

## **Significance of personality disorders in the face of drop-outs from psychiatric hospitalizations. The case of selected psychiatric units**

Maja Biała<sup>1</sup>, Andrzej Kiejna<sup>2</sup>

<sup>1</sup> Day-care Unit for Neurosis Treatment, Department of Psychiatry, Wrocław Medical University

<sup>2</sup> Department of Psychiatry, Wrocław Medical University

### **Summary**

The World Health Organization's estimations indicate that about 50% of patients in well developed countries may not adhere to long-term therapies. In the field of psychiatry, drop-outs from psychiatric treatment are particularly important. Personality disorders are a significant part of this sphere.

**Aim.** The aim of this research was to empirically verify the hypothesis regarding the relation between comorbid personality disorders and drop-outs from treatment among patients of psychiatric wards.

**Method.** This study was a prospective cohort study. 110 patients, hospitalized in 3 different psychiatric wards, were included. Personality disorders were assessed with the Structured Clinical Interview For DSM-IV Personality Disorders (SCID-II). The research was financed by the Polish National Science Center (DEC-2011/01/N/NZ5/05364).

**Results.** The response rate was 89.1%. 72.56% of patients suffered from personality disorders (SCID-II) (among them the most prevalent were: personality disorder – not otherwise specified – 40.7% and borderline personality disorder – 12.38%; 22.95% of patients dropped out from treatment). However, occurrence of personality disorders was not relevant for those drop-outs. On the other hand, relationships at the level of certain criteria of borderline personality disorders and passive-aggressive personality have been revealed. These relationships became stronger when considered from the perspective of differences in the organization of treatment at individual wards.

**Conclusions.** Some personality disorders may play an important role in drop-outs from psychiatric treatment. Presented results require further research.

**Key words:** personality disorders, comorbidity, personality assessment

The word psychopathy (here: personality disorders) stands for psychic pain. (...) psychopath is a man, who suffers and (or) who makes others suffering; his psychopathic “spine” is directed at the same time inwards and outwards.

A. Kępiński, *Psychopatie* [1]

## Introduction

### Drop-outs from treatment and personality disorders

The World Health Organization’s estimations indicate that, about 50% of patients may not adhere to long-term therapies in well-developed countries [2]. That concerns not only psychiatry, but once the problem is more highlighted on its field, it may provide new procedures for treatments in other branches of medicine.

Drop-outs from psychiatric treatment are increasingly becoming a problem. Differences in functioning between medical procedures may be multifactorial – groups of patients which do not adhere to treatment are not homogenic, neither clinically, nor in the perspective of personality or demography (psychosocial factors, as being under a lot of stress, are also important) [3–4]. Relationship between non-psychotic diagnoses like depression [5] or bipolar disorder [6] and personality disorders is being underlined (for personality disorders – see [7]). Growing number of published results support high prevalence and also relation between personality disorders and functioning in treatment procedures [8–12]. Personality disorders may be one of the factors predisposing to more intense use of psychiatric care [8, 9, 11, 13–16]. Yet, the question arises if this phenomenon is a result of occurrence of personality disorders themselves or is it more embedded in their multiplicity or severity? Personality disorders distort satisfying functioning in a close long-term relationship, that would involve deeper personality structures [17]. Attitude to one’s health, therapy, medications, doctor are examples of those.

### Issue of types of personality disorders and organization of treatment

Tyrer [18] distinguished “treatment-seeking” and “treatment-rejecting” personality disorders. That would be respectively: group C (avoidant, dependent and obsessive-compulsive personality disorder) and A (paranoid, schizoid and schizotypal), as organized in DSM-IV. Vuorilehto [16] pointed out, that the characteristics of patients in the face of personality disorders can differ between different psychiatric settings. Forms of treatment, most efficient in case of specific personality disorders and patient’s needs, are studied [19, 20].

Currently published results are not sufficient to create useful procedures for clinical practitioners.

### Aim of the study

The aim of the presented research is to empirically verify the hypothesis regarding the relation between comorbid personality disorders and drop-outs from treatment, among patients in psychiatric hospitalizations. Kępinski's psychopathic "spine" can cause suffering of patients and their relatives, undermining the possibility of benefiting from treatment, although its intensive use.

### Method

The presented study has epidemiological and organizational character; it is a prospective cohort research. Three units of the Department of Psychiatry, Wrocław Medical University were included in the study: General Psychiatric Inpatient Unit, General Psychiatric Day-care Unit and Day-care Unit for Neurosis Treatment (with psychodynamic group psychotherapy). All units are co-educational. First two have diagnostic and therapeutic character. The inpatient unit runs diagnostics and mental disorders treatment, often in the case of therapeutic difficulties or drug resistance occurring in the past. Most important here is biological treatment with psychoeducation for patients and their families, sociotherapy, elements of art therapy or psychotherapy. General psychiatric day-care unit concentrates on diagnostics (psychiatric and general-medicine), pharmacotherapy and rehabilitation (individual and group psycho- and sociotherapy). Unit for neurosis treatment performs intensive 3-months psychodynamic group psychotherapy not only for patients with anxiety disorders but also with personality disorders or psychogenic depression. This research is based on therapeutic programs which are used in the aforementioned institutions. This affects the possibility of generalization of the presented results (see [21]). At the same time, according to the author's knowledge, this study is the first of its kind in Poland, and its goal is to provide initial results and plan further research. The multiplicity of personality aspects (as independent variable) was taken into account: groups of personality disorders (according to DSM-IV [22]), categories, specific criteria and dimensions [23].

This study was financed by the Polish National Science Center (DEC-2011/01/N/NZ5/05364) and approved by the Bioethics Committee at the Wrocław Medical University.

### Study sample

110 patients were invited to take part in this study. They were hospitalized 124 times in 3 aforementioned psychiatric units (inpatient unit:  $n = 42$ , day-care unit:  $n = 37$  and unit for neurosis treatment:  $n = 45$ ). Data was collected by one researcher (psychologist and psychotherapist), professionally trained in using SCID-II [24]. This is a result of a compromise between the possibility of this study and a plan to fulfill international standards of appropriate training [24].

Participants were invited into the study after (consecutive) admissions to units. Among inclusion criteria were: age (18–65) and signed informed consent. Exclusion

criteria were as follows: refusal to participate in the research, lack of possibilities of informed consent (as the result of mental state), organic states or active psychosis.

### Tools

- Subsequent rigorous measures were used (in order of administration):
- Brief Psychiatric Rating Scale (BPRS) [25] allowed an initial psychopathological assessment of patients in the context of inclusion and exclusion criteria (24-item version [26]).
  - Self-prepared interview concerning sociodemographic variables, based on the Composite International Diagnostic Interview (CIDI [27]).
  - The Structured Clinical Interview For DSM-IV Personality Disorders (SCID-II, Polish version [23]) was used to assess groups, categories, dimensions and specific criteria for personality disorders. The tool is based on DSM-IV due to a lack of Polish structured interviews concerning personality disorders prepared for ICD. Since SCID-II requires collecting data from all possible sources [23], questions about observed personality pathology were also addressed to doctors working with patients (patients were informed in detail about these procedures).
  - Self-prepared interview concerning treatment discontinuation based on CIDI. At the end of hospitalization both, patients and psychiatrists, were interviewed regardless of early termination or complement of hospitalization (if it was unable to obtain data from the patient, the interview was carried out only with doctors).

The presented research defines a drop-out from treatment as giving up therapy before the term, contrary to or without consulting it with the medical personnel. The definition used in this study did not encompass circumstances independent from therapy (e.g., giving up therapy as a consequence of an intervention of the patient's relatives in a situation when such patient is completely dependent from them; death of a patient).

### Statistical analysis

Descriptive statistics (mean values, standard deviations and 95% confidence interval) were prepared for quantitative characters. Frequency analysis was performed using the  $\chi^2$  test. T-test for independent samples or Mann-Whitney  $U$  test were used to compare two mean values. Comparisons of mean values between the three units were performed using the analysis of variance and the LSD test (Least Significant Difference). The relations between quantitative attributes were studied using the Pearson's linear correlation coefficient. Their statistical significance was evaluated by means of the t-test. All hypotheses were verified at the level of  $\alpha = 0.05$ . For more clarity, following categories of significance were established (the more stars, the more significance): \*:  $p = 0.05-0.01$ ; \*\*:  $p = 0.01-0.001$ ; \*\*\*:  $p < 0.001$ . Sample size did not allow for multivariate analyses.

## Results

### Study sample

Response rate in the whole research was 89.1%.

72.56% of the study sample were women (what would be associated with sampling), 30.97% of participants were married, 37.16% had higher education, 39.09% were financially dependent on others (see [28 and 29]. The abovementioned characteristics did not differentiate patients who either suffered or did not suffer from personality disorders. Because of small sizes of each group of patients analyses regarding categories of personality disorders were not possible at this point.

The strong relation of personality disorders and lack of employment should be underlined at this point (42.68% of patients with personality disorders, 16.13% of other patients,  $p = 0.004^{**}$ ). Similar results were published by other authors, especially in the case of borderline personality disorder [30]. Lower levels of employment were observed not only among psychiatric patients, but also among students suffering from personality pathology; some of those were participants of prospective studies who were observed for even 27 years. Only half of those people were employed, and among others – only half were satisfied with their current employment.

Among the subject groups, the most prevalent diagnosis were personality disorders, most frequently ( $p = 0.000^{***}$ ) observed among patients of neurosis treatment unit (Tab. 1). Next: anxiety disorders and affective disorders (most frequently observed among patients of stationary unit; respectively:  $p = 0.018^*$ ,  $p = 0.003^{**}$ ).

### Personality disorders

According to SCID-II, 72.56% of the study participants suffered from personality disorders. These results are comparable international reports, however, this value is much higher than suggested by few Polish studies. The most prevalent were: unspecified (40.7%), borderline (12.38%), narcissistic (4.42%), histrionic, passive-aggressive (both 3.53%), schizoid and dependent (2.56%) personality disorders. No case of schizotypal and antisocial personality disorder was reported. No differences concerning categories and groups of personality disorders were observed between units. 40% of patients diagnosed with mood disorder (by psychiatrists – at the end of hospitalization), also suffered from personality disorder (according to SCID-II). That concerned 60.63% of patients with anxiety disorders.

### Drop-outs from treatment

22.95% of patients dropped out from treatment. This figure includes: 9.83% of patients discharged due to breaking the unit's regulations and 13.11% of patients who resigned from therapy. These patients spent, on average, 56.91 ( $\pm 28.76$ ) days in psychiatric units (3-months treatment program at the Unit for Neurosis Treatment must be noted).

In our research the occurrence of personality disorders was not important for drop-outs from treatment. Again – due to the size of the sample specific categories of personality disorders were not analyzed at this point. However, some of the specific personality disorders criteria were important at this point:

**Table 1. Relationship between criterion 6. of passive-aggressive personality disorder and drop-out from treatment**

p = 0.005**	"Voices exaggerated and persistent complaints of personal misfortune"	
Treatment discontinuation	NO	YES
YES	16	8
%	17.02%	47.05%
NO	78	9
%	82.97%	52.94%
Total	94	17

**Table 2. Relationship between criterion 3. of borderline personality disorder and drop-out from treatment**

p = 0.026*	"Identity diffusion"	
Treatment discontinuation	NO	YES
YES	10	14
%	14.70%	32.55%
NO	58	29
%	85.29%	67.44%
Total	68	43

These personality aspects – identity diffusion and exaggerated and persistent complaints of personal misfortune – may be significant for identifying patients, which may not complete therapy.

Considering differences between settings in particular psychiatric units revealed stronger relationships.

#### Differences between psychiatric settings

##### *Unit for Neurosis Treatment*

Treatment at the Unit for Neurosis Treatment has not revealed any relations between personality aspects and drop-outs from treatment.

*General day-care unit*

Drop-outs from treatment at the general day-care unit were significantly related to dimension of borderline and passive-aggressive personality (number of fulfilled criteria for the specific category of personality disorders [23]).

**Table 3. Mean values (and standard deviations) for dimensions of borderline and passive-aggressive personality and drop-outs from treatment – general day-care unit**

	Personality disorder			
	Borderline: $p = 0.013^*$		Passive-aggressive: $p = 0.029^*$	
Treatment discontinuation	Mean	n	Mean	n
YES	2.5±2.61	12	1.58±1.56	12
NO	0.7±1.26	20	0.65±0.74	20
Total	1.37±2.04	32	1±1.19	32

Furthermore, the more severe was the borderline personality dimension, the less time patients spent at the unit ( $r = -0.42$ ;  $p = 0.041^*$ ;  $n = 33$ ). Likewise – patients who exhibited different forms of suicide tendencies (as a borderline personality criterion): were hospitalized on average for 31.5±24.07 days compared with 59.62±23.38 in the case of patients who did not meet this borderline criteria ( $p = 0.012^*$ ;  $n = 33$ ).

*General inpatient unit*

The obsessive-compulsive dimension was correlated with the number of days spent in this unit:  $r = 0.51$ ;  $p = 0.001^{**}$ ;  $n = 36$ . Similar correlation was also revealed for the criteria of overconscientiousness, scrupulousness (obsessive-compulsive personality criteria): those patients were hospitalized on average for 74.42±47.03 days (in comparison with other patients who were hospitalized on average for 33.2±19.11 ( $p = 0.000^{***}$ ,  $n = 36$ )). Those results are coherent with previously published studies which indicated that dimensions of disordered personalities were correlated with the reduced time spent in psychiatric hospitalizations. This relation was independent from clinical diagnoses. The only exception was the obsessive-compulsive dimension, associated with longer hospitalizations [13]. That could result from compulsive scrupulousness of those patients.

## Sociodemographic variables

For sociodemographic variables, parallel analyses were conducted. None of the relationships between demographic variables and drop-outs from treatment or the time of hospitalization were significant at  $^{***}$ :  $p < 0.001$ . No relations were found for psychiatric diagnosis at the end of hospitalizations and drop-outs from treatment.

## Discussion

Presented research points to higher occurrence rates of personality disorders in psychiatric units, than other Polish sources would suggest [31–33]. The most frequently diagnosed disorder was borderline personality disorder, regardless the psychiatric unit. This can reflect frequent redirecting of these patients to hospitals. The fact that the study lacks examples of schizotypal and antisocial personality disorder raises questions: is it because of real low prevalence, study design or rejecting treatment (what would agree with other author's studies [18])? This issue may be ground for further analyses. High prevalence rate of unspecified personality disorders (40.7%) may reflect difficulties that clinicians face in everyday practice (related to diagnosis, but also to the issue that existing classifications tend to miss personality problems). At the same time it seems that there is a number of patients, who may not benefit from psychiatric hospitalizations. Additional description of observed personality pathology seems even more important. It should be emphasized, that it is possible, that high prevalence rates in current study result from specific tendency to diagnose personality disorders, especially borderline personality disorder, in the units included in the study. Though, it would have to be observed in all psychiatric units included in this research and additionally – in the case of the researcher administering SCID-II. The comparison of presented results with data from other psychiatric centers would be interesting in this perspective.

No differences in drop-outs from treatment were found between groups of patients with and without personality disorders (assessed using SCIDI-II). Presented results call for further research. On one hand, they may confirm clinical intuition. For example, maintaining that any category of personality disorders increase the risk for treatment drop-out can be reductive. At the same time – this result can be a statistical consequence of small sample size (type II error). This research is a one-institution study, what further limits the possibility for generalization of the presented data.

Relationship between personality disorders and drop-outs occurred when variety of personality disorders, personality aspects (dimensions, categories) and psychiatric settings were taken into account. Regardless of psychiatric unit single criteria of borderline and passive-aggressive personality disorder (respectively: identity disturbance and exaggerated and persistent complaints of personal misfortune) were associated with higher risk for drop-out from therapy. This result is consistent with reports published by other researchers: borderline and passive-aggressive personality disorders may increase the risk of drop-outs from psychiatric treatments – both in day-care and inpatient units [24, 35]. Studying of specific personality mechanisms may provide important information allowing for understanding of the therapeutic phenomenon. This issue needs further research. Primarily due to the limitations of present study described above. The obtained results suggest that psychodynamic group psychotherapy can be the most adequate treatment for patients with personality problems. Further studies are also required here, especially those taking into account the clinical picture of psychopathology of patients qualified for therapy in this particular unit. Further research should also enable pointing to the character of additional therapeutic help for patients

who, due to personality problems, may not benefit from treatment procedures in the psychiatric units.

Before we have published this report, the American Psychiatric Association prepared a new version of the classification – DSM-5 [35]. Although the present study is based on DSM-IV it does not seem to have lost any of its relevance (basic version of DSM-V maintains 10 categories of personality disorders presented in DSM-IV with possibility to add descriptions of observed personality traits).

Finally, there is a question: are personality aspects, that can be important for course of the treatment, easy to assess with existing personality measures? SCID-II can be a useful instrument, although it is time consuming and needs special training.

### **Limitations**

This research, although high response rate, has a lot of limitations in generalization of results. Small study sample ( $n = 110$ ) in the context of number of personality disorders categories. This may have a consequence in lack of relationship between the occurrence of personality disorders and drop-outs from treatment.

This was a one-institution study, conducted by one researcher.

Future studies should take into account the whole spectrum of the patient's psychopathology. Three units included in the study differ significantly in terms of treatment procedures; qualification of patients was not random.

### **Conclusions and implications**

Personality pathology may be significant in the context of drop-outs from treatment in psychiatric units. In particular borderline and passive-aggressive personality mechanisms should be taken into account. Further research should focus on identifying the nature of additional therapeutic support.

Patients with personality pathology seem to be treated differently, dependently on form of personality disorder. Schizotypal and antisocial patients may not benefit enough from psychiatric hospitalizations.

Personality disorders may be much more prevalent than psychiatric diagnoses suggest. It may reveal real diagnostic difficulties and should be taken carefully into account. In case of unspecified personality disorders, the description of the observed personality traits should be provided.

---

## References

1. Kępiński A. *Psychopatie*. Krakow: Sagittarius; 1992.
2. Sabate E. *Adherence to long-term therapies: Evidence for action*. Geneva: World Health Organization; 2003.
3. Bell L. *What predicts failure to engage in or drop out from treatment for bulimia nervosa and what implications does this have for treatment?* Clin. Psychol. Psychot. 2001; 8(6): 424–435.
4. Gajowy M. *Analiza przyczyn przerywania psychoterapii grupowej (drop-out) w aspekcie czynników dotyczących pacjenta*. Psychoterapia 2010; 2(129): 33–48.
5. Holma IAK, Holma KM, Melartin TK, Isometsä ET. *Treatment attitudes and adherence of psychiatric patients with major depressive disorder: A five-year prospective study*. J. Affect. Disorders. 2010; 127(1–3): 102–112.
6. Colom F, Vieta E, Martínez-Arán A, Reinares M, Benabarre A, Gastó C. *Clinical factors associated with treatment noncompliance in euthymic bipolar patients*. The Journal of Clinical Psychiatry 2000; 61(8): 549–555.
7. Grabski B, Gierowski JK. *Zaburzenia osobowości – różne spojrzenia i próby ich integracji*. Psychiatr. Pol. 2012; 46(5): 829–844.
8. Ansell EB, Sanislow CA, McGlashan TH, Grilo CM. *Psychosocial impairment and treatment utilization by patients with borderline personality disorder, other personality disorders, mood and anxiety disorders, and a healthy comparison group*. Compr. Psychiat. 2007; 48(4): 329–336.
9. Bender DS, Dolan RT, Skodol AE, Sanislow CA, Dyck IR, McGlashan TH et al. *Treatment utilization by patients with personality disorders*. Am. J. Psychiat. 2001; 158(2): 295–302.
10. Percudani M. *Monitoring community psychiatric services in Italy: Differences between patients who leave care and those who stay in treatment*. Brit. J. Psychiat. 2002; 180(3): 254–259.
11. Tyrer P, Simmonds S. *Treatment models for those with severe illness and comorbid personality disorder*. Brit. J. Psychiat. 2003; 44(Suppl.): 15–18.
12. Tyrer P, Mulder R. *Management of complex and severe personality disorders in community mental health services*. Curr. Opin. Psychiatr. 2006; 19(4): 400–404.
13. Keown P. *The impact of severe mental illness, co-morbid personality disorders and demographic factors on psychiatric bed use*. Soc. Psych. Psych. Epid. 2005; 40(1): 42–49.
14. Lana F, Fernández San Martín MI, Sánchez Gil C, Bonet E. *Study of personality disorders and the use of services in the clinical population attended in the mental health network of a community area*. Actas Esp. Psiquiatri. 2008; 36(36): 331–336.
15. Tyrer P. *Paterson CTR. Personality abnormality in severe mental illness and its influence on outcome of intensive and standard case management: A randomised controlled trial*. Eur. Psychiat. 2000; 15(Suppl. 1): 7–10.
16. Vuorilehto MS, Melartin TK, Rytsälä HJ, Isometsä ET. *Do characteristics of patients with major depressive disorder differ between primary and psychiatric care?* Psychol. Med. 2007; 37(6): 893–904.

17. Kernberg OF. *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press; 1984.
18. Tyrer P. *Treatment rejecting and treatment seeking personality disorders: Type R and Type S*. *J. Pers. Disord.* 2003; 17(3): 263–267.
19. Bartak A, Andrea H, Spreeuwenberg MD, Ziegler UM, Dekker J, Rossum BV et al. *Effectiveness of outpatient, day hospital, and inpatient psychotherapeutic treatment for patients with cluster B personality disorders*. *Psychother. Psychosom.* 2010; 80(1): 28–38.
20. Mykowska A, Chadzińska-Bielaszka A, Mickiewicz A. *Badanie potrzeb i oczekiwań pacjentów z zaburzeniami osobowości*. Boguchwał Winid Foundation for the development of psychoanalytic psychotherapy, Peron 7F Personality Disorders Treatment Center. Krakow; 2013.
21. Styła R. *Differences in effectiveness of intensive programs of treatment for neurotic and personality disorders. Is it worth to monitor the effectiveness of the therapeutic team?* *Psychiatr. Pol.* 2014; 48(1): 157–171.
22. *Diagnostic and statistical manual of mental disorders (4<sup>th</sup> Text Revision)*. Washington, DC: APA; 2000.
23. First MB, Gibbon M, Spitzer RL, Williams JBW. *SCID-II – Ustrukturalizowany Wywiad Kliniczny do Badania Zaburzeń Osobowości z Osi II DSM-IV. Podręcznik klinicysty*. Warsaw: Psychological Test Laboratory of the Polish Psychiatric Association; 2010.
24. Lobbstaël J, Leurgans M, Arntz A. *Inter-rater reliability of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I) and Axis II Disorders (SCID II)*. *Clin. Psychol. Psychot.* 2011; 18(1): 75–79.
25. Ventura J, Lukoff D, Nuechterlein KH, Liberman RP, Green MF, Shaner A. *Manual for the Expanded Brief Psychiatric Rating Scale*. *Int. J. Meth. Psych. Res.* 1993; 3: 227–243.
26. Adamowski T, Hadryś T, Kiejna A. *Efektywność leczenia na psychiatrycznym oddziale dziennym, w porównaniu z oddziałem stacjonarnym, na podstawie analizy objawów psychopatologicznych, subiektywnej oceny jakości życia oraz częstości rehospitalizacji po zakończeniu leczenia*. *Psychiatr. Pol.* 2008; 42(4): 571–581.
27. Moskalewicz J, Kiejna, A, Wojtyniak, B. *Kondycja psychiczna mieszkańców Polski: raport z badań „Epidemiologia zaburzeń psychiatrycznych i dostęp do psychiatrycznej opieki zdrowotnej – EZOP Polska”*. Warsaw: Institute of Psychiatry and Neurology; 2012.
28. National Mental Health Program. Regulation of the council of Ministers of 28 December 2010 r. <http://www.mz.gov.pl/>.
29. Department of Health Care Organization, Institute of Psychiatry and Neurology. *Statistical Yearbooks*. Year 2009. <http://www.ipin.edu.pl/>.
30. Sansone RA, Sansone LA. *Employment in borderline personality bisorder*. *Innov. Clin. Neurosci.* 2012; 9(9): 25–29.
31. Grabski B, Dudek D. *Współwystępowanie zaburzeń osobowości, zaburzeń lękowych i uzależnień w zaburzeniach nastroju w populacji polskiej – analiza wyników rejestru epidemiologicznego*. [www.sanofi.pl](http://www.sanofi.pl) (retrieved: 14.11.2013). No: DPKIN\_L\_01684.

32. Smoczyński SA, Landowski J. *Zaburzenia osobowości u chorych z zaburzeniami: depresyjnymi lub lękowymi. Wpływ na obraz kliniczny, przebieg i terapię*. Academic work. Medical Academy in Gdansk, Faculty of Medicine; 2003.
33. Wojtulewska-Supron AM. *Zaburzenia osobowości w ujęciu klinicznym wśród pacjentów leczonych metodą psychoterapii grupowej*. Medical Academy in Białystok, Faculty of Medicine with the Division of Dentistry, Department of Psychiatry. Supervisor: Andrzej Janusz Czernikiewicz.
34. Gunderson JG, Frank AF, Ronningstam EF, Wachter S, Lynch VJ, Wolf PJ. *Early discontinuance of borderline patients from psychotherapy*. *J. Nerv. Ment. Dis.* 1989; 177(1): 38–42.
35. [www.dsm5.org](http://www.dsm5.org).

Address: Maja Biała  
Day-care Unit for Neurosis Treatment  
50-367 Wrocław, Pasteura Street 10