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Emerging as a Personality Disorder Service

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Personality Disorder Services working along psychotherapeutic lines are gaining appeal with Health Care Commissioners following the publication of the NICE guidelines for Borderline & Antisocial Personality Disorders and the emerging successful application of psychoanalytically-derived approaches.

Establishing a new Personality Disorder Service is akin to constructing a ‘home’ within which the therapeutic work with patients can develop. As clinicians, we are required to question what facets are important to the development of this new home, and to further endure the unfamiliar state of being ‘not at home’ while the identity of the service is established.

We address how this process parallels the task facing the patient as they struggle to establish their own identity. We also highlight some important tenets in the work of securing a robust identity for both the service and the patient suffering from a personality disorder.

\textbf{Keywords:} personality disorder; mentalization; unheimlich; creativeapperception

\textbf{Introduction}

The Department of Health acknowledges that ‘people with a primary diagnosis of personality disorder are frequently unable to access the care they need from secondary mental health services’ (DOH, 2003, p.5). The poor impulse control, self-harm and aggression to others that characterize cluster B personality types (dramatic, emotional and erratic) are highlighted as major burdens to psychiatric settings and so we are guided towards the provision of specialist teams and day services in areas of high morbidity, to establish good clinical practice. Moreover, it has been suggested that traditional psychiatric responses to the burdens highlighted have fallen far short of good clinical practice (Fonagy & Bateman, 2006).

The naturalistic, longitudinal course of borderline psychopathology is now thought to span approximately six years, far shorter than previous clinical estimates based upon traditional psychiatric interventions (Zanarini, Frankenburg, Hennen, & Silk, 2003). There thus exists the high probability that personality disturbance had been prolonged by our own clinical hand, bringing the need for a revision of practice into clear focus. In line with this need, a ‘Personality Disorder
Day Service’ was commissioned in the London Borough of Croydon, our area of practice.

One of the authors [BJ] was invited to lead in establishing this new personality disorder service. The second author (SM) was asked to consult with this process. Utilizing the developing service as the principal case vignette this paper describes this experience. Through the metaphor of the developing infant it offers a psychoanalytic understanding of the process. We highlight important aspects of the emerging service identity, so that we may also better understand the difficult issues also facing the patients for whom we now care.

The therapeutic home

The recent proliferation of psychotherapeutically-informed treatment models in the previously neglected field of personality disorder has introduced the possibility of choice and therein ambiguity when determining the most appropriate treatment methodology. Neither are the models themselves wholly distinct from one another. For instance, in her discussion of dialectical behavioural therapy (DBT), Linehan states that DBT is ‘more similar to the psychodynamic emphasis on transference behaviours than it is to any aspect of standard cognitive behavioural therapies’ (Linehan, 1993, p. 21). Bateman & Fonagy (2004), see the ‘mindfulness’ of DBT as a core aspect of Mentalization Based Therapy (MBT). Cognitive behavioural approaches themselves are as diverse as psychoanalytic approaches to Borderline Pathology.

Given the plurality of approaches, the limited evidence-base and the overlap between models, choosing an approach is difficult. However, one evaluation of 11 pilot community personality disorder services identified widespread agreement about the principles that should underpin service delivery, including ‘the need for open communication, explicit boundaries [and a] consistent theoretical model’ (Crawford, 2007, p. 191). The emphasis upon the use of an explicit and consistent model as part of good practice has specific relevance to borderline pathology, wherein the ‘internal representational system [of the patient] is inherently unstable.’ (Bateman & Fonagy, 2004, p.135). It is therefore especially important to be clear about what model one uses and why. If we were to meet the patient’s pathology with a similarly unstable representation of our own professional identity, the possibility of over-identification with patients and resultant confusion of identities would likely be further promoted. Rather, emphasis should be placed on establishing and maintaining a robust professional identity capable of enduring contact with the patient’s disordered identity. In keeping with this important facet of therapeutic intervention, the NICE treatment guideline for Borderline Personality Disorder recommends the consideration of twice-weekly psychotherapy sessions using an explicit and integrated theoretical approach (NICE, 2009).

The emphasis placed upon the importance of an integrated approach belies the risk of a more disintegrated, disordered approach to care by staff. If we also
keep in mind that, in establishing a service, our own identity is ‘in genesis’ then we might expect to find additional elements of a parallel process between our development as a service and the patient’s developmental struggle.

The financial imperative to reduce costs represents an additional burden on the developing service. Within our borough, an estimated 4000 people have a diagnosis of personality disorder (SLAM, 2007), tasking our service with catering for the highest percentage of personality-disordered patients within any given population, across the country while facing the costing constraints typical of any new service. The increasingly familiar emphasis upon targets, set down by Commissioners, brings with it the possibility of a compliance with that reality at the expense of meaningful therapeutic work. Negotiating this difficulty is important for the clinician but success in this area is also of paramount importance for the patient if they are to bring meaning to their lives. For both patient and clinician, establishing a Personality Disorder Service is akin to constructing a ‘home’ within which the therapeutic work together can develop. Both may be invited to question what facets are important to the construction of this home, enduring the unfamiliar state of being ‘not at home’ as service and patient identities are developed.

**Conception: Theory & recruitment**

We may conceptualize this first phase of development of the service as being like that of a baby. In Winnicott’s terms, ‘the maturational processes depend for their evolution on the environmental provision … to realize potential … by a high degree of adaptation (to) the whole of the infant’s ego development that has its own needs’ (Winnicott, 1965 pp. 84–86). The ‘infantile service’ may thus gradually be helped to ‘arrive at being’ in the present, with a meaningful and separate identity. The recruitment phase, seen in this light, reflects a stage of absolute dependency. The lead clinician hoped for the chance to support a development that would culminate in him being able to perceive the service as arising out of, but separate to, his own past experience. As we hope to show, these developmental achievements would also seem a necessary pre-requisite to the successful treatment of patients.

Freud reminds us that the word ‘heimlich’ (homely) ‘belongs to two sets of ideas … on the one hand [meaning] what is familiar and agreeable and on the other, what is concealed and kept out of sight’ (Freud, 1919, pp.224–225). It is to this second idea that Freud attached the word unheimlich (un-homely). He notes therefore that ‘heimlich is a word that develops in the direction of ambivalence, until it finally coincides with its opposite’. Parsons, in his writings, attaches great importance to the ability to bear contact with this unfamiliar state, noting it to produce ‘a particular quality of anxiety … it calls into question the framework of understanding within which we feel safe [and] being fully alive means being open to the unheimlich…’ (Parsons, 2009). Inhabiting this ‘unheimlich’ place could also lead us towards contact with the patient’s experience, wherein they are most
certainly ‘not at home’ with who they are. We suggest, here, that the inhabiting of the ambivalent ‘unheimlich’ position was also necessary for the lead clinician in the very early development of an infantile ‘living service’ capable of meaningful work.

The recruitment process

Ambivalence characterized the process of recruitment to the new service from the outset. Uncertainty about whether to advertise the post of lead clinician to psychotherapists, psychologists or psychiatrists resulted in a confusing advert, almost lost within these vague mists. When the lead clinician was interviewed and appointed, the lacking representation of necessary panel members later resulted in the necessity for re-interview. Thus, the lead clinician had from the outset to bear the confusion around identity which continued for a considerable time thereafter. This may have been the first containing function of the lead, which enabled the members of the appointments committee to distance themselves from the uncertainty around the service identity, also inherent in the work envisaged. There existed a particular demand upon the lead when dealing with this uncertainty around identity. His previous habitual ways of making sense of the world were now destabilized as new tasks presented themselves for consideration in the construction of the service. He had therefore to bear contact with all with which he was ‘not at home’.

During that recruitment process, it then emerged that the directorate had secured funding on the basis of a commitment to provide treatment for double the number of patients of any existing similar Personality Disorder Service, with half the number of staff. The rationale given for this was that this was in keeping with the expectations of Commissioners, who were keen to reduce bed occupancy, the cutting of bed numbers having in part funded the service. While these issues have obvious links to hospital politics and to the competing disciplines, together with the pressure to appoint within a specific timeframe, we should also consider the clinical implications. It seemed that the steering group had felt so consumed with the pressure to comply with commissioning demands that it had been impossible to reflect upon these elements in order to establish a coherent reality-based context.

Winnicott describes two distinct modes of living and engaging with the world (Winnicott, 1971, p. 65). One is based on a compliance with reality, with ‘the world and its details being recognized, but only as something to be fitted in with or demanding adaptation.’ The other involves the task of perception and setting this perception in relation to one’s past experience. He states that it is this method of ‘creative apperception’ that ‘makes the individual feel that life is worth living, while living by compliance produces in the end a sense of futility.’

This task of creative apperception would appear important if the emerging service is (and those within it are) to escape a sense of futility. After all, the therapeutic work envisaged would likely place a great emotional burden upon staff members, all of whom would be arriving in post from separate and varied backgrounds. Their own identity is therefore under great strain at this juncture,
with staff probably entertaining internally such common questions as ‘Will I be acceptable to colleagues? Will I succeed or fail in this job? Will my past experience count for anything?’ A therapeutic culture is required that recognizes individual differences as strengths and supports a new creative application of these strengths. This is then a culture in which the staff member may feel sufficiently supported into their developing new professional identity to enable them to bear meaningful contact with a disturbed patient group. Staff members can then feel less encumbered by questions as to what is acceptable, right or wrong, so that compliance is less to the fore. This further promotes a sense of acceptance of and curiosity about difference when working with patients and so a sense that the patients’ identities are both acceptable and worthy of interest is fostered. Staff can then truly be open to and curious about the ‘unheimlich’ individual experience of the patient. We are not suggesting here that no place exists for compliance in the therapeutic work, but rather its place is relegated such that a sense of being creatively alive within the work may flourish ahead of it. Neither is this simply the encouragement of a process of reflecting within therapeutic work, not least because reflecting may still be possible within a culture of compliance. In the context of service development, the lead clinician noted the missing attention to detail within the steering group, arising from the preliminary commissioning expectations. This marked the beginning of the lead clinician setting the developing service in relation to his personal past clinical experience, itself an act of creative apperception. It paved the way for the infantile service to be more meaningfully brought into being. The lead clinician was then able to discuss with commissioners what was and was not feasible, resting upon the bedrock of his own experience while acknowledging the constraints of present funding, enough to think about flexible alternatives for provision of care, thus relegating the notion of compliance to a lesser position and placing ahead of it the possibility of a creative therapeutic culture.

Steering towards an identity

When the lead clinician joined this steering project, he was told that while the group hoped for success, many colleagues believed that it would fail. The anxiety about whether development could be successfully negotiated seemed to infiltrate the process of the steering meetings, which often ran over time. Items were repeatedly brought from one meeting to the next, as if being presented de novo. The group oscillated between despair that the service would never function and the hope that perhaps it could accomplish far more than initially hoped for. There was very little evidence of reflection on and progression of agenda issues in the space between meetings, with the consequence that they arose afresh and unprocessed at the next.

In Kernberg’s terms, this situation, ‘split along the lines of idealized and persecutory relations . . . needs to be clarified (if we hope to achieve a) resolution of the syndrome of identity diffusion and the establishment of a normal ego
identity' (Kernberg, 2003, p.521). Kernberg’s statement helps us in the recognition that this ‘identity diffusion’ syndrome can be an affliction also borne by professionals (in this case the steering group). By referencing the models and staffing complement of similar existing services, the lead clinician constructed a model for the new service. This served to focus the steering group and counter the oscillating hope and despair such that the identity of the future service could then be considered. A more normal (ego) functioning within the steering group was established and the service planning was progressed. While this may seem an obvious step, involving the provision of an explicit model to promote thinking, it parallels the recommendations by NICE to be explicit in the model used with patients in reflecting upon their identity disturbance within therapy. Once again, the task facing the staff group and the patient appear to be similar.

When the staff group did take up their appointments, it emerged that clandestine deals had been struck with regards to the timings of holidays and the possibility of continuing work with existing patients, as if to tempt staff into their new posts. In discussion with the steering group, the lead clinician highlighted this situation as perhaps reflecting the anxiety of staff in coming into contact with an identity disturbance in patients, such that they felt a need to maintain a foothold in old roles and establish ‘escape routes’ of holidays. While all staff had clinical experience in working with personality-disordered individuals, the new service model required a revision of old practices and so stripped staff of the defences previously adopted in relation to such work. This new work, with a new orientation, was experienced as an interruption to their ‘continuity of being’ and (like the lead clinician before them) required staff to occupy the ‘unheimlich’ position. The staff group also faced the prospect of separation from their previous jobs and ways of being. Successfully occupying the ‘unheimlich’ position, while facing this separation, requires the existence of new identifications (and their incorporation) to aid the developmental progression towards a robust collective service identity. We have already made mention of the importance of successfully negotiating this task in the emergence of a creative culture. We stress now that this stage hangs in a delicate balance as ‘owing to the intimate connection existing between … identification and … incorporation, and consequently between separation and excretory expulsion, the conflict of the transition period also presents itself as a conflict between an urge to expel and an urge to retain contents’ (Fairbairn, 1952, p. 44).

Fairbairn’s underlining of urges to retain or expel highlights for us the task of being open to new ways of being while resisting ‘throwing the baby out with the bathwater.’ Attention to the conflict in staff between a manic flight to ‘expel’ what is newly available to their collective developing identity and the wish to hold onto or ‘retain’ older identifications that are already in existence is paramount. In the attempt to bring about this separation that was necessary for the development of our service, two facets appeared to be important. First, an end date was set for the steering group and within the intervening ‘transitional’ meetings the steering chair was able to give up the ‘lead’ role in development and
allow the lead clinician to be more clearly charged with this task. This provided
the staff group with an object with whom to more clearly identify. Second, a
succession of staff group meetings, chaired by the lead clinician, was set up. The
staff group was encouraged to consider their ideas around the development of the
new service in relation to their past experience. Creative apperception, initially
performed by the lead, therefore then became increasingly a function of the staff
group. The team, now together, began to occupy the ‘unheimlich position’ in a
manner that afforded creative and meaningful thinking about existing and
working within a living service.

Tenets of a model

Any psychotherapeutic model that aims to address the issue of identity
disturbance has to focus on an integration of affectively laden representations of
self and other and acknowledge that reality testing may at times be impaired in
the clinical work. This places a heavy emotional burden upon staff and requires
the formation and continued protection of a collective, robust professional
identity, which itself is subject to the distortions of idealization and denigration
by both patients and referring agencies, as well as having to inhabit the
‘unheimlich’ position that we have made mention of.

We began our attempt to structure the service by clearly delineating the
models to be used and the patient groups for which they could be of use. During
this phase of development, the voluntary sector provided useful support and made
a valuable contribution to the service identity. Meetings were arranged in which
service users could voice their past experience of existing mental health services
and their opinions about what shape the future service should take. Once again,
this act of creative apperception afforded collaboration a sense of ‘being alive’ to
the developmental challenge of constructing the service.

The service users generated a shortlist of names for the service, from which
the final name was chosen. A working party for service development consisted of
service users and staff working in collaboration to form boundaries, establish
group rules and draft information leaflets. Such a patient-centred approach is
clearly advocated by NICE guidelines, while also promoting a sense of
communalism and task-sharing through which change may be effected. Many of
the service users involved in this endeavor subsequently became patients of the
service that they had helped to create. In this manner, both the identity of the
service and those of the patients involved were supported and galvanized in
parallel to one another. This ‘mutuality’ calls to mind the famous phrase that
‘there is no such thing as a baby’ (Winnicott, 1975, p. 99). Rather, it is the dyadic
nature of the nursing couple that brings into being a mother and a baby, or indeed
a service and its patients.

Just as the nursing couple hopes for a flexible routine to care, allowing for
developmental needs to be met, so too did our new partnership benefit from the
flexible provision of explicit models within a set structure.
The establishment of hierarchy

The flattened hierarchy that often characterizes therapeutic community practice may at first glance seem likely to be beneficial to an emerging Personality Disorder Service, offering the possibility of developing relatively unimpeded under the umbrella of communalism and task-sharing without the burden of demands from (and compliance with) a super-ego figure. However, such flattening has significant implications for the treatment of patients suffering from identity diffusion, with the inherent possibility of confusion of roles and identities.

Rather, a clear delineation of roles within a hierarchy is vital in working with this population, just as within a family. The lead clinician and service manager worked together to clarify roles. At times this proved to be challenging. For example, the lead clinician voiced a preference for using surnames in speaking to patients within the day service, since this helped to maintain the clarity of a relation between professional and patient. He felt that it would further enable the patient to experience being thought about with another while feeling safely distanced enough to continue in that thinking without feeling overwhelmed by the experience. Some team members disagreed, citing previous experiences of practice and expressed the desire to keep the issue under review. Patients also voiced mixed feelings about this practice, with some feeling it ‘more professional and safer’ while others felt ‘too distanced’. The lead clinician emphasized that he welcomed thinking about how one may be held in mind by another person, by both staff and patients, as this could well benefit the course of therapy. However he also stated that the practice would remain standing for the moment. The service manager supported the ‘lead clinical view’ in recognition of this as a clinical issue. This in turn led to discussions between the lead clinician and service manager about how to balance the need for ‘open enquiry’ in the team with the need at times to follow a lead opinion (to comply). The balance between parental roles offers an obvious parallel here. The more feminine, receptive nature of ‘open enquiry’ requires consideration alongside the firmer paternal position if a creative relationship is to be achieved.

It is vital that such discussions can happen, as it is our experience that situations like these arise frequently. The balance between promoting reflective functioning within a none the less clear structure continues to require regular attention. If negotiated well, the creative apperception of the staff group can through this balance, be allowed to flourish, leading to a sense of being alive within a creative process. If performed less well, the service may descend either into a state of dictatorship or into a state of overwhelming confusion. The practice of using surnames was indeed subsequently revised, but only after a year of the service being operational. This timing reflected having reached the stage as a service of having a robust enough identity to provide clarity to patients and be capable of withstanding over-identifications without such concrete rules in place. Negotiating this dynamic successfully is a continuing process though, and one that also faces the borderline patient, where a creative ‘arriving at being’ has
never happened in development and where an overwhelming confusion (or collapse in ‘mentalizing’) is a frequent occurrence. As Ogden writes:

The goal ... is ... larger than that of the resolution of unconscious intrapsychic conflict, the diminution of symptomatology, the enhancement of reflective subjectivity and self-understanding, and the increase of personal agency. The experience of aliveness is a quality that must [also] be considered in its own terms. (Ogden, 1995, p. 696)

The principal benefit of delineating a hierarchy may be that it affords the provision of a protective function by those in charge, in relation to the outer ‘clinical reality’ of service demands. Staff need to be able to face the demands of patient contact as separate from the demands upon the service, if they are to act in any effective way as an ‘auxiliary ego’ to the struggling patient. In our service, a weekly senior managers meeting was established in order to address interface issues. The wider staff group can ask for topics to be raised within that forum and are given feedback as required, but also are able to attend to their clinical work without having to attend to referrers’ external demands.

**The theoretical models**

Two models were chosen for the service.

(1) **The MBT Day Service**

Within the day service we established a three-day and two-day mentalization-based therapy programme for borderline pathology (MBT).

MBT rests upon the premise that traumatic experiences within the early attachment period leaves the individual prone to experiences of mental collapse, especially in times of affective arousal. Later, this vulnerability can give rise to Borderline pathology. In therapy, specific emphasis is given first to the identification of the current affective state of the patient, with the therapist acting to contingently mirror the patient’s internal experiences. As this process continues and a therapeutic alliance is established, the patient is helped increasingly towards continued thinking about themselves in relation to the other and about other people’s states of mind (mentalizing) especially during times of affective arousal. Resilience to stress is gradually promoted within the context of a therapeutic ‘attachment’ relationship. Collapses in mentalizing become less frequent and borderline pathology improves.

The principle clinical differential between the two MBT day programmes within our service was the level of self-harm. Those patients exhibiting more intense or more frequent self-harm were generally referred to the 3-day programme.

**Clinical vignette**

Jane had moved to supported accommodation just before starting in the day programme, in recognition of her diagnosis of borderline personality disorder and
frequent attempts at self-harm, the most recent of which had culminated in her being ventilated in an intensive care unit for four days. She had voiced both the desire to receive help and the anxiety that she would be made worse should she do so. This is typical of the ‘approach-avoidance dilemma’ of the borderline patient, occurring when the attachment system is activated as the need for care arises. Patients who have BPD have been characterized as having a specific type of disorganized, anxious preoccupied attachment focused around an approach–avoidance dilemma in which the attachment figure is simultaneously perceived as a source of threat and a secure base (Crandell, Patrick, & Hobson, 2003). As a result, Jane’s attendance in the programme had been erratic. Telephone contact to prompt attendance had been attempted but had not succeeded and so a management meeting had been offered:

Jane: I didn’t come yesterday. I didn’t have much sleep. I was up most of the night. I self-harmed. I called the staff and they phoned the ambulance and the police. I won’t be doing that again.

Therapist: Phew! That’s a relief.

Jane: What? No, that’s not what I meant! (laughs) I will self-harm, but I won’t be calling anyone.

Therapist: I wonder why you did call the staff?

Jane: I suddenly realized what I’d done. I felt scared. (pause) Oh, no... no... this isn’t working. I should go. This isn’t helping.

Jane shifted nervously on her chair.

Therapist: I wonder if, like with the staff yesterday, you suddenly find yourself just now thinking with me about what happened? It seems that when that occurs, you want to quickly withdraw. If that is the case, I guess going on being here may feel quite frightening.

Jane: Yes. It does. It really does... but I do want to be helped.

Therapist: Maybe we have to keep hold of how frightening it can feel to be helped though.

Jane had attended for the management meeting, despite prior poor attendance, as this was viewed as a concrete enough structure to allow for contact. When the therapist humourously (and deliberately) misunderstood what she ‘would not do’ again, Jane appeared to reflect upon what she had said enough to correct the misunderstanding. Humour can be important, if used judiciously in this way. When she continued to think with her therapist about her self-harm, the ‘approach-avoidance’ dilemma entered the transference and was acknowledged.

Jane continued to attend the programme and became a valued and insightful member of the community. Her attendance was initially promoted by the provision of MBT within clearly delineated clinical structures. Later in her treatment, when new patients began the programme, she remarked to her therapist, ‘I was thinking about how ‘Borderline’ I am. I see the new patients.
I can see myself in them. At least, that’s myself as I was. But I suppose we all come from somewhere and are going somewhere else’.

Jane’s capacity to ‘mentalyze’ is apparent here. Moreover, she has now ‘arrived at being’ in the present and can imagine a future. This accomplishment parallels the process of contextualization, within the service development, that we have already remarked upon.

(2) The SUN Project model

The SUN Project is a group-based, open access, community intervention, set up in collaboration with a voluntary sector organization and in consultation with a neighbouring borough, where it was already in existence. Groups are facilitated four times a week, with members choosing how often they wish to attend according to need. The model accepts only self-referrals, catering for people with or without a formal diagnosis of personality disorder and no member is ever discharged. All SUN groups are highly structured, running over the course of 2½ hours. The group begins with ‘check-in’, which is an opportunity for members to say who they are, how they are and what they may like from the group that day. After a break, the middle part of the group commences, which may entail welcoming new members (welcome group), attending to members in crisis (crisis management group), providing general support (emotional support group) or attending to practical issues (practical group). Core activities, whereby members are invited to partake in pre-arranged facilitated social activities, also occur alongside the SUN groups.

All SUN groups follow the same basic structure, although implemented flexibly according to clinical need. For example, a member presenting in crisis at a practical group would still receive crisis management. Where this new derivation of model differed was in the intention to integrate it with the MBT model.

The SUN Project itself is a tripartite model integrating aspects of psychoanalytic epistemology, therapeutic community principles, and cognitive coping psychology to create a coherent theoretical model clearly linked to clinical practice (Miller & Crawford, 2010). It comprises:

(a) Psychoanalytically informed supervision: A working knowledge of the mechanisms of splitting and projective identification and the related concepts of transference and counter-transference, delivered within supervision of groups, aids the team in both maintaining a capacity to think (mentalyze) and an ability to tolerate the emotional burden of contact with patients’ suffering identity disturbance as a function of a Personality disorder.

(b) The Therapeutic Community principle of ‘Community as Doctor’: The resource to provide help and support is seen to lie within the SUN group as a whole. Patients represent a resource of ‘experts by experience’ that can be utilized for the good of individuals and the group as a whole.
Coping Process Theory: This may be defined as the ongoing efforts to manage threats to one's psychological integrity (Lazarus, 1993). A patient is here recognized as possessing a repertoire of strategies and which can be employed in a flexible manner. Coping is context dependent, and the responses will vary depending on the stressors placed upon the individual. Coping responses can be divided into problem-focused strategies and emotion-focused strategies. Problem-focused strategies involve taking action and include behaviours. Emotion-focused strategies link to psychoanalytic theory and include the use of unconscious defence mechanisms. When stressful conditions are refractory to change emotion-focused coping predominates. The role of the group, as an ‘expert’ resource to the patient, involves generating alternative coping strategies such that the difficulty encountered is seen as less refractory to change so that the problem-focused strategies may then be employed (so averting a ‘collapse in mentalizing’).

Clinical vignette

Joe was a middle-aged, solitary man. He had previously attended a two-year MBT therapy in an existing service, but after discharge had continued to episodically and seriously self-harm. He had a diagnosis of Borderline Personality Disorder, had been sexually abused in childhood, exhibited a gender identity difficulty and was ‘plagued’ (his word) by ruminative thoughts of sexually molesting young children, although never having done so. Prior to attendance at SUN, his attempts to broach these ruminative thoughts with others had resulted in either his team distancing themselves from him by them seeking long hospital admissions or by his hitting himself in the head with a hammer after any discussion. He had sustained numerous fractures to facial bones.

After attending SUN groups for a number of months, Joe began increasingly to voice his distress about his ruminative fantasies. Initially, when he was not met with a harsh reproach from the group, he would instead seriously self-harm. Some members left the group. Some staff also expressed the wish to expel Joe from the groups. His community team took the view that he posed no risk and the issue of his ruminations should at all costs not be broached in SUN, voicing the opinion that the group itself had become abusive. The desire to disavow the risk was perhaps best exemplified by his previous community team having placed him next to an infant school.

Within supervision, the team was helped to see the wish to expel Joe as reflective of his own internal experience, wherein his ruminative fantasies must be ‘banished’ from consciousness under the instruction of a harsh super-ego. The SUN members began to focus on Joe’s self-harming as a consequence of fantasies and helped him construct a letter to the social services department, in which he expressed the need to have his ruminations acknowledged as a risk by all agencies, as opposed to being left in isolation. He was re-housed. His self-harming
diminished. He continued to attend SUN and support others. There have been no instances of abuse to children.

(3) The flexible provision of alternatives and a need for integration of models

Some similarities did exist between the two models outlined. For instance, in the SUN Project, psychoanalytic technique is not directly employed in patient contact; the focus is more on conscious and pre-conscious material, considered in the company of others in the here and now. Similarly, MBT does not address unconscious conflict and focuses on inter-personal ‘attachment system’ generated anxieties in the here and now.

An emphasis upon reflecting is of course central to any psychoanalytically informed approach. This is, perhaps, even more true of the SUN & MBT models, however. Both models actively and explicitly call upon the patient to consider themselves now and in relation to an historical context – to engage in the task of creative apperception.

Within MBT, this task is undertaken within the therapeutic ‘attachment’ relationship. Within SUN, the highly structured nature of the group model itself promotes this possibility. SUN members make reference to the structure of the groups in order to challenge misperceptions and generate coping strategies for others. For example, a member may present in crisis, voicing the idea of not being able to cope after splitting from their partner on the previous day. Another group member may then challenge this, stating that the individual in crisis attended a practical group in a similar crisis, but used the group well and indeed at checkout agreed to attend a core activity, which they subsequently enjoyed. This accurate ‘referencing’ aids the establishment of members within a context-specific narrative, such that they may then be invited to consider what they wish to do in the present with the resource of the group members, i.e. to mentalize.

Individuals working within both services also require a working knowledge of basic psychoanalytic tenets such as splitting and projective identification and the related concepts of transference and counter-transference, so that the integrity of the team can be maintained in relation to the work.

One difference between the models, however, is the SUN group’s emphasis on challenging the coping style of individual patients and providing practical, less maladaptive alternatives to be tested. The ‘therapist stance’ of open enquiry, which is a core aspect of MBT, is thus replaced by a more directive approach to a potentially more diversely disturbed and chaotic patient group. This approach is used not only by the therapist, but also as highlighted above, by patients too. Members are called to help with the therapeutic task, in line with therapeutic community principles, as in the example above. Also, unlike the MBT day service, the SUN Project operated a self-referral pathway that allowed people with or without a formal diagnosis of personality disorder to access the structured, facilitated and community-based group. Within our developing service, consultation began with the existing SUN staff in the neighbouring Trust. Training occurred initially at that site and later across
Trusts and between sites, so that a more fluid uptake of the model could be effected. A close collaborative alliance was forged between teams that further facilitated the developing identity of the new service.

The issue of the interface between the two models within the new service itself then began to emerge in a variety of ways:

First, the provision of open access SUN groups as an alternative for those patients who were not suitable for the day programme served to lessen discontent from some referrers, although many others continued to express ‘incredulity’ that patients should be charged with the task of helping one another in an open setting, as if this was somehow inferior to other types of care. This was not simply a product of ignorance of therapeutic community principles, as senior staff had toured the referring agencies to explain the two models being used. Rather, in the face of a required cultural shift, the SUN model represented to many an impingement upon the established caregiver-patient dyad (and so to their continued practice) to be then ‘gathered into the area of omnipotence’ and sensed, as a projection, of an external threat to be overcome (Winnicott, 1965, p.47).

This ‘incredulity’ could not be resolved by direct challenges, which would have required the detractors to take back that unwanted projection and so suffer the anxiety of a threat to their own continuing professional identity once more. Resolution depended on the capacity of the newly established service to bear that projection enough to allow the referrers the chance to observe the functioning of the group at a safe distance, so that no impingement was again experienced, i.e. to provide a holding environment. When they saw that patients could be discharged from hospital, with ready access to a group support and further that patients voiced a benefit from this community intervention, without return to hospital, the SUN groups began to be experienced more as a support to the continuity of professionals’ work, rather than a threat to it.

However, alongside these successes, through the assessment process, it also emerged that there existed a group of patients who could not be served by either a three-day MBT programme, which was experienced as too structured, or by SUN attendance alone because this, being open access, was viewed as too threatening. Those referred with the additional diagnosis of a major psychotic illness typically presented as chaotic and socially isolated. Any attempt at thinking together led to fears of annihilatory attack such that the patients maintained a marked narcissistic defence and were ‘cut-off’ from the possibility of any therapeutic work. The very prospect of being called upon to think with another was, for these patients, instead sensed as an impingement. That is, while ‘impingements may be met and dealt with by the ego organization, gathered into the infant’s omnipotence and sensed as projections … they may get through this defence in spite of the ego support… then the central core of the ego is affected, and this is the very nature of psychotic anxiety’ (Winnicott, 1960, p. 591).

In these cases, attempts to promote engagement through telephone contact and additional meetings would probably have been experienced as further
unwanted penetrations to the central core of the ego, culminating in a psychotic anxiety. Instead, a graded method of establishing a therapeutic rapport and of fostering a sense of omnipotence in the patient seemed urgently required for this group. We therefore offered the option of SUN group attendance, the frequency of which the patient could regulate according to their need, together with the possible addition of a two-day MBT programme at a later stage, if desired by the patient. This presented this group of patients with a graded and flexible structure, within which their own omnipotence could be supported enough to counter the psychotic anxiety of annihilation that contact with another mind brought with it. While it might at first glance seem counter-intuitive to provide a more disordered group of patients with a less intense intervention, this type of flexible approach allows patients greater choice in the frequency of their own attendance. In turn, this fosters a sense of self-determination and empowerment (Gillard et al., 2010). The graded approach, established in this way, appeared to work well, lessening the potential for the intervention to be experienced as an impingement.

Clinical vignette

Anna had experienced a physically abusive upbringing by her mother, running away from home at the age of 13 years when her stepfather had attempted to sexually assault her. She developed an eating disorder and began to self-harm. Despite this, she had successfully finished her A-level studies and had begun to study for a University degree, although she later dropped out, when she began to voice the increasingly persistent anxiety that she would be attacked by fellow class-mates. At this point, she was diagnosed with schizophrenia. Later, her continued attempts at self-harm, aggressive outbursts and marked social isolation had led to an additional diagnosis of borderline personality disorder and a belief in her care team that she had been wrongly diagnosed initially, although her diagnosis of schizophrenia was never revised. This reluctance to revise diagnoses, which is often encountered in our experience, again perhaps points to an unconscious awareness in the staff of the fragility of the patient’s sense of identity.

At the point of assessment, Anna had dropped out of contact with all other mental health services. She was significantly underweight and lived alone. She was offered a place on the two-day MBT programme and began attending, though always left her therapy structures early. Alongside, she began to attend SUN. There, too, she always left the group prematurely. She began, in both programmes, to make creative offerings. For instance, she offered to help to design the SUN leaflet and took pride in finishing a painting for the day service décor. In this manner, she could be seen to be negotiating contact with others through an intermediate transitional object (in fact several).

Anna reached a point in therapy where she asked to be admitted to an eating disorder unit. The staff group at that unit was reluctant initially, as she had previously been admitted and had threatened staff. The SUN group helped her construct a letter to the Eating Disorder Team and members accompanied her to
the assessment, from which she was admitted. As well as being visited by SUN members, she continued to attend her MBT therapy programme. At a subsequent session with her therapist, the following exchange occurred.

Anna: I can’t cope with the regime on that eating disorder unit. It’s like I’m rotten inside. I have this persistent feeling that I’m spoiling. It’s an awful feeling.

Anna begins to cry.

Therapist: Awful and upsetting it seems.

Anna nods.

Anna: The food there is crap. I’m sure everything is off. How do they expect me to eat that?

Therapist: You’re going to have to help me out, because I’m confused. You were telling me about how you were feeling, rotten and spoiling, but now we’ve slid onto talking about food. Do you think food is also a way to represent how you feel then, or have I got it wrong?

Anna: Maybe. The thing is, my mum winds me up. To everyone else she appears to be kind and motherly, but it always turns out that she stabs me in the back.

Therapist: A relationship that turns rotten and spoils.

Anna: That’s so insightful! But I don’t want to be angry with my mum! You know, I picked some flowers earlier today, but I’m sure they will die.

Therapist: That’s what happens with flowers. But you might be wondering if this relationship will die too, or whether this understanding between us can survive.

Anna begins to cry.

Anna: This is a good tearfulness. Thank you.

Anna finished her inpatient stay at the eating disorder unit. The SUN members helped support her with an eating plan after discharge, meeting socially in groups for meals. Anna is no longer anorexic and still attends both therapy programmes.

As these clinical vignettes highlight, the development of our service required an integration of MBT & SUN models such that the individual presentations of patients could be adequately addressed at the same time as meeting commissioning expectations of the service. Our experience is of these models complementing one another. The flexible, open-access and open-ended nature of SUN fosters in some patients a greater sense of autonomy in managing contact with others, as they can more easily regulate attendance according to their present need without fear of ever being discharged. The MBT programmes, with a more ‘timetabled’ and repeating structure that spans whole days, offer a greater sense of safety for others. The provision of two such programmes within the week allows for a flexible inter-digitation of the two models (MBT & SUN), with members of either of the two MBT programmes afforded the possibility of SUN attendance at the weekend. Patients attending the two-day MBT programme can additionally attend SUN on three occasions within the week, just as Anna had done in the vignette above.
This arrangement allows for flexibly attending to the varying clinical presentations associated with personality disorder within one service (Figure 1).

Concluding remarks

Our experience of establishing a service identity brought us into close proximity with the ‘unheimlich’. We had to re-examine our own professional identities in the face of strange, new demands. The importance of a space for staff to establish their own identity within a service is not a simple attempt to reduce confusion and over-identifications with patients, however. This space also affords staff a chance to perceive themselves now in relation to their own past professional life. Neither is it merely a way of promoting reflective functioning. It affords staff the added sense of being alive within their own experience and within a service upon which much demand is continually placed. This parallels the task of the patient, to re-examine all that they have experienced in ‘arriving at’ who they are now. We lay great emphasis on the importance of daily staff process meetings alongside patient activities, so that differentiation within the process of creative coupling may occur. Patients may then be supported in their own bid to feel alive within their experience and to think about a future that they have a part in creating.

However, inhabiting this ‘unheimlich’ place requires a robust internal psychic structure, similar to the new parent that is recruited to care. We first require the provision of a flexible structure from which routine can emerge. It is too simplistic to assume that the external, hierarchical service structure negates any potential for therapeutic community principles to exist. Rather, the dynamic between hierarchy and creative expression requires constant attention. When negotiated well, flexible adaptation to reality can occur and mentalizing is promoted. A developmental history can be acknowledged and reflected upon. Referencing, whereby one is located in the present within a context specific history, injects a meaningful depth to identity, both in terms of the service, the staff and the patients. The successful engagement of patients with our service is testament to this process. Creative potential and the capacity to support others in their development is clearly evident beyond the staff group as a result.

![Figure 1. The Service Structure](image-url)
References