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Factors related to the level of personality functioning and implications for the mental health care system in Poland

Czynniki związane z poziomem funkcjonowania osobowości oraz implikacje dla systemu ochrony zdrowia psychicznego w Polsce

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Abstract

Introduction and objective: The data regarding personality disorders is ambiguous; it is estimated that their prevalence may range from 6% to 30%. In Poland, there is a lack of up-to-date and precise data on the occurrence of personality disorders, partly due to diagnostic difficulties. Currently implemented classifications of mental disorders take into account the dimensional nature of personality disorders. The project reported on below is based on the dimensional approach and has three main objectives. Firstly, it aims to determine the possibility of distinguishing groups that present different levels of personality functioning. Secondly, it seeks to analyse differences between the identified groups in terms of socio-demographic variables, experiences related to the treatment of mental health disorders, traumatic experiences in childhood and adolescence, as well as self-harm and suicidal behaviours throughout life. The third goal is to present a practitioner's perspective on the treatment of individuals with personality difficulties and disorders depending on their severity. **Materials and methods:** The study was conducted by a research panel (N = 1,030; representative sample). The level of personality functioning was measured using the self-report Level of Personality Functioning Scale–Brief Form 2.0 according to DSM-5 (LPFS-BF 2.0). **Results:** The results indicated the possibility of distinguishing three groups presenting different levels of personality functioning. These groups differed significantly in variables including age, gender, education, size of place of residence, depressive/anxiety symptoms, and history of traumatic experiences. **Conclusions:** The findings of the study may have significant implications for the development of effective mental health prevention strategies and tailored medical care for individuals with personality difficulties and disorders.

Keywords: personality disorders, mentalisation, group psychotherapy, LPFS-BF 2.0, dimensional diagnosis

Streszczenie

Wprowadzenie i cel: Dane dotyczące zaburzeń osobowości są niejednoznaczne, szacuje się, że zaburzenia te mogą dotyczyć 6–30% światowej populacji. W Polsce brakuje aktualnych i precyzyjnych danych dotyczących ich występowania. Wynika to między innymi z trudności diagnostycznych. Aktualnie wprowadzane klasyfikacje chorób psychicznych uwzględniają dymensjonalny charakter zaburzeń osobowości. Diagnoza dymensjonalna skupia się między innymi na poziomie i rodzaju nieprawidłowości w funkcjonowaniu osobowości, a nie na typie zaburzenia, co stanowi znaczącą zmianę w podejściu diagnostycznym. Aktualny projekt jest oparty na podejściu dymensjonalnym i ma trzy podstawowe cele: 1) określenie możliwości wyróżnienia grup, które prezentują różne poziomy funkcjonowania osobowości; 2) przeanalizowanie różnic pomiędzy wyłonionymi grupami dotyczących zmiennych socjodemograficznych, doświadczeń związanych z leczeniem zaburzeń zdrowia psychicznego, traumatycznych przeżyć w dzieciństwie i adolescencji, a także samookaleczeń i zachowań samobójczych w ciągu życia; 3) przedstawienie perspektywy praktyków dotyczącej leczenia osób z trudnościami

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osobowościowymi i zaburzeniami osobowości w zależności od ich nasilenia. **Materiał i metody:** Badanie miało charakter kwestionariuszowy i zostało przeprowadzone przez panel badawczy na próbie reprezentatywnej (N = 1030). Poziom funkcjonowania osobowości był mierzony z użyciem samoopisowej Krótkiej Skali Poziomu Funkcjonowania Osobowości według DSM-5 (Level of Personality Functioning Scale–Brief Form 2.0, LPFS-BF 2.0). **Wyniki:** Wyniki wskazują na możliwość wyróżnienia trzech grup prezentujących różny poziom funkcjonowania osobowości, odnoszący się do głębokości zaburzenia funkcjonowania intrapsychicznego i interpersonalnego. Grupy te różniły się istotnie pod względem zmiennych takich jak wiek, płeć, wykształcenie, wielkość miejsca zamieszkania, objawy depresyjne/lękowe oraz historia doświadczeń traumatycznych. **Wnioski:** Rezultaty badania mogą mieć istotne znaczenie dla rozwoju skutecznych strategii profilaktyki zdrowia psychicznego i dostosowanej opieki medycznej dla osób z trudnościami i zaburzeniami osobowości.

Słowa kluczowe: zaburzenia osobowości, mentalizacja, psychoterapia grupowa, LPFS-BF 2.0, diagnoza dymensjonalna

The latest data suggests that approximately every other person worldwide will experience mental disorders at least once in their lifetime (McGrath et al., 2023). Presumably, one of the significant reasons is the impact of civilisational changes, particularly the weakening of social networks and bonds, as well as the stress experienced in everyday life and technological advancements (Hidaka, 2012; Walsh, 2011; World Health Organization, 2022). It can be assumed that the increase in mental health problems also extends to personality disorders, although global prevalence data is not precise and varies widely, ranging from 6% to even 30% (Huang et al., 2009; Torgersen, 2009).

In 2015, data on the prevalence of mental disorders in Poland became available (Kiejna et al., 2015). However, these did not include personality disorders. One of the reasons could be diagnostic difficulties associated with collecting and analysing data based on categorical criteria for the diagnosis of personality disorders. According to the traditional categorical approach, personality disorders are treated quantitatively as separate disease entities, qualitatively different from mental health (Nowak, 2015). At the same time, there is no compelling scientific evidence supporting the categorical approach to the diagnosis of personality disorders or a rigid division into personality disorder types (Clark, 2007; Hopwood et al., 2017; Trull and Durrett, 2007; Widiger et al., 2005). It has also been pointed out that dichotomous diagnostic criteria are artifacts and do not reflect clinical practice (Cramer et al., 2010; Nowak, 2015). The categorical approach used in previous classifications did not allow for capturing individuals with lower intensity of personality difficulties in statistics. The current classifications of mental disorders (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5 and International Classification of Diseases, 11th Revision, ICD-11) incorporate the dimensional nature of personality disorders. One of the key elements of this approach is the diagnosis of the level of abnormality in personality functioning (Hualparuca-Olivera and Caycho-Rodríguez, 2023). The level of personality functioning is related to the structure of the self and relationships with other people, while the severity of difficulties in both areas is the basis for determining personality disorders (American Psychiatric Association, 2013; World Health Organization, 2022). The dimensional diagnosis takes into account, on the one hand, the severity/depth of personality disorder rather than primarily focusing on the specific type of disorder, as was characteristic of the previous categorical approach to personality disorder diagnosis. Additionally, besides the level of personality disorder, it also identifies leading traits or personality patterns (Sharp and Wall, 2021). An example is the alternative model of personality disorders (AMPD) (Krueger and Markon, 2014) in Section III of DSM-5, which consists of Criterion A related to the level of abnormalities in personality functioning and Criterion B referring to the profile of pathological traits (American Psychiatric Association, 2013; Krueger and Markon, 2014).

MEASUREMENT OF DISORDER SEVERITY

One of the tools used for personality diagnosis is the Level of Personality Functioning Scale (LPFS), which is based on the assumption of a continuum of personality disorder severity, forming the basis for Criterion A within the AMPD (Krueger and Markon, 2014). The LPFS is a clinical assessment scale, and the essence of personality disorder is understood as difficulties related to the self (intrapersonal) and interpersonal spheres. Based on the results obtained on the LPFS, different levels of personality functioning can be distinguished, ranging from little or no impairment (i.e. healthy, adaptive functioning; Level 0) to some (Level 1), moderate (Level 2), severe (Level 3), and extreme (Level 4) impairment. Assessment using the LPFS is crucial for the diagnosis of personality disorders (diagnosis requires identifying at least moderate abnormalities) and can also be used to monitor the severity of the disorder (American Psychiatric Association, 2013). The LPFS has served as the starting point for the development of various short psychometric tools. One of them is the Level of Personality Functioning Scale–Brief Form 2.0 (LPFS-BF 2.0), enabling the measurement of the severity of personality functioning abnormalities in two domains – intrapsychic (self) and interpersonal, in accordance with the guidelines for the diagnosis of personality disorders in the AMPD (Weekers et al., 2019). It is important to note that the numerical result obtained from LPFS-BF 2.0 is not identical to the result on the LPFS scale from DSM-5.

IMPLICATIONS OF PERSONALITY FUNCTIONING LEVEL FOR TREATMENT AND PROJECT OBJECTIVES

According to Niezgoda et al. (2020) from the Department of Personality Disorders and Neurosis Treatment at the Józef Babiński Clinical Hospital in Krakow, one of the centres in Poland specialising in the treatment of patients with personality disorders, "the lack of specific data and fragmentary treatment of mental health issues – narrowing mental health problems only to selected diagnoses from the so-called first axis according to DSM-IV, including the omission of personality disorders issues – contributes to the marginalisation of this area, and, for example, in the financing of treatment, it continues to be placed alongside neurotic disorders" (p. 2).

However, individuals with personality difficulties and personality disorders generate high costs for the state system (Sveen et al., 2023). This may be associated, among others, with high absenteeism from work, difficulties in caring for children, and hospitalisations resulting from suicide attempts. Personality difficulties and personality disorders often co-occur with other mental conditions (Newton-Howes et al., 2010), such as depression (Köhne and Isvoranu, 2021; Newton-Howes et al., 2006). Additionally, the presence of personality disorders significantly worsens the prognosis for many mental health disorders (Beard et al., 2007; Newton-Howes et al., 2008) and reduces the quality of life to a greater extent than other conditions (Cramer et al., 2007). Therefore, there is a need to pursue epidemiological studies on the prevalence of personality disorders. This will facilitate the design of appropriate programs for their prevention. The long-term goal would be to create a psychiatric and psychotherapeutic care system dedicated to a group of patients with personality difficulties and disorders.

A comprehensive diagnosis of personality disorders requires in-depth clinical interviews. On the other hand, LPFS-BF 2.0 can provide information about the degree of severity of personality pathology (Weekers et al., 2019). Therefore, based on this tool, one cannot conclusively determine whether an individual or group exhibits high, average, or low depth of personality disorder. In fact, individuals or groups obtaining different results on this scale demonstrate varying levels of personality functioning. However, this does not imply that individuals from a particular group have personality disorders. The dimensional nature of personality disorders does not specify an exact cut-off point indicating whether the disorder's structure is more or less severe, or a point that definitively indicates psychopathology.

In summary, in the current project: 1) We focused on estimating the number and size of groups in Poland that exhibit different levels of personality functioning based on the LPFS-BF 2.0 questionnaire. The tool is recommended for assessing the scope of dysfunction and the degree of severity of personality disorders (PD) and has been classified as part of the recommended standard set of tools for studying PD, established to facilitate the measurement of treatment outcomes for patients with PD worldwide (Prevolnik Rupel et al., 2021). 2) We analysed differences between the identified groups in terms of sociodemographic variables, experiences related to the treatment of mental health disorders, traumatic experiences in childhood and adolescence, as well as self-harm and suicidal behaviours throughout life. 3) We focused on issues related to the prevention of personality disorders and presented the perspective of practitioners regarding the treatment of individuals with personality difficulties and disorders, depending on their severity, while keeping in mind that the results obtained through LPFS 2.0 do not allow for the diagnosis of the disorder level.

METHODS

Study participants

A total of N = 1,030 participants aged 18–65 were recruited (M = 42.39; SD = 13.06); 541 (52.5%) female, and 489 (47.5%) male. The sample was selected to reflect the population structure of Poland in terms of gender, age, size of the place of residence, and education based on data from Statistics Poland (Główny Urząd Statystyczny, 2022). Three hundred eighty-three respondents (37.2%) lived in rural areas, 213 (20.7%) – in a town with fewer than 49,999 inhabitants, 121 (11.7%) – in a town with 50,000–99,999 inhabitants, 182 (17.7%) – in a town with 100,000–499,999 inhabitants, and 131 (12.7%) – in a city with 500,000 or more inhabitants. Thirty-four respondents (3.3%) had elementary education, 31 (3%) had lower secondary education, 222 (21.6%) had vocational education, 360 (35%) had secondary education, 39 (3.8%) were university students, 337 (32.7%) had higher education, and seven (0.7%) declared other educational backgrounds. Five hundred nineteen participants (50.4%) were married, 181 (17.6%) were in an informal relationship, 233 (22.6%) were not in a relationship, 25 (2.4%) were widowed, and 71 (6.9%) were divorced. Five (0.5%) participants chose the option of "other situation" as their relationship status.

Procedure

The study had a questionnaire format and was conducted through the ReaktorOpinii® research panel. The participants were registered users of the panel. The survey could be completed on any device with Internet access. Before starting the study, the participants familiarised themselves with study description, including its objectives. They were also informed about its anonymous and voluntary nature, along with the right to withdraw at any time without providing a reason and without facing any consequences. Given the nature of the study and its subject matter, the final screen of the survey included contact information for mental health helplines. Upon survey completion, the participants received compensation in the form of points which they could later exchange for rewards offered by the research panel.

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Measures

Level of personality functioning

The level of personality functioning was assessed using the self-reported LPFS-BF 2.0 according to DSM-5 (Weekers et al., 2019) in the adaptation by Łakuta et al. (2023). The tool consists of 12 items forming two subscales: intrapsychic functioning and interpersonal functioning. The participants indicated the extent to which they agreed with each statement on a four-point Likert scale ranging from 1 (definitely untrue or very often untrue) to 4 (definitely true or very often true). A higher score in a particular subscale indicates a more profound disturbance in that domain of functioning. The overall scores were calculated as the average positions of the components within a given subscale, following the tool's key. For reference purposes and to relate the results to norms, the overall scores were also calculated as the sum of the positions of the components within a given subscale, in accordance with the tool's key. In our study, Cronbach's α was 0.88 for the intrapsychic functioning scale and 0.80 for the interpersonal functioning scale.

Sociodemographic variables

Sociodemographic variables were measured using a self-designed survey. Questions regarding gender, age, education, marital status, and place of residence were taken into account.

Traumatic experiences in childhood and adolescence

A series of survey questions (Gawęda et al., 2020) addressed traumatic experiences in childhood and adolescence. The questions covered experiences of emotional, physical, and sexual violence. The participants could respond with "yes" or "no", or choose to skip the question.

Self-harm and suicidal behaviours

A series of survey questions (Gawęda et al., 2020) focused on self-harming and suicidal behaviours throughout life. The participants could respond with "yes" or "no", or choose to skip the question.

Analytical strategy

Data analyses were conducted using IBM SPSS 29 software (IBM, 2023). A two-step cluster analysis was performed (method discussed with its limitations in Kent et al., 2014) on the subscales of the LPFS-BF 2.0 tool, using standardised results (standardisation method: *Z*-scores). Subsequently, a frequency analysis was carried out for specific demographic variables and those related to traumatic experiences within the identified clusters. Some of the data used in this article have been analysed in other articles (Zajenkowska et al., 2024). However, the analyses and conclusions presented here are new and have not been published before.

RESULTS

To assess the distributional shape of scores on the analysed scales across all samples, an examination of skewness and kurtosis values, the Shapiro–Wilk test and histograms were conducted. The values of skewness and kurtosis fell within the range of [−1; 1], suggesting that the distribution of scores did not deviate significantly from normal. However, the Shapiro–Wilk test statistic was significant for all analyses, indicating that the score distributions deviated from a normal distribution. Histogram analysis suggests that the variable distributions are characterised by a high frequency of low scores and substantial positive skewness. Consequently, the scales exhibit limited differentiation among individuals with low scores but enable a precise distinction between high and very high scores. This pattern is typical for scales designed to assess psychopathological aspects.

Cluster analysis

In the description of standardised results, the following convention was applied: <−0.5; 0.5> – average result, <−1.0; −0.5> – relatively low result, <0.5; 1.0> – relatively high result, result less than −1.0 – low result, result greater than 1.0 – high result.

The analysis revealed the existence of three clusters, silhouette score = 0.50, group size ratio = 2.22. The first cluster consisted of 347 study participants (33.7%), Bayesian information criterion (BIC) = 1,454.63; the second cluster – of 471 participants (45.7%), ΔBIC = −570.21; and the third cluster – of 212 participants (20.6%), ΔBIC = −242.21. Tab. 1 presents unstandardised and standardised means and standard deviations for the variables used in cluster analysis in each identified cluster.

Additionally, norms for the LPFS-BF 2.0 scale were developed based on percentile and T-score scales (see Supplementary Material, Tabs. 5S, 6S).

Cluster	Intrapsychic functioning (depth of disturbance)		Interpersonal functioning (depth of disturbance)	
	M **(*SD*) unstandardised**	***M*** **(*SD*) standardised**	***M*** **(*SD*) unstandardised**	***M*** **(*SD*) standardised**
1	1.23 (0.27)	−0.99 (0.35)	1.37 (0.30)	−1.03 (0.48)
2	2.08 (0.46)	0.11 (0.59)	2.15 (0.34)	0.22 (0.55)
3	3.08 (0.42)	1.39 (0.55)	2.75 (0.45)	1.19 (0.72)
M – mean; ***SD*** – standard deviation.				

Tab. 1. Means and standard deviations in the subscales of LPFS in identified clusters

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Variable	Value	Cluster		
		1 (L) *n* = 347	2 (A) *n* = 471	3 (H) *n* = 212
Basic demographic data				
Gender	Female	164 (47.3%)	252 (53.5%)	125 (59.0%)
	Male	183 (52.7%)	219 (46.5%)	87 (41.0%)
Age		19–65 (*M* = 45.51; *SD* = 11.79)	18–65 (*M* = 42.18; *SD* = 13.37)	18–64 (*M* = 37.71; *SD* = 12.94)
Education	Basic	8 (2.3%)	19 (4.0%)	7 (3.3%)
	Lower secondary	10 (2.9%)	11 (2.3%)	10 (4.7%)
	Vocational	100 (28.8%)	82 (17.4%)	40 (18.9%)
	Secondary	120 (34.6%)	167 (35.5%)	73 (34.4%)
	Currently in higher education	3 (0.9%)	21 (4.5%)	15 (7.1%)
	Higher	105 (30.3%)	166 (35.2%)	66 (31.1%)
	Other	1 (0.3%)	5 (1.1%)	1 (0.5%)
Marital status	Single	43 (12.4%)	108 (22.9%)	82 (38.7%)
	Married	210 (60.5%)	241 (51.2%)	68 (32.1%)
	In a domestic partnership	62 (17.9%)	76 (16.1%)	43 (20.3%)
	Widow	15 (4.3%)	7 (1.5%)	3 (1.4%)
	Divorced	16 (4.6%)	40 (8.5%)	15 (7.1%)
	Other	2 (0.6%)	2 (0.4%)	1 (0.5%)
Place of residence	Rural	125 (36.0%)	172 (36.5%)	86 (40.6%)
	City with <49,999 inhabitants	72 (20.7%)	102 (21.7%)	39 (18.4%)
	City with 50,000–99,999 inhabitants	35 (10.1%)	62 (13.2%)	24 (11.3%)
	City with 100,000–499,999 inhabitants	68 (19.6%)	80 (17.0%)	34 (16.0%)
	City with 500,000 inhabitants or more	47 (13.5%)	55 (11.7%)	29 (13.7%)
Province of residence	Dolnośląskie Province	26 (7.5%)	42 (8.9%)	10 (4.7%)
	Kujawsko-Pomorskie Province	26 (7.5%)	22 (4.7%)	13 (6.1%)
	Lubelskie Province	20 (5.8%)	32 (6.8%)	15 (7.1%)
	Lubuskie Province	6 (1.7%)	10 (2.1%)	2 (0.9%)
	Łódzkie Province	16 (4.6%)	32 (6.8%)	14 (6.6%)
	Małopolskie Province	24 (6.9%)	40 (8.5%)	21 (9.9%)
	Mazowieckie Province	40 (11.5%)	57 (12.1%)	26 (12.3%)
	Opolskie Province	11 (3.2%)	13 (2.8%)	8 (3.8%)
	Podkarpackie Province	22 (6.3%)	32 (6.8%)	15 (7.1%)
	Podlaskie Province	14 (4.0%)	6 (1.3%)	5 (2.4%)
	Pomorskie Province	20 (5.8%)	26 (5.5%)	11 (5.2%)
	Śląskie Province	43 (12.4%)	58 (12.3%)	24 (11.3%)
	Świętokrzyskie Province	8 (2.3%)	10 (2.1%)	8 (3.8%)
	Warmińsko-Mazurskie Province	15 (4.3%)	21 (4.5%)	14 (6.6%)
	Wielkopolskie Province	39 (11.2%)	54 (11.5%)	17 (8.0%)
	Zachodniopomorskie Province	14 (4.0%)	14 (3.0%)	9 (4.2%)
	No data	3 (0.9%)	2 (0.4%)	0 (0.0%)
Psychiatric diagnoses				
Type of diagnosis throughout life	Intellectual disability	4 (1.2%)	4 (0.8%)	7 (3.3%)
	Anxiety disorders	13 (3.7%)	19 (4.0%)	38 (17.9%)
	Depression	7 (2.0%)	27 (5.7%)	45 (21.2%)
	Bipolar affective disorder	0 (0.0%)	1 (0.2%)	7 (3.3%)
	Schizophrenia or other psychotic disorders	0 (0.0%)	1 (0.2%)	3 (1.4%)
	Obsessive-compulsive disorders	1 (0.3%)	2 (0.4%)	7 (3.3%)
	Substance abuse/dependency (e.g. sedatives, narcotics)	0 (0.0%)	1 (0.2%)	1 (0.5%)
	Alcohol abuse/dependency	1 (0.3%)	4 (0.8%)	4 (1.9%)
	Eating disorders	0 (0.0%)	3 (0.6%)	8 (3.8%)
	Personality disorders	1 (0.3%)	4 (0.8%)	9 (4.2%)
	Other	2 (0.6%)	3 (0.6%)	3 (1.4%)
	Refusal to answer	0 (0.0%)	2 (0.4%)	1 (0.5%)

Tab. 2. Sociodemographic data categorised by clusters

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Psychiatric disorders in the family				
Diagnosis of psychiatric or mental disorders in a family member	Father	3 (0.9%)	14 (3.0%)	14 (6.6%)
	Mother	14 (4.0%)	23 (4.9%)	22 (10.4%)
	Siblings	17 (4.9%)	16 (3.4%)	10 (4.7%)
	Grandparents	7 (2.0%)	7 (1.5%)	3 (1.4%)
	Aunt or uncle	11 (3.2%)	25 (5.3%)	16 (7.5%)
	Other family member	8 (2.3%)	22 (4.7%)	14 (6.6%)
Type of psychiatric diagnosis in a family member	Anxiety disorders	9 (2.6%)	23 (4.9%)	13 (6.1%)
	Depression	23 (6.6%)	42 (8.9%)	26 (12.3%)
	Bipolar affective disorder	7 (2.0%)	10 (2.1%)	6 (2.8%)
	Schizophrenia or other psychotic disorders	14 (4.0%)	28 (5.9%)	17 (8.0%)
	Obsessive-compulsive disorders	1 (0.3%)	1 (0.2%)	6 (2.8%)
	Substance abuse/dependence (e.g. sedatives, narcotics)	0 (0.0%)	2 (0.4%)	4 (1.9%)
	Alcohol abuse or dependence	6 (1.7%)	13 (2.8%)	10 (4.7%)
	Eating disorders	1 (0.3%)	7 (1.5%)	2 (0.9%)
	Personality disorders	6 (1.7%)	4 (0.8%)	0 (0.0%)
	Other disorders	1 (0.3%)	5 (1.1%)	4 (1.9%)
	Refusal to answer	1 (0.3%)	8 (1.7%)	3 (1.4%)
Treatment of one's own mental health disorder				
Utilisation of specialist services in the 12 months preceding the study	Psychologist	17 (4.9%)	64 (13.6%)	45 (21.2%)
	Psychiatrist	13 (3.7%)	39 (8.3%)	47 (22.2%)
	Psychotherapist	12 (3.5%)	25 (5.3%)	23 (10.8%)
School of psychotherapy the person has used	Cognitive-behavioural	4 (1.2%)	6 (1.3%)	8 (3.8%)
	Psychodynamic/psychoanalytic	3 (0.9%)	6 (1.3%)	4 (1.9%)
	Systemic or any family	3 (0.9%)	9 (1.9%)	8 (3.8%)
	Other	0 (0.0%)	0 (0.0%)	3 (1.4%)
	Unknown	3 (0.9%)	8 (1.7%)	3 (1.4%)
Taking medication for mental health issues throughout life	Antidepressants	24 (6.9%)	59 (12.5%)	62 (29.2%)
	Anxiolytics	10 (2.9%)	42 (8.9%)	32 (15.1%)
	Antipsychotics	1 (0.3%)	4 (0.8%)	6 (2.8%)
	Sleeping pills	12 (3.5%)	34 (7.2%)	34 (16.0%)
	Mood stabilisers (e.g. Depakine)	5 (1.4%)	11 (2.3%)	15 (7.1%)
	Other	1 (0.3%)	2 (0.4%)	3 (1.4%)
Traumatic experiences from childhood and adolescence				
Percentage of affirmative responses to the questions	When you were a child or teenager, did you ever feel emotionally neglected (e.g. being left alone, not getting enough emotional expression) by your parents or siblings?	88 (25.4%)	201 (42.7%)	127 (59.9%)
	When you were a child or teenager, did you ever feel emotionally abused (e.g. belittling, teasing, verbal threats, unjust punishment) by your parents or siblings?	64 (18.4%)	145 (30.8%)	99 (46.7%)
	When you were a child or teenager, did you experience psychological violence (e.g. name-calling, teasing) or physical violence (e.g. pulling, beating) from peers?	92 (26.5%)	210 (44.6%)	118 (55.7%)
	When you were a child or teenager, did you ever have any unwanted sexual experiences?	24 (6.9%)	55 (11.7%)	27 (12.7%)
	Did anyone ever force you to have sexual intercourse against your will before the age of 17?	15 (4.3%)	28 (5.9%)	15 (7.1%)
	Do you recall any unpleasant sexual experiences that occurred before the age of 17 with an adult relative or another person, such as a teacher?	21 (6.1%)	31 (6.6%)	21 (9.9%)
Self-harming and suicidal behaviours				
Percentage of affirmative responses to the questions	Have you ever considered taking your own life (e.g. thought that life is not worth living)?	47 (13.5%)	139 (29.5%)	123 (58.0%)
	Have you ever made plans to take your own life (e.g. thought about how you could end your life)?	28 (8.1%)	70 (14.9%)	81 (38.2%)
	Have you ever attempted to take your own life?	10 (2.9%)	22 (4.7%)	27 (12.7%)
	In the past 12 months, have you considered taking your own life?	4 (1.2%)	32 (6.8%)	41 (19.3%)
	Have you ever intentionally harmed or mutilated your body?	21 (6.1%)	43 (9.1%)	58 (27.4%)
	When you harmed yourself, did you have suicidal thoughts?	10 (2.9%)	25 (5.3%)	49 (23.1%)
In the case of marital status, respondents could mark more than one answer.				

Tab. 2. Sociodemographic data categorised by clusters (cont.)

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Variable	Value	Compared pair of clusters					
		1 (L) vs. 2 (A)		1 (L) vs. 3 (H)		2 (A) vs. 3 (H)	
Basic demographic data							
		χ^2	*p*	χ^2	*p*	χ^2	*p*
Biological sex	Female/Male	3.11	0.078	7.21	0.007	1.76	0.184
Education	Basic	1.87	0.171	0.50	0.479	0.21	0.644
	Lower secondary	0.24	0.625	1.29	0.257	2.78	0.095
	Vocational	15.03	<0.001	6.94	0.008	0.21	0.645
	Secondary	0.07	0.796	0.00	0.971	0.07	0.796
	Currently in higher education	9.06	0.003	16.29	<0.001	2.01	0.157
	Higher	2.24	0.134	0.05	0.828	1.10	0.294
	Other	1.64[b]	0.200	0.12[b]	0.724	0.58[b]	0.445
Marital status	Single	14.74	<0.001	52.38	<0.001	18.06	<0.001
	Married	7.06	0.008	42.59	<0.001	21.51	<0.001
	In a domestic partnership	0.43	0.513	0.50	0.478	1.75	0.186
	Widow	6.14	0.013	3.57	0.059	0.01[a]	0.943
	Divorced	4.72	0.030	1.53	0.217	0.40	0.529
	Other	0.10[b]	0.758	0.03[b]	0.869	0.01[b]	0.931
Place of residence	Rural	0.02	0.884	1.16	0.282	1.02	0.313
	City with <49,999 inhabitants	0.10	0.754	0.46	0.499	0.95	0.330
	City with 50,000–99,999 inhabitants	1.81	0.179	0.21	0.645	0.45	0.502
	City with 100,000–499,999 inhabitants	0.92	0.338	1.12	0.291	0.09	0.759
	City with 500,000 inhabitants or more	0.64	0.424	0.00	0.964	0.54	0.461
Province of residence	Dolnośląskie Province	0.53	0.466	1.69	0.195	3.67	0.056
	Kujawsko-Pomorskie Province	2.88	0.090	0.38	0.540	0.64	0.423
	Lubelskie Province	0.36	0.551	0.39	0.534	0.02	0.893
	Lubuskie Province	0.16	0.688	0.58[b]	0.448	1.18[a]	0.278
	Łódzkie Province	1.72	0.189	1.03	0.310	0.01	0.927
	Małopolskie Province	0.69	0.407	1.59	0.208	0.36	0.549
	Mazowieckie Province	0.06	0.802	0.07	0.793	0.00	0.952
	Opolskie Province	0.12	0.731	0.15	0.702	0.50	0.478
	Podkarpackie Province	0.07	0.796	0.12	0.734	0.02	0.893
	Podlaskie Province	6.38	0.012	1.13	0.289	1.09[a]	0.298
	Pomorskie Province	0.02	0.881	0.08	0.773	0.03	0.859
	Śląskie Province	0.00	0.973	0.14	0.705	0.14	0.712
	Świętokrzyskie Province	0.03	0.861	1.02	0.312	1.55	0.213
	Warmińsko-Mazurskie Province	0.01	0.925	1.39	0.238	1.38	0.239
	Wielkopolskie Province	0.01	0.920	1.51	0.219	1.86	0.172
	Zachodniopomorskie Province	0.68	0.409	0.02	0.903	0.73	0.394
Psychiatric diagnoses							
		χ^2	*p*	χ^2	*p*	χ^2	*p*
Type of diagnosis throughout life	Intellectual disability	0.19[b]	0.663	3.15[a]	0.076	5.55[a]	0.018
	Anxiety disorders	2.64	0.104	44.99	<0.001	36.88	<0.001
	Depression	6.92	0.009	57.56	<0.001	37.22	<0.001
	Bipolar affective disorder	0.74[b]	0.390	11.60[b]	<0.001	12.06[a]	<0.001
	Schizophrenia or other psychotic disorders	0.74[b]	0.390	4.94[b]	0.026	3.63[b]	0.057
	Obsessive-compulsive disorders	0.10[b]	0.750	8.47[b]	0.004	9.31[a]	0.002
	Substance abuse/dependence (e.g. sedatives, narcotics)	0.74[b]	0.390	1.64[b]	0.200	0.34[b]	0.562
	Alcohol abuse or dependence	1.04[b]	0.309	3.79[b]	0.051	1.36[a]	0.244
	Eating disorders	2.22[b]	0.136	13.28[b]	<0.001	9.08[a]	0.003
	Personality disorders	1.04[b]	0.309	11.73[a]	<0.001	9.03[a]	0.003
	Other disorders	0.01[b]	0.913	1.04[b]	0.307	1.02[b]	0.313
	Refusal to answer	1.48[b]	0.224	1.64[b]	0.200	0.01[b]	0.931
Psychiatric disorders in the family							
		χ^2	*p*	χ^2	*p*	χ^2	*p*
Diagnosis of psychiatric or mental disorders in a family member	Father	4.36	0.037	14.70	< .001	4.90	0.027
	Mother	0.33	0.564	8.79	0.003	7.17	0.007
	Siblings	1.16	0.281	0.01	0.922	0.70	0.404
	Grandparents	0.34	0.563	0.27[a]	0.602	0.01[a]	0.943
	Aunt or uncle	2.17	0.141	5.49	0.019	1.30	0.254
	Other family member	3.16	0.075	6.43	0.011	1.09	0.296

Tab. 3. Between-group comparisons regarding demographic variables and variables related to psychiatric diagnoses/treatment as well as traumatic experiences

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Type of psychiatric diagnosis in a family member	Anxiety disorders	2.79	0.095	4.36	0.037	0.46	0.499
	Depression	1.43	0.232	5.23	0.022	1.83	0.177
	Bipolar affective disorder	0.01	0.916	0.38[a]	0.536	0.32[a]	0.572
	Schizophrenia or other psychotic disorders	1.50	0.221	3.99	0.046	1.02	0.312
	Obsessive-compulsive disorders	0.05[b]	0.828	6.88[b]	0.009	9.88[b]	0.002
	Substance abuse/dependence (e.g. sedatives, narcotics)	1.48[b]	0.224	6.59[b]	0.010	3.59[b]	0.058
	Alcohol abuse or dependence	0.94	0.333	4.23	0.040	1.72	0.190
	Eating disorders	2.96[b]	0.085	1.06[b]	0.304	0.33[a]	0.565
	Personality disorders	1.28[a]	0.258	3.71[b]	0.054	1.81[b]	0.178
	Other disorders	1.64[b]	0.200	3.79[b]	0.051	0.77[a]	0.382
	Refusal to answer	3.65[a]	0.056	2.35[b]	0.125	0.07[a]	0.785
Treating one's own mental health disorders							
		χ^2	*p*	χ^2	*p*	χ^2	*p*
Utilisation of specialist services in the 12 months preceding the study	Psychologist	16.91	<0.001	35.58	<0.001	6.36	0.012
	Psychiatrist	6.90	0.009	46.62	<0.001	25.63	<0.001
	Psychotherapist	1.58	0.208	12.25	<0.001	6.87	0.009
School of psychotherapy the person has used	Cognitive-behavioural	0.02[a]	0.876	4.30[a]	0.038	4.55[a]	0.033
	Psychodynamic/psychoanalytic	0.31[a]	0.579	1.11[b]	0.292	0.38[a]	0.537
	Systemic or any family	1.51	0.219	5.77[a]	0.016	2.09	0.149
	Other	n/d	n/d	4.94[b]	0.026	6.69[b]	0.010
	Unknown	1.05[a]	0.306	0.38[b]	0.540	0.07[a]	0.785
Taking medication for mental health issues throughout life	Antidepressants	6.90	0.009	50.40	<0.001	28.03	<0.001
	Anxiolytics	12.23	<0.001	28.25	<0.001	5.77	0.016
	Antipsychotics	1.04[b]	0.309	6.88[b]	0.009	3.98[a]	0.046
	Sleeping pills	5.32	0.021	27.58	<0.001	12.68	<0.001
	Mood stabilisers (e.g. Depakine)	0.83	0.361	12.11	<0.001	8.97	0.003
	Other	0.10[b]	0.750	2.35[b]	0.125	1.97[b]	0.160
Traumatic experiences from childhood and adolescence							
		χ^2	*p*	χ^2	*p*	χ^2	*p*
Percentage of affirmative responses to the questions	When you were a child or teenager, did you ever feel emotionally neglected (e.g. being left alone, not getting enough emotional expression) by your parents or siblings?	26.41	<0.001	67.67	<0.001	18.03	<0.001
	When you were a child or teenager, did you ever feel emotionally abused (e.g. belittling, teasing, verbal threats, unjust punishment) by your parents or siblings?	16.11	<0.001	51.75	<0.001	16.59	<0.001
	When you were a child or teenager, did you experience psychological violence (e.g. name-calling, teasing) or physical violence (e.g. pulling, beating) from peers?	28.24	<0.001	48.72	<0.001	7.57	0.006
	When you were a child or teenager, did you ever have any unwanted sexual experiences?	5.16	0.023	5.45	0.020	0.17	0.676
	Did anyone ever force you to have sexual intercourse against your will before the age of 17?	1.07	0.302	2.02	0.155	0.34	0.562
	Do you recall any unpleasant sexual experiences that occurred before the age of 17 with an adult relative or another person, such as a teacher?	0.09	0.761	2.89	0.089	2.38	0.123
Self-harming and suicidal behaviours							
		χ^2	*p*	χ^2	*p*	χ^2	*p*
Percentage of affirmative responses to the questions	Have you ever considered taking your own life (e.g. thought that life is not worth living)?	28.92	<0.001	123.08	<0.001	50.46	<0.001
	Have you ever made plans to take your own life (e.g. thought about how you could end your life)?	8.90	0.003	76.72	<0.001	46.28	<0.001
	Have you ever attempted to take your own life?	1.71	0.191	21.13	<0.001	14.68	<0.001
	In the past 12 months, have you considered taking your own life?	15.08	<0.001	59.42	<0.001	24.63	<0.001
	Have you ever intentionally harmed or mutilated your body?	2.63	0.105	49.58	<0.001	38.34	<0.001
	When you harmed yourself, did you have suicidal thoughts?	2.95	0.086	58.10	<0.001	48.46	<0.001

[a] In the cross table 25% of cells had an expected count of less than 5.
[b] In the cross table 50% of cells had an expected count of less than 5.

Tab. 3. Between-group comparisons regarding demographic variables and variables related to psychiatric diagnoses/treatment as well as traumatic experiences (cont.)

Cluster 1 was labelled as the cluster with low scores on the LPFS-BF 2.0 scale (Cluster L) due to relatively low scores in both intrapsychic and interpersonal functioning subscales. In relation to the norms, the overall LPFS scale score fell within the range of 12–20 (7–33 percentile, 32–46 T-score). Cluster 2 was named the cluster with average scores on the LPFS-BF 2.0 scale (Cluster A) due to moderate scores in both intrapsychic and interpersonal functioning subscales. In relation to the norms, the overall LPFS scale score ranged from 20–30 (33–77 percentile, 46–57 T-score). Cluster 3 was named the cluster with high scores on the LPFS-BF 2.0 scale (Cluster H) due to high scores in both intrapsychic and interpersonal functioning subscales. In relation to the norms, the overall LPFS scale score ranged from 31–47 (81–100 percentile, 59–83 T-score). There is a higher probability that individuals with undiagnosed personality disorders may be in this group, although the scale of the presence of these individuals is challenging to estimate based on the conducted research. The Kruskal–Wallis *H* test and post-hoc Mann–Whitney *U* test indicated that for both LPFS subscales, all clusters differed significantly at a significance level of $p < 0.001$. However, it is important to note that high, average, and low levels refer only to the specific research group, where all three profiles differ from each other. This does not imply that individuals belonging to them generally exhibit high, low, or average levels of personality functioning.

A detailed breakdown of demographic variables, experiences in treating mental health disorders, traumatic experiences from childhood and adolescence, as well as self-harming/suicidal behaviours throughout life, categorised by clusters, is presented in Tab. 2.

To assess the significance of differences between clusters in terms of demographic characteristics, psychiatric diagnosis and treatment data, as well as traumatic experiences, pairwise comparison tests were conducted. All clusters differed significantly in terms of age; Cluster L included the oldest respondents (comparison between L and A; $U = 69{,}966.00$; $p < 0.001$; comparison between L and A; $U = 24{,}246.00$; $p < 0.001$), while in Cluster A, respondents were older than in Cluster H ($U = 40{,}386.00$; $p < 0.001$). For the remaining variables, χ^2 tests were conducted for pairwise comparisons. Detailed results of the tests are presented in Tab. 3.

Below, based on detailed data from Tabs. 2 and 3, the key results of intergroup comparisons will be discussed.

Firstly, the proportion of women to men is higher in the H group than in the L group. In the L group, there is a higher proportion of individuals with vocational education compared to the A and H groups. In the H group, there is a higher proportion of individuals currently pursuing higher education compared to the A and L groups.

In the H group, there is the highest proportion of singles (individuals not in a relationship), and in the A group, the proportion is higher than in the L group. In the L group, however, there is a higher proportion of individuals in a marital relationship compared to the A group, and in the A group, it is higher than in the H group.

In the H group, there is a higher proportion of individuals with a diagnosis of anxiety disorders than in the L and A groups. The H group also exhibits a higher proportion of individuals with a diagnosis of depression than the A group, and the A group has a higher proportion than the L group.

In the H group, there is a higher proportion of individuals whose fathers had diagnoses of psychiatric or mental disorders than in the A group, and in the A group, it is higher than in the L group. The H group also has a higher proportion of individuals whose mothers had diagnoses of psychiatric or mental disorders compared to the A and L groups.

In the H group, there is a higher proportion of individuals using the services of a psychologist or psychiatrist than in the A group, and in the A group, the proportion is higher than in the L group. Additionally, in the H group, there is a higher proportion of individuals using the services of a psychotherapist compared to the A and L groups.

In the H group, there is a higher proportion of individuals who have taken antidepressant, anxiolytic, and sleep medications throughout their lives compared to the A group, and in the A group, the proportion is higher than in the L group. The H group also has a higher proportion of individuals taking mood stabilisers than in the A and L groups.

In the H group, there is also a higher proportion of individuals with experiences of emotional neglect, abuse by parents or siblings, and peer violence than in the A group, and in the A group, it is higher than in the L group. Moreover, in the L group, there is a significantly smaller proportion of individuals with unwanted sexual experiences in childhood or adolescence compared to the A and H groups.

In the H group, there is a higher proportion of individuals who have considered suicide, made suicidal plans, and considered suicide in the 12 months preceding the study compared to the A group, and in the A group, the proportion is higher than in the L group. Furthermore, in the H group, there is a higher proportion of individuals with a history of suicide attempts, deliberate self-harm, and suicidal thoughts during self-harm incidents than in the A and L groups.

DISCUSSION

Based on our study, we identified three profiles of participants with varying levels of scores on the LPFS-BF 2.0 scale, and thus, presumably, different levels of personality functioning: a low level of scores on the LPFS-BF 2.0, indicating a relatively high level of personality functioning (L, 33.7%), a medium level of scores on the LPFS-BF 2.0, suggesting a relatively average level of personality functioning (A, 45.7%), and a high level of scores on the LPFS-BF 2.0, indicating the lowest level of personality functioning in the studied group (H, 20.6%). However, based on the findings obtained, it is not possible to determine how many individuals in the identified cluster have personality disorders. Simultaneously, based on demographic data, one can observe that in profiles A and H, certain variables indicating abnormalities in personality functioning emerge.

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Individuals in the H group, in comparison to those in the L group, more frequently reported depressive and/or anxiety disorders. Moreover, individuals in the A and H groups included those declaring bipolar affective disorder, schizophrenia, or eating disorders, while no such individuals were present in the L group. Individuals in the A and H groups also more often reported family members (e.g. mothers, fathers) having a diagnosed mental health condition than those in the L group. A higher frequency of treatment by specialists (e.g. psychotherapists, psychiatrists) was observed in individuals from the A and H groups, who more often declared using such forms of support or treatment.

One of the significant findings was that relational traumas, experiences of violence during childhood and adolescence, as well as sexual violence (albeit to a lesser extent), were much more frequently reported by individuals classified in the A and H groups than the L group. Moreover, the H group stood out with the highest percentages of reported self-harm and suicidal behaviours. In light of the obtained results, this appears to be the most serious consequence of personality dysfunction.

Practitioners' perspective – prevention and psychotherapeutic treatment of personality difficulties and disorders

Based on the analysis of our results, it can be concluded that in the general population, groups with varying levels of personality functioning can be distinguished, associated with predisposing factors (risk factors) to personality difficulties or disorders. In the H group, as many as 58% of individuals considered suicide, and 38% made plans to take their own lives (Tab. 2). Simultaneously, none of these groups predominantly reported a self-diagnosis of personality disorders in the survey; the participants primarily reported diagnoses of depressive and anxiety disorders. This is not surprising, as these symptoms often coexist with personality disorders (Brandes and Bienvenu, 2006). Some researchers indicate that pharmacotherapy may be more effective when psychotherapy is concurrently undertaken, with a focus not only on depressive symptoms but also on personality disorders (e.g. Bozzatello et al., 2020; Stoffers-Winterling et al., 2021). Considering the obtained results, it would be advisable to design a systematic preventive support programme concerning personality functioning, starting from adolescence, a period when personality dynamically shapes and develops.

The continuation of research and analysis of the prevalence of personality disorders in Poland should be the next step. Additionally, it is important to provide treatment programmes for individuals diagnosed with personality difficulties and disorders. These actions should be carried out in close collaboration between scientists and practitioners. Evaluation of the effectiveness of the applied interventions is particularly important. Such large-scale projects are not yet available in Poland, therefore, in the further part of the article, we present clinical experiences from two centres in Poland that offer both outpatient and inpatient treatment, which to a certain extent correspond to the diversity of groups identified in the study discussed above. These centres are: Dialog Therapy Centre and Department of Personality Disorders and Neurosis Treatment at Józef Babiński Clinical Hospital. We hope that insights into the psychotherapeutic programmes offered to patients with personality difficulties and disorders in the presented centres will contribute to the emergence of future research projects aimed at analysing mechanisms of change in personality functioning.

Experiences related to psychotherapeutic treatment of individuals with a moderate level of personality disorders – outpatient treatment

In 2023, at Dialog Therapy Centre, we initiated a pilot programme dedicated to patients with mild and moderate personality difficulties and disorders. The treatment scheme offered to such individuals involves a consultative process, participation in psychoeducational mentalisation training, and involvement in a psychotherapeutic group conducted within the psychoanalytic approach (group analysis). This type of treatment is based on current research findings in the field of personality difficulties and disorders (Karterund, 2024). The two-stage treatment process – mentalisation training followed by group analysis – is associated with therapeutic factors in patients with personality disorders. The modification of maladaptive cognitive schemas and the development of mentalisation provide "tools" for better self-awareness, improved relationships with others, and the enhancement of insight (Karterud, 2024; Karterud i Bateman, 2010). Meanwhile, the foundation of psychodynamic/psychoanalytic psychotherapy lies in the analysis of unconscious transference processes, which has positive effects in the management of personality disorders (Johansson et al., 2010). Through the interpretation of transference, the level of insight can increase, leading to improved interpersonal functioning and the development of reflexivity (Gabbard and Westen, 2003; McGlashan and Miller, 1982; Messer and McWilliams, 2007; Strachey, 1934 – 1981).

Simultaneously, in the treatment process, data are collected regarding changes in symptoms (e.g. depressive symptoms) as well as in self-perception and relationships with others, both from patients and from psychotherapists involved in the treatment process. This allows for the analysis of changes occurring during treatment at the level of social information processing.

Consultations – typically consist of three sessions during which an interview is conducted to gather information about the presenting situation, past issues, and life history. Additionally, patients complete a battery of tests and prepare an essay describing their motivation for treatment. After the consultations, the specialist determines the most suitable form of treatment, such as mentalisation training followed by group psychotherapy. Individual psychotherapy may also be offered in specific cases, such as for patients with severe social anxiety, active addiction, or self-harm

tendencies. This approach is generally considered when symptoms are so intense that they significantly impair the ability for reflection and introspection, and the threshold for frustration is very low.

Psychoeducational mentalisation training – aims to build knowledge about mentalisation, develop mentalisation skills, and strengthen motivation for treatment. Motivation is a crucial factor in the effectiveness of psychotherapy (Yalom and Leszcz, 2006). Mentalisation, in turn, is a cognitive activity that enables the perception, awareness, and interpretation of human behaviour (both one's own and that of others) in terms of intentional mental states (Bodecka-Zych et al., 2021; Coates, 2006). Mentalisation is also associated with the flexible and constant interpretation of emotional signals from others, as well as the regulation of one's own emotions (Bateman and Fonagy, 2004).

Psychoeducational mentalisation training is based on the mentalisation-based treatment (MBT) programme created by Bateman and Fonagy (2013 – Bateman and Fonagy, 2016). Initially applied primarily when working with patients with borderline personality disorder (BPD), this programme is currently utilised by professionals working with individuals with various levels and specificities of personality disorders (Bodecka-Zych et al., 2021).

Group psychotherapy – conducted within the psychoanalytic framework (e.g. group analysis) (Karterud, 2024), provides an opportunity for individuals to experience themselves in relation to others. The psychoanalytic approach is grounded, among others, in the analysis of transference relationships. During socialisation, individuals acquire patterns of relationships that become internalised. In the course of group work, through interactions with fellow participants and the group leader, patients uncover maladaptive and often unconscious patterns in their functioning. The matrix of mutual interactions within the group becomes a source of information about how social relationships are experienced. Consequently, patients can learn about their most commonly used defence mechanisms, explore how these mechanisms hinder their social and emotional functioning, and gain insight into their interpersonal dynamics. Moreover, through interpretations that connect aspects of their life histories with their current situation and group dynamics, patients gain insight that enables them to understand their difficulties and make changes in their functioning (Burlingame et al., 2001; Pawlik, 2008).

Experiences related to psychotherapeutic treatment for individuals with a high level of personality disorders – inpatient psychotherapeutic treatment

For patients with personality difficulties and personality disorders, an appropriate form of treatment is group therapy (Karterud et al., 2003), typically conducted within psychodynamic or cognitive-behavioural approaches (Karterud et al., 1998). Interestingly, centres practicing treatment based on both cognitive-behavioural and psychodynamic models often utilise psychoanalytic conceptualisation of patients' issues (Gabbard, 2015; Karterud et al., 2003) – in Poland, the Department of Personality Disorders and Neurosis Treatment at Józef Babiński Clinical Hospital. Generally, working with patients with personality difficulties and disorders, because of their use of primitive defence mechanisms such as frequent projections and enactment of emotional situations, requires collaboration within a team and a psychodynamic/psychoanalytic, insight-oriented understanding (Gabbard, 2015).

Patients undergoing treatment at the Department of Personality Disorders and Neurosis Treatment at Józef Babiński Clinical Hospital are a group characterised by a high intensity of psychopathological features, where the severity of symptoms and the depth of functional disorders significantly hinder treatment in outpatient settings. During the course of insight-oriented psychotherapeutic treatment, there is often an increased risk of transient intensification of self-destructive behaviours (e.g. self-harm), especially in the initial phase. Such a situation poses a real threat to the patient's health and life, frequently leading to the discontinuation of treatment. Therefore, the structure provided by the hospital ward plays a crucial role in the effective treatment of patients, offering a secure space for psychotherapeutic interventions. Another vital aspect, and simultaneously a source of challenges in working with this group of patients, is that their primary defence mechanisms are based on splitting and projective identification. To recognise and address these mechanisms through appropriate therapeutic interventions, close collaboration among the entire treatment team is essential.

The Department of Personality Disorders and Neurosis Treatment at Józef Babiński Clinical Hospital is based on three main methods of working with patients: psychoanalytic psychotherapy, therapeutic community, and psychosocial nursing.

Individual and group psychoanalytic psychotherapy – combining both forms helps circumvent certain limitations associated with both individual and group work. On the one hand, each individual therapy session may contribute to alienation and excessive focus on the internal world. Individuals with personality disorders often feel they cannot connect with the ordinary world around them or grasp the governing rules. In such cases, the only way out may be to base their identity on idealising the fact of being "different". Another issue here, often stemming from trauma, is the lack of a sense of self-worth and self-respect, which is replaced by a sense of uniqueness. Individual contact in the therapist's office, where the therapist's entire attention is focused on the patient, may not foster changes in this area. On the other hand, recognising one's own difficulties is necessary to begin managing them. This is a painful process, full of experiences of shame, humiliation, and guilt, and it is challenging to imagine it happening anywhere other than in the intimacy of the therapist's office.

Therapeutic community – an essential element of the community's work involves daily forty-five-minute meetings

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during which the functioning of patients and current issues faced by the community are discussed. These meetings include patients, community therapists, nurses on duty, and interns. Additionally, once a week, the department head and the ward nurse join. The community's work is discussed during therapeutic team meetings, attended by psychiatrists, therapists, and nurses. These meetings provide crucial information about the functioning of individual patients. Experience shows that withholding information and secrets that arise between some individuals negatively affect the community's functioning and hinder therapy. This happens because such attitudes divert from the goals of therapeutic treatment, which include assistance in problem resolution. Sometimes, creating secrets is also a way to express hidden anger towards the staff. In such situations, understanding and discussing such a process can unlock the flow of information. Patients are also encouraged to bring all matters important to their functioning in the ward to community meetings, especially information about suicidal thoughts, self-harm, and violations of regulations (such as breaking abstinence, prohibition of intimate contacts, or rules regarding passes).

Psychosocial nursing – each patient is treated by a therapeutic team consisting of a psychotherapist and a nurse. These pairs regularly discuss their work with the patients. Upon admission and familiarising themselves with the ward's regulations, the patient is informed about the open flow of information among the team members and the reasons why the ward operates in this manner. All team members, including interns, are obligated to maintain confidentiality. The open flow of information is particularly significant for the work of the therapeutic team.

Working within the team enables better handling of the effects of projection and splitting that are extensively employed by patients. Patients experiencing profound personality disorders often attribute various disassociated parts of their internal world to individual members of the therapeutic team. The team's role, on a broader scale, involves recognising and attempting to integrate these "areas". The process entails describing to the patient in a safe and acceptable manner the content that previously evoked fear and suffering. This marks the beginning of the process of changes in the patient's thinking, experiencing, and gradually, also in their behaviour.

SUMMARY

In the face of contemporary social and health challenges, including wars and crises, and the rapid development of technology, the study of personality difficulties and disorders becomes a critical area that requires special attention and investment. Given the presence and potential increase in the number of personality disorders, there is an urgent need to delve into and understand these difficulties, especially in the context of treatment. In this empirical study, we demonstrated the existence of diverse profiles in terms of personality functioning that coexist with risk factors (e.g. self-harming and suicidal behaviours) associated with personality disorders. However, it is essential to note that the study group was not a clinical sample. Further studies should verify the level of personality functioning primarily in a representative clinical population. Consequently, regular psychological assessments of patients seeking outpatient and inpatient treatment, along with data collection and analysis, should become the norm in Poland. At the same time, one of the main limitations of the current project is the absence of a group of individuals with the most severe disturbances. These are likely patients who qualify for community-based treatment and are often not included in panel studies due to difficulties in accessing them (e.g. technological challenges). As a result, the findings may not reflect the full spectrum of mental disorders, especially those with greater severity. The lack of full representativeness of the sample may also be related to self-selection bias. Individuals who choose to participate in psychological studies may present, for example, higher levels of personality or depressive disorders compared to the general population, and seek psychological support in such studies (Kaźmierczak et al., 2023).

Future research should not be limited to panel studies; in addition to exploring the depth of disorders, it would be beneficial to consider various personality types. At the same time, it is worth noting that current diagnostic classifications, such as DSM-5 or ICD-11, do not encompass all aspects of personality disorders. For instance, vulnerable narcissism, despite its clinical significance, is not fully reflected in current classification systems.

Another important consideration is that in the conducted study, the group of participants with personality disorders was taking antidepressant and/or anxiolytic medications. Considering the co-occurrence of personality disorders with depressive or anxiety disorders, there is a justified need to incorporate personality disorders into clinical research and pharmacotherapy for anxiety and depression. In this context, initiating the practice of assessing the depth of the disorder and its impact on the effectiveness of pharmacotherapy is warranted.

Conflict of interest

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Author contribution

Original concept of study: AZ, KCŁ, AW, ACS. Collection, recording and/or compilation of data: AZ, AW. Analysis and interpretation of data: AZ, IN, JC, ETS. Writing of manuscript: AZ, KCŁ, AW, ACS, EN. Critical review of manuscript: AZ, KCŁ, AW, ACS. Final approval of manuscript: AZ.

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