OSVRT SPECIJALIZANTICE PSIHIJATRIJE NA TEKST BOLESNIKA S POREMEĆAJEM LIČNOSTI U KOJEM BOLESNIK IZRAŽAVA SVOJ DOJAM O VLASTITOJ PSIHOPATOLOGIJI I PSIHIJATRU

/ A PSYCHIATRY RESIDENT'S REFLECTION ON A TEXT WRITTEN BY A PERSONALITY DISORDER PATIENT DETAILING THE PATIENT'S THOUGHTS REGARDING HIS PSYCHOPATHOLOGY AND PSYCHIATRIST

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SAŽETAK/*SUMMARY*

Okosnica ovog rada je osvrt na tekst koji je bolesnik s dijagnozom poremećaja ličnosti uputio svojoj psihijatrici nakon završetka dugogodišnjeg liječenja. Citatima iz teksta koji upućuju na to kako je bolesnik doživio svoju psihopatologiju i svoju psihijatricu opisani su bolesnikovi aspekti reakcije na pojašnjenje dijagnoze i transfer, samostigmatizaciju s pozicije specijalizanta psihijatrije.

/ The main objective of this study is to reflect on the text written by a patient diagnosed with a personality disorder who sent the text to his psychiatrist after finishing long-term treatment. Quotes are provided to illustrate the patient's thoughts regarding his psychopathology and his psychiatrist and to illustrate aspects of the patient's response to his diagnosis as it was explained to him, as well as transference and self-stigmatization from the point of view of a psychiatry resident.

KLJUČNE RIJEČI / *KEYWORDS*

Poremećaj ličnosti / Personality disorder, reakcije na pojašnjenje dijagnoze / reaction to diagnosis, transfer / transference, samostigmatizacija / self-stigmatization

Katarina Šore, dr. med., specijalizantica psihijatrije, za vlastite potrebe
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UVOD

Nije rijetkost da bolesnici ostanu u kontaktu sa svojim psihijatrom i nakon dugogodišnjeg liječenja. U ovom slučaju bolesnik je i nekoliko godina nakon završetka dugogodišnjeg liječenja komunicirao sa svojom psihijatricom šaljući joj tekstove mail-om. Jedan od tih tekstova sam pročitala, a čitajući ga sam se najprije dobrano nasmijala. Nasmijao me način na koji je bolesnik u vrlo pitkom tekstu, jednostavnim jezikom opisao, svoje viđenje vlastite zdravstvene problematike, načine na koje je pokušavao sebi pomoći, kako je doživio svoju psihijatricu, kako se nosio sa svojim zdravstvenim problemima, kako doživljava sustav,... i još mnogo toga.

Kada sam prvi puta pročitala tekst, nasmijala sam se, ali kod drugog čitanja, kada sam se zadubila i malo podrobnije iščitala tekst, uočila sam cijeli niz odnosa, doživljaja, prizvanih sjećanja, reakcija...

Ovaj osvrt pišem iz pozicije specijalizanta psihijatrije. Dakle, kako razmišlja specijalizant psihijatrije čitajući „humoresku"? Kako razumije tijek liječenja sa stajališta specijalizanta?

KAKO RAZMIŠLJA SPECIJALIZANT PSIHIJATRIJE ČITAJUĆI „HUMORESKU"

Procjena bolesnikovog doživljaja vlastite psihopatologije može se proma-

INTRODUCTION

It is not uncommon for patients to maintain contact with their psychiatrists even after the end of long-term treatment. In this case, the patient stayed in touch with his psychiatrist through e-mail for several years after the end of his long-term treatment. Having read one of his texts, it primarily made me laugh. I was amused by the patient's view – using simple language in a very easy read – on his own health concerns, his retelling of how he tried to get help, what he thought about his psychiatrist, how he coped with his condition, his opinion on the system... and much more.

When I first read the text, I found it amusing. However, as I delved deeper into the text and paid more attention to detail during my second reading, I noticed a broad range of relationships, experiences, evoked memories, reactions, etc.

I am writing this reflection from the point of view of a psychiatry resident. So, what does a psychiatry resident think while reading a humorous "anecdote"? How does a resident understand the course of treatment?

A PSYCHIATRY RESIDENT'S THOUGHTS ON A HUMOROUS "ANECDOTE"

A patient's experience of their own psychopathology may be observed and evaluated using various parameters. Let's take a look at some of these parameters:

trati kroz više parametara. Pogledajmo neke od tih parametara.

- Uvid i kritičnost prema vlastitoj psihopatologiji
- Reakcija na pojašnjenje dijagnoze i funkcioniranje
- Subjektivni kriterij normalnosti
- Stigma i samostigmatizacija

Uvid i kritičnost prema vlastitoj psihopatologiji

Uvid i kritičnost bolesnika prema vlastitom zdravlju tj. zdravstvenim tegobama su povezani s težinom bolesti te su liječniku od velikog značaja prilikom donošenja odluke o liječenju. Općenito govoreći, bolesnici s anksioznim poremećajima su kritičniji u odnosu na psihotične bolesnike. Sagledavajući uvid i kritičnost uočavamo više različitih situacija:

- Bolesnik može biti svjestan i doživljavati svoje stanje kao promijenjeno, patološko, pa u tom slučaju smatramo da je bolesnik kritičan prema svojoj bolesti/stanju.
- Postoje situacije kada je bolesnik svjestan da je njegovo stanje promijenjeno, ali smatra da se ne radi o ozbiljnom problemu, da će se sve izregulirati samo od sebe, da će on vlastitom voljom razriješiti nastalu situaciju. U ovom slučaju bolesnik ima djelomični uvid u svoje stanje.

- Insight into and criticism of one's own psychopathology
- Reaction to diagnosis and functioning
- Subjective criteria of normality
- Stigma and self-stigmatization.

Insight in and criticism of one's own psychopathology

A patient's insight in and criticism of their own health concerns correlate with the severity of the disorder and are a crucial factor in a health professional's decision-making on appropriate treatment. In general, patients with anxiety disorders are more critical than psychotic patients. As regards insight and criticality, we may observe different scenarios:

- A patient may be aware of their condition and understand it as being altered/pathological, so in this case, we may say that the patient is critical of their illness/condition.
- In some cases, patients may be aware of their altered condition, but they will question the severity of the problem, believe that it will be fixed by itself, or that they, by themselves, may find a solution to the problem. In such cases, patients have a partial insight into their condition.
- In certain cases, we may encounter dissimulation. These patients consciously hide their symptoms or, failing that, downplay their significance.

- U određenim situacijama imamo disimulaciju. Tada bolesnik svjesno prikriva simptome, a ako simptome ipak ne može sakriti onda umanjuje njihov značaj.
- Neki bolesnici su pak bez uvida u svoje stanje te nekritični prema vlastitim simptomima. U ovom slučaju bolesnik smatra da on nema simptoma, da nije bolestan te da ne treba pomoć.
- U doživljaju vlastite bolesti bolesnici mogu svoje simptome doživjeti prenaglašeno i dramatično te tražiti pomoć liječnika iako se ne radi o bolesti koja zahtijeva medicinsku intervenciju (1).

Ako navedeno promotrimo u svjetlu simptomatologije koju je opisao bolesnik u tekstu, uočavamo da bolesnik ima i uvida i kritičnosti prema svojoj bolesti. Sukladno tome u tekstu je bolesnik jasno opisao napad panike: *„Nisan moga disat i srce mi je lupalo. Sve slabije san osjeća ruke i noge. U glavi mi je bija iznered. Nije me ništa bolilo, al mi se činilo da ću umrit.“*. Dakle, simptome shvaća kao ozbiljne te odlazi na Hitnu pomoć.

Reakcija na pojašnjenje dijagnoze i funkcioniranje

Bolesnik je tijekom psihijatrijskog liječenja i suportivne psihoterapije tražio i dobio stručni naziv svojih zdravstvenih problema te mu je rečeno da ima i

- Some patients lack insight and are uncritical of their own symptoms. These patients deny having any symptoms and believe that they are not ill and that they do not need help.
- Some patients may have an over-exaggerated, overdramatized experience of their symptoms and seek medical help even for illnesses that do not require medical intervention (1).

If we compare these scenarios to the symptomatology described in the patient's text, we observe that the patient has insight as well as a critical attitude towards his illness. For instance, the patient provided a clear description of a panic attack*: "[in the Southern dialect] I couldn't breathe and my heart was beating hard. I started losin' sensation in my arms and legs. My head was a mess. Nothin' hurt, but I thought I was goin' to die.*" Evidently, he understood that his symptoms were serious and visited the ER.

Reaction to diagnosis and functioning

In the course of his psychiatric treatment and supportive psychotherapy, the patient sought and received an official diagnosis of his condition and was told that he had a personality disorder. For a long time, people with a personality disorder were perceived as "unwanted child" for psychiatrists because of their

dijagnozu poremećaja osobnosti. Osobe s poremećajem osobnosti su dugo vremena za psihijatre bili „neželjeno dijete" zbog vrlo loše prognoze liječenja. Danas se taj stav mijenja i nove spoznaje govore u prilog pozitivnim rezultatima liječenja. U daljnjem tekstu ću ukratko opisati poremećaj osobnosti koristeći nekoliko modela. Zatim ću koristeći dijelove teksta povezati dijagnozu s načinom na koji je bolesnik reagirao kada mu je pojašnjeno kako se dolazi do definicije bolesti.

DSM-5 klasifikacija poremećaj osobnosti komentira na način da je dio osobina osoba s poremećajem osobnosti na suboptimalnoj razini, a daleko veći dio na optimalnoj. To nam objašnjava zbog čega je ovaj obrazac ponašanja i danas prisutan. Nadalje, dijagnoza poremećaja osobnosti uz prepoznavanje psihopatologije koja se vezuje uz samu osobnost bolesnika definira i adaptivni potencijal osobnosti bolesnika. Adaptivni potencijal je važan jer, ako je visok, bolesnik s poremećajem osobnosti se može pozicionirati visoko na ljestvici socijalne uspješnosti. Ovo može objasniti zbog čega određeni postotak ovih bolesnika nikada ne bude dijagnosticiran (2).

Jedno od evolucijskog objašnjenja poremećaja osobnosti su dali Michael T. McGuie i Alofonso Troisi (1998). Oni komentiraju da osobe s graničnim poremećajem osobnosti ne uspijevaju stvoriti siguran model privrženosti s bliskim osobama. Kod njih je trajno prisutan

bleak treatment prognosis. Today, this attitude is changing as new research speaks in favor of positive treatment outcomes. Below, I provide a brief definition of a personality disorder using several different models. Then, using excerpts from the text, I draw connections between the diagnosis and the patient's reaction to an explanation of how disorders are defined.

According to the DSM-5 classification, a person with a personality disorder will exhibit some suboptimal personality traits, but a majority of their traits are at an optimal level. This explains the continued existence of this behavior pattern. Furthermore, a personality disorder diagnosis defines the adaptive potential of that personality. Adaptive potential matters because a personality disorder patient with high adaptive potential may rate high on a social success scale. This may explain why a certain portion of these patients never receive a diagnosis (2).

Michael T. McGuire and Alfonso Troisi provided a Darwinian explanation of personality disorders (1998). According to the authors, people with borderline personality disorder fail to establish a secure attachment model with their loved ones. They have a permanent fear of rejection. Out of this fear, they tend to frequently change partners and commonly exhibit pathological reactions to rejection (3).

Several studies have recognized rigidity as a common personality trait in these

strah od odbacivanja. Zbog tog istog straha od odbacivanja skloni su čestom mijenjanju partnera i često ispoljavaju patološke reakcije na odbacivanje (3).

Više istraživanja je ukazalo na rigidnost kao čestu karakternu osobinu ovih bolesnika. Rigidni stav ne dozvoljava osobi da raste i da se razvija. Osoba nije u stanju vidjeti sebe iz različitih kuteva te se rigidnost dodatno pojačava (2).

U jednom od susreta s psihijatricom dobije informacije o napadu panike. U tekstu to komentira ovako: *„U nje san sazna da se moji zdravstveni problemi zovu napadaji panike, da su jako neugodni, al i da se od njih ne umire. Sazna san i da oni sami po sebi nisu bolest, nego simptom koji se obično javlja kod stresnog načina života. Tu nisan moga ništa prominit. Ili nisan tija ništa prominit. Kako se uzme."* Komentar bolesnika da nije htio ili nije mogao ništa promijeniti bi se mogao objasniti kroz nemogućnost bolesnika da sebe vidi iz različitih kuteva što je stav koji je opisan u bolesnika s poremećajem osobnosti. On bolesniku ne dozvoljava da raste i da se razvija.

Pogledajmo sada kako je bolesnik reagirao kada mu je objašnjeno kako se općenito u psihijatriji definira poremećaj. U jednoj od seansi psihijatar ga suočava s dijagnozom na slijedeći način: *„Psihijatrica mi je još rekla da iman poremećaj osobnosti. Kad san je pita šta je to, rekla mi je da se svake godine ili svaku par*

patients. A rigid attitude hinders a person's ability to grow and develop. He or she is then unable to see herself/himself from different perspectives, thus reinforcing rigidity (2).

During one of the sessions with his psychiatrist, the patient learned about panic attacks. In this text, he wrote: *"[in the Southern dialect] She taught me that my health condition is known as a 'panic attack', that these are very unpleasant, but they won't kill you. I also learned that this in itself is not a disease, but a symptom that usually occurs with a stressful lifestyle. I couldn't really do anythin' about that. Or I didn't really want to. Depends on how you look at it."* The patient's confession that he did not want to/could not change may be perceived as his inability to view himself from a different angle, which is an attitude identified in personality disorder patients. This attitude hinders the patient's ability to grow and develop.

Now, let's consider the patient's reaction to being explained how psychiatry generally defines a disorder. In one of the sessions, the psychiatrist confronted him with his diagnosis: *"[in the Southern dialect] The psychiatrist also told me that I have a personality disorder. When I asked her what that was, she told me that every year or every couple of years, the big-shot psychiatrists of the world have a get-together where they decide what somethin' (that they think is a disorder) should be called. And then they decide how it should be named. … I*

godina sastanu najrazvikaniji svjetski psihijatri i da onda na tom svom druženju usput odluče kako će se nešto (šta oni misle da je bolest) zvat. I onda se to tako zove. .....Nisan bija zadovoljan objašnjenjen, al je nisan dalje pila. A možda nisan ni tija čut šta stručno misli o meni." Bolesniku je objašnjeno tko i na koji način definira poremećaj. On jasno komentira kako nije zadovoljan objašnjenjem, ali ne traži dodatna pojašnjenje. Ovo bi mogli objasniti lošim mehanizmima adaptacije i strahom od suočavanja s dodatnim objašnjenjem.

DSM-IV klasifikacija (*Diagnostic and Statistical Manual*) u osi V prepoznaje značaj poremećaja funkcioniranja bolesnika stoga ga uvrštava u čimbenike koji mogu determinirati težinu i prognozu ishoda liječenja. Poremećaj funkcioniranja se može javiti u svim segmentima života (privatni, javni, emotivni, obiteljski, seksualni,...). Teškoće u funkcioniranju mogu biti vezane za jedno ili nekoliko područja, a jednako tako mogu varirati u intezitetu. Primjerice, osoba može loše funkcionirati u partnerskim odnosima, ali ne zbog psihičke bolesti već zbog lošeg seksualnog funkcioniranja koje je vezano za organske razloge. Dijagnosticirati psihičku bolest u ovakvim slučajevima bi bilo pogrešno.

Ako poremećaj funkcioniranja pak povežemo s psihičkom bolesti bilo bi dobro pratiti poremećaj funkcioniranja jer nam je on često značajan prognostički

wasn't happy with the explanation, but I let it go. Maybe I didn't even want to hear her professional opinion on me." The patient received an explanation about who defines a disorder and how. He plainly reported that he was not satisfied with the explanation, but he did not ask for further clarification. This may be explained by his poor adaptation mechanisms and fear of facing an additional explanation.

Axis V of the DSM-IV (Diagnostic and Statistical Manual) classification recognizes the significance of a patient's functional impairment and lists it as a factor that may contribute to the severity as well as prognosis of the treatment outcome. Functional impairment may occur in any area of life (private, public, emotional, family, sexual, etc.). Difficulties in functioning may concern one or more areas and may vary in intensity. For instance, a person may function poorly in intimate relationships due to organic causes not due to any mental illness. In such cases, diagnosing a mental illness would be inappropriate.

If we correlate a functional impairment with a mental illness, it may be advisable to monitor the functional impairment as an important prognostic factor in predicting the treatment outcome. Here we should keep in mind that some psychiatric illnesses that are characterized as severe (e.g., schizophrenia) may, but also may not, cause significant functional impairments. Consequently, a patient suffering from schizophrenia may func-

čimbenik koji nam predskazuje ishod liječenja. Ovdje moramo imati na umu kako neke psihijatrijske bolesti koje su okarakterizirane kao teške (primjerice shizofrenija) mogu, ali jednako tako i ne moraju, uzrokovati značajne poremećaje u funkcioniranju. Sukladno tome bolesnik koji boluje od shizofrenije može vrlo dobro funkcionirati u obitelji, profesionalnoj, socijalnoj dimenziji. S druge strane, možemo imati bolesnika koji boluje od anksioznog poremećaja i koji nije u stanju izaći iz stana ili čak iz sobe. Iz navedenoga možemo zaključiti da težina duševne bolesti ne mora biti proporcionalna smetnjama u funkcioniranju (4).

Bolesnik je svjestan svog poremećaja funkcioniranja te u tekstu komentira: *„.....najprije san osjetija da neman glasa. Onda su mi se oduzele ruke, pa noge. Opet me stislo u prsima i nisan moga do zraka. Sija san na kauč. Nisan uopće ima kontrolu nad svojin tijelon. Nisan moga ni hodat."*

Dalje u tekstu bolesnik navodi: *„Osim napadaja panike, ima san i drugih problema. Nisan moga otić nigdi di je puno ljudi. U kino na primjer. Na utakmicu isto tako. Nisan podnosija blizinu nepoznatih osoba. Kad bi iša u psihijatrice, znalo se desit da je deset ljudi nabijeno isprid njenih vrata, a ja bi bija sam, skroz na drugon kraju hodnika."* Bolesnik je jasno definirao u kojim segmentima ga je bolest omela u funkcioniranju.

tion very well in the family, professional, or social dimension. On the other hand, we may encounter an anxiety disorder patient who is unable to leave their home or even their room. We may, therefore, conclude that the severity of a mental illness may not correlate with functional impairments (4).

The patient appears to be aware of his functional impairment, as he wrote: *"... [in the Southern dialect] at first, I felt as if I'd lost my voice. Then, I couldn't feel my arms, then my legs. Again, I felt tightness in my chest and I couldn't breathe. I sat down on the couch. I had no control over my body. I couldn't even walk."*

Further in the text, the patient stated: "[in the Southern dialect] Other than the panic attacks, I had other problems. I couldn't go anywhere where there were big crowds. To the cinema, for example. Or a [soccer] match. I couldn't handle the proximity of people I didn't know. When I had an appointment with my psychiatrist, sometimes there would be a dozen people crammed in front of her door, and I would be [standing there] alone, all the way on the other side of the corridor." The patient clearly defined the areas where his functioning was affected by his illness and to what extent. Given that the patient kept in touch with his psychiatrist via e-mail even after the end of his therapy, I am under the impression that he found it easier to express himself in writing, unseen by the person he was communicating with. I also believe that the patient's

cioniranju i u kojoj mjeri. S obzirom na to da je bolesnik i nakon završene terapije ostao u komunikaciji s psihijatricom putem mail-a stječem dojam da se lakše izražava putem pisane forme, tj. da mu je lakše kada ispred sebe nema sugovornika. Isto tako uočavam da je bolesnikovo funkcioniranje svakako poboljšano jer je na početku liječenja šutio, a sada i po završetku liječenja svojevoljno ostaje u kontaktu s psihijatricom. Usuđujem se zaključiti da i u ostalim segmentima bolje funkcionira te da je, primjerice, uspio otići na mjesta gdje ima puno ljudi (kino, utakmica).

S obzirom na to da se radi o dugogodišnjoj terapiji, a tekst nudi samo kratak uvid u istu smatram da su se izmijenili različiti doživljaji psihijatrice pa tako i transfera prema njoj. Ono što bih naglasila su različiti doživljaji. Različito ovdje ukazuje na to da se bolesnik mijenja, a sa promjenom mijenja se i njegov doživljaj psihijatrice. Smatram da je bolesnik tijekom terapije doživio brojna korektivna emotivna iskustva koja su mu pomogla u razvoju zrelijih mehanizama obrane. Rezultat svega navedenoga je promjena bolesnika, tj. napredovanje u terapiji.

Subjektivni kriterij normalnosti

Kako bi se zadovoljio ovaj kriterij, bolesnik mora sam primijetiti da postoji odstupanje u ponašanju i sam zaključiti da je riječ o bolesti. Iskusni psihija-

functioning must have improved since he maintained voluntary contact with his psychiatrist post-treatment even though he was silent at the beginning of the treatment. I dare conclude that his functioning improved in other areas as well and that he might have managed to go to crowded places (cinemas, soccer matches).

Although the text provides only a brief insight into his long-term treatment, I believe that his perception of psychiatrists as well as transference with his psychiatrist shifted many times. I want to highlight this shift. By "a shift", we here mean that as the patient changes, his perception of his psychiatrist changes as well. I believe that the patient had many corrective emotional experiences during therapy that helped him develop more mature defense mechanisms. This changed patient. Because he changed, he was able to progress in therapy.

Subjective criteria of normality

In order to meet these criteria, a patient has to be aware of their behavioral deviation and independently acknowledge that they are dealing with a disorder. According to experienced psychiatrists, this is the seminal sign of a mental disorder. This acknowledgment is relevant for both the prognosis and the treatment. A patient who is critical of their condition need not necessarily be subjective. For example, a person with anxiety may or

tri navode da je upravo ovo najvažniji znak postojanja psihičkog poremećaja. Značaj ovog prepoznavanja leži i u prognostičkom i u lječidbenom segmentu. Bolesnik može biti kritičan prema svom stanju, ali ne mora nužno biti i subjektivan. Primjerice, osoba može biti anksiozna, ali ne mora moći procijeniti je li njegova/njena anksioznost patološka ili ne. Ovisno o ovoj procjeni osoba će potražiti pomoć ili, pak, neće (1).

Kod ovog bolesnika ponavljanje stresa, ponovno dovodi do simptoma. On vrlo plastično opisuje svoj stav prema ponovljenim simptomima: *„Ovi put nisan moga samo tako nastavit sa životon. Stalno san mislija na to šta mi se dogodilo. Nisan ima nikakvo objašnjenje. To me je počelo opterećivat. Živija san u stalnon straju kad će me opet uvatit."* Ovaj komentar jasno govori da je bolesnik svjestan da ima problem i da mu je jasno da treba pomoć. Stoga bolesnik zadovoljava subjektivni kriterij normalnosti.

Stigma i samostigmatizacija

Način na koji će bolesnik doživljavati svoju bolest tj. svoj zdravstveni problem uvelike ovisi i o tome kako okolina i društvo u cijelosti doživljavaju taj njegov zdravstveni problem. Taj specifični odnos okoline i društva prema bolesti i bolesniku, a i njegovim bližnjim, nerjetko određuje kako će bolesnik po-

may not be able to assess if their anxiety is pathological or not. Depending on their assessment, a person may or may not seek help (1).

In this patient, repeated stress led to a reoccurrence of symptoms. His attitude toward his recurring symptoms is described in vivid detail: *"[in the Southern dialect] This time around, I couldn't just go on with my life. I couldn't stop dwellin' on what had happened to me. I couldn't explain it. This started to weigh on me. I lived my life in constant fear of it happenin' again."* This comment clearly shows that the patient was aware of his problem as well as that he needed help. Therefore, the patient meets the subjective criteria of normality.

Stigma and self-stigmatization

A patient's self-perception of their illness or condition largely depends on how their community and society as a whole perceive their condition. The particular attitude of the community/society toward an illness/patient, as well as their family and friends, often determines how the patient will deal with their condition and who the patient will turn to for help. Therefore, we may encounter different scenarios. Some patients may try to hide their illness, whereas others may join a support group for patients with their condition. Some patients may behave in accordance with social expectations, whereas others may flout them...

stupati sa svojim zdravstvenim problemom, kome će se bolesnik obratiti za pomoć. Tako svjedočimo raznoraznim situacijama. U nekima, bolesnici pokušaju sakriti svoju bolest, u nekima će se učlaniti u udrugu bolesnika s istom zdravstvenom problematikom, u nekima će se ponašati u skladu s očekivanjima okoline ili pak suprotno tome.....

Pojasnimo malo sam pojam stigme i samostigmatizacije, koja ide ruku pod ruku sa stigmom. Na službenim stranicama HZZJZ stigma je definirana kao: „....proces negativnog obilježavanja osobe, dodavanja negativnih obilježja na temelju jedne karakteristike koju posjeduje." U grčkom jeziku riječ stigma nema negativan smisao te se tumači kao naglasiti/istaknuti. S druge strane latinski jezik istoj riječi daje negativnu konotaciju pa se definira kao sramoćenje i degradacija. Ovo negativno tumačenje riječi, nažalost, danas prevladava. Dodatno pogoršava i to što stigmatizacija ne dotiče samo psihičkog bolesnika već i njegovu obitelj. Stigmatizirane osobe, u ovom slučaju psihički bolesnici, doživljavaju se kao slabe, opasne, nesposobne,... Nije rijetka ni diskriminacija psihičkih bolesnika (5). Iz ovoga je jasno da bolesne okolina i društvo promatraju kroz njihov zdravstveni problem, ali jednako tako i bolesnici sami sebe često modeliraju prema očekivanjima okoline. Bolesnicima se lakše uklopiti u stereotip

Let's explain the concepts of stigma and self-stigmatization that goes hand in hand with stigma. According to the official website of the Croatian Public Health Institute (HZZJZ), stigma is: "...the process whereby an individual is viewed in a negative way, adding negative traits based on a distinguishing characteristic." In Greek, the word "stigma" did not have a negative connotation and may be translated as "to mark, emphasize." Subsequently, Latin gave the word its negative connotation, defining it as "humiliation" or "degradation." Unfortunately, the negative meaning of the word prevails today. To make matters worse, stigmatization affects not only the mental patient, but also their family. Stigmatized individuals – in this case, mental patients – are seen as weak, dangerous, or disabled. Discrimination against the mentally ill is not uncommon (5). Evidently, society sees the sick through the lens of their condition, but the sick also often model themselves based on societal expectations. Patients may find it easier to fit a stereotype of their illness and behave as expected. In such cases, patients may become withdrawn and passive, renouncing their dreams and plans. Only a few stand up to the stigma, refuse to self-stigmatize, and bravely strive to follow their dreams (6).

In some cases (for example, with oncology patients), society may react with exceptional empathy, and almost everyone who comes into contact with the patient may try to help, sympathize, be considerate... However, some conditions fail to

o bolesti te raditi upravo ono što se od njih očekuje. U tom slučaju bolesnici se najčešće povlače, postaju pasivni, odričući se svojih snova i planova. Tek se rijetki suprotstavljaju stigmi, odbijaju sami sebe stigmatizirati i hrabro nastoje slijediti svoje snove (6).

Kod nekih bolesti, npr. onkoloških, okolina reagira s osobitom empatijom prema bolesniku tako da gotovo svi koji su u kontaktu s bolesnikom nastoje pomoći, suosjećaju, obzirni su,... Neke pak bolesti ne izazivaju empatiju prema bolesnoj osobi, dapače, upravo suprotno, okolina počinje zazirati od bolesnika i njegovih bližnjih,... Razlozi za takvu reakciju okoline prema bolesniku tj. bolesti, mogu se naći u stigmi (6).

Bolesnik u tekstu vrlo plastično opisuje napad panike koji mu se dogodio kada mu je psa udario auto te navodi: *„... stislo me u prsima i nisan moga doć do zraka,...."* Kako se kod prethodnog napada panike odlučio otići liječniku nekako sam očekivala da će to i ovoga puta napraviti, ali nije. Odlučio je otići kod bioenergetičara. Odlazak bioenergetičaru, a ne liječniku bi se dalo prokomentirati stigmom.

U jednom trenu bioenergetičar prekida tretman, te izvodi bolesnika van iz prostorije i savjetuje mu da potraži psihijatrijsku pomoć. Da bioenergetičar nije ovo napravio pitanje je bi li bolesnik ikada došao do psihijatra. Dakle,

provoke empathy toward the sufferer; on the contrary, peers may shun the patient and their friends and family... The cause of this reaction towards the patient/condition may be found in stigma (6).

In his text, the patient very vividly described a panic attack he experienced when his dog was hit by a car: *"... [in the Southern dialect] I felt tightness in my chest and I couldn't breathe..."* Seeing as he decided to see his physician after his previous panic attack, I somewhat expected that he would do the same this time, but he didn't. He decided to visit a bioenergetic therapist. Choosing a bioenergetic therapist instead of a physician may be viewed through the lens of stigma.

At a certain point, the bioenergetic therapist discontinued the treatment, escorted the patient out of his office, and advised him to seek psychiatric help. If the bioenergetic therapist had not done this, our patient may never have seen a psychiatrist. Consequently, he decided to see a psychiatrist because, and I quote, *"the most renowned bioenergetic expert in Split"* refused to provide further treatment, or – in other words – out of necessity, as he had no other therapeutic options.

In the text, the patient recounted that he informed his psychiatrist in no uncertain terms that he would deny knowing her if they ever happened to meet outside of her office. The patient wrote: *"... [in the Southern dialect] the psychiatrist gained my*

na odlazak psihijatru se odlučio jer ga je, citiram: *„.....napoznatiji splitski bioenergetičar...“*, odbio dalje tretirati, tj. iz krajnje nužde jer više nije imao drugih terapijskih opcija.

Bolesnik u tekstu jasno komentira svojoj psihijatrici da će negirati da je poznaje ako se slučajno sretnu van njene ordinacije. Bolesnik piše: *„..... psihijatrica je stekla moje povjerenje, isto san joj reka da ona za mene ne postoji izvan zidova njene ordinacije. Reka san joj da, ako se ikad sretnemo negdi vanka, da ću se pravit da je ne znan.“* Ovu odluku bismo također mogli promatrati pod prizmom stigme. Vidimo da je psihijatrica zadobila povjerenje bolesnika, ali ipak, on jasno najavljuje da će u javnosti negirati da je poznaje. Negiranje poznavanja psihijatrice u javnosti, sakrivanje tog odnosa ne iznenađuje s obzirom na sve navedeno o stigmi. Upravo ovakva situacija se i dogodila kada su se bolesnik i psihijatrica slučajno susreli u Getrou. Bolesnik opisuje scenu susreta dok je bezbrižno šetao Getro-om: *„nda san se okrenija i ugleda nju. Moju psihijatricu. Dok mi je tijelon prolazila struja nepatvorenog užasa, uspija san samo ispustit neartikulirani zvuk, gurnit ona kolica od sebe i pobić glavon bez obzira.“*.

Kako vidimo bolesnik se prilikom slučajnog susreta odlučio na bijeg. Da, dobri stari bijeg,...bijeg u hipu rješava probleme. Možemo pretpostaviti da

trust, but I still told her that she did not exist to me outside the walls of her office. I told her that if we ever met somewhere outside, I'd pretend not to know her.” We may also view this decision in the context of stigma. As we see, the psychiatrist won the patient's trust, but he still explicitly announced that he would deny knowing her in public. This public denial of knowing a psychiatrist and hiding the relationship is not surprising considering everything we mentioned regarding stigma. This is exactly what happened when the patient and the psychiatrist ran into each other at a Getro supermarket. The patient retold the chance encounter that happened while he was strolling through the supermarket: *“[in the Southern dialect] Then I turned around and saw her. My psychiatrist. As a current of unadulterated horror zapped through my body, I could only make an inarticulate sound, ditch the cart, and beat a hasty retreat.”*

Evidently, the patient decided to run away from the chance meeting. Yes, the good old escape… Escape solves every problem in no time. We may assume that his desire to not be associated with a psychiatrist, or a psychiatric diagnosis, stems from stigma. This was the reason for his escape. One thing is clear – the patient was deeply afraid. Whether the fear was warranted or not makes no difference at all. This was his experience – his fear was intense, and that is all that matters. The patient had every right to feel this way. What is important is the fear that existed then, during the encoun-

nije htio biti povezan sa psihijatrom i psihijatrijskom dijagnozom upravo zbog stigme. I to je razlog bijegu. Jedno je jasno, a to je bolesnikov strah, veliki strah. Koliko je isti opravdan, to uopće nije bitno. Bitno je da je to njegov doživljaj, bitno je da je intenzivan. Bolesnik na njega ima potpuno pravo. Ono što je bitno za taj osjećaj straha jest da je strah postojao tada, prilikom susreta, u jednom prošlom i završenom poglavlju bolesnikova života i da ga sada više nema.

Sada je situacija potpuno drukčija. Bolesnik je dao dozvolu za objavu njegovog teksta, jednako tako je dozvolio da ga se spomene imenom i prezimenom. Sada nema bijega, bolesnik jasno obznanjuje da je bio u tretmanu psihijatrice, jasno priznaje svoje tegobe, jasno verbalizira svoju dijagnozu, dozvoljava psihijatrima i psihoterapeutima uvid u svoje probleme. Otvorio je svoju „Pandorinu kutiju", promijenio se. Ne brine za stigmu, a samostigmatizaciju je odlučno odbio. Svjedočimo transformaciji bolesnika od stanja *„nepatvorenog užasa"* zbog jednog običnog susreta na javnom mjestu do javnog obznanjivanja teksta koji govori o njegovim zdravstvenim problemima i liječenju. Napredak u terapiji je neosporan. Samo kroz ovaj mali dio osvrta jasno vidimo značaj i učinkovitost psihijatrijskog liječenja i suportivne psihoterapije. Promjena na bolje se ne može zanijekati!

ter, is now an old, closed chapter of the patient's life. There is no more fear.

Currently, his circumstances could not be more different. The patient gave permission for his text to be published and also consented to his real name being used. Now, there is no escaping – the patient readily acknowledges that he has undergone psychiatric treatment, openly admits his issues, explicitly verbalizes his diagnosis, and allows other psychiatrists and psychotherapists insight into his problems... He has opened his "Pandora's box" – he has changed. He is unconcerned by stigma and resolutely rejects self-stigmatization. We are witnessing the patient's transformation from the state of *"unadulterated horror"* provoked by a run-of-the-mill meeting in a public space to a public acknowledgment of a text dealing with his health-related issues and treatment. The progress achieved in therapy is indisputable. Even this short reflection clearly shows the importance and effectiveness of psychiatric treatment and supportive psychotherapy. Change for the better is undeniable!

THOUGHTS ON THE COURSE OF TREATMENT

Let's now take a look at the development of the therapeutic relationship in this case, first with the bioenergetic therapist and then with the psychiatrist. It is worth noting that from the very beginning,

DOŽIVLJAJ TIJEKA LIJEČENJA

Pogledajmo kako se u ovom našem slučaju razvijao terapijski odnos najprije s bioenergetičarem, a potom s psihijatricom. Uočimo da je u samom startu situacija upravo dijametralno suprotna kada uspoređujemo početak ova dva odnosa. Za bioenergetičara je imao pozitivne preporuke, a na odlazak k psihijatru se odlučio jer nije imao drugog izbora. Bioenergetičar je „*spasio*" bolesnikovu suprugu kada su liječnici digli ruke od nje. Stoga pretpostavljam da je rado otišao k njemu. K tome on je bio „najpoznatiji" splitski bioenergetičar što dodatno pojačava povjerenje i vjeru u terapijski uspjeh.

Postoje jasne naznake negativnog predznaka u terapijskom odnosu s psihijatrom jer je bolesniku psihijatar i odlazak k njemu bio zadnja opcija, nakon što se ostale opcije zbog nekog razloga nisu pokazale uspješnima. Na samom početku bolesnik komentira da ga je dopala „plavuša". I zatim: „*Po njezinon kazivanju, jer ja toga nisan bija svjestan, u prvih šest miseci bi samo uša i sija. Ni jedanput joj nisan reka ni „Dobar dan", ni „Ej", ni ništa. Iako je žena bila skroz OK, ja joj to ničin nisan dava do znanja, a zna san bit i nepristojan.*" Pokušala sam se zamisliti u bolesnikovoj situaciji. Poslan je tamo gdje nije htio otići, tj. kod psihijatra. Tamo odlazi jer mu je to bila jedina opcija i uza svu na-

these two relationships were diametrically opposite. The patient had received positive recommendations for the bioenergy therapist, but he decided to visit a psychiatrist because he had no other choice. The bioenergy therapist "saved" the patient's wife when physicians gave up on her. Thus, I would assume that he went to him willingly. Furthermore, he was "the most renowned" bioenergetic therapist in Split, which further reinforced the trust and faith in therapeutic success.

There are clear indications of a negative attitude to the therapeutic relationship with the psychiatrist, since seeing a psychiatrist was a last-resort option for our patient after his other options failed for one reason or another. At the very beginning, the patient remarked that he was saddled with "*a blonde*". And then: "*[in the Southern dialect] According to her, as I'd not been aware of this, during the first six months, I would just go in and sit down." I'd never say 'Good afternoon', or 'Hey', or anythin' to her. She was an okay woman, but I never let her know this – sometimes, I was even rude to her."* I tried to put myself in the patient's shoes. He was referred to someone he did not want to see – a psychiatrist. He showed up for his appointment as a last resort, and then, after he went through all this trouble, waiting for him in the doctor's office was just *"a blonde"*. "A blonde..." is she even a real person!?!? "A blonde..." not a doctor, not a qualified psychiatrist, not a qualified psychother-

vedenu muku ga u ordinaciji dočekuje *„plavuša"*. *„Plavuša"*,.... da li to uopće podrazumijeva osobu!?!? *„Plavuša"*,..... ne liječnica, ne kvalificirani psihijatar, ne kvalificirani psihoterapeut, ne netko tko je uložio poprilično truda u svoju edukaciju. Strah me i promisliti što je bolesnik podrazumijevao pod „plavuša". Stereotip koji podrazumijeva spomenuta riječ ne treba previše komentirati. Sve navedeno nam ukazuje da iz bolesnika upravo vrišti otpor, otpor prema terapijskom savezu, otpor prema liječenju, otpor prema psihijatru, tj. „plavuši". Smatram da na samom početku terapijski odnos nije bilo moguće uspostaviti zbog težine stanja bolesnika iz kruga poremećaja osobnosti. Njegovo tadašnje stanje mu nije dozvoljavalo da vidi išta pozitivno u terapiji, da vidi ispred sebe osobu iza kojeg stoje godine edukacije. Međutim, empatijski kapacitet psihijatrice, kao i kapacitet za sadržavanje bolesnikove agresije stvaraju mogućnost terapijskog odnosa. Bolesnikov otpor slabi, formira se terapijski odnos i počinje promjena tj lječidbeni proces (7).

I onda, jasna promjena u stavu bolesnika. „Plavuša" se u očima bolesnika pretvara u visoko kvalificiranog i stručnog psihijatra koji uspijeva utjecati na bolesnika, njegov otpor prema terapiji i događa se promjena. Bolesnik sazrijeva, mijenja sebe i svoj stav i kaže: *„U jako kratko vrime mi je razbila sve predrasude o plavušama. Za razliku od puno*

apist, not someone who has put a lot of effort to obtain an education. I shudder to think what the patient really meant by "a blonde". The stereotype implied by the word requires no further comment. All of this hints at the patient's screaming resistance – to the therapeutic alliance, to treatment, to the psychiatrist, or, as he put it, "the blonde". I believe that early on, forming a therapeutic relationship was an impossibility due to the severity of the patient's personality disorder. At the time, his condition prevented him from seeing any benefit of the therapy or acknowledging that the person in front of him had many years of schooling under her belt. However, a foundation for a therapeutic relationship was built on the psychiatrist's empathy as well as her ability to contain the patient's aggression. As the patient's resistance abated, a therapeutic relationship formed and a change – the therapeutic process – was underway.

This led to an obvious shift in the patient's attitude. In the patient's eyes, "the blonde" transformed into a highly qualified, skilled psychiatrist who knew how to manage her patient and his resistance to therapy, thus engendering change. The patient matured and changed, as did his attitude: *"[in the Southern dialect] In a very short time, she smashed all my stereotypes about blondes. Unlike so many people who screw up when choosin' their career, she made just the right choice."* Apparently, a promising therapeutic relationship seems to have formed (8). The

ljudi koji se zajebu u izboru životnog zanimanja, ona je pogodila čime će se bavit." Sudeći po ovome, uspostavljen je terapijski odnos koji obećava (8). Psihijatrica je dotakla zdravi dio ličnosti, uspostavila terapijski odnos i proces liječenja je mogao započeti.

Kako je vrijeme odmicalo, kako je terapija mijenjala bolesnika, tako je bolesnik ipak stekao povjerenje u svoga psihijatra, promijenio stav i krenuo mu povjeravati svoje probleme, razgovarati s njim... Vjerujem da su se paralelno s ovom promjenom događale i promjene u drugim segmentima bolesnikova života što je uočila i bolesnikova okolina.

Nije jednostavno izgraditi terapijski odnos. Svaki terapijski odnos je priča za sebe, izgrađuje se različito dugo, ovisno o težini stanja pacijenta, stupnju regresije, stupnju otpora bolesnika... (5). To je profesionalni odnos sa svojim zakonitostima. U tom odnosu bolesnik treba doživjeti psihijatra/psihoterapeuta kao empatičnu osobu koja mu pruža podršku te razumije njegove probleme. Terapijski odnos uključuje međusobno povjerenje, nadu u oporavak te zajednički dogovor o ciljevima liječenja. U ovoj specifičnoj interakciji prožetoj povjerenjem, poštovanjem i nadom u oporavak stvara se plan liječenja i zajednička odgovornost obaju sudionika da će surađivati u ostvarenju terapijskih ciljeva. (8) Ovaj odnos ima za svrhu nadvladavanje neurotskog ili psihičkog otpora

psychiatrist was able to reach the healthy part of the personality, establish a therapeutic relationship, and so the treatment process could begin.

As time went on, as the therapy changed the patient, the patient also gained trust in his psychiatrist, changed his attitude, and began to confide in her, talk to her... I am confident that simultaneously, the patient experienced changes in other areas of his life, and this was picked up by other people in the patient's life.

Building a therapeutic relationship is not an easy task. Every therapeutic relationship is a different story – it may take varying lengths of time to develop, depending on the severity of a patient's condition, the degree of regression, and the level of a patient's resistance... (5). It is a professional relationship with its own rules. For the relationship to work, the patient has to perceive the psychiatrist/psychotherapist as an empathetic person who can provide support and understand the patient's problems. A therapeutic relationship includes mutual trust, faith in recovery, and mutual agreement on treatment objectives. This unique interaction is imbued with trust, respect, and faith in recovery. It is the basis for a treatment plan as well as a source of the mutual responsibility of participants to cooperate on achieving the therapeutic objectives (8). The purpose of this relationship is to overcome the patient's neurotic or psychological resistance, as this hinders change and hampers the healing process. This mutual agreement

kod bolesnika koji blokira promjenu i lječidbeni proces. Ovaj zajednički dogovor se definira kao terapijski savez (5). Terapijski savez se kroz povijest različito definirao. Moderni terapijski savez temelji se na suradnji i konsenzusu. To je svjestan odnos (8).

Bolesnik može na različite načine doživljavati svoga psihijatra. U nastojanju što boljeg razumijevanja bolesnikovog doživljaja psihijatra odlučila sam se opisati dinamiku terapijskog odnosa i dinamiku bolesnikovog transfera služeći se dijelovima teksta „humoreske". Donoseći ovu odluku, rukovodila sam se činjenicom da je transfer nesvjestan proces, a terapijski savez je svjestan proces. Smatram da ću obuhvaćajući i svjesno i nesvjesno dobiti potpuniji uvid u bolesnikov doživljaj psihijatrice, tj. promjene u bolesnikovom doživljaju. Promatrajuću transfer i terapijski odnos vidjet ćemo da je kod oba navedena odnosa došlo do promjene. Ti odnosi su se mijenjali jer se i sam bolesnik mijenjao. Mijenjanju stavova bolesnika pridonijela je suportivna psihoterapija. Cilj psihoterpije je pomoći bolesniku da se promijeni kako bi bolje spoznao sebe, svoju prirodu te da sam sebe kao takvog i prihvati. U ovom procesu je bitno postići psihičku ravnotežu (3). Ove promjene pomažu bolesniku da se bolje adaptira i da bolje funkcionira u svakom životnom aspektu. Ove promjene su jasno vidljive u pacijentovom tekstu.

is also called the therapeutic alliance. (5) Historically, the therapeutic alliance has had many definitions. The modern therapeutic alliance is based on cooperation and consensus. It is a conscious relationship (8).

A patient may harbor various perceptions of their psychiatrist. In an effort to better understand the patient's perception of his psychiatrist, I decided to describe the dynamics of this therapeutic relationship as well as the patient's transference using parts of the patient's "anecdote." This decision was guided by the fact that transference is an unconscious process, whereas the therapeutic alliance is a conscious process. I believe that by encompassing both the conscious and the unconscious, I may get a more complete insight into the patient's perception of his psychiatrist and shifts in his perception. Observing the transference and the therapeutic relationship will provide a clear picture of the shift in both of these relationships. These relationships changed as the patient himself changed. Supportive psychotherapy contributed to the patient's changing attitude. The goal of psychotherapy is to help patients change in order to better understand themselves and their nature, and to accept themselves for who they are. Striking a psychological balance in this process is key (3). These changes help a patient to adapt and function better in every area of their life. These changes are clearly visible in the patient's text.

Elementi transfera

Transfer je nesvjestan proces koji je manifestacija nekog objektnog odnosa iz prošlosti koji je prenesen na neku osobu u sadašnjosti, tj. ponavljaju se neki uzorci ponašanja iz prošlosti (6). Osobno me je naviše dojmila manifestacija transfera koja se pretakala iz jedne dimenzije u drugu tijekom cijelog teksta. Bolesnik je u procesu liječenja mijenjao svoj doživljaj psihijatrice, ali i stav prema psihijatriji, prema sustavu.

Što sve utječe na transfer? Da bi to lakše shvatili, pogledajmo kako izgleda trenutak kada se nekome dogodi bolest, neki zdravstveni problem? Što se u tom trenutku događa? Kako izgleda oblikovanje transfera? Vrlo često se okolina samoinicijativno, i s najboljom namjerom, umiješa u donošenje odluke o liječenju i odabiru liječnika. Ako je bolesnik hospitaliziran vrlo često je izložen pričama bolesnika iz sobe ili odjela koji opisuju svoj doživljaj liječnika. Bolesnik u čekaonici je također izložen informacijama o svom liječniku (7). Te informacije kojima se bolesnik upravo nije mogao othrvati, koje nije tražio već ih je dobio servirane čekajući svoj red u čekaonici ili boraveći u bolnici zasigurno su modelirale njegov stav prema liječniku. Najčešće nama bliske osobe preporuče neke, po njima dobre terapijske metode i terapeute. Te preporuke su u pravilu nastale iz osobnih pozitiv-

Elements of transference

Transference is an unconscious process whereby a manifestation of an object relationship from the past is transferred to a person in the present, so certain past patterns of behavior are repeated (6). Personally, I was particularly fascinated by the manifestation of transference that changed dimensions throughout the text. During the treatment process, the patient changed not only his perception of the psychiatrist but also his attitude toward psychiatry and the system.

What may affect transference? To make this easier to understand, let's consider the point in time when someone gets sick or has a health problem. What happens at that moment? How does transference occur? Very often, well-intentioned people around us deliberately intervene in our decision-making regarding treatment and choice of doctor. When a patient is hospitalized, they are often exposed to stories from other patients in their room or ward about their experience with a certain health professional. A patient in the waiting room is also exposed to information about his or her doctor (7). Information that the patient just couldn't resist, that they did not ask for but was served to them while waiting for their appointment or during a hospital stay surely affects their attitude to their health professional. Very often, our family and friends may recommend a therapeutic method or therapist they value. In general, these recommendations are

nih iskustava s dotičnim terapeutom ili se radi o prepričanim pozitivnim iskustvima nama bliskih osoba. Ovo nam govori da u formiranju transfera veliku ulogu može imati okolina, tj. iskustva naših bližnjih (9).

Bolesnik je bio na tretmanu kod bioenergetičara i bio je vrlo zadovoljan tretmanom. Jedva je čekao sljedeći susret s bioenergetičarem i kaže: *„Sutra san jedva dočeka doć kod njega."* Međutim, tijekom jednog tretmana kod bioenergetičara bolesnik doživljava simptome paničnog napada te bioenergetičar prekida tretman, izvodi bolesnika iz prostorije i objašnjava mu da se treba obratiti psihijatru. Ovaj naprasni prekid je najvjerojatnije bio veliko i neugodno iskustvo. Mogu samo pretpostaviti koji je šok doživio bolesnik i koliko mu je bilo teško u tom trenutku.

Gledajući na transfer prema bioenergetičaru iz bolesnikove perspektive jasno je da je bolesnik razvio pozitivan transfer prema bioenergetičaru. Sukladno tome vjerojatno je bio uvjeren u uspješno liječenje i rješavanje svog zdravstvenog problema. Bioenergetičaru je olakšan posao jer ne mora bolesnika privoliti na liječenje i objašnjavati mu značaj ustrajnosti u terapiji. Čak i da terapija kod bioenergetičara ne poluči uspjeh u početku, bolesnik će sigurno biti strpljiv i ustrajan u dolascima. Ne iznenađuje me ovakav stav,

based on a positive personal experience with a therapist or a retelling of a positive experience from an acquaintance. This shows that our social environment and the experiences of our loved ones can play a significant role in the formation of transference (9).

The patient received the treatment by the bioenergetic therapist and was very satisfied with it. He eagerly anticipated his next appointment with the bioenergetic therapist: *"[in the Southern dialect] I could hardly wait for our next appointment the following day."* However, during a session with the bioenergetic therapist, the patient experienced symptoms of a panic attack. At this point, the bioenergetic therapist ended the session, escorted the patient out of his office, and convinced him to see a psychiatrist. This abrupt break was likely a significant, unpleasant experience. I can only imagine the kind of shock experienced by our patient and how difficult this must have been for him.

Considering transference from the patient's point of view, the patient evidently developed a positive transference with the bioenergetic therapist. Accordingly, he likely had faith in the success of the treatment and resolution of his health concerns. The bioenergetic therapist's task was made easier by the fact that he did not have to persuade the patient to undergo treatment or explain the importance of persistence in therapy. Even if the bioenergy treatment initially failed to yield results, the patient would

jer sam u mnogim slučajevima svjedočila pozitivnom stavu bolesnika prema raznoraznim terapeutima temeljen na usmenoj predaji osoba iz okoline.

Odlazak psihijatru-znakovi negativnog transfera

Bolesnik piše: *„Nije mi preostalo ništa nego se javit psihijatru. Otiša san u svoje doktorice po uputnicu i krenija u spašavanje svoga zdravlja."* Ako opet iz bolesnikove perspektive pokušamo pretpostaviti kako će bolesnik doživjeti psihijatra mislim da ćemo na prvu vidjeti da tkogod bude njegov psihijatar morat će se dobrano potruditi kako bi zadobio bolesnikovo povjerenje. Prethodna osoba kod koje se „liječio" je bila idealizirana, i nakon idealizacije idol ga je jednostavno odbacio. Osobe s poremećajem osobnosti često nisu uspješni u ostvarivanju sigurnih modela privrženosti (10). Sada zamislimo bolesnika koji je pronašao idola u bioenergetičaru, a taj idol ga u vrlo kratko vrijeme odbacuje. Često je kod bolesnika s poremećajem osobnosti trajno prisutan i strah od odbacivanja (10). Bolesniku se upravo taj strah i ostvario. Mogu samo zamisliti koliko je bio razočaran i koliko mu je bilo teško. Pretpostavljam da se bolesnik osjećao napušteno i u velikom strahu, a velik stupanj očaja iščitavam iz riječi: *„...krenuo sam u spašavanje svoga zdravlja."* Doživljavam bolesnika kao osobu koja

have certainly been patient and regularly showed up for sessions. I am not surprised by this attitude, as I have witnessed the positive attitude of many patients toward all sorts of therapists based on word-of-mouth from people in their social milieu.

Seeing a psychiatrist – signs of negative transference

The patient wrote: *"[in the Southern dialect] I had no other choice than to contact a psychiatrist. I saw my doctor for a referral and set out to save my health."* If we again try to assume the patient's perspective and predict his perception of the psychiatrist, we may shortly realize that any psychiatrist would have to work hard to gain this patient's trust. He idealized his previous "treatment" provider, who then simply rejected him. People with personality disorders often fail to develop secure attachment models (10). Let's now think about our patient, who found an idol in the bioenergetic therapist, and was summarily rejected by his idol. Patients with a personality disorder often have a persistent fear of rejection (10). The patient's fear came true. I can only imagine how disappointed he must have felt and how difficult it was for him. I presume that the patient felt abandoned and fearful, as I can detect a great degree of despair in his words: *"... I set out to save my health."* I see the patient as someone grasping at straws of salvation in a place he never intended to visit.

je otišla po zadnju slamku spasa, tamo gdje uopće nije niti mislio otići.

Dakle, pozitivni transfer prema bioenergetičaru i njegovo početno idealiziranje naprasno završava. Nakon toga slijedi odlazak psihijatru *„po spašavanje vlastitog zdravlja"*, onda ga na mjestu psihijatra dočeka *„plavuša"* prema kojoj ima otpor koji je jasan iz samog naziva *„plavuša"*. Kako je terapija napredovala otpor se polako „otapao", negativan transfer prelazi u pozitivan, psihijatrica postaje osoba od povjerenja te on samovoljno odlučuje i nakon završetka liječenja ostati u kontaktu s njom. Pogledajmo sada detaljnije dinamiku transfera prema psihijatrici.

Bolesnik u prvim susretima opisuje psihijatricu kao *„plavušu"*. Komentira je kroz negativan stereotip, ali to me i ne iznenađuje s obzirom na to da ga je idol, bioenergetičar naprasno odbacio. Stah od odbacivanja koji je prisutan kod bolesnika s poremećajem osobnosti je sada postao stvaran. Nije mu lako. Pokušavam se zamisliti u njegovoj situaciji. Ispred mene stoji *„plavuša"*, na prethodnom tretmanu me idol odbacio, imam zdravstveni problem koji moram riješiti, da bih ga riješio moram uspostaviti odnos, razgovarati, povjeravati se,..... i što ako opet budem počeo vjerovati, i onda opet budem odbačen,.... Po ovome se čini da je otpor koji je vjerojatno uzrokovan strahom trajao prvih

In summary, the positive transference with the bioenergetic therapist and the initial idealization came to an abrupt end. This was followed by a visit to a psychiatrist "to save [own's own] health", only to be met by "a blonde" in place of a psychiatrist – the choice of word clearly signaling the patient's resistance. As the therapy progressed, the resistance slowly "melted" –negative transference turned into positive transference, the psychiatrist became a person he could trust, and the patient finally decided, of his own accord, to maintain contact with the psychiatrist even after the end of his treatment. Let's now take a closer look at the dynamics of transference with the psychiatrist.

During the early sessions, the patient referred to the psychiatrist as "the blonde." He referred to her as a negative stereotype, which is not surprising in the wake of his abrupt rejection by his idol, the bioenergetic therapist. The fear of rejection that is present in personality disorder patients had now become a reality. It was not easy for him. I try to imagine myself in his situation. I am standing in front of "a blonde", my idol rejected me during my previous treatment, I have a health concern that needs solving, to solve it I have to establish a relationship, talk, confide in someone... and what if I start to trust again, only to be rejected... From the text, it appears that the resistance, likely caused by fear, continued over the first six months. It is a great success to keep a patient with this attitude in therapy. Apparently, the psychiatrist succeeded as

šest mjeseci. Veliki je uspjeh zadržati bolesnika s ovakvim stavom na terapiji. Očigledno je psihijatrica uspjela u tome jer se bolesnik liječio 11 godina.

Nakon terapije pozitivni osvrt na cjelokupni proces kroz humoresku

Po završetku terapije bolesnik je osjetio potrebu napisati tekst koji je svojevrstan pozitivni osvrt na cjelokupni proces liječenja. Pozitivni osvrt se odnosi na psihijatricu i cjelokupni proces liječenja, što je sasvim suprotno u odnosu na prvotni negativni stav prema samom odlasku kod psihijatra i viđenje psihijatrice kroz stereotip *„plavuše"*.

Kroz tekst vidimo promjenu bolesnika. Liječenje potiče ove promjene jer potiče dostizanje psihičke ravnoteže. Liječenje aktivira procese koji obuhvaćaju reintegraciju nesvjesnog i otuđenih dijelova u jedinstvenu cjelinu. Tijekom tog procesa bolesnik spoznaje sebe i svoju prirodu, mijenja se (4). Mijenjajući se mijenja i svoje stavove. Ovoj promjeni svjedočimo kroz izmjenu transfera u bolesnika. Na početku dugogodišnjeg liječenja vidimo jasan negativni transfer prema psihijatrici jer je *„plavuša"* i uz to je *„dio sistema"*. Onda imamo pasivnu agresivnost u vidu šestomjesečne šutnje. Po završetku terapije pozitivni transfer u vidu osvrta na cjelokupni period liječenja kroz humor u „humoreski".

the patient continued his treatment for 11 years.

A positive, humorous reflection on the overall process post-treatment

At the end of his therapy, the patient felt compelled to write a text that is a sort of a positive reflection on the overall treatment process. The positive reflection concerning the psychiatrist and the overall treatment process is in stark opposition to the initial negative attitude to seeing a psychiatrist and then defining the psychiatrist through the "blonde" stereotype.

The text reflects a change within the patient. Treatment fosters these changes as it promotes the attainment of psychological balance. Treatment activates processes that involve a reintegration of the unconscious and alienated parts into a unified whole. In this process, having learned about himself and his nature, the patient changed (4). These internal changes also shifted the patient's attitude. We can witness this change through the transference shift in our patient. At the beginning of his long-term treatment, we observe a clear negative transference with the psychiatrist, who is referred to as "the blonde" as well as "part of the system". Then, there is passive aggression, namely in the form of six months of silence. At the end of the therapy, we see a positive transference in the form of a humorous reflection on the overall treatment period.

ZAKLJUČAK

Poanta svakog liječenja, tj. terapije je pomoći bolesniku. Posebno je zadovoljstvo kada je bolesnik svjestan da je cijeli proces imao smisla. Upravo zbog toga ova „humoreska" odiše pozitivnom emocijom i zahvalnošću prema psihijatrici što se vidi iz teksta: *„Sa psihijatricom san osta u kontaktu. Šaljen joj tekstove na mail, a ona me svako toliko pohvali. Neka. Lipo je to."*

Čitajući tekst, pokušala sam se zamisliti u ulozi psihijatrice u više navrata. Zapitala sam se koji bi mi trenuci bili najteži u opisanom terapijskom procesu? Kako bih reagirala? Da li bih imala dovoljno snage i strpljenja ustrajati u liječenju tako teškog bolesnika? Da li bih odustala i prepustila bolesnika nekom drugom kolegi?

U iskrenom razgovoru sa sobom sam zaključila da bi mi najteže bilo tijekom bolesnikove šestomjesečne šutnje. Smatram da bi me upravo ta bolesnikova osobna patnja „natjerala" da ustrajem u pomaganju bolesniku jer šutnja govori o njegovoj patnji. Teško da bih odustala i odlučila se prepustiti bolesnika drugom psihijatru, ali bih se zasigurno konzultirala s nekim iskusnijim kolegom ili pak pokušala u iščitavanju relevantne literature pokrenuti proces liječenja koji je „zapeo".

Kao psihijatar na početku karijere, kroz „humoresku" sam jasno vidjela cijeli niz

CONCLUSION

The point of any treatment or therapy is to help the patient. The patient's awareness that the whole process made sense brings a special kind of satisfaction. For this reason, this "anecdote" exudes positive emotions and gratitude toward the psychiatrist, as can be seen from the statement: *"[in the Southern dialect] I've stayed in touch with the psychiatrist. I send her e-mail messages, and she praises me every so often. I'm glad. It's nice."*

While reading the text, I tried to imagine myself in the psychiatrist's role on several occasions. I asked myself, what moments in the described therapeutic process would I find the hardest? How would I react? Would I possess enough strength and patience to persevere in treating such a difficult patient? Would I give up and refer the patient to a colleague?

In a candid conversation with myself, I concluded that the patient's six months of silence would be the hardest part to take on. I believe that the patient's personal suffering would "force" me to persist in trying to help him because the silence speaks of his suffering. I do not believe I would give up and refer the patient to another psychiatrist, but I would likely consult a more experienced colleague or try to kickstart the stalled treatment process by consulting the relevant literature.

From the point of view of a psychiatrist at the beginning of her career, this "an-

pozitivnih promjena kod bolesnika koje su se izmjenjivale zahvaljujući dugogodišnjem odnosu s psihijatricom. Od početnog otpora prema odlasku psihijatru autor humoreske je „dogurao" do osobe koja i po završetku terapije ostaje svojom voljom u kontaktu s psihijatricom.

Na kraju zaključujem da je suportivna psihoterapija važna i učinkovita terapijska metoda koju bi trebalo ponuditi bolesnicima kada god za to postoji indikacija.

ecdote" provided me with a glimpse into a whole series of positive changes in the patient that were set in motion by his long-term relationship with his psychiatrist. From the initial resistance to seeing a psychiatrist, our patient worked hard to become a person who voluntarily maintains contact with his psychiatrist even after the end of his therapy.

In conclusion, supportive psychotherapy is an important and effective therapeutic method that should be offered to patients whenever there is an indication for it.

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