PSYCHOTERAPIA 2 (181) 2017
pages: 37–48

Daniel Melerowicz

PERSONALITY QUALITIES AND THE RISK OF SOCIAL EXCLUSION FROM THE PERSPECTIVE OF OTTO KERNBERG'S OBJECT RELATIONS THEORY — A CASE STUDY

SWPS University of Social Sciences and Humanities in Warsaw

social exclusion
object relations theory
psychotherapy

Summary

The article features a case study of an adult patient at risk of social exclusion due to being out of employment for a long time, which, according to the author, is the result of a specific personality structure. The patient underwent a three-year psychotherapy in a psychodynamic approach. The conceptualization of patient problems and the therapeutic methods were based on Otto Kernberg's object relations theory. Typical problems of a person featuring dysfunctions in terms of personality inflexibility, sense of identity, defensive mechanisms and relations with the object are presented as well as ways of overcoming them in order to fully function in the society.

Introduction

Contemporary psychodynamic approach is focused on the relation between a subject and its social environment. Everyone functions in a complex net of social relations – the way we experience them influences significantly our social functioning [1]. The majority of modern social exclusion theories concentrate on the external environment seeing it as a main cause of exclusion from society. According to the above conceptions, exclusion can be prevented by rising social benefits and adequately shaping employment market. However, taking into consideration low efficiency of such actions [2] it is worth paying attention to different understanding of reasons for staying outside of society. Literature provides various definitions of both social support [3], and social exclusion and their conceptualization depends on a scientific discipline and individual interpretation.

In the article social exclusion is defined as a multidimensional process leading to the limitation of someone's activity in the field of electoral decisions, participation in labour market, material resources and involvement in cultural and social life [4, 5].

The approach focused on relatively fast effects (behavioural-cognitive, support, psychological counselling) dominates in the work with the socially excluded people. In such

case work is focused on alteration of cognitive biases (exaggerated thinking patterns e.g. grief about the past, dichotomous thinking, negative filter [6]), known also as automatic thoughts [7].

Analysis of the literature shows that relatively few authors consider the risk of social exclusion from the perspective of object relations theory. This aspect, especially personality inflexibility, is mentioned by Caligor [8]. The author presents examples of people functioning on the higher level of borderline personality, who due to personality inflexibility experience difficulties in professional life – e.g. because of excessive fear overwhelming them in confrontational situations. Literature also describes examples of social difficulties due to appearance of specific dyads especially: neglected child in relation to neglecting parent, which in real life leads to withdrawal from social interactions [9].

Personality model presented in this work will be based on the object relations theory developed by Otto Kernberg and his associates [1, 8]. From the earliest years every person aims to create relation with an object, which is understood as an internal, mental representation of another person. Early relations with an object influence the experience of all subsequent relations and the outside world. In case of dysfunctional personality it can lead to avoiding social and personal relations [10, 11].

Kernberg [8] describes four dimensions, which may be useful in personality diagnosis. They are: personality inflexibility, identity, defence mechanisms and reality testing. It is believed that the level of functioning in each of those dimensions gives basis to describe the level of personality functioning – normal, neurotic, borderline [1]. Table 1 shows each dimension used in structural personality diagnosis.

Table 1. **Structural personality diagnosis**

Personality	Normal	Neurotic	Borderline higher level (light pathology)	Borderline lower level (serious pathology)
Personality inflexibility	lack of inflexibility	light to moderate	significant	extreme
Identity	stable	stable	light / moderate pathology	strong pathology
Defences	mature	based on repression	based on repression and splitting	based on splitting
Reality testing	stable, intact	stable, intact	intact (light deficits)	intact, deficits – temporal psychotic states
Relations with objects	deep, mutual	deep, mutual	some mutual	orientated on satisfying needs
Moral functioning (ethical behaviour, values, ideals)	internalised, elastic	internalised, elastic	inconsistent	pathology – lack of moral values

Source: own elaboration based on Caligor, Kernberg, Clarkin, 2007 [8].

Personality inflexibility may be described as a specific „style" or set of personal qualities, which may be maladaptive (dwelling on the failures, inability to look into the problem with humour) [8].

Second dimension mentioned by Kernberg, used in structural diagnosis of personality is identity. In case of sound personality, individual can experience other, important people in considerably integrated and stable way. In case of identity diffusion the structure of identity includes unstable, inconsistent set of conflicted experiences, in which there is a lack of Self sense. What is very important, healthy sense of identity enables engaging in long term, professional and recreational activities in social life, which result from someone's own values, beliefs and opinions [9].

Another dimension used in personality structure diagnosis is a type of defence mechanisms. At the one end of the spectrum there are mature defences like humour or sublimation. Next there are neurotic defences based on repression – rationalization, reaction formation and finally primitive defences – projected identification, idealisation – devaluation. However mature defences do not cause significant distortions of the real world, primitive mechanisms change the experiencing significantly – both of the inner and outer reality.

The last dimension proposed by Kernberg is the level of reality testing [12]. Healthy and neurotic people do not show any dysfunctions in the scope of recognising general beliefs about the real world (intact reality testing). People with light or heavy pathology, experience temporary dysfunctions in this field (temporal psychotic states).

It is suggested that, in order to accurately specify heaviness of personality pathology, additional relations with close people (deep, mutual or relations orientated solely on fulfilling ones needs) as well as moral functioning (internalised – elastic, inflexible or inconsistent) are analysed [8, 13, 14].

Ms. M.: Initial information about the patient and her life story.

Ms. M.[1] came[J1] to this paper author's private psychotherapeutic practice. Around a year prior she participated in a 3-month long group therapy, which she completed as scheduled. According to her, it was a difficult experience, because she thought many comments she received from other participants were aggressive and critical. This information was very important for the therapist as knowing previous therapeutic relations gives a lot of precious information [15, 16]. The therapist got to know the way she was functioning in a therapeutic

[1] Data allowing identification of the patient were changed. The patient's consent for the publication of the case study was obtained.

group: seeing others as a threat. Direct reasons of her registration with the group were heavily low mood, feelings of hopelessness, prolonged lack of employment, developing isolation and social fears (including intensifying fear of leaving the house). The patient admitted, that she has had all of these symptoms since she remembered – all her life.

At the moment of her entry, the patient was living with her mother (father died four years earlier of cancer). Ms. M. underwent psychiatric consultation – anxiety disorder with anxiety attacks were diagnosed (F41.0). Psychiatrist recommended pharmacotherapy (SSRI antidepressants), which was applied accordingly.

After a few sessions based on structural interview the therapist preliminarily diagnosed the patient as functioning on higher borderline level. Long-term psychotherapy with unspecified end was set, frequency - one session per week. Ms. M., asked about a source of financing the therapy, to which she said that she had savings (money inherited after father), which she intended to spend on therapy until she can find a job.

After initial diagnosis during the first few consulting sessions, based on features such as feelings of social inadequacy, reluctance to engage in close relations, avoiding social and professional contacts for fear that she would be criticised and rejected, according to ICD-10 classification, the therapist diagnosed her with anxious (avoiding) personality [17].

At the moment of commencing therapy the patient was 32 years old, graduated 5 year pedagogical studies, without obtaining MA. After studies she moved out of home (she rented a flat with two other flatmates), started work as a waitress and quite quickly was promoted to the room manager.

Ms. M was complaining that despite the fact that her earnings were not too bad, she could never save any money, because she was spending them on interim pleasures. She worked for 3 years in a restaurant. At the beginning she was satisfied with the job but after some changes, when she had to come back to direct service, she disliked it. She found waitressing humiliating. Relations at work worsened. At this moment depressive-anxiety symptoms appeared and she went for a three-week sick leave. After coming back to the restaurant (despite still having the symptoms) the patient found out that her contract was not prolonged. She finished her job and has not been working ever since. At this time she started living with her mother – as she stated - due to financial reasons and to support her mother after losing her husband. The patient was talking about losing her job with huge emotions, she felt extremely aggrieved.

Since then (three years before commencing therapy) the patient remained professionally passive, stating that she could not find any job. At this time, she was spending her time wondering about life, fantasising about better fate, occasionally meeting with friends although

these contacts were becoming less frequent. It was difficult to obtain more information as the patient could not describe any other activities she did.

At the time of beginning of therapy Ms. M. was not in any romantic relationship. She started sexual life at the age of 18 with her, at that time , partner. As she said it was her first, long-term (two and a half years) relationship. Her partner lived in a far-away town and – as she said – was not visiting her often enough, that is why she decided to end this relationship. After that, she was in two other relationships finished by her partners. In her relations with men she was functioning in a specific way – was never interested or excited. She agreed to the relationships, but felt that deserved someone better. In the end she provoked them to leave her – stopped showing interest, expressed disappointment in the relationship and finally, when the partner finished the relationship, she felt even more disappointed. Ms. M. was talking about sexual life as "satisfactory", although she expressed disappointment that "nothing special" was happening – sex seemed to be average and ordinary. Men seemed unable to fully satisfy her needs. Moreover, she did not know what her needs exactly were.

The patient was saying that she is very close to her mother. She described her as fearful and conservative – that her mother feared everything all her life. She had a boring, office job and never fully developed her potential. Patient's father was in her experience a good and honest man but also lacking courage. He was a builder, Ms. M claimed he could set up his own business but was afraid to do so. She said that after his death she experienced a very difficult time (during which she did not function properly at work, had a lot of absences), felt abandoned and disappointed – she was talking about her anger at father directly after his death, because she felt he gave up on fighting the disease.

Forgoing life seemed to the therapist to be reactionary and focused on avoiding risks. During school (primary, college, university) the patient did not engage in any additional activities. Despite being interested in art and graphics (she read a lot about them) she did not take up any creative work in this direction, stating that she did not know where to start from and that no one would ever appreciate her effort. Thus, her life before, during and after studies was limited to fulfilling imposed obligations without showing own initiative.

In the first phase of therapy the patient described people as self-centred, concentrated on their own lives. She had a small group of friends – 3 close girl-friends, who she often was disappointed with. She was complaining that they were not interested in her, did not call to ask how she was doing. There was a lot of envy towards her friends, she admitted that it was difficult for her to be happy, that most of her friends have partners, kids and jobs. Talking about

it she distinctly stated that others "were just lucky" and she never was. She could not see that other people worked hard for their success.

In the early stage of therapy Ms. M. was describing the world as a terrible, bad, demanding and difficult place, in which life was tough. She saw herself in the future as an employee in an interesting company (though could not give details), eventually having her own business. She evinced the need to do something interesting. This picture seemed unrealistic, as if she did not realised that in every job tedious effort is needed.

In the process of analysing the life story of the patient, repeating schemes emerged – beginning new projects without finishing them. Psychological diagnosis indicated that the main problems of the patient were moderate personality inflexibility, identity diffusion and frequent activation of dyads – weak, vulnerable Self in relation with abandoning object. On the basis of Kernberg's personality pathology classification [1, 8] therapist thought that patients personality structure represents higher borderline level. She was qualified to individual, long term, expressive psychodynamic psychotherapy.

The aim of the therapy was to: analyse and realise by the patient that she identifies with the weak Self in relation to abandoning, critical object, changing stiff behaviours into greater flexibility and confronting repeating schemas such as beginning and dropping specified actions. In further stages of the therapy re-processing unconscious motives of being under mother's protection. The therapist believed that understanding her way of functioning, in which she did not engage in any activities (assuming, that she is not capable to do so and someone should do it for her or beginning an activity and quickly dropping it), will help the patient to undertake specific steps (enhance her activity). Larger personality flexibility (not thinking too much about failures, not hiding resentment) together with realising her own share in creating relations, could contribute to engaging in more satisfactory relations with other people.

Description of the therapeutic relationship

In the first phase of therapy the therapist had an impression that Ms. M. pays attention to his every word. He was conscious he could say something that would hurt or irritate her. As it turned out in the further phases, it was the therapist's response to the patient's transference, who placed a critical, rejecting image of the object in him because she experienced relations with others that way. The therapist noticed that Ms. M. judged the person in her environment as such, who do not believe in her and for whom she is uninteresting. Negative image of Self (seen as incompetent, worse than others) and negative image of others (seen as critical, rejecting) could be seen [18].

During this period, the patient also brought a lot of material related to the relationship in the former work place. She often talked about the huge injustice that she had got from the company. At that time, the therapist had a strong identification with this "weak and abused" part of the patient's Self (concordant transference) [19], he believed that her workplace had to be threatening and supervisors unjust. It was only after the supervision that the therapist became more confrontational. He was interested in how Ms. M. was looking for a job. It turned out that the patient did not take almost any action to find employment. In this way Ms. M. "drifted" towards first professional and next social exclusion.

After about six months of therapy, the patient spoke less about her grievance towards previous employer. At that time, the therapist helped to discover her one-sided way of perceiving reality and participating in creating such state of affairs (showing dissatisfaction, incomplete execution of supervisor's tasks, lack of smile). Therapist understood that as a progress in the integration of the image of the workplace - Ms. M. was able to admit that "it also happens to other people", the supervisor can sometimes assign "dull" tasks. She presented a more realistic approach to the whole situation.

The patient began marketing and management degree. Therapist recognized this as a step towards bigger integration with the social world. Therapist's image in patient's experience was changing; from the initial idealization to devaluation. She repeated that she expected bigger change in her life and that it is the therapist who should help her make the change: "I'm coming over here for a few months and I'm still not working." At this moment once again a dyad was activated - weak, incompetent self and abandoning object. The therapist discussed this way of perceiving social relationships with the patient - others perceived either as kind, good (when they met all her needs) or as uninterested, abandoning (if they did not meet all her expectations).

During sessions, the patient's relations with close ones were also discussed. The therapist checked how Ms. M. perceived the lives of others. It turned out that she idealised their living situation and envying them at the same time.

After a year of therapy, the patient started a language course financed by employment office, where she began an intimate relationship with her classmate. However, after 3 months, Ms. M. considered termination of this relationship. She claimed that she lacked partner's involvement - once again she was disappointed. Ms. M. took the therapist's comments stating that she seemed unconcerned, but claimed that the relationship would end anyway because she had little connection with her partner. She fantasized a lot about her future – ideal partner. The therapist understood these fantasies as a need to find a perfect, caring object that would satisfy most of the needs and at the same time would do all difficult life tasks. Similar expectations

were placed in the therapist who was supposed to help her find a job without real effort on her part. When this did not happen, Ms. M. was disappointed. In the countertransference, the therapist often felt he ought to find Ms. M. job, for example by pointing out where to look for employment. When he did not do that, he had a feeling that he disappointed her.

At the same time, due to the cessation of anxiety symptoms, the patient considered stopping the pharmacotherapy. After consultation with psychiatrist, within the next three months she was taken off the medicine. After that, the climate during sessions changed temporarily. Ms. M. reported the return of anxiety, which this time concerned her body - she was afraid of cancer (of which her father died), she complained about dizziness, dyspnoea and spinal pain. The therapist bound this situation with the ending of the relationship with the psychiatrist - since then she was "under care" of only one specialist (man). For the patient (for whom the unconscious motive of being cared for was very important) it was of great importance and in the opinion of the therapist caused anxiety. In addition, exploring the above symptoms he discovered that although the termination was not established, the patient understood the cessation of medication as a sign of her recovery and feared the therapist's suggestion that the psychotherapeutic treatment would be terminated. In this sense, the persistence of symptoms would (unknowingly) prevent the end of therapy.

Another motive for the above symptoms was anxiety against returning to work - the therapist discovered the patient's belief that she should first recover from therapy and then resume her professional life. During this period, the therapist being in concordant countertransference felt helpless and had an impression of no influence over the situation. He had a feeling of energy depletion and weakened competences.

At the same time, he felt a fear of confronting Ms. M. with her inactivity, because at that moment he was in complementary countertransference [19] in which he identified with a severe critical object having the impression that when he showed the patient her way of functioning it was injurious to her. As a result, the therapist abstained from many comments - he was deprived of "therapeutic power". Further supervisions allowed him to emerge from this state. The supervisor showed him type of countertransference emphasizing that showing the patient her passivity is beneficial to her and may result from concern rather than cruelty. In the following months, the focus of the sessions was mainly on the above features and her fear of work and unrealistic expectations regarding other people. The therapist also analysed the fact that Ms. M remained dependent on her mother. He understood this as unconscious desire to remain under constant care (weak Self expected supportive object) – Ms. M. claimed that after her father’s death, mother is the only close living relative.

After about two years of treatment, the patient's anxiety symptoms have subsided. She spoke a lot about her sadness, guilt and wasted time. At the same time, she admitted she could not wait to finish therapy and then start living, she had to start functioning normally during therapy. The patient's relations with loved ones were also discussed. A greater integration in the perception of other people was noticed. Ms. M. was able to imagine that other people could care for her and at the same time had problems that they also want to take care of. During this period, there was a constant sequence of beginning activities and suspending them, leading to passivity of the patient and expectation of the therapist to take care of her real life. This scheme was repeatedly discussed during subsequent sessions. Ms. M. began to make changes in everyday functioning, noting that "activity serves me, and passivity leads to despair."

In the following months, the patient started internship as an assistant, was attending interviews, and finally was offered a job which she accepted. However, she did not make any relationships with men claiming that she could not meet anyone interesting. The therapist realized that he was the only man in her life at that time, additionally he was experienced as an attentive listener. However such interpretations were always rejected by the patient, who stated that in this relationship it is irrelevant that the therapist was a male, which, according to the author, was a symptom of denial.

After three years of therapy, during which the therapist took two weeks off each year and the patient once went away for two weeks, in many aspects of Ms. M.'s life improvement in functioning could be seen. The patient could see the change that happened during therapy. The images of the world and objects have been integrated. She perceived people around her more holistically. She admitted that people around often worked hard, she realised that many of them were concerned and worried about her. She also experienced the world as a more friendly place. The patient was able to talk about her plans and projects, in which she participated in a consistent manner, she graduated from a university.

Ms. M. admitted that she experienced the therapist as a supportive, caring person. Starting a job, the patient considered renting an apartment again together with other people. She also proposed termination of the therapy - as she claimed, with less time, willingness to commit to additional occupations and treatment costs. The aspect of funding the therapy was discussed with her, as it drew the attention of the therapist - especially since she started working. Ms. M. claimed that her needs increased - she had more active life, she wanted to invest in personal development, participate in social life. The therapist had a great sense of personality integration, but he noted that areas of relationships with men and still being strongly dependent on her mother, needed further work. Despite the therapist's interpretation of another example of her

unfavourable pattern of not finishing what she started and terminating therapeutic relationship as a result of not fulfilling all her needs the patient decided to end the treatment. It was terminated after three years.

Interpretation in regard to Otto Kernberg's object-relations theory.

The first aspect that was highlighted in working with Ms. M. was the degree of personality inflexibility which was rated moderate to large. In her job she kept resentment for a long time, in other areas she focused too much on details (unfinished master's thesis). During the therapy process, she improved in these areas. Writing another master's thesis she drew attention to the practical aspects of her graduation, and in her new work she was able to "cut a deal" with her boss.

Another dimension analysed was the patient's identity, which showed moderate pathology. First of all, she was unable to determine her passion and interests, claiming she had nothing to offer. Also in this aspect Ms. M. has made progress. By the end of the therapy, she obtained a Master's degree, maintained a job, and had fixed, permanent plans for future work life.

The patient used both primitive and neurotic defence mechanisms [20]. In the first stage of therapy, her image of the world and society was strongly negative and unfair (dismissal from work) and cruel (everybody only has demands). In turn, the work of her friend was wonderful, people seemed to be always polite to each other.

Ms. M. frequently used projection describing others as selfish, while she actually did not help anyone and was very focused on herself. She was often in denial. The patient did not recognize her jealousy or even envy towards other people. Those defence mechanisms were the main cause of the patient's symptoms (anxiety and sadness) [21]. In the course of therapy, the patient has achieved considerable integration, recognizing that people are neither good nor bad. It was very helpful in maintaining employment because it eliminated her avoidance of work in a conflict situations.

In Ms. M.'s case, the reality testing seemed completely preserved. As for the relationship with object, Ms. M. was able to create and maintain relationships with other people, but she showed some difficulties in this aspect. She described others in a holistic way, seemed to be attached to them, however, she often expected one-way engagement from them, while at some point it was difficult for her to understand expectations of others. On completing the therapeutic process the patient could realize that every person has his own needs and has the right to fulfil them. She was able to imagine what people think and feel (increased mentalization [22, 23]). It

seemed that thanks to that it was easier for her to create relationships in which she did not feel rejected. She also offered help more willingly to others. This resulted in an increase in social activity of Ms M., who in her new job was a popular person.

As far as morality functioning is concerned, Ms M. seemed to have kept the general ethical standards. It also seems that she was capable of feeling guilt. Her moral functioning could be described as internalized.

Conclusion

According to most modern concepts of social exclusion, the cause of alienation is: poverty (lack of a job) and social stratification which contributes to the isolation of the individual [2, 24]. However, action undertaken in the external world do not cause expected changes [2], that is why it is worth considering the impact of internal factors on staying at the frontier of society.

The object relations theory (psychodynamic concept) can provide a whole new perspective and a better understanding of the roots of social exclusion by locating some of the underlying causes within the individual, as demonstrated in the present case study. In terms of the object relation theory presented by Kernberg [1, 25] an individual can experience the outside world in a way that predisposes to its avoidance, and even provoke the rejection by the outside world, which can be changed, according to the author of this article, by therapeutic interventions.

In a fast changing reality, flexibility and adaptability seem to be crucial. Dwelling on the failures, too much attention to detail - all this hinders functioning in the modern world. Therapy also includes strengthening the individual's sense of identity. A person who knows himself is able to determine his or her resources, is able to plan his or her actions and draw somebody’s attention. Increasing personality flexibility and enhancing identity were the basis of Ms M. therapy. Confronting comments repeated in safe therapeutic environment helped the patient become aware of her defence mechanisms - mainly projecting her own aggressiveness on others and the social system as a whole. This has led to greater integration, and thus better relations with the environment. Based on a secure, caring relationship, a person at risk of exclusion has the opportunity to develop a capacity for reciprocity and attachment, which contributes to the weakening of the isolation tendencies. [1] The patient – thanks to the confrontation and interpretation in the therapeutic relationship, in which she saw in the therapist various, often rejecting objects from her outside world, or expected care and taking care of her affairs - had the opportunity to re-assess this experience of reality. She also saw other, more valuable aspects of her own Self, which contributed to her increased activity in the social environment.

References

1. Clarkin JF, Yeomans FE, Kernberg OF. Psychotherapy for borderline personality. Focusing on object relations theory. Washington, DC: American Psychiatric Publishing Inc.; 2006.
2. Frieske KW, Poławski P. Opieka i kontrola. Instytucje wobec problemów społecznych, Seria Biblioteka Pracy Socjalnej. Katowice: Wydawnictwo Naukowe „Śląsk"; 1999.
3. Sęk H. Wsparcie społeczne – sposoby definiowania, rodzaje i źródła wsparcia, wybrane koncepcje teoretyczne. In: Sęk H, Cieślak R. Wsparcie społeczne, stres i zdrowie. Warszawa: Wydawnictwo Naukowe PWN; 2011.
4. Byrne D. Social exclusion. Berkshire: Open University Press; 2005.
5. Bernstein MJ, Claypool HM. Social exclusion and pain sensitivity. Why exclusion sometimes hurts and sometimes numbs. Personality and Social Psychology Bulletin. 2011; 10 (62):185–196.
6. Leathy RL, Holland SJ, McGinn LK. Treatment plans and interventions for depression and anxiety disorders. New York: The Guilford Press; 2011.
7. Beck JS. Terapia poznawcza. Podstawy i zagadnienia szczegółowe. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2005.
8. Caligor E, Kernberg OF, Clarkin JF. Handbook of dynamic psychotherapy for higher level personality pathology. Arlington: American Psychiatric Publishing Inc.; 2007.
9. Gabbard GO. Psychiatria psychodynamiczna w praktyce klinicznej. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2009.
10. Kernberg OF. Object relations theory and clinical psychoanalysis. Oxford: Rowman and Littlefield Publishing Group, Inc.; 2004.
11. Kenberg OF. Severe personality disorders: psychotherapeutic strategies. New Haven and London: Yale University Press; 1984.
12. Yeomans FE, Clarkin JF, Kernberg OF. A primer of transference-focused psychotherapy for the borderline patient. Oxford: Rowman and Littlefield Publishing Group, Inc.; 2005.
13. Izdebska A, Pastwa-Wojciechowska B. Organizacja osobowości i jej pomiar — polska adaptacja kwestionariusza IPO Kernberga i współpracowników. Czasopismo psychologiczne. 2013; 1: 17–27.
14. Kernberg OF. Internal world and external reality: object relations theory applied. Oxford: Jason Aronson Incorporated; 1980.
15. Bach S. The how-to book for students of psychoanalysis and psychotherapy. London: Karnac Books; 2011.
16. McWilliams N. Diagnoza psychoanalityczna. Gdańsk: GWP; 2009.
17. World Health Organization. Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD-10. Opisy kliniczne i wskazówki diagnostyczne. Kraków-Warszawa: Uniwersyteckie Wydawnictwo Medyczne „Versalius"; 2000.
18. Svartberg M, McCullough L. Zaburzenia osobowości z wiązki C – rozpowszechnienie, fenomenologia, skuteczność terapii i zasady leczenia. In: Clarkin JF, Fonagy P, Gabbard GO, ed. Psychoterapia psychodynamiczna zaburzeń osobowości. Podręcznik kliniczny, ed. 1. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2013, p. 401–434.
19. Racker H. Transference and countertransference. Madison: International Universities Press, Inc.; 1968.
20. Gabbard GO. Długoterminowa psychoterapia psychodynamiczna. Wprowadzenie. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2011.
21. Frederickson J. Współtworzenie zmiany. Skuteczne techniki terapii dynamicznej. Gdańsk: Harmonia Universalis; 2013.
22. Allen JG. Mentalizing. Bull. of the Menninger Clinic. 2003; 67 (2): 91–112.
23. Marszał M. Mentalizacja w kontekście przywiązania. Warszawa: Difin S.A.; 2015.
24. Szarfenberg, R. Ubóstwo, marginalność i wykluczenie społeczne. In: Firlit-Fesnak G, Szylko-Skoczny M, ed. Polityka społeczna. Warszawa: Wydawnictwo Naukowe PWN; 2007, p. 317–331.
25. Appelbaum AH, Carr AC, Kernberg OF, Koenigsberg H, Selzer MA. Psychodynamiczna terapia pacjentów borderline. Gdańsk: GWP; 2007.

E-mail address : daniel.melerowicz@gmail.com