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THE MODEL OF THERAPY IN THE PERSONALITY DISORDER AND NEUROSIS UNIT

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Summary

Adequate management and prevention of personality disorders are a huge challenge for both clinicians and administrators of health care. It seems that social awareness about the existence of these disorders has been growing in recent years but it still remains an insufficiently recognised problem, especially in Poland. In the health care system, the scale of the phenomenon and various costs involved are still underestimated. The insufficient awareness of the basic legal regulations affecting social and health policy makes it impossible to develop effective forms of treatment and assistance for people with personality disorders. These issues have been extensively addressed in an article that lucidly discusses the difficulties in organising and conducting the treatment of personality disorders in Poland [1, 2]. In this text, for the purpose of introduction, the solutions postulated therein will be recalled, supported by the experience of some European centres and conducted scientific research. This will be followed by the presentation of a model of treatment of personality disorders, developed by the staff of the Personality and Neurosis Unit of the Dr Józef Babinski Clinical Hospital in Kraków (OLZON). This model may constitute a blueprint for creating a system of specialist care for people with deep personality disorders in Poland.

Introduction

Prevalence and diagnosis of personality disorders

Epidemiological studies carried out in various countries give very different figures describing the prevalence of personality disorders, ranging from 2.1 to 18 percent of the general population, which constitutes 5–8 percent of all people seeking help from medical practitioners of various specialties, and about 7.4 to 50 percent of patients treated in psychiatric hospitals [3]. Unfortunately, we do not have data on the Polish population. The only study on the prevalence of mental disorders that has been conducted in Poland, "Epidemiology of mental disorders and access to mental health care: EZOP – Poland" [4], did not include personality

disorders. The reason was that the interviews conducted by numerous interviewers did not take into account the criteria for diagnosing these disorders. It is well known that conducting epidemiological studies in the area of mental disorders is an extremely complex issue. Additional difficulties arise from the problems posed by personality disorder diagnostics itself, which is a laborious and complicated process, requiring a certain amount of experience and appropriate professional competence. Therefore, it was practically impossible to prepare a study which would allow for a reliable examination of ten thousand respondents, also in terms of personality disorders. Unfortunately, the lack of Polish data in this area means that we still do not have information which would fully and reliably reflect the true prevalence of one of today's most common mental disorders. The lack of specific data and the fragmentary treatment of mental health issues – narrowing down mental problems to selected diagnoses from the so-called "first axis" of the DSM-IV and omitting the issue of personality disorders – contribute to marginalising these disorders and, for example, when financing their treatment is considered, they are still placed next to neurotic disorders. It should be emphasised that these are two different medical conditions, and personality disorders may coexist with or predispose to other disorders, including anxiety disorders. While a "healthy" personality, *i.e.* a flexible personality with a wide range of traits enabling appropriate adaptation to various life conditions, protects against the occurrence of some mental problems, a "disordered" personality, on the contrary, is conducive to their occurrence. Individuals with personality disorders usually have serious difficulties in dealing with their emotions, controlling their impulses, and establishing satisfactory relations with others. These problems take years to develop and manifest themselves in all areas of life, so their treatment is a complex and lengthy process. Analyses conducted around the world clearly indicate that the treatment of personality disorders requires the use of therapeutic interventions specific to this group of patients, and the basic and effective method of treatment is long-term psychotherapy. In this case, "long-term" means lasting years, not months.

Treatment

It is worth emphasising that the hospitalisation of patients with personality disorders in general psychiatric wards should be limited only to crisis situations [9, 10]. As shown by some of the data cited above, it often happens that people with this diagnosis account for up to half of the patients who are treated in psychiatric hospitals. This happens when there are no specialised programmes dedicated to this group of disorders. Long-term hospitalisations in general psychiatric wards for people with this diagnosis are definitely iatrogenic interventions. They often result in the invalidation of patients and, in consequence, people who are potentially capable of independent and creative living become chronic psychiatric patients, dependent on their families and/or the welfare state. An optimal solution is provided by intervention/crisis units offering the possibility of short-term hospitalisation in situations where, for reasons of the

patient's mental state or safety, this is necessary, as it is done, for example, in Germany (Ravensburg Hospital) [9].

For personality disorders, the treatment of choice is psychotherapy. Such theoretical approaches as Mentalisation Based Therapy (MBT), Transference Focused Psychotherapy (TFP), Dialectical Behaviour Therapy (DBT) and Schema Focused Therapy (SFT) are currently considered to have proven effectiveness. It is worth noting that the selection of the treatment method is not only important for the patients but it is also important for the people working with the patients. The treatment method, as a theoretical concept, provides a point of reference, support, and direction for treatment. In situations of frustration or uncertainty, which are essential stages in the treatment of patients with personality disorders, it helps to jointly overcome emerging crises, often originating in the psychopathology of the disorders. Therefore, when choosing a particular theoretical approach, it is important that all members of the therapeutic team are familiar with it and are able to use it, *i.e.* that everyone "speaks the same language." This does not mean, however, that everyone has to be a qualified psychotherapist in the chosen approach.

Two of the theoretical approaches mentioned above, TFP and MBT, are based on psychoanalytic concepts. In MBT, early disturbances in the interaction with parents are considered to be a central problem, leading to serious difficulties in interpersonal relations later in life. The therapeutic work is based on the therapeutic relationship and the emerging transference. The same is true for TFP. This approach was created by Otto Kernberg who operationalized Klein's theory of object relations, thus enabling scientific research in the field of psychotherapy in the psychoanalytic approach [11]. The other two methods emphasise more behavioural (DBT) and cognitive (SFT) aspects.

The lack of specialist treatment for patients with personality disorders, that is, the so-called "treatment as usual," not only adversely affects the patients themselves but also entails enormous costs for the health and social care system [12]. These costs are borne first by general psychiatric wards, where these people are usually admitted in crisis, and other hospital wards – toxicology, surgery, or accident and emergency. The costs thus incurred are not related to causal treatment but to emergency measures, for example life-saving after a suicide attempt.

Another source of costs is absence from work and so-called indirect costs, *i.e.* various types of social benefits used by the patients themselves or their relatives (unemployment benefits, alimony fund, *etc.*) Effective help aimed at causal treatment makes it possible, above all, to improve the patients' functioning and quality of life. This helps to significantly reduce the expenses borne by the state budget [13, 14, 15]. In Germany, for example, the annual cost of inpatient treatment for borderline personality disorder alone is 4 billion euro. This represents 20 percent of the total budget for the treatment of mental disorders [16]. Available economic analyses indicate that the costs borne by Europe in connection with this disorder amount to more than 27 billion euro per year [17]. This is more than the costs generated jointly by people with autism, ADHD, and behavioural disorders. The vast majority of these costs are indirect

expenses, primarily resulting from sickness absence. Unlike it is the case in somatic diseases, the indirect costs of mental disorders account for more than two-thirds of all expenses [17]. It seems that in the case of patients with personality disorders this proportion may be even higher.

A comprehensive model of assistance

The postulated model for helping people with personality disorders is a three-stage system involving social, psychotherapeutic, and psychiatric interactions. One of the key points is the assumption that the type of help should be tailored to the needs of the patients, which depend more on the severity of the disorder than on the diagnosis itself in terms of ICD-10 or DSM-5. The population of patients with personality disorders is very diverse and includes both people who function quite well socially (*e.g.* maintain a job, interpersonal relations) but suffer from their disorder and seek treatment, and those who experience severe mental crises and sometimes do not undertake any social activities. The latter group will include people with short-term psychotic episodes, suicidal thoughts and/or attempts, people who periodically require psychiatric hospitalisation, who are not working and are dependent on their relatives or social welfare institutions. Three basic criteria, allowing to divide patients with personality disorders into three subgroups, have been deemed important from the point of view of the organisation of treatment. These are: the patient's level of frustration tolerance, ability to engage in reflection and introspection, and motivation for treatment. This assessment is made by a multi-specialist team of experts (consisting of at least a psychiatrist, a psychotherapist, and a psychosocial nurse and/or community therapist) during the so-called consultation and diagnosis process.

It has already been mentioned above that diagnosing personality disorders should not be limited to making a psychiatric diagnosis according to ICD or DSM criteria. It is equally important to determine the severity of the disorder by checking the capacity for insight work, motivation for treatment, and frustration tolerance. This enables the appropriate choice of the treatment method (psychotherapeutic approach) and the mode in which the treatment should be conducted. For example, an assessment of the capacity for insight work is essential if the patient is offered psychodynamic or psychoanalytic treatment. If the capacity is low, then cognitive and behavioural approaches will be more helpful. Minimal motivation is necessary for the patient to face the difficulties involved in receiving treatment for their disorder. Sometimes helping a patient with a personality disorder needs to start with building such motivation. This initial assessment makes it possible to divide patients into three groups, regardless of the psychiatric diagnosis [18].

A system of care adapted to the patient's needs and abilities

The first group includes patients with very low levels of frustration tolerance, low levels of self-reflection (or lack thereof), with little motivation for treatment and often with no self-motivation at all. Co-occurrence of other mental disorders is also common, most often addiction to alcohol and/or other psychoactive substances. These patients should not be

qualified for treatment in institutions requiring intensive interpersonal contact (*e.g.* 24-hour wards), as therapeutic interventions may be too intensive for them and may involve a high risk of psychological decompensation. The best form of influence in this group is community-based treatment, as indicated by the Dutch experience [19]. In the Netherlands, the Flexible Assertive Community Treatment (FACT) model has been used since 2012 for working with patients with severe personality disorders who are not eligible for standard forms of treatment. This means that the treatment and care of the patient take place in the wider community (from the street through the patient's home to various types of support and treatment facilities); an active attitude on the part of those providing assistance adapted to the patient's current needs is assumed. At the beginning of the treatment, the so-called "treatment plan" is drawn up together with the patient, and it takes into account the patient's current needs and abilities, including, for example, the need for pharmacological treatment, social needs, and dealing with crisis situations, such as the occurrence of suicidal thoughts or self-aggressive behaviour. Crisis management takes into account not only the help of professionals but also of other people in the patient's immediate environment (family, friends, neighbours, other programme participants). The aim of this procedure, called illness management, is to prevent hospitalisation and to remain in constant contact with the same therapeutic team which includes a psychiatrist, nurses, psychosocial nurses, a psychologist, an employment/education specialist, an addiction specialist and people with experience of being treated (*i.e.* who themselves have undergone the treatment currently offered to patients with similar problems).

The method is based on three elements that influence each other: (1) psychotherapy that uses mentalization skills, (2) intervention involving boundary setting, and (3) ongoing support that makes it possible to "hold" the patient in the treatment process. The proposed duration of treatment is up to 2 years.

Treatment in this patient group should be based on: 1. an active outreach by the treatment team to the patient; 2. provision of therapeutic help in the patient's place of residence and/or in the community; 3. adapting the intensity of interventions to the patient's needs (choice of the type of contact – phone, e-mail, home visits, or visits at the centre); 4. ensuring continuity of care by a multi-specialist treatment team which, without assuming excessive responsibility for the patient, actively monitors their condition, remaining alert to early signs of crisis. The team members are in constant contact with each other to ensure an adequate flow of information. In case of a mental crisis (*e.g.* increased suicidal tendencies, difficult-to-control impulses leading to self-harm, psychotic symptoms, significant psychomotor agitation, *etc.*), the patient can quickly contact a psychosocial nurse and a psychiatrist. Then the patient may be offered the so-called "prescription bed". This means that the psychiatric care system has psychiatric intervention units dedicated exclusively to patients with personality disorders where the patients can be hospitalized for a short period of time, *e.g.* one or two days only.

Unfortunately, the described-above model of community-based treatment with intervention units is currently not available in the Polish health care system. Some community treatment

teams sometimes attempt to work in a similar way with this group of patients but there is a lack of sufficiently trained professionals and resources to provide such care, as it is not an accepted standard of practice. During (or after) treatment, some patients in this group will be able to benefit from psychotherapy designed for the second group.

At the opposite end of the scale, there are patients who fall into the third group. These are people who can take care of their own treatment. Usually, they are able to maintain a job, and their level of introspection and self-reflection is quite high. They are equally able to tolerate frustration. Often, these are patients who were initially classified into the second group and have undergone treatment with positive results. These patients usually seek out therapy and psychotherapists suitable for them. They are treated in long-term (that is, lasting several years) therapeutic processes. In Poland, this treatment is sometimes refunded, when patients are treated in psychotherapeutic groups run within the framework of the National Health Fund. However, in most cases, these patients use individual therapy which they pay for with their own money.

In between the groups described above, there are patients in the so-called second group. This group comprises people whose ability to tolerate frustration, level of self-reflection, and motivation for treatment place them between the two groups described above. These patients are able to follow basic rules, for example, regular attendance at therapy sessions. They are able to find the causes of their problems and failures within themselves and not only look for the causes in the external world, and they have their own motivation to start treatment.

In Poland, there are various places that offer psychotherapeutic treatment to patients with personality disorders in this group, although the offer is insufficient and the refunded treatment time is too short and does not take into account the need to combine therapy with work. Usually, treatment takes place in centres between which there is no regular communication. There is also no clear map of places offering specialist treatment for personality disorders in Poland.

Despite these various difficulties, however, it has been possible to develop an effective therapeutic model adapted to the needs of this group of patients. The programme has been developed for over 15 years and it is still undergoing transformations as a result of the changing conditions of the health care system in Poland, legal regulations, and, above all, the needs of patients who come for treatment.

Description of the OLZON work model

General information

An effective model for diagnosing and treating patients has been successfully developed in the Personality Disorder and Neurosis Unit (OLZON) at the Dr Józef Babiński Clinical Hospital in Kraków, Poland. In its current form, the unit has been functioning since 2002. It was established as a separate unit dedicated to the treatment of patients with so-called specific personality disorders. The unit has been constantly evolving over the years. The team members

have developed an original diagnostic system which allows for the above-described functional division of patients into three groups.

Currently, hospitalization in OLZON lasts 24 weeks. The unit has 35 inpatient places. Every year around 70-80 patients are admitted for treatment. It is not a closed ward, which means that from 8.00 a.m. to 8.00 p.m. patients can move freely around the hospital park. The unit's therapeutic team consists of medical practitioners, psychologists, psychoanalytically oriented psychotherapists, a social worker, an occupational therapist, psychosocial nurses and interns. For many years, a nutritionist has also played an important role in the ward's community.

OLZON offers treatment for adults who are qualified for admission after a four-stage consultation process. Exclusion criteria are as follows: diagnosis of schizophrenia or antisocial personality disorder, high risk of aggressive behaviour, and – in the case of persons addicted to or abusing psychoactive substances (medications, alcohol, drugs) – a period of abstinence shorter than six months. Persons who are currently accused in criminal court cases and those before completion of their sentence, convicted by a criminal court, are also not eligible for treatment.

Initially, the vast majority of patients coming to the unit had a long history of psychiatric treatment, including numerous hospitalizations in general psychiatric units due to a variety of symptoms, *i.e.* anxiety disorders, depressive disorders, self-aggressive behaviour, suicide attempts, addiction to psychoactive substances, and eating disorders, sometimes also episodes of transient psychotic disorders. The diagnosis of personality disorders quite often appeared as the last one. Nowadays, more and more people with personality problems receive a correct diagnosis relatively quickly and are referred for appropriate treatment. The profile of patients is also changing. There is an increasing number of deeply narcissistic patients with psychotic episodes, with an obsessive-compulsive disorder which is difficult to treat, schizoid patients, schizotypal patients, and deeply traumatised persons, including those with chronic post-traumatic stress disorder (PTSD), and patients with autism spectrum disorders, including Asperger syndrome.

Patients receiving treatment at OLZON belong to the second group described above. On the one hand, the intensity of their symptoms and the severity of their disorders make it difficult for them to be treated in an outpatient clinic, and, on the other hand, they meet the criteria for treatment in an inpatient unit. These are largely patients with a borderline personality organisation according to Otto Kernberg's classification, which is not the same as the diagnosis of borderline personality according to DSM or ICD criteria. Caligor and Clarkin, based on Kernberg's concept, describe patients in this group as follows: "they are characterised by a significant rigidity of personality, disturbed identity, primitive defence mechanisms based on splitting, generally intact reality testing (unlike psychotic patients) but with some social deficits and possible transient psychotic states. Their object relations are largely used for satisfying their own needs, and their ethical attitudes and stances towards values and ideals are usually also

disturbed" [11, p. 27-28]. Patients with these characteristics of their functioning receive very different diagnoses, referring to the current psychiatric classifications: from patients with personality disorders of the avoidant, dependent, or histrionic type, to narcissistic, borderline, antisocial, paranoid or schizoid personality disorders. These patients very often tend to engage in acting-out behaviour, for example, self-harm, suicidal behaviour, psychoactive substance abuse, bulimic and anorectic behaviour, and many others. During insight psychotherapy, the risk of temporary intensification of such behaviours often increases, especially in the initial phase of the therapy. This poses a real threat to the patient's health and life and may lead to discontinuation of the treatment. Therefore, the structure provided by the hospital ward, which offers a safe space for psychotherapeutic interventions, is very often crucial for the effective treatment of the patient.

Another very important aspect and a source of difficulty in working with this group of patients is constituted by the above-mentioned primitive defence mechanisms based on splitting and projective identification. In order to be able to perceive them and to make appropriate therapeutic interventions, it is essential to maintain close cooperation between all the members of the treatment team [5,10].

Moreover, it is estimated that personality disorders are also diagnosed in about half of the patients with symptoms of Axis I disorders seeking psychotherapy in outpatient settings. Such co-occurrence of diagnoses significantly reduces the effectiveness of standard treatment of these symptoms. It is then necessary to undertake specialist interventions aimed at personality problems.

Recently, we have been admitting more and more patients whose psychopathology is organised around autistic defences such as adhesive behaviour, psychosomatic solutions, or stereotypies (which, at initial diagnosis, look like obsessive-compulsive disorders). The patients usually come with a diagnosis of personality disorders or adaptive disorders, and a more precise diagnosis of their difficulties is possible only in the unit setting. Only after a longer period of observation in the community and in individual therapeutic contact it becomes clear that they do not have such defence mechanisms as projection or projective identification. These patients require an environment that – at least periodically – will take care of their basic ego functions for them [5, 6, 10, 17].

Diagnostic procedure

The diagnostic procedure begins with a personal telephone call from the patient to the unit's secretary or nurse to schedule the first of four consultations. The waiting time between the telephone call and the appointment varies and depends both on the length of the waiting queue and on the patient's motivation. It usually takes about a year. However, it is possible to speed it up, as some people cancel their appointments for various reasons and then the waiting time for a consultation can even be less than a month. During the first interview (as in all initial consultations, face-to-face contact is advisable, but due to the pandemic it has been temporarily

changed to online contact), lasting up to 50 minutes, conducted by a psychiatrist, a decision is made regarding referral for further consultations. Apart from checking the exclusion criteria, the patient's motivation for treatment, their ability for self-reflection and their level of frustration tolerance are also initially reviewed. A diagnosis in terms of psychiatric classifications is made. If possible, the people who accompanied the patient to the hospital – usually parents or life partners – are invited to take part in a section of this meeting. This helps the consultant to see the dynamics of the family system. Sometimes it provides valuable information about the patient's functioning.

The next interview, the so-called second consultation, is devoted to collecting the patient's life history. Before the interview, the patient fills in a questionnaire which is the basis for self-anamnesis. The consultation is conducted by different people, usually community therapists or psychosocial nurses, sometimes interns. Then, at the third interview, the consulting psychotherapist tries to deepen the initial diagnosis on the basis of the information obtained earlier. First of all, the consultant examines the patient's capacity for insight work in the ward setting and formulates initial hypotheses regarding problems with which the patient has come for treatment. An outline of the so-called psychotherapeutic diagnosis is created.

The next stage is the discussion of the patient by the therapeutic team. The fact that the patient has spoken with several members of the team usually allows for a broader view of the patient and his/her problems. Sometimes, already at this stage of contact with the ward, the splitting phenomena occur and, for example, some members of the team are in favour of the patient's admission and some are against it. The discussion allows for more in-depth reflection on the patient's psychopathology, and it ends with some preliminary conclusions about their capacity to benefit from treatment. It is worth noting that this way of diagnosis allows for checking whether the patient is able to tolerate the frustration related to the flow of information in the team. The final decision regarding admission to OLZON is made in dialogue with the patient during the fourth consultation, *i.e.* a summing-up conversation with a physician. It is usually conducted by the head of the unit or their deputy. During this meeting, the team's conclusions from the whole qualification process are presented to the patient. We are interested in the patient's reflection and their own conclusions from the consultation process. The patient's ability to modify their beliefs and to get in touch with their own suffering are decisive for starting treatment. In the case of a refusal of admission, the person concerned is also given oral and written justification for this decision, together with an explanation of why treatment is not possible or not advisable at the time, and a proposal for further therapeutic proceeding.

For patients who are difficult to diagnose or who find it difficult to travel back and forth to the unit, we offer a two-week diagnostic stay, which additionally includes observation of the patient in the therapeutic community.

The procedure of admission to the unit includes, apart from psychiatric and internist examination with elements of neurological examination, detailed familiarisation of the patient with the unit's rules, regulations, and therapeutic programme.

Treatment methods

A prototype of the unit's model was taken from the Cassel Hospital, London, which is based on three main methods of working with patients, *i.e.* psychoanalytic psychotherapy, therapeutic community, and psychosocial nursing. This model makes it possible to avoid certain limitations of both individual and group work. On the one hand, any individual therapy may foster alienation and an exaggerated focus on the inner world [5]. Patients with personality disorders often feel that they cannot find an agreement with the ordinary world around them, nor can they grasp the rules that govern it. Then the only way out may be to base one's identity on the idealization of the fact of being "Different". The problem here is also a lack of self-esteem and self-respect, often resulting from trauma, which is replaced by a sense of uniqueness [6, 8, 20]. And again, individual contact in the consulting room, where the therapist's whole attention is focused on the patient, may not be conducive to change in this area. On the other hand, recognizing one's own difficulties is necessary in order to at least begin to control them. It is a painful process, full of shame, humiliation, and guilt, and it is hard to imagine that it could take place anywhere else than in the intimacy of the therapist's consulting room [5, 7, 21]. Moreover, working in a team allows to better deal with the effects of projection and splitting massively used by the patients. The authors of the book "Reflective Enquiry into Therapeutic Institutions" [18] described how patients can place (project) their inner objects in different parts of a hospital. The patient experiencing severe personality disorders often assigns different split-up parts of their inner world to different members of the therapeutic team. The role of the team is to notice and try to integrate these areas. This involves describing to the patient, in a safe and acceptable way, the content that previously caused them fear and distress. This constitutes the beginning of a process of change in the patient's thinking, experiencing, and – gradually – behaviour [10].

The concept described above was the starting point for OLZON to build its own model for treating patients with personality disorders, which is still undergoing dynamic transformations. The therapeutic work and the understanding of the patient's difficulties are based primarily on the psychoanalytic theory of object relations. It constitutes the aforementioned specific language that is understood by all members of the team. It enables the creation of common hypotheses about the observed phenomena and helps to solve – often very difficult – problems faced by patients, which also affect the therapeutic team.

Each patient is treated by a therapeutic team consisting of a psychotherapist and a nurse. These pairs regularly discuss their work with the patients. On admission, the patient is informed of the open flow of information between the members of the team and the reasons why the unit functions this way. At the same time, all members of the team, including interns, are obliged to maintain confidentiality. This means that no information concerning community members may be taken outside the unit. The open flow of information is particularly important for the work of the therapeutic team, that is, the psychotherapist and the leading nurse.

The therapeutic community

The effectiveness of the unit's work depends to a great extent on the work of the therapeutic community, which is based on analytical principles. One of the community therapists is also a group analyst, another has completed the course in psychotherapy organised by the Psychotherapy Scientific Section of the Polish Psychiatric Association. The community's work mobilises the patients to undertake and discuss various interpersonal tasks and activities within their environment. As Biernacki and Kowaleczko describe in their paper "Therapeutic community in the treatment of personality disorders": "In addition to working with the psychotherapist, the essential components of the treatment model based on the therapeutic community are: community meetings, team meetings, and live learning. The basic principle is to create an environment for patients to participate in the hospital's life that is as close as possible to normal life outside the ward..." [6, p. 47]. This means that patients are obliged, as part of their treatment, to take care of their environment and the unit: from making their beds and tidying their room, through cleaning duties in the common room and the dining room, helping with the serving of meals, to taking care of flowers in pots and fish in the aquarium. Psychotherapy, pharmacotherapy, and social training are complemented by obligatory psycho-drawing classes and voluntary bibliotherapy, cooking classes, various forms of occupational therapy, music therapy, or theatre classes, *etc*. [23, 24]. The community therapists are constantly in touch with the people conducting the additional activities and exchange information with them. It should be noted that patients have to be on duty in pairs or in larger teams. This forces them to communicate, mediate, and cooperate. Over time, patients supplement these activities with their own ideas: dance lessons, zumba classes, singing in a choir, participating in a film discussion club, organising bonfires, excursions, trips to the theatre. Also, patients often start to teach each other: foreign languages, computer programmes, how to write a curriculum vitae, how to search for a job, *etc*. They also become involved in more "external" activities: musical and theatrical presentations for patients from geriatric wards, helping homeless cats, gardening, or showing visitors around the hospital exhibition. The patients' participation in these activities in a relatively safe environment, together with discussing the difficulties they encounter in doing so, helps them to acquire new social skills and to improve the ones they already have. It prepares them to take on tasks in life outside the hospital, which they were previously unable to do for various reasons. Sometimes, this was due to the disorder itself, sometimes, it was caused by the environment, *e.g.* overprotective parents. Besides learning the importance and value of dutifulness and regularity in social life, the patients also learn how to build more mature relationships with others. This is done through the necessity to work together to resolve conflicts and crises that arise in everyday community life. Patients meet each other not just for meals, joint activities, or during leisure time. As the unit has neither single bedrooms nor individual bathrooms, they also have to share such intimate areas as bedrooms, toilets, and showers 24 hours a day. On the one hand, this creates inevitable problems but, on the other

hand, it helps to make visible such difficulties in functioning that patients do not usually talk about with a psychotherapist.

The results of the study of the effectiveness of treatment in OLZON [25] allow us to assume that it is thanks to the therapeutic community that the functioning of patients in interpersonal relations improves significantly. This is because they have a unique opportunity to observe themselves in social relationships. Personality disorders are often connected with blaming others – *e.g*. parents, life partners, colleagues, bosses, *etc*. – for one's own failures. In contact with the community, patients are given the opportunity to see, analyse, and understand the motives and consequences of their actions. When they recognise these consequences with the help of other members of the community, they also have the opportunity to learn how to be responsible. Thus, the way is opened for them to change their attitudes and behaviour and acquire new social skills. Being a member of the community satisfies the need to belong, which also increases the motivation for change. These changes are desirable and expected by the patients and their relatives at the beginning of treatment but at the same time, they require a lot of courage and work, which leads to many crises and discouragement. However, the community helps to feel understood, to regain a sense of influence on reality, and to survive crises.

An important part of the community's work is played by the daily forty-five minute meetings during which the functioning of the patients and the current problems facing the community are discussed. These meetings are attended by patients, community therapists, nurses on duty, and interns. In addition, the head of the unit, and the unit nurse join in once a week. The community's work is discussed at meetings of the therapeutic team – psychiatrists, therapists, and nurses. It provides very important information about the functioning of individual patients. Experience has shown that withholding information, the secrets that are shared between certain people, adversely affect the community's functioning and impede therapy. Sometimes, it is also the case that creating such secrets is a way of expressing hidden anger towards the staff. In this situation, the ability to discuss and understand such a process helps to unblock the flow of information. Patients are also encouraged to bring to the community meetings all matters of importance for their functioning in the unit, and in particular information about suicidal thoughts or intentions, self-aggression, and any transgressions of rules (violation of the abstinence rule, the prohibition of sexual contacts, or the rules regarding passes).

Psychosocial nursing

The theoretical model adopted by the team does not exclude referring to other theories or making interventions that may be useful in specific situations. For example, much of the nursing work is based on behavioural and cognitive interventions and makes use of the patient's mentalizing skills. Nevertheless, nurses regularly use psychoanalytic supervision. Some of them have completed psychotherapeutic courses.

It is worth noting that the role of psychosocial nurses is different from the classic role of psychiatric nurses, although it also includes administering medication and monitoring the patient's condition. This is because psychosocial care is based on analytical thinking and on seeing what is "healthy" in the patient. Moreover, the understanding of the patient's problems is not conveyed in the form of interpretation, as in psychotherapy, but in the form of "ordinary" conversation, in relation to the patient's daily activities. This model is based on the assumption that even very severely disturbed patients have at least a minimal healthy part that enables them to function socially [10]. In practice, this often means teaching patients basic behaviours – taking care of personal hygiene and tidiness in the space they have at their disposal in the unit (beds, lockers, *etc*.). The nurses monitor (together with the community chairperson) the patient's fulfilment of duties assigned by the community and help them to acquire basic social skills, *i.e*. to understand how what a person says and how they behave affects other people. They give the patients their first information about the culture of inquiry – the belief that knowledge and understanding can help to manage anxiety, that it is helpful to talk about what one sees. The patients' regression in their relationship with the nurses is not as deep as in the therapeutic relationship. The patients observe the nurses in everyday situations and see their spontaneous, emotional responses. They know that what they hear from them is personal, based on their experience and their way of experiencing things. They see differences among nurses – in their temperament, opinions, openness, strictness, or leniency towards the patient's behaviour, and often get angry that each of them may have a different opinion on something. The nurses give advice to the patients, suggest how they can benefit from treatment, but also how to sort things out outside the unit. As a result, they quite quickly cease to be – from the patient's perspective – omnipotent objects that can be filled only with the patient's own projections, and they become real persons [5, 10].

The frequency of conversations with nurses is decided by the patients themselves. Usually, these meetings last about 20-30 minutes. The topics of conversation can be very diverse, from problems with taking care of proper hygiene to traumatic experiences. Attention is directed primarily to the patient's resources, *i.e*. their abilities and skills. In case of urgent problems that cannot wait until the leading nurse is on duty, the patient can ask for the so-called intervention talk. Examples of such urgent crisis situations may be the appearance or intensification of suicidal thoughts, or resorting to self-aggressive or aggressive behaviour.

It is equally important in what circumstances the patient leaves the unit and where they are going. In this context, the community nurses and therapists are case managers who are planning with the patient their further development, work or study, and further treatment. Over time, we have developed a practice of contacting the patient with a vocational counsellor who is trained by us in dealing with patients with personality disorders. The role of a social worker, fulfilled by one of the community therapists, is also important; the patient can benefit from their competencies.

The nurses, unlike other members of the team, are in the unit 24 hours a day, as part of their twelve-hour shift, during which they make reports describing individual conversations with patients, the community's weekend meetings, and other important events in the life of the unit. The report book is available to all members of the team, and each day in the unit begins with reading the previous day's and night's reports.

Psychotherapy

The task of the psychotherapists in the unit is to help the patient to understand the nature of his/her problems, consisting in an inability to establish close and honest relationships with oneself and with others. Margot Waddell believes that the primary aim of psychotherapy is to help patients "to become free of the deadening grip of narrow self-interest; to be more open to the truthfulness of intimate relationships; to have a mind of one's own and respect for that of others" [21, p. 18].

The psychotherapeutic sessions take place at fixed times and are conducted by one therapist, which means that in the situation of their absence from work (illness, holiday) the therapeutic session is cancelled, just as it is in an outpatient setting. At the same time, unlike in outpatient settings, the patient is not left alone, without any care. The continuity of the treatment is guaranteed by the therapeutic community, contact with the unit's nurse or physician, and this reduces the risk of acting-out behaviour. Therapy sessions take place twice a week in individual therapy and last 50 minutes, or three times a week in group therapy and last 90 minutes. Patients with social contact difficulties and patients with adolescent crisis problems are directed to group therapy. Deeply traumatised patients are referred to individual therapy.

It is also worth noting that all senior OLZON psychotherapists have had their own psychoanalytic therapy or training analysis, and others are, or have been, in psychodynamic psychotherapy. According to the therapists themselves, the experience of one's own therapy is as important as suitable theoretical training and is essential in order to effectively help patients with severe personality disorders. The therapists' work is regularly supervised psychoanalytically.

Pharmacotherapy

Psychotherapy is complemented by pharmacotherapy also applied in the psychodynamic model, *i.e.* taking into account the current stage of psychotherapeutic treatment and referring to the understanding based on psychoanalytic theories. In treatment, the psychological meaning that patients attribute to their medication as well as the communicative meaning of their somatic symptoms is explored. In cases of patients manifesting formal thought disorders, we decide to use neuroleptics in order to safeguard their ability to benefit from psychotherapy.

Teamwork

At this point, it is worth emphasising again the differences between psychoanalytic psychotherapy in an outpatient setting and treatment in the unit. As mentioned earlier, understanding and therapeutic work are carried out in the psychoanalytic approach but individual or group psychotherapy is complemented and supported by the work of the whole community and all the staff in the unit. This means that the psychotherapists have and benefit from much broader knowledge and observations than that gained "only" from contact with the patient during therapy sessions, as in the traditional analytic approach. On the other hand, the analytic setting provides a sense of security and stability. Information from nurses, community therapists, sometimes from additional activities, as well as relevant information from the psychiatric examination or that concerning the patient's general health problems (*e.g.* the course of diabetes or asthma) help the therapist to see what the patients cannot talk about themselves, or more or less consciously try to hide from the therapist, and sometimes from themselves. The opportunity to look at one's own problems from various perspectives – the psychotherapy session, the therapeutic community, the conversations with a physician, with a nurse, with another patient – is healing for the patient. As is well known, making changes in the area of personality is an extremely difficult and lengthy process. During the six-month treatment in OLZON, this process is usually initiated. Patients are able to recognise their needs better and to appreciate their own skills, they gain a sense of acceptance and understanding. They also often decide to make important life decisions, such as moving away from home, taking up a job, and in some cases ending problematic or clearly abusive relationships.

Franco De Masi writes that the strength of the pathological process "also depends on the patient's passive participation" [10, p. 71]. Neville Symington notes that in the case of people with personality disorders, "something has prevented them to develop character traits that would help them to cope with life situations" [26, p. 23]. Elsewhere, he adds: "That person is mentally healthy who is able to create for him/herself the emotional capacity to pursue truth, love, courage, integrity, and tolerance" [27, p. 237]. Therapy in the unit helps the patients to begin work on the "strength of character", as traditionally understood, which enables them to resist their own psychopathology. We believe that our work is successful if the patients begin to understand the nature of their mental problems and to have an active attitude towards them.

The treatment system discussed above requires a relatively numerous and highly qualified team, consisting of:

- a **psychiatrist**, head of the unit, supervisor of the Psychotherapy Scientific Section of the Polish Psychiatric Association (SNP PTP) (permanent position, full time),
- a **unit physician**, deputy head of the unit (permanent position, 30 hrs per week), dealing with psychiatric and somatic problems of patients (does not conduct psychotherapy),
- a resident physician,
- a **supervisor**, an external professional supervising psychotherapists in the unit (on contract),

- **psychotherapists** with certificates and in the process of obtaining psychotherapist qualifications (five permanent positions, full time; one on contract),
- two **community therapists** (two permanent positions – one full time, and one 32 hrs per week),
- thirteen **nurses** (nine completed specialisation in psychiatric nursing and two completed the SNP PTP psychotherapy course),
- five **ward attendants**.

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