Značenje simptoma shizofrenog bolesnika tijekom trajanja grupne psihoterapije i nakon njenog završetka

/ *Meaning of symptoms in a schizophrenic patient during and after long-term psychodynamic group psychotherapy*

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Značajan doprinos psihoanalitičkih teorijskih koncepata i znanja u liječenju shizofrenih bolesnika je u razumijevanju značenja simptoma u kontekstu individualnih životnih događaja. Iako se shizofreni bolesnici međusobno značajno razlikuju, njihovi se simptomi najčešće mogu razumjeti kao obrana od nepodnošljivih iskustava. Svjesna i nesvjesna značenja iskustava derivat su unutarnjeg svijeta individuuma, koji isto tako biva formiran od životnih iskustava, najviše onih iz ranog djetinjstva kada se počinje razvijati osjećaj selfa i identiteta.

Mogućnost razumijevanja simptoma i ponašanja shizofrenih bolesnika koju daje primjena psihodinamskih teorija i znanja kao i participacija u psihoterapijskom procesu pružaju kliničarima platformu za cjeloviti uvid u psihodinamiku i funkcioniranje ličnosti pacijenta oboljelog od shizofrenije, a time i adekvatno planiranje terapijskih intervencija i procesa liječenja u cjelini. Rad sadrži prikaz dugogodišnjeg grupnog procesa s kroničnim shizofrenim bolesnicima te razvoj razumijevanja psihotičnih simptoma jednog od članova grupe.

/ Understanding the meaning of symptoms in the context of individual life events would be a significant contribution to psychoanalytic theoretical concepts and knowledge in treating schizophrenic patients. Although schizophrenic patients differ significantly, their symptoms can usually be understood as a defence from unbearable experiences. Conscious and unconscious meanings of experience are a derivative of the inner world of the individual, which is also formed of life experiences; most of them come from the early childhood when the feeling of self and identity begins to develop. The ability to understand the symptoms and behaviour of schizophrenic patients by applying psychodynamic theories and knowledge as well as participation in the psychotherapeutic process provides clinicians with a platform for a complete insight into psychodynamics and functioning of a person suffering from schizophrenia and also contributes to adequate planning of therapeutic interventions and treatment process as a whole. This paper presents a long-term group process with chronic schizophrenic patients and the development of understanding of the psychotic symptoms in one member.

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UVOD

Značajan doprinos psihoanalitičkih teorijskih koncepata i znanja u liječenju shizofrenih bolesnika je u razumijevanju značenja simptoma u kontekstu individualnih životnih događaja (1). Psihoanalitički koncepti mogu učiniti razumljivim manifestacije bolesti kao što su halucinacije i sumanutosti kao i specifična, često bizarna ponašanja, i time olakšati uspostavljanje terapijske alijanse te provođenje cjelovitog plana liječenja. Iako se shizofreni bolesnici međusobno značajno razlikuju, njihovi simptomi se najčešće mogu razumjeti kao obrana od nepodnošljivih iskustava (2). Takva iskustva uključuju kronični užas (*terror*) (3-5), prijetnju anihilacijom ili nedostatkom humanog kontakta (6), a zajednička im je psihotična obrana koja štiti oboljelog tako da mijenja iskustvo realnosti. To znači da je subjektivni životni stres jedan od bitnih elemenata u nastanku shizofrenije, a težina stresnih događaja je determinirana svjesnim i nesvjesnim značenjima proživljenih iskustava te kvalitetom socijalnog suporta (1).

Svjesna i nesvjesna značenja iskustava su derivat unutarnjeg svijeta individuuma, koji isto tako biva formiran od životnih iskustava, najviše onih iz ranog djetinjstva kad se počinje razvijati osjećaj selfa i identiteta. Osobna značenja iskustava determiniraju način na koji individuum percipira sebe i druge, doživljava anksioznosti i emocije, te razvija obrane i kapacitete nošenja sa stresom (1,7).

Poznato je da psihotični bolesnici imaju velike teškoće na planu interpersonalnih odnosa koji ograničavaju njihov kapacitet za komunikaciju, intimnost i participaciju u socijalnom matriksu (8). Od svih psihotičnih bolesnika kronični shizofreni bolesnici su najoštećeniji te često imaju vrlo malo odnosa izvan najuže obitelji i često žive emocionalno udaljeni, izolirani, uz izbjegavanje socijalnih kontakata. Lucas (9) naglašava da kronični psihotični bolesnici trebaju

INTRODUCTION

A significant contribution of psychoanalytic theoretical concepts and knowledge in treating schizophrenic patients is understanding the meaning of symptoms in the context of individual life events (1). Psychoanalytic concepts can make sense of manifestations of illness such as hallucinations and delusions as well as specific, often bizarre behaviours, thus facilitating the establishment of a therapeutic alliance and the implementation of a comprehensive treatment plan. Although schizophrenic patients differ significantly from each other, their symptoms are most commonly understood as a defence from unbearable experiences (2). Such experiences include chronic terror (3,4,5), the threat of annihilation or the lack of human contact (6), which share a psychotic defence that protects the patient by changing the experience of reality. This means that subjective life stress is one of the most important elements in the development of schizophrenia, and the severity of stress events is determined by the conscious and unconscious meanings of lived experience and the quality of social support (1).

Conscious and unconscious meanings of experience are a derivative of the individual inner world, which is also formed of life experiences, most of them from early childhood when the feeling of self and identity begins to develop. The personal meanings of experiences determine the way an individual perceives himself and others, experiences anxiety and emotions, and develops defence and stress-carrying capacities (1, 7).

It is known that psychotic patients have great difficulties in interpersonal relationships, which limits their capacity for communication, intimacy and participation in the social matrix (8). Of all psychotic patients, chronic schizophrenic patients are most affected and often have very few relationships outside the immediate family, often leading an emotionally distant and isolated life, avoiding social contacts. Lucas (9) emphasizes that, first of all, chronic

prije svega suportivnu okolinu „da za njih misli i o njima brine“.

Grupna psihoanalitička psihoterapija pruža mogućnost socijalizacije odnosno poboljšanja kvalitete interpersonalnih odnosa psihotičnih bolesnika (10,11). Grupni terapijski okvir kao demokratska situacija omogućuje članovima kontakt s osobama sa sličnim tegobama, i komunikaciju te učenje iz interpersonalnih odnosa koje uzajamno uspostavljaju u sigurnoj i zaštićujućoj sredini. Sličnosti s ostalim članovima grupe smanjuju doživljaj usamljenosti i stigmatizacije (12). ''Vertikalni transfer'' prema terapeutu slabijeg je intenziteta nego u individualnoj terapiji i lakše se izbjegava duboka regresija, a ''horizontalni transferi'' su raspršeni između članova grupe tako da je emocionalni naboj u grupi slabiji i time podnošljiviji psihotičnim pacijentima te lakše dostupan terapijskoj intervenciji (14,15). Susret s vlastitim bolesnim dijelom i psihopatologijom ostalih članova izgrađuje kritičniji odnos prema poremećaju i adekvatniji uvid u njihove probleme. Radom u grupi postiže se i bolje testiranje realiteta, budući da je lakše razlikovati objektivnu i subjektivnu realnost u doživljaju drugih članova (12-14).

CILJ RADA I HIPOTEZA

Cilj rada je prikaz postupnog stjecanja uvida u značenje psihotičnih simptoma i ponašanja kroničnog shizofrenog bolesnika u dugotrajnoj psihodinamskoj grupnoj psihoterapiji, reakcija članova grupe kao i reperkusije grupne dinamike na funkcioniranje pacijenta u realitetu.

Hipoteza je da će u dugotrajnoj psihodinamskoj grupnoj psihoterapiji pacijenti razviti uvid u svoju bolest te razumijevanje značenja svojih psihotičnih simptoma što će im pomoći pri boljoj adaptaciji na socijalnu sredinu uz poboljšanje kvalitete bliskih interpersonalnih odnosa.

psychotic patients need a supportive environment “to think and care for them”.

Group psychoanalytic psychotherapy provides the possibility of socialization or improvement of the quality of interpersonal relationships of psychotic patients (10,11). The group therapeutic framework as a democratic situation enables members to contact people with similar disorders, and communication as well as learning from interpersonal relationships that are reciprocally established in a safe and protected environment. Similarities with other members of the group reduce the experience of loneliness and stigmatization (12). “Vertical transference” towards the therapist is weaker in intensity than in individual therapy and it is easier to avoid deep regression, while “horizontal transferences” are dispersed among group members so that the emotional charge in the group is weaker and more tolerable *to psychotic patients and more readily accessible to therapeutic intervention (14,15*). A confrontation with their own illness and the psychopathology of other members engenders a more critical attitude towards the disorder and a more adequate insight into their problems. Group work means a better testing of reality since it is easier to differentiate between objective and subjective reality in the experience of other members (12-14).

OBJECTIVE AND HYPOTHESIS

The aim of this paper was to provide a gradual overview of the psychotic symptoms and behaviour of chronic schizophrenic patients in long-term psychodynamic group psychotherapy, reactions of group members and repercussions of group dynamics for patient functioning in reality.

The hypothesis is that during long-term psychodynamic group psychotherapy patients will gain insight into their illness and understand the meaning of their psychotic symptoms, which will help them to better adapt to the social environment while improving the quality of close interpersonal relationships.

OPIS SLUČAJA I GRUPNI PROCES

Opis slučaja – anamneza

Pacijent Ranko u vrijeme opisanih događanja imao je 57 godina. Rođen je u jednom dalmatinskom gradu, u obitelji pomorca kao stariji sin. U okviru školskih obveza iznadprosječno uspješan, ali introvertiran, socijalno izoliran, s malo prijatelja zbog čega je od rane dobi nesretan. Od djetinjstva se interesira za šah.

Psihičke smetnje se prvi put manifestiraju nakon završetka srednje škole kad se ne uspijeva upisati na fakultet u rodnom gradu (sam izričito želi studirati u Zagrebu), pa ga otac šalje na rad rođacima u inozemstvo. Nakon nekoliko mjeseci razvija opsesivnu simptomatiku pa se vraća u domovinu, a otac mu odobrava studij izvan rodnog grada. Upisuje jedan od tehničkih fakulteta, živi u studentskom domu gdje manifestira teškoće u komunikaciji i socijalnoj adaptaciji. Na četvrtoj godini studija umire mu otac, što Ranko teško doživljava. Počinje se psihoterapijski liječiti u tadašnjem Centru za mentalno zdravlje, a nakon manifestacije floridne psihoze na četvrtoj godini studija s paranoidno-halucinatornom simptomatikom biva hospitaliziran. U individualnu psihoterapiju ga uzima poznati psihijatar koji se bavi ovim poremećajima, ali prima i psihofarmake i EST. Iznimno motiviran za studij, uči za ispite na odjelu tijekom liječenja. Uz terapiju uspješno završava studij s visokim prosjekom. Šahovske probleme počinje konstruirati na drugoj godini studija, objavljuje ih i aktivan je u klubu problemista. Nakon studija zaposlio se u struci kao inženjer i u istoj tvrtki radi 30 godina do invalidske mirovine.

U dobi od 32 godine se upoznao, a kasnije i oženio, s intelektualno inferiornom ženom i uskoro dobio kćer. Ženini roditelji su aktivno pomagali mladi par i unuku do svoje smrti desetak godina kasnije i do tada je brak funkcionirao. To je razdoblje od 13 godina stabilne faze

CASE DESCRIPTION AND GROUP PROCESS

Case description – anamnesis

Patient Ranko was 57 years old at the time of the described events. He was born in a Dalmatian town, as an older son in a seaman's family. Regarding academic obligations he was above-averagely successful, but was introverted, socially isolated and with few friends, which is why he had been unhappy since an early age. He had been interested in chess since childhood.

His mental disturbances manifested for the first time after he graduated from high school and failed to enrol in his hometown college (he explicitly wanted to study in Zagreb), and his father sent him abroad to work with relatives. After several months he developed obsessive symptoms and returned to his homeland. His father approved of his studies outside the hometown. He enrolled in one of the technical faculties in Zagreb and lived in a student home, where he manifested difficulties in communication and social adaptation. His father died during the fourth year of his studies, which Ranko found difficult to endure.

He started with psychotherapeutic treatment as an outpatient at the Mental Health Center, and when paranoid-hallucinatory symptomatology of florid psychosis manifested during the fourth year of study, he was hospitalized. He was treated with individual psychotherapy by a well-known psychiatrist who worked with such disorders and he also took medication and EST. He was exceptionally motivated to study, and studied for exams in hospital wards during his treatment. While being treated, he successfully completed the course with high-level grades. In the second year of study he started developing chess puzzles which were published. He was also active in the chess club. After graduation he worked as an engineer in the same company for 30 years until his disability retirement.

At 32 years he met and later married a less educated woman and soon had a daughter. His wife's

bolesti, bez hospitalizacija, ali uz individualnu psihoterapiju i psihofarmake.

Nakon smrti ženinih roditelja počinje kriza u braku, dijete počinje manifestirati psihičke smetnje i socijalna služba kćerku dodjeljuje Rankovoj majci i bratu na odgoj (u drugom gradu), a on se rastaje od žene nakon četiri godine. Godine 1990. hospitaliziran je zbog egzacerbacije bolesti i tada započinje grupnu psihoterapiju u kojoj participira devet godina.

U kontinuitetu se pacijent bavi sastavljanjem šahovskih problema, kojih je do 1995. godine sastavio 360. U svjetskim časopisima je objavio pedesetak problema, sudjelovao je u radu kluba, te sudio na natjecanjima i dobio status majstora.

Nakon rastave, od 1995. godine živi sam. Tijekom sudjelovanja u grupnom procesu postaje evidentno i psihopatološko značenje bavljenja problemskim šahom.

Grupa

Radi se o grupi od osam shizofrenih pacijenata vođenoj koterapijski prema principima grupne analize, s modificiranom tehnikom primjerenom psihotičnim pacijentima. Grupa je počela radom 1990. godine, a vodila su je dva grupna analitičara u izvanbolničkim uvjetima, jedanput tjedno, u trajanju od jedan sat. Svi članovi grupe bili su shizofreni pacijenti, višekratno hospitalno liječeni, s višegodišnjim trajanjem bolesti, koji su uključeni u grupnu psihoterapiju u fazi remisije. Svi su bili u redovnom ambulantnom psihijatrijskom tretmanu uz uzimanje odgovarajućih psihofarmaka.

Pet članova grupe sudjelovalo je u kontinuitetu svih devet godina, a tri člana su se uključila kasnije, jedan u petoj te dva člana u šestoj godini trajanja grupe.

Boris, profesor filozofije, liječi se od studentskih dana. U 35. godini života, nakon četvrte hospitalizacije uključen je u grupu. Živi s roparents were actively helping the young couple and granddaughter until they passed away ten years later, and the marriage functioned until they died. This was a period of 13 years of stable course of disease, without hospitalization, but with individual psychotherapy and medication.

After the death of his wife's parents the crisis in their marriage started, as the child began to manifest mental distress and social service assigned the daughter to Ranko's mother and brother for upbringing and education (in another city). Four years later, he divorced his wife. In 1990 he was admitted to the hospital due to disease exacerbation and started with group psychotherapy in which he participated for nine years.

The patient was continuously engaged in developing chess puzzles and developed 360 of them until 1995. He published fifty puzzles in international journals, he participated in the activity of the club, was the referee at the competition and obtained the status of a master. He has been living alone since the divorce in 1995. During the participation in the group process, the psychopathological significance of dealing with chess puzzles became evident.

The group

The group consisted of eight schizophrenic patients cotherapeutically guided by the principles of group analysis, with a modified technique appropriate for psychotic patients. The group began working in 1990 and was led by two group analysts on an outpatient basis, once a week, for one hour. All members of the group were schizophrenic patients, repeatedly hospitalized, had the disease for years, and were included in group psychotherapy in the remission phase. All of them were in regular outpatient psychiatric treatment with the use of appropriate medication.

Five members of the group participated in continuity for all nine years, three members joined the group later, one in the fifth and two members in the sixth year of the group's existence.

diteljima, nikad nije radio zbog kontinuirano prisutnih slušnih halucinacije te povremenih ideja odnosa refrakternih na psihofarmake. U grupi aktivan, konstruktivan, često propituje uvriježene stavove i stereotipe, „grupni filozof".

Davor, mladi pravnik, uključen je u ovu grupu nakon kraćeg, neuspješnog sudjelovanja u grupi više funkcionalne razine gdje je ometen kognitivnim teškoćama i produktivnim simptomima teško sudjelovao te prestao dolaziti. U sadašnjoj grupi redovit, sve obilnijih verbalizacija i interakcija, boljeg funkcioniranja, tijekom grupe uspijeva položiti pravosudni ispit i zaposliti se.

Nenad dolazi u grupu nakon višegodišnjeg liječenja simpleks forme shizofrenije uz simptomatski alkoholizam. U prve dvije godine izrazito šutljiv, autističan, da bi postupno postao aktivniji, topliji i boljih interakcija. U grupi uspostavlja stabilniju remisiju i apstinenciju od alkohola.

Nela je u dobi od trideset četiri godine i tri hospitalizacije uključena u grupu, stomatolog, ali nikad nije radila u struci. U adolescentnoj dobi izgubila je oba roditelja, odrasla uz stariju sestru s kojim ima ambivalentan simbiotski odnos. U grupi vrijedan, aktivan i analitičan član, dobrih interakcija.

Andrija, dolazi u petoj godini rada grupe, nakon svoje pete hospitalizacije, sklon prekidima liječenja, neuzimanju lijekova, u grupi ima ulogu „zločestog djeteta", ali i ulogu člana koji otvoreno izražava otpor autoritetima općenito, kao i otpor terapeutima. Dobro prihvaćen, na kraju rada grupe bolje funkcionira u realitetu.

Renata, uključena u grupu nakon druge hospitalizacije, ukupno je participirala u grupi zadnje tri godine njenog trajanja. Najmanje regresivna članica, najboljeg socijalnog funkcioniranja izvan grupe, udata, majka dvoje djece, aktivan član, dobrog testiranja realiteta, u

Boris, a professor of philosophy, has been in psychiatric treatment from his student days. At the age of 35, after the fourth hospitalization, he was included in the group. He lived with his parents, never worked because of the constantly present auditory hallucinations and the occasional ideas of reference refractory to psychopharmacological treatment. He was very active in the group, constructive, often challenging conventional attitudes and stereotypes and nicknamed the "group philosopher".

Davor, a young lawyer, was included in this group after a shorter, unsuccessful participation in a group of higher functional level, where, hindered by cognitive disabilities and positive symptoms, he had difficulties participating and stopped joining the group. In the current group he attended regularly, more often verbalized and interacted, functioned better, and during the group therapy he passed the bar exam and found employment.

Nenad joined the group after years of treatment for the simplex form of schizophrenia with symptomatic alcoholism. In the first two years, he was extremely silent, autistic and only gradually become more active, warmer, with better interaction. The group established a more stable remission and alcohol abstinence.

Nela joined the group at the age of thirty-four and after three hospitalizations; she was a dentist but had no work experience. In adolescence, she lost both her parents and grew up with an older sister with whom she had an ambivalent symbiotic relationship. In the group she was a valuable, active and analytic member, with good interactions.

Andrija joined the group in the fifth year of the group's work, after his fifth hospitalization; he was prone to discontinuation of therapy, not adhering to drug treatment and had the role of a "malicious child" but also the role of a member who expresses opposition to the authorities in general as well as resistance to therapists. He

grupi zauzima majčinsku ulogu, savjetuje, konfrontira, sklona konkretnijim oblicima pomoći (telefonira izvan grupe kad netko nije dobro, poziva na kavu i sl.). U grupi stječe uvid u svoju pretjeranu potrebu da brine o svima i sve kontrolira, uspostavlja stabilnu, dugotrajnu remisiju.

Ivo, najmlađi član, uključen nakon prve epizode bolesti, sa značajnim hereditetom (sestra i brat boluju od teškog oblika shizofrenije), participira u grupi devet godina. Socijalno i materijalno ugrožen, bez podrške obitelji (sam se uzdržava na studiju strojarstva u Zagrebu), inače, rodom iz Bosne, predmet je pažnje i skrbi grupe na emocionalnoj pa i konkretnoj razini, ima ulogu „djeteta grupe" koje tijekom godina napreduje, završava studij, a isto tako ostvaruje dobru remisiju.

Ranko je najstariji član grupe, unatoč dugotrajnoj shizofreniji ostvario je obitelj kao i uspješno profesionalno funkcioniranje. Prošao mnoge tretmane, terapeute i bolnice, predstavlja pravu „povijest psihijatrije" i često je u službi savjetnika te identifikacijskog modela za mlađe članove.

Grupa je prošla dugi proces uspostavljanja kohezije, prevladavanja psihotičnih modela komunikacije (autističnih monologa) preko dijeljenja iskustava hospitalizacija, psihotičnih simptoma, lijekova i nuspojava, stigme duševne bolesti, da bi u petoj godini počela obrađivati i razumijevati značenje simptoma bolesti.

U prikazima grupnog procesa vezanima za cilj ovog rada sudjelovali su sljedeći članovi grupe: Ranko, Boris, Davor, Nela, Nenad, Renata.

Iz protokola

192. seansa, 1995. godina

Davor: Razmišljao sam o prošloj grupi. Razgovarali smo o paranormalnim pojavama. Mislim da je to interesantno i da možemo na taj način objasniti svoju bolest.

was well-accepted, and, at the end of the group work, functioned better in reality.

Renata joined the group after her second hospitalization and has participated in the group for the last three years. She was the least regressive member with the best social function outside the group, married, a mother of two children, and an active member with good reality testing; she took a maternal role in the group, advised, confronted, was prone to more concrete forms of help (phone calls outside the group when someone is not well, invites for a cup of coffee and similar). In the group she gained insight into her overwhelming need to care for everyone and control everything, establishing a stable, long-lasting remission.

Ivo, the youngest member, joined after the first episodes of illness with significant heredity (sister and brother suffered from severe forms of schizophrenia) and participated for nine years. Socially and materially endangered, without family support (supporting himself during the study of mechanical engineering in Zagreb). He was born in Bosnia and became the subject of care and attention of the group on both the emotional and concrete level, assuming the role of "group child" that progressed over the years; he finished his studies and also had a good remission.

Ranko was the oldest member of the group. Despite his long-lasting schizophrenia, he started a family and succeeded in professional life. He went through many treatments, therapists and hospitals and represents the right "history of psychiatry"; he often provided counselling and was the identification model for younger members.

The group has gone through the long process of establishing cohesion, overcoming the psychotic models of communication (autistic monologues), sharing experiences of hospitalization, psychotic symptoms, drugs and side effects and mental stigma, so as to begin to deal with and understand the symptoms of the disease in the fifth year.

Ranko: To je nešto što se događa svima nama psihičkim bolesnicima.

Nenad: Da, tu se pojavljuju neke stvari koje se ne mogu uvijek objasniti.

Davor: Tu se pojavljuju neke stvari koje se normalnim ljudima ne mogu dogoditi. *Osjećaj paranoje*.

Nenad: Da, to je istina.

Nela: Ja ne znam zašto mi o tome razgovaramo.

Ranko: Ja sam se problemima posvetio od malih nogu. Kad to meni puno znači. Ja sam preko šaha prognozirao atentat, zbog toga sam došao u jedno pogoršanje situacije, jer sam imao zle slutnje i ogromnu krivicu za ono što se zbilo. To je nekakva megalomanija, omnipotencija, da ja mogu utjecati na sve događaje, a s druge strane ja to nikad nisam želio upotrijebiti, da bih ja nekome učinio zlo, točno sam htio da bude manje žrtava, i kad bi problem stremio prema katastrofi, ja sam u zadnji čas skrenuo misli. Kao da ću parapsihološki utjecati na događaje i stvarno se tako kasnije i dogodilo.

Nenad: Pred jedno osam godina bila je neka emisija u kojoj je rečeno da si zamislite što bi željeli da se dogodi. Ja sam si tako u nekom euforičnom raspoloženju slušao muziku, i pomislio da dođe do potresa u Panami, da se razdvoje dvije Amerike. Nakon šest sati dogodio se taj potres.

Davor: Ozbiljno?

Ranko: Netko te vodio. Zašto si došao na ideju u Panami, a zašto ne u Gvatemali. Da ovakve stvari pričaš nekom drugom mislio bi da si lud.

Nenad: Ja se tada još nisam liječio.

Ranko: Onda to koincidiranje izaziva paranoičnu reakciju, osjećaj da si jako moćan. Baš sam Igoru govorio kako sam razmišljao o nekim svojim problemima i tu je večer bilo izvlačenje lota, i onda su došli ti brojevi koji su bili povezani bilo preko leksikona, bilo preko mojih problema.

In the presentation of the group processes related to the objective of this study, the following members of the group participated: Ranko, Boris, Davor, Nela, Nenad, Renata.

From the protocol

192nd session, 1995

Davor: I was thinking about the last group. We talked about paranormal phenomena. I think it is interesting and that we can explain our disease in that way.

Ranko: This is something that happens to all of us who are mentally ill.

Nenad: Yes, there are some things that cannot always be explained.

Davor: There are some things that do not happen to ordinary people. The feeling of paranoia.

Nenad: Yes, that's true.

Nela: I do not know why we talk about it.

Ranko: I have dedicated myself to puzzles since childhood. This means a lot to me. Through chess I predicted an assassination, which is what led to a deterioration of the situation, because I had a bad feeling about it and huge guilt for what happened. It is a kind of megalomania, omnipotence, that I can influence all the events, on the other hand I never used it, that I would do something wrong, I wanted there to be fewer victims, and when the puzzle would head towards a disaster, I would divert my thoughts at the last moment. As if I was going to influence the events parapsychologically and it really happened that way later.

Nenad: Eight years ago, there was a broadcast in which you were told to imagine what you would like to happen. I'd been listening to music in some euphoric mood, and I thought about an earthquake in Panama, which would separate the two Americas. Six hours later the earthquake occurred.

Davor: Seriously?

Boris: Nisi me uvjerio.

Ranko: Nisam jer si krajnji skeptičar.

Terapeut 1 (T1): Ranko je svojim problemima povezan sa cijelim svijetom i to mu daje osjećaj moći.

Terapeut 2 (T2): Nela je rekla da te probleme povezuje sa svojim unutrašnjim i vanjskim svijetom.

Ranko: Da, u fazi apstinencije od šaha ja sam izgubljen.

Davor: Možda ste tako rješavali emocionalni problem.

Ranko: To je bio pokušaj neke sublimacije, ali samo pokušaj. U početku moj slagateljski rad nije bio uspješan, a kad je postao uspješan koincidirao je s mojim pogoršanjem. Ja sam u početku bio racionalan. Ja sam bio svjestan da su moja inteligencija i racionalno mišljenje oštećeni već u početnoj fazi moje bolesti. Onda sam se trudio maksimalno disciplinirati i učiti u smislu neke mentalne higijene, da bi se novo znanje moglo asimilirati s razumijevanjem.

T1: Izgleda da je nešto zapelo u emocijama.

Ranko: Ja sam emocionalno strahovito bio prikraćen jer sam znao da neću imati uspjeha. U mojem emocionalnom životu ja sam se oženio i dobio kćer, samo se to ostvarilo. Moj je mozak bio tako strukturiran da ja nisam bio spreman za nikakvu uzajamnu torturu (zajednički život) nego za samostalnu strukturu. Naravno da mi je trebala ljubav, toplina i seks, ali sam se ja toga dobrovoljno odrekao i priuštio si druga zadovoljstva preko šaha. To me je nekad izluđivalo.

Boris: Čovjek može naći interes i zadovoljstvo u sebi.

Ranko: Sve što je paranormalno ne znači da ne postoji i da se s time ne može funkcionirati. To mi ostavlja neki prostor za sebe i izlaz, uvijek izlaz...

Ranko: Somebody guided you. Why did you come up with an idea for Panama, and why not in Guatemala? If you talked to someone else, he would think you are crazy.

Nenad: I was not in treatment at that time.

Ranko: Then this coincidence leads to a paranoid reaction, a feeling that you are very powerful. I was just telling Boris that I was thinking about some of my problems and that night was the lotto numbers were drawn, and then there came those numbers that were connected either through the lexicon or my puzzles.

Boris: I'm not convinced.

Ranko: That's because you're the ultimate sceptic.

Therapist 1 (T1): Ranko is connected with the problems of the whole world and that gives him a sense of power.

Therapist 2 (T2): Nela has said that that she relates these problems with her inner and outer world.

Ranko: Yes, in the phase of abstinence from chess I'm lost.

Davor: Perhaps you were solving an emotional problem in this way.

Ranko: It was an attempt of some kind of sublimation, but only an attempt. Initially, my work was not successful, and when it became successful it coincided with deterioration. I was initially rational. I was aware that my intelligence and rational thinking had been already damaged in the initial phase of my illness. Then I had to discipline myself to the maximum and learn in a sense some mental hygiene, so that the new knowledge could be assimilated with understanding.

T1: It seems as if something got stuck in terms of emotions.

Ranko: I was emotionally terribly crippled because I knew I would not be successful. In my

Davor: S tim treba biti oprezan.

Nenad: Ti tome previše posvećuješ pažnje. Ispada da ti je to najvažnija stvar u životu.

Ranko: To mi je važno, iako se grupa s tim ne slaže.

Nela: Znate li još koga tko tako rješava šahovske probleme?

Ranko: Ne, nikoga. Dapače, kad sam pokušao na takav način razgovarati s njima u klubu bili su jako neprijateljski raspoloženi prema meni.

Nela: Rekli ste da se iza takvih problema osjećate lošije i onda dolazite na kontrolu. Ne mislite da vas šahovski problemi dovode u lošu fazu bolesti?

Ranko: Jednim dijelom.

Nela: Ako ste usamljeni možemo se sastati u Maksimiru…

Ranko: Nisam rekao kakav je bio epilog tog problema. Poslije je izbio rat, 15.11. je razarač gađao Split. Granata je točno pogodila tu kuću u kojoj je bio uzorak tih pločica.…

T2: Nela vam je dala prijedlog…

Ranko: Pitanje je da li ću ja to prihvatiti, odbaciti ili razmotriti…

256. seansa, 1997. godina.

U grupu se vratio Andrija poslije hospitalizacije i pokušaja suicida. Ranko objavljuje da se osjeća loše, da je eksperimentirao s terapijom i da je dobio neurovegetativne simptome za što krivi lijekove. Renata mu kaže da neurovegetativna distonija nije od lijekova nego zbog nezadovoljstva unutarnjim i vanjskim svijetom.

Ranko: Napravio sam jedan pokus što spada u zonu sumraka. Sastavio sam jedan problem s elektroničkim uređajem, isti dan su se sudarila dva aviona, Tupoljev i Boing. To je jedno opterećenje, jedno s drugim u koliziji.

Renata: Rješenje je baciti šah i probleme, i izaći iz zone sumraka.

emotional life I got married and got a daughter, only that was realized. My brain was so structured that I was not ready for any reciprocal torture (shared life), but for an independent structure. Of course I needed love, warmth and sex, but I voluntarily gave up on it and through chess I enjoyed other pleasures. It drove me crazy sometimes.

Boris: A man can find interest and pleasure within himself.

Ranko: Everything that is paranormal does not mean it does not exist and that one cannot function with it. It leaves room for myself and a way out, always a way out…

Davor: You have to be careful with this.

Nenad: You pay too much attention to that. It ends up being the most important thing in your life.

Ranko: That matters to me, although the group does not agree with it.

Nela: Do you know anyone else who solves chess puzzles in such a way?

Ranko: No, no one. In fact, when I tried to talk to them in such a manner, they were very hostile toward me.

Nela: You said that after such problems you feel worse and then come to a check-up. Don't you think chess puzzles bring trigger a bad stage of illness?

Ranko: Only partly.

Nela: If you are lonely we can meet in Maksimir…

Ranko: I did not say what the epilogue of that problem was. The war broke out later, November 15 the destroyer fired at Split. The grenade struck the exact house in which a pattern of those tiles was.…

T2: Nela made a suggestion…

Ranko: The question is whether I will accept this, dismiss or consider…

U dvije prikazane seanse u razmaku od dvije godine (5. i 7. godina terapije) Ranko opširno iznosi svoje preokupacije problemskim šahom, koji osim realne afirmacije (niz objavljenih problema u svjetskim časopisima, član FIDE) ima i psihotično značenje te zadovoljava omnipotentne i grandiozne potrebe. Tijekom svih sedam godina uz kontinuirano bavljenje šahom na svoj način, pacijent je u remisiji, socijalno funkcionira, radi. U grupnom kontekstu Rankovi šahovski problemi omogućavaju grupi bavljenje psihotičnim dijelovima ličnosti, iako grupa u cijelosti konfrontira Ranka s omnipotentnim i grandioznim aspektima njegovih sadržaja i traži od njega da se okrene realitetu i realnim odnosima.

Grupa dogovorno završava u proljeće 1999. godine. Zadnje dvije godine sadržaj diskusija se premješta na aktualne probleme s Rankovom kćeri, koja se psihoterapijski liječi. U stalnom je konfliktu s bakom i stricem, u kojem Ranko često telefonski posreduje, kao i u njenom dogovorenom dolasku u Zagreb na studij. Ranko se u tom razdoblju uglavnom odriče bavljenja šahovskim problemima i preokupiran je realitetom. Jednoj od svojih grupnih koterapeuta nastavlja dolaziti na kontrolne preglede (T1), a drugoj (T2) na individualnu psihoterapiju s idejom da nauči bolje komunicirati s kćeri. S dolaskom kćeri nastupaju novi problemi. Ona odbacuje njegove pokušaje preuzimanja očinske uloge. Zahtjevna je, osobito na materijalnom planu, konfliktna, nesigurna, odbacuje njegove pokušaje da joj se približi i daje podršku, osim kad je i sama u regresivnom stanju. Tada komuniciraju na stari način iz ranog djetinjstva: igraju se s medvjedićima, u toj igri on igra razne uloge koje ona čas prihvaća čas odbacuje. Majka i brat se upliću u odnos s kćeri, brat rivalizira u očinskoj ulozi, te odnos s kćeri postaje sve konfliktniji. Ranko postupno razvija brojne somatizacije, jača njegova anksioznost te počinje svakodnevno tražiti pomoć različitih medicinskih službi (HMP, raznih specijalista, dežurnih

256th session, 1997

Andrija returned to the group after hospitalization and attempted suicide. Ranko said he feelt bad, experimented with therapy, and got neurovegetative symptoms because of the wrong medication. Renata told him that neurovegetative dystonia is not because of drugs but because of dissatisfaction with the inner and outer world.

Ranko: I did one experiment that best fits the twilight zone. I developed a problem with an electronic device, and the same day two planes collided, Tupoljev and Boeing. It's a burden, one is in collision with the other.

Renata: The solution is to throw away chess and puzzles and get out of the twilight zone.

In the two presented sessions in two years (5th and 7th year of therapy), Ranko extensively outlined his preoccupation with chess puzzles, which besides real affirmation (a series of chess puzzle publications in world journals, FIDA member) also had a psychotic meaning and satisfied his omnipotence and grandiose needs. During all seven years and continuous dealing with chess in his own way, the patient was in remission, socially functioning, working. In a group context, Ranko's chess puzzles enabled the group to engage in psychotic aspects of personality, although the group completely confronted Ranko with the omnipotent and grandiose aspects of his content and asked him to turn to reality and real relationships.

The group concluded in the spring of 1999. In the last two years, the content of the discussion shifted to the current problems with Ranko's daughter, who was treated psychotherapeutically. She was in constant conflict with her grandmother and uncle in which Ranko often intervened by phone calls, as well as in her scheduled arrival to Zagreb to study. In that period, Ranko mostly relinquished chess puzzles and was concerned with reality. He continued to come to check-ups to one of his group co-therapists (T1)

psihijatara u bolnici). Počinju se razvijati smetnje pamćenja, postaje sve konfuzniji, kognitivno dezorganiziran, gubi stvari, zaboravlja terapijske termine, redovito uzimanje lijekova i sl. Brat počinje razmišljati o oduzimanju poslovne sposobnosti i postavljanju skrbnika. Opisano stanje traje oko godinu i pol; na kraju prestaje uzimati lijekove. U psihičkom pogoršanju Ranko sam dolazi u bolnicu i biva hospitaliziran prvo na zatvorenom odjelu, a potom na otvorenom odjelu sa psihoterapijskim programom, koji vodi njegov terapeut (T1). Za vrijeme boravka u bolnici pacijent relativno brzo prestaje biti zaboravljiv i u bolničkim okvirima funkcionira potpuno neupadno (pohađa program u cjelini i na vrijeme, kontaktira s ostalim pacijentima, odlazi na vikende i sl.). Ponovno se počinje baviti šahovskim problemima i odlazi u klub. Po otpustu dobro funkcionira, bez značajnijih kognitivnih smetnji, a u fazama anksioznosti sada konzultira terapeute telefonom, a izvan radnog vremena terapeute medicinske sestre s odjela koje su psihoterapijski educirane i upoznate s njegovom cjelokupnom situacijom i kliničkom slikom te mu pružaju suport i kontejnersku funkciju. Odnos s kćeri se sada ustalio, Ranko se pomirio s razinom njihove komunikacije (igre s medvjedićima), uz njeno promjenjivo raspoloženje.

RASPRAVA

Iako formulacije o shizofrenoj psihopatologiji reflektiraju naoko bezbroj različitih kliničkih slika koje ovi pacijenti prezentiraju, postoji nekoliko činjenica koje prihvaća svaki psihodinamski obrazovani kliničar. I vrlo neobična ponašanja i doživljavanja shizofrenih pacijenata mogu se razumjeti kao izraz specifičnih psihičkih procesa, odnosno mehanizama obrane kao što su npr.: projekcija, poricanje disocijacija i sl. Sa strukturnog gledišta shizofreni pacijent ima slabo definirane granice između unutarnjeg i vanjskog svijeta koji vode oštećenjima testira-

and to the other (T2) for individual psychotherapy with the idea of learning how to better communicate with his daughter. New problems arose with the daughter's arrival. She rejected his attempts to take over his fatherly role. She was demanding, especially in a material sense, conflicting, uncertain and rejected his attempts to approach her and provide support except when in regressive state. Then they communicate in the way they used to when she was a child: they play with teddy bears in which he plays various roles that she accepts at one moment and at the other dismisses. The mother and brother meddled with their relationship; the brother was a rival for the role of the father, and the relationship with his daughter became increasingly conflicting. Ranko gradually developed numerous somatizations, his anxiety intensified and he started to seek help from various medical services on a daily basis (emergency service, various specialists, attending psychiatrists in the hospital). Memory disorder begin to develop, and he was becoming more confused, cognitively disorganized, losing things, forgetting his scheduled therapies and administering of medication regularly, etc. The brother began to consider limiting his business ability and setting up a guardian system. The described condition lasted for about a year and a half, and eventually he ceased to take medication. Amid psychotic decompensation, Ranko came to the hospital and was hospitalized first in a closed ward and then in an open ward with a psychotherapy program led by his therapist (T1). During the hospital stay, the patient relatively quickly stopped being forgetful and in hospital conditions he functioned completely normally (he visited the program in general and in time, had contacts with other patients, left during weekends, etc.). He started to work with chess puzzles again and attended to the club. Upon discharge he was functioning well without any significant cognitive impairments, was consulting the therapist by phone in phases of anxiety and outside therapy sessions he consulted nurses within departments who are psy-

nja realiteta praćenih poremećajima mišljenja. Konačno, objektni odnosi su poremećeni, a ti poremećaji oslikavaju i poremećenu konstrukciju self-reprezentacije (15).

Neki psihoanalitičari (16-18) pretpostavili su da kod svih emocionalno poremećenih individuuma postoji psihotična jezgra. Psihotična jezgra može se sagledati kao primitivna strukturna konstelacija koja je ishod psihičkih trauma koje je dijete iskusilo u specifičnom matriksu (dijadi) majka-dijete (15) gdje se prema Winnicottu (19) poremećaj manifestirao, i u funkciji „objektne majke" koja regulira instinktne potrebe, kao i „okolinske (*environmental*) majke" čija je uloga pružanje podržavajuće okoline uz zadovoljavanje potrebe ega. Emocionalni razvoj dalje se odvija na poremećen način rezultirajući strukturnim defektima, nedostatkom konsolidacije ego granica, psihopatološki konstruiranim reprezentacijama selfa, razvojnim fiksacijama, kompenzatornim obranama i adaptacijama, s mogućim sumanutim distorzijama vanjskog svijeta. Shizofreni pacijenti zbog nedostatka stratifikacije strukturne hijerarhije nemaju dovoljnu integraciju, strukturu i perceptivnost za stvaranje normalnih ljudskih odnosa. Umjesto da se direktno odnose s vanjskim objektima prema svojim mogućnostima, oni se povlače iz poznate realnosti i konstruiraju drugu realnost koja je samo njihova. Ono što se čini objektnim odnosima u shizofrenom svijetu nisu stvarne interakcije između dviju osoba temeljene na izmjeni osjećaja. Iako se čini da se shizofreni pacijenti odnose prema objektima, oni u stvari uspostavljaju odnos prema različitim dijelovima selfa (1,2,15). Bion (16) naglašava da kad imamo pred sobom pacijenta u psihotičnom stanju treba misliti o njegova dva dijela ličnosti: psihotičnom i nepsihotičnom, a ne o cjelovitoj osobi. Cilj psihotičnog dijela ličnosti je olakšavanje emocionalne boli projekcijom. Psihotični dio napada sve dijelove uma (*mind*) koji imaju veze s doživljajem emocionalne svje-

chotherapeutically trained and acquainted with his overall situation and clinical presentation and provide support and container function. The relationship with his daughter was now stable, and Ranko reconciled with the level of their communication (playing with teddy bears) and with her changing mood.

DISCUSSION

Although the formulations of schizophrenic psychopathology reflect the seemingly countless different clinical images presented by these patients, there are several facts accepted by every psychodynamically trained clinician. Both very strange behaviours and experiences of schizophrenic patients can be understood as an expression of specific psychic processes, i.e. defence mechanisms such as projection, denial, dissociation, etc. From a structural point of view, a schizophrenic patient has poorly defined boundaries between the internal and external worlds that lead to reality-testing damages followed by thinking disorders. Finally, object relations are disturbed, and these disorders also depict a disrupted self-representation structure (15).

Some psychoanalysts (16-18) have assumed that there is a psychotic core in all emotionally disturbed individuals. The psychotic core can be viewed as a primitive structural constellation that represents the result of psychic trauma that the child experienced in the specific mother-child matrix (dyad) (15) where, according to Winnicott (19), the disorder manifested, and in the function of the "object mother" that regulates instinctive needs as well as the "environmental mother", whose role is to provide a supportive environment meeting the needs of the ego. Emotional development unfolds in a disturbed manner, resulting in structural defects, lack of consolidation of ego boundaries, psychopathological constructed representation of the self, developmental fixations, compensatory defences and adaptations, with possible delusional distortions

snosti (*awareness*) i o unutarnjoj i o vanjskoj realnosti.

U pokušaju da izbjegne neizbježnu bol u odnosu prema odvojenim objektima, psihotični self poduzima napad na svaki mentalni proces koji može zaprijetiti da donese svjesnost o ljudskoj potrebi i potencijalnoj zdravoj ovisnosti (16,17,20).

Ranka je privukao šah od najranijeg djetinjstva i tada mu je ispunjavao usamljenost i prazninu. Nakon manifestacije bolesti u situaciji separacije odlaskom na studij, i boravkom u stranom gradu, usamljenom u novoj sredini, šahovski problemi počinju služiti kao nadomjestak za realne objektne odnose, te zadovoljavaju emocionalne potrebe za afirmacijom i omnipotencijom. Nakon smrti oca na zadnjoj godini fakulteta i nemogućnosti prolaska kroz proces žalovanja u pravom smislu riječi, bavljenje šahovskim problemima se intenzivira i involvira na magijski način cijelu obitelj u svjetske događaje, osobito nakon što ostvaruje svoj vlastiti brak i dobiva dijete. Usprkos višegodišnjem dobrom socijalnom funkcioniranju, bez egzacerbacije bolesti, psihotični grandiozni dio je uvijek aktivan. Uz to se veže realna afirmacija jer je na tom planu izuzetno uspješan.

U grupnom procesu pacijent obilno iznosi psihotične sadržaje vezane uz šah, intenzivnije nakon prvih godina rada grupe kada to budi veliku radoznalost i interes ostalih članova, da bi ga postupno članovi grupe ponovljeno konfrontirali s realitetom i značenjem šaha za njegovu bolest. Prije završetka grupe Ranko gotovo u cijelosti prestaje s konstruiranjem problema okrećući se realitetu odnosa s kćeri. Frustriran i odbačen u tom odnosu ulazi u regresiju, somatizira, traži pomoć na sve strane, frustracija se nastavlja, te pacijent konačno razvija sliku suspektne pseudodemencije (21). Kognitivne smetnje se mogu razumjeti kao napad na kognitivni aparat prema Bionu (16), i svjesnost o bolnim osjećajima povezanih s ovisnošću o objektu te ima značenje poziva u

of outside world. Schizophrenic patients lacking the stratification of structural hierarchy do not have sufficient integration, structure and perceptiveness to create normal human relations. Instead of directly relating to external objects according to their capabilities, they are withdrawing from the known reality and construct another reality that is only theirs. What seem to be object relations in the schizophrenic world are not the real interaction between two people based on the exchange of feelings. Although it seems that schizophrenic patients are related to the objects, they actually establish relationship to various parts of the self (1,2,15).

Bion (16) points out that when we have a patient in a psychotic state before us we should consider them as having two personalities – psychotic and nonpsychotic – not as about wholesome person. The goal of the psychotic part of personality is to alleviate emotional pain by projection. The psychotic part attacks all components of the mind that are connected with experience of emotional awareness and inner and outer reality.

In an attempt to avoid the inevitable pain in relation to the separate objects, the psychotic self takes offense at every mental process that can threaten to bring awareness of human need and potential healthy addiction (16,17,20).

Ranko was attracted by chess from early childhood, and then it filled the loneliness and emptiness. After the manifestation of the disease in the separation situation due to leaving to study and staying in a strange town, lonely in the new environment, chess puzzles began to serve as a substitute for real object relationships and satisfy the emotional need for affirmation and omnipotence. After the death of his father in the final year of study and his inability to go through the process of mourning in the real sense, dealing with chess puzzles intensified and involved, in a magical way, the whole family into global events, especially after achieving his own marriage and getting a child. Despite the many years of good social functioning without

pomoć, izraz je bespomoćnosti i regresije. Mnestičke smetnje se povlače nakon hospitalizacije na odjelu sa psihodinamskim psihoterapijskim programom koji, i nakon otpusta, sa svojim educiranim osobljem pruža mogućnost zrcaljenja (22) i kontejnersku funkciju, zajedno s nastavkom psihoterapijskog odnosa sa psihoterapeutima. Bolesnik se ponovo vraća sastavljanju šahovskih problema koji služe istoj funkciji kao i ranije te na taj način uspostavlja svoju homeostazu. Danas Ranko ima 71 godinu. U remisiji je, redovitom psihijatrijskom tretmanu, od spomenute hospitalizacije nije bio u bolnici. Živi s kćeri, i dalje sastavlja šahovske probleme, povremeno ih objavljuje. Psihotični dio je i dalje aktivan, ali uz uvid da „ne smije pretjerati, jer postaje previše paranoičan", kako sam kaže.

ZAKLJUČAK

Mogućnost razumijevanja simptoma i ponašanja shizofrenih pacijenata koju pruža primjena psihodinamskih teorija i znanja kao i participacija u dugotrajnom psihoterapijskom procesu pruža kliničarima platformu za cjeloviti uvid u psihodinamiku i funkcioniranje ličnosti pacijenta oboljelog od shizofrenije, a time i adekvatno planiranje terapijskih intervencija i procesa liječenja u cjelini.

the exacerbation of the disease, the psychotic grandiose part was always active. In addition to this, there was a real affirmation because he was exceptionally successful in this respect.

In the group process, the patient brought out a lot of psychotic content connected with chess, more intensively after the first years of the group's work when this aroused great curiosity and interest of the other members, in order for them to gradually confront him with the reality and meaning of the chess for his illness. At the end of the group work, Ranko almost completely stopped constructing chess puzzles, turning to the reality of his relationship with daughter. Frustrated and rejected in this relationship he entered regression, somatised, sought help everywhere, was continuously frustrated, and finally developed a suspected pseudodementia (21). According to Bion (16), cognitive impairments can be understood as an attack on the cognitive apparatus and awareness of painful feelings related to dependence to the object, and is a cry for help, the expression of helplessness and regression. Today, Ranko is 71. He is in remission, regular psychiatric treatment, he has not been in hospital since the abovementioned hospitalization. He lives with his daughter, still compiles chess puzzles and occasionally publishes them. The psychotic part is still active, but with the insight that he "should not overdo it, because he becomes too paranoid" as he says himself.

CONCLUSION

The ability to understand the symptoms and behaviour of the schizophrenic patients provided by the application of psychodynamic theories and knowledge as well as participation in the long-term psychotherapeutic process provides clinicians with a platform for a complete insight into psychodynamics and functioning of a person with a schizophrenic illness, and thus adequate planning of therapeutic interventions and the treatment process as a whole.

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