POVIJESNI PREGLED RAZVOJA PSIHODINAMSKOG RAZUMIJEVANJA PSIHOZE

/ HISTORICAL OVERVIEW OF PSYCHODYNAMIC UNDERSTANDING OF PSYCHOSIS

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SAŽETAK/*SUMMARY*

Od starog vijeka ljudi su pokušavali razumjeti uzroke i pronaći načine liječenja psihičkih bolesti. Spektar uzroka kretao se od demona i zlih duhova do stanja tjelesnih sokova i animalnog magnetizma. Tek u dvadesetom stoljeću razvija se psihodinamsko razumijevanje lakših i težih psihičkih poremećaja i počinje osmišljavanje različitih terapijskih pristupa. U 21. stoljeću nastavljaju se razvijati stari i stvarati novi terapijski pristupi pacijentima s težim psihičkim smetnjama.

U ovom radu ponuđen je teorijski pregled psihodinamskog razumijevanja psihoze i terapijskog pristupa pacijentima s iskustvom psihoze.

/ Since ancient times, people have been trying to understand the causes as well as ways of treating mental illness. The spectrum of causes ranged from demons and evil spirits to the state of bodily juices and animal magnetism. It was not until the twentieth century that a psychodynamic understanding of minor and severe psychiatric disorders was developed, along with the development of different therapeutic approaches. In the twenty-first century, old and new therapeutic approaches to patients with severe mental health problems continue to develop. This paper presents a theoretical overview of the psychodynamic understanding and therapeutic approach to patients with psychosis.

KLJUČNE RIJEČI / KEYWORDS

povijesni pregled / *historical overview*, psihodinamika psihoze / *psychodynamics of psychosis*, psihoterapija psihoze / *psychotherapy of psychosis*

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UVOD

Otkad postoji civilizacija i kultura ljudi su pokušavali shvatiti uzroke psihičkih bolesti. U starom vijeku smatralo se da su demoni glavni uzrok psihičkih smetnji, a terapijski su pristupi, u skladu s time, bili egzorcizam, magija i trepanacija lubanje. U antičko doba Hipokrat je smatrao da je mozak središte duševnih zbivanja, a poremećaje (npr. melankoliju) je povezivao sa stanjem tjelesnih sokova (npr. sa stanjem žuči). U srednjem vijeku glavni uzrok psihičkih smetnji bio je vrag, ali i astrološki utjecaj nebeskih tijela na čovjeka, a pacijenti su često završavali na lomači ili u tamnici. Do 18. stoljeća odnos prema psihičkim bolesnicima najčešće je bio nehuman i oni su često bili čuvani u okovima. U novo doba P. Pinel insistira na humanijem pristupu psihičkim bolesnicima i u okviru Francuske revolucije od revolucionarnog konventa dobiva dozvolu za skidanje okova sa psihijatrijskih bolesnika te tako pokreće tzv. prvu psihijatrijsku revoluciju. Nakon toga F. A. Mesmer uvodi ideju o postojanju animalnog magnetizma, a osnovni mu je terapijski pristup sugestija. U smjeru psihološkoga nastavlja i J. M. Charcot, koji primjenjuje hipnozu u terapiji pacijenata s konverzivnim smetnjama (1).

Psihijatrija je vrlo mlada medicinska grana, pojavljuje se tek u 19. stoljeću.

INTRODUCTION

Ever since the beginning of civilization and the existence of culture, people have been trying to understand the causes of mental illness. In ancient times, demons were thought to be the major cause of psychological distress, and therapeutic approaches were, accordingly, exorcism, magic, and skull trepanation. In ancient times, Hippocrates considered the brain to be the seat of mental occurrences, and he associated related disorders (e.g. melancholia) with the state of bodily juices (e.g. with the state of bile). In the Middle Ages, the main cause of psychological disturbance was the devil and the astrological influence of celestial bodies, and patients were often sent to a pyre or a dungeon. Until the 18th century, the treatment of psychiatric patients was most often inhumane, and they were often kept in shackles. In the new era, P. Pinel insisted on a more humane approach towards the mentally ill and, under the French revolution, obtained a license from the revolutionary convention to remove the shackles from psychiatric patients, thus launching the so-called first psychiatric revolution. After that, F. A. Mesmer introduced the idea of the existence of animal magnetism, and his basic therapeutic approach was suggestion. J. M. Charcot was also pursuing a psychological course and used hypnosis in the treatment of patients with conversion disorders (1).

Psychiatry as a profession is a very young medical branch, dating back only

U 20. stoljeću psihijatrija je ostvarila velik napredak u razumijevanju funkcioniranja mozga. Tijekom desetljeća kliničari su dobro opisivali što sve zapažaju kod svojih pacijenata pa su se tako znanstvenici mogli upustiti u istraživanje određenih dijelova mozga. Pokušat ćemo prikazati kliničke opservacije i psihodinamsko razumijevanje težih psihičkih poremećaja koje je uslijedilo.

POVIJESNI PREGLED RAZVOJA PSIHODINAMSKOG RAZUMIJEVANJA TEŽIH PSIHIČKIH POREMEĆAJA

Okolina se bojala težih psihičkih pacijenata. Prvi psihodinamski prikaz paranoidne psihoze pružio je S. Freud (Freud S, 1911.) u svojem djelu „Psihoanalitičke napomene o jednom autobiografski opisanom slučaju paranoje (Schreber)", u kojem navodi da je sudac Schreber imao sumanutost da će, nakon što ga Bog oplodi, roditi novu ljudsku vrstu. Prema Freudu do pojave bolesti dovela je provala homoseksualnog libida prema ocu i bratu, a transferno i prema liječniku koji ga je liječio. Sumanuta tvorba zapravo je pokušaj izlječenja, tj. rekonstrukcija. Freudu upada u oči da u svim dijelovima bolesnikove teorije postoji smjesa plitkosti i bogatstva duha, posuđenih i originalnih elemenata (2).

to the nineteenth century. In the twentieth century, psychiatry made great progress in understanding how the brain functions. Over several decades, clinicians have provided good descriptions of what they observed in their patients, so scientists have been able to investigate specific parts of the brain. We will attempt to show how clinical observations and a psychodynamic understanding of severe psychiatric disorders developed.

A HISTORICAL OVERVIEW OF THE DEVELOPMENT OF PSYCHODYNAMIC UNDERSTANDING OF SEVERE MENTAL DISORDERS

As noted above, the social environment feared severe psychiatric patients. The first psychodynamic review of paranoid psychosis was given by S. Freud in his work "Psychoanalytic notes on an autobiographically described case of paranoia (Schreber)" (1911) in which judge Schreber had the delusion that he would, after being impregnated by God, create a new kind of human being. According to Freud, the outbreak of homosexual libido towards his father and brother, afterwards transferred to the doctor who treated him, resulted in illness. The insane formation is actually an attempt to cure, i.e. reconstruct. Freud noted that a mixture of spiritual shallowness and depth, consisting of both borrowed and original elements, exists in all parts of

Trebalo je i Freudu mnogo vremena da psihodinamski razumije sudca Schrebera te u radu „An Outline of Psycho-Analysis" napisanom većim dijelom 1938., a izdanom 1940. godine (Freud S, 1940.) piše o rascjepu ega pri čemu nastaju dva psihička stajališta: normalno, koje uzima u obzir stvarnost i drugo, koje je pod utjecajem instinkata i koje odmiče ego od stvarnosti. Ta dva stajališta ega postoje istodobno jedan uz drugi. Problemi ovise o njihovoj relativnoj snazi: ako je jači drugi dio (pod utjecajem instinkata), stvoren je preduvjet za psihozu. Ako je jači prvi dio – to predstavlja izlaz iz sumanutog poremećaja. Nakon oporavka od psihoze pacijenti znaju reći da je i tijekom psihoze u nekom kutku njihova uma bila skrivena normalna osoba koja je kao neutralni promatrač promatrala metež bolesti (3).

Viktor Tausk (Tausk, 1919.) objavio je 1919. godine rad pod nazivom „O podrijetlu 'utjecajnog stroja' u shizofreniji". Razmišljajući o psihodinamici bolesti kod svoje pacijentice, Tausk navodi da stroj predstavlja projekciju pacijentičina tijela na vanjski svijet. Sve što se događa stroju događa se i pacijentici. Naprimjer, netko je manipulirao genitalijama na stroju pa je i ona imala seksualne senzacije. Kasnije stroj više nije imao genitalije pa ni pacijentica više nije imala seksualnih osjeta. Ili kad bi netko udario stroj, ona bi osjetila udarac u odgovarajućem dijelu tije-

the patient's theory (2). It also took Freud quite some time to understand judge Schreber psychodynamically, and in his work "An Outline of Psycho-Analysis", written mostly in 1938 and published in 1940, Freud writes about the break of the Ego that produces two psychological attitudes: a normal one, which takes into account reality, and another, influenced by instincts, which drags the ego away from reality. These two attitudes of the ego exist side by side. The problems depend on their relative strength: if the second part (influenced by instincts) is stronger, the precondition for psychosis is created. If the first part is stronger - this represents a way out of the insane disorder. After recovering from psychosis, patients tend to say that even during psychosis, there was a normal person hidden in a corner of their mind, watching the chaos of the disease as a neutral observer (3).

In 1919, Victor Tausk published a work entitled "On the Origin of the 'Influencing Machine' in Schizophrenia". Reflecting on the psychodynamics of the disease in his female patient, Tausk stated that the machine represents the projection of the patient's body into the outside world. Everything that happened to the machine happened to the patient as well. For example, if someone manipulated the machine's genitals, she too experienced sexual sensations. Later, the machine no longer had genitals and the patient no longer had sexual sensations. Similarly, when someone hit the machine, she

la. Tausk smatra da se projekcija tijela može pratiti unatrag do razvojne faze u kojoj dijete doživljava dijelove svojeg tijela kao dio vanjskog svijeta, dakle do faze u kojoj nije jasna granica između *ja* i *ne-ja*. U shizofreniji kao da se ponovo aktiviraju te rane faze s gubitkom ego-granica (4).

Godine 1928. Ruth Mack Brunswick (Brunswick, 1928.) analizirala je čuvenog Freudova pacijenta „čovjeka – vuka", čija je klinička slika bila teška hipohondrija koja je u diferencijalnodijagnostičkom smislu mogla djelovati i kao paranoidna psihoza somatskog tipa. Brunswick je u psihodinamskom smislu prepoznavala kastracijski strah, negativni transfer prema očinskim figurama i potisnute homoseksualne nagone (5).

Viđenje najranijih djetetovih psihičkih doživljaja pruža M. Klein (Klein, 1946). U najranijim početcima života prvi su djetetov objekt majčine dojke, koje dijete dijeli na dobre i zle, a to dovodi do razdvajanja ljubavi od mržnje. Od početka života postoje zamišljeni oralno-sadistički napadi na majčine dojke koji prerastaju u napade na cijelo njezino tijelo. Dijete na oralno-sadistički način napada frustrirajuću dojku i doživljava tu istu dojku u dijelovima. Zbog analno-sadističkih poticaja dijete nastoji unijeti u majčino tijelo svoje izlučevine, a ima i želju da prodre u njezino

would feel a kick in the appropriate part of the body. Tausk believed that the projection of one's body can be traced back to the developmental stage in which the child experiences parts of his or her body as part of the outside world, that is, up to a stage where the boundary between the self and the non-self is unclear. In schizophrenia, these early stages seem to be reactivated with the loss of Ego boundaries (4).

In 1928, Ruth Mack Brunswick analysed the famous Freudian "Man-Wolf" patient who clinically provided a picture of severe hypochondria, which could also act as a paranoid psychosis of the somatic type in a differential diagnostic sense. In a psychodynamic sense, Brunswick recognized the fear of castration, a negative transfer towards paternal figures, and supressed homosexual impulses (5).

Observation of an infant's earliest psychological experiences is provided by M. Klein (1946). In the earliest beginnings of life, the infant's first object is the mother's breast, which the infant divides into good and evil, which leads to the separation of love from hate. From the very beginning of life, there are imaginary sadistic oral attacks on his mother's breasts that grow into attacks towards her entire body. While attacking the frustrating breast in an orally sadistic way, the infant is experiencing that same breast in parts. Furthermore, due to sadistic anal impulses, the infant tends to transfer its secretions into the mother's body and has a desire to penetrate her body so that

tijelo kako bi je moglo nadzirati iznutra. Međutim, taj poriv stvara i strah da će u unutrašnjosti majke biti zatvoreno i izloženo proganjanjima. Dakle, projekcijom takvih oralnih i analnih poticaja stvara se strah od proganjanja, koji je vrlo karakterističan za razvoj paranoje i shizofrenije. Rani mehanizmi obrane jesu: rascjep, projekcija, introjekcija, projektivna identifikacija, idealizacija, poricanje unutarnjeg i vanjskog realiteta, gušenje emocija (6). M. Klein (Klein, 1952.) opisuje dvije osnovne psihološke pozicije: prva tri do četiri mjeseca života mogu se opisati kao paranoidno-shizoidna pozicija. U njoj dominiraju parcijalni objekti (samo loši i samo dobri) i strahovi od proganjanja – koji su temelj kasnijih psihotičnih stanja. Tijekom druge četvrtine prve godine života nastaje tzv. depresivna pozicija što znači da dolazi do spajanja ljubavi i mržnje, dobrih i loših značajki objekata pa tako nastaju cjeloviti objekti. Pojavljuje se briga za voljeni objekt i tjeskoba zbog gubitka objekta (7).

Za razliku od Freuda, Federn (Federn, 1952.) smatra da je psihoza bolest ega (8). U psihozi dolazi do regresije ega, gubitka katekse ego-granica, gubitka testiranja realiteta, gubitka katekse objekta i povećanja narcističke katekse, primarni proces postaje dominantan, tj. nesvjesno postaje svjesno, a projekcija je istaknuti mehanizam obrane uz regresiju (9). Misli su konkretizirane

it can control her from within. However, this impulse also creates a fear that it will be imprisoned inside of the mother and subjected to persecution. Thus, the projection of such oral and anal stimuli gives rise to fear of persecution, which is very important for the development of paranoia and schizophrenia. Early defence mechanisms are: splitting, projection, introjection, projective identification, idealization, denial of internal and external realities, and stifling emotions (6). M. Klein (1952) describes two basic psychological attitudes: the first three to four months of life can be described as a paranoid-schizoid position. It is dominated by partial objects (only bad and only good ones) and fears of persecution - which are the basis of later psychotic conditions. During the second quarter of the first year of life, the so-called depressing position forms, which means that love and hate merge, good and bad properties of objects merge, thus forming whole objects. Concerns about a loved object and anxiety about losing an object occur (7).

Unlike Freud, Federn (1952) believes that psychosis is a disease of the Ego (8). In psychosis, regression of the Ego, loss of the boundaries of the Ego, loss of reality testing, loss of object cathexis and increase of narcissistic cathexis appear, the primary process becomes dominant, i.e. the unconscious becomes conscious, and projection is a prominent defence mechanism, with regression (9). Thoughts are concretized (8). The Ego is split into parts

(8). Ego je rascijepljen na dijelove koji rade istodobno s jednakom kateksom. Ti su dijelovi neovisno organizirani. Nemoguće ih je ujediniti dok traje psihoza. Nakon psihotičnog sloma slijedi psihotična reorganizacija koja može pružiti potpuno promijenjenu koncepciju svijeta (10).

Radeći s grupama psihotičnih bolesnika od 1952. godine, Resnik (Resnik, 1952.) je uočavao slabe ego-granice koje dovode do osjećaja raspadanja, blokadu emocija, otuđenje bolesnika od vlastita tijela, gubitak doživljaja identiteta i gubitak testiranja realiteta te disociranost misli. Oblici obrane od bolnog doživljaja koje su bolesnici primjenjivali bili su: depersonalizacija, hipohondrija, lažni *self* ili psihoza (doživljaj sebe kao stroja ili nežive tvari, npr. željeza, kamena ili leda) (11).

Frieda Fromm Reichmann (Fromm-Reicmann, 1954.) došla je liječeći psihotične pacijente do zaključka da je glavni sukob kod shizofrenih pacijenata – konflikt bliskosti i agresije (12). Pretpostavljala je (Fromm-Reichmann, 1958.) i da kod shizofrenih pacijenata dolazi do narcističkog regresa. Pritom je razlikovanje misli i djela zbog magijskih elemenata u narcističkom pristupu stvarnosti slabo, a velik su problem mržnja, agresija i krivnja izazvana njima. Obrana od agresije može biti: stupor, katalepsija, mutizam. Postoji strah

that work simultaneously with an equal cathexis. These parts are independently organized. It is impossible to unite them while psychosis lasts. Psychotic breakdown is followed by psychotic reorganization that can cause a completely altered conception of the world (10).

While working with groups of psychotic patients, starting in 1952, Resnik observed weak Ego boundaries that lead to feelings of decay, blockage of emotions, alienation of patients from their own body, loss of experiencing identity, as well as loss of reality testing and thought dissociation. The following forms of defence against painful experiences were used by patients: depersonalization, hypochondria, a false self, or psychosis (experience of oneself as a machine or inanimate substance, e.g. iron, stone, or ice) (11).

Frieda Fromm-Reichmann (1954), who treated psychotic patients, concluded that the main conflict in schizophrenic patients is the conflict between closeness and aggression (12). She also suggested that narcissistic regression occurs in schizophrenic patients (Fromm-Reichmann, 1958). As a result, thoughts and actions are poorly distinguished due to magical elements in the narcissistic approach towards reality, and hatred, aggression, and guilt caused by them is a serious problem. Defence against aggression can include stupor, catalepsy, and mutism. There is a fear of closeness due to weak Ego boundaries. Patients are unable to give and receive love because

od bliskosti zbog slabih ego-granica. Bolesnici su nesposobni da daju i prime ljubav jer takva iskustva nisu imali u ranom djetinjstvu. Imaju smanjeno samopoštovanje, tj. osjećaj manje vrijednosti. Prisutne su i ovisničke potrebe i strah od odbacivanja, odnosno istodobno postoji strah od bliskosti i želja za bliskošću što je često vidljivo u potrebi za približavanjem terapeutu i odbacivanju terapeuta (13). Postoji također velika senzitivna perceptivnost shizofrenih bolesnika koja se razvila kao odgovor na njihovu anksioznost u svijetu koji doživljavaju opasnim (12).

Bion (Bion, 1957.) je istodobno došao do zaključka da postoji razlika između psihotične i nepsihotične osobnosti. Psihotičnu osobnost obilježuju dominacija agresije (mržnja prema vanjskom i unutarnjem realitetu), strah od uništenja, rascjep i projektivna identifikacija, paranoidno-shizoidna pozicija, nedostatak simbolizacije, napadnute su misli i veza između misli. Pacijenti pokazuju ovisnički odnos prema terapeutu i fragmentaciju ega čiji se dijelovi projiciraju na vanjske objekte pa nastaju tzv. bizarni objekti. O zadržavanju doticaja ega sa stvarnošću ovisi i usporedno postojanje nepsihotične osobnosti (koja je u sjeni psihotične osobnosti) (14). Sirovi senzorij i konkretni doživljaji (beta-elementi) prema Bionu se (Bion, 2005a) pomoću alfa-funkcije pretvaraju u alfa-elemente (misli i emo-

they have not had such experiences in their early childhood. They have low self-esteem, that is, they have low sense of self-worth. Closeness needs and a fear of rejection are also present (13). A great sensory perception of schizophrenic patients also develops in response to their anxiety in a world they perceive as dangerous (12).

At the same time Bion (1957) concluded that there is a difference between psychotic and non-psychotic personality. In psychotic personality, there is a dominance of aggression (hatred towards external and internal reality), fear of annihilation, splitting and projective identification, paranoid-schizoid position, lack of symbolization, thought-attacks and attacks on the connections between thoughts. Patients show an addictive relationship with the therapist, fragmentation of the Ego, parts of which are projected into external objects, forming so-called bizarre objects. The parallel existence of a non-psychotic personality (which exists in the shadow of the psychotic personality) also depends on maintaining the contact of the ego with reality (14). Raw sensory and concrete experiences (beta elements) are, according to Bion (2005a), transformed by the alpha function into alpha elements (abstract thoughts and emotions). Bion binds the paranoid schizoid position, fragmentation, dissociation, expulsion, and uncertainty - all of which are traits of psychotic states - with beta elements (15).

cije, apstraktno). S beta-elementima Bion povezuje paranoidno-shizoidnu poziciju, fragmentaciju, disociranost, ekspulziju i neizvjesnost – što su sve značajke psihotičnih stanja (15).

U Chestnut Lodgeu, ustanovi koja je bila svjetski poznata po psihoterapiji psihoza, radio je godinama H. Searles (Searles HF, 1959.). Njegovo je iskustvo da u shizofreniji postoje slabe ego-granice i slaba diferencijacija sebe i okoline, živog i neživog, emocionalnog i tjelesnog, konkretnog i apstraktnog, prošlosti i sadašnjosti, jedne osobe od druge. Dijelovi psihičke strukture neintegrirani su: id se doživljava kao strano tijelo, ego je fragmentiran, superego je okrutni tiranin i nedosljedan (kao i bolesnikovi roditelji). Odnosi s drugim ljudima također su neintegrirani u smislu nekoordinirane zbrke ambivalentnih osjećaja (16).

Vlastito iskustvo analize kod Winnicotta sigurno je pomoglo M. Little (Little, 1964.) da bolje shvati svoje pacijente. Ona navodi da u psihozi postoje progoniteljski strahovi, dominira primarni proces mišljenja, tijelo i psiha samo su djelomično diferencirani, objekti su parcijalni, mišljenje je konkretno, nema simbolizacije, percepcija je poremećena, a obrane koje pacijent primjenjuje jesu: projekcija, introjekcija, rascjep, poricanje, magijska svemoć, tjelesne bolesti. Destruktivna agresija

For many years, H. Searles (1959) also worked at Chestnut Lodge, an institution that was known worldwide for psychotherapy of psychosis. His experience is that in schizophrenia there are weak Ego boundaries and poor differentiation of the self from the environment, living from inanimate nature, as well as emotional from physical, concrete from abstract, past from present, one person from another. Parts of the psychological structure are unintegrated: the Id is perceived as a foreign body, the Ego is fragmented, the Superego is a cruel tyrant and inconsistent (as are the patient's parents). Relations with other people are also unintegrated in terms of the uncoordinated confusion of ambivalent feelings (16).

Little`s own experience in analysis with Winnicott had certainly helped her to better understand her patients (Little, 1964). She states that persecution fears exist in psychosis, the primary thought process dominates, the body and the psyche are only partially differentiated, objects are partial, opinion is concrete, there is no symbolization, perception is disturbed, and the defences used by the patient include projection, introjection, splitting, denial, magical omnipotence, and physical illnesses. Destructive aggression has magical qualities. The super Ego is destructive (17).

In his work on schizophrenia, J. S. Grotstein (1989) distinguishes schizophrenic patients whose cause of the disease is neurobiologically based and who are

obojena je magijskim kvalitetama. Superego je destruktivan (17).

U svojem radu o shizofreniji J. S. Grotstein (Grotstein, 1989.) razlikuje shizofrene bolesnike kojima je uzrok bolesti utemeljen neurobiološki, koji su pogodniji za psihofarmakoterapiju, od bolesnika s razvojnim i psihosocijalnim uzrocima, koji su pogodniji za psihoterapiju. Središnji je problem prema njegovu mišljenju dezinvesticija značenja ili smisla objektnog svijeta. To je praćeno i najvećim strahom kod psihotičnih pacijenata, strahom od ništavila i kaosa, od odsutnosti povezivanja i s objektima i sa *selfom* (što se očituje kao osjećaj otuđenosti od drugih i od sebe), uz postojanje samoubilačkih unutarnjih objekata. Psihozu obilježuju: kolaps vremena i prostora, fragmentacija i uništenje, izobličenje objekata, bizarni oblici koji mogu biti mrtvi ili mehanički, stanja u kojima neživo postaje živo, a živo postaje neživo, asocijacije su dezorganizirane ili bolesnik komunicira putem neverbalnih projektivnih identifikacija. Grotstein nudi metaforu crne rupe i njezine granice pri čemu se s jedne strane granice nalaze konvencionalni prostor i vrijeme te značenje, a s druge strane beskrajni prostor i vrijeme, gubitak značenja (dekateksa), reprezentacija *selfa* i objekata, bezimeni užas i bizarni objekti (18).

Ogden (Ogden, 1992.) smatra da je glavni sukob kod shizofrenih pacijenata

more suitable for psychopharmacotherapy than those with developmental and psycho-social causes, who are more suitable for psychotherapy. According to him, the central problem is the decathexing of the meaning or of the sense of the object world. This is accompanied by the greatest fear in psychotic patients, the fear of nothingness and chaos, the absence of attachment to objects and to the self (which manifests as a sense of alienation from others and from oneself), with the existence of suicidal internal objects. Psychosis is characterized by the collapse of time and space, fragmentation and annihilation, distortion of objects, bizarre forms that can be dead or mechanical, states in which the inanimate becomes the living and the living becomes inanimate, while associations are disorganized or the patient communicates through non-verbal projective identifications. Grotstein provides the metaphor of the black hole and its boundaries, where on one side of the border there is conventional space and time as well as meaning, and on the other side of the border there is infinite space and time, loss of meaning (decathexis) representation of self and objects, nameless horror, and bizarre objects (18).

Ogden (1992) thinks that the main conflict in schizophrenic patients is the conflict between the desire to maintain meaning and the desire to destroy the meaning of thought, feeling, and experience (19).

konflikt između želje da se održi značenje misli, osjećaja, iskustva i želje da se ono uništi (19).

Problem je psihotičnih pacijenata prema Benedettiju (Benedetti, 1994.) dezintegracija simbiotskog *selfa* (čija je krajnost fuzija) i odvojenog *selfa* (čija je krajnost autizam) pri čemu pacijent prelazak iz jednog stanja u drugo može doživjeti kao smrt ili uništenje (20).

U psihotičnoj organizaciji osobnosti *self* i objekt-reprezentacije često su fragmentirane, a ti fragmenti uključeni su u stalne i vrlo brze cikluse eksternalizacije i internalizacije sve dok osoba ne razvije kronično psihotično stanje kao što je shizofrenija, smatra Volkan (Volkan, 2010.). Povremeno se *self* i objekt reprezentacije stapaju i tako oštećuju testiranje realiteta (21).

Franco de Masi (De Masi, 2015.) podsjeća na Bionovu teoriju o sanjarenju, tj. o pretvorbi beta-elemenata u alfa-elemente i na Bionovu sintagmu „inverzija alfa-funkcije", pri čemu se alfa-elementi pretvaraju u beta-elemente. Drugim riječima, kod sumanutosti se misli pretvaraju u senzorne percepcije koje bolesnik doživljava stvarnima. Psihotični bolesnik svjestan je sadržaja sumanutosti, ali je nesvjestan procesa inverzije. De Masi podsjeća na neke značajke psihoze kao što su gubitak simbolizacije, gubitak testiranja realiteta, osiromašenje emocionalnosti, sklonost svemoćnosti, stapanju, paranoičnosti. Suma-

The problem of psychotic patients, according to Benedetti (1994), is the disintegration between the symbiotic self (the extreme of which is fusion) and the separated self (the extreme of which is autism), whereby the transition from one state to another can be experienced by the patient as death or annihilation (20).

According to Volkan (2010), in the psychotic organization of personality, the self representation and the object representation are often fase, and these fragments are involved in constant and very rapid cycles of externalization and internalization until the person develops a chronic psychotic condition such as schizophrenia. At times, the self representation and the object representation fuse and demage reality testing (21).

Franco de Masi (2015) refers to Bion's theory of daydreaming, i.e. the conversion of beta elements into alpha elements, as well as Bion's concept of "the inversion of alpha function", whereby alpha elements are converted into beta elements. In other words, in delusion, thoughts are transformed into sensory perceptions that the patient perceives as being real. A psychotic patient is aware of the content of the delusion but is unaware of the inversion process. De Masi points out some traits of psychosis such as loss of symbolization, loss of reality testing, depletion of emotionality, tendency towards omnipotence, fusion, and paranoia. Delusions are presented as the absolute truth, an irrefutable perceptual

nutosti se predstavljaju kao apsolutna istina, kao neoborivo perceptivno iskustvo pri kojem bolesnik „vidi“ i „čuje“ progonitelja ili su mu sumanutosti izvor umirenja i snage. Zbog svega toga bolesnik nema kritičnog odmaka prema sumanutosti. Sumanutosti ne mogu biti potisnute (jer nema simbolizacijske i reprezentacijske aktivnosti), nego jedino mogu biti rascijepljene ili disocirane pri čemu nije riječ o okomitoj disociranosti, kod koje jedan dio bolesnikove osobnosti nije svjestan drugog dijela, već o tome da je bolesnik svjestan i zdravog i bolesnog dijela osobnosti, ali ti dijelovi međusobno ne komuniciraju, ne integriraju se pa bolesnik oscilira od jednog do drugog stanja osobnosti. To se može nazvati bi-okularnom vizijom (ne binokularnom jer nema integracije). Sumanutosti nastoje zavesti zdravi dio i ovladati njime i teže „neprobavljivosti“. Sumanutosti napreduju u malim koracima i iznenada srastaju u naizgled konzistentnu cjelinu kao fragmenti koji su se spojili u mozaik (22). Psihotični dio ima opasnu snagu kojom uvijek može pokoriti zdravi dio, a može i zavoditi zdravi dio osobnosti nudeći mu svemoćnost ili veliku ugodu (23).

Prema Joganu (Jogan, 2017.) u psihozi je *self* krhak, nejasne su granice *selfa* i objekta, postoje simbiotski i progoniteljski odnosi i primjenjuju se primitivni mehanizmi obrane (rascjep, fragmentacija, nijekanje, projekcija, patološka projektivna identifikacija) (24).

experience whereby the patient “sees” and “hears” the persecutor, or the delusions are a source of calm and strength. Because of all this, the patient does not have a critical distance towards delusions. Delusions cannot be suppressed (because there is no symbolic and representational activity), but can only be split or dissociated, whereby this is not a dissociated vertical deviation in which the patient’s one part of the personality is not aware of the other part, but a condition in which the patient is conscious of both the healthy and the sick part of the personality, but these parts do not interact mutually, they do not integrate, and the patient oscillates from one state to another. This may be called bi-ocular vision (not binocular because there is no integration). Delusions are trying to seduce and control the healthy part and have a tendency towards “indigestibility”. Delusions progress in small steps and suddenly fuse into a seemingly consistent whole as fragments that have merged into a mosaic (22). The psychotic part has a dangerous force that can always conquer the healthy part and can also seduce the healthy part of the personality by offering it omnipotence or great comfort (23).

According to Jogan (2017), there is a fragile self in psychosis, the boundaries of the self and the object are unclear, there are symbiotic and persecutory relationships, primitive defence mechanisms (splitting, fragmentation, denial, projection, pathological projective identification) (24).

Uzrok ranih teškoća Civitarese (Civitarese, 2019.) nalazi u prevelikoj potrebi djeteta i traumatičnoj stvarnosti (nedostatku majčine alfa-funkcije). Kad majka samo reflektira djetetovu anksioznost, u djetetu nastaje bezimen užas ili psihička agonija i dijete tada introjicira reverzno mišljenje, tj. transformaciju u halucinozu koja brani psihu od veće opasnosti, tj. potpunog gubitka reprezentacija. Transformacija u halucinozu ima spektar od minimalne do maksimalne (prave halucinacije). U „blažem“ obliku očituje se kao višak konkretnosti i gubitak značenja emocija (postoji ugoda ili bol, ali bez značenja) ili kao poricanje ovisnosti o objektu u vidu superiornosti (25).

Psihotični dio osobnosti djeluje poput unutarnje patološke organizacije (koju neki autori nazivaju i unutarnjim saboterom ili unutarnjom mafijom) koja provodi sadističku tiraniju nad egom putem mučenja ili zavođenja, piše Paul Williams (Williams, 2019.). Zbog slabe internalizacije unutarnjih dobrih objekata pacijenti su ostavljeni na milost i nemilost unutarnjoj patološkoj organizaciji (26).

Lombardi (Lombardi, 2019.) također uočava podjelu na psihotični i nepsihotični dio osobnosti, gubitak testiranja realiteta, razdvojenost uma i tijela, čudnu logiku i jezik (27).

Na važnost tolerancije neizvjesnosti u terapijskoj situaciji upućuje Bion (Bion,

Civitarese (2019) finds the cause of early difficulties in a child's overwhelming need as well as in traumatic reality (mother's alpha function deficiency). When the mother is only reflecting the child's anxiety, within the child a nameless horror or psychological agony arises and the child then introjects reverse thinking, i.e. transformation into hallucination which protects the psyche from greater danger, i.e. complete loss of representations. Transformation into hallucinations has its spectrum: from minimum to maximum (true hallucination). In a "milder" form, it manifests as an excess of concreteness and a loss of the meaning of emotions (there is comfort or pain but without meaning) or as a denial of object dependence through superiority (25).

The psychotic part of the personality acts as an internal pathological organization (also called an internal saboteur or inner mafia by some authors) that exercises sadistic tyranny over the ego through torture or seduction, writes Paul Williams (2019). Due to poor internalization of good internal objects, patients are left at the mercy of the internal pathological organization (26).

Lombardi (2019) also notes the division into a psychotic and non-psychotic part of personality, loss of reality testing, separation of mind and body, and peculiar logic and language (27).

The importance of uncertainty tolerance in a therapeutic situation is addressed by Bion (2005b), who believes that the thera-

2005b), koji smatra da terapeut mora izdržati nekoherentnost bolesnikovih asocijacija dok ih ne shvati, imenuje, poveže i tako dosegne depresivnu poziciju (28).

O neizvjesnosti u terapiji piše i M. Feldman (Feldman, 2013.). Osjećaj neizvjesnosti (koji može biti potaknut i pritiscima i projekcijama pacijenta da mu terapeut ublaži strah i neizvjesnost) može poticati terapeuta da pruži interpretaciju i prije nego što shvati o čemu je na seansi riječ. To može voditi uvjeravanju pacijenta ili ponavljanju interpretacije, a to sve smanjuje terapeutovu sposobnost za otvoreno i fleksibilno stajalište prema pacijentu. Važno je da terapeut tolerira neizvjesnost (pri čemu su važni terapeutovi dobri unutarnji odnosi s primarnim objektima), da razmišlja o uzrocima uznemirujućih mentalnih stanja da bi tako obnovio svoj kapacitet za jasnije razmišljanje i razumijevanje (29).

J. F. Ghused (Ghused, 2016.) navodi da terapeut može osjećati strah kad pacijent govori o samoubojstvu i kad pokazuje znakove maligne regresije i gubitak testiranja realiteta. Osjeća strah i kad ne razumije što se događa na seansi ili neizvjesnost kad u odnosu s bolesnikom s teškim karakternim smetnjama ne zna što može očekivati na sljedećoj seansi. Terapeut u odnosu s nekim pacijentima može osjećati da je izgubio kontrolu nad svojim kapacitetom za analizu (30).

pist must withstand the incoherence of a patient's associations until they are able to understand, name, and connect them, and thereby reach the depressed position (28).

Uncertainty in therapy is also addressed by M. Feldman (2013). The feeling of uncertainty (which can be triggered by a patient's pressure and projections upon the therapist to be relieved from fear and uncertainty) may encourage the therapist to provide their interpretation before understanding the session. This can lead to persuading the patient or repeating the interpretation, all of which reduces the therapist's ability to have an open and flexible attitude toward the patient. It is important that the therapist tolerate uncertainty (whereby it is important that the therapist has good internal relationships with the primary objects) and think about the causes of distressing mental states in order to restore their capacity for clearer thinking and understanding (29).

J. F. Ghused (2016) claims that the therapist may feel fear when the patient talks about suicide, as well as when they show signs of malignant regression and loss of reality testing. They also feel fear when they do not understand what is taking place during a session or feel uncertain when they do not know what to expect in the next session with a patient having severe character disorders. In their relation with some patients, the therapist may feel that they have lost control of their capacity for analysis (30).

NOVA OTKRIĆA I PROMJENE U PRISTUPU PSIHOTIČNOM PACIJENTU

Sva otkrića u razumijevanju psihotičnih pacijenata dolazila su postupno, od kliničara koji su se bavili psihotičnim pacijentima i pokušali ih razumjeti. Posvetili su im vrijeme i prilagođavali tehniku. Tako Sullivan (Sullivan, 1931.),upućuje na dva glavna oblika tretmana: psihoanalizu uz analizu transfera (koja omogućuje emocionalni rast i reorganizaciju osobnosti) i sociopsihijatrijski program. Pacijenta treba skloniti iz konfliktne situacije. Kod hospitaliziranih pacijenata bitno je da osoblje zna da je bolesnik silno osjetljiv. Dobro je ako osoblje pomaže bolesniku u obnovi samopoštovanja ili ga razvija kod pacijenta. Potrebna je edukacija osoblja kako bi imalo dovoljno uvida u vlastitu psihičku organizaciju da može izbjeći prikriveni ili nesvjesni sadizam, ljubomoru ili nerealna očekivanja od terapije. Nikad se ne ignoriraju bolesnikove bolesne misli i ponašanja. Svi bolesnikovi ispadi smatraju se važnima, kao nešto što bi trebalo razumjeti. Kad se bolesnikovo stanje poboljša, nastoji se rekonstruirati stvarna kronologija psihoze. Terapeut treba dugo promatrati bolesnika prije nego što shvati što pacijentu stvara anksioznost (31). Terapeut identificira loše obrasce interpersonalnih odnosa. Psihotični fenomeni istražuju se u odnosu

NEW DISCOVERIES AND CHANGES IN THE APPROACH TO A PSYCHOTIC PATIENT

All gradual breakthroughs in understanding psychotic patients have come from clinicians who treated and tried to understand psychotic patients. They dedicated their time to them and adapted their technique. Sullivan (1931) thus refers to two main forms of treatment: psychoanalysis with transfer analysis (which enables emotional growth and reorganization of personality) and a socio-psychiatric program. The patient should be removed from the conflict situation. In the case of hospitalized patients, it is important that the personnel know that the patient is extremely sensitive. It is good for the personnel to assist the patient in restoring or developing self-esteem. It is necessary to educate the personnel to have sufficient insight into their own psychological organization in order to avoid covert or unconscious sadism, jealousy, or unrealistic expectations from therapy. The patient's sick thoughts and behaviours must never be ignored. All of the patient's manifestations are considered important as something that should be understood. When the patient's condition improves, an attempt is made to reconstruct the actual chronology of psychosis. The therapist must observe the patient for a long time before they can understand what is causing the patient's anxiety (31). The therapist identifies poor patterns of interpersonal relationships. Psychotic phenomena are investigated in

na važne osobe iz pacijentova života. Primjenjuju se i slobodne asocijacije. I snovi su dio analize. Interpretacije se ne forsiraju. Ako bolesnikov uvid napreduje, povremeno se mogu ponuditi interpretacije i zatražiti bolesnikov komentar na njih. Terapeut također pruža informacije pacijentu, ispravlja pogrešne informacije kojima pacijent raspolaže, ispravlja nepraktične vrijednosne sustave (dobro, loše, ispravno, pogrešno), reorganizira učinkovite bolesnikove potencijale, reintegrira disocirana i potisnuta iskustva (32).

U terapiji najprije treba reintegrirati ego, ističe Federn (Federn, 1952.), a zatim terapeut i pacijent zajedno trebaju istražiti i objasniti psihotične reakcije. U terapiji se analizira veza simptoma i traumatičnog sukoba. Svaki bolesnik mora naučiti da postoje dvije reakcije na frustraciju. Jedna je da se pobjegne od frustracije, čime se trenutačno smanjuje bol, ali to se kasnije može platiti trajnijom boli i patnjom. Druga je reakcija da se pokuša izdržati frustraciju i da se pokuša shvatiti njezin uzrok da bi se tako zagospodarilo frustracijom. Zbog bolnosti tog procesa važno je, prema Federnu, njegovati pozitivni transfer. U početku terapije terapeut prihvaća psihotične bolesnikove falsifikacije kao stvarnost. Kad bolesnik osjeti da ga terapeut shvaća, terapeut mu može pomoći da razlikuje zdravi od bolesnog dijela, da shvati da bolesni dio

relation to significant individuals in the patient's life. Free associations are also used. Dreams are a part of the analysis as well. Interpretations are not forced. If the patient's insight advances, interpretations may be offered from time to time and the patient's commentary is asked for. The therapist also provides information to the patient, corrects the patient's false information, corrects impractical value systems (good, bad, right, wrong), reorganizes effective patient potentials, and reintegrates dissociated and repressed experiences (32).

Federn (1952) points out that in therapy the ego must first be reintegrated, after which the therapist and the patient need to investigate and explain the psychotic reactions together. The therapy analyses the link between symptoms and traumatic conflict. Every patient must learn that there are two reactions to frustration. One is to escape the frustration, which momentarily reduces pain, but this might later be paid for by more lasting pain and suffering. The second reaction is to try to withstand the frustration and to try to understand its cause in order to manage the frustration. Because of the painfulness of this process, according to Federn, it is important to nurture a positive transfer. At the beginning of therapy, the therapist accepts the psychotic patient's forgery as reality. When a patient feels that they are understood by the therapist, the therapist helps them to distinguish the healthy part from the sick part in order to understand that the sick part

više nije pouzdan jer miješa fantaziju i stvarnost i pomaže mu da otkrije uzrok regresa. Najteži je dio u svakoj psihoterapiji psihoze rasvijetliti poremećeno testiranje stvarnosti. Za Federna na svakoj seansi postoji problem treba li pacijenta „gurkati" prema normalnosti (u smislu jačanja potiskivanja) ili ga suočavati sa sukobima i strahovima (8). Pri kraju razgovora pozitivne rezultate razgovora treba ponoviti u kratkim rečenicama (10).

Na važnost jezika tijela upućuje Resnik (Resnik, 1952.), jer je tijelo povezano sa psihodinamskim procesima. Resnik nastoji provesti tzv. deflaciju deluzije, koja stvara stanje duboke melankolije, tzv. narcističku depresiju (11).

U terapiji postoji velika potreba za fleksibilnošću, iskustvo je M. Little (Little, 1957.). Teži bolesnici sa sumanutostima i halucinacijama ne mogu iskoristiti transferne interpretacije jer im nedostaje simbolizacija. Jabuka, kolač i sl. mogu imati učinak poput interpretacije, a kasnije, kad se razvije kapacitet za simbolizaciju, mogu biti povezani s verbalnom interpretacijom (33). U terapiji nastaje stanje „baličnog jedinstva", kad bolesnik doživljava regresiju do potpune ovisnosti, dezintegracije, depersonalizacije i uništenja, a ego-funkcije doživljavanja i promatranja prepuštene su terapeutu. Prorada je dug i polagan posao. Potrebna je mo-

is no longer reliable because it mixes fantasy and reality and helps them to discover the cause of regress. The hardest part in any psychotherapy of psychosis is to shed light on disturbed reality testing. For Federn, in every session there is a problem of either pushing the patient toward normality (in terms of strengthening repression) or confronting them with conflicts and fears (8). At the end of the interview, the positive results of the interview must be repeated in short sentences (10).

The importance of body language is emphasized by Resnik (1952) because the body is linked to psychodynamic processes. Resnik attempts to conduct so-called delusion deflation, which in turn creates a deep melancholic state of so-called narcissistic depression (11).

Based on experience, M. Little (1957) claims that there is a great need for flexibility in therapy. Severe patients with delusions and hallucinations cannot use transfer interpretations because they lack symbolization. An apple, a cake, etc. can have a similar effect to interpretation, and later on when the capacity for symbolization develops, they may be associated with verbal interpretation (33). In therapy, a state of "basic unity" occurs when the patient experiences regression to complete dependence, disintegration, depersonalization, and annihilation, and the Ego functions of experience and observation are left to the therapist. Processing is a long-lasting and slow job. Superego

difikacija superega (17). M. Little (Little, 1990.) podsjeća da je Winnicott vjerovao da odnos osim ozbiljnoga i radnoga treba biti i ohrabrujući, ugodan, uz šale, priče i sl. Jednom ga je M. Little (koja je kod njega bila na analizi) pitala zašto je izabrao da ide u mornaricu, a on je rekao da mu je ta uniforma bolje pristajala uz njegove plave oči (34).

Modifikacija klasične psihoanalitičke tehnike nužna je u terapiji psihotičnih osoba, tvrdi Frieda Fromm Reichmann (Fromm Reichmann, 1958.). Vrijeme nuđenja interpretacija ovisi o procjeni odnosa terapeuta i bolesnika, procjeni bolesnikova kapaciteta da usvoji interpretacije i o procjeni stupnja anksioznosti koji bi interpretacija izazvala u bolesniku. Bolesniku se pomaže da ponovo proradi i procijeni svoje izobličene obrasce interpersonalnih odnosa prema drugim ljudima. Pacijenti moraju naučiti integrirati rane gubitke i shvatiti vlastiti udio u interpersonalnim teškoćama s važnim ljudima iz djetinjstva. Bolesnike treba poticati da dođu do vlastitih interpretacija jer im se tako povećava samopoštovanje. Drugim riječima, ne treba žuriti u tumačenju i dešifriranju pacijentovih nejasnih izjava, nego treba strpljivo čekati i slušati bolesnikova vlastita objašnjenja njihove izjave. Poželjno je da terapeuti pokažu svoju empatiju prema bolesnicima, ali više putem neverbalnih nagovještaja nego verbalizacijom jer previše

modification is required (17). M. Little (1990) recalls that Winnicott believed that a relationship, besides being serious and work-oriented, should also be encouraging and enjoyable, as well as contain jokes, stories, etc. M. Little (who participated in his analysis), once asked him why he chose to join the navy, and he said that its uniform better matched his blue eyes (34).

According to Frieda Fromm-Reichmann (1958), modification of the classical psychoanalytic technique is necessary in the treatment of psychotic persons. The timing of interpretations depends on: assessing the relationship between the therapist and the patient, assessing the patient's capacity to adopt interpretations, and assessing the degree of anxiety that interpretation would cause in the patient. The patient is supported in reworking and evaluating their distorted patterns of interpersonal relationships with other people. Patients need to learn to integrate early losses and understand their own part in interpersonal difficulties with important people from their childhood. Patients should be encouraged to come up with their own interpretations as this increases their self-esteem. In other words, one should not rush into interpreting and decoding a patient's ambiguous communication, but rather wait patiently and listen to the patient's own explanations of their communication. It is preferable for therapists to show their empathy for patients but more through non-verbal hints than

otvorene izjave mogu pojačati strah od bliskosti. Bolesnici interpretiraju ljubav prema njima kao dokaz da nisu tako loši (agresivni) u očima terapeuta kao što bolesnici osjećaju da jesu. I halucinacije i sumanutosti često su podložne psihoterapiji. Frieda Fromm Reichmann otvoreno kaže bolesnicima da ne dijeli njihovo halucinatorno ili sumanuto iskustvo. Ona ne preporučuje tumačenje snova iako navodi autore koji s tim imaju dobra iskustva (12).

Kronični shizofreni bolesnik u terapiji ima potrebu za simbiotskim odnosom s terapeutom, smatra Searles (Searles, 1963.). U toj je fazi pacijent nesposoban za primitak i obradbu verbalnih transfernih interpretacija jer je organizacija njegova ega još preslaba i na vrlo primitivnom stupnju. Tek kad pacijent dođe do većeg stupnja diferencijacije i integracije, moguće su i pacijentu prihvatljivije transferne interpretacije (35). Terapeut je pod velikim pritiskom da preuzme ulogu učitelja ili savjetnika. Bolesnik s vremenom postaje dovoljno jak da integrira prethodni psihotični doživljaj u svoj identitet. Pojavljuje se i pitanje stvarnosnog odnosa pacijenta i terapeuta (36).

Bolesniku ne možemo oduzeti sumanutosti dok ih on još treba jer mu to može biti jedina obrana od veće dezintegracije i ne možemo mu pomoći objašnjavajući mu simboliku njego-

through verbalization because overstatements can heighten fears of closeness. Patients interpret love towards them as evidence that they are not as bad (aggressive) in the therapist's eyes as they (the patients) felt they were. Both hallucinations and delusions are often accessible to psychotherapy. Frieda Fromm-Reichmann openly tells her patients that she does not share their hallucinatory or delusional experience. She does not recommend working with dreams, although she quotes authors who have good experiences with them (12).

According to Searles' experience (1963), in therapy, a chronic schizophrenic patient has a need for a symbiotic relationship with the therapist. At this stage, the patient is incapable of receiving and processing verbal transfer interpretations because their Ego organization is still too weak and at a very primitive stage. Only when a greater degree of differentiation and integration is achieved by the patient are transference interpretations possible and more acceptable by the patient (35). The therapist is under great pressure to take on the role of teacher or advisor. Over time, the patient becomes strong enough to integrate an earlier psychotic experience into their identity. The question of the reality of the relationship between the patient and the therapist also arises (36).

S. Arieti claims (1974, 1989) that the patient cannot be deprived of delusions while they still need them, as this may

vih simptoma, navodi S. Arieti (Arieti, 1974., 1980.). Arieti nastoji promijeniti bolesnikovu sliku o sebi, razviti kod bolesnika osjećaj vlastite vrijednosti, individualnost i samopotvrđivanje (uz brigu za drugoga i sl.). Cilj je terapije razviti odnos, „napasti" psihotične simptome (čiji je izvor projicirana loša slika o sebi), shvatiti psihodinamiku problema, psihodinamiku loših odnosa u obitelji i razviti zdravije obrasce funkcioniranja (37, 38).

Pišući o tehnici terapije pacijenta sa psihozom, Schulz (Schulz, 1983.) navodi da treba izbjegavati stereotipnu tehniku. Terapeut treba biti emocionalno uključen, iskren, tolerirati neizvjesnost i različite kontratransferne osjećaje, poštovati bolesnikov tempo, njegovu potrebu za distancom, razgovarati i o sumanutom sadržaju te biti oprezan kod interpretiranja disociranog materijala. Ponekad neerotski tjelesni dodir može smanjiti bolesnikovu napetost. Terapeut radi i sa zdravim i s bolesnim dijelom osobnosti, nudi odnos i uvid, educira bolesnika i potiče ga da pokuša registrirati svoje osjećaje i misli, suočava ga sa sumanutostima, traži uzroke psihotičnog regresa u teškim osjećajnim stanjima koja su mu prethodila, prorađuje psihotične sadržaje i strah od promjene (39).

I Giovacchini (Giovacchini, 1983.) smatra da ne treba žuriti s uklanjanjem

be their only defence against greater disintegration, and that we cannot help the patient by explaining to them the symbolism of their symptoms. Arieti strives to change the patient's self-image, to develop in them a sense of self-worth, individuality, and self-affirmation (while caring for others, etc.). The goal of the therapy is to develop a relationship, to attack psychotic symptoms (the source of which is a poor projected self-image), to understand the psychodynamics of the problem, to understand the psychodynamics of poor relationships in the family, and to develop healthier patterns of living (37,38).

While writing about the therapeutic technique for a patient with psychosis, Schulz (1983) states that the stereotype technique should be avoided, the therapist should be emotionally involved, honest, tolerate uncertainty and different countertransference feelings, respect the patient's pace and their need for distance, talk about delusional content, and be careful when interpreting dissociative material. Sometimes non-erotic physical contact can reduce a patient's tension. The therapist works with both the healthy and the sick part of the personality, offers relationship and insight, educates the patient to try to register their feelings and thoughts, confronts the patient with delusions, looks for the causes of psychotic regression in severe emotional states that preceded it, and elaborates psychotic content and fear of changes (39).

sumanutosti i halucinacija jer one omogućuju koheziju *self*-reprezentacije (40).

Terapijski pristup bez promjene klasične psihoanalitičke tehnike predlaže Rosenfeld (Rosenfeld, 1988.), čak i u terapiji s akutnim halucinirajućim shizofrenim bolesnicima, ali (ipak) u zaštićenoj bolničkoj sredini. Rosenfeld, Segal i Bion radili su na takav način (41).

Ogden (Ogden, 1992.) razlikuje četiri faze u terapiji shizofrenog bolesnika: fazu nedoživljavanja, fazu projektivne identifikacije, fazu psihoze i fazu simboličnog mišljenja (sposobnosti da se misli o svojim mislima) (19).

Osvrćući se na terapiju psihotičnog bolesnika, De Masi (De Masi, 2001.) ističe da u interpretaciji treba ukazivati na borbu psihotičnog i nepsihotičnog dijela osobnosti. Potreban je „uvremenjen" i taktičan opis patogenih funkcija psihotične fantazije, npr. približavanjem bolesniku kako mu sumanutost može laskati da je superiorna osoba. Transfer se interpretira kad se pojavi. Najveća opasnost za terapiju jest psihotični transfer. Potrebno je stalno opisivati bolesniku inverziju alfa-funkcije, tj. zbivanje pri kojem se misli pretvaraju u osjetilne doživljaje (npr. vidne i slušne). U analizi je važno doći do faze u kojoj nepsihotični dio može „vidjeti" psiho-

Giovacchini (1983) also believes that the elimination of delusions and hallucinations should not be rushed because they provide coherence to self-representation (40).

A therapeutic approach without modification of the classical psychoanalytic technique is proposed by Rosenfeld (1988), even in therapy with acute hallucinating schizophrenic patients but (still) in a protected hospital setting. Rosenfeld, Segal and Bion worked this way (41).

Ogden (1992) distinguishes four stages in the treatment of schizophrenic patients: the phase of not experiencing, the phase of projective identification, the phase of psychosis, and the phase of symbolic thinking (the ability to think about one's own thoughts) (19).

Referring to the therapy of the psychotic patient, De Masi (2001) points out that interpretation should point to the struggle of the psychotic and non-psychotic part of the personality. A timely and tactical description of the pathogenic functions of psychotic fantasy is needed, e.g. by explaining how insanity can flatter a patient to be a superior person. The transfer is interpreted when it occurs. The greatest danger for therapy is psychotic transfer. It is necessary to constantly describe the inversion of the alpha function to the patient, i.e. that thoughts are converted into sensory experiences (e.g. visual and auditory). In the analysis, it is important to reach a stage where the non-psychotic part can "see" the psy-

tičnu konstrukciju bez užasa i bježanja. Potrebno je razvijati pravi *self* jer su sumanutosti nepogodne za proradu dok se ne razvije prava osobnost. Potrebna je dekonstrukcija psihotičnog svijeta, koja je i važnija od interpretacije koju bolesnik ne razumije (42).

Za bolesnika sa psihozom analitički prostor nije samo prostor rada nego i mjesto gdje može rasti i bez rada ili s malo rada, kao prostor kuće za malo dijete, smatra A. L. S. Silver (Silver, 2005.). Liječenje pacijenata sa psihozom treba biti ispunjeno optimizmom, zaigranošću, željom da se razumije iskustvo drugoga. Terapiju opterećuju: autoritet, superiorni intelekt, teorija i akademska postignuća (43).

Neke pacijente sa psihozom Volkan (Volkan, 2010.) je liječio i na kauču, nakon prethodnoga pripremnog razdoblja. Terapeut bi trebao razmotriti primjenu parametara koji će izlaziti iz okvira psihoanalize u uskom smislu što uključuje i neke aktivnosti izvan rada s pacijentom dok leži na analitičkom kauču. Dva su stila terapije: jedan je oprezniji, da ne bi došlo do predubokog regresa pacijenta, i kod njega se više primjenjuju elementi potpore. Kod drugog stila terapeut ne sprječava duboku regresiju u kojoj pacijenti doživljavaju privremenu transfernu psihozu (fragmentacija i/ili fuzija reprezentacija *selfa* i objekta). Terapeut nastavlja proradu bolesniko-

chotic construction without horror and running away. It is necessary to develop a true self because delusions are unsuitable for processing until the true personality is developed. The deconstruction of the psychotic world is needed, which is even more important than the interpretation which the patient does not comprehend (42).

For the patient with psychosis, the analytic space is not only a work space but also a place where one can grow without work or with little work, as a home space for a young child, according to the experiences of A. L. S. Silver (2005). The treatment of patients with psychosis should be filled with optimism, playfulness, a desire to understand the experience of another. Therapy is burdened with authority, superior intellect, theory, and academic achievements (43).

Volkan (2010) has also treated some patients with psychosis on the couch after a preparatory period. The therapist should consider using parameters that will go beyond the scope of psychoanalysis in a narrow sense, which also includes some activities beyond working with a patient only while they are lying on the analytical couch. There are two types of therapy: one is more cautious, so that the patient does not regress deeply, and uses more supportive elements. In the second style, the therapist does not prevent deep regression of the patient in which patients experience temporary transfer psychosis (fragmentation and/or fusion

va psihotičnog transfera s nadom da će bolesnik moći uspostaviti novu i zdraviju strukturu osobnosti. Odlučujući je čimbenik za odabir prvog ili drugog stila terapeutov osjećaj koliko će moći tolerirati kontratransferne probleme dok radi s takvim bolesnikom. Kod drugog stila terapije problem može biti generalizacija prethodno lokalizirane transferne psihoze. To znači da pacijent koji je bio paranoidan prema terapeutu može postati paranoidan i u situacijama izvan analitičkog okvira. U takvim situacijama, ako je pacijent dotad ležao na kauču, seansa se može nastaviti sjedeći *vis-a-vis* uz terapeutove intervencije kojima nastoji povratiti testiranje realiteta, npr. malo dulje objašnjenje dotad prorađivanog materijala uz upućivanje na razlikovanje fantazijskog i stvarnog, uz podsjećanje da je terapeutov ured sigurno mjesto za razgovor koji se odnosi na fantazije u vezi s djetinjstvom i slično (21).

Kafka (Kafka, 2011.) ukazuje na potrebu za suradnjom s bolesnikovim nepsihotičnim dijelom osobnosti na terapiji. Istražuju se konflikt između želje za kontaktom i straha od kontakta, bolesnikov psihotični svijet, analiziraju se transfer i kontratransfer, primjenjuje se prilagođeni psihoanalitički pristup u slučajevima psihotične krize (44).

Kod teških bolesnika problem nije samo u konfliktu nego i u deficitu, Jo-

of self and object representation). The therapist continues to work on the patient's psychotic transfer with the hope that the patient will be able to organize a new and healthier structure. The deciding factor for choosing the first or second style is the therapist's sense of how much they will be able to tolerate countertransference problems while working with such a patient. In the second style of therapy, the generalization of previously localized transfer psychosis may be a problem. This means that a patient who has been paranoid towards the therapist may become paranoid in other situations beyond the setting as well. In such situations, if the patient has been lying on the couch until then, the session may continue while sitting face to face with the patient, with the therapist's interventions that seek to return to reality testing, e.g. through a slightly longer elaboration of the material worked up to that point, followed by encouragements to distinguish between fantasy and reality, with the reminder that the therapist's office is a safe place to talk about childhood fantasies and similar content (21).

In therapy, Kafka (2011) points to the need for cooperation with the patient's non-psychotic part of personality, investigating the conflict: contact and fear of contact, the patient's psychotic world is investigated, transference and countertransference are analysed, in cases of psychotic crisis modified psychoanalytic approach is used (44).

ganovo je iskustvo (Jogan, 2017.). Zato terapeut mora imati dvostruku ulogu: i transfernog objekta i novog objekta, i mora neprestano prelaziti iz jedne pozicije u drugu. U pristupu takvim pacijentima ne smijemo biti rigidno profesionalni jer to za njih može biti vrlo frustrirajuće i može izazvati zavist. Treba primijeniti ljudskiji pristup; terapeut treba biti sposoban priznati neku vlastitu slabost kako bi se lakše približio tim bolesnicima. Terapeut može primjenjivati i samootkrivanje u smislu otkrivanja vlastita kontratransfernog doživljaja, ponekad može izravno odgovoriti na konkretno pitanje ili prepričati neku zgodu iz svojeg života koja je povezana s pacijentom i njegovim iskustvom. Takvi pacijenti teško izdržavaju veće emocionalno opterećenje pa terapeut treba pozorno pratiti bolesnikove reakcije na njegove intervencije. Primarna je izgradnja dobrog emocionalnog odnosa, nakon koje se terapeut bavi i transfernom dinamikom, a rad na uvidu moguć je tek povremeno, kad je bolesnik već dovoljno strukturiran. Treba obratiti pozornost na okolnosti koje su dovele do pojave psihoze. Što se tiče analitičkog okvira, Jogan počinje sa seansama jedanput tjedno (24).

Lombardi (Lombardi, 2019.) na terapiji osim poticanja samopromatranja radi uvida u psihotični dio osobnosti i poticanja testiranja realiteta nastoji

Jogan (2017) finds that with severe patients, the problem is not only in conflict but also in deficit, which is why the therapist must have a dual role: both that of the transferring object and of the new object, and they must constantly move from one position to another. We must not be rigidly professional in approaching such patients (as this can be very frustrating for them and can cause envy), we must use a more humane approach and be able to acknowledge some of our own weaknesses so that we can approach these patients more easily. The therapist can also use self-disclosure to open up some of their countertransference experiences, sometimes they can directly answer a specific question or can relate a story from their life that is related to the patient and their experience. Such patients find it difficult to withstand great emotional burden, and therefore the therapist should closely monitor the patient's reactions to the therapist's interventions. The primary goal is to build a good emotional relationship, following which the therapist deals with the transfer dynamics, while work on insight is possible only occasionally, when the patient is already sufficiently structured. The circumstances that led to the onset of psychosis should be observed. Regarding setting, Jogan starts with weekly sessions (24).

In therapy, in addition to stimulating self-observation for insight into the psychotic part and for stimulating reality testing, Lombardi (2019) seeks to enhance

pojačati vezu uma i tijela sanjarenjem o tjelesnim stanjima, koja povezuje s emocijama, mislima i odnosom. U kontratransferu treba izdržati neizvjesnost (27).

Važno je sklopiti savez s pacijentovim nepsihotičnim dijelom osobnosti, smatra P. Williams (Williams, 2019.). Treba graditi emocionalni odnos s pacijentom jer to slabi unutarnju patološku organizaciju. Potrebno je nastojati što bolje razumjeti psihotični i nepsihotični dio osobnosti i osvijestiti bolesniku kako psihotični dio provodi sadističku tiraniju nad nepsihotičnim dijelom osobnosti (26).

Kao i Sullivan, Blechner (Blechner, 2019.) se usmjeruje na intenzivno istraživanje razdoblja koji je neposredno prethodio prvom psihotičnom slomu. Traže se povrede samopoštovanja. Važni su detalji i dosljednost priče (45).

Civitarese (Civitarese, 2019.) ukazuje na to da je tehnika rada s teškim pacijentima potpuno drugačija od klasične frojdovske tehnike. Umjesto reflektiranja (zrcaljenja), terapeut treba biti reflektivan, tj. iskoristiti svoju alfa-funkciju da pruži smisao i značenje bolesnikovim ranim preverbalnim i prereflektivnim doživljajima. Terapeut kontejnira i sanjari o bolesniku, otkriva i imenuje emocije te tako pomaže bolesniku da razvije kapacitet za mišljenje.

the mind-to-body connection through daydreaming of physical conditions that he associates with emotions, thoughts, and relationships. Within countertransference, uncertainty should be withstood (27).

According to P. Williams (2019), it is important to make an alliance with the patient's non-psychotic part of the personality to build an emotional relationship with the patient as this weakens the internal pathological organization. Efforts should be made to understand as much as possible the psychotic and non-psychotic part of the personality and to make the patient aware that the psychotic part exercises sadistic tyranny over the non-psychotic part of the personality (26).

Like Sullivan, Blechner (2019) focuses on the intense exploration of the period that immediately preceded the first psychotic breakdown. Self-esteem violations are sought. Details and consistency of the story are important (45).

Civitarese (Citivarese, 2019) indicates that the technique of working with severe patients is completely different from the classical Freudian technique. Instead of reflecting (mirroring), the therapist should be reflective, i.e. the therapist should use their alpha function to provide sense and meaning to the patient's early pre-verbal and pre-reflective experiences. The therapist uses their containing function and daydreaming in relation to the patient, identifies and

Bolesnikove slike (halucinacije) treba razviti pričom i simbolizacijom. Što je sanjarenje više senzorno i halucinatorno, to više zahvaća ranije neverbalne bolesnikove doživljaje. Sanjarenje nije korisno samo kod bolesnika sa psihozom i autizmom nego i kod pacijenata s perverzijom, ovisnošću, somatizacijama i neafektivnim stanjima. Terapeut ne treba biti šutljiv, nego stalno treba biti živ, zainteresiran, budan i empatičan objekt koji poštuje bolesnika i koji ne bi trebao imati preambiciozan terapijski cilj (25).

U našoj zemlji (Urlić, 2009., 2010., Štrkalj-Ivezić, 2008., 2017., Restek-Petrović, 2014., 2019., Tošić, 2019.) također se primjenjuje psihodinamički pristup u terapiji pacijenata sa psihozom, najčešće u obliku izmijenjenoga grupnoanalitičkog tretmana (46 – 52). Psihodinamička znanja primjenjuju se i u raznim psihosocijalnim postupcima, npr. terapijskoj zajednici, psihoedukaciji (učenju o bolesti, lijekovima i zdravim stilovima života), obiteljskoj terapiji, treningu socijalnih vještina, na kreativnim terapijama (*art*-terapiji, muzikoterapiji, terapiji plesom i pokretom, psihodrami) (51).

Bolesnik pomoću terapije treba naučiti prihvatiti i integrirati činjenicu da je imao psihozu. Svaki terapeut mora pronaći vlastiti stil u psihoterapijskom pristupu shizofrenom bolesniku (13).

names the emotions and thus helps the patient to develop the capacity for thinking. The patient's images (hallucinations) should be developed through storytelling and symbolization. The more sensory and hallucinatory the daydreaming, the more it captures the patient's earlier non-verbal experiences. Daydreaming is not only useful for patients with psychosis and autism but also for patients with perversion, addiction, somatization, and non-affective states. The therapist does not need to be silent but should be a constantly lively, interested, alert, and emphatic object who respects the patient and who should not have an excessively ambitious therapeutic goal (25).

In our country (Urlić 2009, 2010, Štrkalj-Ivezić 2008, 2017, Restek-Petrović 2014, 2019, Tošić 2019), a psychodynamic approach is also used in the treatment of patients with psychosis, most often through modified group analysis treatment (46-52). Psychodynamic knowledge is also used in various psychosocial procedures, e.g. therapeutic community, psychoeducation (learning about illnesses, medicines, and healthy lifestyles), family therapy, social skills training, creative therapies (art therapy, music therapy, dance and movement therapy, psychodrama) (51).

Through therapy, the patient should learn to accept and integrate the fact that they have had psychosis. Each therapist must find their own style in the psychotherapeutic approach to a schizophrenic patient (13).

ZAKLJUČAK

Psihodinamika psihotičnih poremećaja razlikuje se od psihodinamike neurotskih poremećaja. Kod psihoze su na djelu slabost ega u obliku rascjepa ega na psihotični i nepsihotični dio, nestabilne *self*- i objekt-reprezentacije, slabost granica ega, gubitak testiranja realiteta, strah od nestajanja (anihilacije), slabost simbolizacije, konkretizacija, blokada emocionalnosti, primitivni mehanizmi obrane, jačanje ida, primarno, jačanjem agresivnosti, i sadistički superego.

U terapiji se može primjenjivati prilagođeni ili modificirani psihoanalitički pristup ili u širem smislu psihodinamski pristup. Važno je prihvatiti da razni oblici pacijentovog ponašanja imaju određeno psihičko značenje. Potrebno je dugo promatrati bolesnika da bi ga se razumjelo. U terapiji se nastoje otkriti loši obrasci interpersonalnih odnosa i značenje psihotičnih simptoma u odnosu na te obrasce. Trebalo bi pomoći pacijentu u razlikovanju zdravog i bolesnog dijela osobnosti te reintegrirati disocirana i potisnuta iskustva.

Potrebno je graditi odnos s pacijentom. Terapeut je pacijentu transferni, ali i novi objekt koji treba biti emocionalan, iskren, poštovati bolesnikov tempo i potrebu za distancom, koji može priznati svoju slabost, ispripovijedati neku situaciju iz svojeg života, odgovoriti na neka

CONCLUSION

The psychodynamics of psychotic disorders differ from the psychodynamics of neurotic disorders. In psychosis, the following are at work: Ego weakness in the form of an Ego split into a psychotic and a non-psychotic part, unstable self representation and object representation, weakness of Ego boundaries, loss of reality testing, fear of disappearing (annihilation), weakness of symbolization, concretization, blocking of emotionality, primitive defence mechanisms, strengthening of the Id, primarily through reinforcing aggressiveness, and a sadistic super Ego. A modified psychoanalytic approach, or more broadly a psychodynamic approach, may be used in therapy. It is important to accept that many patients' manifestations have some psychological meaning. One needs to observe the patient for a long time in order to understand them. In therapy, therapists try to identify poor patterns of interpersonal relationships and the significance of psychotic symptoms in relation to these patterns. One should help the patient distinguish between a healthy and a sick part of the personality and reintegrate dissociated and repressed experiences. It is necessary to build a relationship with the patient. The therapist is a transference object to the patient, but also a new object that needs to be emotional, honest, respect the patient's pace and need for distance, who can acknowledge some of their own weaknesses, talk about some experience from their own life, and

bolesnikova pitanja. Poželjno je izbjegavati autoritativnost, moraliziranje i postavljanje visokih terapijskih ciljeva.

Kad je regres dubok i kad nema verbalizacije, važno je pokušati razumjeti pacijenta putem njegova neverbalnog, tjelesnog izražavanja, a ako je ono oskudno, osluškivanjem svojeg kontratransfera. Kod slabe simbolizacije terapeut bi trebao pokušati pomoću svoje alfa-funkcije osmisliti pacijentovo konkretno izražavanje.

Neki autori smatraju da se jedino putem tzv. temeljnog jedinstva ili terapijske simbioze može postići važniji terapijski pomak u terapiji pacijenta sa psihozom.

Bolesnik na terapiji treba naučiti prihvatiti i integrirati činjenicu da je imao psihozu.

answer some of the patient's questions. It is desirable to avoid authoritativeness, moralizing, and setting excessively high therapeutic goals.

When regression is profound and there is no verbalization, it is important to try to understand the patient through their non-verbal, physical manifestations, and if these are scarce, then by listening to one's own countertransference. In case of poor symbolization, the therapist should try to design the patient's specific manifestations using their alpha function.

Some authors think that a more significant therapeutic shift in the therapy of a patient with psychosis can only be achieved through so-called basic unity or therapeutic symbiosis.

Therapy should help the patient learn to accept and integrate the fact that they had psychosis.

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