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4 Borderline personality disorder BPS and behavioral disorder according to ICD.10 V. F. 60

As the author has described the personality disorder BPS - Behavioral Disorders in a severe disorder of the personal and social behavior of the affected show.

This disorder occurs in early childhood or adolescence and persists throughout adulthood. The causes are not directly due to brain damage or psychiatric disorder, but rather to a structural lack of education. Rohde et al. cite the loss of primal love and trust, as well as abuse and ill-treatment of the child as reasons for the development of this disorder (Andrawis A, 2018).

Personality and behavioral disorders can be found in Dilling et al. (2011) under the classification F60 - F69:

- paranoid personality disorder F60.0,
- dissocial personality disorder F60.2,
- emotionally unstable F60.3,
- impulsive type F60.30,
- schizoid personality disorder F60.1,
- Bordeline type F60.31,
- histrionic personality disorder F60.4,
- anxious (avoiding) personality disorder F60.6,
- anancastic (compulsive) personality disorder F60.5,
- Dependent (asthenic) personality disorder F60.7,
- other specific personality disorders F60.8,
- other narcissistic personality disorder F60.80,

- passive-aggressive personality disorder F60.81,

other other specific personality disorders F60.88 and so on. (Möller et al. 2005)

Here the author limits himself to F60.31 "Borderline type" as the most frequent manifestation of a personality disorder (Andrawis A, 2018).

Introduction

Borderline Type Pathology and Psychoanalysis

As Rohde-Dachser (2006) described, the history of borderline type in psychiatry goes back a long way. It was first practiced by Aichhorn in a group of his patients in 1925, where he found that his patients suffered from a lack of impulse control. In 1938 Stern mentioned Borderline as a diagnosis to distinguish patients of this type from psychotic patients.

As already mentioned, Stern had described patient characteristics that Kernberg (2008) had later adopted and published in his work on Borderline's ego pathology. From an analytical point of view, there is a tendency in patients to idealize the object-to-mother relationship and at the same time switch from idealization to devaluation. This is called an ambivalent state. Grinker et al. describes in his described empirical criteria of borderline patients a subdivision of four character types (Rohde-Dachser 2006):

Subgroups of characterization

1.) anacastic designations

2.) Tantrums

3.) lack of identity as an individual

4.) Depression through loneliness

Thus, Kernberg simultaneously developed theories about the borderline type personality organization, in which he found phenomena of psychodynamics, whereby ego pathology was proven among the patients, which can be traced back to primitive defense

mechanisms of early childhood experiences of trauma, and which are based on projective identification, (Andrawis A, 2018)

and denial. Originally, a pathology of the object relationship and the superego occurs, which can be described as ego weakness due to a lack of fear tolerance, impulse control, and a lack of sublimation ability (ibid.).

This early disorder can be traced back on the one hand to the relationship between mother and child, in which basic trust and love were violated, and on the other hand to early childhood traumatic experiences. Here the psychosocial components play a role, including housing shortage, unemployment, poverty, alcoholism, separation, parental divorce and violence in the family. The father is also involved in authority, absence and the relationship to the family. Furthermore, the relationship of the parents in their cohabitation, within conflict resolution, as well as a fraternal relationship, free of rivalry, is important in acceptance and appreciation. The child does not necessarily have to be traumatized, this can also be an epidemiology which can lead to symbiotic attachment (ibid.).

Exact diagnosis according to DSM-III-R criteria

For an exact diagnosis of the borderline type, 5 of the following 8 criteria must be met.

1. impulsivity in at least 2 areas where one is actively self-damaging. E.G.: Sexuality, spending money, shoplifting, substance abuse, ruthlessness in interpersonal relationships and seizures.

2. exhibiting a certain pattern of instability, which also affects interpersonal relationships and is reflected in an alternation between devaluation and overidealisation.

3. excessive anger or inability to control this anger, e.g. outbursts of anger, persistent anger or fights (Möller et al. 2005).

4. instability in the form of mood changes, from normal mood to depression, anxiety or irritability, which can last from a few hours to a few days.

5. identity disorder that is persistently pronounced and manifests itself in uncertainty in at least two of the following areas of life: Self-image, sexual orientation, long-term goals, career aspirations, choice of friends or partners, personal values.

6. suicide attempts, self-mutilation and repeated suicidal threats.

7. boredom and chronic feeling of emptiness.

8. desperate effort to prevent imaginary loneliness or real loneliness (Kernberg 1998).

Borderline - Type F 60.31

Diagnostic criteria according to ICD10 F international classification of mental disorders:

- Presence of emotional instability of one's own self-image, inner preference, including unclear and disturbed sexuality.

- chronic feeling of inner emptiness

- Tendency to intense but volatile relationships that can lead to repetition of emotional crises, including excessive effort not to be abandoned. In addition, self-harm and suicide threat, which can occur without cause and without trigger (Dilling et al. 2011). The DSM-III-R criteria of borderline personality disorder may overlap with other severe personality disorders, particularly schizotypal, histrionic, antisocial, and narcissistic personality disorder (Andrawis A, 2018).

Three criteria for diagnosis of borderline type disorder

Kernberg (2008) cited the following three criteria for the borderline fault:

I. Level of Defense Operations

II. Identity diffusion (lack of integration)

III. Ability to check reality

In contrast to neurotic personality disorder, in which the defense organization centers around repression and other mature defense mechanisms, in patients with borderline disorder or psychotic organizational level, primitive mechanisms of cleavage represent the central form of defense (Kernberg 1998). Division and other mechanisms such as projective identification, primitive idealization, or devaluation, denial, omnipotent control (control zeal) and

devaluation interact. This happens in order to protect one's own self from conflicts and shows itself in contradictory experiences of the self, where the defense mechanisms attempt to do so (Andrawis A, 2018).

To keep contradictory meanings separate from each other. Thus one can speak of a division through these defense mechanisms.

These characteristics can also be seen in patient interaction. The division leads to a division of the external objects and the self into "absolute evil" and "absolute good". This means that in transmissions in the form of projection, people are indiscriminately divided into good and evil (ibid.).

Primitive idealization

It shows itself to be "good", for example, by exaggerating external objects. Good qualities in the other are displayed pathologically exaggerated. This can go so far that patients do not want to admit human errors. If a person is overidealized by a patient, then he must not show any mistakes. The patient believes that the idealized person is perfect. The opposite of over-idealization is absolute devaluation. The other is also perceived as dangerous and persecuting. Early forms of projection and projective identification differ from mature forms of projection by assigning one impulse to another. This is an indication of early repression. As Kernberg has described, projective identification is characterized by 3 steps:

1. fear of other persons, which is apparently characterized by projected impulses.

2. to control the need of this person (the therapist). The goal is to provoke a certain behavior that seems to confirm the patient's projection. This happens due to the lack of ego structure. At the center are the defense mechanisms of the repressions. This is based on projective identification, which manifests itself through division or primitive actions (ibid.).

3. the tendency to find an impulse in oneself while it is simultaneously projected onto the other (ibid.).

Ability to check reality

In both borderline personality disorders and neurotic personality disorders, the ability to test reality remains intact. In contrast, this is not the case with psychotic personality organization. The reality test can be separated from the self as a "non-self". The intrapsychic perceptions and stimuli, which were originally intended to distinguish one's own affects, are intensified,

so that social norms cannot be observed. This loss of ability must be healed in order to return to reality: The patient, to whom things seem strange, must be made aware of reality.

"The borderline personality organization also manifests itself in secondary structural features, such as unspecific signs of ego weakness (lack of impulse control, lack of fear tolerance, and poorly developed ability to sublimate), super-ego pathology (infantile, immature value systems, contradictory inner moral demands, or even antisocial traits). (Andrawis A, 2018). Secondary structural features are based on the pathological finding. The diagnosis is based on the criteria of defensive operations, identity diffusion and reality testing.

Identity diffusion and lack of integration

The lack of integration is defined as identity diffusion and at the same time understood as the concept of the object. This means that the subjective experience is characterized by inner emptiness, contradictory perceptions and contradictory behavior. The contradictory perceptions of others, as well as of oneself, manifest themselves in the inability to live interpersonal relationships. In a short interview, a person concerned also spoke about the difficulty of being able to exchange realistically and properly information about a situation with their partner.

Practical applications for the borderline type

The individual, pathological images during the therapeutic process show hypomaniac personality disorders (psychosomatic disorders), which in all cases are counted as social personality disorders.

Kernberg assumes that borderline disorders occur during childhood as a result of physical or sexual abuse. For Herman et. al (1989), the diagnosis of those affected can be replaced by that of severe post-traumatic stress disorder because no definitive diagnosis can be made for borderline. Sexual abuse always occurs in connection with personality disorders.

Treatment concepts

Expressive psychotherapy is based on a psychodynamic model and aims to increase the patient's ability to experience himself and others as coherent, integrated and realistically perceived individuals. The patient should learn to control his impulses, tolerate fears, regulate affects, sublimate desires and experience intimacy and love. This happens on a psychoanalytic-expressive psychotherapy model.

Prerequisites for the therapy are transmission phenomena, forms of resistance, defence mechanisms and interpretation techniques. This form of therapy requires some modifications (transformation of therapeutic techniques and technical neutrality) and connects them with recognized principles of psychoanalytic treatment. Continuity, reliability, acceptance, esteem and authenticity as well as healthy communication towards empathy play an important role in all forms of psychotherapy which contain non-specific aspects. Consistency and discipline are important in therapy (Andrawis A, 2018).

Subject, treatment methods and objectives

As Kernberg has described in relation to expressive psychotherapy for borderline psychopathology, the ability of understanding and empathy for oneself and oneself in the affected person should be increased. Coherent (coherent), integrated connections should be perceived and implemented individually. According to Andrawis (2018), it is important to pay attention to the reduction of defense mechanisms at the same time, while the ego structure is weakened by the reduction of reaction possibilities. The patient's ability to develop is achieved by controlling his own impulses, regulating his emotions, being able to tolerate fear and sublimate his desires while developing stable and satisfying interpersonal relationships to experience love and intimacy (ibid.). These goals can be achieved by recognizing and clarifying the split-off parts of the inner object world of the person concerned. The transfer to the therapist makes this division visible. Each transfer disposition means the patient's self-imagination through the reconstruction of the object's conception and the affective state and therefore connects self-imagination and object's conception with each other. According to the author, the patient in this object conception strives to suppress and avoid his inner conflicts through interaction of primitive transmission. The therapy recommendation for borderline patients is to understand this transmission and to accept the interpretation instead of pursuing the current need for avoidance and suppression.

The patient should be informed of the interpretation of tensions in the psychological experiences of the affected person. By interpreting and clarifying the split elements, (split) self-representations move slowly towards complete self-representation, by understanding the image of aggressive and libidinal tendencies. This results in a differentiated realistic view of the self of the object world. This is how the self and the object world develop, as well as the recognition of the inner states of affect. The integrated object representations reflect a realistic parental image and the integration with them, from earlier childhood experiences, so that the borderline patient is able to realistically accept his past (ibid.).

Building block towards the treatment goal

Presence and esteem towards the therapist and all other persons is very important and can be seen as a great help for interactions among people, as well as for the whole therapy, in order to bring together the two integrated parts of the patient, the object representations with oneself. Through splitting and internalized object relationships, as well as character traits of splitting that manifest themselves in aggression and love, overidealization and devaluation arise. The integrations are in turn improved by the analysis of the defensive operations that maintain this split. Important for these patients is the recognition of primitive, split ego states and their integration by dissolving defensive operations that exist split off from each other. This happens with the help of integration techniques (ibid.).

Technical neutrality

Psychoanalytic psychotherapy involves an open dialogue between therapist and patient. The patient's instruction to speak openly is part of the standard rule of free association. Therapy intervals usually take place two to three times a week. Expressive psychotherapy, which is regarded as the basic technique of psychoanalysis, is similar to it in its reconstruction of the patient's biography and its connection with the patient's psychodynamics and the resulting interpretation and therapy. Both treatment approaches show transfer analysis as well as technical neutrality, whereby this can also be temporarily suspended in expressive psychotherapy and must then be renewed by interpretation technique. For long-term therapeutic goals, the monitoring of external reality must be taken into consideration (ibid.).

In forms of suppurative psychotherapy, which can also be described as supportive therapies, the therapist supports the patient's "self-confidence" in order to be able to guarantee positive

cooperation in the initial phase of the therapy, in which support of the patient is particularly important. In this phase, confrontational therapies should be avoided. The interpretation process is based on the "here and now", the "there and then". The main strategy of supportive psychotherapy is cognitive and affective support, whereby the therapist should steer rather than analyse, whereby the life circumstances of the patient are only intervened in later phases of the therapy. The therapist's task is to guide the patient's transmission phenomena to the present and reality through object effects. Technical neutrality can easily be abandoned and does not necessarily have to be restored.

Expressive Psychotherapy

In borderline patients, this method is only used in advanced therapies because of the "here and now" treatment process by reconstructing the patient's biographical anamnesis. In psychoanalysis, on the other hand, the reconstruction of the patient's biographical anamnesis is transferred to current events through interpretation and linkage. In contrast to psychoanalysis, the analysis of the transmission is rethought in relation to the patient's current life situation so that therapeutic goals are not endangered and the patient can overcome his difficulties. Kernberg points out the danger that patients use isolation to dissociate (separate) from the stresses of everyday life (ibid.). A further difference to psychoanalysis is that the severity of the borderline patient's action often forces the therapist to abandon the attitude of technical neutrality. However, it must be restored as soon as the situation threatening the treatment, which made this deviation necessary, no longer exists (ibid).

Supportive psychotherapy

In contrast to the expressive psychotherapy of borderline patients, this approach allows words of encouragement, praise, persuasion, intervention, and the patient's environment to be freely used to provide assistance. If necessary, additional therapy methods can be approved, although this may not always be the case. In the implementation of the therapy, educational reference is made to transmission by means of light confrontation in order to reduce transmission by referring to the inappropriate state of behaviour.

The supportive psychotherapy model involves confrontation, clarification, but no interpretation. In contrast, expressive psychotherapy avoids the direct expression of affective/emotional and cognitive/mental support, as well as intervention in life

circumstances. Experienced therapists are able to apply the framework conditions directly in their work (ibid.).

Method of treatment

Expressive psychotherapy has the concept of a stable, pathological, intra-psychic structure for the treatment of borderline disorders. This technique in psychoanalysis is specialized in the treatment of pathological states of this disorder. From a psychoanalytical point of view, the Freud´sche model presents itself as a differentiated, three-part system "EGO, SUPER-EGO and IT". These three components are in conflict with each other. The structural organization of classical character neurosis (strongly pathological personality formation and psychosexuality) and psychoneuroses (psychogenetically triggered neurosis, in which the triggers are suppressed conflicts in early childhood) is based on this three-part model (Andrawis A, 2018).

As already mentioned, borderline personality organization is an early pathological and intrapsychological conflict. These differ from a neurotic personality in the nature of the intrapsychic conflicts, which are part of the pathological picture, and in the structural conditions. Within these conditions the conflicts are reflected, so that a neurotic personality develops. The original cause lies in the Oedipus complex - the psychosexual - aggressive impulses from early childhood development. The borderline disorder impresses with the prevalence of pre-edipal conflicts associated with psychic conceptions associated with those of the Oedipal phase.

The triangular sexual disorder is related to the early relationship between mother and child. Drive offspring express themselves through oral and anal conflicts that manifest themselves through aggressive behavior patterns originating in pre-edipal relationships. Boderline personalities develop through this structure, especially through all repressed conflicts and traumas. This is why infantile behavioral patterns that interact with the ego state appear in the unconscious. These behavioural patterns become noticeable in the form of defence through division. The ego states split off within a primitive I-EX matrix through repressions in which the ego is differentiated from the ego and the super-ego. The simple forms of the I-ES matrix are accompanied by a programmed division and projection, whereby the superego can be described as a paranoid state (ibid).

Object Relationship Theory

In 1972, M. Mahler described object relationship theory as an individual and segregating separation process. The important time for the determination of pathological symptoms to a parental object is from the second to the fourth year of life and shows up as an earlier emergence of aggressive-psychological experiences. Thus the psychological theories and techniques describe that in the activation of earlier internalized object relationships and their repressions, pathological transmission through affect states can be visibly recognized. These must be diagnosed and interpreted both as integrated partial object relationships and as split-off or entire object relationships from earlier transmission structures to the transmission of oedipal development. This plays a large role in the analysis of the transmission by a reactive, past, internalized displacement of the object relationship in the sense of the "here and now".

For the analysis of the building blocks of "ego- superego and it" one needs the forms of transmission of the internalized relationship to the object, as well as their displacements, in connection with fantasized and realistically distorted object relations. Past object relationships are distorted internalized, and there are also defense reactions with influential projections of instinct of stressed impulses.

The most important goal of the psychotherapy of borderline patients is the complete interpretation as well as plausibility by making the unconscious conscious and finally internalizing these insights and putting them into action (ibid.).

The Psychoanalytical Interpretation

For expressive psychotherapy, the technical instrument of interpretation plays an important role for borderline patients. The patients get lost in intellectual utterances and mix between consciously and unconsciously within the session. So there's no connection, no cause. Early childhood repressions have an influence on transmission phenomena and their confusion between reality and fantasy and their causes (ibid.).

Interpretive language

The language of interpretation is based on three levels:

I. Reconstruction from the biographical anamnesis

II. the link between biography and psycho-dynamics

III. the formulation of therapeutic plans and goals from the "language of interpretation

The difficulties encountered during the therapeutic process are the patient's defence and resistance. The affected person is afraid. This is caused by the mechanisms of defense, which in turn counteract the therapeutic goals counterproductively. Ur trust and primeval love play an important role here. If they have been injured for biographical reasons due to an early Oedipal complex, pattern behaviour manifests itself. Personal life conflicts are then regressed in stressful situations. Here there is a need for reconstruction from the patient's biography in connection with the intrapsychic state and thus the psycho-dynamics.

The connection and interpretation between the conscious and the unconscious is based on the verbal interpretations which have arisen from hypothetical-free associations of the patient. Effective interpretation is very important for an understanding patient. This is followed by clarification and confrontation on the way to the goal. Confrontation, clarification or interpretation techniques obtained from one or more sessions are prerequisites for a complete interpretation (ibid.).

Psychoanalytical clarification

Clarification represents the plausibilities of the first steps in the cognitive interpretation process and can refer to various fields addressed by therapists and physicians:

- The expressions of the reality of the patient

- The transmission phenomena

- The history of the patient or the present defence (ibid.).

Confrontational therapy

After confrontation therapy, a confrontation consists of two steps:

The first step is the confrontation in the interpretation process and precedes the clarification of the interpretation. The aim is to raise awareness of unconscious conflicts.

In the second step, the patients are confronted with their separate pre-conscious and conscious contents in the so-called interpretation process in order to make them aware of these contents as help and hints to details. Above all, they are made aware of their own "mask of fantasies"; and the resulting distraction from reality. The ambivalent, contradictory attitudes and actions are pointed out and presented in addition to the unity consciousness of reality. If

patients have rejected both the confrontation and the clarification by the therapist, the therapist can draw their attention to the fact that the therapeutic observations and clarification in sitting were rejected by the patients without thinking and at the same time they claimed to have learned nothing in the lesson (Andrawis A, 2018).

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The extended Therapeutic Interpretation

The interpretation is based on confrontation and clarification approaches, with the aim of making the unconscious and the conscious aware together. It also serves the basic anxiety defense of the ratio of the unconscious to the conscious. This creates a motivation for therapeutic plans and goals in order to resolve the conflict contents of the unconscious and to interrupt the defense mechanisms. During the sessions the therapist determines hypothetical interpretations and corrects and clarifies the meaning and aims of the therapies. Here the metaphor of the unconscious as a burial chamber can be pointed out again, in which all repressions and their infantile behaviour patterns, which manifest themselves in the different situations as syndrome or symptom, for example as transmissions, are stored. From the depot of the burial chamber a pattern of behaviour is established which is unconscious and is also carried outwards (ibid.).

Transmission phenomena

The experiences of the transmissions from the patient to the therapist are based on perceptions, fantasies, affects that appear during the therapeutic interaction. These transmissions never emanate from the therapist, but always from the repressions of the patients through their history.

The transmissions are unconscious contents that repeat earlier internalized object relationships („there and then";) in the here and now. They are often rationalized by the patients as „realistic"; reactions to correctly perceived aspects of the therapist. They are for patients to separate from the distortions. Transfer is the inappropriate or distorted aspect of the patient's response to the therapist (ibid.).

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Primitive and mature transmissions

The primitive transmissions are quickly mobilized in the patient, with absolute and extreme distortions. In the foreground there is a lack of stable self-esteem in the patient. He is mistaken because it is something completely different and does not act in the „here and now";. The causes lie in earlier displaced objects or other objects and different situations. Every transmission phenomenon can tilt into the opposite or be assumed as its own perfect identity.

The therapist finds this transmission confusing, chaotic and often threatening because it is impossible to empathize with it. The threat is that the patient might interrupt the therapy. If the patient has unconscious difficulties, he reacts with defense. He wears a mask and sees it as his subjective truth. This can be seen as an infantile-destructive behaviour pattern that can go so far that the patient does not accept reality and is unable to overcome his psychological conflicts. This is one reason why the affected person withdraws and believes that this is the best way for him or her. „Primitive forms of transmission deal with sub-object relationships, while mature transmissions reflect whole object relationships." (ibid.).

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Treatment of borderline personality disorder

The borderline disorder can be treated using either behavioural or psychoanalytic methods. Both therapeutic approaches have the aim of establishing a stable therapeutic relationship, structuring the psychotherapeutic setting and setting limits where otherwise self-destructive or alien destructive behavior could occur. It is also legitimate to combine any borderline treatment with psychiatric drugs (Andrawis A, 2018).

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With regard to the school-specific orientation, it should be mentioned that, on the one hand, behavioral therapies deal with strict thought patterns, behaviors and emotions, while the psychodynamic healing method pays more attention to unconscious conflicts and inner-psychic structures, to be more precise, to those unconscious conflicts that can only become conscious of the ego because of symptoms because they elude its control.

By staging the inner conflicts during treatment with the psychotherapist or psychoanalyst, one makes the patient aware of them and changes them in this way. Böker points to Fonagy's approaches to psychodynamic therapy. On the other hand, there is also the dialectical-behavioral therapy of Marsha Linehan (1993/1996), which was crowned with particular success. Since all three types of therapies mentioned are available as a disorder-specific

manual, the psychoanalytic method has developed further and can therefore be applied to a large number of borderline patients today (Andrawis A, 2018).

An important aspect during the therapeutic process is that patients with destructive-infantile behavioural patterns try to control the therapist or destroy his efforts for therapeutic success. While the therapist tries to find a common therapeutic relationship for the cooperation with the borderline patients, the patients concentrate on their prejudices towards the therapist and are busy projecting preconceived opinions onto him that deviate from reality (ibid.).

Black-and-white thinking

The therapist is experienced by the patients as absolutely good or absolutely evil and thus either idealized or devalued by them. Kernberg describes this phenomenon as „black-and-white thinking";, the designation as either angel or devil, due to repressed object relationships through which the therapist is perceived as a foreign object representative. In the therapeutic process, there is an important aspect to transmission and countertransmission: Affects are transmissions outside reality by contents of earlier traumas that have been repressed. These forms of transmission repeat themselves again and again during the therapy process. If patients get bogged down in topics and their statements do not agree with their behaviour, it is not the narrative that counts, but their behavior. This transmission is an important criterion for psychic dynamics (ibid.).

Reasons why the therapy is stopped by the patient

There are many reasons for patients to discontinue therapeutic treatments:

1.) A transfer appears to the patient as a shift of feelings of love and hatred from early childhood displacements of the original objects. This is transferred from the patients as a foreign representation (scapegoat) to the therapist.

2.) The narcissistic proportions in borderline patients lead to a feeling of jealousy, envy and competition due to the constant relationship with the therapist. They perceive these narcissistic parts as an attack on their personal self-esteem and perception. They see the success of the therapist as their own defeat. This can be a major problem, as patients may feel inferior and less intelligent than before, may be jealous of other participants in therapy, and

may feel out of place. These proportions can be seen as a threat to the therapeutic process (ibid).

3.) The patients lose themselves in a fantasy that makes them believe that everything around them is unhealthy, which is why they have to flee from therapy. Furthermore, they are afraid of becoming dependent on the therapist and want to prevent this as well. Also, the knowledge of the therapist's concern that the patient might stop the therapy will attract the patient's attention, thus exerting even more pressure.

4.) As soon as the affected persons feel a first improvement, it can come to the fact that the therapy is stopped prematurely as processing of psychological suffering, although the healing process is not yet completely finished.

5.) The patients feel a threat of failure or failure due to the intensity of the intervals.

6.) The patients leave the session in order not to be abandoned themselves.

7.) A deficient perception of the patients, which makes them believe out of shame that the therapist or other people have sexual desires towards them, which are regarded as sadistic, can be a reason for therapy interruption.

8.) The influence of the patient's relatives or family members can also influence the course of therapies to the extent that they want to bring about their discontinuation so that long-standing patterns or behavior patterns of the patient are maintained and the psychological equilibrium within the family is not disturbed.

9.) If the patients feel like victims and perceive their therapist as a persecutor, they change roles and leave the helpless therapist.

10.) Patients can experience their therapist either idealized or humiliating. Therefore they believe to overtax him, because he seems to be partly angry and therefore incompetent. Furthermore, they believe that the therapist is not able to cope with the treatment and leave the therapy out of consideration so that they can finally relieve him.

Kernberg recommends for all these reasons to recognize them in time and to have a clarifying conversation with the patient (ibid.).

Withholding information and the pathological lie

During the most important interventions, patients feel a threat to their lives and to the lives of others in the event of continuation of therapy. Why they then resort to deceptive maneuvers and evasive methods in the form of lies can have various causes:

a) the prevention of retaliation and disapproval of the therapist

b) the avoidance of the confrontation with the possible result of having to take responsibility for their actions

c) Exertion of power and control over the therapist

d) Patients want to dominate the therapist by lying, believing that all relationships are either exploitative or persecuting anyway.

Paranoid transmission can lead to notorious dishonesty, manipulation and deception. Neurotic transmission phenomena are the cause of this. Furthermore, patients may believe that their therapist is hostile, aggressive and primitive because the success or failure of therapies depends on the openness of communication. Therefore the therapist has the task to take the lies of his patients as seriously as if the patient wanted to harm himself with it (ibid.).

Psychoanalysis and development of mental disorders

As the author has already described, the development of mental disorders is favored by early childhood trauma, as well as genetic risks with unfavorable social environment. All repressed traumas, which were never uncovered and which manifest themselves in the unconscious, can be uncovered and treated, lead to the outbreak of disease. The structural defects, especially the primary and secondary ones, all promote the development of various personality disorders, such as narcissistic, schizoid and paranoid, psychosis and borderline type (ibid.).

This is not surprising, but all the more shameful.

The emergence of dependence and attachment and the development of past fears, basic trust and security experiences have a lasting impact on the mental health of adults.

As Andrawis have described, the dependence of a child begins immediately after birth, taking into account its social environment. From a physiological point of view, a child's anxiety begins when the mother moves away from him and/or when strangers meet him. Others may

arise if the child fails to meet a loss of primeval love and trust due to disregard for the infantile sense of security and a need for closeness.

Prof. Dr. Andrawis