PSIHOSOMATIKA I AGRESIJA

/ PSYCHOSOMATICS AND AGGRESSION

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SAŽETAK/*SUMMARY*

U svojemu kliničkom radu često smo se susretale s pacijentima sa psihosomatskim bolestima koji su tražili pomoć psihijatra. U ovom radu razmatramo teorijske koncepte pojma agresije i njihovu povezanost s pojavom, simptomima i tijekom psihosomatskih bolesti. Je li agresija emocija ili crta ličnosti, na koji se način očituje u psihoanalitičkom procesu? Primjeri iz naše kliničke prakse prikazuju različite manifestacije agresije u bolesnika sa psihosomatskim bolestima i upućuju na teškoće u psihoterapijskom radu, osobito vezano uz kontratransferne osjećaje.

/ In our clinical work, we have often encountered patients with psychosomatic diseases who sought psychiatric help. In this paper, we will review the theoretical concepts of aggression and their connection to the occurrence, symptoms and course of psychosomatic diseases. Is aggression an emotion or a personality trait, how is it presented in the psychoanalytic process? Case reports from our clinical practice show different manifestations of aggression in patients with psychosomatic disorders and indicate difficulties in psychotherapeutic work, especially in relation to countertransference feelings.

KLJUČNE RIJEČI / *KEYWORDS*

psihosomatski / *psychosomatic*, agresija / *aggression*, agresivnost / *aggressiveness*, nagon za agresijom / *aggressive instinct*, psihoterapija / *psychotherapy*

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PSIHOSOMATIKA

Pojam psihosomatski prvi se put spominje u prvoj polovici 19. stoljeća. Smatra se da je taj pojam uveo njemački liječnik Johann Heinroth 1818. g. (1). Pojam psihosomatske medicine uvodi Felix Deutsch 1922. g. (2,3). Tadašnja nova struja u medicini imala je za cilj povezati psihičko s organskim, osobito u razjašnjavanju etiopatogeneze određenih bolesti.

Osnivačem psihosomatske medicine smatra se Walter Georg Groddeck, koji 1917. g. u pismu S. Freudu piše:

„... kod mene se učvrstilo uvjerenje da je razlikovanje duše i tijela samo u nazivu, a ne u njihovoj biti, da su tijelo i duša jedno, da se u tom jedinstvu nalazi Ono, sila koja nas pokreće, živi, dok vjerujemo da mi živimo" (4).

U drugoj polovici 20. stoljeća Svjetska zdravstvena organizacija predlaže dva značenja pojma psihosomatski. Prvo značenje obuhvaća holistički pristup medicini koji pacijenta promatra u njegovu okruženju, socijalnom i psihološkom. Drugo značenje pojma psihosomatski odnosi se na bolesti pri kojima psihološki čimbenici imaju posebno važnu ulogu (3,5).

F. A. Whitlock (1976.) definira psihosomatska stanja kao ona pri kojima emocionalni utjecaji imaju bitnu ulogu u

PSYCHOSOMATICS

The term psychosomatic was first used in the first half of the 19th century. It is believed that the term was introduced by the German physician Johann Heinroth in 1818 (1). The term psychosomatic medicine was introduced by Felix Deutsch in 1922 (2, 3). The aim of the new direction in medicine at that time was to connect the psychic with the somatic, especially in clarifying the etiopathogenesis of certain diseases.

It is considered that the founder of psychosomatic medicine is Walter Georg Groddeck, who wrote the following in a letter to S. Freud in 1917:

"... I have become convinced that the distinction between body and mind is only verbal, and not essential, that body and mind are one unit, that this unity contains an It, the force which lives us, while we believe we are living." (4)

In the second half of the 20th century, the World Health Organization proposed two meanings of the term psychosomatic. The first meaning refers to the holistic outlook in medicine which observes the patient in their environment, both social and psychological. Another meaning of the term psychosomatic refers to those disorders in which psychological factors play a particularly important role (3, 5).

F.A. Whitlock (1976) defines psychosomatic conditions as those in which emotional influences play a significant role in

genezi, ponovnom pojavljivanju ili intenziviranju simptoma (5).

Već iz ovih činjenica možemo vidjeti širinu pojma psihosomatskog (psihosomatike) te se postavlja pitanje kako ga sagledava psihoanalitička teorija.

Kako se pojam psihosomatski uklapa u psihoanalitičku teoriju?

Freudovo otkriće psihoanalize otvara nove mogućnosti razumijevanja tjelesnih bolesti postavljanjem temelja psihoanalitičkog razumijevanja i liječenja.

U Freudovim radovima ne nalazimo istraživanja koja bi se odnosila specifično na psihosomatiku, no, bavećі se histerijom i hipohondrijom, njegova istraživanja i koncepti znatno će pridonijeti razumijevanju pacijenata sa somatskim bolestima. S. Freud (1898.) razmatra povezanost tijela i uma, spominjući „zbunjujući skok od mentalnog do fizičkog". Proučavajući „Aktualne neuroze": neurasteniju, anksioznu neurozu i hipohondriju, kontinuirano se do prve teorije anksioznosti bavi pitanjima „transformacije" psihičkog u fizičko (6-11).

C. Bronstein postavlja pitanja razlikujemo li koncepte „somatsko" i „tjelesno" , podrazumijevamo li psihičke reprezentacije tijela ili konkretno tijelo, pripadaju li ovamo istraživanja u sklopu neuropsihoanalize (3).

the genesis, recurrence or potentiating of symptoms (5).

From these facts already, we can recognize how broad the concept of psychosomatic (psychosomatics) is, which raises the question of how psychoanalytic theory understands it.

How does the term psychosomatic fit into psychoanalytic theory?

Freud's discovery of psychoanalysis opened new possibilities for understanding physical illnesses, by setting the foundations for psychoanalytic understanding and treatment.

In Freud's works we do not find research that would be specifically associated with psychosomatics, however, in working with hysteria and hypochondria, his studies and concepts would significantly contribute to the understanding of patients with somatic diseases. S. Freud (1898) considered the connection between body and mind, mentioning "a confusing leap from the mental to the physical". Studying the "Actual Neuroses": neurasthenia, anxiety neurosis and hypochondria, until his first theory of anxiety, he continuously dealt with issues of "transformation" of the psychic into the physical (6-11).

C. Bronstein raises the questions of whether we see a difference between the concepts of "soma" and "body", whether we are talking about psychic representation of the body or the actual body, and whether we should include research of neuro-psychoanalysis in this aspect (3).

A. Green razlikuje somatsko od tjelesnog, navodeći da se tjelesno odnosi na libidno tjelesno (erotsko, agresivno, narcistično), a somatsko se odnosi na biologijsko (3).

U pokušaju da razumijemo psihološke mehanizme koji su u podlozi psihosomatskog reagiranja možemo se koristiti dvama pristupima. Prvi pristup razmatra simptome kao produkte psihičkog konflikta u čijoj su podlozi nesvjesne fantazije, a drugi deficite u strukturi pacijentove ličnosti. Tako se postavlja pitanje jesu li psihosomatski simptomi posljedica manjkavosti strukture ili manjkavosti obrana (3).

AGRESIJA

U psihoanalitičkoj literaturi nalazimo dva pojma vezana uz agresiju: agresija i nagon za agresijom (agresivni nagon).

Pojam agresije podrazumijeva: „Tendenciju ili sklop tendencija koje se aktualiziraju u stvarnim i fantazijskim ponašanjima, sa svrhom da se nanese šteta drugomu, da ga se uništi, prisili, ponizi i sl. Osim nasilne i destruktivne motorne akcije, poznati su i drukčiji oblici agresije i ne postoji bilo negativno (odbijanje pomoći) bilo pozitivno, simbolično (ironija) ili u zbilji ostvareno ponašanje koje ne bi moglo funkcionirati kao agresija" (Laplanche – Pontalis) (12).

A. Green distinguishes the somatic from the body, stating that the body refers to the libidinal body (erotic, aggressive, narcissistic), and the somatic refers to the biological (3).

In an attempt to understand the psychological mechanisms underlying psychosomatic reactions, we can use two approaches. The first approach considers symptoms as a product of psychic conflict that has underlying unconscious fantasies, while the second approach considers deficits in the patient's psychic structure. The question, thus, arises of whether psychosomatic symptoms are the result of a deficit in structure or a deficit in defense mechanisms (3).

AGGRESSION

In the psychoanalytic literature, we can find two terms related to aggression: aggression and aggressive instinct (instinct of aggression).

The concept of aggression implies the following: "Tendency or cluster of tendencies finding expression in real, or phantasy behavior intended to harm other people, or to destroy, humiliate or constrain them, etc. Violent, destructive motor action is not the only form that aggressiveness can take indeed, there is no kind of behavior that may not have an aggressive function, be it negative - the refusal to lend assistance, for example - or positive; be it symbolic (e.g. irony) or

U engleskome govornom području pojavljuju se izvedenice iz osnove agresija, odnosno engleski *aggression*, kao npr. *aggressiveness* i *aggressivity*, koje možemo pronaći u literaturi (12).

S. Freud u svojoj terminologiji ne razgraničava pojmove agresija i agresivnost, nego se koristi samo pojmom agresija. Proučavajući tugovanje i melankoliju, S. Freud govori o manifestacijama autoagresivnosti i o mazohističkim tendencijama (8). Metapsihološki je polje djelovanja agresivnosti prošireno, destruktivni nagon nije više usmjeren samo prema van nego i prema unutra.

Pojam nagona za agresijom uvodi Adler 1908. godine (12).

Nagon za agresijom za S. Freuda je naziv za nagone smrti kad su usmjereni prema van, a dio su dvojne teorije nagona smrti i nagona života (1920.) (9).

Proučavajući definiciju agresije, H. Musaph navodi pet različitih obilježja koncepta agresije: agresija kao nagon, kao obrazac ponašanja, kao osjećaj, kao crta ličnosti i agresija kao obrana (13).

Agresija kao nagon

S. Freud prvobitno nije bio sklon agresivne tendencije pripisati samosvojnom nagonu, no zamjećuje agresiju u terapijskome procesu, suočavajući se

actually carried out" (Laplanche – Pontalis) (12).

In the English language there are derivatives based on the term aggression, such as aggressiveness and aggressivity, which can be found in literature (12).

S. Freud does not differ the concepts of aggression and aggressiveness in his terminology, but uses only the concept of aggression. In his studies of mourning and melancholia, S. Freud makes observations about the manifestations of auto-aggression and masochistic tendencies (8). Within metapsychology, the field in which aggressiveness is acknowledged to be at work is broadened, destructive drive is no longer directed only outwards, but inwards as well.

The term aggressive instinct was introduced by Adler in 1908 (12).

For S. Freud, the instinct of aggression is the term used for the death instincts when they are directed outwards, and are part of the dual instinct theory dealing with the death and life instincts (1920) (9).

In his study of the definition of aggression, H. Musaph proposes five different aspects to the concept of aggression: aggression as an instinct, as a behavior pattern, as an emotion, as a trait of character, and aggression as a defense (13).

Aggression as an instinct

S. Freud was not originally prone to attribute aggressive tendencies to an in-

s otporima i njihovim agresivnim obilježjima. U kliničkoj praksi uočava neprijateljske tendencije prema analitičaru i uvodi pojam ambivalencije, u kojoj se ljubav i mržnja isprepleću. Freud nagone smatra „graničnim fenomenima" između tjelesne i duševne sfere. Smatrao je da je izvor nagona u tijelu.

S. Freud je mijenjao i nadograđivao nagonsku teoriju, u početku je agresija razmatrana kao sadistički aspekt libidnog nagona, potom se pripisuje ego-nagonima, a u konačnici se agresija, prema Freudovim shvaćanjima, odvojila od ego-nagona, i uz razvoj strukturne teorije (1923.) agresija se kao nagon pripisuje Idu (10).

S. Freud 1920. u „S onu stranu načela ugode" uvodi pojam nagon za agresijom i uklapa ga u dvojnu teoriju nagona života i nagona smrti. Uvodeći nagon smrti, on ga smatra izvorom destruktivnog nagona koji se pojavljuje u obliku primarnog mazohizma – sadizma, agresije usmjerene na objekt i sekundarne destruktivnosti – agresije koja je usmjerena na self. Ego se bori s agresijom slično kao i s libidom, može omogućiti gratifikaciju, potiskivanje, sublimaciju, mijenjanje s pomoću reaktivne formacije, fuzioniranje s libidom ili nudi sebe kao objekt investicije (9).

H. Hartmann prihvaća koncept agresije kao nagona, opisuje fuziju libida i

dividual instinct, however he noticed aggression in the therapeutic process, facing resistances and their aggressive features. In clinical practice, he noticed hostile tendencies towards analysts and introduced the concept of ambivalence where love and hate coexist. S. Freud considered instincts to be a concept on the frontier between the mental and the somatic sphere. He believed that the source of the instinct was the body.

Freud changed and improved the instinct theory, at first aggression was viewed as a sadistic aspect of the libidinal instinct, then it was attributed to Ego instincts, and finally, according to Freud's understandings, aggression was separated from the Ego instincts, and with the development of structural theory (1923), aggression as an instinct was attributed to Id (10).

In 1920, S. Freud introduced the concept of the instinct of aggression in his work entitled "Beyond the Pleasure Principle" and fit it into the dual instinct theory of the life instinct and the death instinct. By introducing the death instinct, he considered it to be a source of destructive instinct that occurs in the form of primary masochism – sadism, object-oriented aggression and secondary destructiveness – aggression that is directed at the self. The Ego struggles with aggression similar to struggling with the libido, it can enable gratification, repression, sublimation, changing with the help of reactive formation, fusion with libido or it can offer itself as an object of cathexis (9).

agresije. Agresiju smatra funkcijom Ida i bavi se neutralizacijom agresije koja se onda manifestira u nekom socijalno prihvatljivu obliku. Kapacitet za neutralizaciju upućuje na stupanj zrelosti ega, a neutralizirana agresivna energija nužna je za uspostavu stabilnih objektnih odnosa (14).

Teoretičari koncepta objektnih odnosa tumače agresiju putem odnosa self – ego – objekt.

M. Klein smatra agresiju manifestacijom nagona smrti. Na razini objektnih odnosa i, dajući mehanizmu projekcije odlučujuću ulogu, smatra da se nagon smrti prvobitno projicira na vanjski svijet, na dojku, a potom se introjicira i vraća kao loš objekt (15).

M. Mahler misli pak da agresija uvijek sadržava libido i obrnuto i da su ta dva pojma nerazdvojna (16).

H.Hartmann, E. Kris i R. Loewenstain smatraju da je muskulatura aparat za pražnjenje nagonskog poriva (17).

Brojni autori razmatraju pitanje destruktivnosti agresije, odnosno može li agresije biti nedestruktivna. S. Freud 1930. navodi da agresivni nagon može biti „izmijenjen i ublažen u svom cilju" (11).

P. Greenacre misli da se nenasilna agresija očituje u smislu rasta, širenja i diferencijacije organizma (18).

H. Hartmann accepted the concept of aggression as an instinct, described the fusion of libido and aggression. He considered aggression to be a function of the Id and dealt with the neutralization of aggression, which then manifests itself in some socially acceptable form. The capacity for neutralization indicates the degree of maturity of the Ego, and neutralized aggressive energy is necessary for the establishment of stable object relations (14).

Theorists of the concept of object relations interpret aggression through the relationship of self – ego – object. M. Klein considered aggression to be a manifestation of the death instinct. At the level of object relations and placing the projection mechanism in a decisive role, she believed that the death instinct is initially projected onto the outside world, on the breast, and is then introjected and returned as a bad object (15).

M. Mahler believed that aggression always contains libido and vice versa, and that these two concepts are inseparable (16).

H. Hartmann, E. Kris and R. Loewenstein believed that the muscular system is used for discharging instinctual impulses (17).

Numerous authors addressed the question of the destructiveness of aggression, that is, whether aggression can be non-destructive. S. Freud stated in 1930 that the aggressive instinct can be "modified and tempered in its goal" (11).

H. Parens, nadovezujući se na teorijske koncepte separacije – individuacije M. Mahler, razmatra aspekte agresivnog nagona koji omogućuju prilagodbu i ovladavanje tijekom ranog razvoja u odnosu s primarnim objektima. Bijes smatra prvim oblikom prirođene sposobnosti djeteta da se oslobodi neugode, a sisanje i jedenje oblicima neafektivnog pražnjenja destruktivnosti (19,20).

Agresija kao obrazac ponašanja

Vezano uz aspekt agresije kao obrasca ponašanja, R. H. Cawley navodi da je važno razlikovati otvorenu od prikrivene agresije, normalno od patološkoga agresivnog ponašanja. Agresivno ponašanje može biti i obrana od emocije, npr. straha ili neke želje (13).

Agresija kao osjećaj

Agresija kao osjećaj može obuhvaćati osjećaje mržnje, ljutnje, bijesa, ogorčenosti i neprijateljstva. Važno je razlučiti je li agresija usmjerena prema drugima ili prema sebi.

Ako govorimo o agresiji kao osjećaju, otvara nam se mogućnost psihoanalitičkog razumijevanja. Godine 1895. J. Breuer dolazi do otkrića da psihopatološki simptomi nastaju kao posljedica zatomljenih osjećaja. S. Freud se slagao s ovim otkrićem i dalje ga razradio

P. Greenacre believed that non-violent aggression manifests itself in terms of growth, expansion and differentiation of the organism (18).

Building on the theoretical concepts of separation – individuation by M. Mahler, H. Parens examined the aspects of aggressive instinct which enable adapting and mastering in the course of early development in relation to primary objects. He considered anger to be the first form of a child's inborn ability to free itself from discomfort, while sucking and eating are forms of non-affective discharge of destructiveness (19, 20).

Aggression as a behavior pattern

In relation to the aspect of aggression as a behavior pattern, RH Cawley observed that it is important to distinguish between open and disguised aggression, normal and pathological aggressive behavior. Aggressive behavior can also serve as a defense against emotions, e.g. against fear or certain desire (13).

Aggression as an emotion

Aggression as an emotion can include feelings of hatred, anger, rage, resentment and hostility. It is important to distinguish whether aggression is directed against others or against oneself.

If we view aggression as an emotion, we create the possibility of psychoanalytic understanding. In 1895, J. Breuer discovered that psychopathological symptoms

kada spominje zaglavljene afekte navodeći da „simptom proizlazi iz nagonskog impulsa koji je zahvaćen štetnim djelovanjem potiskivanja" (6-11, 13).

Agresija kao crta ličnosti

Agresija kao crta ličnosti označuje stanja kada je agresija integrirana u ego. Najčešći primjer vidimo kod pojedinaca čije ličnosti nisu patološke, čije ponašanje nije agresivno, nema manifestacija agresivnih osjećaja, međutim, to su pojedinci koji izazivaju agresivne osjećaje ili agresivno ponašanje u drugih osoba u svojoj okolini (13).

Agresija kao obrana

Obrana agresijom može poprimiti različite oblike a da svi ti oblici ponašanja u podlozi imaju ljutnju, ogorčenost i mržnju. S pomoću premještanja agresija se iskazuje na nekom drugom objektu, pretvara se u suprotno i pojavljuje u obliku pretjerane ljubaznosti. Neutralizirana i sublimirana agresija može imati svoje različite pojavnosti (13).

AGRESIJA I PSIHOSOMATSKI POREMEĆAJI

Značenje koje agresija ima kod psihosomatskih poremećaja proučavali su brojni psihoanalitičari.

occur as result of repressed feelings. S. Freud agreed with this discovery and elaborated further on it when he mentioned strangulated affects, stating that "the symptom arises from an instinctual impulse which has been detrimentally affected by repression" (6-11, 13).

Aggression as a trait of character

Aggression as a trait of character defines conditions when aggression is integrated into the Ego. The most common example is seen in individuals whose personalities are not pathological, whose behavior is not aggressive, there are no manifestations of aggressive emotions, however these are individuals who induce aggressive emotions or aggressive behavior in other people in their environment (13).

Aggression as a defense

Aggression as a defense can take many forms, and all these forms of behavior are rooted in anger, resentment and hatred. Through displacement, aggression is expressed at another object, can be turned into the opposite and appears in the form of excessive kindness. Neutralized and sublimated aggression can have its different expressions (13).

AGGRESSION AND PSYCHOSOMATIC DISORDERS

The significance of aggression in psychosomatic disorders has been studied by numerous psychoanalysts.

L. Luborsky, J. P. Docherty i S. Penick objavili su istraživanje koje je pokazalo da agresija, u obliku zamjeranja i neprijateljstva, ima odlučujuću ulogu u genezi psihosomatskog simptoma (21). Slična zapažanja navodi i H. Musaph vezano uz psihogeni svrbež i i alergijski kontaktni dermatitis. B. Stokvis navodi da potisnuti agresivni osjećaji prevladavaju kod svih psihosomatskih poremećaja (13). Do sličnih su saznanja došli i drugi istraživači u vezi s arterijskom hipertenzijom (Kaplan) i hipertireozom (Wittkower, Lipowski) (13,21).

Kako izmjeriti agresiju?

Brojni su biheviorist pokušali mjeriti agresiju, i to onaj njezin aspekt koji bi se odnosio na obrazac ponašanja.

Zanimljivo je interdisciplinarno istraživanje V. G. Ragozinskaye (2013.) u kojemu su se procjenjivala obilježja agresivnosti i neurofiziološke manifestacije agresivnosti u pacijenata sa psihosomatskim poremećajima, uključujući hipertenziju, Gravesovu bolest, čir na želudcu i čir na dvanaesniku. Istraživanje se temeljilo na pretpostavci da su agresivnost i hostilnost osnovni etiopatogenetski čimbenici za razvoj psihosomatske bolesti. Pretpostavka je da je riječ o narušenu mehanizmu emocionalne regulacije. Istraživanje je uključivalo primjenu psihologijskih testova, analizu EEG-a i anamnezu ra-

L. Luborsky, JP Docherty and S. Penick published a study which showed that aggression, in the form of resentment and hostility, plays a decisive role in the genesis of the psychosomatic symptom (21). Similar observations were also made by H. Musaph with regard to psychogenic itching and allergic contact dermatitis. B. Stokvis pointed out that repressed aggressive emotions predominate in all psychosomatic disorders (13). Similar findings have been made by other researchers in relation to arterial hypertension (Kaplan) and hyperthyroidism (Wittkower, Lipowski) (13, 21).

The question arises on how to measure aggression.

Numerous behaviorists have tried to measure aggression, and in particular the aspect of aggression that would refer to a pattern of behavior.

An interesting interdisciplinary study was conducted by V.G. Ragozinskaya (2013), which evaluated the features of aggressiveness and the neurophysiological manifestations of aggressiveness in patients with psychosomatic disorders, including hypertension, Graves' disease, gastric ulcer and duodenal ulcer. The study was based on the assumption that aggressiveness and hostility represent the basic etiopathogenetic factors for the development of psychosomatic diseases. The assumption is that there is a disturbed mechanism of emotional regulation. The study included the use of psychological tests, EEG analysis, and

nog razvoja. Rezultati psihodijagnostike pokazali su da pacijenti sa psihosomatskim bolestima imaju više razine anksioznosti, osjećaja ljutnje i reakcija ljutnje, autoagresivnosti i hostilnosti, i mnogo više razine nekih karakteristika kao što su ljutnja, somatizacije, opsesije i kompulzije. Interpretacijom EEG nalaza ustanovljene su u bolesnika sa psihosomatskim bolestima hiperaktivnost stražnjih regija desne moždane hemisfere i hipoaktivnost prefrontalnih i okcipitalnih regija. Ove neurofiziološke osobitosti pacijenata sa psihosomatskim poremećajem s visokim stupnjem agresivnosti upućuju na kroničnu hiperaktivnost vegetativnoga živčanog sustava. Pacijent neurofiziološki reagira kao da je stalno u situaciji opasnosti (22).

Istraživanje J. F. Thayer i J. F. Brosschot ispituje na koji način autonomni živčani sustav povezuje negativna afektivna stanja i stanja bolesti. Nadovezujući se na istraživanja A. R. Damasia o povezanosti središnjega živčanog sustava, koji ima ulogu regulacije ravnoteže autonomnih funkcija, sa sustavima izvršnih, socijalnih, afektivnih i voljnih funkcija, navedeni su autori ustanovili da neravnoteža autonomnoga živčanog sustava (simpatikusa i parasimpatikusa) koja je mjerljiva praćenjem varijabilnosti srčane frekvencije (HRV) upućuje na pojačanu aktivnost simpatikusa. Organizam bi trebao biti dovolj-

medical history of early development. The results of psychodiagnostics have shown that patients with psychosomatic diseases have higher levels of anxiety, feelings of anger and angry reactions, auto-aggression and hostility, and significantly higher levels of some personal characteristics such as anger, somatizations, obsessions and compulsions. The analysis of EEG results indicated hyperactivity in the posterior regions of the right brain hemisphere and hypoactivity in the prefrontal and occipital regions in patients with psychosomatic diseases. These neurophysiological peculiarities of patients suffering from a psychosomatic disorder with a high degree of aggressiveness indicate chronic hyperactivity of the vegetative nervous system. The patient's neurophysiological reaction is as if they are in constant danger (22).

A study conducted by J.F. Thayer and J.F. Brosschot explored how the autonomic nervous system connects negative affective states with pathological conditions. Building on the research conducted by AR Damasio on the connection of the central nervous system, which regulates the balance of autonomic functions, with the systems of executive, social, affective and attentional functions, these authors observed that an imbalance in the autonomic nervous system (sympathetic and parasympathetic) that is measurable through the monitoring of heart rate variability (HRV) indicates increased sympathetic activity. The body should be adaptable enough to react to environmental

no prilagodljiv da na utjecaje iz okoline reagira promjenama srčanog ritma, što označuje varijabilnost srčanog ritma. Smanjena varijabilnost srčanog ritma upućuje pak na izostanak prilagodbe organizma, što povećava mortalitet i općenito se smatra prediktorom bolesti. Pojačana aktivnost simpatikusa, povezana sa sniženom varijabilnošću srčanog ritma može postati patogena ako je prisutna tijekom duljeg razdoblja. Neravnoteža ovih dvaju dijelova autonomnoga živčanog sustava može nastati npr. pod utjecajem okolinskih čimbenika ili negativnih emocija, čime organizam postaje osjetljiv za razvoj patoloških stanja. Izostanak uobičaje inhibitorne funkcije prefrontalnog korteksa dovodi do pojačane simpatičke aktivnosti, što bi onda moglo objasniti povezanost psihičkog i somatskog. Poznato je da su brojna psihička stanja i bolesti, kao npr. anksioznost, depresija, PTSP i shizofrenija, povezani sa smanjenom aktivnošću prefrontalnog korteksa. U stanjima neizvjesnosti i prijetnje smanjuje se, inače prisutan, inhibirajući učinak prefrontalnog korteksa, što dovodi do aktiviranja borba – bijeg odgovora, sa svrhom preživljavanja. Zapravo je riječ o kompleksnim sustavima neurovisceralne integracije i somatske samoregulacije. Dugotrajna dominacija simpatikusa može imati i patogene učinke na somatsko zdravlje. Postoje brojna istraživanja povezivanja

influences with changes in heart rhythm, which indicates heart rate variability. Low heart rate variability indicates a lack of adaptation of the body, which increases mortality and is generally considered as a marker for disease. Increased sympathetic activity, associated with low heart rate variability, can become pathogenic if it is present over a long period of time. An imbalance of these two parts of the autonomic nervous system can occur, for example, under the influence of environmental factors or negative emotions, which makes the body more vulnerable to the development of pathological conditions. An absence of the usual inhibitory function of the prefrontal cortex leads to increased sympathetic activity, which could then explain the connection between the mental and the somatic. It is well known that numerous mental health conditions and diseases, such as anxiety, depression, PTSD and schizophrenia, are associated with reduced activity of the prefrontal cortex. In conditions of uncertainty and threat, the usually present inhibiting effect of the prefrontal cortex is reduced, which leads to the activation of the fight-or-flight response, with the purpose of survival. These are, in fact, complex systems of neurovisceral integration and somatic self-regulation. Long-term sympathetic dominance can also have pathogenic effects on somatic health. There are numerous studies on the association between negative affective states and disease predisposition. Given that the frontal structures of the brain are associated with affective, cog-

zanosti negativnih afektivnih stanja i sklonosti bolesti. S obzirom na to da se prednje moždane strukture povezuju s afektivnom, kognitivnom i autonomnom regulacijom, autori smatraju da bi inhibitorni kortikosupkortikalni neuralni krugovi mogli biti poveznica između psiholoških procesa, kao što su emocije i fiziološki procesi, odnosno poveznica između psihe i tijela.

Ostaje i dalje otvoreno pitanje djeluje li agresija u razvoju psihosomatskih bolesti preko navedenih mehanizama i, ako djeluje, u kojoj mjeri (23).

AGRESIJA U PSIHOTERAPIJSKOJ SITUACIJI

J. A. M. Meerloo, nizozemski psihoanalitičar, smatra da se agresija kao emocija zapravo ne može izmjeriti, već je možemo promatrati u analitičkoj situaciji (13, 24).

Jednu od manifestacije agresije u psihoanalitičkoj terapiji opisuje W. Bion govoreći o napadima na povezivanje – „attacks on linking". To su destruktivni napadi pacijenta u psihoanalitičkoj terapiji na sve što je doživljeno kao povezujuće među objektima (25). Nadovezujući se na teoriju M. Klein o djetetovim fantazijama sadističkih napada na dojku i projektivnoj identifikaciji, W. Bion upravo takve napade sma-

nitive and autonomic regulation, the authors believe that inhibitory cortico-subcortical neural circuits could represent a link between psychological processes, such as emotions and physiological processes, that is, a link between the psyche and the body.

The question remains whether aggression affects the development of psychosomatic diseases through these mechanisms, and if so, to what extent (23).

AGGRESSION IN A PSYCHOTHERAPEUTIC SITUATION

J.A.M. Meerloo, a Dutch psychoanalyst, believed that aggression as an emotion cannot actually be measured, but can be observed in an analytical situation (13, 24).

One of the manifestations of aggression in psychoanalytic therapy was described by W. Bion in reference to attacks on linking. These are destructive attacks done by a patient undergoing psychoanalytic therapy, on anything which is perceived as a link between the objects (25). On the grounds of M. Klein's theory about child's fantasies of sadistic attacks on the breast and projective identification, W. Bion considered precisely such attacks to be the prototype of attacks on all objects with which there is a connection, i.e. "a link", and viewed projective identification as a mechanism employed by the psyche to

tra prototipom napada na sve objekte s kojima postoji veza, odnosno „link", a projektivnu identifikaciju vidi kao mehanizam kojim se psiha oslobađa dijelova ega koji su nastali fragmentacijom koja je posljedica vlastite destruktivnosti.

O destruktivnoj agresiji u psihoterapiji psihosomatskih poremećaja pisala je E. Cividini-Stranić i potvrdila da destruktivna agresija ima bitnu ulogu u nastajanju psihosomatske bolesti, odnosno da u simptomima somatske bolesti prevladavaju derivati agresivnog nagona, ali i derivati libida, uz pokušaje prevladavanja strahova koji dolaze od lošeg objekta (26). Prema teoriji M. Klein, nesvjesna fantazija stalno je prisutna gotovo od rođenja i pokazuje kako se pojedinac odnosi prema drugim osobama i svijetu. U nesvjesnoj je fantaziji objekt prvo podijeljen na dobar i loš objekt te poslije tijekom razvoja dolazi do integracije u cjelovit objekt. Loš je objekt nastao kao rezultat cijepanja i u njega se projiciraju sve djetetovo neprijateljstvo i sva se loša iskustva (doživljena bilo u vanjskom bilo u unutarnjem svijetu) pripisuju njegovim aktivnostima. Tu se ponovno otvara pitanje zastoja u razvoju, odnosno stupnja integracije objekta (15).

Zanimljive su opservacije i razmišljanja S. Kleina o slučaju pacijenta s ulceroznim kolitisom kojeg je liječio. Naime,

dispose of the ego fragments produced by fragmentation which is a consequence of its destructiveness.

E. Cividini – Stranić wrote about destructive aggression in the psychotherapy of psychosomatic disorders, and confirmed that destructive aggression plays an important role in the development of psychosomatic diseases, i.e. that the symptoms of somatic diseases are dominated by the derivatives of aggressive instinct, but also the derivatives of libido, with attempts to overcome fears emerging from a bad object (26). According to M. Klein's theory, unconscious fantasy is constantly present basically from birth, and shows how an individual relates to other people and the world. In unconscious fantasy, the object is first divided into a good and a bad object, and later during development, integration into a whole object occurs. The bad object developed from splitting and all the child's hostility is projected onto it, and all bad experiences (experienced either in the external or internal world) are attributed to its activities. This again raises the question of delays in development, i.e. the level of object integration (15).

S. Klein's observations and thoughts on the case of a patient with ulcerative colitis are very interesting. After a significant somatic improvement, his patient developed a psychotic episode. S. Klein explained the emergence of the psychotic episode as proof that the colitis had probably up until then served the purpose of splitting of primitive paranoid and de-

nakon značajnog somatskog poboljšanja njegov pacijent je razvio psihotičnu epizodu. Pojavljivanje psihotične epizode S. Klein objašnjava time da je kolitis do tada vjerojatno omogućivao *splitting* primitivnih paranoidnih i depresivnih anksioznosti povezanih sa sadističkim napadima na dojku, opisujući ranu fazu razvoja, kada se još ne može razlikovati tjelesna bol od njezine emocionalne komponente, a defekacija omogućuje pacijentu oslobađanje od neugode, kako somatske, tako i emocionalne. Navedeno S. Klein povezuje s nemogućnošću toleriranja separacije i razvojem destruktivnih osjećaja (3,27).

Kako navodi M. Schur, psihosomatski simptom kao oblik rasterećenja upućuje na dosegnut stupanj zrelosti ega, odnosno ego nije dovoljno razvijen da bi se rasterećenje omogućilo zrelijim procesima, prvo mišićnom akcijom, a zatim mišljenjem (28).

Prema teoriji objektnih odnosa, obilježje arhajskih introjekata jest da zadržavaju veliku količinu nagonske energije, osobito agresije koja se „prazni" preko tijela u obliku psihosomatskog simptoma. Riječ je o ranim fazama razvoja kada je još nedostatna fuzija libida i agresije u odnosu prema primarnom objektu.

Zanimljivo je istraživanje N. Sarajlić (1988.) o dinamici agresije u formiranju strukture ličnosti psihosomatskog pacipressive anxieties connected with sadistic attacks on the breast, describing the early stage of development when physical pain cannot yet be distinguished from its emotional counterpart, and defecation allows the patient to be relieved of discomfort, both somatic and emotional. S. Klein links this to the patient's inability to tolerate separation and the development of destructive feelings (3, 27).

As proposed by M. Schur, the psychosomatic symptom as a form of relief indicates a reached level of Ego maturity, i.e. the Ego is not developed enough to able to ensure relief through more mature processes, first by muscle action, and then by thinking (28).

According to the theory of object relations, it is the characteristic of archaic introjects to retain a large amount of instinctual energy, especially aggression that is "discharged" through the body in the form of a psychosomatic symptom. This describes the early stages of development when there is still inadequate fusion of libido and aggression in relation to the primary object.

Interesting is the study conducted by N. Sarajlić (1988) on the dynamics of aggression in the formation of a personality structure of a psychosomatic patient and the genesis of the psychosomatic symptom. The study has shown that the basic defects of the Ego result from unresolved practicing and rapprochement phases, and that separation or association of separation activates the defense

jenta i u genezi psihosomatskog simptoma. Istraživanjem je ustanovljeno da su defekti ega nastali kao posljedica neriješene faze vježbanja i približavanja te da separacija ili asocijacija na separaciju aktivira obrane *splittinga*, projekcije i introjekcije i dovodi do pojave psihosomatskog simptoma. Ovakva psihička konstelacija upućuje na preedipsku razinu, s mješavinom oralnih i analnih karakteristika, a na razini objektnog odnosa riječ je o konfliktu zbližavanja, kada još nije postignuta konstantnost objekta. Nadovezujući se na teoriju reakcije borba – bijeg kod koje agresivni nagon u stresnim situacijama pomaže borbom kao prilagodbom, Sarajlić uočava da u pacijenata sa psihosomatskim bolestima izostaje ova prilagodba i dolazi do blokade agresivnog nagona.

A. Gilić istražuje traumatske doživljaje, crte ličnosti i manifestacije agresije pacijenata koji imaju oscilatornu hipertenziju, metodom analitički orijentirane psihoterapije, te otkriva konflikt u dinamici: autoritativna roditeljska figura – agresivna želja – strah – somatski simptom (30).

H. Musaph razmatra dvije hipoteze koje nudi psihoanalitički model u razumijevanju psihosomatike: 1) abreakcija potisnutog ili suzbijenog osjećaja i 2) *pensee operatoire* (operativno mišljenje).

Pojam *pensee operatoire* uvodi pariška škola psihosomatike (Marty, de

mechanisms of splitting, projection and introjection, and leads to the occurrence of the psychosomatic symptom. Such mental constellation points to the pre-oedipal level of development, with a mixture of oral and anal characteristics, and at the object relations level it refers to a conflict of rapprochement, when the object constancy has not yet been established. Building on the theory of the fight-or-flight reaction, in which the aggressive instinct in stressful situations helps by fighting as an adaptation, Sarajlić notices that in patients with psychosomatic diseases, this adaptation is absent, and the aggressive instinct is blocked.

A. Gilić investigated traumatic events, character traits and manifestations of aggression in patients with oscillatory hypertension, using the method of analytically oriented psychotherapy, and revealed a conflict in the pattern: authoritative parental figure – aggressive desire – fear – somatic symptom (30).

H. Musaph explored two hypotheses posed by the psychoanalytic model in the understanding of psychosomatics: 1) the abreaction of repressed or suppressed strangulated affects and 2) the *pensee operatoire* (operational thinking).

The term *pensee operatoire* was introduced by the Paris Psychosomatic School (Marty, de M'Uzan, Fain, David). Through the term operational or mechanical thinking these authors described the way in which the patient functions and

M'Uzan, Fain, David). Pod pojmom operativnog ili mehaničkog mišljenja ovi autori razumijevaju način na koji pacijent funkcionira i misli, a to je način koji ima obilježja konkretnog. Pacijent kao da je odvojen od vlastita psihološkog iskustva. Ovaj je koncept sličan pojmu aleksitimije koji uvode J. C. Nemiah i P. E. Sifneos (13).

U vezi s agresijom P. Marty uvodi pojam progresivne dezorganizacije, kada dolazi do destrukcije libidne organizacije uz nestanak nekih mentalnih funkcija kao što su identifikacija, projekcija, sposobnost asociranja i simbolizacije. Tako se manifestira nagon smrti koji u konačnici može dovesti do smrti razvojem teške psihosomatske bolesti. Nagon postaje nagonski poriv kada je povezan s reprezentacijom, a mogućnost mentalizacije određuje hoće li somatizacije biti reverzibilne ili ireverzibilne. P. Marty prihvaća postojanje nagona života i nagona smrti, no, za razliku od Freudove dualne nagonske teorije povezanosti dvaju nagona i škole M. Klein koja podrazumijeva istodobnu aktivnost obaju nagona koji su u stalnom konfliktu, P. Marty smatra da nagon smrti djeluje tek kada nagon za životom prestane djelovati (3).

P. Marty i M. M'Uzan smatraju da psihosomatski simptom zamjenjuje fantaziju, a J. C. Nemiah i P. E. Sifneos postavljaju hipotezu prema kojoj pathinks, which is a way that has characteristics of the concrete. It is as if the patient is alienated from their own psychological experience. This concept is similar to the term alexithymia introduced by J.C. Nemiah and P.E. Sifneos (13).

With regard to aggression, P. Marty introduced the concept of progressive disorganization, which describes the process of destruction of the libidinal organization, with a disappearance of some mental functions such as identification, projection, ability to associate and symbolize. In this way, the death instinct asserts itself, which can eventually lead to death through the development of a serious psychosomatic disease. The instinct becomes a drive when it becomes connected to representation, and the ability to mentalize determines whether somatizations will be reversible or irreversible. P. Marty accepted the existence of both life and death instincts, however, unlike Freud's dual instinct theory of the life instinct and the death instinct working together and the theory of M. Klein, which implies the simultaneous activity of both instincts that are in constant conflict, P. Marty believed that the death instinct operates only after the life instinct fails (3).

P. Marty and M. M'Uzan believed that the psychosomatic symptom replaces fantasy, while JC Nemiah and P. E. Sifneos hypothesized that patients suffering from psychosomatic diseases possess weaker capacity to experience and express their feelings (13).

cijenti koji boluju od psihosomatskih bolesti imaju slabiji kapacitet za doživljavanje i izražavanje osjećaja (13).

Budući da postoje teškoće u definiranju koncepta agresije i njezinoj procjeni, koja može biti i subjektivna, ovisno o socijalnim, kulturološkim i strukturnim svojstvima procjenitelja (analitičara, psihoterapeuta, psihijatra), H. Musaph predlaže da se treba voditi osnovnom idejom u terapijskoj situaciji, putem abreakcije potisnuti osjećaj učiniti svjesnim. No, ishodi mogu biti različiti, a postavlja se i pitanje što u slučaju zaglavljenog afekta koji se pojavljuje periodično, odnosno kada se psihosomatski simptom reaktivira samo u specifičnim situacijama koje su „okidač" za ponovno pojavljivanje simptoma (13).

Brojni psihoterapeuti nemaju iskustvo rada s pacijentima sa psihosomatskim bolestima koji nemaju fantazija i/ili imaju teškoće u izražavanju emocija. Slična su iskustva imale i autorice ovog članka.

U našem kliničkom radu susretali smo se s različitim pojavnostima agresije u naših pacijenata sa psihosomatskim simptomima.

Primjer 1.

Pacijentica u ranim tridesetima javila se na pregled zbog intenzivnog znojenja, osobito izraženog u pazušnim regi-

Because of difficulties in defining the concept of aggression and its evaluation, which can also be subjective, depending on the social, cultural and structural characteristics of the evaluator (analyst, psychotherapist, psychiatrist), H. Musaph proposed that the main idea in the therapeutic situation should be to make the suppressed emotion conscious by means of abreaction. However, this can lead to different results, and the question arises of what to do in case of strangulated affects that break through periodically, i.e. when a psychosomatic symptom reactivates only in specific situations that act as a trigger for the recurrence of a symptom (13).

Numerous psychotherapists have no experience in working with patients suffering from psychosomatic diseases who do not have fantasies and/or have difficulties in expressing emotions. The authors of this article had similar experiences as well. In our clinical work, we have encountered various manifestations of aggression in our patients who suffered from psychosomatic symptoms.

Case report 1

A female patient in her early thirties contacted us for an examination because of excessive sweating, mainly in armpit area. Coming to a psychiatrist was for her the last hope in her efforts to get rid of excessive sweating which interfered with her everyday activities because she had sweat stains on her

jama. Dolazak psihijatru bila je zadnja postaja u pokušajima da se oslobodi prekomjernoga znojenja koje ju je ometalo u svakodnevnom funkcioniranju jer je danomice imala tragove znoja na odjeći, zbog čega je osjećala neugodu. Dominantan je osjećaj zapravo bila ljutnja, ljutnja na znojenje, ljutnja na samu sebe jer znojenje ne može kontrolirati i, konačno, ljutnja na terapeuta koji je ne može osloboditi znojenja. Agresivni je transfer znatno ometao psihoterapijski proces, koji je formalno tekao, no kao da nije niti započeo, pacijentica se nikako nije mogla prepustiti intrapsihičkom istraživanju, i uz moja objašnjenja da ja ne liječim znojenje, ali da se možemo baviti njezinim osjećajima i mislima, da ih pokušamo povezati sa znojenjem, pacijentica bi odgovarala da to nikako nije povezano; kao da je bila odvojena od vlastita psihičkog iskustva. U nekoliko navrata pacijentica ima izljeve ljutnje, gotovo bijesa jer dolazi na terapiju, a i dalje se znoji, počinje vrijeđati terapeuta. Na interpretacije da vjerojatno očekuje svemoćnog terapeuta, reagira ljutnjom. Činilo se da pacijentica ima znatno narušene kapacitete za razmišljanje o mentalnim stanjima i manifestira destruktivnu agresiju. Nakon nekoliko mjeseci pacijentica je, nezadovoljna terapeutom, prekinula psihoterapiju. Postavlja se pitanje možemo li pomoći u ovakvim slučajevima kada pacijentu ne pomažu ni kontejniranje ni interpretacije. Kontra-

clothes daily, and it made her feel uncomfortable. The dominant feeling was actually anger, anger at sweating, anger at herself for not being able to control the sweating, and ultimately anger at the therapist who could not fix her sweating issue. The aggressive transference significantly interfered with the process of psychotherapy, which formally did take place, but it was as if it had not even begun, while the patient could not initiate intrapsychic exploration, and after my explanations that I am not able to 'cure' sweating, but we could try to relate her feelings and thoughts to the sweating, she denied that connection as if she was alienated from her own mental experience. On several occasions, the patient had outbursts of anger, almost fury, insulting the therapist because, as she explained, she continues to sweat, despite attending therapy. She reacted with anger to interpretations that she was expecting an omnipotent therapist. It seemed that the patient had a significantly impaired capacity to think about mental states, and she manifested destructive aggression. After a few months, the patient, dissatisfied with the therapist, quit psychotherapy. The question arises of whether we can help in such cases when neither containment nor interpretations help the patient. In countertransference, it is very difficult to endure verbal aggression from the patient, as well as the feeling of helplessness that arises in the therapist through the defense mechanism of projective identification.

transferno je vrlo zahtjevno podnositi verbalnu agresiju koja dolazi od pacijenta, kao i osjećaj bespomoćnosti koji je izazvan u terapeutu mehanizmom projektivne identifikacije.

Primjer 2.

Adolescentica, studentica, javlja se na pregled, zbog, kako navodi, negativnih misli, razmišlja da bi joj se nešto loše moglo dogoditi. „Okidač" za javljanje jest smrtni slučaj u obitelji, koji se dogodio u isto vrijeme kada i smrt jedne poznanice. Pacijentica opisuje misli agresivnog sadržaja, pomišlja na moguće samoozljeđivanje. Misli imaju prisilan karakter, nametajuće su i uznemirujuće. Od razdoblja djetinjstva ima prisilne misli, najčešće vezano uz školski neuspjeh, a, kada bi se misli intenzivirale, kadšto bi i povratila. Čini se da je povraćanje bilo oblik somatskog rasterećivanja anksioznosti. Kasnije se koristi motoričkom aktivnošću koja uključuje i kreativne elemente (ples i glazbu) za rasterećivanje anksioznosti i agresivnih impulsa. Saznaje se da od rane dobi ima atopijski dermatitis koji oscilira u svojoj pojavnosti ovisno o stresnim situacijama. Razmišlja o odlasku iz roditeljskog doma, no čini joj se da bi roditelji „umrli bez nje". Objektni su odnosi na simbiotskoj razini, roditelji su kontrolirajući, a ona sama manifestira potrebu za kontrolom u prijateljskim odnosima, kao i u odnosu prema

Case report 2

An adolescent girl, a student, contacted us for an examination because of, as she states, her negative thoughts, thoughts that something bad could happen to her. This was triggered by a recent death of a family member, which occurred at the same time as the death of an acquaintance. The patient described thoughts of aggressive nature, thoughts about possible self-harm. The thoughts were obsessive, intrusive and disturbing. She had had obsessive thoughts since childhood, often related to the fear of failure at school, sometimes so intense that she would vomit. The vomiting appeared to have been a form of somatic relief of anxiety. Later, she used motor activity that included creative elements (dance and music) to relieve anxiety and aggressive impulses. We found out that in early childhood she developed atopic dermatitis, which oscillates in the occurrence of symptoms depending on stressful events. She was considering moving out of her parents' house, but it seemed to her that her parents would "die without her". Her object relations level was at a symbiotic level, her parents were controlling, and she herself manifested the need for control in relationships with friends, as well as in relation to her parents. The false self dominated, and the only thing she could not hide were visible changes on the skin of her face and hands. During psychoanalytic psychotherapy, the patient did not manifest direct aggression, but rather aggression

roditeljima. Dominira lažni self, a jedino što ne uspijeva sakriti jesu vidljive promjene na koži lica i ruku. Tijekom psihoanalitičke psihoterapije pacijentica nije otvoreno agresivna, a agresija se više manifestira kroz kontrolu terapeuta i samoga terapijskog procesa iznenadnim otkazivanjem seansi, kašnjenjem ili sjedenjem na udaljenom kraju čekaonice. Konfrontacijama i interpretacijama uspijevamo omekšati otpore i razumjeti njezinu snažnu potrebu za kontrolom koju očituje u odnosu prema terapeutu kako bi obranila lažni self. Postiže se uvid, odnosno pacijentica uspijeva razumjeti kako s vremenom razvija sve veću ovisnost o terapeutu, što je plaši, jer ima osjećaj da gubi kontrolu, „sram ju je što me treba, osjeća se jadno", što kompenzira jačanjem kontrole gotovo do agresije. Otkrivajući pravi self, umanjuje se potreba za tako snažnom kontrolom terapijskoga procesa.

Primjer 3.

Mlada žena, zaposlena, živi sama, boluje od ulceroznog kolitisa posljednjih 5 godina. Javila se zbog problematičnih odnosa na radnom mjestu. Saznaje se o gubitku majke zbog zloćudne bolesti tijekom njene pubertetske dobi, o lošem odnosu s ocem posljednjih godina, od kojeg se odselila jer su se „kontinuirano svađali oko sitnica i nije uvažavao njeno mišljenje". Ulazila je u emocionalne veze, no nijedna nije potrajala dulje

manifested itself through the control of the therapist and the therapeutic process, i.e. unexpected cancellations of sessions, being late for sessions or sitting at the far end of the waiting room. Using confrontations and interpretations, we managed to soften her resistances and interpret the strong need for control which she manifested in relation to the therapist in order to defend the false self. Insight was achieved, i.e. the patient managed to understand that over time she was developing an increasing dependence on the therapist, which scared her because she felt she was losing control, and "she was ashamed that she needed me, she felt miserable", which she tried to overcome by increasing the control nearly to the point of aggression. By revealing the true self, the need for such strong control of the therapeutic process was reduced.

Case report 3

A young woman, employed, living alone, had been suffering from ulcerative colitis for the past five years. She contacted us because of problematic relationships in the workplace. During therapy, it was revealed that she had lost her mother due to a malignant disease during her puberty, and that she had a bad relationship with her father in recent years, from whom she moved away because they "continuously argued about small things and he did not respect her opinion". She had emotional relationships, but none of them lasted longer than a few months, and lately she felt uncomfortable start-

od nekoliko mjeseci, a u posljednje se vrijeme osjeća nelagodno i boji se započeti novu vezu zbog svoje bolesti. Na psihoterapiju ju je uputio njezin internist. Prvo vrijeme govori najviše o odnosima na poslu, gdje bi se često uznemirila, nije prepoznavala svoju ljutnju, potom je nije niti prihvaćala, nije znala što napraviti s tim osjećajem. Jasno je mogla povezati te osjećaje s pogoršanjem svoje bolesti. Dobro reagira na konfrontacije koje prihvaća, mijenja svoje ponašanje i uviđa povoljan učinak na odnose na radnom mjestu za koje je smatrala da će morati napustiti koliko se loše i bezizlazno osjećala prije psihoterapije. Daljnja je terapeutova inicijativa bila povezati to s njezinom primarnom obitelji, odnosno s ocem. To je naizgled prihvatila, no ubrzo nakon toga napušta terapiju, objašnjavajući da je na poslu prihvatila unapređenje i da joj više ne ostaje mnogo slobodnog vremena, a ono je po što je došla, i dobila. Na jedno od posljednjih terapeutovih pitanja koje je bilo „kako se sad osjeća", samo se pristojno nasmiješila i nije dopustila daljnji razgovor o ljutnji na terapeuta. Kontratransferno je bio prisutan, s jedne strane, osjećaj olakšanja jer više nema brige zbog mogućih pogoršanja njezine osnovne bolesti i tapkanja s intervencijama u psihoterapijskom procesu, a, s druge strane, i pitanje je li se moglo napraviti više, bi li se čekanjem možda moglo otvoriti pitanje agresije i na oca i na terapeuta.

ing a new relationship because of her disease. She was referred to psychotherapy by her internist. At first, she talked mostly about the relationships at work, where she would often get upset, but she did not recognize her anger, was not able to accept it, and did not know what to do with that feeling. She could clearly associate these feelings with the worsening of her disease. She responded well to confrontations, which she accepted, changed her behavior and saw a beneficial effect on the relationships in the workplace which she thought she would have to let go of because how bad and hopeless she felt before psychotherapy. A further initiative of the therapist was to connect this with her primary family, that is, with her father. She seemingly accepted it, but soon after that she quit therapy, explaining that she accepted a promotion at work and that she no longer had much free time, and what she came for, she got. To one of the last questions of the therapist, which was "how does she feel now", she just smiled politely and did not allow further conversation about anger at the therapist. In countertransference, on the one hand there was a sense of relief because there were no longer worries about possible exacerbations of her underlying disease and meddling with interventions in the psychotherapeutic process, and on the other hand, the question of whether more could have been done, if by waiting a little longer, the question of aggression towards both the father and the therapist could have been discussed.

ZAKLJUČNO RAZMIŠLJANJE

G. Lerotić opisuje načine ekspresije agresivnog nagona. Agresivni se nagon može otpuštati preko akcije, misli, osjećaja, fantazija i snova, što se može opservirati i s čime se može raditi u psihoterapijskom procesu (31). Nažalost, iz kliničkog iskustva autoricâ kod psihosomatskih pacijenata, to često nije tako, odnosno psihosomatski pacijenti ili u potpunosti nemaju razvijen kapacitet za psihološko (um koji ne može misliti), nemaju fantazija i asocijacija na snove ili je taj kapacitet nedovoljno razvijen. Psihoterapija psihosomatskih pacijenata traži dodatnu strpljivost i početno učenje pacijenta psihološkom promišljanju. Za terapeuta može biti i kao „hodanje po rubu". Kako nešto naučiti pacijenta, pokazati mu, doživjeti s njim, a istodobno prihvatiti moguće pogoršanje psihosomatske bolesti koje može zahtijevati i bolničko liječenje i za koje se onda terapeut osjeća djelomično ili potpuno odgovornim. Drugim riječima, psihoterapija psihosomatskih pacijenata je zahtjevna, s čestim oscilacijama između suportivnog i analitičkog pola, ovisno o pacijentovoj spremnosti i trenutačnim kapacitetima.

FINAL OBSERVATIONS

G. Lerotić described some modalities of aggressive instinct expressions. The aggressive impulse can be released through patient's actions, thoughts, feelings, fantasies and dreams, which can be observed and worked through in the psychotherapeutic process (31). Unfortunately, from the clinical experience of the authors, this is often not the case in psychosomatic patients, i.e. psychosomatic patients either do not have a developed capacity for psychological thinking (a mind that cannot think), for fantasies and associations to dreams, or this capacity is insufficiently developed. Psychotherapy of psychosomatic patients requires additional patience and initial learning of psychological thinking in patients. For the therapist, it can also mean "walking on the line". How to teach the patient, to show them, experience with them, and at the same time accept the possibility of psychosomatic deterioration that may require hospital treatment for which the therapist might feel partially or fully responsible. In other words, psychotherapy of psychosomatic patients is demanding, with frequent oscillations between supportive and analytical poles, depending on the patient's willingness and current capacities.

LITERATURA/*REFERENCES*

1. Smadja C. Psychoanalytic psychosomatics, Int J Psychoanal. 2011 92:221–230.
2. Lipowski ZJ. Psychosomatic medicine: Past and present. Can J Psychiatry.1986 31:2–21.
3. Bronstein C. On Psychosomatics: The Search for Meaning. International Journal of Psycho-Analysis. 2011 92:173-195
4. Back T. GRODDECK – FREUD Briefwechsel 1917-1934. str.6 DOI: 10.13140/2.1.2267.1360
5. Whitlock FA. Psychosomatic classification definitions and methodology. In: Psychological aspects of skin disease. 1976. str.15-23.
6. Freud S. Three essays on the theory of sexuality. The standard edition of the complete psychological works of Sigmund Freud, 7 (1905), str.123-243.
7. Freud S. Instincts and Their Vicissitudes.The standard edition of the complete psychological works of Sigmund Freud, 14 (1915), str.109-140.
8. Freud S. Mourning and Melancholia. The standard edition of the complete psychological works of Sigmund Freud, 14 (1917). str. 237-58.
9. Freud S. Beyond the Pleasure Principle. The standard edition of the complete psychological works of Sigmund Freud, 18 (1920), str.1-64
10. Freud S. The Ego and the Id. The standard edition of the complete psychological works of Sigmund Freud, 19 (1923), str. 1-66.
11. Freud S. Civilization and Its Discontents. The standard edition of the complete psychological works of Sigmund Freud, 21 (1930), str. 57-146
12. Laplanche J,Pontialis JB. Rječnik psihoanalize. Zagreb: Naprijed; 1992. str 7-11.
13. Musaph H, The Role Of Aggression In Somatic Symptom Formation. Int J Psychiatry Med. 1974 (5) 4:449-460.
14. Hartman H. Essay on Ego Psychology. 4 th Ed. New York: Inter.Univ. Press; 1976.
15. Segal H. Introduction to the Work of Melanie Klein (1st ed.). Routledge. 1973. https://doi.org/10.4324/9780429476198
16. Mahler M. Aggression in the Service of Separation-Individuation, Case Study of Mother-daughter relationship, Psychoanal. Quart. 1981. 50(4): 625-38.
17. Hartmann H, Kris E, Loewenstein, RM. Notes on the Theory of Aggression. The Psychoanalytic Study of the Child, 1947 3(1), 9–36. https://doi.org/10.1080/00797308.1947.11823076
18. Greenacre P. Considerations Regarding the Parent-Infant Relationship. The International Journal of Psycho-Analysis; Jan 1960 41: 571-84.
19. Parens H. Aggression: A Reconsideration. J.Am.Psychoanal. Assn, 1973 21:34-60
20. Parens H. Aggression: The Development of Aggression in Early Childhood, New York 1979.
21. Luborsky L, Docherty JP, Penick S. Onset conditions for psychosomatic symptoms: a comparative review of immediate observation with retrospective research. Psychosom Med 1973 35:187-204.
22. Ragozinskaya VG. Features of Psychosomatic Patients' aggressiveness. Procedia - Social and Behavioral Sciences. 2013 86:232 – 235.
23. Thayer JF, Brosschot JF. Psychosomatics and psychopathology: looking up and down from the brain. Psychoneuroendocrinology 2005 30:1050–1058.

24. Meerloo JAM. Human Violence Versus Animal Aggresion, Psychoanalityc Quarterly. 1968 Spring (55) 1:37-56
25. Bion WR. Attacks on Linking. International Journal of Psychoanalysis. 1959 40:308-315.
26. Cividini-Stranić E. Destruktivna agresija u psihoterapiji psihosomatskih poremećaja. Psihoterapija. 1986 16:101-106.
27. Klein S. Notes on a case of ulcerative colitis. Int. J Psychoanal 1965 46:352-51.
28. Schur M. Comments on the Metapsychology of Somatization1. The Psychoanalytic Study of the Child, 1955 10(1), 119–164. https://doi.org/10.1080/00797308.1955.11822553
29. Sarajlić N. Psihodinamski odnos agresije, hostilnosti i psihosomatskog simptoma. Psihoterapija. 1988 18:25-35.
30. Gilić A. Psihoterapija pacijenata sa simptomima oscilatorne hipertenzije. Psihoterapija. 1996 26:71-88.
31. Lerotić G. Manifestacije agresije i neuroza. Psihoterapija 1976 6(2): 227- 42.