KONTRATRANSFER U PSIHOTERAPIJI POREMEĆAJA LIČNOSTI ILI KAKO BITI ŠAPTAČ LJUDIMA?

/ COUNTERTRANSFERENCE IN PSYCHOTHERAPY FOR PERSONALITY DISORDERS: HOW DOES A THERAPIST BECOME A PEOPLE WHISPERER?

Dolores Britvić

SAŽETAK/*SUMMARY*

U članku je prikazan kratki tijek suportivne psihoterapije pacijenta koji je ustupio humoristično-ironičan prikaz svog poremećaja i terapije kao i opis vlastitog kontratrasfera terapeuta tijekom terapije. U drugom dijelu članka autor se kratko osvrnuo na definicije kontratransfera, osobitosti kontratransfera u radu s osobama s Poremećajem ličnosti kao i kontratransfera kod pacijenata s graničnom i narcističkom organizacijom ličnosti. Na kraju članka se navode preporuke terapeutima u psihoterapijskom radu s pacijentima s Poremećajem ličnosti koje će pomoći osobito mladim terapeutima na početku njihova rada.

/ This article provides a brief case study of the supportive psychotherapy provided for a patient who bore his illness and treatment with humour and irony. It also outlines the therapist's countertransference reactions during these therapy sessions. The second part of the article briefly discusses the definitions of countertransference, the peculiarities of countertransference in cases of patients with personality disorders, and the experience of countertransference while working with patients with borderline and narcissistic personality organisation. At the end of the article, there is a list of recommendations for psychotherapists who work with patients with personality disorders; this list can be especially helpful for new psychotherapists.

KLJUČNE RIJEČI / *KEYWORDS*

kontratransfer / *countertransference*, poremećaj ličnosti / *personality disorder*, borderline / *borderline*, narcistička organizacija ličnosti / *narcissistic personality organisation*

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UVOD

Čitajući članak Psychosis neurosis, brzo sam se vratila u početke svog psihoterapijskog rada kojeg je odlikovao veliki entuzijazam i vjera u terapijsku moć ljudskog odnosa. Bila sam na početku svoje psihoterapijske edukacije oduševljena postojanjem naizgled nevidljivih, a upućenima i te kako vidljivih transfera i kontratransfera. Otkrivala sam i prepoznavala vlastite reakcije na pacijente. Bila sam neispunjena bilježnica psihoterapeutske prakse kojoj je svaki novi pacijent nosio lekciju koju tek treba naučiti. Svi koji su imali hrabrosti učiti se psihoterapiji dobro znaju koliko su te lekcije teške, prvenstveno zato što ovdje za učenje nije dovoljno pročitati udžbenik, već treba stalno propitivati i opservirati vlastite emocionalne reakcije, dati im kontekst i značenje, učiti ih kontrolirati i koristiti u dijagnostičke i terapijske svrhe. U tom se razdoblju paralelno s profesionalnim razvojem razvijala i moja obitelj, podizala djeca i razvijao odnos s partnerom. Sjesti preko puta pacijenta značilo je odmaknuti se od vlastitih razmišljanja i strahova vezanih uz svakodnevne životne situacije što sam na sreću najčešće uspijevala.

INTRODUCTION

While reading the text *Psychosis Neurosis*, I could not help but remember the early days of my career as a psychotherapist, during which I had passionate enthusiasm and faith in the therapeutic power of human relationships. At the beginning of my journey to becoming a psychotherapist, I was delighted to learn about the seemingly invisible processes of transference and countertransference, which my experienced colleagues could easily recognise. I discovered and recognised how I, as a therapist, reacted to patients. Being a novice therapist myself, each new patient became a lesson that I had to learn. Everyone who has had the courage to undertake psychotherapy training knows the difficulty of these lessons, which cannot be learned or prepared for by reading the textbook. Instead, one should constantly question and observe their own emotional reactions to the patients, find the context and meaning of these reactions, and learn to control and use the reactions for diagnostic and therapeutic purposes. At the beginning of my own journey, I was working to advance my career while also starting a family, raising children, and building a relationship with my partner. When working with patients, however, I had to leave my thoughts and everyday worries at the door, which I fortunately managed to do.

SJEĆANJA NA TIJEK I RAZVOJ PSIHOTERAPIJSKOG PROCESA S R.

Ono što sam od početka psihoterapije osjećala bila je zatvorenost, visoki zid koji je pacijent podigao prema vanjskom svijetu, a tako i prema meni, od prvog dolaska na terapiju. Teško je govorio, na pitanje bi odgovorio upečatljivo i sadržajno, ali jednom rečenicom. Na značajan broj pitanja nije ni htio, odnosno mogao odgovoriti. Doživljaj neprijateljstva prema svijetu oko sebe odražavao se cijelim njegovim bićem, držanjem, stavom. U pravilu je gledao izvan ljudi, ne dopuštajući verbalnu komunikaciju ne samo s drugim pacijentima, već i s osobljem, medicinskom sestrom, drugim liječnicima. Njegov izgled bi kod drugih izazivao nelagodu, o čemu će i sam govoriti tijekom terapije. Njegova obrijana glava, mrk pogled, brojne tetovaže i na vidljivim dijelovima tijela stvarali su asocijaciju da se radi „o opasnom tipu". Početak seanse čekao bi na drugom kraju hodnika, na značajnoj udaljenosti od ostalih ljudi, pogleda i stava koji je govorio „ne približavaj mi se". Prvih šest mjeseci terapije (kako i sam opisuje u prikazu) je uglavnom šutio. U početku su te šutnje bile za mene pune nelagode. Pokušavala sam ih prekidati pitanjima s ciljem da potaknem otvaranje. Moja su pitanja nastojala prodrijeti u različite aspekte života, ali svaki put jednako neuspješ-

REFLECTING ON THE COURSE AND UNFOLDING OF THE PSYCHOTHERAPEUTIC PROCESS WITH R.

From the beginning of the process, I could tell that the patient was very guarded; he built a wall between himself and the rest of the world, including me, from the very first session. He spoke with difficulty and tended to give answers that were remarkable and substantial, yet short. Many questions the patient either could not or did not want to answer. His whole demeanour, including his posture and attitude, exuded hostility towards the world around him. He looked straight through people, making it impossible for other patients, staff, nurses, and doctors to establish verbal communication with him. The patient's appearance made people feel uncomfortable, which he himself mentioned during the sessions; his shaved head, permanent scowl, and ink-covered body made him look like a "bad guy". He waited for the start of each session at the far end of the hall, keeping his distance, his body language saying "stay away from me". For the first six months of psychotherapy, he remained largely silent (as he described himself). At first, I found the silence horribly uncomfortable. I tried to ask him questions. I tried to connect with him and different aspects of his life, but each attempt failed. He did not want to talk about his marriage, his job, or his parents. He always gave short, closed answers, using simple sentences, and then sank back

no. Ni o čemu se nije moglo pričati, ni o braku, ni o poslu, ni o roditeljima. Dao bi kratki, zatvarajući odgovor najčešće jednostavnom rečenicom i ponovo potonuo u šutnju. Kako je vrijeme odmicalo lakše sam podnosila šutnje, sve su manje bile nelagodne, postajale su poznat okvir moje komunikacije s njim. Kako smo se u šutnji bolje osjećali, tako je on sve lakše i sve više pričao. Kad se konačno osjećao dovoljno sigurno da može početi govoriti o sebi dobila sam uvid u vrlo rigidne obrane, pomalo grandioznu sliku o sebi, a s druge strane duboki osjećaj nesigurnosti i ugroženosti vanjskim svijetom.

Kako udžbenik kaže, tijekom terapije ovakvih pacijenata važno je ponuditi korektivno emocionalno iskustvo koje će omogućiti da se kreiraju novi kvalitetniji objektni odnosi, stoga sam se trudila ne osuđivati ga, slušati i prihvaćati ga. Testirao je moju kontejnirajuću sposobnost kao objekta. Prva gratifikacija je nastupila kad je nesvjesno odlučio odustati od bavljenja ilegalnim aktivnosti i kad je „dopustio da ga uhvate". Po izlasku iz zatvora kao da je došlo do velikog preokreta u terapiji, počeo se više otvarati, no i dalje sam bila pod kritičkim okom, stalno u opasnosti da mi nešto prigovori i da me kritizira. Srećom, koristio je humor koji nam je oboma olakšao put njegova emocionalnog sazrijevanja. Jedne prilike sam kasnila na seansu a on meni kaže: „Vama bi bilo najbolje da se zaposlite u Prometa (gradski prije-

into silence. As time went on, I grew more comfortable with silence, and such moments became less uncomfortable as I eventually came to understand his communication boundaries. I felt his aggression towards me diminish and, as we became more comfortable with silence, he felt more confident to talk. Once he finally felt safe enough to start talking about himself, I identified very rigid defences, a slightly grandiose self-image and, contrastingly, a deep sense of insecurity and intimidation by the outside world.

The textbooks say that, when working with such patients in psychotherapy, a therapist must offer a corrective emotional experience that will help the patient develop new and improved object relations. To this end, I tried not to judge the patient. Instead, I chose to be supportive and accepting of him. He was testing my containment ability as an object. My first gratification came when he decided to give up illegal activities and let himself be caught. When he got out of prison, I felt a major shift in our therapy sessions. He started to open up more, but I still felt insecure under his critical eye and was constantly fearful of being scolded or criticised. Fortunately, he frequently used humour, which made his journey towards emotional maturity easier for both of us. On one occasion, I was running late for a session. He said in response, "you may want to get a job at Urban Transport Group. Then you could combine two of your favourite

voznik, op. autora), spojili bismo svoje omiljene aktivnosti, mogli bismo se vozikati po gradu i pričati s ljudima.

O tome koliko se on mijenjao tijekom terapije, kako je mijenjao sliku o sebi govori i činjenica da je tijekom pete godine došao s pitanjem mogu li se skidati tetoaže jer je odlučio da bi neke skinuo. Veliku gratifikaciju sam osjetila kad me obavijestio da je upisao višu školu koju je uspješno i završio. Pri tome trebam naglasiti da me njegova inteligencija i snažna intuicija često oduševljavala, vrlo brzo bi osjetio i prepoznao zbivanja u terapiji, ponekad mi se činilo i prije terapeuta.

OSOBNA RAZMATRANJA O KONTRATRANSFERU TIJEKOM TERAPIJE R.

U ovom odjeljku osvrnula bih se na vlastiti kontratransfer tijekom terapije autora prikaza.

U početku terapije prevladavala je profesionalna znatiželja, bila sam oduševljena kad sam kao edukant iz psihoterapije na djelu vidjela i doživjela transfer i kontratransfer osoba s Poremećajem ličnosti. S druge strane koliko god bio zatvoren osjećala sam da me jednim dijelom prihvaća i uvažava. Možda je to bila patološka idealizacija koja je odgovarala mom narcizmu. Ili sam i ja njega dijelom prihvaćala jer me svojim izgledom podsjećao na muške članove moje

activities, driving around and talking to people".

Five years into the therapy, the patient asked me whether tattoos could be removed, as he had decided to remove some. This question spoke volumes about how much he and his self-image had changed. I was delighted to learn that he started community college and eventually earned a degree. His intelligence and strong intuition often delighted me in our sessions, as he quickly felt and predicted the course of our sessions, sometimes before I did.

PERSONAL CONSIDERATIONS ABOUT COUNTERTRANSFERENCE DURING THE SESSIONS WITH R.

In this section, I will reflect on my own countertransference in the psychotherapy sessions with the aforementioned patient.

In the beginning, my professional curiosity prevailed. Being an early career therapist, I was delighted to recognise and experience transference and countertransference in a person with a personality disorder. As much as the patient struggled to open up to me, I still felt accepted and appreciated. Perhaps this reaction was just a pathological idealisation that suited my narcissism. Perhaps I was inclined to accept him because his appearance reminded me of the male

obitelji što je predstavljao libidinozni dio kontratransfera. Godinama kasnije sam doznala da potječe iz susjednog zaseoka istog sela kao i moj otac. U svakom slučaju bili su prisutni kontradiktorni kontratransferni osjećaji.

Osjećala sam da mu treba stabilnost, sigurnost, mir i toplina terapeuta kao odgovor na njegov duboki osjećaj ugroženosti od vanjskog svijeta. Činjenica da je čekao na drugom kraju hodnika, na značajnoj udaljenosti od ostalih ljudi, pogleda i stava koji je govorio ne približavaj mi se, ukazivala je na potrebu agresivne obrane. Danas mi se čini da izdržati tu šutnju nije bilo tako teško, a onda se sjetim da sam jedne prigode, sjedeći preko puta njega, zabacila glavu prema straga i snažno udarila potiljkom o zid. U tom trenu sam promislila da je to što se desilo rezultat uloge koji mi je njegova projektivna identifikacija namijenila. Naravno da sam se za cijelo vrijeme dugotrajnih šutnji osjećala bezvrijedno i neuspješno kao terapeut iako mi je bilo jasno da izdržati tu šutnju znači kontejnirati njegove strahove od bliskosti. Također sam osjećala duboko neznanje, nisam ništa znala o njegovom životu, o sadašnjosti vrlo malo, o prošlosti gotovo ništa. Imala sam osjećaj izgubljenosti, lutala sam kao terapeut ali intuitivno osjećajući i vjerujući da će doći bolji dani. Osjećala sam da mu treba stabilnost, sigurnost, mir i toplina terapeuta, a danas mi se čini da je to idealizirajući kontratransfer mladog terapeuta.

members of my family – a connection that was probably a libidinal component of countertransference. Years later, I learned that he came from the same village as my father. Regardless, I had to deal with contradictory countertransference in the room.

I felt that the patient needed a therapist to give him stability, security, peace, and warmth in response to his intimidation by the outside world. His decision to wait for sessions at a considerable distance from the other people, his look, and his attitude that cried "stay away from me" supported his tendency to aggressive defence. I now feel that the silent treatment I received was not so painful. However, I remember that, sitting across from him, I once tilted and hit my head forcefully on the wall. I now realise that this incident was the result of the role I was given by his projective identification. As I received his usual silent treatment, I was wrestling with a sense of failure as a therapist, despite knowing that enduring the silence meant containing his fear of intimacy. I felt incompetent, knowing nothing about what his life was really like. I knew very little about his current situation and nothing about his past. As a therapist, I felt lost. However, I trusted my intuition and believed that better days were coming. I felt that he needed stability, security, peace, and warmth from his psychotherapist. Now, it seems to me that my interpretation of his needs was just a young therapist's idealistic countertransference.

Povremeno sam osjećala strah, pogotovo kad bi pričao o svom bull terijeru. Nisam se usudila glasno stati na stranu preplašenih prolaznika. Znala sam da bi to doživio kao odbacivanje i neprihvaćanje njegovog najosjetljivijeg i najkrhkijeg dijela stoga je trebalo kontejnirati i taj agresivni dio njegove ličnosti. Sigurna sam da je vidio strah u mojim očima i da ga je on na neki način zabavljao. Pitala sam se je li se tu radilo o mazohističkom kontratransferu?

Humor koji bi donosio na seansu, a koji mi je ukazivao na njegovo duboko razumijevanje i sebe i drugih bio je način koji sam i ja počela sve češće koristiti pa sam i vlastitu agresiju kanalizirala kroz humor, naravno nakon 5, 6 godina terapija. Tada sam mu mogla reći da ću mu dati papir da je zdrav, tako da ga više ne moram gledati, da mi se popeo na vrh glave, da sam ostarila uz njega. Htjela sam prikazati sebe, terapeuta kao ljudsko biće, sa svojim različitim pa i kontradiktornim osjećajima. U tom sam trenutku osjećala da je uspostavio cjelovitost objekta i da se, unatoč mojim izjavama, neće naljutiti na mene i zbog njih. Njegov, sada ne više tako krhak ego, neće se osjetiti odbačenim.

Definicija i koncept kontratransfera

Brojni su se autori okušali u definiciji ovog pojma te je povijest analitičke

Occasionally, I was terrified during sessions, especially when the patient talked about his bull terrier. I did not dare take the side of frightened bystanders. I knew that he would take this perspective as a rejection of his most sensitive and fragile side, and I was also aware that his aggression needed to be contained. He must have seen the fear in my eyes and found it somewhat entertaining. I cannot help but wonder whether my interpretation was a masochistic countertransference.

His sense of humour during the sessions, which signalled to me that he had a deep understanding of himself and others, was something that I started to embrace more often as time went on. I began to channel my own aggression into humour. However, this process took 5 or 6 years. Only after this length of time was I able to joke with him; I could playfully tell him that I would lie about his recovery only to make him go away, or that working with him turned my hair grey. As a psychotherapist, I wanted the patient to see me as a human being with feelings that sometimes contradict each other. By that time, I felt that he had managed to restore the integrity of his object relations, and I believed that he would not get angry with me and that his empowered ego would not let him feel rejected.

Countertransference: Definition and Concept

Many authors have tried to define the concept of countertransference. The his-

misli povijest razvoja koncepta kontratransfera. Od raznih definicija izdvojit ću onu koja kaže da je fenomen koji se pojavljuje u odnosu između pacijenta i terapeuta i predstavlja reakciju terapeutovog nesvjesnog na nesvjesno pacijenta.

U početku je Sigmund Freud smatrao da je kontratransfer prepreka terapiji te je koncept bio ograničen na neriješene konflikte i probleme terapeuta, a 1912. god. navodi da je neizbježan dio u analizi i da je put za razumijevanje nesvjesnog pacijenta. Paul Heimann navodi da je kontratransfer sve što terapeut osjeća prema pacijentu. Danas se kontratransfer smatra neizbježnom pojavom koja treba biti prihvaćena i prorađena od strane terapeuta. (1) Potiče vlastitu analizu kao ključ boljeg razumijevanja kontratransfera, a time i pacijenta. Kontratransfer je prerušeni blagoslov za korisnu upotrebu agresivnih i libidnih odgovora prema pacijentu. (2)

Važan zadataka terapeuta je postaviti pitanje što je potaknulo kontratransferne osjećaje. U nastajanju kontratransfera važnu ulogu igraju terapeutovi vlastiti konflikti i otpori, transferni osjećaji koje terapeut razvija prema pacijentu, a imaju veze s važnim osobama iz terapeutova djetinjstva, anksioznost terapeuta, crte ličnosti samog terapeuta, ograničenja koja u terapeutu izaziva pojedini pacijent.

torical development of psychoanalytic thinking coincides with the development of the concept of countertransference. Although many definitions are available, I will be referring to countertransference as the phenomenon that occurs in the relationship between client and therapist when the latter has an unconscious reaction to the patient's unconscious thoughts and feelings.

Sigmund Freud initially viewed countertransference as a major impediment in the therapeutic endeavour. The concept was, therefore, limited to the therapist's own unresolved conflicts and problems. In 1912, however, Freud suggested that countertransference was an inevitable part of psychoanalysis and the main tool for understanding the patient's unconscious communications. Paula Heimann saw countertransference as all therapist's feelings towards a patient. At present, countertransference is held to be an inevitable part of therapy that should be accepted and handled by a psychotherapist (1). Self-analysis is encouraged as a key to better understanding both countertransference and the patient. Countertransference is actually an valuable tool for putting aggressive and libidinal responses towards the patient to good use (2).

The psychotherapist's task is to examine what triggered the countertransference feelings. Countertransference reactions can result from the psychotherapist's conflicts and resistances; transference feelings that the psychotherapist has de-

No nije kontratransfer samo rezultat opisanih zbivanja kod terapeuta već on može predstavljati i svojevrsni otisak pacijentovih objektnih odnosa. Kontratransfer može biti rezultat konkordantne i komplementarne identifikacije. Konkordantne identifikacije odraz su empatijskog odgovora na pacijentove osjećaje i misli dok su one komplementarne rezultat identifikacije s projiciranim, u pravilu neželjenim dijelovima pacijenta. Time dolazimo do projektivne identifikacije koja se često zbiva pogotovo kod psihoterapija „teških" pacijenata (s psihozama i poremećajima ličnosti). Prilikom projektivne identifikacije pacijent projicira neželjene self ili objekt reprezentacije u drugu osobu što kod primatelja stvara pritisak da osjeća osjećaje slične projiciranima. Jay R. Grinberg opisuje projektivnu kontraidentifikaciju kao terapeutov nesvjesni odgovor na masivnu projekciju na način da se terapeut ponaša u skladu s projiciranim sadržajem na konkretan i realan način. Ovo ponašanje nije posljedica nesvjesnih konflikata terapeuta već konflikata pacijenta koje analitičar treba prepoznati i time dobiti značajan uvidu u svijet unutarnjih objekata pacijenta (3). Glen O. Gabbard smatra da je kontratransfer zajednička „tvorevina" pacijenta i terapeuta nastala pomoću projektivne identifikacije i odigravanja (engl.

veloped towards the patient, which are closely linked to important people in the therapist's childhood; or the therapist's anxiety, personality traits, and limitations that are triggered by a patient.

However, countertransference is not simply the result of the psychotherapist's reactions to the patient; it can also be viewed as the expression of the patient's object relations. Countertransference results from concordant or complementary identification. Concordant identifications are empathic responses to the patient's thoughts and feelings, while complementary countertransference involves the therapist's identification with the unconscious, mostly unwanted, and projected representations of the patient. This leads to projective identification, which is quite common especially in psychotherapies with "severe" cases (patients with psychotic and personality disorders). Projective identification means that the patient projects unwanted self- or object-representations into other people, exerting pressure that coerces the recipient into experiencing what has been projected. Jay R. Greenberg described projective counter-identification as a psychotherapist's unconscious response to a massive projection, wherein the therapist starts behaving in a manner congruent with the projection. This behaviour is not a result of the psychotherapist's unconscious conflicts but rather a result of those of the patient; the psychotherapist needs to recognise these conflicts to gain insight into the patient's internal object world (3). In Glen O. Gab-

Enactment) u terapijskom odnosu. Pacijent u analitičaru pobuđuje određene reakcije a analitičarevi vlastiti konflikti i unutarnje self- i objekt- reprezentacije određuju završni oblik kontratransfernog odgovora (4). Tako Otto Kernberg i Donald Winnicott ističu kako u potpunosti treba iskoristiti emocionalna reagiranja analitičara prema pacijentu te da imaju posebnu dijagnostičku vrijednost (3, 5, 6). Prepoznavanje i analiza kontratransfernih osjećaja vrijedan je dijagnostički psihoanalitički instrument koji nam pomaže da bolje upoznamo unutarnji svijet pacijenta, ali i terapijsko sredstvo pomoću kojeg možemo naći put do pacijenta i potaknuti njegovu promjenu. (7)

Kontratransfer kod osoba s poremećajima ličnosti

U našem svakodnevnom radu, kad se kaže da netko ima poremećaj ličnosti o njemu se u pravilu stvara negativna slika. Često se ova dijagnoza „prilijepi" osobama koje su teške za liječenje ili neizlječive. Osoba s ovom dijagnozom gleda se sa zadrškom, oprezom i distancom, što pokazuje da ova dijagnoza ima snažan stigmatizirajući učinak. (8, 9, 10)

Kontratransfer kod osoba s poremećajem ličnosti ovisi o vrsti i dubini poremećaja ličnosti kao i samom terapeutu.

bard's view, countertransference must be thought of as a joint "creation" between patient and psychotherapist, formed by projective identification and enactment in the therapeutic relationship. The patient evokes certain responses in the therapist, while the therapist's own conflicts and internal self- and object-representations determine the final shape of the countertransference response (4). Otto Kernberg and Donald Winnicott highlighted that the therapist's emotional reactions to the patient should be fully investigated, given their special diagnostic value (3, 5, 6). Recognition and analysis of countertransference feelings are valuable diagnostic and psychoanalytical tools, which help therapists better understand the patient's inner world, as well as therapeutic tools, by which therapists can reach out to the patient and inspire positive change (7).

Countertransference in Working with Persons with Personality Disorders

In the daily work of therapists, the label of personality disorder usually has a negative connotation. Patients with severe or incurable diseases are very likely to receive this label. People often approach those with personality disorders with reservations, caution, and distance, demonstrating the strong stigmatising effect of this diagnosis (8, 9, 10).

Countertransference in working with persons with personality disorder depends on the type and severity of per-

Duboka patologija objektnih odnosa uz korištenje nezrelih obrambenih mehanizma dominantne su značajke ovih osobnosti, stoga ovi pacijenti u nama izazivaju burna i teška emocionalna doživljavanja na koja trebamo biti pripremljeni i stalno ih prorađivati. Kod njih postoji opasnost od regresivne fragmentacije od koje se brane izbjegavanjem, disocijacijom i izolacijom. (11) Upravo stoga kod ovih „teških pacijenata" terapeut treba djelovati kao „novi objekt" ili „konstruktivni novi objekt" ili „reparacijski objekt". (12)

Kod pacijenata s poremećajem ličnosti suočeni smo s raznim oblicima agresivnosti u transferu koja može biti usmjerena direktno prema terapeutu, prema psihoanalitičkom *settingu* ili samom analitičkom procesu. Ponekad će se manifestirati kroz nerealne zahtjeve prema terapeutu da prekrši ulogu terapeuta i bude pacijentu roditelj, ljubavni partner i sl. Također na razne načine može kršiti *setting*, ne pridržavati se dogovora o terminu, stalno ga mijenjati, mijenjati način održavanja seanse (virtualni *setting*), tražiti sastanke izvan ordinacije i sl. Ponekad može doći i do verbalnog ili fizičkog napada prema terapeutu optužujući ga za pogoršanje stanja, da mu je uzrokovao nove tjeskobe i strahove, traumatska iskustva.

Ove agresivne i *acting out* reakcije obrambene su prirode i često služe da

sonality disorder, as well as the psychotherapist.

Severe pathology of object relations and use of immature defence mechanisms are dominant characteristics of these patients' personalities. These patients evoke turbulent and difficult emotional experiences in therapists, who need to be prepared to confront and process such experiences. These patients are at risk of regressive fragmentation, which they try to tackle by choosing avoidance, dissociation, and isolation (11). Therefore, in these severe patients, the psychotherapist should act as a "new object", a "constructive new object", or a "reparative object" (12).

When working with patients with personality disorders, the therapist may be confronted with different forms of aggressive behaviour in transference that can be directed towards the psychotherapist, the psychoanalytic setting, or the analytical process. Sometimes this transference manifests in the form of unrealistic demands where the patient insists that the therapist violates the framework of psychotherapy and extends the relationship into the social roles usually filled by parents or romantic partners. The patient may also choose to violate the therapeutic setting in other ways: they may not keep to the appointment schedule, they may frequently change the time or format of the session (online setting), they may ask the therapist to see them outside of the office, and so on. The possibility of being verbally or physically attacked; accused of aggravating the pa-

bi se pacijent zaštitio od raznih neželjenih odnosa koje je iskusio u djetinjstvu. Takva djeca su često rođena kao neželjena, odbačena još prije rođenja ili su služila kao prijelazni ili parcijalni objekti roditelja ili su putem projektivnih identifikacija predstavljala odlagalište projiciranih neželjenih unutarnjih dijelova roditelja. Stoga nisu mogli upoznati što pripada njima a što je nečije drugo, prisilno projicirano u njih. Ponekad pacijenti čije su majke bile emocionalni nedostupne, pasivne, često bez životne energije i sami postaju emocionalno otupjeli i distancirani. Ovakav pacijent nerijetko očekuje da ga se cijeni i voli kao osobu i da ga terapeut stavi ispred psihoanalitičkog *settinga*. (5, 11)

S druge strane pacijent kroz ovakav objektni odnos, kod terapeuta često izaziva osjećaj ugroženosti ili nekompetentnosti u terapijskoj ulozi. Tada terapeut, u skladu s projektivnom identifikacijom, može i sam reagirati agresivno na svjesnoj ili nesvjesnoj razini. (11)

Pacijenti koji su rano iskusili traumatsko iskustvo ili kasnije u životu iskusili traume koje su dovele do promjena osobnosti putem projektivne identifikacije projiciraju u terapeuta neželjene osjećaje bespomoćnosti i praznine. Uslijed toga terapeut može nesvjesno prihvatiti ulogu žrtve ili ulogu zlostavljača. (5)

tient's condition; or triggering new fears, trauma, and anxiety are concerns for many psychotherapists.

Aggressive behaviour and acting out are defensive reactions that usually serve to protect the patient from the unwanted relationships experienced in childhood. Most of these patients seem to have been unwanted children who were rejected before birth; for many, their parents used them as transitional or partial objects or, through projective identifications, as containers for their parents' projected unwanted inner parts. Therefore, they could never learn what is theirs and what actually belongs to others but was projected into them. Patients raised by emotionally unavailable, passive, and unmotivated mothers may become emotionally numb and distant. They usually expect the therapist to make them feel appreciated and loved, asking the therapist to prioritise them as a person over the psychoanalytic setting (5, 11).

However, because of this kind of object relation, therapists often feel threatened or incompetent in their role. Projective identification coerces the therapist to respond with aggression, whether consciously or unconsciously (11).

Patients who had traumatic experience early in life or experienced trauma later in life leading to personality changes through projective identification, project their unwanted feelings of helplessness and emptiness onto the therapist. As a result, the therapist may fall unwittingly into the roles of victim or abuser (5).

Kontratransfer kod narcistički i graničnih struktura

S obzirom na opis tijeka suportivne psihoterapije i prirode kontratransfera smatram da je za teoretsku obradu i razumijevanje istih potrebno osvrnuti se na osobitosti kontratransfera kod narcističkih i graničnih struktura ličnosti.

Pacijenti s graničnom strukturom ličnosti iskazuju „bazičnu pogrešku" (*basic failure*) u terapiji zbog koje se atmosfera u terapiji brzo i odjednom mijenja, nedostaje opservirajući ego, nema terapijskog saveza niti radne alijanse. Pacijent često riječi terapeuta doživljava kao napad, narcističku povredu i prekid razumijevanja. (11)

Kernberg navodi da granične i narcistične organizacije ličnosti imaju sličnu organizaciju obrambenih mehanizama na način da koriste rascjep i primitivnu disocijaciju koja se odražava kroz istodobnu prisutnost dva disocirana ili rascjepljena ego stanja. Ohola grandioznost, stidljivost i inferiornost mogu koegzistirati bez da diraju jedan drugog. Ovaj rascjep se pojačava i održava primitivnim formama projekcije, posebno projektivne identifikacije, primitivne i patološke idealizacije, ominipotentne kontrole, narcističkog povlačenja i devalvacije.

I narcističnu i graničnu organizaciju ličnosti karakterizira „patološka kon-

Countertransference in Working with Narcissistic and Borderline Personality Organisations

Considering the course of supportive psychotherapy and nature of countertransference, I believe that the specificities of countertransference in narcissistic and borderline personality structures need to be addressed for the sake of argument and understanding.

Patients with borderline personality disorders show a basic failure of emotional regulation, causing rapid and sudden in-session mood changes. An observing ego and a therapeutic or working alliance are missing. The patient often misinterprets the therapist's words as a personal attack, a narcissistic injury, and therapist's unwillingness to understand them (11).

According to Kernberg, borderline and narcissistic personality organisations have similar defence mechanisms, which are characterised by splitting and primitive dissociation reflected through the simultaneous presence of two dissociated or splitting ego states. Overbearing grandiosity, shyness, and inferiority can coexist and be kept separate from each other. Splitting is intensified and maintained by primitive forms of projection, especially projective identification, primitive and pathological idealisation, omnipotent control, narcissistic withdrawal, and devaluation.

Both narcissistic and borderline personality organisations are characterised

denzacija" genitalnih i pregenitalnih nagonskih potreba s dominacijom utjecaja pregenitalne (posebno oralne) agresije. Kernberg također naglašava posebnu skupinu narcističnih pacijenata koji ilustriraju bliski odnos s graničnom organizacijom ličnosti, kod kojih je uz grandiozan self prisutna slabost ega, nemogućnost tolerancije anksioznosti, slabost u kontroli impulsa, nedostatak mogućnosti kanaliziranja sublimacijom te im narcistička struktura ne omogućuje integraciju dostatnu za učinkovito socijalno funkcioniranje. Kod pacijenata s *borderline* organizacijom ličnosti smjenjuju se aktivacije dobrih i loših objekata, dok kod narcističkih pacijenata omalovažavajući bijes kontaminira cijeli odnos s terapeutom te, ako je dulje vrijeme prisutan, remeti kontinuitet terapije. Narcistički bijes rano i na početku terapije predstavlja ozbiljan rizik za tretman. (5) S druge strane, zbog opasnosti od regresivne fragmentacije preporučuje se ne koristiti klasičnu analizu otpora. Stoga je za ovu kategoriju pacijenata suportivni psihoterapijski pristup, terapija izbora.

Navedeni opisi struktura obrana i transfera skupine pacijenata kod kojih se isprepliću narcističke i *borderline*-ske osobine ličnosti svakako predstavljaju veliki izazov za kontratransfer terapeuta. Izražavanje primitivne agresije od strane ovakvih pacijenata, koju pone-

by pathological condensation of genital and pregenital instinctive needs, with a dominant influence of pregenital (especially oral) aggression. Kernberg explained that there is a special group of narcissistic patients who present the clearest illustration of the intimate relationship between borderline personality organisation and the development of the grandiose self. They present low ego strength, lack of anxiety tolerance, lack of impulse control, and absence of sublimation. Their narcissistic structure does not provide sufficient integration for effective social functioning. In borderline patients one also finds alternating activation of "all good" and "all bad" object relations. Narcissistic patients typically react with narcissistic rage that seems to contaminate their relationship with the psychotherapist, which can adversely affect continuity of care. Early expression of narcissistic rage represents a serious risk for the treatment (5). However, a classical resistance analysis method is not recommended, given that it may lead to regressive fragmentation. For narcissistic patients, a supportive psychotherapeutic approach may be the treatment of choice.

Countertransference seems to be particularly challenging in cases of previously described defence and transference structures in patients with narcissistic and borderline personality traits. In addition to direct expression of primitive aggression, or use of silent treatment, such rage reactions may have the defen-

kad može predstavljati i uporna i dugotrajna šutnja mogu imati obrambenu svrhu kako bi se pacijent zaštitio od primitivnog straha od terapeuta ili od osjećaja jake krivnje ili od separacijske anksioznosti (5).

Terapeutov osjećaj unutarnje sigurnosti i njegovo uvjerenje o tome što on može stvarno ponuditi pacijentu vrlo su važni u osiguravanju pacijenta od preplavljujuće prirode njegovih fantazija i agresije. Ovakvi objektni odnosi koje nudi pacijent s poremećajem ličnosti predstavljaju veliki izazov terapeutu.

Kod ostalih poremećaja osjećaji razočarenja i ogorčenosti terapeutom, osjećaj srama i poniženosti obično su privremeni i manje intenzivni, prisutni su zajedno s kapacitetom za ovisnost o terapeutu, separacijskom anksioznošću ili reakcijama žalovanja u transferu (primjerice kod odvojenosti od terapeuta tijekom pauza za vrijeme ljeta) dok je kod narcističkih struktura upečatljiv izostanak separacijske anksioznosti ili žalovanja za terapeutom.

Kako će to terapeut prihvatiti? Kod nekih terapeuta izostanak brige i interesa pacijenta o podacima iz terapeutovog osobnog života može predstavljati olakšanje.

S druge strane idealizacije s istovremenom prisutnošću potpune nesvjesnosti

sive function of protecting the patient against primitive fears of the psychotherapist, against overwhelming guilt against them, or separation anxiety (5).

The therapist's own sense of inner security and their ideas about how they can serve the patient are crucial in reassuring the patient against their fantasies and the overwhelming nature of their own aggression. This kind of object relation in a patient with a personality disorder poses major challenges to the psychotherapist.

In patients who do not have the narcissistic personality structure, resentment towards the analyst, disappointment reactions, feelings of shame and humiliation are temporary and less intense, and their reactions coexist with a clear capacity for dependence upon the analyst, as indicated by separation anxiety or mourning reactions in the transference (e.g. separation in connection with summer holidays). In patients who have the narcissistic personality structure, there is a striking absence of separation anxiety or mourning reactions.

Therapists can react to this type of patient in a variety of ways. Some therapists are relieved to learn that their private life is of no interest to the patient.

However, the simultaneous presence of idealisation and complete obliviousness towards the analyst alerts us to the existence of pathological idealisation. Psychotherapists can react to pathological

o terapeutu ukazuje na patološku prirodu ove idealizacije. Kako se terapeut nosi s ovom patološkom idealizacijom? Heinz Kohut ukazuje na nemir analitičara i njegovu „suptilnu" tendenciju da odbaci pacijentovu idealizaciju. Nerazriješeni narcistički konflikti terapeuta mogu pobuditi patološku reakciju na pacijentove idealizacije, u vidu ekscesivnog prihvaćanja ili odbijanja pacijentove idealizacije. Ona se ogleda kroz prihvaćanje njegova „divljenja" ili kritičnu „pretjeranu objektivnost". Narcistični pacijenti spremni su reagirati na interpretaciju kao odbacivanje. S druge strane prihvaćanje njegova obožavanja nosi zamku da se terapeut „gurne" u situaciju koju pacijent lako interpretira kao zavođenje od strane terapeuta. Ovi pacijenti imaju „nevjerojatni talent da uđu u terapeutovu kožu", neki narcistični pacijenti vrlo vješto osjete aspekte svoje idealizacije koje točno pogađaju analitičarevu „slabu točku". Nemir terapeuta dolazi od kontrolirajućih i izmjenjujućih (*switch on- off*) aspekata ove patološke idealizacije pacijenta. Kernberg opisuje da nakon patološke idealizacije terapeuta dolazi do izmjenjivanja faza vlastite idealizacije i idealizacije terapeuta. Kohut kaže da iako se terapeut može osjećati „potlačen" pacijentovim neizrečenim zahtjevima te potrebom za ovladavanjem njim kao objektom, upravo odsutnost instinktivne katekse često otežava terapeutu zadržati stav pouzdanosti i

idealisation in a variety of ways. Heinz Kohut explained that this may cause the analyst's uneasiness and bring about a subtle tendency to reject the patient's idealisation. Unresolved narcissistic conflicts in the analyst may evoke a pathological response and foster excessive acceptance and rejection of the patient's idealisation. The pathological response is reflected in accepting the patient's admiration or critical overobjectivity. Narcissistic patients readily react to interpretations as if they were rejections. Conversely, in accepting the patient's admiration, the analyst is in danger of being forced into a situation in which the patient interprets seduction by the analyst. Narcissistic patients tend to intrigue the therapist, and some of them skilfully sense which aspects of their idealisation of the analyst feed the analyst's own narcissistic weak spot. The analyst's uneasiness may stem from the combination of the controlling elements in the pathological idealisation and its "switch on–switch off" quality. Kernberg explained that, after a patient creates the pathological idealisation of their analyst, an idealised image of themself alternates with the idealisation of the psychotherapist. Kohut explained that, while the analyst may feel "oppressed" by the patient's silent demands, which are tantamount to total subjugation, the absence of object-instinctual cathexis often makes it difficult for the psychotherapist to remain reliably attentive in the long run (11).

pažljivosti tijekom duljeg trajanja terapije. (11)

Nesvjesni pokušaji pacijenta da negira značenje odnosa s terapeutom mogu kod terapeuta izazvati kronični osjećaj frustracije, bespomoćnosti, dosade i nedostatka razumijevanja. Ova negacija odnosa se daleko teže podnosi nego li patološka idealizacija. Upravo zbog ovog kroničnog umanjivanja vrijednosti terapeuta, postoji rizik od odbacivanja pacijenta. Ponekad terapeut osjeća analitičku situaciju kao čudnu i beživotnu. Može se osjetiti paraliziranim, bez emocionalne povezanosti s materijalom sa seansi što ga čini nesigurnim u tome kad i kako intervenirati. (4) Iskusni terapeut iskusi dijelove pacijenta koji imaju „preverbalni karakter", a kontratransfer prestaje biti logičan i razumljiv kroz sekundarni proces mišljenja. Stoga terapeut ne može razumjeti vlastite reakcije, nalazi se pred iskušenjem da čeka i pusti da se stvari odvijaju nadajući se da će kasnije uspjeti naći put prema intuitivnom razumijevanju pacijenta. Iskusni terapeut znat će, koristeći sadržaj seanse i neverbalnu komunikaciju, osvijestiti pacijentu što se dešava u terapiji, što može dovesti do naglog napretka u terapiji. (11)

Pacijent će puno lakše prihvatiti teoretska i intelektualna objašnjenja nego suočavanja s tim kako psihoterapeut osjeća njegova unutarnja *self* stanja ili kako

The patient's unconscious efforts to deny the meaning of the analytic relationship may induce in the analyst a chronic sense of frustration, helplessness, boredom, and lack of understanding. The patient's efforts to deny the analytic relationship are more difficult for the therapist to tolerate than the pathological idealisation. In response to the patient's devaluation, the therapist may eventually refuse to treat a patient. Sometimes the therapist may feel that the entire analytic situation has become strange and lifeless. At other times, the analyst may feel completely paralysed and no longer able to decide how and when to intervene or feel no emotional relation to the treatment (4). An experienced psychotherapist wants to feel the preverbal side of the patient, and countertransference ceases to be logical and easy to understand through secondary process thinking. The analyst is unable to understand their own reactions. At times, the analyst is strongly tempted to just relax and surrender, hoping that they will find a way back to an intuitive understanding of the patient. An experienced psychotherapist knows how to use the session-specific content and non-verbal communication to make the patient aware of what is occurring in a session, which may lead to abrupt progress in therapy (11).

Patients are more willing to accept theoretical and intellectual explanations than to accept the psychotherapist's feelings about their internal states of the self or current mood. At this stage, it is as if the

analitičar vidi njegovo trenutno stanje raspoloženja. Psihoterapeut to može otvoriti kad osjeti da je postao odlagalište dijelova *selfa* i objekta povezanih s osjećajem odbačenosti, usamljenosti, frustracije i beznadnosti protiv koji se pacijent i te kako brani, koje teško tolerira, disocira, potiskuje i zamjenjuje patološkim grandioznim selfom. (5)

Ponekad pacijentova potreba za kontrolom terapeuta kod njega može proizvesti kontratransferne *acting out* reakcije (u vidu „re-edukacije" pacijenta o njegovom potkopavanju terapije), sklonost moraliziranju ili zabrinutost zbog prognoze.

Nekim terapeutima transferi ovih pacijenata pobude vlastite arhajske objektne odnose ili narcističke rane i stvara se tzv. mazohistički kontratransfer. Takav se terapeut može bojati bijesa pacijenta ili se boji da će ga razočarati. S druge strane zbog straha od napuštanja i u krajnjoj mjeri potrebe za simbiotskim spajanjem sa svemogućim objektom, pretjerano će zadovoljavati transferne potrebe pacijenta i oklijevat će ili uopće neće postaviti primjerene granice. Mazohizam terapeuta mješavina je empatijskih osjećaja i osjećaja pokornosti. Kod ovakvih kontratransfera mazohizam ponekad smjenjuje prijezir kojim se postaje svemoćni objekt i time se ponovo izbjegava žalovanje i ranjivost kod terapeuta. **Dok**

analyst becomes the depository of the patient's self- and object images that are linked with the emotional experiences of abandonment, loneliness, frustration, and hopelessness; these experiences are ones against which the patient was previously defending themself and which the patient, being unable to tolerate the feelings, thus repressed and replaced with their pathological and grandiose self (5).

Acting in response to the countertransference reactions motivated by the patient's ongoing efforts of omnipotent control of the analyst may take a variety of forms on the analyst's part: re-educative efforts (such as pointing out to the patient how they are undermining the analytic process), patronisation, or concern about the future.

The patient's transference may provoke the therapist's archaic object relations or narcissistic injury and help the therapist develop masochistic countertransference. In this case, the therapist may be wary of the patient's rage or afraid of disappointing the patient. Meanwhile, the fear of abandonment and the need for symbiotic fusion with an omnipotent object urges the therapist to satisfy all transference needs of the patient and makes them reluctant to set appropriate boundaries. Masochism in the therapist is a blend of empathy and submission. In this type of countertransference, masochism may alternate with contempt, which helps the therapist become an omnipotent object and avoid mourning

mazohizam dovodi do opasnosti da se terapeut stopi u kontratransfernoj reakciji, prijezir ga mami da se odrekne svoje sposobnosti identificiranja i izgubi sposobnost za osobno iskustvo. Upravo složenost rada psihoterapeuta zahtjeva održavanje ravnoteže između bliskog i dalekog u stalnom dijalektičkom procesu. Upravo se rast odvija kroz slobodu kretanja u jednom i drugom pravcu, ali ne da se utopimo ili da umremo od samoće. (10)

PREPORUKE U RADU S KONTRATRANSFEROM

Na kraju, ipak bih završila s razmatranjima o osnovnim smjernicama koje mogu pomoći mladim terapeutima u radu s pacijentima s poremećajem ličnosti.

Autori predlažu da se ne inzistira na neutralnosti, već upravo zbog potrebe bivanja „novim, drugačijim objektom" i stvaranja novog drugačijeg objektnog odnosa treba diskretno pokazati autentičnost i ljudski element. Takvi pacijenti ne bi razumjeli izraziti analitički pristup. Autori također govore da terapeut treba biti fokusiran na empatijsko povezivanje između terapeuta i pacijenta. (11)

Promatrati i osluškivati vlastiti kontratrasfer nezaobilazan je dio terapije. Su-

and vulnerability. While masochism may cause the therapist to experience the countertransference reaction, contempt deprives them of their ability to identify with the patient and removes their capacity for personal experience. The complexity of psychotherapists' work requires them to maintain a balance between closeness to and distance from the patient throughout the ongoing dialectical process. Growth happens through freedom to move in both directions, without being drowned or dying of solitude (10).

HOW TO WORK WITH COUNTERTRANSFERENCE

I will conclude by sharing some basic guidelines that can help early career therapists in their work with patients with personality disorders.

The authors referenced in this paper do not support the insistence on therapeutic neutrality; given the need to build new object relations, the therapist also needs to be authentic and add a personal touch. A strictly psychoanalytic approach is not a good fit for such patients. The authors explain that the psychotherapist should focus on creating empathic connection between themself and the patient (11).

Observing and acknowledging one's own countertransference is an indispensable part of psychotherapy. Supervision can help therapists who are dealing with narcissistic and borderline structures,

pervizija nam može pomoći da se lakše nosimo s narcističkim i graničnim strukturama ali i ostalim pacijentima s poremećajem ličnosti. Na taj način možemo razumjeti kako se drugi ljudi osjećaju s pacijentom i kako se njemu nositi s njihovim reakcijama. Ne reagirati onako kako reagiraju drugi, uspjeti kontrolirati vlastiti kontratrasfer, vratiti prerađenu i neutraliziranu agresiju pacijentu znači biti roditelj koji ga prepoznaje i adekvatno odgovara na njegove dječje regresivne potrebe. Time se njegovim neuronima stvaraju nove sinapse, grade nove putevi kojima će kreirati jedan novi, manje opasan unutarnji svijet.

UMJESTO ZAKLJUČKA

Terapija je uvijek obostrani odnos koji tijekom terapijskog procesa razvija oboje sudionika, i terapeut i pacijent. Kao što terapeut utječe na pacijenta tako i pacijent neminovno utječe i na terapeuta. Potiče ga da istražuje vlastite osjećaje, da traži način da ostane blizak s pacijentom a opet na sigurnoj distanci. Put ove komunikacije značajno se više odigrava na neverbalnoj nego li na verbalnoj razini, a kad se dosegne verbalna razina znači da se neverbalna komunikacija već davno odvila. Kad se sjetim ove terapije pred sobom imam sliku iz filma „The horse whisperer". Mislim da se i naš posao psihoterapeuta može nazvati šaptačem ljudima.

as well as other personality disorders. In this way, therapists can witness how other people feel about the patient and how those individuals deal with their own reactions. Learning how to respond and not react, managing to control countertransference, and sending the processed and neutralised aggression to the patient are actions which align therapists with parents, who listen and respond adequately to their children's regressive needs. This relationship fosters synapse formation in the patients' brains and helps build new pathways that will create a new and less threatening inner world.

IN LIEU OF A CONCLUSION

Psychotherapy is a relationship that develops throughout the psychotherapeutic process between both participants involved in the interaction: the psychotherapist and the patient. The psychotherapist has an impact on the patient, and vice versa. Throughout the process, the psychotherapist is encouraged to explore their own feelings and find a way to accompany the patient, while simultaneously keeping a safe distance. Most of the psychotherapeutic communication is non-verbal. By the time verbal communication is reached, therapists have both given and received information from non-verbal cues. When recalling the session I described previously in this paper, I immediately envisage a scene from *The Horse Whisperer*. After all, the art of "people whispering" is the heart of the job of a therapist.

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