretary employed at both the Hospital and the University. She plays a key role in coordinating the team's work, accepts family referrals for therapy, and participates in supervision sessions. The secretary has comprehensive knowledge of the issues that couples and families bring to therapy, as well as how organizational matters impact therapeutic processes. The other team members, who focus on carrying out these processes, receive information about their colleagues' activities primarily during clinical meetings and supervision sessions.

This team structure helps to integrate scientific and theoretical thinking with clinical practice. A strong clinical commitment to working with patients enriches scientific activity and ensures that it is grounded in practical experience. The integration and synthesis of

<sup>5)</sup> Among others: Helm Stierlin, Lyman Wynne, Don Bloch, Hugh Jenkins, Alan Cooklin, Gill Gorell Barnes, Gianfranco Cecchin, Maurizio Andolfi, Mory Elkaïm, Harlene Anderson, Salvador Minuchin, Tom Andersen, Klaus G. Deissler, Hugh Fox, Esther Perel, Peter Rober, Jill Scharff, and David Scharff.

these two areas—clinical work and science—is a strength of the team; however, addressing various issues entails a heavier workload.

The Department of Family Therapy and Psychosomatics is a unit where individuals training in psychotherapy can practice their professional skills. The center hosts approximately five therapists on internship at any given time. These are typically individuals who are either in the midst of or have completed their comprehensive training and are awaiting their certification exam. Occasionally, the interns include physicians specializing in psychiatry; for them, this internship is not mandatory, but they may choose to participate if they are interested in family therapy.

Trainees have the opportunity to participate as observers in family and couples therapy sessions. They actively contribute by taking part in discussions held during breaks and in debriefings of the therapy sessions they observe. In processes where this approach is used, they also become members of the reflective team. Families are informed about their participation and role in the therapy process. Interns also function as co-therapists, which allows them not only to learn about family and couples therapy but also to make their own personal, unique contributions to the therapeutic processes. The internship is completed with a written report on the course of a selected psychotherapeutic process. This form of collaboration benefits everyone involved in the exchange, and especially the patients, as it provides an opportunity to broaden the scope of reflection on their situation.

Under certain conditions, trainees are invited to lead the therapeutic process. In such situations, they are provided with continuous, in-person supervision—conducted by a staff member of the Department who accompanies them throughout the process, regardless of whether such therapy can be supervised during the Department's regular clinical supervision sessions. It is not possible to implement this training model on a routine basis, but those who participate in it have a unique opportunity to train in a way that is difficult to obtain elsewhere. Internships at the Department are very popular both because of the opportunity for trainees to directly observe the work of psychotherapists and to make a real contribution to the therapeutic process.

### **Advances in clinical practice**

In the early days of the family therapy team's work, when it was still based at the family therapy clinic of the psychosis ward, a psychoeducational approach focused on improving emotional relationships within the family was common [7]. Following initial training at foreign centers, transgenerational analysis, structural and strategic interventions, as well as other approaches stemming from group therapy, communication work, and reflection on family experiences, began to appear more frequently in therapy.

As the team grew—and through numerous seminars, both internal and led by teachers visiting Kraków—the approach to therapy evolved. As a result of collaboration with colleagues who had training experience in the Milan approach, the structure of the sessions

took shape: observers began participating from behind a one-way mirror, a break was introduced during the session, and an intervention followed a joint reflection on the session [8].

As the center's training program expanded, the role of co-therapists behind the one-way mirror began to be filled by psychotherapists in training who were completing their internships at the center. Circular questioning, hypothesis generation, a focus on neutrality, and the active cultivation of curiosity began to take the place of strategic interventions. Methods based more on dialogue, active listening, agreeing on meanings, and jointly seeking solutions were put into practice relatively quickly, supplanting expert-driven approaches [9]. Sessions began to emerge that incorporated Tom Andersen's reflective team method [10]. With the development of narrative and constructivist approaches in family therapy worldwide, these concepts began to dominate therapeutic practice [11, 12].

Notwithstanding the above, the experiences of earlier approaches—strategic, structural, and communicative—as well as various contributions from the Milan School remained very much alive in the therapists' practice. Differences between individual working styles began to emerge. The team always maintained a high degree of acceptance for differing approaches to psychotherapy; there was no tendency to rigidly structure the work around a single mandatory model.

As the second generation of therapists at the Family Therapy Department became more active—having been trained in both psychodynamic and systemic approaches through structured training programs and having undergone psychoanalytic therapy themselves—these approaches were increasingly integrated into the therapeutic processes they conducted [13]. This was facilitated by the team's supervisors and the increasingly long duration of therapy processes.

Team supervisors have become essential to a practical approach in clinical work. Years ago, a routine was established whereby the Family Therapy Unit's work is supervised by a supervisor from the Family Therapy Outpatient Clinic of the Department of Child and Adolescent Psychiatry, while a supervisor employed by the Unit supervises that team. This arrangement had and continues to have its pros and cons. It facilitates mutual learning and the exchange of experiences, but it is more applicable to the consultation of clinical cases than to deeper supervision addressing certain areas of the therapist's personal life or interpersonal dynamics within the team and among therapists jointly conducting the therapeutic process. Consequently, since the Family Therapy Department began its work, the team has also been supervised by external supervisors. Of particular importance for the development of our working method were: several years of supervision (clinical supervision and team supervision) conducted by a group analyst also experienced in family therapy, as well as several further years of supervision with a psychiatrist working psychoanalytically and systemically with families.

This period has clearly influenced the way we work with couples, particularly those in which one partner has a personality disorder. The dominant profile of the Center's patients has also changed. Currently, couples make up the majority of referrals to the Family Therapy Outpatient Clinic. This is due to a growing social need for this type of therapy.

In contrast, families in which the identified patient is a teenager are referred to the Family Therapy Clinic.

### Current clinical practice

As part of the Department's clinical work, we accept families and couples seeking therapy primarily due to existing parenting difficulties, systemically rooted emotional problems experienced by a family member—including mental disorders—conflicts within the couple, psychosomatic disorders strongly intertwined with the family system, eating disorders, complicated grief, or the mental illness of a family member.

Initially, we relied on referrals from psychiatrists and psychologists; however, due to the high dropout rate among patients referred in this way, we developed a practice of self-referral for families. Even if the initial contact person (a family doctor, another therapist, or a distant relative) sees a need for family consultation and refers the family to us, we ask the family to contact us in person and provide an initial description of the problem. A secretary takes the phone call, collecting basic administrative information and recording the content and manner of the referral. Based on this, the family is invited to an initial consultation to determine whether their problem can be addressed by the Center's therapists. A contract is then established: preliminary therapy goals are formulated, and a preliminary plan is outlined.

Before registering, families are required to review the center's statement regarding its policies and procedures, published on the website<sup>6</sup>. Information for patients wishing to undergo couples or family therapy includes a description of who is eligible for assistance and who is not, the composition of the team and its competencies, how therapeutic activities are linked to teaching activities, the rules governing the participation of trainees in sessions, and the principles of confidentiality in therapy and professional secrecy. The website also states that sessions are recorded and explains the purpose of recording and how the recordings are handled. The principles of supervision and the individuals supervising the team are also presented. Additionally, there is a note regarding the necessity of an initial psychiatric consultation and a description of its purpose, information about the methods and techniques used, and potential difficulties encountered during the therapy process.

The decision to begin therapy is made during consultation meetings. Therapy is conducted by one or two therapists employed at the Center, with interns observing as co-therapists. The sessions are recorded. Families are fully informed about the procedures for handling the recorded material. It serves as the basis for supervision and for introducing new interns to ongoing therapeutic processes. The recordings are stored on a secure server, not connected to the Internet, and are deleted upon completion of therapy. They do not constitute part of the officially defined patient records.

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<sup>6</sup> Department of Family Therapy and Psychosomatics, Chair of Psychiatry, Jagiellonian University Medical College, <https://ztrip.cm-uj.krakow.pl/dla-pacjentow>.

The team does not impose a specific format tied to a particular therapeutic approach on its therapists. However, every team member is trained in systemic and psychodynamic psychotherapy. Over the years, the techniques used by each therapist have been shaped largely by their experience, training, workshops, supervision, and personality. The Milan approach has had the greatest influence on the team's working methods, particularly from the second period of the Milan team's operation [14, 15]. The most visible manifestation of this school's influence is the structure of each session—including a break during which the session's progress is discussed with co-therapists, and a final commentary following the break. Our work also shows significant influences from the transgenerational [16], constructivist [11, 12], and narrative [17] approaches. In many situations, we utilize more traditional structural, strategic, or communication techniques.

In working with couples, in addition to systemic methods, interventions based on psychoanalytic or psychodynamic approaches are also employed [18]. This shift was a result of the growing number of couples seeking help, in which one partner had a personality disorder. At that time, the team was supervised by a group analyst who encouraged us to extend the processes beyond the typical duration of systemic therapy and to understand marital relationships in light of object relations theory [19]. The team had already been prepared for this through psychodynamic training and their own psychoanalytic therapy. This created a unique opportunity to help individuals with personality disorders who were poorly motivated for psychotherapy. The growing popularity of psychoanalytic couple therapy in Poland, along with the opportunity to participate in conferences, training sessions, and supervision in this field, played a significant role in this shift. In 2015, the Department organized workshops on psychoanalytic couples therapy led by David and Jill Scharff. However, the team remains committed to the systemic approach and works in accordance with its principles, particularly in family therapy.

The primary methods for evaluating the effectiveness of therapeutic processes are supervision and clinical assessment of treatment outcomes. However, various research programs are periodically undertaken to verify the effectiveness of our work using scientific methods. These programs are inspired by research interests and reflections on current therapeutic processes. The Department has conducted research on dropouts [20], the therapeutic alliance [21], couple therapy involving patients with personality disorders [22], and couple therapy in the context of perinatal loss [23]. Currently, a project is underway involving a qualitative analysis of interactions between the therapist and the couple in the context of borderline personality disorder.

Another key area of work involves consultations and supervision of care for patients hospitalized in psychiatric wards, as well as in other psychiatric clinics at the University Hospital. A team member serves as a supervisor for two inpatient wards, including the general adult psychiatric ward, as well as the Addiction Treatment Clinic and the Day Treatment Unit for Addiction designed for patients with dual diagnosis. This is particularly important for patients who, due to relational issues, do not achieve good results from pharmacological treatment in the hospital. An example of a systemic intervention was

a consultation between the medical and psychological teams regarding a crisis that arose in connection with the treatment of a severely disturbed patient with Münchhausen syndrome.

The team has the most experience in counseling patients with treatment-resistant depression and their families. This provided the basis for conducting systematic qualitative studies of the families of patients with this form of depression, which included all cases reported by the ward [24]. The studies aimed to analyze the functioning of the patient's family both in terms of the presence of interactions that might sustain the patient's depression and the family's potential to change the psychological mechanisms that sustain depression. These activities were part of a research program but also led to the initiation of family, couple, or individual psychotherapy for some patients.

It is standard practice to discuss cases of hospitalized patients whose treatment is complicated by issues related to their family dynamics. Although most wards typically conduct family consultations for hospitalized patients on their own, the therapeutic and diagnostic experience gained through training and systemic practice adds significant value to the work of these units, particularly in difficult and complex clinical situations.

### **Training, teaching, and research activities**

In the mid-1990s, after gaining initial experience in family therapy and having assembled a team experienced in psychotherapy with some training experience, the Family Therapy Center began activities aimed at training psychotherapists. It was one of the first centers in Poland to offer training in psychotherapy and the first to offer training in family therapy. In 1994, the Department's team published a basic textbook on family therapy, *Wprowadzenie do systemowego rozumienia rodziny* (Introduction to a Systemic Understanding of the Family) [25]. It was the first Polish textbook for training in this field.

The first three-year courses, offered since the mid-1990s, focused primarily on family therapy. Shortly after the year 2000, as the psychotherapy training system in Poland developed under the supervision of the Scientific Section of Psychotherapy of the Polish Psychiatric Association, these courses were integrated into the training program for psychodynamic psychotherapy. A four-and-a-half-year, and later five-year, so-called comprehensive psychotherapy course was established, accredited by the Polish Psychiatric Association. These were the beginnings of the development of psychotherapy training standards in Poland. The Family Therapy Department had an experienced team of psychotherapists working together under regular supervision, maintaining contacts and collaborating with other training centers. For organizational reasons, the training was overseen by the Krakow Department of Psychiatry Foundation and took place in the building of the Psychiatric Clinic.

In 2012, in connection with organizational changes at the Jagiellonian University and the University Hospital, the training program was transferred outside these structures. The team established the "Na Szlaku" Foundation for the Development of Family Therapy, which took over the organization of the courses. It also began to provide clinical family therapy.

To this day, training is conducted within the Foundation, with significant involvement of staff from the Department of Family Therapy and Psychosomatics. Both the Department and the Foundation are active members of the European Family Therapy Association (EFTA), in particular its Training Institutes Chamber (TIC). The Department regularly participates in conferences organized by this association. Currently, the Foundation operates autonomously, bringing together over 20 family and couples therapists, organizing scientific conferences, and participating in national and international scientific meetings. To date, more than 600 psychotherapists have completed the full systemic–psychodynamic training courses. The Center maintains contact with its graduates, inviting them to participate in events organized by the Department and the Foundation.

The staff of the Department of Family Therapy and Psychosomatics is involved in undergraduate teaching—they teach courses in psychiatry and various areas of psychology to medical students, as well as courses in family therapy to psychology students. Postgraduate education is another important area of activity. The Department participates in conducting courses for physicians specializing not only in psychiatry but also in family medicine. Shortly after the Department of Family Therapy was established in 1994, the specialty of family medicine was introduced in Poland. The department actively participated in the development of the specialty curriculum. Training in the systemic understanding of the family remains a core component of this specialty, although its scope has recently been reduced.

In connection with this collaboration, research projects on psychosomatic disorders were undertaken. As family physicians became increasingly aware of the family context of psychosomatic disorders, there was a surge in referrals for family therapy from medical practices. Publications began to appear: Bogdan de Barbaro published the book *Pacjent w swojej rodzinie* (The Patient in His Family) [26], and articles on psychosomatics from a systemic perspective also began to appear. The systemic approach to the treatment of psychosomatic disorders was introduced as a course topic within psychotherapy training programs.

The professional responsibilities of those team members employed by the University include conducting scientific research. The topics they address include fundamental theoretical issues, such as comparing the functioning of families experiencing various clinical problems, studies of families of patients with somatic illnesses and of families forcibly displaced after the war, analyses of mentalization patterns in families across various clinical and developmental contexts, and the family mourning process, particularly complicated grief and dying. However, the most interesting, inspiring, and motivating work for the team is research on psychotherapy. This includes the aforementioned qualitative studies of families of patients with depression, as well as research on communication processes during therapy sessions in couples where one partner has a personality disorder [27]. Currently, a research project is underway examining interactions in couples where one partner has borderline personality disorder, analyzed in terms of conversation and other interactive behaviors. The initial findings were presented at conferences of the Society for Psychotherapy Research and the European Family Therapy Association in 2025.

In conducting our research, we collaborate with scholars—many of whom also have clinical experience—from universities in Nordhausen, Helsinki, Hamburg, and Heidelberg. Our research integrates scientific inquiry with the therapist's practical work, enabling its validation. It involves not only researchers but also clinicians. Therefore, the research process directly influences the level of reflection on clinical work with families and couples.

### Current issues

The demand for psychotherapy and awareness of its benefits are growing rapidly in Poland. The crisis of the family as an institution, relationship issues stemming from disruptions in the stability of the family environment, and the pace of social change are major factors affecting family relationships and individual well-being. The number of couples and families seeking therapy is rising sharply. At private centers, waiting lists range from several months to a year. The Department of Family Therapy and Psychosomatics is one of the few such facilities, and in its region, it is the only one where family and couples therapy is covered by health insurance; the current wait for therapy is over two years. In special cases, such as the death of a child and complicated grief, a decision is made to admit the family out of turn. A similar situation applies to the families of patients hospitalized in the clinic's wards that we consult. However, in most cases, the waiting time is too long for the family to receive help when they need it.

Family and couples therapy is undervalued by insurers. For a two-hour couples therapy session conducted by two therapists, the hospital receives half the amount it would receive for a one-hour individual psychotherapy session conducted by a single therapist. As a result, the work time of a couples therapist is valued nearly eight times less than that of a therapist conducting individual therapy, even though couples or family therapy is more demanding and requires additional skills.

Numerous interventions carried out at decision-making bodies (the Ministry of Health, the Agency for Health Technology Assessment and Tariff System, and the National Health Fund) by representatives of the Polish Psychiatric Association, hospital management, and even the Mayor of Kraków have yielded no results. The team has managed to remain within the hospital's structure because family and couples therapy is regarded by the clinic as an important activity that impacts the overall effectiveness and quality of other services. Unfortunately, in light of the hospital's financial difficulties, activities deemed unprofitable are being scaled back.

Family therapy in Poland's public healthcare system is on the decline, with the exception of child and adolescent psychiatry, which is treated differently. Family therapists typically also hold qualifications in individual therapy, and this skill is preferred. This situation is further exacerbated by the lack of legal regulations governing the profession of psychotherapist. As a recognized and leading center for family and couples therapy, the Department of Family Therapy and Psychosomatics strives to participate in the crea-

tion of new legal regulations and ethical standards; however, we are undoubtedly facing a state of deep crisis.

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