TRANSFER KOD POREMEĆAJA LIČNOSTI – DOŽIVLJAJ PACIJENTOVOG AUTO-IRONIČNOG PRIKAZA SVOJE POVIJESTI BOLESTI

/ TRANSFERENCE IN PERSONALITY DISORDERS – EXPERIENCE OF A PATIENT'S AUTO-IRONIC PRESENTATION OF HIS MEDICAL HISTORY

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SAŽETAK/*SUMMARY*

U radu su dani vlastiti doživljaji nekih transfernih situacija u tekstu „Psychosis/Neurosis“, kojeg je pacijent, kao polu-ironični prikaz svoje povijesti bolesti, dostavio svojoj nekadašnjoj psihoterapeutkinji, uz dozvolu da taj tekst može koristiti za stručne ili znanstvene svrhe. S obzirom na to da je pacijent bio primarno doživljen kao miješani poremećaj ličnosti, prije kliničkih primjera iz pacijentovog teksta navedeni su sažeti teorijski prikazi koji se odnose na prepoznate poremećaje ličnosti. Pacijent je ulazio u transferne odnose koji su se ticali i neurotičnog i psihotičnog sloja pa je i to navedeno u analizi.

/ The paper presents author's personal experiences of transference situations described in the text Psychosis Neurosis, which the patient, as a semi-ironic presentation of his medical history, submitted to his former psychotherapist, with permission to use the text for professional or scientific purposes. Since the patient was primarily seen as having a mixed personality disorder, summarized theoretical presentations related to the recognized personality disorders are presented before the clinical examples from the patient's text. As the patient was entering into transference relationships touching on both the neurotic and psychotic layers, it was also mentioned in the analysis.

KLJUČNE RIJEČI / *KEYWORDS*

transfer / *transference*, poremećaj ličnosti / *personality disorder*, neuroza / *neurosis*, psihoza / *psychosis*

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UVOD

U svakodnevnom psihoterapijskom radu sa pacijentima/klijentima nema „čistih" kliničkih slika. I u kliničkom prikazu ovog pacijenta mogu se prepoznati miješane slike nekih poremećaja ličnosti, a također i neka neurotična pa zatim i psihotična stanja.

S obzirom na to da je pacijent primarno doživljen (od strane autora ovog teksta) kao miješani poremećaj ličnosti, prije konkretnih primjera iz pacijentovog teksta „Psychosis/Neurosis", dat će se kraći teorijski prikazi nekih poremećaja ličnosti prepoznatih kod pacijenta. Neće se ulaziti u teoriju neurotičnih ili psihotičnih stanja jer bi to prelazilo okvire ovog teksta nego će se dati samo klinički primjeri tih stanja i njihovih transfernih pojavnosti.

Klinički dijelovi koji se odnose na neurotične simptome pacijenta su u njegovom tekstu opsežniji od simptoma koji se odnose na poremećaje ličnosti ili kratkotrajna psihotična stanja. To možemo tumačiti većom učestalosti neurotičnih (paničnih) simptoma (koji su ego-distoni) a također i time da su simptomi poremećaja ličnosti bili ego-sintoni i pacijent ih nije doživljavao kao problem. Zbog nedostatka empatije nije imao uvid da ti simptomi stvaraju teškoće ljudima s kojima je u odnosu.

INTRODUCTION

In everyday therapeutic work with patients/clients, there are no "pure" clinical pictures. The clinical presentation of this patient was also a mix of personality disorders combined with some neurotic and then psychotic conditions.

Since the patient was primarily perceived (by the author of this text) as a mixed personality disorder, brief theoretical descriptions of some of the personality disorders recognized in the patient will be presented before the concrete examples from the patient's text *Psychosis Neurosis*. Discussing the theory of neurotic or psychotic states would go beyond the scope of this text, so only clinical examples of these states and their transfer occurrences will be presented.

The clinical parts related to the patient's neurotic symptoms are more extensive in his text than the symptoms related to personality disorders or short-term psychotic states. This can be explained by the higher frequency of neurotic (panic) symptoms (which are ego-dystonic) and also by the fact that the personality disorder symptoms were ego-syntonic and the patient did not perceive them as a problem. Due to his lack of empathy, he was not aware of the fact that these symptoms create difficulties for the people he is in a relationship with.

We will refer to the person whose text is being analysed as the "patient" hereafter.

U nastavku ćemo se na osobu čiji se tekst analizira referirati kao na „pacijenta“.

TRANSFERI U SLOJU POREMEĆAJA LIČNOSTI

U pacijentovom tekstu prepoznati su simptomi sljedećih poremećaja ličnosti: narcističnog, graničnog, paranoidnog, ovisnog i antisocijalnog. Slijedi kraći teorijski prikaz svakog od tih poremećaja ličnosti uz primjere iz pacijentovog teksta.

1. Narcistični poremećaj ličnosti

Fenomenološki, neki autori razlikuju otvoreni (bučni) i prikriveni (tihi) tip narcističnih osoba. Otvoreni tip je često arogantan, agresivan, traži centar pažnje, neosjetljiv je na povrede, neki ga nazivaju „debelokožac“. S druge strane prikriveni narcis je jako osjetljiv na povrede, izbjegava centar pažnje, pažljivo sluša druge da otkrije kriticizam (po čemu su slični paranoidnim bolesnicima), grandioznost ostaje prikrivena, imaju osjećaj srama (za razliku od otvorenog tipa). Heinz Kohut i Otto Kerberg su autori koji su se puno bavili sa narcističnim poremećajima ličnosti s tim da su Kohutovi bolesnici bili više ambulantni, funkcionalniji i društveno uspješniji, a Kernbergovi su

TRANSFERENCES IN THE LAYER OF PERSONALITY DISORDERS

Symptoms of the following personality disorders were recognized in the patient’s text: narcissistic, borderline, paranoid, dependent and antisocial. The following is a brief theoretical presentation of each of these personality disorders with examples from the patient’s text.

1. Narcissistic personality disorder

Phenomenologically, some authors distinguish between overt (loud) and covert (silent) types of narcissistic persons. The overt type is often arrogant, aggressive, and seeks to be in the centre of attention. As he is insensitive to injuries, sometimes he is called “thick-skinned”. On the other hand, a covert narcissist is very sensitive to injuries, avoids being in the centre of attention, listens carefully to others to detect criticism (in which they are similar to paranoid patients), their grandiosity remains hidden, they have a sense of shame (unlike the overt type).

Heinz Kohut and Otto Kernberg are authors who wrote a lot about narcissistic personality disorders. But while Kohut’s patients were more ambulatory, more functional and socially successful, Kernberg’s were more often hospitalized, more aggressive and prone to antisocial behaviour (1).

bili češće bolnički, agresivniji i skloniji antisocijalnom ponašanju (1).

Transferi kod narcističnog poremećaja ličnosti

Heinz Kohut (Kohut, 1990) je kod svojih bolesnika uočio razvoj zrcalnog, idealizirajućeg i blizanačkog transfera. Zrcalni transfer nastaje iz djetetove potrebe da bude gledano i uvažavano. Idealizirajući transfer nastaje iz potrebe da se bude dio snažne osobe koja će dati sigurnost, zaštitu i pružiti utjehu. Blizanački transfer nastaje iz potrebe za „srodnom dušom", koja će u potpunosti razumjeti bolesnika. Kohut je smatrao da je idealizacija zamjena za nedostajuću psihičku strukturu i da agresija proizlazi iz narcističke povrede (2).

Otto Kernberg (Kernberg, 2012) je kod svojih bolesnika češće uočavao razvoj negativnog transfera u smislu zavisti i agresije (nasljedne ili okolinske) kao i idealizacije u smislu obrane od agresije (prezira i obezvrjeđivanja). Također je primjećivao da neki bolesnici ne mogu prihvatiti pomoć terapeuta kao i ovisnost o njemu, pri čemu nude svoju pseudo-dovoljnost (očito zbog uljepšane slike o svojim sposobnostima). Neki bolesnici rivaliziraju sa terapeutom, odbacuju sve ono što nauče od terapeuta, pri tome mogu biti dugotrajno arogantni. Neki bolesnici imaju potrebu za

Transferences in narcissistic personality disorder

Heinz Kohut (Kohut, 1990) observed the development of mirroring transference, idealizing transference and twinship transference in his patients. Mirroring transference arises from the child's need to be seen and respected. Idealizing transference arises from the need to be part of a strong person who will provide security, protection, and comfort. Twinship transference arises from the need for a "soul mate" who will fully understand the patient. Kohut believed that idealization is a substitute for a missing psychic structure and that aggression results from narcissistic injury (2).

Otto Kernberg (Kernberg, 2012) often observed the development of negative transference in his patients in the sense of envy and aggression (hereditary or environmental) as well as idealization in the sense of defence against aggression (contempt and devaluation). He also observed that some patients cannot accept help from or the dependence on the therapist, thereby offering their pseudo-sufficiency (obviously due to an embellished image of their abilities). Some patients compete with the therapist, reject everything they learn from the therapist, and can be arrogant for a long time. Some patients have a need for omnipotent control of the therapist. A negative therapeutic reaction is also possible i.e., worsening of the condition after the initial feeling that the therapist helped them. In the case of

omnipotentnom kontrolom terapeuta. Moguća je i negativna terapijska reakcija tj. pogoršanje stanja nakon početnog osjećaja da mu je terapeut pomogao. U slučaju idealizacije bolesnici obično idealiziraju sadašnjeg, a obezvrjeđuju prijašnjeg terapeuta što je obrana koju bi terapeuti trebali prepoznati. Moguć je i narcistični bijes ako terapeut ne reagira na neke potrebe ili zahtjeve bolesnika. Nekad su moguće pasivno-parazitske težnje. Pacijent može lagati terapeutu. Može biti i repetitivno suicidan i trijumfirati u svojoj sposobnosti šokiranja terapeuta svojim ponašanjem. Neki bolesnici nastoje u terapeutu izazvati osjećaje zavisti i pohlepe i tako se putem projektivne identifikacije osloboditi tih teških osjećaja (3).

Sram je čest kod ovog poremećaja ličnosti. Kod osoba sklonih sramu dominira psihičko funkcioniranje na razini paranoidno-shizoidne pozicije. Često je prisutna težnja proširenja obezvrjeđivanja s jednog detalja na cijeli self. Kod izrazitog srama osoba doživljava urušavanje cijelog selfa, naglo i potpuno nestajanje svoje cjelokupne vrijednosti. Sram se pojavljuje kad osoba doživljava da je objekt ne empatijskog promatranja i procjenjivanja, da je u središtu pažnje i procjene socijalne okoline koja nije dobronamjerna ni empatijska već kritična i emocionalno hladna. Taj doživljaj može biti projekcija vrlo kritičkog samo procjenjivanja tj. vrlo kritičkog

idealization, patients usually idealize the current and devalue the previous therapist, which is a defence that therapists should recognize.

Narcissistic anger is also possible if the therapist does not respond to some needs or requests of the patient. Sometimes, passive-parasitic tendencies are possible. The patient may lie to the therapist. He can also be repetitively suicidal and triumphant in his ability to shock the therapist with his behaviour. Some patients try to provoke feelings of envy and greed in the therapist and thus get rid of these hard feelings through projective identification (3).

Shame is common in this personality disorder. In people prone to shame, psychological functioning at the level of the paranoid-schizoid position dominates. There is often a tendency to extend the devaluation from one detail to the whole self. With extreme shame, a person experiences a collapse of the whole self, a sudden and complete disappearance of his entire value. Shame appears when a person perceives that he/she is not the object of empathetic observation and assessment, that he/she is the centre of attention and assessment of a social environment that is neither benevolent nor empathic but critical and emotionally cold. This experience can be a projection of a very critical self-evaluation, i.e. a very critical Super ego, whereby the patient judges himself more harshly and evaluates himself more negatively than others evaluate him (4-6).

Super ega pri čemu bolesnik sam sebi sudi strože i procjenjuje se negativnije nego što ga procjenjuju drugi (4-6).

Klinički primjer

Svoje psihičke teškoće pacijent prvo pokušava riješiti kod bioenergetičara. Kratka je i intenzivna terapija koju nudi bioenergetičar: tretman je 5 dana u tjednu a zatim je pauza od 3 tjedna. To svi želimo: izliječiti se brzo i efikasno i po mogućnosti besplatno. Tako valjda radi, transferno, idealni roditelj koji voli bezuvjetno, brine i njeguje intenzivno, bdije uz bolesno dijete. Pacijent bioenergetičara doživljava kao Isusa, u početku dobrog i idealnog objekta. Bioenergetičar ga uči metodi relaksacije, pacijent se vraća u bezbrižno djetinjstvo, toplo je, more se ljeska, pijesak, lopatice, gradimo kule, kreiramo, vrijeme više ne postoji. Imao je tada 3 ili 4 godine. Zamišljamo da je roditelj vjerojatno u blizini a on iako mali ipak dovoljno zreo da bi se, po Winnicottu (Winnicott, 1958), igrao sam u prisustvu majke koja je, čini se, neintruzivna jer je on ne spominje u toj sceni sjećanja (7). Za ovog pacijenta to je rijetka, idilična sličica.

Pacijent se, kako simptomi postaju teško izdržljivi, javlja psihijatru. Ona je mlada, plavuša, a on ima predrasude o plavušama: očito sebe smatra pametnim a plavuše su – zna se kakve. Ipak navodi da taj prvi dojam traje jako

A clinical example

The patient first tries to solve his psychological difficulties with a bioenergetic specialist, who offers a short and intensive therapy: the treatment is provided 5 days a week and then there is a 3-week break. That's what we all want: to be cured quickly and efficiently and, if possible, free of charge. I guess that is how, in a transference manner, an ideal parent who loves unconditionally, cares and nurtures intensively, watches over a sick child. The patient perceives the bioenergetic practitioner as Jesus, initially a good and ideal object.

The bioenergetic specialist teaches him the relaxation method: the patient returns to his carefree childhood, it's warm, the sea sparkles, there is sand, the paddles, sandcastles building, creativity, time no longer exists. Back then, he was 3 or 4 years old. We imagine that the parent is probably nearby and that he, although small, is mature enough to, according to Winnicott (Winnicott, 1958), play alone in the presence of his mother, who seems to be non-intrusive because he does not mention her in that memory scene (7). For this patient, it is a rare, idyllic image.

As the symptoms become unbearable, the patient consults a psychiatrist. The psychiatrist is a young woman with blonde hair and he has prejudices against blondes: he obviously considers himself smart and blondes - you know what they are like. However, he states that this first impression did not last long. In the

kratko. U početku je napet, tijekom vremena se opušta, njegov narcistični, obezvrjeđujući stav prema psihijatrici lakše dolazi do izražaja, na seansi čita novine, pravi se da psihijatrica ne postoji, kad pročita novine ustane i ode.

Pacijent je sklon nezrelim mehanizmima obrane. Razdvaja, disocira terapiju od običnog života. Psihijatrici kaže da ona za njega ne postoji izvan zidova njene ordinacije. Ta dva dijela Ega, nazovimo ih terapijski i svakodnevni, kao da se ne smiju prožimati. Možda je to i potreba da se ne narušava idealizacija psihijatrice koja jedino takva (idealna) može biti protuteža unutarnjim lošim objektima o kojima je pisala Melanie Klein, u smislu pre-simboličnih, konkretnih, „crno-bijelih" entiteta (Klein, 1946) (8), dok je Ronald Fairbairn (Fairbairn, 1944) (9) koristio naziv „unutarnji saboter" kao dio strukture Ega, a Anie Reich (Reich, 1954) (10) je govorila o arhajskim elementima u Superegu) koji su vrlo destruktivni kod poremećaja osobnosti. Je li možda u pitanju i obični sram i strah od stigme da ga netko vidi vani u razgovoru s poznatom psihijatricom i pomisli da je i on možda „lud"? Narcistična slika o sebi bi to teško podnijela.

2. Granični poremećaj ličnosti – *borderline*

Zbog problema u ranim odnosima (česta su seksualna zlostavljanja i obitelj-

beginning, he is tense, but relaxes over time, his narcissistic, devaluing attitude towards the psychiatrist is expressed more easily, he reads some newspaper during the session, pretending that the psychiatrist does not exist and, when he finishes reading the newspaper, he gets up and leaves.

The patient is prone to immature defence mechanisms. He separates, dissociates therapy from ordinary life. He tells the psychiatrist that she does not exist for him outside the walls of her office. Those two parts of the Ego, let us call them therapeutic and daily Ego, seem like they should not be interwoven. Perhaps it is also the need not to violate the idealization of the psychiatrist, who is the only (ideal) one who can be a counterweight bad internal objects (which Melanie Klein wrote about, in the sense of pre-symbolic, concrete, "black and white" entities (Klein, 1946) (8), while Ronald Fairbairn (Fairbairn, 1944) (9) used the expression "inner saboteur" as a part of the Ego structure, and Anie Reich (Reich, 1954) (10) talked about archaic elements in the Superego) which are very destructive in personality disorders. Is it perhaps the simple shame and fear of the stigma that someone would see him outside talking to a famous psychiatrist and think that he too might be "crazy"? A hard blow for the narcissistic self-image.

2. Borderline personality disorder

Due to problems in early relationships (sexual abuse and family violence in

sko nasilje u djetinjstvu) ove osobe ne dostižu stupanj razvoja s konstantnosti objekta zbog čega teško toleriraju separaciju. Nagonske potrebe (seksualne i agresivne) mogu biti pojačane i u apsolutnom smislu (nasljedna sklonost) ili u relativnom smislu (zbog slabosti Ega). Zbog ranih fiksacija česti su primitivni mehanizmi obrane kao što su: rascjep, idealizacija, obezvrjeđivanje, projektivna identifikacija, poricanje, omnipotencija. Ove su osobe također sklone regresu i psihotičnim epizodama (1).

Sram u okviru ovog poremećaja djeluje kao jaka narcistična povreda. Obrana od srama može biti bježanje i povlačenje od izloženosti objektima ili može uključivati napad na te objekte radi njihova nestajanja, sve do potpunog uništenja (11).

Transfer kod pacijenata sa graničnim poremećajem ličnosti

U transferu su česte potrebe za idealizacijom ili obezvrjeđivanjem terapeuta što govori o rascjepu i neintegraciji reprezentacija objekta koje su zato ili samo dobre ili samo loše. Zato oni zbog neke povrede od strane terapeuta mogu naglo razviti negativni transfer. Bolesnik može terapeuta manipulirati suicidom pa zbog terapeutovog straha da se bolesnik ne ubije, bolesnik može imati omnipotentnu kontrolu nad tera-

childhood are common), these people do not reach the level of development where there is object constancy, which is why they have difficulty tolerating separation. Instinctive needs (sexual and aggressive) can be intensified in an absolute sense (hereditary tendency) or in a relative sense (due to weakness of the Ego). Due to early fixations, primitive defence mechanisms, such as splitting, idealization, devaluation, projective identification, denial, and omnipotence, are common. These people are also prone to regression and psychotic episodes (1).

Shame within this disorder acts as a strong narcissistic injury. Shame defence may consist of fleeing and withdrawing from exposure to objects or may involve attacking these objects to make them disappear, up to and including complete destruction (11).

Transference in patients with borderline personality disorder

In the transference, there is a frequent need to idealize or devalue the therapist, which speaks of the split and non-integration of representations of the object, which are therefore either only good or only bad. That is why they can suddenly develop a negative transference due to some breach by the therapist. The patient can manipulate the therapist with committing suicide, so due to the therapist's fear that the patient would kill himself, the patient can have omnipotent control over the therapist. For this reason, the

peutom. Zbog toga terapeut ne bi smio na sebe preuzeti potpunu odgovornost za bolesnikov život ili smrt. Mnogi bolesnici traže produljenje seanse, smanjenje cijene, dostupnost u svako doba, a zbog temeljne nezasitnosti, zahtjevi se mogu proširiti na traženje zagrljaja, sjedenje u krilu, traženje seksualnog odnosa. Po iskustvu Kernberga, *borderline* će testirati terapijske granice, stalno provocirati terapeuta (fizički ili seksualno) ili uništavati stvari u njegovom uredu. On navodi primjer kako je jedan bolesnik „provalio" šifru i čitao terapeutov e-mail (3).

Klinički primjer

Pacijent testira granice svoje psihoterapeutkinje: ne pozdravlja je kad dođe na seansu. Na seansi čita novine a kada ih pročita samo ustane i ode – nema komunikacije sa psihoterapeutkinjom. Odnos prema psihoterapeutkinji se kreće od idealizacije do obezvrjeđenja što je česta situacija u terapijama ovih poremećaja osobnosti.

U svojoj povijesti bolesti pacijent opisuje i kratka psihotična stanja za koja znamo da su moguća kod graničnih poremećaja osobnosti.

3. Paranoidni poremećaj ličnosti

Ove su osobe na oprezu i u sumnji jer kod njih dominira paranoidno-shizo-

therapist should not take full responsibility for the patient's life or death.

Many patients are asking for session extension, price reduction, availability at any time, and other requests which, due to their basic insatiability, can extend to asking for a hug, sitting on a lap, or asking for sexual intercourse. In Kernberg's experience, borderlines will test therapeutic boundaries, constantly provoking the therapist (physically or sexually) or destroying things in the therapist's office. He cites an example of how one patient "cracked" the password and read the therapist's e-mail (3).

A clinical example

The patient tests the limits of his psychotherapist: he does not greet her when she comes to the session. During the session, he reads some newspaper, and when he finishes reading it, he just gets up and leaves - there is no communication with the psychotherapist. The attitude towards the psychotherapist ranges from idealization to devaluation, which is a common situation in therapist for these personality disorders. In his medical history, the patient also describes brief psychotic states, which we know are possible in borderline personality disorders.

3. Paranoid personality disorder

These people are alert and suspicious because they are dominated by a para-

idna pozicija. Pomoću rascjepa se razdvaja ljubav od mržnje koja se projicira na vanjski svijet koji se onda doživljava kao opasan. Često imaju osjećaj manje vrijednosti od kojeg se brane vlastitom grandioznosti. Rani odnosi sa njegovateljima nisu bili adekvatni pa otud postoji i prikrivena žudnja za ljubavlju i bliskošću.

Transfer kod pacijenata sa paranoidnim poremećajem ličnosti

Bolesnik često tretira terapeuta kao progoniteljski loš objekt. Bolesnici mogu biti jako zabrinuti da će ih autoritet poniziti ili podčiniti. I dugotrajno dobri odnos sa terapeutom može biti pokvaren malim razočaranjem nakon kojeg bolesnik doživljava terapeuta kao da mu je skinuta maska na što može reagirati sa ljutnjom. Ponekad putem projektivne identifikacije bolesnici imaju potrebu kontrolirati terapeuta (1).

Klinički primjer

Početkom terapije pacijent je u problemu: ako se želi liječiti i riješiti neurotskih tegoba mora iskreno govoriti o sebi. Ali, zbog nelegalnih aktivnosti, ako bude iskren, mogao bi završiti u zatvoru. Djeluje kao da je zbunjen: pola godine ni ne pozdravlja svoju psihijatricu, uđe, sjedne, kao da je ustrašen,

noid-schizoid position. By splitting, love is separated from hate, which is projected onto the outside world, which is then perceived as dangerous. They often have a feeling of inferiority against which they defend themselves with their own grandiosity. Early relationships with caregivers were not adequate, so there is a hidden longing for love and closeness.

Transference in patients with paranoid personality disorder

The patient often treats the therapist as a bad persecutory object. Patients may be very worried about being humiliated or subjugated by an authority figure. Even a long-term good relationship with the therapist can be spoiled by a small disappointment, after which the patient perceives the therapist as if his mask has been removed, to which he may react with anger. Sometimes, through projective identification, patients have a need to control the therapist (1).

A clinical example

At the beginning of the therapy, the patient has a problem: if he wants to be treated and get rid of neurotic problems, he must speak honestly about himself. But, due to illegal activities, if he is honest, he could end up in prison. He seems confused: he does not even greet his psychiatrist for half a year, he comes in, sits down, as if he is scared, distrustful. There are illegal activities in the background,

nepovjerljiv, u pozadini su nelegalne aktivnosti, hoće li ga doktorica odati? Odlučuje se za šutnju. Izostaje i najelementarnija pristojnost u pozdravljanju. Transfer je negativan, čini se da je paranoidan, doima se kao da je pacijent kod isljednika, u velikom je oprezu.

4. Ovisni poremećaj ličnosti

Separaciju ove osobe doživljavaju tragično. Jako su ovisni o self-objektima i njihovim funkcijama (vrednovanja, empatije, regulacije afekta). Neovisnost doživljavaju kao opasnost. U djetinjstvu su česti pretjerano intruzivni njegovatelji koji djetetu nisu dozvoljavali separaciju.

Transfer kod ovisnog poremećaja ličnosti

Ovi se bolesnici boje završetka terapije pa onda i svog napredovanja u terapiji koje se povezuje sa završetkom terapije. Skloni su navoditi terapeuta da im daje savjete pa tako podržavaju svoju ovisnost. Idealiziraju terapeuta kao nekog tko će riješiti sve njihove tegobe (1).

Klinički primjer

Pacijent više ne odlazi na psihoterapiju ali i dalje šalje svoje dopise, razmišljanja o životu, opservacije i sl. svojoj, sada već bivšoj, psihoterapeutkinji.

will the doctor betray him? He chooses to remain silent. Even the most elementary politeness in greeting is missing. The transference is negative, he seems to be paranoid, he seems to be a patient with an interrogator, he is on high alert.

4. Dependent personality disorder

These people experience separation tragically. They are highly dependent on self-objects and their functions (evaluation, empathy, affect regulation). They perceive independence as a danger. Excessively intrusive caregivers who did not allow the child to separate are common in childhood.

Transference in dependent personality disorder

These patients are afraid of the end of the therapy and then of their progress in the therapy, which relates to the end of the therapy. They tend to get the therapist to give them advice, thus supporting their dependence. They idealize the therapist as someone who will solve all their problems (1).

A clinical example

The patient is no longer attending the psychotherapy, but is still sending his letters, thoughts about life, observations, etc. to his now former psychotherapist. The relationship still exists, it has not been broken, the patient continues to

Veza i dalje postoji, nije prekinuta, pacijent je i dalje održava, treba mu povremeno ohrabrenje, pohvala i slično.

U situaciji kada psihijatrica poželi prekinuti odnos s njim kao sa pacijentom koji seansu koristi za čitanje novina, bez drugog oblika komunikacije sa svojim psihoterapeutom, tada pacijent prijeti tužbom njenom šefu, očito je da ne može podnijeti separaciju. Prijetnju koristi kao obranu od razdvajanja što je element sljedećeg poremećaja ličnosti: antisocijalnog.

5. Antisocijalni poremećaj ličnosti

Ove osobe su često zlostavljane i odbacivane u djetinjstvu. Veze sa drugim ljudima su sadističke po tipu predator-plijen. Vrlo su sposobni za manipulaciju kroz iščitavanje skrivenih potreba drugih ljudi. Mogu pobuditi loše ponašanje u drugim ljudima. U drugima mogu stvoriti duboki strah kroz „predatorsko buljenje“. Nesposobni su voljeti, nemaju empatije (12).

Zbog teških iskustava u djetinjstvu oni nemaju umirujući majčinski introjekt i nemaju bazično povjerenje u druge ljude. Imaju zavist na ljubav i dobrotu i imaju potrebu aktivno uništiti izvor svoje zavisti. Obrana od ovisnosti i osjećaja bezvrijednosti je grandiozni self i obezvrjeđivanje drugih ljudi. Zbog manjka razvoja Super ega nemaju kriv-

maintain it, he needs occasional encouragement, praise and similar.

In a situation where the psychiatrist wants to end the relationship with him as with a patient who is using the session to read newspapers, without any other form of communication with his psychotherapist, and the patient then threatens to sue her to her boss, it is obvious that he cannot bear the separation. He uses the threat as a defence against separation, which is an element of the following personality disorder: the antisocial.

5. Antisocial personality disorder

These persons have often been abused and rejected in childhood. Relationships with other people are sadistic in the predator-prey type. They are very capable of manipulation by reading the hidden needs of other people. They can arouse bad behaviour in other people. In others, they can create deep fear through the “predatory stare”. They are incapable of love; they have no empathy (12).

Due to difficult experiences in childhood, they do not have a soothing maternal introject and lack basic trust in other people. They are envious of love and kindness and have a need to actively destroy the source of their envy. The defence against addiction and feelings of worthlessness is the grandiose self and the devaluation of other people. Due to the lack of Super ego development, they have no guilt or shame. Deactivation of affect, ac-

nje ni srama. Deaktivacija afekta, po Bowlby-ju je obrana od dezorganizacije selfa zbog gubitka *attachmenta*. Zbog toga ove osobe, također, disociraju svoja slaba *self* stanja žrtve. Pod velikim stresom mogu regredirati u psihozu (1, 12).

Transfer kod pacijenata s antisocijalnim poremećajem ličnosti

U transfernom odnosu ovi pacijenti mogu lagati, varati, narušavati strukturu, prijetiti, stvarati odnos predator-plijen, kao i u drugim odnosima izvan terapije. Mnogi kliničari su skeptični u vezi terapijskog efekta psihoterapije kod ovih pacijenata (12).

Klinički primjer

Pacijent, u situaciji kada psihijatrica poželi prekinuti odnos s njim, reagira prijetnjom tj. tužbom njenom šefu. Psihoterapeutkinja, u pacijentovom doživljaju, mora podnositi njegov sadistički način, stvara se odnos predator – plijen pri čemu je jasno tko je tko.

TRANSFERI NEUROTIČNOG SLOJA

Na početku svoje povijesti bolesti pacijent nas uvodi u svoj doživljaj snijega.

cording to Bowlby, is a defence against the disorganization of the self due to the loss of attachment. Because of this, these people also dissociate their weak victim self-states. Under great stress, they can regress into psychosis (1, 12).

Transference in patients with antisocial personality disorder

In the transference relationship, these patients can lie, cheat, disrupt the structure, threaten, create a predator-prey relationship, as in other relationships outside of therapy. Many clinicians are sceptical about the therapeutic effect of psychotherapy in these patients (12).

A clinical example

The patient, in a situation where the psychiatrist wants to end the relationship with him, reacts with a threat, i.e. he threatens to sue the therapist to her boss. The psychotherapist, in the patient's experience, must put up with his sadistic ways, a predator-prey relationship is created where it is clear who is who.

TRANSFERS OF THE NEUROTIC LAYER

At the beginning of his medical history, the patient introduces us to his experience of snow. Our client reacts with panic to the snow that hides familiar shapes and offers a new, unknown, different

Na snijeg koji skriva poznate oblike i nudi novu, nepoznatu, drugačiju sliku pejzaža naš klijent reagira panikom. On i supruga nemaju auto (ili supruga ne vozi a on je u panici) pa se na hitnu ide autobusom. Njemu je teško a supruga kao da ne preuzima ulogu pomoćnog ega, da se primjerice bolje obuku pa on ide u trenirci i smrzava se hodajući od stanice do hitne službe još oko 200 metara. Da li je supruga i sama bila u panici koju nije mogla kontejnirati? Da li je takva možda bila i klijentova majka po kojem modelu je i supruga izabrana?

U ordinaciji, pred doktorom, transferno, kao pred zubarom ili kastrativnim ocem, sve tegobe prestaju (jer je bolje tako nego trpjeti zubarsku bušilicu). Munjeviti je to nestanak simptoma kao i kad se, transferno u terapiji, simptomi brzo povuku iako struktura ostaje nedirnuta. O očinskoj figuri ne znamo ništa, možemo samo nagađati.

Slijedi prometna nesreća, stradanje psa ljubimca, njegov bijeg, nestanak i opet pacijentov panični napad. Separacija se preteško podnosi. Evociraju li se opet stari gubitci kada nema voljenog i bliskog objekta, možda majke, možda nekog drugog, kada je doživljaj kao da je objekt zauvijek izgubljen jer ga tjelesno nema a upitna je i simbolična reprezentacija objekta. Stres je prevelik, tijelo se konverzivno paralizira.

picture of the landscape. He and his wife do not have a car (or his wife does not drive, and he is in panic), so they go to the emergency service by bus. It's hard for him, and his wife doesn't seem to take on the role of an auxiliary ego to, for example, put on more clothes, so he is wearing a tracksuit and is freezing walking from the station to the emergency service for another 200 meters. Was the wife herself in a panic that she was not able to handle? Was the client's mother like that too, according to which model was the wife chosen?

In the office, in front of the doctor, by transference, like in front of a dentist or a castrating father, all problems stop (because it's better that way than enduring the dentist's drill). It is a lightning-fast disappearance of symptoms, as well as when, in transference therapy, the symptoms quickly recede even though the structure remains intact. We don't know anything about the father figure, we can only guess.

This is followed by a traffic accident, the suffering of a pet dog, its escape, disappearance and again the patient's panic attack. Separation is too hard to bear. The old losses may be evoked again when there is no loved and close object, maybe a mother, maybe someone else, when the experience is as if the object is lost forever because it is not physically there, and the symbolic representation of the object is also questionable. The stress is too great, the body becomes paralysed. Donald W. Winnicott (Winnicott, 1962) wrote

Donald W. Winnicott (Winnicott, 1962) je pisao o lošoj majci i posljedičnoj depersonalizaciji u smislu raskida veze psihe i tijela (13). Ovdje tijelo ne sluša psihu, gubi se kontrola nad tijelom, ne može se hodati. Slično je (u vezi panike) kad u trgovini iznenada shvati da je sam, da nema supruge s kojom je došao u trgovinu. Bliske osobe nema, slaba je internalizacija i simbolična reprezentacija, odmah slijedi panični napad.

Transferno je, poput adolescenta, u psihijatrici vidio sistem, skup pravila, dominantnu kulturu, a on je prema svemu tome imao otpor. Kakav otpor? Oralni. Nije pričao. Da li su u pitanju rane fiksacije? Kao da se boji kazne, ali, barem u početku, drsko, buntovnički, ne odustaje od svojih poslova protiv sustava, poslova koje nije mogao a možda, kako kaže, nije ni htio promijeniti. Postupno se, transferno, mijenja i slika u terapiji. Sada pacijent i njegova psihoterapeutkinja postaju kao „stari bračni parovi". Nepovjerenje je nestalo, libido se oslobodio, doktorica se doživljava kao supruga. Ne želi tablete od nje, sada je cijeni, želi upiti njeno znanje. Ne želi grupnu psihoterapiju, želi emocionalni, dijadni odnos sa njom. Tablete i grupa kao da bi ga udaljili od nje. Kao da je s oralnog i konkretnog došao do emocionalnog i simboličnog i želi se tako nahraniti, ne želi majčinsku figuru dijeliti sa drugom

about a bad mother and the consequent depersonalization in terms of breaking the connection between psyche and body (13). Here the body does not listen to the psyche, control over the body is lost, one cannot walk. It is similar (in relation to panic) when he suddenly realizes that he is alone in the store and that his wife, with whom he came to the store, is not there. There is no close person, there is weak internalization and symbolic representation, and a panic attack follows immediately.

By transference, like an adolescent, he saw a system, a set of rules, a dominant culture in the psychiatrist, and he had resistance to it all. And what kind of resistance? Oral. He didn't talk. Are there early fixations? It's as if he is afraid of punishment, but, at least in the beginning, he brazenly, rebelliously, does not give up his work against the system, he does not give up on work that he could not and perhaps, as he says, did not even want to change. Gradually, by transference, the image changes in therapy. Now the patient and his psychotherapist become like "old married couples". Mistrust has disappeared, libido has been released, the doctor is perceived as a wife. He doesn't want pills from her, he appreciates her now, he wants to absorb her knowledge. He doesn't want group psychotherapy, he wants an emotional, dyadic relationship with her. The pills and the group seemed to distance him from her. It is as if he has come from the oral and concrete to the emotional and symbolic and wants to

djecom, baš kao da ima oko 3 godine iz kojeg vremena i potječe idealna sličica na pijesku. Opet pomišljamo da je rani odnos sa majkom bio insuficijentan, sa rijetkim sretnim trenutcima, pa ga sada želi nadoknaditi sa psihijatricom/majkom. Pojavljuje se još jedan oblik transfera kada pacijent psihoterapeutkinju doživljava kao „popa" koji ga je vidio skoro pa golog a on imao veliku neugodu. Da li se radi o neugodi od otvaranja (homo) erotskog, možda incestnog transfera?

TRANSFERI PSIHOTIČNOG SLOJA

Prva seansa kod bioenergetičara. Tretman počinje: bioenergetičar pucketa prstima, a pacijent osjeća na ramenima „dvije ručetine" koje ga vuku unazad, ne može im se oduprijeti, bioenergetičar ga ne dodiruje, na svom je mjestu, na djelu je čista, moćna energija, pacijentov strah postaje nesavladiv, kaže: „usra san se živ". Otišao je kući „zbunjen i prepadnut". Možda se radilo o kratkom psihotičnom iskustvu sa transfernim doživljajem bioenergetičara kao nadljudski moćne, magijske, omnipotentne i opasne figure.

Kao da se slična situacija dogodila kad je vidio svoju psihijatricu u trgovačkom centru. Jer, kad ju je vidio, a već načet strahom od nestanka supruge, tijelom mu je „prolazila struja nepa-

feed himself that way, he does not want to share the mother figure with other children, just as if he is about 3 years old, from which time the ideal image in the sand originates. Again, we think that the early relationship with his mother was insufficient, with rare happy moments, so now he wants to make up for it with the psychiatrist/mother. Another form of transference occurs when the patient perceives the psychotherapist as a "priest" who saw him almost naked, and he was very embarrassed. Is it about the discomfort of opening a (homo) erotic, perhaps incestuous transfer?

TRANSFERENCES OF THE PSYCHOTIC LAYER

The first session with a bioenergetic specialist. The treatment begins: the bioenergetic specialist snaps his fingers and the patient feels "two arms" on his shoulders pulling him backwards, he cannot resist them, the bioenergetic specialist is not touching him, he is in his place, so pure, powerful energy is at work, the patient's fear becomes uncontrollable, he says: "I nearly shit myself". He went home "confused and overwhelmed". Perhaps it was a brief psychotic experience with a transference experience of the bioenergetic specialist as a superhumanly powerful, magical, omnipotent, and dangerous figure.

It was as if a similar situation happened when he saw his psychiatrist in the mall.

tvorenog užasa“, ispustio je neartikuliran zvuk, gurnuo kolica i „pobjegao glavom bez obzira“, očajnički je htio što prije izaći iz te zgrade. Sve to se doima kao kratki, a intenzivni paranoidni transfer prema svojoj psihijatrici. Nije li se možda negativni transfer dovoljno otvarao u terapiji? Je li došlo do „kratkog spoja“ terapijskog i svakodnevnog Ega, koji su morali ostati disocirani? Ne znamo. Pada mi na pamet jedna slična situacija pacijenta sa paranoidnom psihozom: djevojka ga je ostavila, to je teško podnio, pokušao je sa njom razgovarati, doživljen je kao nasilan, dobio je zabranu prilaska, postao je akutno psihotičan, malo se oporavio ali je ostala psihotična jezgra i sada sa majkom u autu ide u nabavku u trgovački centar. Na cesti, iz suprotnog smjera prepoznaje jedan auto, auto bivše djevojke s kojom se mimoilazi. On i majka dolaze do trgovine, ulaze, traže stvari, majka je već kod blagajne, on još nešto traži i kad se okrene ugleda nju, bivšu djevojku kako ga prodorno gleda kao da hoće evocirati sve što se prije događalo. U silnom strahu on pobjegne, majci na blagajni kaže da će je vani sačekati. Dugo se oporavlja od tog susreta, nije mu jasno kako se djevojka stvorila u trgovini, a autom je išla u suprotnom smjeru. To što se dogodilo ne može objasniti, ne zna zašto se toliko uplašio, sebi je potvrdio da je zbilja paranoičan (14).

He was already startled by the fear of his wife's disappearance, "a current of unadulterated terror ran through his body", he made an inarticulate sound, pushed the wheels and "he got the hell out of there", he desperately wanted to get out of that building as soon as possible. All this seems like a short and intense paranoid transference towards his psychiatrist. Could it be that the negative transference was not opened enough in the therapy? Was there a "short circuit" between the therapeutic and the everyday Ego, which had to remain dissociated? We do not know. A similar situation of a patient with paranoid psychosis comes to my mind: his girlfriend left him, he took it hard, he tried to talk to her, he was perceived as violent, he got a restraining order, he became acutely psychotic, he recovered a little, but the psychotic core remained and now with his mother in the car he is going to the shopping centre to get groceries. On the road, he recognizes a car from the opposite direction, the car of his ex-girlfriend, whom he is passing. He and his mother arrive at the store, they enter the store, they are looking for things, his mother is already at the cash register, he is still looking for something, and when he turns around, he sees her, his ex-girlfriend, staring at him as if she wants to evoke everything that happened before. In great fear, he runs away, tells his mother at the cash register that he will wait for her outside. He is recovering from that encounter for a long time, it is not clear to him how the girl appeared at the store if she was driving in the opposite direction. He cannot explain what happened,

Evo još jednog nezrelog mehanizma obrane: rascjepa. Rascjep koji dijeli dobrog bioenergetičara koji ga vodi u divna sjećanja na igru na plaži do opasne, svemoćne figure koja ga čvrsto drži u svojim šakama (jesu li možda očeve šake bile slične?). Ili, rascjep od dobre psihijatrice koja ga liječi do zastrašujuće figure koja stvara „nepatvoreni užas". Rascjep je obogaćen omnipotentnom kvalitetom objekta (bioenergetičara i psihijatrice) i time dobiva psihotičnu kvalitetu koja nadilazi doživljaj „običnog" poremećaja ličnosti.

ZAKLJUČAK

Osobe sa poremećajem ličnosti često dolaze iz problematičnih primarnih obitelji (15, 16). Roditelji su i sami emocionalno nezrele osobe, sklone raznim ovisnostima, često su nezainteresirani za svoju djecu, nesposobni za empatiju i voljenje ali zato vrlo sposobni za cijeli spektar agresivnih odnosa. Problemi, u smislu zrcaljenja, počinju od najranijih dana. Kasnije je, ponekad, agresija direktna i otvorena bilo da je fizička ili psihička u vidu obezvrjeđivanja, prijetnji ostavljanjem, izazivanja teških osjećaja krivnje, a ponekad je suptilnija u smislu, primjerice, pretjerane brige za opstanak u svijetu, svog nesposobnog potomka. Dječja seksualnost

he does not know why he was so scared, he confirmed to himself that he is really paranoid (14).

Here's another immature defence mechanism: splitting. Splitting that divides a good bioenergetic specialist leading him to wonderful memories of playing on the beach from a dangerous, all-powerful figure that holds him firmly in its grip (maybe his father's grips were similar?). Or splitting of the good psychiatrist who treats him from the terrifying figure who creates "unadulterated horror". The splitting is enriched by the omnipotent quality of the object (bioenergetic and psychiatrist) and thus acquires a psychotic quality that goes beyond the experience of an "ordinary" personality disorder.

CONCLUSION

People with a personality disorder often come from problematic primary families (15, 16). Parents themselves are emotionally immature people, prone to various addictions, often uninterested in their children, incapable of empathy and love, but therefore very capable of the entire spectrum of aggressive relationships. The problems, in terms of mirroring, start from the earliest days. Later, sometimes, the aggression is direct and open, whether it is physical or psychological in the form of devaluing, threatening to leave, causing heavy feelings of guilt, and sometimes, it is more subtle, for example, in the form of excessive concern for

najčešće straši takve roditelje jer budi separacijske strahove, ali provocira i neke roditeljske incestne, potisnute fantazije.

Manjak ljubavi bliskih osoba i višak agresije stvara u psihološkom dječjem svijetu unutarnje loše objekte koji se, po Josephu J. Sandleru (Sandler, 1986), u terapiji, žestoko opiru promjeni starih, nezrelih, ustaljenih formi odnosa (17). Neadekvatno zrcaljenje i općenito ne empatijsko prilagođavanje roditelja djetetu (18-20) vodi u razvoj lažnog selfa ili u razne oblike poremećaja ličnosti sa širokim rasponom nezrelih emocionalnih situacija: od velikih ovisničkih potreba, nezrele seksualnosti, manjka empatije, usmjerenosti na sebe, slabe regulacije osjećaja, male tolerancije na frustracije, impulzivnosti, teško kontrolirajuće agresivnosti, kao i dosade i emocionalne praznine. Rane nezadovoljene self-objekt potrebe stvaraju, kasnije u životu, pa dakle i u terapiji, nezrele transferne narcistične potrebe. Sve nezrele situacije iz prošlosti mogu se ponovo oživljavati u transferu prema terapeutu. Nakon dugotrajne terapije neki pacijenti uspiju napraviti pomak u smislu veće osjećajne zrelosti, razvoja empatije, manje povredljivosti, nalaženja pravog selfa, boljeg prepoznavanja svoje agresivnosti, zrelije seksualnosti koja nije blokirana incestnim i perverznim fantazijama.

survival of one's incapable child in the world. Children's sexuality most often scares such parents because it arouses fears of separation, but also provokes some parental incestuous, repressed fantasies.

The lack of love from close ones and the excess of aggression creates internal bad objects in the psychological world of children, which, according to Joseph J. Sandler (Sandler, 1986), in therapy, fiercely resist the change of old, immature, established forms of relationships (17). Inadequate mirroring and generally non-empathetic adjustment of parents to the child (18-20) leads to the development of a false self or to various forms of personality disorders with a wide range of immature emotional situations: from highly dependent needs, immature sexuality, lack of empathy, self-centeredness, poor regulation of feelings, low tolerance for frustration, impulsiveness, hard-to-control aggressiveness, as well as boredom and emotional emptiness. Early unsatisfied self-object needs are creating immature transference narcissistic needs later in life, and also in therapy. All immature situations from the past can be revived in the transference towards the therapist.

After long-term therapy, some patients manage to make a shift in terms of greater emotional maturity, development of empathy, less vulnerability, finding the true self, better recognition of their aggressiveness, and more mature sexuality that is not blocked by incest and perverse fantasies.

LITERATURA/*REFERENCES*

1. Gabbard GO. Psychodynamic Psychiatry in Clinical Practice. Fifth Edition. Washington-London: American Psychiatric Publishing, 2014.
2. Kohut H. Analiza sebstva. Zagreb: Naprijed, 1990.
3. Kernberg OF. The Almost Untreatable Narcissistic Patient. U: Kerberg OF. The Inseparable Nature of Love and Aggression. Arlington: American Psychiatric Publishing, 2012.
4. Bilić V. Sram u psihoterapiji bolesnika izloženim brzim vanjskim promjenama. U: Marčinko D, Rudan V i sur. Psihoanalitički modeli komunikacije u vremenu brzih promjena. Zagreb: Medicinska naklada, 2016; 65-91.
5. Bilić V. „Nisam dovoljno savršen" Krivnja i sram. U : Marčinko D, Rudan V.Narcistični poremećaj ličnosti. Zagreb: Medicinska naklada, 2013; 83-101.
6. Bilić V. Sram i poremećaji ličnosti. U : Marčinko D, Jakovljević M, Rudan V i sur. Poremećaji ličnosti. Zagreb: Medicinska naklada, 2015; 88-103.
7. Winnicott DW. The capacity to be alone. Int.J Psychoanal. 1958; 39(5):416-20.
8. Klein M. Bilješke o nekim shizoidnim mehanizmima (1946). U: Klein M. Zavist i zahvalnost.Zagreb: Naprijed, 1983.
9. Fairbairn WR. Endopsihička struktura s obzirom na objektne odnose (1944). U : Fairbairn WR. Psihoanalitičke studije ličnosti. Zagreb: Naprijed, 1982.
10. Reich A. Early Identifications as Archaic Elements in the Superego. Journal of the American Psychoanalytic Association. 1954; 2(2):218-38.
11. Bilić V. Sram kao „okidač" za nasilje. U : Rudan V, Marčinko D i sur. Od nasilja do dijaloga. Zagreb: Medicinska naklada, 2014; 60-8.
12. Howell EF. Outsiders to Love: The Psychopathic Character and Dilemma. Contemporary Psychoanalysis. 2018; 54(1): 17-39.
13. Winnicott DW. Ego Integration in Child Development (1962). U: The Maturational Processes and the Facilitating Environment. London: Routledge, 1984.
14. Tošić G. Od paranoidne psihoze do neodsanjanih fantazija. Psihoterapija. 2020; 34(1):50-91.
15. Gunderson JG, Kerr J, Woods Englund D. The Families of Borderlines. Arch Gen Psychiatry. 1980; vol 37 jan:27-33
16. Zanarini MC, Gunderson JG, Marino MF, Schwarc EO, Frankenburg FR. Childhood Experiences of Borderline Patients. Comprehensive Psychiatry. 1989; vol 30(1) jan/feb:18-25
17. Sandler J. Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. Int J Psychoanal. 1983; 64(1): 35-45.
18. Winnicott DW. Mirror-role of Mother and Family in Child Development (1967). U: Playing and Reality. London and New York: Toutledge, 1994:111-118.
19. Stern DN. The Interpersonal World of the Infant. New York: Basic Books, 2000.
20. Fonagy P, Target M, Gergely G, Allen JG, Bateman AW. The Developmental Roots of Borderline Personality Disorders in Early Attachment Relationships: A Theory and Some Evidence. Psychoanalytic Inquiry. 2003; 23:412-59.