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SUPPORTIVE HOUSING AS A SPACE FOR CONTAINER AND CONTAINED

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Summary

Supportive housing is an attempt to find an alternative to the asylum model of treatment while ensuring continuity of psychiatric care that goes beyond mere hospitalization. It take different forms and is based on other ways of understanding the disease, the patient's capabilities, and the assumptions made about the purpose of the care provided. Usually, analyses of its functioning focus on technical aspects, leaving reflections on the influence of the candidates' psychological structure, group processes, the dynamics of transference-countertransference processes, and the recurring experiences of participants outside the main focus.

This article describes the experience of working in supportive housing for psychotic patients as part of the Mental Health Center. From November 2019 to August 2022, the author was a coordinator responsible for organizing the work and qualifying participants. The presented material aims to show the possibilities of using supportive housing as an effective therapeutic tool to broaden participants' insight into the motives behind their decisions and willingness to bear the consequences. At the same time, it attempts to draw attention to several psychological factors and mechanisms influencing the course of the stay and the dynamics of the relationships between residents and staff.

Introduction

Supportive housing can take a variety of forms, including hostels, separate housing units within social welfare institutions, housing with additional accommodations, individual housing with specialized services, and sheltered housing of both training and assisted types [1, 2]. In Poland, its legal framework is defined by Article 53 of the Law on Social Assistance [3] and the Decree of the Minister of Family, Labor and Social Policy of April 26, 2018 [4]. The specific rules of organization and the criteria for participant qualification, however, are established by the managing institutions themselves, reflecting differing conceptions of mental illness, assumptions about patients' capacities, and varying interpretations of the goals of care.

Reflection on the psychological processes that accompany residence in supportive housing offers a means of interpreting the behaviors and symptoms of residents within the broader context of their life histories and mental structures [5, 6]. In this way, supportive housing can be understood as a therapeutic tool grounded in the creation of a container space.

Drawing on Bion's concept [7], the relationship between the container and contained is based on the openness and ability to accept, tolerate and process the thoughts and emotions of one person through the mind of another. This allows for a better understanding and integration of the experienced states, thus enabling the individual to expand his or her insight and make changes in his or her functioning.

It is possible to think about the meeting of the container and contained from multiple perspectives. The associations that seem to be triggered most quickly are those involving the relationship between patient and therapist. However, it is worth considering the importance of the group as a container space for its members and the experience of the therapist embedded in the therapy team. Given this, it is important to look at the feelings of professionals, *reverie*[1] states and relationships in therapy teams in a way that takes into account the impact of both group processes and the reproduction of patients' experiences.

This article is an attempt to illustrate the above approach by presenting the experience of the work of a supportive house run within a Mental Health Center.

Circumstances of the establishment and development of the center

The described center began its work in November 2019. Its establishment was made possible thanks to funds obtained as part of the project "Warsaw Integrated System of Treatment and Community Support for Persons with Mental Disorders – Testing and Implementation" (part of the Operational Program Knowledge Education Development 2014-2020, co-financed by the European Social Fund). In an effort to create a comfortable space for residents, a 120-square-meter premises in a pre-war building was adapted, which was thoroughly renovated and comprehensively equipped. The tenants had single and double rooms, two bathrooms, a kitchen, and a large living room with an adjoining specialist's office. Residents had free access to all amenities and equipment.

The interior aesthetics were initially quite minimalist, as space was left for the "content" contributed by subsequent residents. Their involvement – both in personalizing the decor of the apartment and in shaping the rules that governed it – allowed for the gradual "emergence of the apartment", i.e., the formation of the container's inner space. The adopted approach referred to the notion of "trauma-informed design," which has been gaining popularity in recent years. The term refers to recognizing in the environment in which an individual is embedded the potential to support mental health recovery. A review of studies conducted in the U.S. and Canada [8, 9, 10] characterized trauma-informed environments as predictable, calm, clean and quiet, while also respecting the need for privacy and providing opportunities for individuals to decide how to interact with others. This unveiled the importance of

[1] *Reverie* – understood as the ability to give meaning to the patient's projections, which allows to develop his thinking skills (development of alpha function) [7].

variables such as furniture layout and floor plan as factors that can help create a shared space for its users. In addition, the results of the cited studies emphasized the importance of self-selection of decorative objects, which can evoke a sense of constancy and provide a secure base for building one's identity.

The adopted rules, the rhythm of functioning, and the role of each member of the team were intended to provide a sense of security, grounding and stability in working with residents – to build a framework, an internal setting. The stay was meant to foster the building of internal motivation to lead an autonomous life and increase awareness of the decisions made.

Individual and group support at the center

The supportive house offered therapeutic and training programs, a therapeutic community, and the support of three therapists, a psychologist, a social worker, and a housing coordinator. The specialists were not on duty 24/7, but were present for 3-5 hours each day (depending on the need). Such an arrangement was intended to ensure a sense of security while enhancing residents' autonomy. The assumptions behind the apartment's functioning, however, implied a requirement that candidates demonstrate at least basic skills in self-care and independent housekeeping. A conscious attitude, at least partial insight into the illness, and a stable state of health were important. Nonetheless, priority was given to a willingness to cooperate and make changes in one's functioning.

An exclusion criterion was the presence of traits of profound personality disorders, making it impossible to enter into a situation of dependence and accept the offered help without maliciously destroying it or destructively exploiting the environment. Admission was also refused to individuals presenting with acute psychotic disorders, addiction to gambling or psychoactive substances, and displaying tendencies toward aggressive or self-destructive behavior. In these situations, the apartment could not ensure adequate care or an appropriate level of safety for the subjects themselves and the other participants.

During recruitment, efforts were made to create a group with relatively similar types of difficulties. Avoiding the inclusion of individuals who differed significantly from the rest of the group was aimed at facilitating the participants' adaptation process and increasing the relevance of the proposed offer.

The requirements of the program imposed an additional criterion – the recipients of support could only be adults with experience of a mental crisis, residing within the capital city of Warsaw. In addition, due to the legal solutions in place [11, 12], candidates were asked during the qualification process to indicate a possible place to which they could move after their stay in the facility ended. Discussing this issue, although it sometimes raised tensions, made it possible to introduce the perspective of limited time and the need to responsibly prepare the patient and their loved ones for this new experience and to realistically set the patient's goals.

The length of stay in the apartment ranged from six months to a year and a half. Initially, only long-term stays were assumed, but observations showed the value of shorter ones as well. Regardless of the length of the planned residence, a wide variety of emotions were

evident in the candidates. Some were apprehensive about the new experience, and the vision of even a short stay made them fearful of change and doubtful whether they could handle separation from their loved ones. They feared long-term commitments and preferred to declare themselves "only on a trial basis" to see how they would cope. At the time, the possibility of regulating the length of stay acted as a reassurance. For others, the vision of even a year and a half's accommodation seemed too short. Sometimes, candidates or their relatives even hoped for the possibility of permanent residence. They feared another change and having to make decisions about the future. In such cases, it was important to prepare the patient and his relatives for a return to the family home. Various end-of-stay scenarios also took into account the possibility of relatives providing support in efforts to obtain independent housing.

Building residents' independence

For some people, staying in the supportive house became the beginning of independent living. Often, however, it was an experience that allowed one to return to the family home on different terms, with a new attitude or new skills.

Acquisition of new competencies or development of already possessed resources was supported by various types of training: cognitive functions, social skills, self-care, as well as cooking, housekeeping, budgeting, communication, and organizing leisure time and pursuing personal interests. These trainings served as practical accompaniment for residents in their daily activities. A fundamental aspect of the therapeutic program was to work on relationships built both among participants and with specialists. Creating a therapeutic community allowed participants to receive support in their difficulties and to feel that they themselves could help others. Roommates, for example, were able to draw on their own crisis experiences to help others efficiently monitor their condition. With this in mind, participants were encouraged to actively participate in community meetings. During these meetings, current issues were discussed and plans were made for the coming week. Residents made arrangements for various outings, organized a Christmas dinner or informed about a planned trip. They were also able to share their feelings about what was happening in their mutual relationships. During the initial period, a clear structure of meetings and more active staff helped. Later, the participants themselves undertook to negotiate mutual arrangements.

One of the issues often raised at community meetings was the maintenance of cleanliness in the apartment. This was a task that tenants took care of on their own. For some people, performing cleaning work was not a problem or even an important part of the day, while for others it became a challenge that aroused considerable resistance. The vision of cleaning their own room or taking responsibility for some common part of the apartment triggered feelings of rebellion similar to a teenager's protest against parental orders. They resented the prospect that household chores were part of their chosen self-reliance. That's why the staff sometimes got involved, supporting the participants' motivation or helping them reflect on the meaning of particular tasks. The seemingly trivial issue of cleaning allowed questions to be raised about the meaning attributed to cleanliness and clutter and

what they express in relationships, as well as how they translate into a willingness to enter into dependence or bear the effort of building one's independence. The topic of cleanliness opened up a space for the expression of participants' unspoken resentments, grievances or desires. It was also an area revealing an increase in psychopathological symptoms.

One extreme example of a violation of cleanliness standards was the soiling of a sizable portion of the bathroom with fecal matter during a participant's psychotic decompensation. Less drastic ways of expressing perceived anger were seen in leaving unwashed dishes behind or failing to carry out the declared cleaning of the common area, which hindered the functioning of the other residents. When the causes of these emotions could be uncovered, the problems described usually disappeared or decreased significantly. For this to be possible, the team had to demonstrate a willingness to reflect and to seek understanding of the observed events and their dynamics, as well as an openness to contain the emotional states of their co-workers.

For each participant, being in the apartment meant something different and involved different needs. With this in mind, each tenant, together with their assigned therapist, created a plan for independence. Around the end of the first month, there was a series of meetings devoted to the participant's goals and the actions that would facilitate their achievement. It was discussed in which areas the person needed help and what resources he or she could use. The plan was expanded to include the perspective of the support offered by the psychologist and social worker. Evaluation of the findings was done every six months. At that time, it was summarized what had already been achieved and what still required further work. It was considered whether the participant's view of their previously chosen goals had changed in any way, and whether new goals had emerged. A meeting held at the end of the stay took stock of the overall experience in sheltered housing. Sometimes, if so desired by the participant, his relatives were also invited and, in their presence, further plans and possibilities were discussed. Such conversations took place with the participation of two members of the staff – the attending therapist and a psychologist or social worker. They were also preceded by a reflective team discussion during supervision.

Residence in the apartment was free of charge. However, participants were required to contribute a fixed amount of money each month for shared maintenance. Household budget management trainings were based on these funds. As part of these, residents made purchases of groceries and cleaning products. Carrying out such activities was important due to the nature of the difficulties faced by people with mental illnesses. Lack of experience in managing one's own budget often translates into weaker planning skills and inappropriate spending. This, in the long run, can lead to housing debt and failure to function independently. Budget trainings also provided an opportunity to discuss the advisability of certain actions and to confront the consequences of choices made.

An illustration of this process was a situation that occurred in the early stages of the apartment's operation. At that time, participants noted with dismay that they had spent a significant portion of their budget on food ordered from restaurants. During the community meeting, they had an opportunity to express the feelings caused by the clash between imagination and reality, as well as to discuss the reasons for the situation and make sense of it by referring to the group process. Participants spoke about attempts to integrate, while at the same time reporting reluctance to put effort into preparing meals on their

own, lack of sufficient cooking skills, unclear rules for sharing meals, and fears of being taken advantage of by people who might come and get something effortlessly. The question of which part of the purchased food was shared, and to what extent food items could be used freely, also proved to be an important dilemma. Setting boundaries and rules for sharing became a recurring theme in the group's discussions. Once established, the rules were subject to modification depending on the needs of the participants at a given stage in the "life of the house."

Cooperation with a social worker had a significant impact on building residents' economic independence. He provided information on the benefits to which they were entitled and the possibility of receiving assistance from various institutions and non-governmental organizations. He also offered support in dealing with official matters and maintaining contact with the community. Sometimes this involved attending meetings with the patient's family and discussing possible solutions that would allow the participant to apply for his own housing. In other situations, the social worker encouraged participants to sort out legal matters. Above all, however, his actions were aimed at strengthening the residents' ability to solve problems on their own.

In parallel, participants were encouraged to contact job coaches, whose availability was ensured by the POWER program[2]. Some of the therapists employed at the apartment also had the necessary qualifications. Residents were able to get help from them in creating resumes and talk to them about their vocational resources. The coaches could accompany the residents during their first days in their new jobs, as well as provide support in building an understanding between employer and employee.

Watching others go through the stages of recruitment and find an attractive job for themselves made people who had not been active in this area so far start to act. Roommates prompted each other on how to talk about illness at work or college; how much disclosure about one's condition was necessary, and how much could be kept discreet. They provided knowledge that had a calming and motivating effect. In addition, their own room in the suportive housing provided a space to study or work remotely, which, for some people, was a comfort they lacked in their family home.

One of the younger participants, 22-year-old Ms. M., used her stay in the supportive house and conversations with the guiding therapist to reflect on her interests and how to apply them in her life. She volunteered at an animal shelter. She later began a veterinary technician course and was offered an internship at one of the veterinary clinics. When she finished her stay at the supportive house, she could not afford to rent an apartment on her own, so she returned to her mother's house. During a visit to the supportive house (after her stay was over), she happily told us that she was now contributing to the rent and washing her own clothes. Previously, she had a strong notion that her parents should still support her for a long time. Ms. M.'s story was an inspiration to other residents, who, after her visit, reported wanting to talk about how to write their resumes.

[2)] The project "Warsaw Integrated System for Treatment and Support of People with Mental Disorders – Testing and Implementation", part of the Operational Program Knowledge Education Development 2014-2020 co-financed by the European Social Fund.

On the other hand, observing the development of roommates – their professional and personal successes – was, for some people, extremely difficult and aroused envy, as it confronted them with the emptiness and stagnation in their own lives. These individuals did not use the experiences of others to trigger or reinforce a more active attitude in themselves, but reacted by distancing themselves from the group and by behaving in a destructive manner toward the progress they had made so far. An example was the experience of Mr. A., who, observing the benefits to other residents of seeking employment or establishing social and romantic relationships, began to report a worsening of his mood and an increase in psychopathological symptoms. This was accompanied by a withdrawal from group therapy provided by the community treatment team, which he had been attending for several years. He thought about dropping out of psychotherapy, claiming it had no effect. He made similar comments about the supportive housing stay. In both settings, he saw people who were interested in changing their situation, which sharply contrasted with his non-verbalized but clearly held goals of staying in his current position. Understanding the patient's underlying mechanisms and responding appropriately was made possible by the integrated and collaborative care of the Mental Health Center. Discussing the progress of work and the difficulties encountered with members of the various teams under whose care the patient remained enabled the exchange of information needed to create a holistic and coherent treatment process.

The observations also led to the reflection that for some patients, experiencing positive interactions, being able to get close to the other person and feeling interdependent lead to an increase in tension and the need to act out, resulting in an increase in symptoms of the illness. Experiencing satisfaction together is not possible at this stage of their functioning. It is important to be attentive and take such tendencies into account when developing an integrated therapeutic plan.

Benefits of comprehensive interventions

Psychotherapy was not provided within the supportive house. However, the benefits of combining the interventions offered at the center with individual or group psychotherapy, provided, for example, at a mental health clinic or by a community treatment team, were evident. The involvement of family members in a support group or family therapy was also a factor in increasing the effectiveness of the residential stay. These activities allowed participants to more consciously notice and respond to the emotions accompanying the change process. As a result, it protected against taking actions that could block the achievement of goals developed in the apartment.

Facing the not easy process of separation evoked many emotions, both in the participants and in their loved ones. This led to a polarized view of the situation and the adoption of a defensive position. Staff sometimes noticed the ease with which participants attributed to themselves the characteristics of those seeking separation, while in parents they perceived tendencies to block such efforts. Interestingly, similar feelings were verbalized by family members during residential meetings. They pointed out, among other things, that they were tired of the previous intensity of their interactions and hoped for relief through

the move-out and their child's increased independence. At the same time, they were accompanied by a sense of loss and abandonment. In several cases, the experience was so difficult and aroused such strong anxiety and the need for control that the parent came to the supportive house with the need to check the state of cleanliness of their adult child's room. In the course of holistic work, it became possible to grasp a perspective in which both participants and their relatives could feel that the need for separation and the fear of it were present on both sides.

Psychological processes affecting the course of a stay in supportive housing

The stay in the described supportive house required participants to enter a group, face the process of integration, and negotiate the rules of cooperation. It confronted participants with feelings toward others and triggered numerous emotional processes, providing opportunities to expand self-knowledge and develop new skills. In this process, dynamically changing phases were evident. At first, anxiety and uncertainty about how one would be received by the group dominated. Later came a phase of building cooperation and dealing with conflicts. The final phase required facing separation and loss, but also offered hope for more independent and mature functioning.

Patients presenting for qualification already came with certain fantasies (not always consciously verbalized) about the whole process and the apartment itself. Due to the low availability of centers of this type, few had the opportunity to hear friends' accounts of their stay in similar places. As a result, they most often referred to associations with hospitalizations and hospital conditions. This heightened fears of both unpleasant housing conditions and the presence of disruptive roommates.

During the qualification process, it was crucial to examine the participants' motivations and perceptions they had about the stay. What made the person come to the consultation? Did she show up on her own initiative, or was she somehow persuaded to do so? What was this moment in her life? With what hopes and expectations did she come? In what did she perceive difficulties or threats? Exploring these areas, and at the next stage, allowing candidates to visit the apartment and get to know the tenants already there, curbed anxious fantasies. This was also important for those who, when applying for admission to the supportive house, were not interested in changing their situation. During the interview, these individuals reported on the attempts made by those around them to arouse their motivation. However, the interested parties themselves did not show any initiative or readiness to realize their potential. According to the information provided, the main motive for directing such a person to qualify for sheltered housing was the feeling of helplessness of those around them in dealing with the patient. Perhaps relatives held out hope for the group's helpful influence. However, accepting a patient who rejects and devalues the support received from others would have a negative impact on the functioning of the apartment and the work of the group as a whole. This is because it would have been associated with a high probability of unfavourable rifts in relations between the household members. The group could try to place its unwanted parts in the new member, intensifying his or her isolation and provoking him or her to abandon treatment with feelings of failure, rejection and disappointment.

Participants unwilling to try new activities (e.g., participating in a patient club), with a tendency to linger in bed or spend most of their time in their room, had more difficulty enjoying their stay in the apartment than participants who made an effort to integrate into the community and fill their schedule with a variety of activities. Sometimes, however, the experience of interacting with a non-directive and empathetic staff member helped to reduce the resistance of the resident and arouse his or her desire to become involved in the life of the apartment and to seek out activities that would give him or her satisfaction. Therapists had to be attentive to the sources of difficulties and the ability to containe emotions. Signals of emerging resistance needed to be understood, named, and then faced by the participant with the question of how much they serve a supportive function for him and how much they bring losses. This enabled more informed decision-making while reducing the tension felt by the other residents.

Roommates spent almost 24 hours a day with each other, which encouraged the reproduction of relationships and situations familiar from family arrangements or reflecting their intra-psychic dilemmas. Sometimes these processes were extremely intense. Leonard Horowitz [as cited in: 13] points out that in groups where projective identification is dominant, there can be a mechanism for delegating one person to the role of "spokesperson," unconsciously expressing the experiences of the entire group. An important task of the staff, therefore, was to recognize and prevent situations in which one participant might be invited to play the role of "scapegoat," for example, because of lower cognitive abilities or more pronounced severity of symptoms. At times, it was easier for the group to peel away the unacceptable, "damaged" parts and attribute them to one member who was deemed weaker or prone to step into the proposed role. This, in turn, could lead to a repetition of the participant's traumatic experience of contact with the group and a desire to withdraw. The group, more or less consciously, wanted to get rid of the participant who was stirring up difficult emotions. This was usually accompanied by an unconscious fantasy that this would get rid of the inconvenient phenomenon.

In parallel with testing the readiness of the candidate, it was important to ensure that the group was prepared to welcome the new member. Tenants of the supportive house experienced the arrival of new residents, their assimilation process, and saying goodbye to their tenants who were ending their stay. At times, they also had to face changes in the composition of the staff. These situations, on the one hand, were a source of stress and influenced the deterioration of their well-being or exacerbation of their symptoms, while on the other hand, they created curiosity and optimistic anticipation. This is because each person brought something new and contributed to the development of the apartment's functioning as a whole. This meant that while the group was a whole, it was also constantly changing.

Each moment of change in the life of the apartment promoted regression and led to an increase in anxiety or conflict. This was manifested, among other things, by the return of problems that seemed to have already been resolved. During such periods, previously established boundaries had to be discussed again, as they were tested or violated by the household members. One such case was the drinking of alcohol despite the previously established rule that abstinence must be maintained while in the facility. There were also instances of participants trying to level out or act out experienced feelings by attempting to form amorous or sexual relationships with roommates. Such relationships were

not recommended, as they carried the risk of exploitation and caused discomfort for the other residents. At the same time, they blocked the development of the group, especially when those involved tried to hide their relationships and keep them secret. It was the task of the staff to keep a close eye on signals indicating rule-breaking. The ability to connect observed behaviour to the context of the experiences of both individual participants and the group as a whole makes it possible to understand the causes and tailor an appropriate intervention. Sometimes this involved talking to the participant about ending the stay early.

The group, becoming angry, expected more activity from the staff in enforcing rules and order, and demanded that consequences be applied. Especially in the early stages of the stay, participants needed a clear structure that provided reassurance. Over time, the benefits of inviting housemates to work together to solve dilemmas and uphold the rules became apparent. This allowed them to build their sense of responsibility and influence over the functioning of the group, and also strengthened social competence and protected them from infantilization.

Typically, anger or rivalry toward a staff member was difficult to reveal. Participants faced fears about the consequences of showing hostile feelings. When fearful perceptions dominated, participants devalued one of the group members or revealed frustration over some previously unimportant aspect of the center's functioning. The comments made were considered on several levels – from analyzing the actual annoyance of a particular phenomenon to giving it meaning on a more symbolic level. Showing the staff's way of thinking, including recognizing the multiple meanings of the reported problems, allowed participants to reflect on the actual motives behind their behaviour or statements. To some extent, this built mentalization skills and demonstrated how to effectively cope with the experienced frustration.

There were also times when a participant expressed unpleasant feelings, but not directly, and then quickly withdrew from contact. On one occasion, a man who usually did well in a game of chess lost to his therapist. The feeling of defeat hurt his self-esteem so much that his first reaction was to say: "but you are ugly." After that, he gave up playing and left the apartment, leaving his opponent and the observers of the situation in dismay.

During the center's operations, residents pointed out that sharing a common space with another person was a challenge for them. Encountering difference confronted them with the question of whether – and how – dialogue and cooperation were possible. There was a risk that difficulties in tolerating frustration and disappointment could lead them to blame others for the discomfort of their own position or even contribute to a desire to leave the center early. This issue was raised several times by those accommodated in a double bedroom. The roommates had agreed to this arrangement in advance, and the room was large and furnished in a way to give them independence. However, when compared to the situation of those in single rooms, it caused dissatisfaction. For some participants, the feeling of being treated in exactly the same way as others played an important role. Perceived disparities aroused jealousy and a desire to compete, somewhat reminiscent of sibling dynamics in large families. On the other hand, there were also candidates who felt safer being in an apartment full of people. The presence of others gave them a sense that, in a difficult situation, they would be able to count on someone.

The ability to accept discomfort or dissatisfaction, and to seek solutions that allow one to perceive advantages in a non-ideal environment, was considered one of the most important factors in personal development within the assumptions of the described facility. It was recognized that the feeling of frustration, when appropriate to the participant's capabilities, allows the participant to better find his or her way through the demands of independent living and feel satisfaction with the goals achieved.

Ending the stay was one of the most difficult transitions. Our observations indicated that some participants, realizing the approaching move-out date, began to show greater mobilization. For others, saying goodbye proved too painful, and they began to somehow destroy what they had built or received so far: they were repeatedly late to their newly acquired jobs (risking dismissal), refused to fulfill their duties, skipped group meetings, and became irritated by group rules that had previously been unchallenged. Sometimes, the frustration and grief proved too strong and participants preferred to part from the group with feelings of anger, protecting them from experiencing loss or longing. In the history of the described apartment, there was once a situation in which a participant moved out without informing the group beforehand and left behind a badly damaged room. The damage was so severe that the staff, along with the other residents, had to repaint the walls, clean the paint off the floor, and wash the carpet. However, most participants were able to maintain positive feelings when ending their stay. Even after leaving the center, some enjoyed visiting their former roommates and the staff. They would come by to drink tea or attend a Christmas party, and in the process would talk about the changes in their lives. Thanks to their stay at the center, they expanded their network of friends to include people they met in the apartment.

The intensity of the processes taking place in the supportive house meant that supervision and regular team meetings were an important part of the work. At these meetings, the candidacies of new participants, the current situation of the residents, and the dilemmas faced by the specialists were discussed. This was because the staff had to both use their energy to motivate others and find within themselves an understanding of participants' emotions and decisions. This resembled the experiences faced by the families of patients. Thus, it was easy to succumb to transference and countertransference processes and lose the ability to think symbolically or position oneself as a reflective observer. The state of such confusion became apparent, among other things, in the dilemma of whether and how staff could enter a participant's room. What does this mean, and to what extent can it be perceived as an aggressive violation of privacy boundaries? This was accompanied by a strong desire to resolve the doubt unequivocally and as quickly as possible. Discussing this issue during supervision helped to weaken the emotions blocking thought and to recognize the analogy to the experience of household members facing the challenge of setting boundaries.

Conclusions

The functioning of the supportive housing was significantly shaped by its integration with the Mental Health Center (of which the house was a part) and the Social Welfare

Center. This collaboration ensured continuity of care, facilitated coordinated interventions, and provided staff with an additional source of professional support. For participants, it created opportunities to interact with specialists they already knew and trusted and trusted – professionals who were also familiar with their clinical histories.

Even a relatively brief stay yielded valuable diagnostic insights, enabling both participants and professionals to better understand patterns of functioning and adjust therapeutic interventions accordingly. The staff, experiencing emotions similar to those of the participants' families, were able to identify, among other things, factors blocking the separation process that did not surface in other situations (such as during a visit to the doctor's office).

The involvement of specialists with experience in working with groups (including groups of patients experiencing psychotic states of mind) helped in understanding the dynamics of residents' relationships, their experiences and reactions to the staff's actions, and the team's dilemmas at various stages of work. An extremely important factor in ensuring the quality of the work was the regular supervision of the entire team. The reflective presence of others, providing the perspective of "analytic third", helped relieve the occasional sense of confusion accompanying the intense processes taking place in the apartment.

Although staying in a sheltered apartment did not constitute a psychotherapeutic process, it took the form of a relationship between the container and contained. The forming group housed its members – both participants and staff. The experience of being in contact with an empathetic and attentive human being was a key value in the process of building residents' independence. Creating a therapeutic community and a space for asking questions – such as why an individual might or might not want to become independent, and what that truly means to him or her – supported the development of an informed attitude among participants and promoted transparent communication.

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