PSIHOANALITIČKI KONCEPTI U PSIHOSOMATICI

/ PSYCHOANALYTIC CONCEPTS IN PSYCHOSOMATICS

Zvonimir Paštar

SAŽETAK/*ABSTRACT*

U ovom su radu prikazani psihodinamski koncepti u psihosomatici koji se u literaturi dijele na homogeni i heterogeni model. Čikaška psihosomatska škola konceptualno je bliže homogenom modelu. Utemeljitelj te škole bio je Franz Alexander i slijedila je princip kontinuiteta tijela i psihe, a bliže je heterogenom modelu pariška psihosomatska škola koja polazi od diskontinuiteta tijela i psihe. Najvažniji predstavnici te škole bili su Ziwar, Marty, Fain, de M'uzan i drugi. U radu se detaljnije elaborira pariška psihosomatska škola s obzirom na činjenicu da je taj model prisutniji na europskome tlu. Objašnjeni su i temeljni pojmovi važni za razumijevanje pariškoga psihosomatskog koncepta kao što su: automatsko-mehanicistički način mišljenja (franc. *pense operatoire*), reduplikacija, nedostatak fantazije i aleksitimija. Osim toga, objašnjen je i ekonomski koncept organizacije i reorganizacije u psihosomatskog pacijenta.

/ This paper presents the psychodynamic concepts in psychosomatics, which are divided into homogeneous and heterogeneous models in the literature. The Chicago Psychosomatic School is conceptually closer to the homogeneous model, and its founder, Franz Alexander, followed the principle of continuity of body and psyche, while the one closer to the heterogeneous model is the Paris Psychosomatic School which is based upon the discontinuity of body and psyche, and its most important representatives were Ziwar, Marty, Fain, de M'uzan and others. In this paper, the Paris Psychosomatic School is elaborated in more detail, considering the fact that this model is more present in Europe. The basic terms important for understanding the Paris psychosomatic concept are also explained, such as the following: automatic-mechanistic way of thinking (pense operatoire), reduplication, lack of fantasy and alexithymia. In addition, the economic concept of organization and reorganization in the psychosomatic patient is explained.

KLJUČNE RIJEČI / *KEY WORDS*

psihosomatika / *psychosomatics*, psihodinamika / *psychodynamics*, čikaška psihosomatska škola / *Chicago Psychosomatic School*, pariška psihosomatska škola / *Paris Psychosomatic School*

Zvonimir Paštar, prim. dr. med., psihijatar, psihoanalitički psihoterapeut, Zavod za psihoterapiju, Klinika za psihijatriju Vrapče, Zagreb. *E-mail:* zvonimirpastar@gmail.com

/ Primarius Zvonimir Paštar, *MD, psychiatrist, psychoanalytic psychotherapist, Department for Psychotherapy, University Psychiatric Hospital Vrapče, Zagreb. E-mail: zvonimirpastar@gmail.com*

UVOD

Prikaz psihoanalitičkih koncepata psihosomatike može se započeti Freudovim doprinosom koji je razlikovao dvije forme neuroze s izraženom somatikom: psihoneurozu i aktualnu neurozu. Pri tome je po strani ostavljao tjelesne bolesti, tj. prepuštao ih je internistima. Kod psihoneuroze je uzrok u psihološkom, npr. zbog nepoželjnih nagonskih impulsa. Pri aktualnoj neurozi uzroci su tjelesne prirode i pojavljuju se vegetativni simptomi. Dakle, Freud je bio oprezan glede povezivanja tijela i psihe. Upravo na temelju toga možemo govoriti o formiranju koncepata u psihosomatici koji se, prema njemačkoj literaturi (1), mogu svrstati u dva modela: homogeni i heterogeni.

Za homogeni je model specifično monističko poimanje poveznica tijela i psihe, što ima svoje posljedice u terapiji. Ovdje treba spomenuti autore kao što su G. Groddeck (2,3) i M. Klein, koji psihosomatske poremećaje poimaju kao varijante konverzivne histerije. Dakle, nesvjesne fantazije i emocionalni konflikti „materijaliziraju" se kroz tijelo. H. H. Wolf (4) postulira: „Psihosomatski simptomi su način kako se potisnute fantazije, nagonski impulsi i konflikti izražavaju tjelesnim jezikom jer im nije omogućeno izraziti se psihološkim jezikom." Psihosomatski poremećaji nemaju, u sklopu ovog mode-

INTRODUCTION

The presentation of psychoanalytic concepts of psychosomatics can begin with Freud's contributions, who distinguished two forms of neuroses with pronounced somatics: psychoneurosis and actual neurosis. In doing so, he set physical illnesses aside, i.e. he left them to internists. In case of psychoneurosis, the cause is psychological, for example due to undesirable instinctive impulses. In case of actual neurosis, the causes are of a physical nature, and vegetative symptoms appear. Freud was, therefore, cautious about connecting the body and the psyche. Based precisely on this, we can talk about the formation of concepts in psychosomatics, which according to German literature (1) can be classified into two models: homogeneous and heterogeneous.

A monistic understanding of the links between the body and the psyche is specific for the homogeneous model, which has its consequences in therapy. Authors such as G. Groddeck (2, 3) and M. Klein who understand psychosomatic disorders as variants of conversion hysteria should be mentioned here. Unconscious fantasies and emotional conflicts, therefore, "materialize" through the body. H. H. Wolf (4) postulates the following: "Psychosomatic symptoms are a manner in which repressed fantasies, instinctual impulses and conflicts are expressed through body language, given that they are not allowed to be expressed through psychological language". Within the

la, strukturnu specifičnost. Groddeck je smatrao kako id upravlja svime, i psihom i tijelom, a simptomi svih bolesti, pa i tjelesnih, kako je tvrdio, simboli su ekspresije pulzija iz ida. Dakle tijelo i psiha dvije su forme istoga ida bez zasebnih zakonitosti.

Franz Alexander (1891. – 1964.), rođen u Budimpešti, nakon završetka edukacije u Berlinskom psihoanalitičkom institutu, gdje je bio prvi student, 1930. godine odlazi u SAD, gdje osniva čikašku psihosomatsku školu. On se konceptualno udaljio od Groddecka smatrajući da su somatski poremećaji odvojeni od psihičkih, svaki imaju zasebne modele funkcioniranja, te je potrebna i zasebna dijagnostika. On je inače najvažniji predstavnik „psihofiziološke" faze razvoja psihosomatike. Njegovo se učenje udaljilo od Groddeckova, ali se nije potpunosti distancirao od njega. Naime, ipak je smatrao kako su tijelo i psiha u kontinuitetu, pregenitalne nagonske konflikte smatrao je osnovom patogenog djelovanja pri psihosomatskim zbivanjima smatrajući da kod psihoneuroza dolazi do ekspresije oralne i analne nagonske pulzije. U osnovi, Alexander je smatrao da uvijek postoji neurotska pozadina kod vegetativnih i organskih neuroza, ti su oblici neuroza afektivni korelati stukturnoga neurotskoga nagonskog konflikta, tj. tjelesne komponente jednoga simultanoga psihosomatskog događaja. Nadalje, Alexander

framework of this model, psychosomatic disorders do not have structural specificity. Groddeck believed that the id governs everything, both the psyche and the body, and according to him, the symptoms of all diseases, including the physical ones, are symbols of the expression of impulses from the id. The body and the psyche are, thus, two forms of the same id without separate regulations.

Franz Alexander (1891 – 1964) was born in Budapest and after his education at the Berlin Psychoanalytical Institute, where he was the first student, in 1930 he left for the USA where he founded the Chicago Psychosomatic School. He conceptually distanced himself from Groddeck, considering that somatic disorders are separate from the psychological, that each has their separate models of functioning and requires a separate diagnosis. He is also the most important representative of the "psychophysiological" phase of psychosomatics development. His teaching moved away from Groddeck's, but he did not completely distance himself from it. Namely, he still believed that the body and the psyche are in continuity, he considered pregenital instinctual conflicts to be the basis of pathogenic action in psychosomatic events, believing that an expression of oral and anal instinctual impulses occurs in psychoneurosis. Basically, Alexander considered that there is always a neurotic background in vegetative and organic neuroses, that these forms of neuroses are affective correlates of

se nije oslanjao na strukturne aspekte kao što su nedostatak fantazije i unutrašnja praznina, niti je s pomoću regresije ega na razinu primarnog procesa objašnjavao nastanak psihosomatskih simptoma (5). S obzirom na to da nije ulazio dublje u analizu ega psihosomatskih simptoma, nije ni došao do strukturnih defekata i manjkavosti funkcije ega, koje Stephanos (6) opisuje kao „psihosomatski fenomen i regresiju na automatistično-mehanicistički način mišljenja". Za Alexandera nije bilo relevantno to što takvi pacijenti nisu sposobni uspostavljati valjane kontakte, tj. Alexander nije toliko obraćao pažnju na posebnu kvalitetu objektnih odnosa takvih pacijenata. On se u svojem nauku prije svega oslanjao na karakterne osobine pacijenata koje su produkt psihoseksualnog razvoja koji pak nije tekao adekvatno. A tomu je najviše pridavao važnost jer je upravo neadekvatan psihoseksualni razvoj opservirao kao najčešću pojavu u pacijenata u kojih je došlo do neurotske dekompenzacije s pojavom psihosomatskog simptoma. Stoga je čikaška škola zastupala tezu o kontinuitetu između psihe i some, dakle nema diskontinuiteta između psihičkog događaja i tjelesnog simptoma, kao što je to slučaj u pariškoj psihosomatskoj školi. Ego ne dekopmnenzira, ne dolazi do „smjene moći" sa psihičkog na tjelesno. Od nešto recentnijih predstavnika čikaške škole treba spomenuti Joycea McDougalla i Christopha Dejoursa (7).

structural neurotic instinctive conflict, i.e. a physical component of a simultaneous psychosomatic event. Furthermore, Alexander did not rely on structural aspects such as lack of fantasy or internal void, nor did he explain the emergence of psychosomatic symptoms through the regression of ego to the level of the primary process (5). Since he did not delve deeper into the analysis of the ego of psychosomatic symptoms, he did not reach the structural defects and deficiencies of the ego function either, which Stephanos (6) describes as a "psychosomatic phenomenon and regression to an automatistic-mechanistic way of thinking". For Alexander, it was not relevant that such patients are not capable of establishing valid contacts, i.e. Alexander did not pay so much attention to the special quality of these patients' object relations. In his study, he primarily relied on the character traits of the patients, which are the product of psychosexual development that did not develop adequately. He also attached the most importance to this because he observed that inadequate psychosexual development was the most common phenomenon in patients who experienced neurotic decompensation with the appearance of psychosomatic symptoms. The Chicago School, therefore, advocated the thesis of continuity between the psyche and the soma, stating that there is no discontinuity between a psychic event and a physical symptom, as is the case with the Paris Psychosomatic School. The ego does not decompensate, there is no "change

A. Mitscherlich (8) i M. Schur (9) konceptualno su se razlikovali od Alexandera po tome što su potupno relativizirali neurotski konflikt kao najvažniji patogeni čimbenik u razvoju psihosomatkih poremećaja. U prvi je plan stavljen ego sa svojom funkcijom i strukturom, osim toga, pitanje ekonomije također je stavljeno u prvi plan. Time se utire put odvajanju neuroze od psihosomatskoga zbivanja, što je heterogeni model koncepta u psihosomatici. Ovamo pripada i pariška psihosomatska škola, koja se konceptualno oslanjala na Freudov pojam aktualne neuroze, ali i na Freudova promišljanja o traumatskoj neurozi. Autori pariške psihosomatske škole (Ziwar, Marty, Fain, de M'uzan, David, Sami-Ali, Schur, Stephanos) stavljaju naglasak na aspekt diskontinuiteta, prema kojemu psihosomatski simptom nema izravnu poveznicu sa psihičkim konfliktom. Osim toga, stavlja se naglasak na to da napori i napetosti izravno djeluju na ljudsko tijelo, bez posredništva psiholoških mehanizama. Ti napori i napetosti izazivaju tjelesne reakcije koje s vremenom mogu prijeći u prave organske lezije. Psihosomatski simptom nije kompromisna tvorba nastala zbog djelovanja različitih instancija ličnosti, npr. želje iz ida nasuprot zabranama iz superega. Psihosomatika stoga ima svoju strukturnu specifičnost.

of power" from the psychological to the physical. Among the more recent representatives of the Chicago School, we should also mention Joyce McDougall and Christoph Dejours (7).

A. Mitscherlich (8) and M. Schur (9) conceptually differed from Alexander in their complete relativization of the neurotic conflict as the most important pathogenic factor in the development of psychosomatic disorders. The ego with its function and structure is placed in the foreground, and so is the issue of economy. This paves the way for the separation of neurosis from psychosomatic events, which represents a heterogeneous concept model in psychosomatics. The Paris Psychosomatic School also belongs here, conceptually relying on Freud's notion of actual neurosis, but also on Freud's reflections on traumatic neurosis. The authors of the Paris Psychosomatic School (Ziwar, Marty, Fain, de M'uzan, David, Sami-Ali, Schur, Stephanos) emphasize the aspect of discontinuity according to which the psychosomatic symptom has no direct link with the psychological conflict. In addition, emphasis is placed on the fact that efforts and tensions directly affect the human body, without the mediation of psychological mechanisms. These efforts and tensions cause physical reactions that can turn into real organic lesions over time. A psychosomatic symptom is not a compromise formation resulting from the action of different instances of the personality, such as

PARIŠKA ŠKOLA PSIHOSOMATIKE

Egipatski psihoanalitičar M. Ziwar (10) može se smatrati osnivačem pariške psihosomatske škole. U svojim radovima o bronhalnoj astmi, juvenilnom glaukomu, esencijalnoj hipertenziji i ulkusu dvanaesnika opisuje pojam arhaične agresivne energije koja nije ni dovoljno potisnuta niti je vezana na neki neurotski sustav. Dolazi do spoznaje o tome da je pacijent sklon psihosomatskoj bolesti uvijek u nekom stanju kronične pobuđenosti. Pierre Marty i Michael Fain (11,13) objavljuju 1958. godine članak o objektnim odnosima u jednog alergijskog pacijenta. Godine 1960. dvama se navedenim autorima pridružuju Michel de M'Uzan i Christian David (12) čineći time radni krug autora koji su započeli sistematizirati svoje spoznaje iz brojnih pregleda tjelesnih pacijenata. Zanimljivo je da je većina tih pacijenata bilo sasvim drukčija od tipičnoga neurotskog pacijenta, praktički bez neurotskih simptoma i vrlo dobre socijalne prilagođenosti. No jedna je osobina bila izražajna gotovo za sve pacijente, naime, nisu bili sposobni slobodno asocirati. Upravo je to razlog zašto su se pariški autori distancirali od modela konverzivne neuroze kao podloge nastanka psihosomatskih simptoma. Priklonili su se Freudovu modelu aktualne neuroze. Prvi intervjui s navedenim

desires from the id as opposed to prohibitions from the superego. Psychosomatics, therefore, has its own structural specificity.

PARIS PSYCHOSOMATIC SCHOOL

The Egyptian psychoanalyst M. Ziwar (10) can be considered as the founder of the Paris Psychosomatic School. In his works on bronchial asthma, juvenile glaucoma, essential hypertension and duodenal ulcer, he describes the concept of archaic aggressive energy that is neither sufficiently suppressed nor tied to some neurotic system. He realized that the patient who is prone to psychosomatic illness is always in a state of chronic excitement. In 1958, Pierre Marty and Michael Fain (11, 13) published an article on object relations in an allergic patient. In 1960, Michel de M'Uzan and Christian David (12) joined these two authors, thus forming a working circle of authors who began to systematize their observations from numerous examinations of physical patients. It is interesting how the majority of these patients were quite different from the typical neurotic patient, practically without neurotic symptoms and socially very well adjusted. However, one feature was prominent in almost all of these patients, the fact that they were not capable of free association. This is precisely the reason why the Parisian authors distanced themselves from the model of conversion neurosis as the basis for the emergence of psychosomat-

pacijentima bili su uočljivi po tome što pacijenti nisu pokazivali nikakav interes za ispitivača, samo su čekali na pitanja na koja su mehnicistički odgovarali, ne upuštajući se u nekakvo započinjanje asocijativnoga procesa. Na temelju tih saznanja francuski su istraživači pariške škole osmislili poseban analitički intervju usmjeren na tjelesne simptome, te su u svojem radu s takvim pacijentima posebnu pažnju poklanjali objektnim odnosima.

Automatsko-mehanicistički način mišljenja (Pense operatoire „Pense operatoire" (u prijevodu:) je uz pojam „reduplikacije" i temeljne inhibicije fantazije („inhibition fantasmatique de base" (u prijevodu:) ono što je patognomonično za psihosomatsku patologiju. Tim se pojmovima pokušao objasniti jedan arhaični, primarni proces mišljenja koji uvijek i iznova ostaje zarobljen u konkretnom i aktualnom. Tako se pokazalo, ako se takvim pacijentima otvori prostor za slobodno asociranje, pri čemu bi oni mogli o sebi govoriti, vrlo često ti pacijenti zakazuju, to im je previše. Ne uspijevaju ovladavati nestrukturiranim, otvorenim i spontanim situacijama. Vrlo često se događa da je uopće razgovor moguć s pacijentom tek onda kada se postavi usko i strukturirano pitanje, pri čemu pacijenti taksativno nabrajaju svoje simptome, često pokušavajući te simptome izložiti prema vremenskom slijedu, a sve

ic symptoms. They adhered to Freud's model of actual neurosis. The first interviews with the aforementioned patients were striking in that the patients did not show any interest in the examiner, they just waited for the questions which they answered mechanically, without engaging in any kind of initiation of the associative process. Based on this knowledge, the French researchers of the Paris School designed a special analytical interview focused on physical symptoms, and in their work with such patients, they paid special attention to object relations.

The automatic-mechanistic way of thinking (*pense operatoire*) is, along with the concept of "reduplication" and the basic inhibition of fantasy (*inhibition fantasmatique de base*), what is pathognomonic for psychosomatic pathology. These terms were an attempt to explain an archaic, primary thought process that always remains trapped in the concrete and current. Thus, it turned out that if such patients are given space for free association in which they could talk about themselves, these patients very often fail and it is too much for them. They fail to master unstructured, open and spontaneous situations. It often happens that a conversation with the patient is only possible when a narrow and structured question is asked, whereby the patients exhaustively list their symptoms, often trying to present them in chronological order, all in order to fulfil the expectations of the examiner. In doing so, they often

sa svrhom ispunjanja očekivanja od ispitivača. Pri tome, vrlo često, ostavljaju dojam da su nepotpuno „izvršili svoj zadatak". Uočljivo je da pacijenti opisuju svoje simptome potpuno apersonalno, kao da opisuju stvari, predmete koji se njih i ne tiču. Kao da su ti pacijenti promatrači sa strane, a ne izravno pogođeni određenim simptomom. Ako su prethodno već liječeni, onda često kao da reproduciraju mišljenja prijašnjih liječnika, ne vezujući emocije uz taj sadržaj. Pacijentov govor bude obilježen specifičnim načinom mišljenja, ono je mehanicističko, neosobno, formalno, konkretističko, nedostaju nijanse, govor kao da je osiromašen. Ta govorna osiromašenost u skladu je sa sveukupnim dojmom da takvi pacijenti žive na afektivno reduciran način i u stalnom stanju obuzdavanja nečega. To pak ima svoju ekonomsku funkciju poricanja dubokoga straha od psihičkoga sloma. Pacijenti kruto ostaju u svojoj fiksaciji na sad i ovdje, na sadašnjost, jer prošlost i budućnost već pripadaju fantazijskom svijetu, što je pak izvan mehanicističkih tendencija takvih pacijenata. Pacijenti kao da izlažu svoje simptome, pri čemu „ispunjavaju svoju obvezu", na što očekuju objašnjenje i recept. Oni ne povezuju svoju biografiju sa svojom bolešću, tj. oni ne vide poveznicu između promjena u njihovim životima kao što je npr. vjenčanje, rođenje djeteta ili nečija smrt, s nastupom svojih simptoma. Tako i ne mogu na

leave the impression that they have incompletely "completed their task". What is very noticeable is that these patients describe their symptoms in a completely impersonal manner, as if describing things or objects that are of no concern to them. It is as if these patients were outside observers and not directly affected by a certain symptom. If they have been treated before, they often seem to reproduce the opinions of previous doctors, without attaching emotions to that content. The patient's speech is characterized by a specific way of thinking, it is mechanistic, impersonal, formal, concrete, nuances are missing, and speech seems to be impoverished. This speech impoverishment is consistent with the overall impression that such patients live in an affectively reduced manner and in a constant state of restraining something. This, in turn, has its economic function of denying a deep fear of a mental breakdown. The patients rigidly remain in their fixation on the here and now, on the present, because the past and the future already belong to the fantasy world, which is beyond the mechanistic tendencies of these patients. The patients seem to be presenting their symptoms, thereby "fulfilling their obligation" and expecting an explanation and a prescription. They do not connect their biography with their illness, i.e. they do not see a link between changes in their lives such as a wedding, the birth of a child or someone's death, with the onset of their symptoms. This is the reason why they cannot react "emotionally" to the doctor, and the doctor is

liječnika „emocionalno" reagrati, liječnik je reduciran samo na funkciju mehanicističkog slušatelja. Ima se osjećaj kao da se ispitivač (liječnik, psiholog...) uopće ne doživljava kao osoba, odnos kao da je prazan (franc. *relation blanche*). Ta praznina odnosa korelira s dojmom koji nastaje kod ispitivača o pacijentovu psihičkom aparatu čiji djelovi kao da su čvrstim granicama odijeljeni jedni od drugih, bez međusobne povezanosti. No takav model odnosa nije samo s ispitivačem, to je način kako pacijent funkcionira i s drugima. Takav automatsko-mehanicistički način života zapravo je obrana od eventualnog preplavljivanja podražaja u kriznim stanjima. Ako ovaj način funkcioniranja nije neutralizirao napetosti, onda nastaju tjelesne komplikacije, što se naziva „patološkom dezorganizacijom". Pri tome je pacijentovo tjelesno stanje stalno ugroženo fiziološkim slomom.

Objektni odnosi psihosomatskih pacijenata

Objektni odnosi psihosomatskih pacijenata karakterizirani su tzv. reduplikacijom – „lijevani po istom kalupu". Psihosomatski pacijenti nisu kadri druge osobe sagledati u njihovoj punini, individualnosti i različitosti. Takvi pacijenti ne mogu prihvatiti da se neka druga osoba od njih razlikuje te se odmiču od odnosa. Oni imaju tendenciju na druge gledati kroz prizmu nestruk-

reduced to the function of a mechanistic listener. It feels as if the examiner (doctor, psychologist...) is not perceived as a person at all, the relationship seems empty (French – *relation blanche*). This relational void correlates with the impression created in the examiner about the patient's psychological apparatus, the parts of which seem to be separated from each other by firm boundaries, without mutual connection. However, this relationship model is not present only in relation to the examiner, it is the way in which the patient functions with others as well. This automatic-mechanistic way of life is in fact a defense against possible overwhelming stimuli in crisis situations. If this way of functioning does not neutralize the tensions, physical complications occur, which is called "pathological disorganization". At the same time, the patient's physical condition is constantly threatened by a physiological breakdown.

Object relations of psychosomatic patients

The object relations of psychosomatic patients are characterized by the so-called reduplication – "cast in the same mold". Psychosomatic patients are unable to see other people in their fullness, individuality and diversity. These patients are unable to accept that another person is different from them and they withdraw from the relationship. They tend to look at others through the prism of an unstructured image of themselves, so they

turirane slike o sebi samima pa kao da polaze od pretpostavke da su oni i svi objekti s kojima su u kontaktu „lijevani po istom i jednostavnom kalupu". To rezultira manjim kontaktima, što pacijent i želi ne bi li izbjegao pravu komunikaciju koja pokatkad uključuje napetosti i konflikte s drugima. Objektni odnosi kao da se „mehaniziraju", navode Fain i Marty (13).

Psihosomatski pacijenti najčešće imaju specifične interakcije sa svojim obiteljskim članovima. Najčešće je takav pacijent od samih početaka u primarnoj obitelji u simbiotskom odnosu s primarnim objektom, majkom, čijoj je omnipotenciji pacijent bespomoćno izložen. U obitelji najčešće kao da vlada primarni proces obilježen ponašanjem bez distancije među članovima ili pak pretjeranom, bojažljivom zabrinutošću.

Automatsko-mehanicistički način mišljenja reflektira se na pacijentovu fantaziju, na njegov san, samopoimanje tjelesne sheme, način pisanog izražavanja te na sposobnost detekcije osjećaja.

Nedostatak fantazije

Fantazije kojih smo svjesni često se razlikuju od fantazija kojih nismo svjesni. Nekako je cilj kroz psihoterapijski rad povezati jedne s drugima i pokušati uvidjeti njihovu važnost. A fantazije same po sebi oblikuju naš psihički život, uvelike pridonose našoj

seem to start with the assumption that they and all the objects they come in contact with are "cast in the same and simple mold". This results in fewer contacts, and that is what the patient indeed wants in order to avoid real communication which sometimes involves tensions and conflicts with others. According to Fain and Marty (13), object relations seem to be "mechanized".

Psychosomatic patients most often have specific interactions with their family members. In their primary family, from the very beginning such patient is generally in a symbiotic relationship with the primary object, the mother, to whose omnipotence the patient is helplessly exposed. The primary process seems to rule most often in the family, characterized by behavior without distance between members or, even, excessive and fearful concern.

The automatic-mechanistic way of thinking is reflected on the patient's fantasy, their dreams, the self-concept of the body schema, their way of written expression and the ability to detect feelings.

Lack of fantasy

Fantasies that we are aware of are often different from those that we are not aware of. In some manner, the goal is to connect them with each other and try to see their meaning through psychotherapy. Fantasies in themselves also shape our psychic life, they greatly

psihičkoj realnosti koja se razlikuje od izvanjske realnosti. Upravo to oblikovanje naše psihičke realnosti jest ono što velikim dijelom određuje naš odnos prema izvanjskome svijetu jer fantazije imaju strukturirajući i uređujući učinak na naš odnos prema okolini. U psihosomatskih pacijenata postoji izražajan nedostatak fantazmatskoga svijeta, postoji jedna unutrašnja praznina. Pacijent se prilagođuje okolini, ne pokazuje pritom neke svoje osobitosti ili ekstravagancije, ne pokazuje ni svoje raspoloženje, u svojem je djelovanju neupadan, bez autentičnosti, stereotipiziran. Ne pokazuje znakove posjeda unutarnjega psihičkog prostora, što se može osjetiti kroz kontratransfer. Tako ti pacijenti ne bude nesvjesne seksualne fantazije kako to neurotici rade, nema ambivalencije, nema manipulacije kakvu bi npr. histerik inducirao ili tuge kakvu bi kontratransferno inducirao depresivni pacijent. U radu s takvim pacijentima dolazi do izražaja praznina za koju onda postoji opasnost od terapueta da nesvjesno tu istu prazninu ispuni svojim fantazijama. U takvih se pacijenata osjećaju napor, umor, i iscrpljenost, što kod terapeuta može izazvati strah od vlastite iscrpljenosti.

Mehanicistički san

Pacijenti s „automatsko-mehanicističkim" načinom mišljenja imaju uočljivo banalne snove. Michael Fain navodi

contribute to our mental reality, which differs from external reality. This shaping of our mental reality is what largely determines our relationship with the outside world, because fantasies have a structuring and regulating effect on our relationship with the others. In psychosomatic patients, there is a striking lack of a phantasmatic world and there is an inner void. The patient adapts to the environment, does not show any of their peculiarities or extravagances, does not show their mood either, and in their actions they are inconspicuous and without authenticity, stereotyped. They show no signs of having an inner mental space, which can be felt through countertransference. These patients, therefore, do not have unconscious sexual fantasies as neurotics do, there is no ambivalence, no manipulation such as, e.g. a hysteric would induce, or sadness such as a depressed patient would induce in countertransference. In working with such patients, an emptiness comes to the fore, and there is a danger that the therapist will unconsciously fill this same emptiness with their fantasies. Such patients can experience exertion, fatigue and exhaustion, which can cause the therapists to fear their own exhaustion.

Mechanistic dream

Patients with an "automatic-mechanistic" way of thinking have strikingly banal dreams. Michael Fain states that such dreams have an economic func-

kako takav san ima svoju ekonomsku funkciju. Naime, traumatsko događanje koje pacijent proživi tijekom dana, kroz banalizaciju sna, bude lišeno mogućnosti dezorganizacijskoga djelovanja na ličnost. Često se zna dogoditi da u san izravno dolaze afekti i neke natruhe emocija, npr. zahtjevi od objekta, nesposobnost realizacije tih zahtjeva, dezorijentacija, rezignacija i osjećaj manjkavosti. Uočljivo je kako izostaju mehanizmi sna kakve nalazimo u neurotika, kao npr. pomak, kompresija i reaktivna formacija.

Poremećaji integracije tjelesne sheme

U vezi s ovom problematikom, važno je spomenuti istraživača M. Sami-Alija (14) koji je, promatrajući bolesnu djecu, došao do spoznaje da psihosomatska patologija proizlazi iz poremećene percepcije sheme tijela i defektnoga imaginarnog prostora. Naglašavao je kako pojam o objektu nastaje uklopljen u subjekt, uvodi pojam „taktilnog korpusa" i „vizualnog korpusa", koji su nastali u interakciji djeteta i majke. Opisuje kako psihosomatski pacijent ima temeljnu smetnju vezanu za „taktilni korpus", i to tako da imaginarna aktivnost bude zamijenjena taktilnom. Osim toga, primjećuje kako su u velike većine pacijenata koji pokazuju poremećaj integracije sheme tijela prisutni

tion. Namely, through the banalization of dreams, a traumatic event that the patient experiences during the day is deprived of the possibility of having a disorganization effect on the personality. It often happens that affects and some traces of emotions enter directly into the dream, e.g. demands from the object, the inability to realize those demands, disorientation, resignation and a feeling of inadequacy. It is noticeable that sleep mechanisms that can be observed in neurotics, such as displacement, compression and reactive formation, are absent.

Body schema integration disorders

Regarding this issue, it is important to mention the researcher M. Sami-Ali (14) who, in observing sick children, came to the realization that psychosomatic pathology results from a disturbed perception of the body schema and a defective imaginary space. He emphasized that the concept of the object is created embedded in the subject, he introduced the concept of "tactile corpus", "visual corpus", created in the interaction of a child and its mother. He describes how the psychosomatic patient has a fundamental disorder in relation to the "tactile corpus" in such a way that imaginary activity is replaced by tactile activity. In addition, he notes that in the vast majority of patients displaying a disorder of body schema integration, the following symptoms are present: disorders of laterality, space

sljedeći simptomi: poremećaji lateraliteta, orijentacije u prostoru, osjećaja za vrijeme i poremećaj binokularnog vida.

Mehanicističko crtanje

Poremećaji tjelesne sheme, dezorijentiranost u prostoru i fenomen reduplikacije, sve se to ogledava i u mehanicističkim crtežima psihosomatskih pacijenata. Naime, tijekom razvoja takvi pacijenti nisu došli do „treće dimenzije", nego ostaju stiješnjeni u „dvodimenzionalnosti". Ti su crteži najčešće takvi da nedostaje pojma o dubini prostora, imaju neproporcionalno velike predmete (npr. stablo koje neproprocionalno dominira crtežom krajolika), nedostaje fantazije, a postoji gotovo pa prisila za izvršavanje svoje dužnosti, nedostaje slobode i mogućnost asociranja. Crtežima dominira konkretistički red.

Aleksitimija

Riječ je o pojmu koji opisuje pacijentovu nesposobnost da detektirta osjećaje i nesposobnost za adekvatno opisivanje vlastitih osjećaja („a" – bez; „lexis" – riječ; „thymos" – osjećaj.). Pojam su uveli američki psihijatri Nemiah i Sifneos (15). Obiljažja aleksitimije uključuju: ograničenu mogućnost uvida, nesposobnost učenja novoga emocionalnog ponašanja, osiromašen fantazmatski svijet, poremećaje u afektivnom životu i shizoidne kontakte s drugima.

orientation, sense of time, and binocular vision disorder.

Mechanical drawing

Disorders of the body schema, disorientation in space and the reduplication phenomenon, are all reflected in the mechanical drawings of psychosomatic patients. Namely, during development, these patients did not reach the "third dimension", but remained cramped in "two-dimensionality". These drawings are usually such that they lack an understanding of the depth of space, the objects are disproportionately large (e.g. a tree that disproportionately dominates a landscape drawing), there is a lack of fantasy and almost a compulsion to perform one's duty, there is a lack of freedom and of the possibility of association. The drawings are dominated by a concretist order.

Alexithymia

It is a term that describes a patient's inability to detect feelings and inability to adequately describe their own feelings ("a" = without; "lexis"" = word; "thymos" = feeling). The term was introduced by American psychiatrists Nemiah and Sifneos (15). Characteristics of alexithymia include the following: limited insight, inability to learn new emotional behavior, impoverished fantasy world, disturbances in affective life and schizoid contacts with others. The authors of this term rely entirely on the Paris Psychosomatic

Autori se ovog pojma potpuno oslanjaju na pariško psihosomatsku školu. U svojim promišljanjima navedeni autori povezuju neurotsko potiskivanje i primaran emocionalni defekt kao osnosvicu za psihopatološke procese. Osim toga, bili su uvjerenja da je aleksitimija uvjetovana kongenitalnim i biološkim defektima. Nemiah je zastupao tezu da se psihosomatska patologija zasniva na neurofiziološkoj disfunkciji. Smatrao je da se ta disfunkcija prije svega odražava na slabijoj povezanosti limbičnog sustava, gdje osjećaji nastaju, s neokorteksom, gdje nastaju svjesne reprezentacije osjećaja.

O teoriji psihosomatskih poremećaja, ekonomski koncept organizacije i reorganizacije

Zajednička osobina promišljanja autora pariške škole kao što su Michael Fain, Pierre Marty, Sami-Ali i W. Loch (16) jest sveprisutna fiksacijska regresija u psihosomatskih pacijenata. P. Marty pri trome ističe važnu ulogu nagona smrti za koji smatra da je neizostavan u razvoju pojedinca te ima odlučujuću ulogu u kreiranju fiksacija. I to na sljedeći način: svako novorođenče iskusi prolaznu dominaciju nagona smrti koji se manifestira kroz fiziološku disfunkciju te se remeti biološka ekonomija. Zbog razvoja dolazi do uspostave nove homeostatske ravnoteže, čime disfunkcije budu nadvladane te odlaze u drugi plan.

School. In their reflections, these authors connect neurotic suppression and primary emotional defect as the basis for psychopathological processes. In addition, they believed that alexithymia was conditioned by congenital and biological defects. Nemiah advocated the thesis that psychosomatic pathology is based on neurophysiological dysfunction. He believed that this dysfunction is primarily reflected in the weaker connection of the limbic system, where feelings are created, with the neocortex where conscious representations of feelings are created.

On the theory of psychosomatic disorders, the economic concept of organization and reorganization

A common feature of the reflections made by the authors of the Paris School such as Michael Fain, Pierre Marty, Sami-Ali and W. Loch (16) is the ubiquitous fixation regression in psychosomatic patients. P. Marty points out the important role of the death drive, which he considers to be indispensable in the development of the individual and has a decisive role in the creation of fixations in the following way: every newborn experiences a transient dominance of the death drive, which is manifested through physiological dysfunction and disrupts biological economy. A new homeostatic balance is established during development, whereby dysfunctions are overcome and become secondary. In this way, these dysfunctions lose their im-

Na taj način te disfunkcije gube neposredan patološki karakter, ali ne nestaju, nego formiraju tzv. ligne de faiblesse (latentne slabosti) koje se pak aktiviraju u traumatskim situacijama, organske ili psihičke naravi, kada utjecaj libidnih nagona slabi kao i sposobnost prorade od pojedinca. Tada se takve „latetntne slabosti" pojavljuju u obliku psihosomatskih regresivnih fiksacija.

Promatranje ekonomije dinamike u psihosomatskih pacijenata daje cjelovitu sliku. Upravo su ekonomski principi ti koji kojima se poimaju i međusobno povezuju prisutni biološki mehanizmi, diferencirani intrapsihički mehanizmi i socijalne interakcije. Marty (17) smatra kako se ekonomski koncept kod psihosomatike zasniva na evolucijskom modelu te na teoriji nagona života i smrti. On to objašnjava tako da su sve fiziološke i psihičke funkcije pojedinca u svakoj fazi razvoja pod naizmjeničnim utjecajem „evolucijskih" procesa, koji su pak vođeni Erosom, i „antievolucijskih" procesa promjene strukture, koji su pak vođeni Thanatosom. Marty to naziva „kretanjem života i smrti" (*mouvements de vie et de mort*). Svaki pojedinac ima svoju vlastitu, specifičnu ekonomiju koja je konstitucijski i razvojno određena. No, ako se neka pravilnost dâ naslutiti, onda je Marty ekonomiju psihički zdravog pojedinca i neurotičara svrstao pod tzv. vitalnu ekonomiju koja je karakterizirana dife-

mediate pathological character, but they do not disappear, they form the so-called *ligne de faiblesse* (latent weaknesses) which, in turn, are activated in traumatic situations of an organic or psychological nature, when the influence of libidinous drives weakens, as well as the individual's ability to introspect. These "latent weaknesses" then appear in the form of psychosomatic regressive fixations.

Observation of the economy of dynamics in psychosomatic patients provides a complete picture. It is precisely the economic principles that are used to understand and connect the present biological mechanisms, differentiated intrapsychic mechanisms and social interactions. Marty (17) believes that the economic concept in psychosomatics is based on the evolutionary model and on the theory of life and death instincts. He explains it by stating that all physiological and psychological functions of an individual in each stage of their development are under the alternating influences of "evolutionary" processes, which are guided by Eros, and "anti-evolutionary" processes of structural change, which are guided by Thanatos. Marty calls them the "movements of live and death" (*mouvements de vie et de mort*). Each individual has their own, specific economy which is constitutionally and developmentally determined. However, if some regularity can be sensed, Marty classified the economy of mentally healthy individuals and neurotics under the so-called a "vital" economy, which is characterized

renciranom psihičkom organizacijom. A ekonomiju psihosomatskog pacijenta naziva „lomljivom" s obzirom na to da je ona pak karakterizirana disfunkcionaolnošću i somatskim bolestima. Osim toga, psihosomatski su pacijenti izloženi vlastitim arhaičnim podražajima. Nisu u mogućnosti te podražaje vezati za neke psihičke reprezentacije. Ovdje je vidljivo kako se autori pariške škole u svojoj teoriji oslanjaju na Freudov topički model nesvjesnog, predsvjesnog i svjesnog. Oni postuliraju da predsvjesno kao mjesto vezane energije i svijesti bliskih fantazija jednostavno nedostaje u psihosomatskih pacijenata. To u osnovi znači da je svijet imaginarnosti i simbola jako manjkav u psihosomatskih pacijenata pa zato oni i ne mogu povezati vlastite napetosti s fantazijama, čime bi te iste napetosti bile manje. Psihičke traume dovode u pacijenata do aktivacije fizioloških mehanizama fiksacije, što dovodi do maligne psihosomatske regresije. Takve traume uzrokuju raspad narcističko-energijske ravnoteže, što pak dovodi do patološke dezorganizacije, a to, u konačnici, može dovesti i do smrti.

Dezorganizaciju Marty smatra „svjedokom" nagona smrti, tvrdi da „smrt ide paralelno sa životom i osnovni je sastojak svakoga organizacijskog oblika životnog nagona". U organizaciji ličnosti nagon smrti djeluje tako što izaziva potrebne dezorganizacije, po-

by a differentiated mental organization. At the same time, he calls the economy of a psychosomatic patient "fragile" since it is characterized by dysfunctionality and somatic diseases. In addition, psychosomatic patients are exposed to their own archaic stimuli. They are unable to link these stimuli to some mental representations. It is evident here how the authors of the Paris School rely on Freud's topical model of the unconscious, preconscious and conscious in their theory. They postulate that the preconscious, as a place of bound energy and conscious-related fantasies, is simply missing in psychosomatic patients. This basically means that the world of imaginary and symbols is very deficient in psychosomatic patients, and that is why they cannot connect their own tensions with fantasies, which would make these same tensions less intensive. Mental traumas lead to the activation of physiological fixation mechanisms in patients, which leads to malignant psychosomatic regression. Such traumas lead to a collapse of the narcissistic-energetic balance, which in turn leads to pathological disorganization, ultimately possibly leading to death.

Marty considers disorganization to be a "witness" of the death drive, he claims that "death runs parallel to life and is the basic ingredient of every organizational form of the life drive". In the organization of the personality, the death drive acts by causing the necessary disorganization, especially in childhood. Disorganization provokes the reaction of reorganization,

gotovo u djetinjstvu. Na dezorganizaciju se reagira reorganizacijom, što je pak pod utjecajem životnih nagona, a u konačnici izrasta ličnost „tesana" s jedne i s druge strane. Od ovakvog uravnoteženog omjera djelovanja životnih nagona i nagona smrti kojim nastaje normalna ličnost, odudara patološka dezorganizacija u funcionalnom i organskom smislu kakva se nalazi u psihosomatskih pacijenata. Naime, u pacijenata koji su izgubili potencijal prorade smanjuje se mogućnost reorganizacije, što otvara put somatskim bolestima. U takvih pacijenata u kojih je došlo do povlačenja libidinozne investicije psihičkih i fizioloških funkcija dolazi do brutalnog odvajanja od unutarnjega svijeta. Tada fiziološke disfunkcionalnosti nastupaju na mjestu psiholoških procesa, što u psihološkome smislu dovodi do regresije. Za razliku od klasičnog, frojdovskog pojma regresije kao povratka na prethodni, već prijeđeni stupanj razvoja, psihosomatska se regresija odnosi i na povratak na primarnu fiziološku organizaciju. Upravo ta regresija pridonosi izbijanju, ali i kronificiranju psihosomatskih bolesti.

Problematika psihosomatskog fenomena – stvaranja temelja kliničke slike

Psihosomatski je fenomen skupni naziv za stanje pacijenta u kojeg postoje nedostatak fantazije, psihička pra-

which, in turn, is under the influence of life's instincts, and in the end, personality is shaped from the influence of both sides. Pathological disorganization in the functional and organic sense, as found in psychosomatic patients, deviates from this balanced ratio of action of the life drive and death drive which creates a normal personality. Namely, the possibility of reorganization is reduced in those patients who have lost their introspective potential, which opens the way to somatic diseases. In such patients, where the libidinous investment of psychological and physiological functions has been withdrawn, there is a brutal separation from the inner world. In this case, physiological dysfunctions appear instead of psychological processes, which in the psychological sense leads to regression. In contrast to the classic, Freudian concept of regression as a return to a previous, already passed stage of development, psychosomatic regression refers to a return to the primary physiological organization. This regression is what contributes to the onset and chronification of psychosomatic diseases.

The issue of psychosomatic phenomenon – creating the basis of the clinical picture

The psychosomatic phenomenon is a collective term for the condition of a patient in which there is a lack of fantasy, a mental void, difficulty establishing contacts, ego defects, physiological dysfunctions, reduplication, mechanistic way of

znina, otežana uspostava kontakata, ego-defekti, fiziološke disfunkcije, reduplikacija, mehanicistički način mišljenja (*pensee operatoire*) i mehanizirani objektni odnosi. Karakteristične interakcije psihosomatskih pacijenata s okolinom u smislu reduplikacije i mehaniziranih objektnih odnosa upućuju na defekte tzv. primarnog identiteta, prema H. Lichtensteinu (18). On smatra da taj primarni identitet nastaje onoga trena kad se dijete počne koristiti vlastitim potencijalima ne bi li osjetilo majčine svjesne i nesvjesne potrebe. To još nije osjećaj identiteta, već je nekakav stadij prije toga, stadij praidentiteta u kojem dolazi do preteče psihološkog ravoja. Ovaj je praidentitet analogan organizatorima psihe po R. Spitzu (19). Primarni identitet odgovara fiziološkoj fazi razvoja „pre-ega". Nazivajući ovu fau razvoja „simbiotskim tjelesnim egom", Jones naglašava fiziološki stadij razvoja ega. U toj fazi razvoja ego se adaptira na okolinu kroz fiziološko-tjelesne adaptacijske promjene. Prema Jonesu, normalan ravoj „pre-ega" preduvjet je za autoerotično zaposjednuće vlastita tijela i za uključivanje ego-funkcija. Ta faza, prema Jonesu, traje do trenutka kad dijete bude u mogućnosti svoju majku prepoznati kao ženu koja se razlikuje od drugih žena. U uskoj je vezi s „pra-identitetom" i primarna identifikacija koju Loch objašnjava kao cjelokupnost iskustva odnosa s majkom koja nosi svu težinu njihova odnosa. A majka se uopće

thinking (*pense operatoire*) and mechanized object relations. According to H. Lichtenstein, the characteristic interactions of psychosomatic patients with the environment in the sense of reduplication and mechanized object relations indicate defects of the so-called "primary identity" (18). He believes that this primary identity is created when the child begins to use its own potential in order to feel the mother's conscious and unconscious needs. This does not yet represent a sense of identity, but a certain stage before that, a stage of proto-identity in which the forerunner of psychological development occurs. This proto-identity is analogous to the organizers of the psyche, according to R. Spitz (19). The primary identity corresponds to the physiological stage of the "pre-ego" development. Naming this phase of development the "symbiotic body ego", Jones emphasizes the physiological stage of ego development. In this phase of development, the ego adapts to the environment through physiological-physical adaptation changes. According to Jones, the normal development of the "pre-ego" is a prerequisite for the autoerotic possession of one's own body and for the inclusion of ego functions. This stage, according to Jones, lasts until the moment when the child is able to recognize its mother as a woman who is different from other women. Closely related to the "proto-identity" is the primary identification, which Loch explains as the totality of experiencing the relationship with the mother, which carries all the weight

i može ponuditi kao objekt koji nosi težinu njihova odnosa samo onda ako je kadra „primarne majčine preokupacije", prema Winnicottu (20,21). Dakle stanju povišene senzibilnosti u koje majka ulazi već za vrijeme trudnoće, a koje majci omogućuje da osjeti i prilagodi se potrebama djeteta nakon rođenja. Majčin je holding izuzetno važan kako bi djetetu ublažilo osjećaj da pred vanjskim i unutarnjim utjecajima treba reagirati vlastitom anihilacijom. „Primarna majčina preokupacija" definira se kao sposobnost majke da svoje libidinozno zaposjednuto tijelo, kao i svoje psihobiološke funkcije, stavi neograničeno na raspolaganje djetetu kojeg pak smatra sastavnim dijelom svoga vlastitog selfa. Da bi to majka bila kadra, potrebno je prije toga integrirati svoj osjećaj odgovonosti kao majke sa svojim feminino-seksualnim identitetom. U vrijeme faze primarne identifikacije dolazi do tzv. zaposjedanja objekta, čime dijete uzima majku kao objekt koji nosi težinu njihova odnosa, ali i objekt kojeg libidinozno zaposjeda. Istodobno se događa prelazak s fiziološkog na psihološko doživljavanje, dakle fiziološki „pre-ego" postaje „mentalni ego". Poremećaji kod primarne identifikacije imaju za posljedicu defektan psihobiološki razvoj u smislu pojave „mehanicizma" koji je pak odogovoran za patološku dezorganizaciju.

Navezanost psihosomatskog pacijenta na svoj objekt karakterističan je nalaz

of their relationship. All the while, the mother can be offered as an object that carries the weight of their relationship only if she is in a state of "primary maternal preoccupation", according to Winnicott (20, 21). This is, therefore, the state of increased sensitivity which the mother enters already during pregnancy, and which allows the mother to feel and adjust to the needs of the child after birth. The mother's holding is extremely important in order to alleviate the child's feeling of having to react to external and internal influences by means of own annihilation. "Primary maternal preoccupation" is defined as the mother's ability to place her libidinously possessed body, as well as her psychobiological functions, at the unlimited disposal of the child, whom she considers an integral part of her own self. For a mother to be able to do this, she needs to first integrate her sense of responsibility as a mother with her feminine-sexual identity. During the primary identification phase, the so-called "possession of the object" occurs, in which the child perceives the mother as the object that carries the weight of their relationship, but also an object that it libidinously possesses. At the same time, there is a transition from physiological to psychological experiencing, so the physiological "pre-ego" becomes the "mental ego". Disturbances in primary identification result in defective psychobiological development in terms of the appearance of "mechanism" which, in turn, is responsible for pathological disorganization.

od velike kliničke važnosti. Budući da pacijent nije nadvladao fazu „pra-identiteta" i primarne identifikacije, potreban mu je „omnipotentni objekt" kako bi se s obzirom na druge situirao i u prostoru orijentirao. To potpada pod njegov mehanicistički način prilagodbe, te pacijent okorijeva u reduplikaciji. Ovakav, arhaičan način „opstanka u svijetu", u kojemu je pacijent samo odraz potreba svog objekta, štiti pacijenta od sloma svoje labilne energijske ravnoteže. Omnipotentni objekt nastaje zbog patoloških interakcija koje pak nastaju na temelju kroničnih funkcionalnih ili organskih poremećaja u obitelji. Taj omnipotentni objekt zapravo je „toksična majka" koja koči psihobiološki razvoj i stjecanje autonomije u djeteta. M. Fain (20) opisuje pojam „eksitacijskih štitova" („pare-excitations") pod kojim misli na pretjeranu majčinu zaštitu svojeg dojenčeta od bilo kakvih podražaja, što ima patološke posljedice. Naime, dojenče osjeća svoju hiperprotektivnu majku kao intezivan podražaj i ugnjetavačku nelagodu, što se u djeteta može manifestirati ranom pojavom astme i kolika u prvih šest mjeseci života. R. Spitz tvrdi da mnoge majke skrivaju svoje neprijateljstvo iza pretjerane bojažljivosti, što na dijete može imati učinak „psihološkog toksina". Spitz je istraživao kože bolesti u dojenčadi i utvrdio kako su takva djeca usporena u pocesu učenja i u razvoju svojih socijalnih interakcija;

The attachment of a psychosomatic patient to their object is a characteristic finding of great clinical importance. Since the patient has not overcome the phase of "proto-identity" and primary identification, they need an "omnipotent object" in order to situate themselves in relation to others and to orient in space. This is part of their mechanistic way of adaptation, and the patient hardens in reduplication. This archaic way of "surviving in the world", in which the patient is only a reflection of the needs of their object, protects the patient from the collapse of their unstable energy balance. The omnipotent object arises as a result of pathological interactions, which in turn arise based on chronic functional or organic disorders in the family. This omnipotent object is in fact a "toxic mother" that inhibits the child's psychobiological development and creation of autonomy. M. Fain (20) uses the concept of "excitation shields" (*pare-excitations*), describing a mother's excessive protection of her infant from any stimuli, which has pathological consequences. Namely, the infant feels its hyperprotective mother as an intense stimulus and oppressive discomfort, which can manifest in the child through the early onset of asthma and colic in the first six months of life. R. Spitz claims that many mothers hide their hostility behind excessive timidity. This can have an effect of a "psychological toxin" on the child. Spitz investigated skin diseases in infants and found that these children were slowed down in their learning process and in the development of their

majke takve djece dosegnule su visoke vrijednosti na skalama koje mjere strah. Ustanovljeno je, dalje, da velik broj takvih majki imaju neki oblik pregenitalnog poremećaja i automatističko-mehanicističke osobine karaktera.

D. Baunschwieg i M. Fain (23) pokazali su kakvu važnost ima seksualni život majke za psihičku sudbinu djeteta. Žena koja je svjesna svojih seksualnih želja te se i ravna prema njima, odlazeći k svojem partneru, povremeno odlazi i od svojeg djeteta. Na taj način prepušta dijete svojemu vlastitom snu i upravo na taj način potiče razvoj autoerotike u dojenčeta. Dijete tako, kroz san, može svoje vlastito tijelo libidinozno zaposjesti. Tako san postaje „dobra majka", a to potiče halucinatorno zadovoljenje, što je predstadij fantazije.

Psihosomatski pacijent poznaje svoju majku samo kao pretjerano ustrašenu i na njega navezanu, ne poima je kao ženskog ljubavnika („femme amante"). Zbog tog je razloga njegov rani razvoj obilježen time što procesi projekcije i internalizacije nisu provedeni i dijete se ne uspijeva odvojiti od posesivne majke. Stoga djetetu ne uspijeva razvoj potencijalnog prostora za stvaranje vlastita „libidinoznog objekta".

Očito je da u psihosomatskog pacijenta postoji „toksična okolina", tvz. psihosomatska obitelj koja potiče rasocial interactions; mothers of these children scored high on scales that measured fear. It was further established that a large number of these mothers have some form of pregenital disorder and automatic-mechanistic character traits.

D. Baunschwieg and M. Fain (23) observed the importance of the mother's sexual life for the psychological fate of her child. A woman who is aware of her sexual desires and acts according to them, by going to her partner occasionally leaves her child as well. In this way, she leaves the child to its own dream and in this way encourages the development of autoeroticism in the infant. Thus, through sleep, the child can libidinously possess its own body. In this way, the dream becomes a "good mother", thus encouraging hallucinatory satisfaction, which is a precursor to fantasy.

A psychosomatic patient knows their mother only as excessively frightened and attached, and does not understand her as a female lover (*femme amante*). For this reason, their early development is characterized by the fact that the processes of projection and internalization have not been carried out and the child does not manage to separate from the possessive mother. Therefore, the child fails to develop a potential space for the creation of its own "libidinal object".

It is obvious that a psychosomatic patient has a "toxic environment", a so-called "psychosomatic family" that promotes the development of disorders in an in-

zvoj poremećaja u dojenčeta. U takvoj okolini dijete ne doživljava afektivne kontakte. Majka je na određen ugnjetavački, dezorganizirani i hiperprotektivni način samo tjelesno prisutna. Njoj nije bliska seksualna žudnja te se ona i ne može upustiti u erotski odnos sa svojim partnerom. Ona fantazira o spolnom činu kao o nečemu u čemu se ona samo izlaže partneru, ne predaje mu se u seksualnom smislu kao žena. Stoga takva majka nije kadra ni libidinozno zaposjesti odnos sa svojim djetetom, ometajući tako daljnji psihički razvoj. Otac pak nema nikakav edipski autoritet, osim toga, manjkavi odnosi s vlastitim emocionalnim svijetom onemogućuju mu empatijski pristup i identifikaciju sa svojom partnericom i djetetom. U takvim okolnostima dijete nema šansu otkriti oca kao treću osobu s kojom bi uspostavilo prave objektne odnose. Ne može doći ni do suočavanja s ocem, što je preduvjet za nadvladavanje reduplikacije. Obiteljski odnos obilježavaju dosada i praznina, oni su na određen sterilan način ovisni jedno o drugome, nisu se kadri jedno drugome s ljubavlju davati. Psihosomatska obitelj ne može kreirati prascenu. Dijete se ne suočava s tabuom incesta, što je edipski izazov kojemu dijete treba biti izloženo kako bi zakon oca, unatoč svojim strahovima, moglo sebi pripisati i na taj način otvoriti put razvoju svijeta fantazije i samopoimanja.

fant. In such an environment, the child does not experience affective contacts. The mother is only physically present in an oppressive, disorganized and hyperprotective manner. She does not perceive sexual desire, and she cannot even engage in an erotic relationship with her partner. She fantasizes about the sexual act as something where she only exposes herself to her partner, she does not surrender to him in a sexual sense like a woman. Therefore, such a mother is not even able to have a libidinous relationship with her child, thus hindering further psychological development. The father, on the other hand, does not have any oedipal authority. Moreover, his flawed relationship with his own emotional world prevents him from empathic access and identification with his partner and child. In such circumstances, there is no chance for the child to discover the father as a third person with whom it could establish real object relations. There cannot be a confrontation with the father either, which is a prerequisite for overcoming reduplication. The family relationship is marked by boredom and emptiness, and they are dependent on each other in a sterile way, not being able to give themselves to each other with love. The psychosomatic family is not able to create a primal scene. The child does not face the taboo of incest, which is an Oedipal challenge to which the child needs to be exposed so that, despite its fears, it can claim the father's law and thus open the way to the development of the world of fantasy and self-concept.

ZAKLJUČNO

Razlika između homogenog i heterogenog modela u psihodinamici psihosomatike svodi se na stapanje u kontinuum tijela i psihe ili razdvajanje, čime se naglašava diskontinuitet tijela i psihe. Čikaška psihosomatska škola konceptualno je polazila od kontinuiteta, nalazeći u podležećoj psihološkoj konstelaciji nagonske organizacije ličnosti i u postojanju neurotskih konflikata glavne uzroke u nastanku psihosomatskih simptoma. S druge strane, pariška psihosomatska škola, koja je u ovome radu detaljnije elaborirana, naglašava diskontinuitet tijela i psihe, fokusirajući se na ego, objektne odnose i ekonomske principe. U svojemu teorijskom poimanju psihosomatike, na nagonskoj razini, pariška psihosomatska škola uvelike uzima u obzir i djelovanje nagona smrti. Ovim su radom prikazani pojedinačni doprinosi u razvoju psihosomatskih koncepata najvažnijih predstavnika obiju psihosomatskih škola s većim naglaskom na parišku psihosomatsku školu.

CONCLUSION

The difference between homogeneous and heterogeneous models in the psychodynamics of psychosomatics is in the merging of body and psyche into one continuum, or in separation which emphasizes the discontinuity of body and psyche. The concept of the Chicago Psychosomatic School started from continuity, finding the main causes for the emergence of psychosomatic symptoms in the underlying psychological constellation of the instinctual organization of the personality, and in the existence of neurotic conflicts. On the other hand, the Paris Psychosomatic School, which is elaborated in more detail in this paper, emphasizes the discontinuity of body and psyche, focusing on the ego, object relations and economic principles. In its theoretical understanding of psychosomatics, at an instinctive level, the Paris Psychosomatic School takes into great account the action of the death drive. This paper presents the individual contributions of the most important representatives of both psychosomatic schools to the development of psychosomatic concepts, with greater emphasis on the Paris Psychosomatic School.

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