Helping Chronic Psychiatric Patients Adjust to Sociopolitical Changes in Poland

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ACCORDING to the stress-diathesis model, persons with serious mental disorders, such as schizophrenia, have cognitive and psychophysiological vulnerabilities that under conditions of stress, lead to psychotic symptoms and diminished interpersonal functioning (Nuechterlein and Dawson 1984; Zubin and Spring 1977). Pharmacological and psychosocial treatments provide buffers to disease vulnerabilities by compensating for neurotransmitter abnormalities, directly reducing the experience of stress, teaching a range of social and instrumental skills that help patients cope with life problems, and dispersing patients' stress through a well-functioning support network (Liberman et al. 1984). To conduct psychosocial treatments well, clinicians must have knowledge regarding the community stressors that impact upon the patient, the range of skills necessary to navigate the hurdles of everyday life (Goldfried and D'Zurilla 1969), and the interpersonal factors that facilitate formation and maintenance of support systems (Tolsdorf 1976). Clinicians can develop individual rehabilitation plans that reflect patients' strengths and weaknesses in each of these areas.

The profile of life stressors, coping skills, and support networks reflects the culture in which patients and their treatment teams are immersed. Because of their histories and recent sociopolitical changes, the range of stressors in Poland and other Eastern European nations differs greatly from stressors in the United States. The purpose of this paper is to illustrate how recent changes in Poland have shaped the life-styles and coping repertoire of its severely mentally ill population. Much of this paper reflects insights gleaned from the first author's experiences at the Rehabilitation Day Center of the Institute of Psychiatry and Neurology in Warsaw.

How Have Poles Experienced These Changes?

To Westerners, recent political change in Eastern Europe seemed rapid and dramatic, a sudden miracle of Soviet perestroika. Poles, however, have not experienced a sharp distinction between the "communist" past and the "democratic"

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Recent changes in Poland have created severe economic and political hardships for its citizenry. Despite these difficulties, the average Pole has a range of interpersonal and coping skills that allows him or her to adapt to these hardships. Severely mentally ill patients lack these adaptive skills and, hence, experience the current changes as extremely stressful. Whatever the shortcomings of the communist system might have been, the old regime set priorities for finding home and work for the chronically mentally ill. This prioritization of human needs kept the stress level down for this population. The current changes have removed the safety net for severely ill psychiatric patients. In an effort to cope with these changes, patients are seeking professional help at an increased rate. For example, the number of drop-ins to our Day Center has risen markedly. Similarly, many outpatients are now requesting to be returned to the hospital to "escape" community stressors while inpatients are asking for longer institutional stays.

**The State of Polish**

Unlike Soviet psychiatry, which has been shown to be an abusive instrument of the government (U.S. Delegation 1989), Polish psychiatry has divorced itself from coercive demands of the state. Dissident Poles, including members of Solidarity, have sought to prevent the corruption of the mental health system. For example, in the beginning of the last decade, Walesa blocked implementation of a Mental Health Act in which involuntary commitment would have been determined by "sometimes hostile" government courts. Polish psychiatrists cherish human rights and have widely defended them in organizations like the International Human Rights Committee and the World Psychiatric Association.

Despite the lack of human right abuses, the quality of Polish mental health services is lacking (Dabrowski and Stanczak 1988). Only about 10% of the chronically
oping countries (Jablensky et al. 1980; Sartorius et al. 1978). Now, however, dis-
abled patient cooperatives are forced to com-
pete with other enterprises; in so do-
ing, cooperative supervisors have termi-
nated patients with severe disabilities and have hired individuals with minor
psychiatric or physical difficulties in their
place. In the past, the vocational coun-
seelor at our Day Center had been able to
refer from 30 to 50 clients per year to the
work cooperatives. In 1990, however,
only 1 client with severe mental illness
was accepted. Movement to a freer econ-
yomy seems to be further disenfranchis-
ing the chronic mentally ill from the work-
place.

A relatively small number of patients
in the past, who had concealed their psy-
chiatric symptoms and history, and who
had sufficient work skills, found and
maintained competitive employment. Un-
fortunately, with increased competition
in the workplace, many of these patients
are being squeezed out as well. Prior to
recent economic changes, Polish employ-
ment was characterized as nondemanding
and slow paced. Recent pressures that re-
sult from an open market economy have
translated into more stressors at the job
site. Expectations regarding the quality
and quantity of production have in-
creased as well. As a result, the rela-
tionship between many supervisors and em-
ployees has worsened. Severely mentally
ill patients possess marginal social skills
that are no longer sufficient to meet the
pressured demands of their bosses. Thus,
many patients in competitive work sites
are quitting or being terminated from
their jobs.

A case example: Despite persistent low-
level positive symptoms of schizophrenia
and social withdrawal, Jan had been able
to keep his job as an engineer in the auto
industry for more than 12 years. As de-
mands for product quality and job effi-
ciency increased, Jan’s workload ex-
panded greatly. Unfortunately, he did not
have flexible work skills to help him man-
age his time better, and he quickly fell
behind. His supervisor become more hos-
tile with Jan as the supervisor himself
experienced greater demands for produc-
tivity and as Jan did not meet work quo-
tas. Jan had not experienced supervisory
pressure on the job site before and did not
have appropriate assertion skills to cope
with such demands now. The combined
stressors eventually overwhelmed him
and his psychotic symptoms returned.
Jan subsequently had his first psychia-
tric hospitalization in many years; he was
unable to return to work after he was re-
leased.

Stressors in the Community

Several day-to-day tasks that might
seem minor nuisances to most people pro-
vide insurmountable hurdles to severely
mentally ill patients. Riding public trans-
portation and shopping are two such
tasks in Poland. Buses and trains in War-
saw are very crowded, such that, if pas-
sengers do not loudly say they want to
get off at their destination and push
through the crowd toward the door, the
vehicle will continue on to its next stop.
Many chronic mentally ill patients are un-
able to be sufficiently assertive and
meekly remain on the bus until the throng
of people clears out. Marek, a 34-year-old
male with schizophrenia, was arriving at
his treatment center each day more than
an hour late. Unable to ask people to let
him off the bus, he rode it past his stop to
the end of the line and then hiked back
to the treatment center. Recent economic
changes have only worsened the transpor-
tation crunch.

Shopping in Poland in the past required
consumers to stand in several long lines
each week to pick up various commodi-
ties. To overcome this hurdle, many ex-
tended families shared information with
one another regarding desirable consum-
able they discovered while shopping. For
example, if a housewife found that a few
good pair of shoes still remained at the
local store, she might share the informa-
tion with her parents and in-laws. And,
because the quality of food supplies was
manage instrumental skills in the community was narrowed. Patients were taught to make appointments in person because access to a telephone or private car is severely limited. Because of the rising problem of alcoholism, the effects of consuming alcoholic beverages while using psychotropic drugs were discussed at greater length.

Since this first evolution, the modules conducted at the Day Center have been modified further, reflecting more recent changes in Poland. In the past, periodic rapid fluctuations in prices of commodities prevented successful instruction on budgeting skills. Now that prices have stabilized at extremely high levels, learning money management skills has become a top priority. As another example, with the loss of disabled persons' work cooperatives, a new module was developed to teach skills for finding a job in the competitive job market. Skills in this new module include inquiring about available jobs by phone, searching want ads in the newspaper, and making a good impression during interviews (Jacobs et al. 1984).

More than 150 chronic schizophrenic outpatients have participated in the training modules since the inception of the program. At the end of 1990, a controlled study was designed to field test the UCLA Medication Management Module. A pilot phase of this NIH-funded study is currently underway; data will be available in three years when the study is completed. Anecdotal data, however, suggest that the modular training programs help our patients to acquire the necessary skills to cope with the current stressors.

A case example: Waldemar was a 27-year-old chronic schizophrenic who rarely ventured outside his mother’s home. He was shy, withdrawn, and inept in most community coping skills. For many years, his mother protected him from outside demands by providing for his needs as a homemaker. The restructuring of the Polish economy, however, required her to seek work to maintain the family income. Threatened with hospitalization, Waldemar was enrolled in the day rehabilitation program of the Warsaw Institute of Psychiatry and Neurology and completed training in grooming, self-care skills, and basic conversation skills. He also learned to manage his own maintenance antipsychotic medication and joined two social clubs for leisure-time pursuits. He gained some cooking and housekeeping skills, which he applied at home, thereby relieving his mother of stress in her role. Through participation in skill-building rehabilitation, Waldemar avoided hospitalization and became more independent in his family and community.

**Summary**

Sociopolitical upheaval, regardless of its form or national locale, creates significant life-style changes for most citizens. Severely mentally ill patients do not have the same breadth of coping skills and support networks as the general population; thus, the impact of cultural change is even more pronounced on them. Clinicians should be sensitive to the clinical impact of major economic and political changes in their communities. In the United States, for example, state legislatures and Congress frequently manipulate the budgets that affect social programs. Changes in priorities and reduced expenditures trickle down and adversely affect the mentally ill as supportive programs are cut. In Poland, vast socioeconomic and political changes have threatened the safety net and supportive services previously available for persons with disabling mental disorders. As economic or political policies affect day-to-day living, professionals in mental health programs worldwide need be vigilant to the fragile psychiatric status of their chronically mentally ill patients.

As the impacts of sociopolitical change on patients become better understood, clinicians can adjust treatment plans and programs at the first indication of change. In much the same way that prophylactic medication administration can mitigate