PSIHODINAMSKA GRUPA PSIHOTIČNIH PACIJENATA NA ZATVORENOM PSIHIJATRIJSKOM ODJELU

/ *A PSYCHODYNAMIC GROUP OF PSYCHOTIC PATIENTS ON A CLOSED PSYCHIATRIC WARD*

Goran Tošić, Andreja Horvatić

SAŽETAK/*SUMMARY*

U članku se daje prikaz psihodinamske grupe psihotičnih pacijenata na zatvorenom psihijatrijskom odjelu. Istaknuta je potreba modificiranog pristupa u odnosu na uobičajenu analitičku grupu neurotskih pacijenata. Modifikacije se odnose i na grupu i na voditelja tj. njegov stil vođenja grupe. Dana je važnost konteksta u kojem se održavaju psihoterapijske grupe i mnogobrojnih interakcija između većeg sustava (odjela) i manjeg sustava (grupe). Ukazuje se na važnost adekvatnog odnosa osoblja prema pacijentima kao i na važnost čvrste strukture terapijskih aktivnosti na odjelu.

/ The article presents a psychodynamic group of psychotic patients on a closed psychiatric ward. It highlights the need for a modified approach in comparison with the ordinary analytic group of neurotic patients. Modifications apply to both the group and the leader, that is, his style of leading the group. The article emphasizes the importance of the context in which psychotherapeutic group sessions are held, and of numerous interactions between the larger system (the ward) and the smaller system (the group). The importance of the appropriate relationship between the staff and the patients is pointed out, as well as the importance of the firm structure of therapeutic activities within the ward.

KLJUČNE RIJEČI / *KEY WORDS*

psihoza / *psychosis*, modificirane psihoterapijske grupe / *modified psychotherapeutic groups*, kontratransfer / *countertransference*, projektivna identifikacija / *projective identification*

Prim. mr. sc. **Goran Tošić**, dr. med., psihijatar, psihoterapeut, grupni analitičar, edukator iz grupne analize, član IGA, e-pošta:goran.tosic62@gmail.com

Andreja Horvatić, dr med.

Prim. mr. sc. ***Goran Tošić****, MD, psychiatrist, psychotherapist, group analyst, educator from group analysis, member of IGA, e-mail: goran.tosic62@gmail.com*

Andreja Horvatić*, MD*

UVOD

Shizofreniju kao paradigmu psihotičnih poremećaja i dalje je teško definirati. Po mišljenju mnogih autora (Sadock, Sadock, Ruiz 2015, Medved 2015, Hotujac 2006) vjerojatno se radi o grupi poremećaja, heterogenih etiologija, koje uključuju pacijente čija klinička slika, odgovor na terapiju i tijek bolesti – variraju (1-3). Danas važi podjela na paranoidnu, dezorganiziranu, katatonu, nediferenciranu i rezidualnu shizofreniju uz još deset drugih subtipova (4).

M. Jakovljević (Jakovljević 2011) navodi da postoji preko stotinjak etioloških hipoteza o uzrocima shizofrenije. Nekoliko je velikih skupina teorija: biologijske, psihološke i psihodinamske, socijalne, spiritualne, holističke (5).

Temelje suvremenom psihodinamskom razumijevanju shizofrenije dao je Bion (Bion 1957,2005) pišući o karakteristikama psihotične osobnosti u kojoj dominiraju destruktivni impulsi (omnipotentna fantazija o uništenju vanjske i unutarnje realnosti) (6-9). U psihozi dolazi do jake fragmentacije osobnosti tj. aparata za svjesnost o realitetu i do ekscesivne projekcije tih fragmenata u vanjske objekte. Tako nastaju tzv. bizarni objekti (Bion navodi primjer gramofona koji gleda ili sluša bolesnika). Gubi se simbolizaci-

INTRODUCTION

Schizophrenia, as a paradigm of psychotic disorders, remains difficult to define. According to numerous authors (Sadock, Sadock, Ruiz 2015, Medved 2015, Hotujac 2006), it is probably a group of disorders, heterogeneous etiologies, which include patients whose clinical picture, the response to the therapy, and the course of their disease all vary (1-3). Today there is an accepted division into paranoid, disorganized, catatonic, non-differentiated, and residual schizophrenia, along with ten other sub-types (4).

M. Jakovljević (Jakovljević 2011) claims there are over one hundred etiological hypotheses on the causes of schizophrenia. There are several major groups of theories: biological, psychological and psychodynamic, social, spiritual, and holistic (5).

The basis for the modern psychodynamic understanding of schizophrenia was created by Bion (Bion 1957, 2005), who discussed the characteristics of psychotic personality with a dominance of destructive impulses (omnipotent fantasy on the destruction of exterior and interior reality) (6-9). In psychosis, there is a strong fragmentation of personality, that is, of the instrument for the awareness of reality, and excessive projection of those fragments into external objects. That is how so-called bizarre objects are created (Bion gives the example of a gramophone that watches or listens to the patient). There is loss of symbolization, that is, the onset of concretization (for example,

ja tj. nastaje konkretizacija (npr. riječi se doživljavaju kao stvari). Unošenjem u sebe bizarni objekti postaju progoniteljski Super ego (8). Taj unutarnji objekt je destruktivan prema svim vezama npr. on napada na vezu senzorija i svjesnosti o senzornom doživljaju, napada na vezu unutar procesa mišljenja (npr. na vezu slikovnih i slušnih predodžbi), kao i na vezu između riječi. Preživljavaju veze koje su ne- emocionalne tj. sterilne.

U svom radu o teoriji mišljenja Bion (Bion 2005) tumači da odsutnost žuđene dojke uz slab kapacitet za toleranciju frustracija vodi ili prema izbjegavanju frustracije (i jačanju projektivne identifikacije) ili prema modifikaciji frustracije (i stvaranju omnipotencije). U slučaju dobrog kapaciteta za toleranciju frustracije razvija se aparat za mišljenje. U normalnom odnosu djeteta i majke, dijete putem projektivne identifikacije pobuđuje u majci osjećaje koji su djetetu preteški da ih drži u sebi, majka te osjećaje prihvaća i prorađuje (pomoću svoje alfa funkcije) i tako bezopasne ih vraća djetetu. Ako je majka nesposobna za kontejniranje, dijete reintrojicira ono što je projektivno izbacila i što majka nije metabolizirala i pri tome dijete doživljava bezimeni užas. U odrasloj osobnosti taj užas od uništenja je također jedna od karakteristika psihotične osobnosti. Objektni odnosi psihotičnih osoba su nezreli, optereće-

words are perceived as objects). Through internalization, bizarre objects become a persecuting super ego (8). This internal object is destructive towards all other connections. For example, it attacks the link between the senses and the awareness of sensory experience, the link within the process of thought (for example, the connection between visual and auditory ideas), as well as the link between words. Non-emotional, or sterile, connections survive.

In his article on the theory of thought (Bion 2005), Bion claims that the absence of the desired breast, along with a low capacity for frustration tolerance leads either to frustration avoidance (and the strengthening of projective identification) or frustration modification (and the creation of omnipotence). In the case of a good capacity for frustration tolerance, the instrument for thinking is developed. In the normal relationship between a child and its mother, the child uses projective identification to encourage the mother to feel emotions that are too difficult for the child to hold within itself, the mother accepts those emotions, works through them (using her alpha function), thus rendering them harmless, and then returns them to the child. If the mother is incapable of containing, the child re-introjects that which she had expelled through projection and which the mother failed to metabolize, during which the child experiences a nameless terror. In an adult person, this terror of destruction is also one of the characteristics of psychotic personality. Object relations of psychotic people

ni ovisnošću i nezrelim mehanizmima obrane kao što su rascjep i projektivna identifikacija (9).

U psihotičnom transferu, zapaža H. Searles (Searles 1999), pacijent ne razlikuje prošlost od sadašnjosti, jednu osobu od druge pa zbog toga svjesno vjeruje da je terapeut zapravo njegova majka ili otac, brat itd. (10).

S. Resnik (Resnik 2000) razmišljajući o psihodinamici ukazuje na obranu od bolnih osjećaja na način emocionalne anestezije, gašenja, zamrzavanja, mehanizacije. Self se obrambeno može premještati izvan tijela (depersonalizacija) ili u dio tijela (hipohondija) ili u nečije drugo tijelo (imitacija tuđih gesti) ili u nečiji drugi mentalni prostor (lažni self) (11). Nesvjesno se izražava kroz tijelo, koje se obrambeno doživljava kao željezno, kameno, zamrznuto itd. (12). U transfernoj psihozi, po M. Little (Little 1993) nema „kao da" kvalitete u transferu. Terapeut postaje doslovno primarna figura npr. roditelj koji je idealiziran ili dijaboliziran. Transferna psihoza može biti obrana od stanja nediferenciranosti u kojem su subjekt i objekt – ista stvar (13).

KONCEPTI I KLINIČKI PRIMJERI

Suvremeni teoretičari (Jackson 2001, De Masi 2001) kreativno dalje razvijaju

are immature, burdened with dependence and immature defense mechanisms such as a split and projective identification (9).

In psychotic transfer, according to H. Searles (Searles 1999), the patient does not differentiate between the past and the present, one person from another, and therefore consciously believes that the therapist is actually their mother or father, brother, etc. (10).

While discussing psychodynamics, S. Resnik (Resnik 2000) points to defense from painful emotions through emotional anesthesia, shutting down, freezing, and mechanization. The self can defensively transfer outside of the body (depersonalization), into a body part (hypochondia), someone else's body (imitation of another person's gestures), or into someone else's mental space (false self) (11). This is unconsciously expressed though the body, which is defensively perceived as iron, stone, frozen, etc. (12). In transferential psychosis, according to M. Little (Little 1993), there is no "as if" quality in transference. The therapist literally becomes the primary figure, for example a parent who is idealized or demonized. Transferential psychosis may be a defense from the state of non-differentiation, in which the subject and the object are one and the same (13).

CONCEPTS AND CLINICAL EXAMPLES

Modern theorists (Jackson 2001, De Masi 2001) continue to creatively develop Bi-

Bionove ideje istražujući psihodinamiku psihoze. Oni ističu gubitak simbolizacije uz nastanak perceptivnog kaosa i konkretno mišljenje. Nema mentalnog prostora za deponiranje, procesiranje i korištenje sjećanja. Nestabilne su reprezentacije selfa i objekta kao i diferencijacija reprezentacija selfa i objekta (sklonost fuziji). Gubi se kapacitet za samo-opservaciju, gubi se sposobnost testiranja realiteta, više se ne razlikuje vanjsko od unutarnjeg. Osoba se povlači u svoj izmaštani svijet koji može zadovoljavati nezrele potrebe (14,15). T. Ogden (Ogden 1992) uz netom navedene karakteristike paranoidno-shizoidne pozicije još dodaje poricanje osjećajnosti, laku zamjenljivost objekta (gleda se korisnost objekta). T. Ogden opisuje i autistično-graničnu poziciju u kojoj doživljaj selfa čine jednostavni senzorni doživljaji bez simbolizacije (npr. toplo-hladno, tvrdo-meko, granica, pritisak, ritmičnost). Postoje strahovi od curenja unutrašnjosti selfa kroz propusnu granicu u beskrajni okolni prostor. Obrana od toga može biti tzv. „sekundarna koža“. U patološkom autizmu, neživi objekti (strojevi i stvari) su važniji od živih objekata (16).

Svakodnevno kliničko iskustvo donosi uvid u psihotična stanja i procese bilo da se radi o shizofrenim ili na drugi način psihotičnim pacijentima ili da se radi o dekompenziranim pacijentima s graničnim ili narcističnim po-

on’s ideas by researching the psychodynamics of psychosis. They highlight the loss of symbolization with the onset of perceived chaos and concrete thought. There is no mental space for storing, processing, and using memories. Representations of the self and the object are unstable, and so is the differentiation between representations of self and object (a tendency towards fusion). There is a loss of the capacity for self-observation and a loss of the ability to test reality, and there is no more differentiation between the external and the internal. The person withdraws into a fantasized world that can satisfy immature needs (14,15). To the aforementioned characteristics of the paranoid-schizoid state T. Ogden (Ogden 1992) also adds denial of sensitivity and the ease with which an object can be replaced (the emphasis is on the usefulness of the object). T. Ogden also describes the borderline autistic state, in which the experience of self is made up of simple sensory impacts without symbolization (for example, warm-cold, hard-soft, border, pressure, rhythm). There is fear of the leakage of the inner self through a porous border into a limitless outer space. Defense from this may be the so-called “secondary skin”. In pathological autism, inanimate objects (machines and things) are more real than animate objects (16).

Everyday clinical experience gives insight into psychotic conditions and processes, whether the patients are schizophrenic or psychotic in some other way, or whether the patients are decompensated with a borderline or narcissistic

remećajem osobnosti i njihovim svjesnim iskustvima ili pak stanjima selfa u noćnim morama. Iskustvo je autora ovog članka (Tošić 2006,2007,2008) da psihodinamika psihotičnih pacijenata uključuje nestabilne self i objekt reprezentacije, fuziju self i objekt reprezentacija i prijetnju uništenjem (anihilacijom), gubitak simbolizacije i primitivne mehanizme obrane, omnipotenciju, eskalaciju agresije, prijetnju parcijalnih progoniteljskih objekata, strah od fragmentacije, redukciju i promjenu kvalitete libida (17-19).

Ovako poopćeni i konceptualizirani pojmovi djeluju pomalo daleko od istinski zastrašujućih psihotičnih doživljaja koji su idealno opisani Bionovom (Bion 2005) sintagmom „bezimeni užas" (9). U pokušaju da približimo to iskustvo naših pacijenata navest ćemo neke njihove konkretne, fragmentirane doživljaje.

Primjere započinjemo nediferenciranom objekt reprezentacijom: pacijent koji se jako zanimao za Drakulu, kupio knjigu o njemu i krenuo u Transilvaniju vlakom, najednom, vozeći se vlakom, doživljava jaki strah od te knjige, pali je i pri paljenju začuje strašni vrisak i pokraj njega u kupeu kao da proleti neki duh i izleti kroz zid kupea van iz vlaka. Po povratku kući je u crkvi potražio zaštitu a onda je doživio da Drakula u obliku ljubičaste sile

personality disorder and their conscious experiences, or the states of the self in nightmares. In the experience of this article's author (Tošić 2006, 2007, 2008), the psychodynamics of psychotic patients include unstable self and object representations, fusion of self and object representations, and the threat of annihilation, the loss of symbolization, and primitive defense mechanisms, omnipotence, aggression escalation, the threat of partial pursuing objects, fear of fragmentation, reduction, and a change in libido quality (17-19).

These generalized concepts seem somewhat removed from truly frightening psychotic experiences described by Bion's (Bion 2005) as "nameless terror" (9). In an attempt to illustrate this experience of our patients, we shall list several of their concrete, fragmented experiences.

We begin with a non-differentiated object representation: the patient showed great interest in Dracula, bought a book on him, and went to Transylvania by train, and suddenly, while in the train, experienced a great fear of the book, set it on fire and heard a terrible scream, while something like a ghost passed by him and exited through the wall of the train. On his return home, he sought protection in a church, and experienced Dracula exiting through his head in the form of purple force. The second patient dreams about a terrible force tearing his skin from his trunk. He hears voices in his head and has a feeling that there is a foreign force inside him. He feels he is going mad, and

izlazi iz njegove glave. Drugi pacijent sanja da mu neka strašna sila čupa kožu s trupa. Čuje neke glasove u glavi i ima osjećaj neke strane sile u njemu. Osjeća da ludi, budi se u panici. Treći pacijent čija je majka nakon njegovog rođenja bila depresivna, sanja da majka- vještica živi u njegovom tijelu. Ona je poput nekakvog duha. On radi nešto na računalu i kad je ugleda krajičkom oka, ona strahovito zavrisne.

Deformaciju self reprezentacije pacijenti doživljavaju ovako: pacijent sanja da se gleda u ogledalo. Vidi svoje lice koje najednom postaje čvorasto. Zabrinut je i ustrašen. Tada se lice izobličava i zatim se počinje valovito izduljivati. Ne može se više prepoznati. Pacijent se budi jako uznemiren.

Moguća je transformacija self reprezentacije u drugo živo biće: pacijent sanja da je životinja- vidra. Pliva u vodi i u ustima za njušku drži lisicu. Izlazi na obalu. Vidi kako svojim šapama i kandžama staje lisici na glavu i grize joj vrat da bi je ubio. Zatim jede velike komade sirovog mesa i onda se opet pretvara u svoj ljudski lik. San mu je strašan i čudan: on kao životinja, zvijer.

Primjer transformacije objekt i self reprezentacije u dehumanizirane predmete: pacijent sanja i sa strahom shvaća da je njegov prijatelj pretvoren u metalnog robota sa očima kao malim

wakes up in a panic. The third patient, whose mother was depressed after his birth, dreams that a witch-mother lives in his body. She is like a ghost. He is doing something on the computer when he notices her in the corner of his eye, and she lets out a terrible scream.

The deformation of the representation of the self is experienced by patients in the following way: the patient dreams of looking at himself in the mirror. He sees his face suddenly become knotted. He is worried and frightened. His face then deforms and begins to elongate while undulating. He can no longer recognize himself. The patient wakes up very disturbed.

The transformation of the representation of the self into another living being is possible: the patient dreams he is an animal – an otter. He is swimming in the water and has his mouth around the snout of a fox. He gets out on the bank. He sees himself standing on the fox's head with his paws and claws, biting its neck to kill it. He then eats large pieces of raw meat and finally turns back into his human form. He finds the dream frightening and strange: him as an animal, a beast.

An example of transformation of the representation of the object and the self into dehumanized objects: the patient is dreaming and realizes, terrified, that his friend has been transformed into a metal robot with eyes like small TV screens placed in the inside of a partially torn box. Second example: the patient feels in

TV ekranima koji su smješteni u unutrašnjosti dijelom razderane kutije. Drugi primjer: pacijent u snu osjeća da je mali metalni novčić koji pada u jako veliku pukotinu, u „crnilo i mrak“. Drhti.

Moguća je fuzija selfa i objeka, ili selfa i okoline, uz strah od uništenja : Pacijent leži u krevetu nakon napornog dana. Iznenada, u panici shvaća da svemir počinje ulaziti u njegovo tijelo. Isti pacijent: stojeći na balkonu, gleda u nebo i osjeća da dolazi zastrašujući trenutak rasplinjavanja njegovog tijela u okolni prostor. Strah od uništenja doživio je drugi pacijent dok je sjedio ispred ugašenog računala. Gledajući u crni ekran najednom osjeća kao da ga računalo počinje usisavati u svoju unutrašnjost. U užasu osjeća kao da upada u tamu u kojoj će se „rastočiti“.

Omnipotencija je povezana sa osjećajem ugode: pacijentu su počele dolaziti misli da je „Antikrist“. Osjećao se „fenomenalno“. Imao je osjećaj da može očima povući Sunčevu energiju i usmjeriti je na drugo mjesto. Isti pacijent, u hotelskoj sobi, imao je osjećaj da mu je bjelkasti Drakulin duh ušao u glavu. Pacijent ga je pustio u dubinu sebe kao kroz neki oblak. Kad je Drakulin duh propao, pacijent je brzo zatvorio oblake u sebi a duh je i dalje padao unutar njega u „bezdan i pakao“.

Gubitak simbolizacije ili, po Bionu, gubitak alfa funkcije, vidi se kroz kon-

his dream that he is a small metal coin falling into a very large crack, into "blackness and darkness". He shivers.

There is a possibility for the fusion of self and object, or self and the environment, with the fear of destruction: the patient is lying in bed after a tiring day. Suddenly, in a panic, he realizes that the universe has started entering his body. The same patient: standing on the balcony, he looks at the sky and feels that there will come a frightening moment in which his body will disperse into the surrounding space. The second patient experienced the fear of annihilation while sitting in front of a computer that was turned off. Looking in the black screen, he suddenly feels as if the computer is beginning to suck him into itself. Terrified, he feels he is falling into a darkness in which he will "dissolve".

Omnipotence is tied to a feeling of pleasure: the patient begins to have thoughts about being "the Antichrist". He feels "phenomenal". He had a feeling he could pull the sun's energy with his eyes and direct it to another place. While he was in a hotel room, the same patient had a feeling that Dracula's whitish spirit entered his head. The patient allowed it to enter him as if through some cloud. When Dracula's spirit descended, the patient quickly closed it up in the clouds inside himself, and the spirit kept falling down inside him into "an abyss and hell".

The loss of symbolization or, according to Bion, the loss of alpha function, can be

kretizaciju apstraktnog: pacijent sanja svoju nadljudski veliku i šuplju glavu u kojoj misli stvaraju nerazumljivu buku ječećih glasova. Ništa ne razumije, jedino osjeća veliki strah koji ga budi.

Progoniteljski parcijalni objekti se reprezentiraju ili kao anatomski (u snu: ogromne oči na nebu koje promatraju i procjenjuju) ili kao funkcije ega i super ega: računalo koje nadgleda (gleda), ogromni avion koji zakriljuje nebo i koji u apsolutnoj tišini osluškuje (sluša) da li je netko preživio, računalo koje usisava u sebe (siše), stroj u glavi umjesto mozga (stroj koji misli). Dakle, radi se o bizarnim objektima po Bionu koji su kombinacija reprezentacije neživih stvari i projiciranih (senzornih ili mislećih) funkcija Ega i kontrolirajućih i progoniteljskih funkcija Super ega (6).

Na promjenu kvalitete libida i gubitak osjećajnosti ukazuje pacijent koji sanja sljedeću svemirsku, „zamrznutu“, bez objektnu sliku: sa ogromnog tornja na visini on gleda na zemaljsku kuglu dok ispred njega i sa lijeve i desne strane izlaze tri Sunca. Redukcija libida, se vidi u primjeru koji donosi V. Tausk (Tausk 1933) u svom radu o utjecajnom stroju: pacijentica doživljava da je pod utjecajem električnog stroja koji ima oblik poput njenog tijela ali bez glave. U početku stroj ima genitalije ali kasnije one nestaju. Na tom stupnju regresije kao da nema svjesnosti o genitalnom (20).

seen in the concretization of the abstract: the patient dreams about his extraordinarily large and hollow head in which thoughts create an incomprehensible noise of voices. He understands nothing, only feels a great fear that wakes him.

Partial pursuing objects are represented as either anatomical (in a dream: huge eyes in the sky that are watching and assessing) or as functions of the ego and super ego: a computer that observes (watches), a huge airplane that hides the sky and listens in absolute silence (listens) for any survivors, a computer that sucks into itself (sucks), a machine inside the head instead of the brain (a thinking machine). Therefore, these are bizarre objects, according to Bion, which are a combination of the representation of inanimate objects and projected (sensory or thinking) functions of the ego and controlling and pursuing functions of the super ego (6).

A change in libido quality is indicated by a patient dreaming the following “frozen” image of space that contains no objects: he looks down on planet Earth from the top of a huge tower, while in front of him and to his left and right three suns are rising. The reduction of libido is observable from V. Tusk’s (Tusk 1993) example presented in his article on the influential machine: the patient feels she is under the influence of an electric machine shaped like her body, but without the head. In the beginning, the machine has genitals, but later they disappear. At this stage of regression there seems to be no awareness of the genital (20).

Slabo spominjane faze psiho-seksualnog razvoja u novijoj psihoanalitičkoj literaturi ne sprječavaju da se fantazijska aktivnost pacijenata očituje kroz sirovi oralitet (bilo direktno ili kroz projekciju): pacijent sanja da se na mjestu majčine dojke razjapi ogromna čeljust sa velikim šiljastim zubima. Drugi pacijent osjeća kao da je vampir, došlo mu je da jednog čovjeka ugrize za vrat. Treći pacijent osjeća da je pojeo neke ljude. Osjeća gađenje i mučninu.

Senzorni organi nisu samo aparati za unošenje već i za izbacivanje informacija kao što je već opisivao Bion (Bion 2005) (21). Ranije navedeni pacijent osjeća da Drakula želi izaći iz njegovog tijela kroz njegove oči.

Uz projekciju, najčešći mehanizmi obrane su rascjep i projektivna identifikacija. Rjeđe opisani mehanizam obrane je blokada periferije selfa koju neki autori (Williams 1997) zovu „no entry“ mehanizam obrane (22). On se sastoji u blokadi senzornih organa i u zatvaranju tjelesnih otvora a sve kao obrana od vanjskih progoniteljskih objekata. Shizofreni pacijenti ponekad stavljaju opuške od cigareta u uši da bi umanjili slušne halucinacije, očito doživljene kao vanjski ugrožavajući napad na self (18). S. Resnik (Resnik 2005) navodi primjer pacijenta koji je zamišljao željezni oklop oko sebe koji bi ga štitio od osjećaja i narcističkih povreda (12). U

Rarely mentioned stages of psycho-sexual development in recent psychoanalytic literature do not prevent the phantasy of the patient to be displayed through raw orality (either directly or through projection): the patient dreams an enormous jaw with spiky teeth opening in the place of his mother’s breast. Another patient feels as though he is a vampire, and felt the need to bite a man on the neck. The third patient feels he has eaten some people. He feels disgust and nausea.

Sense organs are not just instruments for the introduction of information, but also for their ejection, as Bion already described (Bion 2005) (21). The aforementioned patient feels that Dracula wants to leave his body through his eyes.

Along with projection, the most common defense mechanisms are split and projective identification. One rarely described defense mechanism is blocking the periphery of the self, which some authors (Williams 1997) call a “no-entry” defense mechanism (22). It consists of blocking sense organs and closing body orifices in an attempt to defend from pursuing external objects. Schizophrenic patients sometimes put cigarette butts in their ears to decrease auditory hallucinations, obviously perceived as a threatening external attack on the self (18). S. Resnik (Resnik 2005) gives an example of a patient who imagined a steel armor around him that would defend him from feelings and narcissistic injuries (12). In a group, according to Bion (Bion 1983), de-

grupi su, po Bionu (Bion 1983), obrane od psihotičnih anksioznosti – osnovne pretpostavke: ovisnost, borba-bijeg, stvaranje parova. Grupe koje djeluju po osnovnim pretpostavkama imaju psihotične obrasce ponašanja, nastaje regresija na najranije faze mentalnog razvoja, nema strukture, slaba je simbolizacija (jezik nije precizan, nema komunikacije ni suradnje, intelektualna aktivnost je ograničena), nema vremena ni razvoja, mehanizmi obrane su rascjep i projektivna identifikacija, voditelj gubi svoju osobnost jer je jako obuzet osjećajima grupe i često nije u dodiru s realitetom (23).

Što je vani a što je unutra, teško je razlučiti kad je oštećeno testiranje realiteta i kad prijeti fragmentacija selfa: jedan pacijent sanja da je u kinu. Na ekranu je rijeka krvi. U njoj plutaju rasječeni komadi ljudskih trupala. Krvava masa se kreće prema njemu i onda se iznenada s ekrana prelijeva u dvoranu. Pod u kinu se poplavljuje, razina krvi raste, prekriva mu stopala. Nije mu više jasno da li krv sa platna ulazi u dvoranu ili iz dvorane odlazi u film tj. na ekran. Čini mu se kao da i sam postaje dio te raskomadane mase.

U regresiji mogu osim simboličkih, biti blokirane i motoričke funkcije: policija je naišla na pacijenta koji je dugo stajao na kiši i nije odgovarao na pitanja. Kasnije je rekao da je imao osjećaj da

fenses from psychotic anxieties are basic assumptions: addiction, fight-or-flight, couple creation. Groups that function on the basic assumptions have psychotic patterns of behaviour, there is regression to earlier stages of mental development, there is no structure, symbolization is weaker (language is imprecise, there is no communication or cooperation, intellectual activity is limited), there is no time nor development, defense mechanisms are split and projective identification, the leader loses their personality because they are deeply involved in the emotions of the group and is often not in touch with reality (23).

It is difficult to say what is inside and what is outside when reality testing is damaged and there is threat from the fragmentation of the self: one patient dreams he is in the cinema. There is a river of blood on the screen. Severed body parts from human corpses are floating in it. The bloody mass is moving towards him and suddenly pours from the screen into the room. The floor of the cinema is flooded, the level of blood rises and covers his feet. He is no longer certain whether the blood is coming into the room from the screen or leaving the room through the screen and into the film. It seems to him that he is becoming a part of that fragmented mass.

Apart from symbolic, motor functions can also be blocked in regression: the police found a patient who had been standing in the rain for a long time and was not answering questions. Later, he

mu govore i Bog i vrag i da nije znao koga da sluša. Motorika i verbalizacija su bili blokirani.

Nekad se primitivne nesvjesne potrebe kombiniraju: pacijent doživljava sebe kao Boga (omnipotencija i libido) koji se bori protiv vraga ili se doživljava kao moćni plavi vrag koji prolazi kroz zidove i ljubi se sa sobaricama (omnipotencija, agresija i libido). Ili, pacijent u svjesnom stanju ima doživljaj ogromnog rotirajućeg morskog vrtloga (u kojem je pacijent poput beznačajne točkice), vrtloga koji se usisavajući gubi u crnom bezdanu (projicirana omnipotencija i katastrofična destrukcija koja završava u fuziji tj. uništenju). Možda je to esencija psihotičnog iskustva: bespomoćnost i užas pred beskrajno moćnim, neljudskim, bezosjećajnim silama.

Iz gornjih primjera može se razlikovati zrelija i nezrelija razina organizacije selfa. Na zrelijoj razini prepoznajemo funkcije Ega (reprezentacije selfa i objekta) i Super ega (npr. sadistički Super ego „govori" selfu „ubij se") koje pripadaju selfu. Na nezrelijoj, primitivnijoj razini, self je osiromašen, doživljava se kao bolje ili slabije ograničeni prazni prostor u kojem su locirani nediferencirani loši objekti tj. kao prostor kojem nedostaje unutarnja struktura i simbolizacijski proces alfa funkcije pa su npr. misli i glasovi nerazumljivi. Interakcije sa realitetnom okolinom tj. objektima

said he had a feeling that both God and the devil were speaking to him, and he did not know who to listen to. Motor and verbal functions were both blocked.

Sometimes unconscious primitive needs are combined: a patient perceives himself as God (omnipotence and libido) who is fighting against the devil or sees himself as a powerful blue devil who passes through walls and kisses housekeepers (omnipotence, aggression, and libido). Another patient experiences in their conscious state an enormous rotating sea whirlpool (in which the patient is a meaningless dot), a whirlpool that is sucking everything in and losing itself in the black abyss (projected omnipotence and catastrophic destruction ending in fusion or destruction). Perhaps that is the essence of psychotic experience: helplessness and terror in the face of the unlimited strength of inhuman, emotionless forces.

From the above example we may distinguish between a mature and an immature level of organization of the self. On the more mature level we recognize the functions of the ego (representations of the self and the object) and super ego (for example, sadistic super ego "tells" the self "kill yourself") that belong to the self. On the less mature, more primitive side, the self is impoverished, is seen as a more or less limited empty space in which there are non-differentiated bad objects, or as a space that lacks an inner structure and the symbolization process of the alpha function, so the thoughts and voic-

mogu biti onemogućene, nema mišljenja ni verbalizacije, motorika je zakočena, a u fantaziji se interakcije svode na ulaženje ili izlaženje iz selfa nediferenciranih sila ili duhova. Periferija tj. rub selfa postaje važna, najčešće u smislu obrane u zastrašujućem svijetu: blokiraju se senzorni organi i otvori u selfu ili se senzorni organi koriste za izbacivanje loših, prijetećih sadržaja. Takvom selfu prijeti fragmentacija i uništenje kao i bizarni objekti, sastavljeni od parcijalnih funkcija Ega (senzorij, mišljenje) i Super ega (kontrola, proganjanje) koje su fuzionirane sa vanjskim objektima. Jedna od mogućih obrana je i omnipotencija uz kontrolu lošeg objekta u vlastitoj unutrašnjosti (Drakula, majka-vještica).

O KOMUNIKACIJI, FENOMENU „OVDJE I SADA“, KONTRATRANSFERU I PROJEKTIVNOJ IDENTIFIKACIJI

Za potrebe ovog rada dajemo kratki osvrt na neke fenomene u grupi kao što su: komunikacija, fenomen „ovdje i sada“, kontratransfer i projektivna identifikacija.

Komunikacija je proces od temeljne važnosti u grupnoj psihoterapiji, smatraju brojni grupni analitičari (24,25). SH. Foulkes (Foulkes 1984) podsjeća da riječi nose mnoge slojeve značenja

es, for example, are incomprehensible. Interactions with the real environment or objects may be disabled, there is no thinking or verbalization, motor skills are locked-up, and in the fantasy, interactions come down to non-differentiated forces or ghosts entering or exiting the self. The periphery or the edge of the self becomes important, most commonly in the form of defense in a frightening world: sense organs and orifices in the self are blocked or the sense organs are used to eject bad, threatening contents. Such a self is threatened by fragmentation and annihilation, as well as bizarre objects consisting of partial functions of the ego (senses, thinking) and super ego (control, pursuit) that are fused with external objects. One possible defense is omnipotence with the control of a bad object in one's own internal world (Dracula, witch-mother).

ON COMMUNICATION, "HERE AND NOW" PHENOMENON, COUNTERTRANSFERENCE, AND PROJECTIVE IDENTIFICATION

For the purposes of this article we will comment on some phenomena in a group, such as communication, the "here and now" phenomenon, countertransference, and projective identification.

Communication is a process that is of crucial importance in group psychotherapy, according to numerous group analysts (24,25). SH. Foulkes (Foulkes 1984)

i ukazuje na rascjep koji uvijek postoji između značenja koje riječi imaju za pošiljatelja poruke i značenja koje imaju za primatelja poruke. On smatra da je ovaj semantički problem od najveće važnosti u terapijskim grupama (24).

Hospitalna psihoterapijska grupa psihotičnih pacijenata, smatra I. Urlić (Urlić 1999), trebala bi imati ove funkcije: poticati verbalnu komunikaciju i razvoj odnosa u grupi (razrjeđenje dijadnog transfernog odnosa u trijadni), dati podršku zdravom dijelu ega, jačati testiranje realiteta, pružiti korektivno simbiotsko iskustvo. Više se obraća pažnja: pojedincima, nego grupi kao cjelini. Pojedinac je objekt terapije a grupa je glavni terapijski faktor. Terapeut mora posjedovati ne-posesivnu toplinu, empatiju, spontanost u ponašanju prema bolesnicima, a važna je i njegova edukacija i teorijski okvir unutar kojeg je grupa definirana (25).

Jedan od najvažnijih fenomena grupe je fenomen „ovdje i sada". Brojni autori, grupni analitičari, su pisali o situaciji ovdje i sada počev od SH. Foulkesa i EJ. Anthonya (Foulkes, Anthony 1990)(26) do I. Yaloma (Yalom 2013) koji govori o tehnici aktiviranja „ovdje i sada": na prvim grupama treba pitati kako članovi doživljavaju jedni druge, treba vraćati članove grupe od apstraktnog na konkretno,sa osobnog na inter-personalno, upućivati članove da se direktno obra-

reminds us that words carry multiple levels of meaning and points to the split that always exists between the meaning that words have for the sender of the message and the meaning they have for the recipient of the message. He believes that this semantic problem is of great importance in group therapy (24).

According to I. Urlić (Urlić 1999), hospital group psychotherapy of psychotic patients should perform the following functions: encourage verbal communication and the development of relationships in the group (diluting a dyadic transferential relationship into a triadic one), give support to the healthy part of the ego, strengthen reality testing, and provide corrective symbiotic experience. More attention is paid to individuals than the group as a unit. The individual is the object of therapy, and the group is the main therapeutic factor. The therapist must possess non-possessive warmth, empathy, spontaneity in their behaviour towards patients, and his education and the theoretical framework within which the group is defined is also of importance (25).

One of the most important group phenomena is the "here and now" phenomenon. Numerous group analysts have written about the here and now situation, from SH. Foulkes and EJ. Anthony (Foulkes, Anthony 1990) (26) to I. Yalom (Yalom 2013), who discuss the technique of activating the "here and now": in the first groups, members should be asked how they see each other, group members should be taken from the abstract back to the concrete,

ćaju jedni drugima i da se gledaju dok komuniciraju, u početku se mogu isticati pozitivne interakcije. Prošlost se koristi za razumijevanje sadašnjosti. U slučaju problema u grupi terapeut ne mora imati gotov odgovor na dilemu ali je mora moći identificirati i izreći. Fokusiranje na situaciju „ovdje i sada“ ima dva koraka: 1. iskustvo doživljaja „ovdje i sada“ i 2. razumijevanje tog iskustva (27).

E. Cividini Stranić i E. Klain (Cividini Stranić,Klain 1975) upućuju da treba misliti na način „ovdje i sada“ kao i da treba povezivati situacije „tamo i tada“ sa „ovdje i sada“. Cilj grupe je razjašnjavati situacije „ovdje i sada“ i težiti da se zrele promjene iz terapijske grupe prenesu u druge ne terapijske grupe. Ipak, putem prošlosti razumijemo individualnu bolesnikovu dinamiku. U grupi se prošlost javlja, nju treba interpretirati ali tako da se uvijek dovede u vezu sa situacijom „ovdje i sada“. Ako je ponašanje izraz repeticije kompulzije onda analizom situacije „ovdje i sada“ dobijemo bolji uvid i u situaciju „tamo i tada“ (28). I drugi autori koji se bave psihoterapijom psihoza, govore o važnosti situacije „ovdje i sada“ (29,30).

U početku razvoja psihoanalize kontratransfer (31) je smatran teškoćom koju terapeut treba prevladati. Definicija je uključivala reakciju terapeuta na pacijentov transfer kao i terapeutov tran-

from the personal to the interpersonal, instruct members to address each other directly and to look at each other while they communicate, and in the beginning positive interactions may stand out. The past is employed to understand the present. In case of problems within the group, the therapist does not have to have the final answer to a dilemma, but does need to be able to identify it and communicate it. Focusing on the "here and now" situation consists of two steps: 1. the experience of being "here and now" and 2. understanding that experience (27).

E. Cividini Stranić and E. Klain (Cividini Stranić,Klain 1975) claim that one should think in the "here and now" and connect situations "there and then" with "here and now". The group's goal is to explain situations "here and now" and to strive to transfer mature changes from group therapy into other non-therapeutic groups. However, the past allows us to understand the dynamics of each patient. The past appears in a group, it should be interpreted, but in a way that always connects it to the situation "here and now". If the behaviour is the expression of the compulsion repetition, then the analysis of the situation "here and now" gives us a better insight into the situation "there and then" (28). Other authors who perform psychosis psychotherapy also point out the importance of the situation "here and now" (29,30).

In the beginning of the development of psychoanalysis, countertransference (31) was considered a difficulty that the therapist had to overcome. The defini-

sfer na pacijenta. Razvojem psihoanalize kontratransfer je od teškoće postao velika pomoć u terapiji. Prekretničku ulogu je u tome imala Paula Heimann (Heimann 1950) svojim radom o kontratransferu (32).

Tijekom godina predložilo se šire značenje kontratransfera koje, po M. Little (Little 1993) obuhvaća sve što terapeut kaže, čini, misli, sanja, osjeća tijekom analize u odnosu na pacijenta. Terapeut mora biti sposoban za sve vrste identifikacija sa svojim bolesnikom, prihvatiti fuziju s njim što često uključuje unošenje u sebe pacijentovog psihotičnog doživljaja dok u isto vrijeme terapeut mora moći ostati cjelovit i razdvojen. Po njenom iskustvu, svaki pacijent testira svog analitičara da nađe njegove slabe točke i ograničenja. Ako pacijent dokaže da njegov terapeut ne može podnijeti anksioznost, psihotičnost, bespomoćnost bilo u svom pacijentu bilo u sebi, tada pacijent doživljava da će se pražnjenjem unutarnje napetosti njegov (pacijentov) svijet fragmentirati (33).

HF. Searles (Searles 1999) piše da terapeutovi primitivni oblici iskustva ponovo oživljavaju tijekom njegovog rada sa shizofrenim pacijentima. Nužno je da terapeut prizna i usvoji neke jezgre realnih pacijentovih percepcija u transferu umjesto da čvrsto stoji na poziciji da je sva bolest u pacijentu. Po

tion included the therapist's reaction to the patient's transference, as well as the therapist's transference on the patient. With the development of psychoanalysis, countertransference went from being a difficulty to a great aid in therapy. A crucial role in this was played by Paula Heimann (Heimann 1950) and her work on countertransference (32).

Over time, a wider meaning of countertransference was suggested, and according to M. Little (Little 1993) it encompasses everything the therapist says, does, thinks, dreams, and feels during the analysis in relation to the patient. The therapist must be able to perform all sorts of identifications with his patient and accept the fusion with them, which often includes taking in the patient's psychotic experience while being able to remain whole and divided at the same time. In her experience, each patient tests their analyst in order to find their weaknesses and limitations. If a patient proves that their therapist cannot bear anxiety, psychosis, or helplessness, either in their patient or in themselves, then the patient feels that by emptying their inner tension their (the patient's) world will be fragmented (33).

HF. Searles (Searles 1999) claims that the therapist's primitive forms of experience are revived while working with schizophrenic patients. It is necessary for the therapist to admit and adopt some cores of the patient's real perceptions in transference instead of firmly believing that all of the illness is in the patient. In

iskustvu Searles-a, u terapiji sa psihotičnim pacijentom terapeut može osjećati da je njegova vlastita osobnost invadirana sa pacijentovom patologijom i može osjećati da je njegov identitet u opasnosti. Što su bolesnikovi sadržaji čudniji, otuđeniji, sličniji životinjskom ili ne-humanom, to će terapeut morati dublje proniknuti u svoje vlastite osjećaje. Isto tako osjećaji terapeuta mogu se iznenada mijenjati:od bijesa do strasti ili bezvoljnosti. Terapeutov kapacitet da izdrži takvu „paljbu" fragmentacijskog iskustva je suštinski element u pomaganju bolesniku da postane bolje integriran kroz identifikaciju sa terapeutom (10). Kontratransfer je najosjetljiviji i najpouzdaniji instrument u terapiji kod teških bolesnika koji slabo verbaliziraju (34).

Po Resniku (Resnik 2000) terapeut se mora boriti sa patološkim kontratransferom jer ekscesivna bol i strah od psihoze mogu terapeuta onesposobiti u terapijskom smislu (11).

Vlastiti kontratransferni osjećaji koje analitičar uspije sam sebi interpretirati, stoje u rezonanciji sa nesvjesnim osjećajima pacijenta ili grupe, iskustvo je D. Josića (Josić 1999). Ta se rezonancija događa na temelju jakih identifikacija tijekom liječenja. Grupni analitičar bi trebao imati sposobnost da regredira jednim dijelom svoje osobe i da tako dođe u rezonanciju sa bolesnikovim ili

Searles' experience, in a therapy with a psychotic patient, the therapist may feel that their own personality is invaded by the patient's pathology and may feel that their identity is in danger.

The stranger, more alienated, more similar to the animalistic or inhuman the patient's experiences are, the deeper the therapist will have to delve into their own emotions. Also, the therapist's own emotions may suddenly change: from anger to passion and apathy. The therapist's capacity for enduring such a "volley" of experiences of fragmentation is the core element in helping the patient become better integrated through their identification with the therapist (10). Countertransference is the most sensitive and most reliable instrument in therapy with severe patients with poor verbalization (34).

According to Resnik (Resnik 2000), the therapist should fight against pathological countertransference because excessive pain and fear of psychosis may disable the therapist in the therapeutic sense (11).

The therapist's own countertransferential feelings which they succeed in interpreting resonate with the patient's or group's unconscious feelings, according to the experience of D. Josić (Josić 1999). This resonance occurs on the basis of strong identifications during treatment. A group analyst should have the ability to regress with one part of their person and thus achieve resonance with the

grupnim nesvjesnim. Isto kao što ego može regredirati u svrhu boljeg razumijevanja pacijenta, ego se može svakog časa i integrirati i napraviti terapijsku elaboraciju emocionalnih sadržaja na razini na kojoj se bolesnik nalazi. Ne treba imati pretjerane zahtjeve na sebe da se svaki kontratransfer prepozna tijekom seanse. Manje iskusni voditelji često su nesvjesno ustrašeni pred većim brojem teških bolesnika u grupi što pojačava njihov osjećaj odgovornosti. Važno je da analitičar ima kapacitet za kontejniranje bolesnikovih loših osjećaja kojih se bolesnik pokušava oslobađati putem projektivne identifikacije (35).

Projektivnu identifikaciju je definirala M. Klein (Klein 1983, Segal 1975) kao prototip agresivnog objektnog odnosa predstavljenog oralnim ili analnim napadom na objekt u smislu stavljanja dijelova ega u taj objekt a u cilju preuzimanja njegovog sadržaja ili njegovog kontroliranja. Događa se u paranoidno-shizoidnoj poziciji. Posljedica može biti oslabljen doživljaj selfa i identiteta sve do depersonalizacije. U projektivnu identifikaciju uključena je i zavist i predstavljena je nasilnim ulaskom u drugu osobu da se unište njene najbolje osobine (36,37).

U teorijski aspekt projektivne identifikacije uvid nam daje RD Hinshelwood (Hinshelwood 1991). On uočava po-

patient's or group's unconscious. Just as the ego can regress in order to better understand the patient, the ego may at any time integrate and achieve therapeutic elaboration of emotional content on the level that the patient occupies. One should not expect oneself to recognize each countertransference during a session. Less experienced leaders are often unconsciously frightened when faced with a large number of severe patients in a group, which increases their feeling of responsibility. It is important for the analyst to have the capacity to contain the patient's negative feelings which the patient is attempting to release through projective identification (35).

M. Klein (Klein 1983, Segal 1975) defined projective identification as a prototype for aggressive object relationship represented by an oral or anal attack on the object in the sense of placing parts of the ego in that object with the purpose of taking over its content or controlling it. It occurs in a paranoid-schizoid position. One consequence may be a reduced awareness of the self and identity until depersonalization. Projective identification includes envy and is represented by an aggressive entry into another person in order to destroy their best characteristics (36,37).

RD Hinshelwood (Hinshelwood 1991) gives us an insight into the theoretic aspect of projective identification. He recognizes the attempts of extending, as well as narrowing, the term projective identification in line with the definition

kušaje širenja kao i sužavanja pojma projektivna identifikacija u skladu sa definicijom koju je dala M. Klein. Uži koncept uključuje slijedeće fantazije u vezi koncepta projektivne identifikacije: izbacivanje tenzije,omnipotentna intruzija, fuzija,pasivno življenje u objektu. Fantazijske posljedice projektivne identifikacije mogu biti: osjećaj fragmentiranosti, bezosjećajnosti, depersonalizacija, konfuzija s objektom, klaustrofobija, strah od oštećenja objekta, strah od osvete objekta. Širenje koncepta projektivne identifikacije, osim patološke podrazumijeva i normalnu projektivnu identifikaciju (u komunikaciji, empatiji, relacijskom odnosu). Zagovornici uže definicije kritiziraju širenje koncepta projektivne identifikacije na empatiju i relacijski odnos jer su u tim stanjima self i objekt diferencirani i pri tome se gubi precizno referiranje na psihotični doživljaj (38).

Lj. Moro (Moro 1990) daje uvid u praktični aspekt projektivne identifikacije. Ona opisuje četvorogodišnju grupu sa regresivnom pacijenticom koja u početku nerazumljivo priča, tijekom terapije počinje biti razumljivija ali onda u kriznoj situaciji (razgovor o završetku grupe) reagira regresivno, psihotičnim transferom prema voditeljici (kao majci koja usisava njene prijatelje tj. grupu), pri čemu su voditeljica i grupa bili iznenađeni slikom koju je o njima

by M. Klein. A narrower concept includes the following fantasies in connection with the concept of projective identification: tension ejection, omnipotent intrusion, passive living in the object. Fantastic consequences of projective identification may be the following: a feeling of fragmentation, lack of emotion, depersonalization, confusion with the object, claustrophobia, fear of harming the object, fear of the object's revenge. Apart from pathological projective identification, the extension of the concept of projective identification also encompasses normal projective identification (in communication, empathy, relational relationship). Proponents of the narrower definition criticize the extension of the concept of projective identification to empathy and relational relationship because in those stages the self and the object are differentiated, and there is a loss of precise reference to the psychotic experience (38).

Lj. Moro (Moro 1990) gives us insight into the practical aspect of projective identification. She describes a four-year-old group with a regressive patient whose speech is initially difficult to comprehend, during therapy becomes more intelligible, but then in a situation of crisis (a conversation about the end of the session) reacts regressively, with a psychotic transference towards the leader (as the mother who sucks in her friends, i.e. the group), causing the leader and the group to be surprised by the image that the patient had about them, with the group

imala pacijentica a grupa se i uplašila te iskrivljene slike. Ipak, voditeljica i grupa te projekcije uspijevaju iskontejnirati i metabolizirati i na primjeren način vratiti pacijentici potičući njen kapacitet za razmišljanje (39).

S. Resnik (Resnik 2000) navodi da je terapijska grupa poput trbuha koji može ili ne može probaviti neka iskustva. Ako ne može, onda se sadržaj izbacuje ekscesivnom projektivnom identifikacijom a posljedica je da se grupa osjeća prazna ili kao velika rupa (11).

T. Ogden (Ogden 1992) kad interpretira pacijentu projektivnu identifikaciju prvo ponudi pacijentu njegovu (pacijentovu) potrebu da putem projektivne identifikacije terapeutu saopći nešto o sebi (da se ne bi izazvala krivnja) a tek onda, vremenom, kad okolnosti dozvole, otvora nesvjesnu fantaziju u stavljanju terapeuta u poziciju subjekta (40). Betty Joseph (Joseph 2003) se bavila kontratransferom u projektivnoj identifikaciji pri čemu analitičar osjeća da je izmanipuliran da igra ulogu u fantaziji nekog drugog. Mogući su jaki osjećaji uz istovremeno vjerovanje da su ti osjećaji opravdani objektivnom situacijom (41). T. Ogden (Ogden 1992) navodi da recipijent pri projektivnoj identifikaciji osjeća prinudu koju ne može spriječiti, može se osjećati iznutra kontroliran (40).

Obzirom da se grupe odvijaju na zatvorenom psihoterapijskom odjelu donijet

becoming fearful of that image. However, the leader and the group managed to contain and metabolize those projections and appropriately return them to the patient by encouraging their capacity for thinking (39).

S. Resnik (Resnik 2000) claims that a therapeutic group is like a stomach that either can or cannot digest some experiences. If it cannot, then the content is ejected through excessive projective identification, and the consequence is that the group feels empty or like one big hole (11).

When interpreting a patient's projective identification, T. Ogden (Ogden 1992) first offers the patient their (the patient's) need to tell the therapist something about themselves through projective identification (in order not to cause guilt), and then, over time, when circumstances allow for it, opens an unconscious fantasy by putting the therapist in the position of the subject (40). Betty Joseph (Joseph 2003) worked on countertransference in projective identification, wherein the analyst feels they are being manipulated into playing a role in someone else's fantasy. There is a possibility for strong feelings with a simultaneous belief that those feelings are justified by the objective situation (41). T. Ogden (Ogden 1992) claims that during projective identification the recipient feels a coercion that they cannot prevent, and may feel controlled on the inside (40).

Since group therapy takes place on a closed psychotherapeutic ward, we shall

ćemo kratak prikaz psihodinamike bolničkog odjela po Searlesu (Searles 1999). Searles prepoznaje da osoblje za bolesnika predstavlja eksternalizirane fragmente vlastitog ega. Eksternalizacija se događa jer bolesnik ne može unutar ega držati jako konfliktne elemente. I zato bolesnik umjesto da bude svjestan rata unutar sebe, on nesvjesno potiče osoblje na međusobno ratovanje npr. između „dobrih majki“ i „loših majki“. Osoblje može biti frustrirano tim parcijalnim ulogama i može biti ljuto pri čemu potiskuje agresiju. Pritajena agresija među osobljem pogoršava bolesnikovu fragmentaciju. U terapijskom smislu, bolesnik mora prvo doživjeti diferencijaciju i integraciju među osobljem da bi ih tek onda i sam mogao doživjeti (10).

present a short overview of the psychodynamics of a hospital ward according to Searles (Searles 1999). Searles finds that for the patient the staff represents externalized fragments of their own ego. Externalization occurs because the patient cannot keep severely conflicted elements within their ego. That is why the patient, instead of being aware of the war inside them, unconsciously encourages the staff to fight amongst themselves, for example, “good mothers” against “bad mothers”. The staff may feel frustrated by those partial roles, and may be angry while repressing aggression. Hidden aggression among the staff increases the patient’s fragmentation. In the therapeutic sense, the patient must first feel differentiation and integration among the staff in order to then experience that himself (10).

TERAPIJSKI PRISTUP PACIJENTIMA S PSIHOZOM

Terapijski pristup psihotičnim pacijentima je biopsihosocijalni. Osim psihofarmakoterapije (42-48) i socioterapije (49) kao i radno-okupacione terapije koristi se i psihoterapija, bilo individualna bilo grupna (50-60).

Individualni psihoanalitički psihoterapeuti imaju različite pristupe. Po iskustvu S. Resnika (Resnik 2005) terapeut može pokušati provesti deziluziju ili deflaciju sumanutosti što dovodi do

THERAPEUTIC APPROACH TO PATIENTS WITH PSYCHOSIS

The therapeutic approach to psychotic patients is biopsychosocial. Apart from psychopharmacotherapy (42-48), sociotherapy, and occupational therapy, psychotherapy is also used, either individually or in a group (50-60).

Individual psychoanalytic psychotherapists have different approaches. In the experience of S. Resnik (Resnik 2005), the therapist can attempt to perform disillusionment, or deflation of delusion, which leads to a deep state of melancholy and

dubokog melankoličnog stanja i tzv. narcističke depresije (12). Terapeut povezuje svijet psihotičnog doživljavanja i svijet realiteta. Interpretacija je prenošenje značenja i reda tamo gdje je prije bio besmisao, nered i praznina (11).

M. Jackson (Jackson 2001) daje težište na empatiji i kontejniranju (14) a E. Jogan (Jogan 2017) na interaktivni odnos koji je primjereniji kad se radi s teškim pacijentima kod kojih je veći problem u deficitu nego u konfliktu. Terapeut ima dvostruku ulogu: transfernog objekta ali ujedno, on je i novi konstruktivni objekt i mora stalno prelaziti iz jedne pozicije u drugu (61).

T. Ogden (Ogden 1992) u terapiji shizofrenog pacijenta razlikuje 4 faze: prva je faza ne-doživljavanja u kojoj terapeut interpretira u sebi, zatim faza projektivne identifikacije u kojoj terapeut mora pokušati izdržati projekcije koje su za pacijenta neizdržive, zatim faza psihoze i konačno faza simboličkog mišljena u kojoj pacijent postiže veći kapacitet za kontejniranje bolnih misli (40).

Na borbu psihotičnog i ne-psihotičnog dijela osobnosti, u interpretaciji, ukazuje F. de Masi (De Masi 2001). Nastoji ojačati alfa funkciju kroz povećanje svjesnosti o značenju psihotične organizacije. Uspjeh je kada se postigne da neurotični dio osobnosti može vidjeti

so-called narcissistic depression (12). The therapist connects the world of psychotic experience with the world of reality. Interpretation is the transmission of meaning and order to a place where there used to be meaninglessness, disorder, and emptiness (11).

M. Jackson (Jackson 2001) emphasizes empathy and containing (14), while E. Jogan (Jogan 2017) places more importance on the interactive relation that is more appropriate in severe patients who have a greater problem with deficit than conflict. The therapist has a two-fold role: they are the transferential object and the new constructive object, and must constantly switch from one position to the other (61).

T. Ogden (Ogden 1992) differentiates between four stages in the therapy of a schizophrenic patient: the first one is the stage of not experiencing, in which the therapist interprets inside himself, the second one is the stage of projective identification, in which the therapist must attempt to endure projections that are overwhelming for the patient, the third is the stage of psychosis, and the final one is the stage of symbolic thinking, in which the patient achieves greater capacity for containing painful thoughts (40).

In one interpretation, F. de Masi (De Masi 2001) draws attention to the struggle between the psychotic and non-psychotic part of personality. He attempts to strengthen the alpha function by increas-

psihotične konstrukcije bez užasa i bježanja (15) .

A. Ferro (Ferro 2009, 2018) i suradnici (Civitarese 2018, Foresti 2018, Politi 2018, Collova 2018) razvijaju tzv. teoriju analitičkog polja (62-69), u kojem se svaku pojavnost doživljava kao element sna kojeg treba odsanjati tj. naći mu adekvatno značenje. Analitičko polje je poput čekaonice u kojoj proto emocije (beta elementi) čekaju zasićenje tj. osmišljavanje. Terapeut koristi tzv. „nezasićene" interpretacije sa potencijalom višeznačnosti. Cilj analize je proširenje sadržaja o kojima se može misliti i kontejnirati ih (70).

Osim interpretativnih, N. Stern (Stern 1998) govori i o tzv. ne-interpretativnim mehanizma u psihoanalitičkoj terapiji. Važni su autentični kontakti, tzv. „trenutci susreta" (to su sadašnji trenutci koji su afektivno bogati npr. uzajamni smijeh pacijenta i terapeuta u nekoj zajedničkoj aktivnosti) koji ponovo oblikuju implicitno znanje o odnosu čime se činjenice iz prošlosti reorganiziraju. U „trenutku susreta" terapeut djeluje kao osoba i dijeli sa bolesnikom svoje subjektivno stanje. Ti trenutci mogu biti verbalni i neverbalni i ne ukidaju profesionalni odnos (71).

Grupni analitičari, kako je i za očekivati, ukazuju na socijalne deficite psihotičnih bolesnika. Za VL. Schermera i M.

ing the awareness of the meaning of psychotic organization. Success is achieved when the neurotic part of personality can perceive psychotic constructions without terror and flight (15).

A. Ferro (Ferro 2009, 2018) et al. (Civitarese 2018, Foresti 2018, Politi 2018, Collova 2018) develop a so-called theory of the analytical field (62-69), in which every event is perceived as an element of a dream that has to be dreamed, that is to say, its appropriate meaning has to be discovered. The analytical field is like a waiting room in which proto-emotion (beta elements) are awaiting saturation, or to be given meaning. The therapist uses so-called "unsaturated" interpretations with the potential of multiple meanings. The goal of analysis is the expansion of the content that can be thought about and contained (70).

Apart from interpretative mechanisms, N. Stern (Stern 1998) also discusses non-interpretative mechanisms in psychoanalytic therapy. Authentic contacts, or "moments of encounter" (moments in the present that are affectively rich, for example, a shared laughter of the patient and the therapist in some mutual activity), are important because the reshape the implicit knowledge about the relationship, thereby reorganizing facts from the past. In a "moment of encounter", the therapist acts as a person and shares their subjective state with the patient. Such moments can be verbal or non-verbal, and do not end the professional relationship (71).

Pinesa (Schermer, Pines 1999) psihoza je kompleksni biopsihosocijalni i inter-personalni sindrom (72). Kapacitet psihotičnih bolesnika za komunikaciju i socijalnu interakciju je ograničen. Psihotični bolesnici pate od jakih strahova, nepovjerljivi su u odnosima, imaju teškoća u vezi intimnosti. Autori daju prikaz različitih pristupa u grupnoj psihoterapiji psihoza. Ti pristupi su: 1-Suportivni/edukativni/rješavanje problema, 2-Interpersonalni/interaktivni/relacijski pristup, 3-Grupna analiza i grupa kao cjelina (po Foulkes-u), 4-Kanas-ov integrativni model: Kanas u svojim grupama koristi edukativni, psihodinamski i inter-personalni pristup.

Grupna psihoterapija psihotičnih bolesnika se može raditi na odjelu (kod subakutnih ili kroničnih bolesnika) ali i ambulantno. I. Yalom (Yalom 2013) daje opis akutne bolničke grupe. Problemi su slijedeći: malo vremena za pripremu bolesnika za grupu, kratko trajanje grupe,otežano stvaranje kohezivnosti,smanjena sklonost bolesnika ka introspekciji,interakcije psihoterapije sa somatskim pretragama, nejasna granica grupe zbog interakcija članova grupe s drugim pacijentima na odjelu. Voditelj takvih grupa je aktivniji,suportivniji, kreira pozitivno ozračje. Tehnika vođenja grupe se fokusira na odnose u grupi ovdje i sada, bolesnici se potiču na aktivnost,jasnu komunika-

Group analysts, as is to be expected, point to social deficits of psychotic patients. For VL. Schermer and M. Pines (Schermer, Pines 1999), psychosis is a complex biopsychosocial and interpersonal syndrome (72). Psychotic patients have a limited capacity for communication and social interaction. Psychotic patients suffer from strong fears, are suspicious of relationships, and have difficulties with intimacy. The authors show various approaches in group psychotherapy of psychoses. Those approaches are the following: 1. supportive/educational/problem-solving, 2. interpersonal/ interactive/ relational approach, 3. group analysis and the group as a unit (according to Foulkes), 4. Kanas' integrative model: Kanas uses educational, psychodynamic, and interpersonal approaches in group therapy.

Group psychotherapy of psychotic patients may be performed on the ward (in subacute or chronic patients), but also in a clinic. I. Yalom (Yalom 2013) gives a description of an acute hospital group. The problems are as follows: lack of time for the preparation of patients for the group, short duration of group therapy, difficulty in creative cohesion, reduced disposition towards introspection, interactions between psychotherapy and somatic tests, unclear group boundaries due to interactions of group members with other patients on the ward. The leader of such groups is more active and supportive, and creates a positive atmosphere. The technique of leading the group focuses on relations in the group here and now,

ciju, izražavanje osjećaja. Cilj ovakvih grupa je smanjenje izolacije bolesnika i priprema za ambulantnu grupnu psihoterapiju (27).

Integrativni pristup grupnoj psihoterapiji psihotičnih pacijenata predlaže N. Kanas (Kanas 1999). Glede setinga, bolničke grupe su otvorene, obično traju 45 minuta, seanse se mogu odvijati do 3x tjedno, u grupi može biti 3-8 pacijenata. Preferira se prisutnost ko-terapeuta jer grupe psihotičnih bolesnika mogu biti kaotične i nepredvidive pa su potrebna dva terapeuta da održe kontrolu i da se suoče sa nesigurnim situacijama. U tehničkom smislu potiču se interakcije sa naglašavanjem interpersonalnih problema u grupi u situaciji ovdje i sada kao i u bolničkom setingu. Izbjegavaju se tehnike koje mogu biti štetne za psihotične bolesnike (duge šutnje, otvaranje nesvjesnih konflikata) jer mogu izazvati anksioznost i regresiju kod psihotičnih bolesnika i mogu pogoršati simptome. Terapeut suočava pacijente sa psihotičnim simptomima (halucinacijama i sumanutostima), nastoji poboljšati testiranje realiteta. Terapeut treba biti aktivan, strukturirati seansu, pomagati bolesnicima da se fokusiraju na problem. Intervencije trebaju biti jasne i konkretne. Terapeut treba biti otvoren i povremeno može dati svoje mišljenje o važnim problemima. Ciljevi ovih grupa (kratkotrajnih grupa psihotičnih paci-

the patients are encouraged to communicate and express their emotions actively and clearly. The goal of such groups is the reduction in the isolation of patients and preparation for clinical group psychotherapy (27).

N. Kanas (Kanas 1999) suggests an integrative approach to group psychotherapy of psychotic patients. When It comes to the setting, hospital groups are open, sessions usually last for 45 minutes, can take place three times per week, and groups can consist of 3 to 8 patients. The presence of a co-therapist is preferred because groups of psychotic patients can be chaotic and unpredictable, so two therapists are required in order to maintain control and face unpleasant situations. When it comes to techniques, there is an emphasis on interactions that focus on expressing interpersonal problems in the group and in the situation here and now, like in the hospital setting. Techniques that could be harmful for psychotic patients should be avoided (long silences, opening unconscious conflicts) because they can cause anxiety and regression in psychotic patients, and may aggravate the symptoms. The therapist confronts the patients with psychotic symptoms (hallucinations and delusions) and attempts to improve reality testing. The therapist should be active, should structure the session, and help the patients focus on the problem. Interventions should be clear and concrete. The therapist should be open and occasionally may give their opinion on

jenata na akutnim bolničkim odjelima) su : smanjenje izolacije i bolja kontrola psihotičnih simptoma. U seansi se neko vrijeme posveti i članovima koji odlaze iz grupe (bolnice) (73).

Naš terapijski pristup se pokušava orijentirati prema prepoznatoj psihodinamici. Zbog krhkosti psihotičnog ega potrebno je razmišljati o jačanju pacijentovog ega radom na prepoznavanju vlastitih, ne pre bolnih osjećaja, poticanjem osjećajnog otvaranja i sazrijevanja. Poticanje osjećajnih interakcija sa drugima jača self i objekt reprezentacije i njihovu diferencijaciju kao i njihovu osjećajnu vezu. Terapeutova alfa funkcija se koristi kao pomoćni ego koji bi trebao pomoći pacijentu da se, barem donekle, uvede red u njegov kaotični svijet i pomagala bi da se razgraniči vanjsko i unutarnje, realitet od fantazije. Izbjegavanjem dubokih interpretacija izbjegava se i regresija na rane faze psiho seksualnog razvoja npr. na oralitet (beskrajnu glad nezadovoljenog djeteta). Intenzitet intrapsihičke destrukcije je teško smanjiti ali se barem može relativno pojačati libidna protuteža putem njege na odjelu koja ima kvalitetu majčinske, dobrim osjećajnim odnosima, reduciranjem nepotrebnih frustracija. Pacijenti se, u grupi, na primjeren način konfrontiraju sa svojim omnipotentnim potrebama i njihovim posljedicama po emocionalne odnose sa drugim ljudima. Sadistič-

important problems. The goals of such groups (short-term groups of psychotic patients on acute hospital wards) are as follows: reduction of isolation and improved control of psychotic symptoms. During sessions, some time is dedicated to group members who are leaving the group (the hospital) (73).

Our therapeutic approach attempts to orientate itself according to the identified psychodynamic. Due to the fragility of the psychotic ego, it is necessary to also think about strengthening the patient's ego by working on recognizing their own emotions that are not too painful, encouraging emotional opening and maturation. Encouraging emotional interactions with other people strengthens the self and object representations and their differentiation, as well as their emotional connection. The therapist's alpha function is used as an auxiliary ego that should help the patient to introduce some level of order into their chaotic world, and is aimed at helping them distinguish between the external and the internal, reality and fantasy. By avoiding deep interpretations, a regression to earlier stages of psychosexual development is also avoided, for example a regression to orality (a limitless hunger of an unsatisfied child). The intensity of intrapsychic destruction is difficult to reduce, but at least the libidinal counterweight can be strengthened by hospital care which has a maternal quality, and also by good emotional relationships, and a reduction of unnecessary frustrations. In the group, patients are

ki super ego barem se dijelom korigira korektivnim emocionalnim odnosima sa transfernim roditeljskim figurama (liječnici, osoblje na odjelu). U grupi se pacijenti mogu konfrontirati sa nezrelim mehanizmima obrane npr. rascjepom (npr. dobri doktori u grupi i loši doktori van grupe ili obrnuto).

KONTEKST UNUTAR KOJEG SE ODVIJAJU BOLNIČKE PSIHOTERAPIJSKE GRUPE

Grupe opisane u ovom radu odvijaju se na zatvorenom muškom subakutnom psihijatrijskom odjelu. Članovi grupe imaju interakcije i van grupe, međusobno, kao i sa drugim pacijentima koji nisu u grupi. Time se mogu zamutiti granice grupe. Voditelj nema samo funkciju vođenja grupe nego je i odjelni psihijatar koji sudjeluje u vizitama, određuje psihofarmakoterapiju, ponekad obavlja somatske preglede pacijenata. Nakon otpusta iz bolnice bolesnici nisu u mogućnosti nastaviti dolazak na psihoterapijsku grupu, zbog udaljenosti kao i zbog nedostatka novca za put (često su bolesnici primatelji socijalne pomoći).

Medicinske sestre i tehničari na odjelu su većinom prošli grupnu psihodinamsku edukaciju. Na odjelnim sastancima osoblje razgovara o problemima na odjelu, odnosu sa bolesnicima i o

confronted in an appropriate way with their omnipotent needs and their consequences on emotional relationships with other people. The sadistic super ego is at least partially corrected through emotional relations with transferential parental figures (parents, ward staff). In the group, patients can confront immature defense mechanisms, such as split (for example, good doctors in the group and bad doctors outside of the group, or the inverse).

CONTEXT FOR HOSPITAL GROUP PSYCHOTHERAPY

The groups described in this article take place on a closed male subacute psychiatric ward. The group members also interact outside of the group, as they do with other patients who are not in the group. This can blur the boundaries of the group. The leader does not have the sole function of leading the group, but is also the ward psychiatrist who takes part in rounds, decides on psychopharmacotherapy, and occasionally performs somatic examinations of patients. After being discharged from hospital, patients are unable to continue attending the psychotherapeutic group due to distance and lack of money for travelling expenses (patients often receive social welfare).

Most medical nurses on the ward have undergone group psychodynamic training. In ward meetings, the staff discuss problems on the ward, relations with patients, and problems in relations between

problemima u odnosima među osobljem. Osoblje nastoji prema pacijentima nastupati homogeno i kompaktno. Svo osoblje se trudi pacijentima biti „dovoljno dobra majka“ koja nastoji zadovoljiti, koliko je to realitetno moguće, biološke, psihološke, obiteljske i socijalne potrebe pacijenata.

PSIHOTERAPIJSKA GRUPA S KLINIČKIM PRIMJERIMA

Ovdje opisana grupa psihotičnih pacijenata ima 9 članova. Po dijagnozama (DSM V i ICD 10) po dva pacijenta imaju shizofreniju, sumanuti poremećaj, shizoafektivni poremećaj i psihotičnu depresiju a jedan pacijent ima neoznačeni psihotični poremećaj (F 29). Grupa se odvija jednom tjedno u prostoriji dnevnog boravka. Na vratima se stavlja kratka obavijest da traje grupa i da se ne ulazi u prostoriju. Iskustvo voditelja je da, kad je u jednom ranijem periodu pokušao voditi grupu dva puta tjedno - pojačala se paranoidnost članova, pa se otada grupe vode jednom tjedno. Seansa traje 60 minuta. Boravak pacijenata u grupi traje 1-3 mjeseca (nakon čega se otpuštaju iz bolnice). Pacijenti za grupu se biraju po principu dovoljno dobre remisije tj. slične razine regresa i dovoljne kognitivne i emotivne očuvanosti da mogu sudjelovati u grupi. Grupa je otvorena. Grupu vode voditelj

staff members. The staff attempt to behave in a homogenous and compact way towards the patients. All staff members attempt to be “a sufficiently good mother” to the patients, one who tries to fulfill, as realistically as possible, the biological, psychological, familial, and social needs of the patients.

A PSYCHOTHERAPEUTIC GROUP WITH CLINICAL EXAMPLES

The group of psychotic patients described here consists of nine members. According to diagnoses (DSM V and ICD 10), two patients have schizophrenia, delusional disorder, schizoaffective disorder, and psychotic depression, and one patient has an undetermined psychotic disorder (F 29). The group meets once a week in the living room. A notice is put outside the door saying that the group is in session and that no one should enter the room. When the leader once attempted to hold group sessions twice a week, the paranoia of the members increased, and since then the group meets only once a week. The session lasts for 60 minutes. Patients remain in the group from one to three months (after which time they are discharged from the hospital). The patients are chosen according to the principle of good remission, that is to say, similar levels of regression and sufficient cognitive and emotional preservation for group participation. The group is open. It is led by the leader (a group analyst) and a resident co-therapist. Notes

(grupni analitičar) i koterapeut-specijalizantica. Bilješke se rade nakon grupe. Ovo je treći sastanak grupe.

Primjer 1

Nakon početnog traženja teme grupa počinje pričati o svojim majkama i očevima. Majke su dobre, očevi su strogi. Neki roditelji su ih i tukli. Josip kaže da je majka govorila ocu što su djeca skrivila a otac je izvršavao kaznu. Uključuju se i drugi. Tukli su ih šibama, remenom a nekad i motkama. Motkama? To su, kažu, malo deblje šibe. Voditelj pita grupu kako doživljava Josipovu situaciju da je samo otac izvršavao kaznu. Članovi govore svoja slična ili različita iskustva, svi osim Petra. Voditelj kaže da samo Petar nije rekao svoj doživljaj Josipove situacije. Petar kaže da ne bi ništa govorio. Voditelj pita Petra za razlog takve odluke. Petar kaže da se boji Josipa. Obzirom da Josip do sada nije ispoljavao agresivnost prema drugim članovima grupe voditelj moli Petra da pokuša malo detaljnije reći od kuda ide taj strah. Petar tada počinje opisivati situaciju koja se dogodila dan ili dva prije: izlazio je iz wc-a i kad je otvorio vrata pred vratima je bio Josip. Petar mu je ostavio otvorena vrata da uđe ali Josip mu je rekao da zatvori vrata i da će on sam vrata otvoriti. Pri tome ga je povukao za rukav pidžame kao da ga opominje. Od tada se Petar boji Josipa.

are taken after the session ends. This is the third meeting of the group.

Example 1

After the initial search for the topic, the group begins to talk about their mothers and fathers. Mothers are good, fathers are strict. Some parents even beat them. Josip says his mother told his father what the children did wrong, and the father performed the punishment. Others join in. They beat them with switches, belts, and sometimes even with rods. Rods? Those are, they say, slightly thicker switches. The leader asks the group how they perceive Josip's situation, in which only the father carried out the punishment. The group members talk about their own similar or different experiences, everyone except Petar. The leader says that Petar is the only one who did not express how he perceives Josip's situation. Petar says he does not want to say anything. The leader asks Petar about the reason for such a decision. Petar says he is afraid of Josip. Since Josip has not shown aggression to other group members, the leader asks Petar to try and explain in more detail where the fear comes from. Petar then begins to describe a situation that took place a day or two earlier: he was leaving the toilet, and when he opened the door, Josip was standing there. Petar left the door open for him, but Josip told him to close the door and that he would open it himself. He also pulled him by the sleeve of his pajamas, as if scolding him. Since then Petar has been afraid of Josip. Silence. The leader

Šutnja. Voditelj pita Josipa kako je on doživio tu situaciju. Josip kaže da njemu nitko ne treba otvarati vrata. Šutnja. Voditelj ponavlja do sada rečeno: znači vrata su bila otvorena i Josip nije htio ući kroz vrata nego je tražio da ih Petar zatvori. Pita se kako bi se drugi članovi grupe ponašali. Članovi se svi izjašnjavaju da bi prošli kroz otvorena vrata i da ne bi tražili od Petra da ih zatvori da bi ih oni opet sami otvorili. Voditelj pita Josipa kako mu se čini ova situacija da bi članovi grupe drugačije postupili od njega. Josip optužuje Petra da je naglo otvorio vrata. Petar se brani da se kroz drvena vrata ne vidi tko je vani, „kako sam mogao znati da ste vi ispred vrata?". Voditelj pita Josipa da li se malo prepao kad je Petar izlazio. Josip potvrđuje i uvrijeđeno optužuje Petra za nepažnju. Petar ponavlja svoju obranu. Voditelj konstatira: Josip kao da se malo uplašio i uvrijedio što je Petar naglo izišao. Grupa se slaže sa tim. Voditelj ponavlja da se Josip uvrijedio i da je potegnuo Petra za pidžamu što je onda Petra uplašilo toliko da se sada u grupi ne usudi reći svoj doživljaj o Josipovoj obiteljskoj situaciji kada je majka govorila ocu što su djeca skrivila a otac je onda izvršavao kaznu tj. tukao djecu. Josip kaže da su ga cijelog života zezali zbog prezimena koje na jednom stranom jeziku znači: otpad, smeće, izmet. Iako ljudi nisu znali taj jezik, znali su što ta riječ znači i stalno su ga zbog

asks Josip how he perceives the situation. Josip says that no one has to open doors for him. Silence. The leader repeats what has been said: the door was open, and Josip refused to pass through them, instead asking Petar to close them. He asks how the other members of the group would have behaved. The group members all say they would pass through the open door and would not ask Petar to close it in order for them to open it themselves. The leader asks Josip what he thinks about the fact that other group members would act differently. Josip accuses Petar of opening the door suddenly. Petar says it is impossible to see who is on the other side of the wooden door, "how could I know that you were outside the door?" The leader asks Josip if he was a bit afraid when Petar was coming out. Josip agrees and, insulted, accuses Petar of being careless. Petar defends himself again. The leader states: Josip seems to have been a bit frightened and insulted by Petar suddenly coming out. The group agrees. The leader repeats that Josip was insulted and pulled Petar by the sleeve, which frightened Petar so much that he does not dare express his perception of Josip's family situation, in which his mother told the father what the children did wrong, after which the father performed the punishment, i.e. beat the children. Josip says that he has been teased about his last name all his life because in one foreign language it means refuse, trash, or excrement. Although people did not know that language, they knew what the word meant and kept teasing him about it. Silence. The leader says

toga zezali. Šutnja. Voditelj kaže da je možda sada jasnije zašto je Josip tako osjetljiv i zašto je Petrovo otvaranje vrata doživio kao napad na sebe i kao obezvrjeđivanje. Voditelj pita Petra da li su mu sada jasniji motivi Josipovog ponašanja. Petar potvrđuje. Josipu je dosta ove priče koja se njemu čini bez veze. Obzirom da je kraj grupe voditelj konstatira da se danas na početku grupe govorilo o roditeljima a u većem dijelu grupe se govorilo o teškoći koju je Petar imao u slobodnom govorenju o svojim osjećajima u odnosu na Josipa, danas, na grupi.

Primjer 2

Ista grupa, u istom sastavu, voditelj i koterapeut-specijalizantica.

Na početku grupa traži temu. Josip govori da se kradu stvari, Franjo i Stjepan da se ulazi u tuđe sobe, Željko upada i misli da je pobačaj velika nevolja. Ulazi med. sestra u prostoriju za grupe i kaže da su došli suci i da traže voditelja odjela da prisustvuje procjeni za prisilnu hospitalizaciju za pacijenta koji nije u grupi. Voditelj se ispričava grupi što mora izaći, kaže da će se brzo vratiti i da će doktorica nastaviti voditi grupu.

Nakon 15-tak minuta voditelj se vraća na grupu. Čim je voditelj sjeo na stolicu Željko kaže da se doktor sigurno slaže sa onim o čemu su oni pričali. Voditelj

it now may be clearer why Josip is so sensitive and why he perceived Petar's opening of the door as an attack on himself and as a disparagement. The leader asks Petar if the motivation behind Josip's behaviour is now clearer to him. Petar confirms that it is. Josip is fed up with this conversation, which he considers pointless. Since it is the end of the session, the leader states that at the beginning they talked about parents, and most of the session was spent discussing the difficulty Petar had with speaking freely about his emotions in relation to Josip during that day's session.

Example 2

The same group, the same members, the leader and the resident co-therapist.

At the beginning, the group searches for a topic. Josip says someone is stealing things, Franjo and Stjepan say someone is going into other people's rooms, Željko interjects and says he thinks abortion is a big problem. A nurse enters the room for group sessions and says judges have arrived and are asking the group leader to be present during assessment for enforced hospitalization of a patient who is not in the group. The leader apologizes to the group for having to leave, and says he would return soon and that the doctor would take over the leadership of the group.

After about 15 minutes, the leader returns to the group. As soon as the leader sits

kaže da bi morao imati posebne moći kada bi znao o čemu je grupa pričala dok ga nije bilo. Josip kaže voditelju: Indijanac. Voditelj pita Josipa da mu objasni što znači Indijanac. Josip se smješka, ponavlja: Indijanac i znakovito sliježe ramenima. Voditelj kaže da ne razumije i moli grupu da mu pomogne da shvati što u ovoj našoj situaciji znači riječ Indijanac. Zdravko objašnjava: Indijanac je kao divljak. Željko kaže da smo svi mi divljaci. Voditelju nije bila puno jasnija situacija ali nije dalje inzistirao na objašnjavanju. Šutnja. Josip ima zavoj na ruci, voditelj ga pita što se dogodilo. Josip opisuje da ga je jedan „divlji" bolesnik udario, Josip je htio izaći iz pušione a „jedan balavac" sa „probušenim ušima" mu se ispriječio na put i nije mu dao da izađe. Zatim Josip nešto mrmlja sebi u bradu. Nenad koji sjedi kraj Josipa odmahuje rukom. Voditelj konstatira da Josip nešto tiho sebi priča u bradu a da Nenad odmahuje rukom. Pita Nenada da li je razumio Josipa. Nenad kaže da nije, da je on i prije pričao sa njim ali da ga često ne razumije. Voditelj pita da li su drugi razumjeli Josipa. Nije nitko. Šutnja. Voditelj pita Josipa da li mu to nešto znači što ga nitko u grupi nije razumio. Josip daje malo dužu elaboraciju iz koje se doznaje da on za sebe misli da je veliki filozof, nešto poput grčkih filozofa. Voditelj se obraća grupi: ja malo prije nisam razumio što znači riječ Indijanac

down, Željko says the doctor must agree with what they have been talking about. The leader says he would need to have special powers to know what the group was talking about while he was away. Josip tells the leader: the Indian. The leader asks Josip to explain what the Indian means. Josip smiles, and repeats: the Indian, and shrugs. The leader says he does not understand and asks the group to help him understand what the word Indian means in this situation. Zdravko explains: the Indian is like a savage. Željko says we are all savages. The leader did not understand the situation any better, but did not insist on further explanation. Silence. Josip has a bandage on his arm, and the leader asks what happened. Josip says one "wild" patient hit him, Josip was trying to leave the smoking room and one "snot-nosed kid" with "pierced ears" stood in his way and would not let him pass. Josip then mutters something. Nenad, who is sitting next to Josip, waves it away. The leader asks Nenad if he understood Josip. Nenad says he did not, adding that he has spoken to him before, but that he often fails to understand him. The leader asks if the others understood Josip. Nobody did. Silence. The leader asks Josip if the fact that no one in the group understood him means something to him. Josip gives a slightly longer elaboration from which it is possible to gather that he considers himself a great philosopher, someone who resembles Greek philosophers. The leader addresses the group: a few moments ago, I didn't understand what the word Indian meant,

i Josip mi nije htio objasniti, ispalo je kao da sam ja glup, blesav što to ne razumijem. Josip se smije kao i neki članovi grupe. Voditelj se glasno pita da li bi to značilo da je Josip nadmoćan u odnosu na voditelja jer Josip nešto razumije a voditelj ne razumije, to kao da bi potvrdilo da je Josip veliki filozof tj. da je jako pametan. Grupa se slaže sa tim pitanjem-konstatacijom, neki se smiju. Šutnja. Josip kaže da sa njim neće nitko pričati. Nenad i Zdravko govore o svojim iskustvima sa Josipom: on kao da je u nekom svojem svijetu – često ga ne razumiju. Voditelj se pita pred grupom: da li nam je više stalo da pred drugima budemo pametni ili da nas drugi ljudi razumiju i da razvijamo dijalog. Neki članovi odgovaraju da je važan razgovor, dijalog. Šutnja. Željko prekida šutnju i kaže da je on više puta bio pobačen tj. abortiran i da je on J. F. Kennedy, po potrebi. Grupi nije jasno kako je to on po potrebi Kennedy što Željko u kraćem tumačenju objašnjava tj. da je on povremeno Željko a po potrebi je Kennedy kad nekom treba nešto pomoći. Odmah se nadovezuje Franjo koji kaže da se sjeća svojih halucinacija u kojima je istočna obala SAD-a bila uništena. Šutnja. Voditelj kaže da se Franjo odmah nadovezao na Željka i pita Franju da li mu se čini da su Željkove riječi možda isto plod halucinacija. Franjo kaže da ne zna. Voditelj kaže da mu se čini da povremeno

and Josip refused to explain it, I looked dumb, stupid for not understanding it. Josip is laughing, and so are some other group members. The leader wonders aloud if that means Josip is more powerful than the leader because Josip understands something that the leader does not, which might confirm that Josip is a great philosopher, that is to say, that he is very smart. The group agrees with that question-statement, and some laugh. Silence. Josip says no one wants to talk to him. Nenad and Zdravko talk about their experiences with Josip: he seems to be in a world of his own – they often do not understand him. The leader wonders in front of the group: do we care more about seeming smart in front of others or being understood by others and developing a dialogue. Some members respond that a conversation, a dialogue is important. Silence. Željko interrupts the silence and says that he has been aborted several times, and that he is J. F. Kennedy when it is required. The group does not understand how he can be J. F. Kennedy when it is required, which Željko briefly explains by saying he is sometimes Željko, and when there is need for it and someone requires help, he is Kennedy. Franjo follows up by saying that he remembers his hallucinations in which the east coast of the USA was destroyed. Silence. The leader says Franjo immediately followed up Željko's comment and then asks Franjo if Željko's words were also a result of hallucinations. Franjo says he does not know. The leader says it seems to him that we sometimes have a great

imamo potrebu biti jako značajni, da budemo veliki ljudi npr. veliki filozofi ili veliki predsjednici, voditelj se pita da li zbog toga pate odnosi sa drugim ljudima jer npr. Josip je rekao da sa njim nitko neće pričati a ni Željka grupa nije razumjela da je on po potrebi Kennedy. Još se malo razgovara o potrebi da se bude jako važan. Zdravko misli da se to ne može promijeniti. Nitko dalje ne komentira. Grupa završava.

Nakon grupe, u kraćoj diskusiji voditelja i koterapeuta, voditelj doznaje da se za vrijeme njegovog odsustva govorilo o nekim neadekvatnim ponašanjima na odjelu (krađa stvari, naguravanje i sl.).

need to feel important, to be great people like, for example, great philosophers or great presidents. The leader wonders if this causes relationships with other people to suffer because, for example, Josip said no one wanted to talk with him, and the group also failed to understand Željko when he said he is Kennedy when there is need for it. There is some more talk about the need to be very important. Zdravko thinks that cannot be changed. No one comments further. The session ends.

After the session, in a short discussion of the leader and the co-therapist, the leader is told that during his absence there was talk about inappropriate behaviour on the ward (stealing, pushing, etc.).

RASPRAVA

Vođenje grupa psihotičnih pacijenata (u relativnoj remisiji), na zatvorenom bolničkom odjelu, ima svoje specifičnosti. Teškoće koje se mogu pojaviti su: kratko trajanje grupa koje ne dozvoljavaju razvoj dubljih odnosa među članovima grupe, problemi u testiranju realiteta pacijenata u grupi, njihova nesklonost komunikaciji i emocionalnoj interakciji, hitno odlaženje na somatski pregled (jer se otvorila mogućnost) za koji bi inače morali dugo čekati a pregled je važan zbog nekog patološkog tjelesnog stanja, van grupna druženja pacijenata (koja potencijalno mogu

DISCUSSION

Leading groups of psychotic patients (in relative remission), on a closed hospital ward, has its specificities. Difficulties that may occur are as follows: the short duration of groups does not allow for the development of deeper relationships among the group members, problems in reality testing among patients in the group, their reluctance towards communication and emotional interaction, an emergency somatic examination (because an opportunity to do so presents itself) which they would otherwise have to wait for a very long time, and the examination is important for a certain pathological physical state, patients socializing outside of the

biti izvor sukoba), van grupne, neplanirane obaveze terapeuta koje mogu biti neodgodive, van grupne interakcije terapeuta sa članovima grupe, interakcije terapeuta sa drugim pacijentima na odjelu koji nisu u grupu ali svoja iskustva iz kontakata sa terapeutom prenose drugim pacijentima na zajedničkom druženju u prostoriji za pušenje. Nadalje, voditelj grupe je također i psihijatar na istom psihijatrijskom odjelu koji pacijentima propisuje lijekove što također izaziva različite emocionalne reakcije pacijenata (pozitivne kada lijek pomogne i negativne kada se jave nuspojave). Voditelj u suradnji sa socijalnim radnikom vodi brigu o smještaju nezbrinutih pacijenata u adekvatne ustanove ili udomiteljske obitelji. Zbog svega toga se prema terapeutu, koji na odjelu ima različite uloge, stvaraju brojni, mješoviti, često ambivalentni osjećaji koji se iz vanjskog, većeg sustava (odjel) prelijevaju u manji sustav (grupa) i obrnuto (npr. na grupi se nekad vide nuspojave lijekova - sedacija i sl.- što u terapeutu izaziva zabrinutost i potrebu da se poboljša takvo stanje pa on modificira psihofarmakoterapiju nakon grupe). (Bez)brojne interakcije, svjesne i nesvjesne, sa pacijentima na odjelu (koji ujedno mogu biti i članovi grupe),nemoguće je sve detektirati a pogotovo ih je nemoguće analizirati.

U takvoj situaciji jasno je da su granice grupe propusne i da se prožimaju zbi-

group (which can be a potential source of conflict), the therapist's unplanned obligations outside of the group, which may be impossible to postpone, interactions between the therapist and the group members outside of the group, interactions between the therapist and other patients on the ward who are not in the group, but who pass along their experiences of interacting with the therapist to other patients while socializing in the smoking room. Moreover, the group leader is also a psychiatrist on the same psychiatric ward who prescribes the patients' medication, which also provokes various emotional responses from the patients (positive when the medication helps them, and negative when there are side effects). The leader cooperates with a social service worker on accommodating homeless patients in appropriate institutions or foster families. For all these reasons, there emerge numerous, often ambivalent feelings towards the therapist, who performs different roles on the ward, which then pour over from the external, larger system (the ward) into the smaller one (the group), and vice versa (for example, group members sometimes show side effects of medication, such as sedation, which causes the therapist to feel concern and a need to improve that condition, so they modify the pharmacotherapy after the group session). It is impossible to detect, and especially impossible to analyze, countless interactions, both conscious and unconscious, with patients on the ward (who can also be group members).

vanja na odjelu sa zbivanjima u grupi. Otvoreno je i pitanje povjerljivosti, iako na prvoj grupi a i svaki put kada u grupu uđe novi član, voditelj podsjeća grupu na potrebu da se sadržaj grupe zadrži u grupi i da ga se ne iznosi drugim ljudima van grupe. Time se nastoje, koliko-toliko, održati granice grupe unutar odjela. Zatim, koterapeut je obično specijalizant/ica koji vodi brigu o somatskom stanju pacijenta što uključuje tjelesni kontakt prilikom pregleda. Ponekad je i voditelj u situaciji da mora napraviti tjelesni pregled, nekad i pacijenata koji su u grupi. Time se krši pravilo zabrane tjelesnog kontakta koje vrijedi u grupama neurotskih pacijenata.

Pod svim navedenim okolnostima anonimnost voditelja je daleko od anonimnosti voditelja u npr. ambulantnoj analitičkoj grupi neurotičnih pacijenata ili u grupama neurotičnih pacijenata koje se vode u privatnoj praksi.

Ako bi se vratili na prikazane seanse mogli bi reći da u obje seanse neke van grupne situacije utječu na zbivanja u grupi. U prvoj seansi to je zajednički život pacijenata na odjelu a u drugoj seansi to je dolazak sutkinje radi procjene potrebe za prisilnom hospitalizacijom.

U prvom prikazu grupa počinje razgovorom o roditeljima, kažnjavanju,

In such situation it is clear that group boundaries are porous, and that events on the ward intersect with the events in the group. There is also the question of confidentiality, although the leader reminds the group in the first session, and every time a new member joins, about the need to keep the content of the group inside the group, and to avoid sharing it with other people outside the group. This is an attempt to retain group boundaries within the ward, at least to some extent. Also, the co-therapist is usually a resident who takes care of the somatic state of the patients, which includes physical contact during examination. The leader sometimes has to perform a physical examination on patients that are members of the group. This is against the rule forbidding physical contact, which applies in groups of neurotic patients.

In all of these circumstances, the leader's anonymity is far from the anonymity of a leader in a clinical analytic group of neurotic patients, for instance, or in groups of neurotic patients in private practice.

If we return to the presented sessions, we may say that in both session some situations outside of the group affect the events in the group. In the first session, this is the everyday life of the patients on the ward, and in the second session it is the arrival of the judge because of the need for enforced hospitalization.

In the first presentation, the group begins with a discussion about parents, punishment, role delegation in a family: the

raspodjeli uloga u obitelji: majka ima „savjetodavnu" ulogu a otac izvršava kaznu. Slobodna komunikacija je prekinuta Petrovim osjećajem straha tj. neugode da bilo što kaže Josipu jer ga se pribojava. Taj tren voditelj doživljava da razgovor o roditeljima pada u drugi plan a primarni zadatak postaje razrješavanje blokade u komunikaciji među članovima grupe. Otvara se situacija cjeloživotnog doživljaja obezvrijeđenosti zbog značenja prezimena na stranom jeziku kod pacijenta Josipa što stvara njegovu povećanu uvredljivost u svakodnevnim frustracionim situacijama. Razgovara se o tome kako Josip djeluje na druge ljude (autoritativno potezanje za pidžamu) i kako drugi ljudi zbog toga doživljavaju Josipa. Na taj način se pokušala umanjiti blokada u komunikaciji (otpor) među članovima grupe. U ovoj seansi se, dakle, razgovaralo o van grupnoj situaciji koja je djelovala kao „remetilački" faktor.

U drugom prikazu voditelj mora nepredviđeno napustiti grupu koju nastavlja voditi koterapeut. Po povratku, Željko u voditelja projicira svoje omnipotentne moći. Josip, u odnosu na voditelja, ostaje tajanstven u vezi značenja riječi „Indijanac" jer ima potrebu pokazati svoju poziciju velikog filozofa kojeg drugi pacijenti pa niti voditelj, ne razumiju lako. Željko otvoreno govori o tome kako je on, osim što je Željko također i Kennedy. Kao da u podlozi

mother has a "counselling" role and the father carries out the punishment. Free communication is interrupted by Petar's fear or discomfort at saying anything to Josip because he is afraid of him. The leader feels that in that moment the focus is no longer on the discussion about parents, and the primary task becomes the resolution of the block in the communication between group members. There is Josip's experience of a life-long feeling of invalidation due to the meaning of his last name in a foreign language, which creates his increased tendency to be offended in frustrating everyday situations. There is a discussion on how Josip affects other people (authoritative pulling by the pajamas) and how other people see Josip because of that. This was an attempt to reduce the block in communication (resistance) among the group members. In this session there was a conversation about a situation that occurred outside of the group, and acted as a "disrupting" factor.

In the second presentation, the leader had to leave the group, and the co-therapist took over. After the leader returns, Željko projects his omnipotent powers onto him. In his communication with the leader, Josip remains cryptic in regard to the meaning of the word "Indian" because he has the need to show himself as a great philosopher who cannot be easily understood neither by the other patients nor by the leader. Željko talks openly about being Kennedy while also being Željko. It seems that there is a sim-

Željkovih i Josipovih teškoća u komunikaciji leži ista potreba – potreba za omnipotencijom. Ali omnipotencija (osim uživanja u vlastitoj važnosti) ima i svoje naličje: velika pamet i moć kao da znači i izolaciju u ljudskom smislu: sa Josipom neće nitko pričati jer ga ne razumiju a ni Željka koji je povremeno Kennedy, grupa ne razumije. Voditelj konfrontira grupu sa tom situacijom: pamet i moć s jedne strane ali i ljudska izolacija sa druge strane. U ovoj situaciji voditelj nije odmah prepoznao o čemu se u grupi radi pa se nije govorilo o „remetilačkom" faktoru (terapeutov izlazak sa seanse) koji je utjecao na dinamiku zbivanja u grupi.

U obje opisane seanse je terapeut bio vrlo aktivan: u prvoj seansi je intervenirao 13 puta a u drugoj 12 puta. Terapeut nije puštao da šutnja dugo traje i dosta je poticao članove grupe na interakcije ili otvaranje. U drugoj seansi terapeut je konfrontirao neke članove grupe sa mogućim psihotičnim simptomima (halucinacije, grandiozne sumanutosti) i to u smislu otežavajuće komunikacije zbog tih simptoma a ne u smislu neke psihodinamske analize simptoma.

Stil voditelja bi najbliže odgovarao interpersonalnom, interakcijskom tipu vođenja grupe sa naglaskom na horizontalnim interakcijama u situaciji „ovdje i sada", uz neke elemente psiho-

ilar need underlying both Željko's and Josip's difficulties in communication – the need for omnipotence. However, omnipotence (apart from providing enjoyment in one's own importance) also has a flip side: great intelligence and power also seem to mean isolation in the human sense - no one wants to talk to Josip because they do not understand him, just like they fail to understand Željko, who is sometimes Kennedy. The leader confronts the group with that situation: intelligence and power on the one side, and human isolation on the other. In this situation, the leader did not immediately recognize what was happening in the group and therefore there was no discussion of the "disrupting" factor (the therapist's departure) which affected the dynamics of the group.

In both sessions the therapist was very active: in the first one, he intervened thirteen times, and in the other one twelve times. The therapist did not allow silence to go on for very long and encouraged group members to interact or open themselves. In the second session, the therapist confronted some of the group members with possible psychotic symptoms (hallucination, delusions of grandiosity) in the sense of difficult communication due to those symptoms and not in the sense of some psychodynamic symptom analysis.

The leader's style would suit the interpersonal, interactive type of group leadership, with an emphasis on horizontal interactions in the situation "here and

dinamskog pristupa kada situacija u grupi to dozvoljava.

Psihodinamska analiza se koristila u analizi kontratransfera: nakon grupe voditelj se pitao da li je bilo prilike otvoriti situaciju njegovog izlaska iz grupe tj. ostavljanja grupe (u situaciji „ovdje i sada“). Činilo mu se da nije bilo prilike i da ga je grupa vodila u drugom smjeru, u smjeru omnipotencije. Možda je to „činilo mu se da nije bilo prilike“ bio izraz voditeljeve krivnje što je ostavio grupu. Po povratku u grupu, ne znajući o čemu se pričalo, voditelj se neko vrijeme osjećao izolirano i usamljeno. Da li je Josipova uskrata informacije bila kazna za odsutnost i neuvažavanje Josipovog značaja? Da li je i voditelj Indijanac-divljak koji ostavlja mladu, tek formiranu grupu sa koterapeutom, isto početnikom? Da li je smijeh grupe što voditelj ispada glup bila osveta za ostavljanje (jer je netko drugi važniji od njih)? To se npr. moglo otvoriti u grupi. Nepotrebno je govoriti da bilo kakva intruzija u grupu tijekom trajanja grupe narušava seting (npr. grupa bez voditelja) i mijenja fino tkanje grupe koje bi se u situaciji bez intruzije vjerojatno „plelo“ u nekom drugom smjeru. Također, voditeljeva unutarnja situacija se ne može mijenjati po principu „pali-gasi“. Za njegovu unutarnju „podešenost“ prema grupi ili nekoj drugoj situaciji je potrebno neko vrijeme pa dakle i povratak u grupu traži ponov-

now”, with some elements of the psychodynamic approach when the situation in the group allows for it.

Psychodynamic analysis was used in the analysis of countertransference: after the session, the leader wondered whether it had been possible to open the situation of his leaving the group, that is, abandoning the group (in the situation “here and now”). It seemed to him that there was no opportunity for that and that the group led him in a different direction, the direction of omnipotence. Perhaps the “it seemed to him there was no opportunity” was an expression of the leader’s guilt for abandoning the group. After returning to the group and not knowing what they had been talking about, the leader briefly felt isolated and lonely. Was Josip’s withdrawal of information a punishment for his absence and not acknowledging Josip’s significance? Was the leader also a savage-Indian who abandons a young, barely formed group and leaves it in the hands of a co-therapist, also a novice? Was the group’s laughter at the leader appearing stupid a revenge for the abandonment (because someone other than them was more important)? This could have been opened in the group. It is unnecessary to say that any sort of intrusion into the group during the session disrupts the setting (for example, a group without a leader) and changes the fine weaving of the group which, in a situation without an intrusion, probably would have progressed in a different direction. Also, the leader’s inner situation cannot be changed according to the prin-

nu prilagodbu koja neko vrijeme traje i tijekom kojeg vremena, više članovi grupe brinu za voditelja nego voditelj za članove tek formirane grupe. Voditeljeve teškoća da prepozna svoju krivnju zbog ostavljanja grupe vjerojatno je utjecala na voditeljeve intervencije u smjeru omnipotencije i izolacije umjesto, možda, u smjeru separacije i izolacije. Da je voditelj više uvažavao svoj kontratransferni osjećaj izoliranosti i samoće pri povratku u grupu, osjećaj koji je možda bio izazvan projektivnom identifikacijom članova grupe (staviti voditelja u poziciju neizvjesnosti i neugode u kojoj su se oni našli nakon što je voditelj izašao iz grupe), vjerojatno bi intervencije na grupi bile točnije. Jer, težište problema ne bi bilo na Josipu i Željku nego na voditelju, njegovom ostavljanju grupe i reakciji članova grupe na to ostavljanje.

Zbog brojnih ambivalentnih osjećaja prema terapeutu (frustracije proizlaze iz različitih zabrana, ograničenja, nesuradljivosti i brojnih drugih interakcija na odjelu) važno je otvarati i razgovarati o negativnom transferu. O tome govori i slijedeća situacija: na jednoj grupi je bolesnik optužio terapeuta da mu je u otpusnom pismu napisao da on (bolesnik) radi honorarno što je bila istina ali je on zbog toga imao problema. Naime on prima i socijalnu pomoć pa su ga zvali iz Centra za socijalnu skrb da se o tome izjasni. Terapeut je

ciple of “on and off”. His inner “adjustment” towards the group or some other situation takes some time, so returning to the group also requires another adjustment that takes time, and during that time group members take care of the leader more than the leader does of the members of the recently formed group. The leader’s difficulty in recognizing his guilt for abandoning the group probably guided the leader’s interventions in the direction of omnipotence and isolation instead of separation and isolation. If the therapist had paid more attention to his countertransferential feeling of isolation and loneliness upon returning to the group, a feeling that may have been caused by projective identification of group members (to place the leader in the position of uncertainty and discomfort that they found themselves in after the leader left the group), the interventions during the session probably would have been more accurate. The focus would not be on Josip and Željko, but on the leader, his abandonment of the group, and the group members’ reaction to the abandonment.

Due to numerous ambivalent feelings toward the therapist (frustrations result from various prohibitions, limitations, lack of cooperation, and numerous other interactions on the ward), it is important to discuss negative transference. The following situation confirms this: in one session, one patient accused the therapist of writing in his discharge letter that he (the patient) works as a freelancer, which was true, but caused him

rekao da se ne sjeća da je tako nešto napisao. Bolesnik je inzistirao na tome da jeste. Terapeut je rekao da mu je žao ako je to napisao i da će ubuduće paziti da svojim pisanjem ne naškodi bolesnicima koje otpušta. Nakon toga je grupa mogla nastaviti sa svojom temom o načinima zarađivanja novca nakon otpusta.

ZAKLJUČAK

Psihoza je teški psihički poremećaj koji remeti emocionalni, intelektualni i socijalni (interaktivni) život pacijenata. Psihodinamski, u psihozi možemo prepoznati gubitak simbolizacijske (alfa)funkcije, nestabilnost self i objekt reprezentacija i slabljenje njihove diferencijacije, oštećeno testiranje realiteta, primitivne mehanizme obrane (rascjep, projekcija, projektivna identifikacija, blokada periferije selfa, kontrola lošeg objekta u vlastitoj unutrašnjosti), omnipotenciju, jačanje destruktivnih nagona, progoniteljske, parcijalne, „bizarne“ objekte, strah od fragmentacije i uništenja, slabljenje i promjenu kvalitete libidnih veza, regres na rane faze psihoseksualnog razvoja.

Grupna psihoterapija psihotičnih bolesnika, sa zrelijom organizacijom selfa, na zatvorenom psihijatrijskom odjelu, jedan je od oblika njihovog liječenja i kao takva zahtijeva značajne modifika-

some problems. He receives welfare, so they called him from the Centre for Social Welfare and asked him to explain himself. The therapist said he did not remember writing something like that. The patient insisted that he had. The therapist said he was sorry if he had done so, and that he would be careful not to harm the patients he is discharging in the future. After that, the group could continue with the topic of ways of earning money after being discharged.

CONCLUSION

Psychosis is a difficult psychological disorder that disrupts the emotional, intellectual, and social life of patients. Psychodynamically speaking, in psychosis we can identify the loss of symbolization (alpha) function, instability of the self and object representations and the weakening of their differentiation, impaired reality testing, primitive defense mechanisms (split, projection, projective identification, blocking of the periphery of the self, controlling a bad object in one’s inner world), omnipotence, strengthening of destructive impulses, pursuing, partial, “bizarre” objects, fear of fragmentation and destruction, weakening and change of libidinal connections, regression to earlier stages of the psychosexual development.

Group psychotherapy of psychotic patients with a more mature organization of the self, held on a closed psychiatric

cije u odnosu na analitičke grupe neurotskih bolesnika, modifikacije koje se tiču i grupe i voditelja.

U takvoj grupi psihotičnih bolesnika elastičnije se doživljavaju granice grupe i pravila grupe. Granice grupe su polupropusne, obostrana je interakcija sa odjelom, češće su intruzije vanjskih situacija u grupu, intruzije koje se ne mogu kontrolirati ali o kojima se može razgovarati kao i o osjećajima koji su tim intruzijama pobuđeni. Brojne interakcije na odjelu stvaraju ambivalentne osjećaje koje treba otvarati kada se pojave tijekom rada grupe. Neka od pravila grupe (povjerljivost, zabrana tjelesnog kontakta, obeshrabrivanje van grupnog druženja) nisu tako čvrsta kao kod grupa neurotskih bolesnika.

Kratkotrajnost bolničkih grupa (kraće seanse, sveukupno nekoliko seansi tijekom hospitalizacije) uvjetuje skromnije ciljeve: poticanje na otvoreniju interakciju sa drugim ljudima, poboljšanje testiranja realiteta, pokušaj postizanja bolje kontrole simptoma.

Voditelj grupa psihotičnih bolesnika je spontaniji, aktivniji, suportivniji, ne pušta duge šutnje, potiče bolesnike na interakcije u situaciji „ovdje i sada“, ne interpretira nesvjesne konflikte, ponekad direktno odgovara na pitanja članova grupe. Ipak, voditelj koristi svoja psihodinamska znanja i, kad osjeća da je to adekvatno ovisno o situaciji u grupi,

ward, is one of the forms of treating such patients, and as such it demands significant modifications in comparison to analytical groups of neurotic patients, modifications that affect both the group and the leader.

In such groups of psychotic patients, the boundaries of the group and its rules are more flexible. The boundaries are semi-porous, there is mutual interaction with the ward, the intrusions of external situations into the group are more frequent, intrusions that cannot be controlled but can be discussed, just like the feelings that those intrusions cause. Numerous interactions on the ward create ambivalent feelings that should be opened when they occur in group sessions. Some rules of the group (confidentiality, prohibition of physical contact, discouraging of socializing outside of the group) are not as firm as in groups of neurotic patients.

The short duration of hospital groups (shorter sessions, a handful of sessions during hospitalization) determines more modest goals: encouraging a more open interaction with other people, improving reality testing, attempting to achieve a better control over the symptoms.

The leader of a group of psychotic patients is more spontaneous, active, supportive, does not allow for long silences, encourages patients to interact in the situation “here and now”, does not interpret unconscious conflicts, sometimes answers the group members’ questions di-

voditelj otvara negativni transfer, jača libidne veze kroz poticanje komunikacije i međusobnih interakcija članova grupe, suočava članove sa nezrelim omnipotentnim potrebama kao i sa nezrelim mehanizmima obrane. Zbog mnogobrojnih različitih uloga na odjelu i brojnih interakcija sa pacijentima nemoguća je anonimnost terapeuta pa se naglasak stavlja na terapeutovu autentičnost i spontanost. Neformalni van grupni odnosi stvaraju mogućnost za spontane „trenutke susreta“. Potrebna je budnost terapeuta u odnosu na kontratransferna zbivanja.

Nužno je da u grupi budu terapeut i koterapeut zbog nepredviđenih okolnosti na grupi ili izvan grupe.

Poželjno je da osoblje bude psihodinamski educirano, da se prema pacijentima odnosi skladno i kompaktno, da bi se umanjila mogućnost rascjepa kojeg neki pacijenti imaju potrebu inducirati u osoblju. Osoblje se prema pacijentima nastoji ponašati kao „dovoljno dobra majka“.

Odjel sa svojom čvrstom strukturom terapijskih aktivnosti djeluje kao stabilni vanjski okvir koji daje potporu slabom psihotičnom selfu pacijenata, selfu koji je sklon urušavanju tj. gubitku strukture.

Iskustvo je autora ovog članka da je liječenju psihotičnih bolesnika na za-

rectly. However, the leader uses their psychodynamic knowledge and, when they feel it is appropriate, the leader opens negative transference, strengthens libidinal connections by encouraging communication and mutual interaction among group members, faces members with immature omnipotent needs and immature defense mechanisms. Due to numerous different roles on the ward and numerous interactions with patients, it is impossible for the therapist to remain anonymous, so the emphasis is on the therapist’s authenticity and spontaneity. Informal relationships outside of the group create the possibility of spontaneous “moments of encounter”. The therapist needs to be aware of countertransferential events.

The therapist and the co-therapist must be in the group due to unpredictable circumstances in the group or outside of it.

It is preferable for the staff to be psychodynamically educated and to behave harmoniously towards the patients in order to reduce the possibility of split, which some patients have the need to induce in the staff. The staff attempts to behave towards the patients like a “sufficiently good mother”.

The ward, with its firm structure of therapeutic activities, acts as a stable external framework that gives support to the weak psychotic self of the patients, a self that tends to collapse, or lose structure.

In the experience of the author of this article, the most appropriate approach

tvorenom psihijatrijskom odjelu najprimjereniji modificirani grupno-analitički pristup vođenja psihoterapijskih grupa uz primjenu svih ostalih uobičajenih terapijskih postupaka na psihijatrijskom odjelu: psihofarmakoterapiju, edukacijske grupe, terapijsku zajednicu, radno-okupacionu terapiju.

for the treatment of psychotic patients on a closed psychiatric ward is a modified group-analytic approach of leading psychotherapeutic groups with the application of all common therapeutic procedures on a psychiatric ward: psychopharmacotherapy, educational groups, therapeutic community, and occupational therapy.

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