Somatizacija kao obrana od narcističke povrede

Somatization as a Defence from Narcissistic Injury

Zrnka Kovačić Petrović[1], Tina Peraica[2,3], Dragica Kozarić-Kovačić[3]

[1] Medicinski fakultet Sveučilišta u Zagrebu i Klinika za psihijatriju Vrapče Zagreb, [2] Klinička bolnica Dubrava, Klinika za psihijatriju, Referentni centar Ministarstva zdravstva za poremećaje uzrokovane stresom, Zagreb, [3]Sveučilišni odjel za forenzične znanosti Sveučilišta u Splitu, Split, Hrvatska

/ [1]*University of Zagreb, Faculty of Medicine and University Psychiatric Hospital Vrapče, Zagreb,* [2]*University Hospital Dubrava, Department of Psychiatry, Referral Center for Stress-related Disorders of the Ministry of Health, Zagreb and* [3]*University of Split, Department for Forensic Sciences, Split, Croatia*

Somatizacijski poremećaj je poremećaj u kojem se psihički problemi i emocionalni konflikti izražavaju tjelesnim simptomima, a somatizacija je psihološki mehanizam u kojem se psihički problemi i emocionalni konflikti manifestiraju tjelesnim simptomima za koje se ne nalazi organska podloga. Može se javiti kao zasebni ili komorbidni poremećaj, osobito s poremećajima raspoloženja, anksioznim poremećajima, poremećajima ličnosti (najčešće histrionski poremećaj ličnosti i opsesivno-kompulzivni poremećaj ličnosti). Ovakve osobe primarno se javljaju u ambulante opće medicine ili tjelesne ambulante i tek kasnije i na psihijatrijska liječenja. Liječenje osoba s tzv. somatoformnim poremećajima je kompleksno, vrlo dugo i zahtjevno te je potrebna cijela lepeza psihijatrijskih vještina, često bez pozitivnih rezultata.

U ovom radu prikazana je pacijentica kod koje je traumatska i konfliktna situacija na poslu doživljena kao narcistička povreda koja je dovela do razvoja dramatične kliničke slike u oblku somatizacija i somatizacijskog poremećaja kod osobe s histronskim poremećajem ličnosti. Nemogućnost suočavanja s povredom selfa kod histrionskog poremećaja ličnosti može dovesti do somatizacije kao načinom rješavanja problema. Prigodom liječenja je važno identificirati točan uzrok, tj. okidač (engl. *trigger*) koji je doveo do nastanka poremećaja te suočiti pacijenta s psihološkom i emocionalnom etiologijom tegoba, što uvelike doprinosi boljem terapijskom ishodu. Važnost pravovremenog prepoznavanja somatizacija je između ostaloga nužna i zbog izbjegavanja nepotrebnih tjelesnih dijagnostičkih postupaka, kao i zbog socijalne i radne disfunkcionalnosti takvih osoba.

/ Somatization disorder is characterized by a tendency of a person to communicate psychological distress and emotional conflicts through physical symptoms, while somatization is a psychological mechanism manifesting psychological distress and emotional conflicts as physical symptoms that lack an organic basis. It can develop as a single disorder or a mental disorder comorbid with other disorders, especially co-occurring with mood disorders, anxiety disorders, and personality disorders (most commonly, histrionic and obsessive-compulsive personality disorders). In most cases, people suffering from such disorders seek help from general practitioners or at healthcare facilities specialized for physical disorders. It is only after this that they seek psychiatric assistance.

The treatment of people suffering from so-called somatoform disorders is complex, time-consuming and demanding and it requires a broad spectrum of psychiatric skills. However, it rarely yields positive outcomes.

This research paper focuses on a case study of a patient with histrionic behaviour who experienced a conflict situation at work as a narcissistic injury. The narcissistic injury triggered the development of a dramatic clinical picture in the form of somatization and, consequently, the development of the somatization disorder.

The inability of a person with a histrionic personality disorder to confront an injury of self can trigger somatization as a defence mechanism. The treatment requires careful identification of the root cause, the so-called trigger that initiated the development of the disorder, and the confrontation of a patient with the psychological and emotional etiology of his/her symptoms. Such an approach has a profound impact on a more positive outcome of the therapy. However, timely detection of somatization is important, among other things, to avoid unnecessary physical diagnostic procedures and to enable the normal performance of social and occupational roles of a patient.

ADRESA ZA DOPISIVANJE /
CORRESPONDENCE:
Zrnka Kovačić Petrović, dr. med.
Medicinski fakultet Sveučilišta u Zagrebu
Šalata 3b
10 000 Zagreb, Hrvatska
Tel: +385 98 230 969
E-pošta: zrnka.kovacic@gmail.com

KLJUČNE RIJEČI / ***KEY WORDS:***
Somatizacija / *Somatization*
Narcistička povreda / *Narcissistic injury*
Histrionski poremećaj ličnosti / *Histrionic personality disorder*
Liječenje / *Treatment*

TO LINK TO THIS ARTICLE:

UVOD

Somatizacija je psihološki mehanizam u kojem se psihički problemi i emocionalni konflikti izražavaju tjelesnim simptomima i manifestira se cijelim nizom polimorfnih tegoba za koje se ne nalazi organska podloga. Somatizacija je tendencija osobe da komunicira psihološki distres somatskim simptomima i traži za njih medicinsku pomoć, pa se somatoformni poremećaji tipično prvo vide u nepsihijatrijskom okruženju (liječnici opće medicine i razni specijalisti tjelesne medicine) (1). Konverzivni poremećaj je specifični oblik somatizacije u kojem su prisutni funkcionalni neurološki simptomi i ako se manifestiraju kao dio multisustavnog somatoformnog sindroma primarna dijagnoza je somatizacijski poremećaj (2).

Povijest somatizacija povezana je s povijesti histerije za koju se smatralo da ekskluzivno zahvaća žene, a njezino poimanje se je počelo mijenjati nakon 1950. godine (3).

Somatoformni poremećaji bili su klasificirani u DSM-IV klasifikaciji (4), kao i u MKB-10 klasifikaciji (5), a u DSM-5 klasifikaciji ova skupina poremećaja je postala poremećaj sa somatskim simptomima (6), dok se poremećaji s organski neobjašnjenim simptomima dijagnosticiraju kao konverzivni poremećaj (poremećaj s funkcionalnim neurološkim simptomima) i više nema somatizacijskog poremećaja. U MKB-10

INTRODUCTION

Somatization is a psychological mechanism of expressing somatic distress and symptoms and attributing them to a wide spectrum of polymorphic health conditions that lack an organic basis. Furthermore, somatization is a tendency of a person to experience and communicate somatic distress and to seek medical assistance to alleviate it. Consequently, somatoform disorders are usually first observed at non-psychiatric medical facilities (by general practitioners and various medical professionals specialized in physical illnesses) (1). Conversion disorder is a specific form of somatization commonly characterized by functional neurological symptoms. If symptoms manifest as a part of the multisystem somatoform syndrome, somatization disorder is the primary diagnosis (2).

The history of somatization is related to the history of hysteria, which was considered to be a female disease exclusively until the 1950s (3).

The Diagnostic and Statistical Manual of Mental Disorders – IV (DSM-IV) classification (4), as well as the International Statistical Classification of Diseases and Related Health Problems – 10 (ICD-10) (5), included somatoform disorder. However, the Diagnostic and Statistical Manual of Mental Disorders – V (DSM-V) classification classifies somatoform disorder as a disorder characterized by somatic symptoms (6). Furthermore, this classification classifies disorders with symptoms lacking an organic basis as a conversion disorder (a disorder characterized by functional neurological symptoms) and omits somatization disorder. The

klasifikaciji konverzivni poremećaj je svrstan u skupinu disocijativnih poremećaja.

Konverzivni poremećaj ima obično iznenadni početak, kratkog je trajanja za razliku od somatoformnih poremećaja koji imaju kroničan tijek. Glavno obilježje konverzivnog poremećaja je prisutnost simptoma ili deficita voljne, motoričke ili osjetilne funkcije koji upućuju na neku neurološku bolest ili neki drugi poremećaj (pareze, paralize, kontrakture, hiperkinezije u obliku tremora glave, ekstremiteta i cijeloga tijela, različiti tikovi kao i poremećaji govora kao mucanje, afazija i mutizam). Uzrokovan je psihološkim čimbenicima jer je zamijećeno da pojavi ili pogoršanju simptoma ili deficita prethodi konflikt ili drugi stresor. Somatizacijski poremećaj je jaki psihijatrijski poremećaj koji se odlikuje mnogim recidivirajućim značajnim tjelesnim tegobama, a simptomi mogu uključivati jedan ili više tjelesnih sustava ili funkcija, kao što su kardiopulmonalni, gastrointestinalni, genitourinarni, muskuloskeletalni, neurološki simptomi uz umor i bol (7).

Kod somatizacijskog poremećaja prisutan je komorbiditet s drugim psihijatrijskim poremećajima, osobito s poremećajima raspoloženja, anksioznim poremećajima, poremećajima ličnosti (najčešće histrionski poremećaj ličnosti i opsesivno-kompulzivni poremećaj ličnosti) (8).

Etiologija somatizacijskog poremećaja je vrlo raznolika jer postoje i različite kliničke manifestacije što i ukazuje na multifaktorsku etiologiju. Predisponirajući čimbenici mogu biti: genetski, psihodinamski, neuropsihološko-neurofiziološko-psihofiziološki, crte ličnosti (neuroticizam, aleksitimija, negativni afektivitet, introspektivnost, itd.), razvojno učenje i sociokulturni (9). Dominantni etiološki čimbenici mogu kod jednog pacijenta biti predominirajući, a kod drugog minorni.

U psihodinamskim teorijama klasično psihoanalitičko razumijevanje konverzivnog poremećaja

ICD-10 classification placed the conversion disorder in the group of dissociative disorders.

Commonly, conversion disorder has a sudden onset and is of a shorter duration, while so-called somatoform disorders are chronic in nature. The main characteristic of conversion disorder is a presence of symptoms or a lack of voluntary motor or sensory control, usually indicative of a neurological illness or disorder (e.g. paralysis, contracture, hyperkinesis including various forms of tremor affecting the head, extremities and the whole body, various forms of tics, as well as speech disorders, namely stuttering, aphasia and mutism). Psychological factors are identified as underlying factors since it has been observed that a conflict or other psychological stressor usually precedes the onset or the deterioration of symptoms. Somatization disorder is a serious psychiatric condition characterized by numerous significant recurring physical symptoms affecting any part or system of the body or several organ systems or functions. The symptoms can be cardiopulmonary, gastrointestinal, genitourinary, musculoskeletal or neurological and are usually accompanied by fatigue and pain (7).

Somatization disorder is often comorbid with other psychiatric disorders, especially mood disorders, anxiety disorders, or personality disorders (most commonly histrionic and obsessive-compulsive personality disorders) (8).

The etiology of the somatization disorder accounts for a wide diversity and broad spectrum of clinical manifestations suggesting its multifactorial etiology. Predisposing factors include genetic, psychodynamic, neuropsychological-neurophysiological-psychophysiological, and personality traits (e.g. neuroticism, alexithymia, negative affectivity, introspection, etc.), developmental-learning and sociocultural factors (9). While dominant etiological factors can be prevalent in one patient, they can be minor in another patient.

In the psychodynamic approach, traditional psychoanalysis explains the conversion disorder as a symbolic representation of subconscious conflicts (violent and sexual in nature). In the contemporary Western world, somatic symptoms explained

mećaja je simbolička reprezentacija nesvjesnih konflikata (agresivnih ili seksualnih). U suvremenom zapadnom svijetu somatski simptomi koji su jednostavna simbolička reprezentacija intrapsihičkih konflikata su iznimno rijetki te se danas mnogi nesvjesni konflikti iz prošlosti smatraju posttraumatskim (10). Somatizacija se prema psihodinamskim objašnjenjima gleda kao oblik simboličke komunikacije, obrambeni mehanizam i razrješenje konflikta. To je proces putem kojega tijelo prevodi mentalni stres u fizičku ekspresiju koja ima simboličku vrijednost. Proces somatizacije također predstavlja primitivni obrambeni mehanizam, poput poricanja i represije, protiv nepoželjnih želja i nakana. Kao sredstvo razrješenja konflikta, osoba koja somatizira baca krivnju na svoje tijelo zbog „grešaka" ili se fokusira na simptome da izbjegne nepodnošljivu situaciju. Teorije koje su povezane s razvojnim učenjem govore o tome kako dijete rano nauči da biti bolestan ili žaliti se na simptome može biti nagrađeno pažnjom i simpatijom, ili opet da takvo ponašanje dovodi do izbjegavanja konflikta i odgovornosti, tako da se somatizacija razvije kao stil sučeljavanja. Istraživanja su pokazala da djeca koja su izložena tjelesnim bolestima i bolnom ponašanju kod članova obitelji imaju povećani rizik za razvoj somatizacije (10,11). Precipitirajući čimbenici uključuju životne događaje i situacije (teški gubitci, tjelesne bolesti ili ozljede, prekidi odnosa, itd.) (11).

Tretman osoba koje spadaju u skupinu tzv. somatoformnih poremećaja je kompleksan, vrlo dug i zahtjevan te je potrebna cijela lepeza psihijatrijskih vještina, često bez pozitivnih rezultata.

Cilj prikaza je pokazati kako je traumatska i konfliktna situacija na poslu, doživljena kao narcistička povreda, dovela do razvoja dramatične kliničke slike u obliku somatizacija kod pacijentice s histrionskim poremećajem ličnosti.

as a simple symbolic representation of intrapsychic conflicts are extremely rare. Similarly, many subconscious conflicts from the past are observed as posttraumatic (10). Psychodynamic explanations of somatization assume that somatization is a mode of symbolic communication, defence mechanism and conflict management. It is a way the body transforms mental stress into a physical manifestation with a symbolic value. Furthermore, somatization is a primitive defence mechanism against unwanted desires and intentions, similar to denial and repression. As a means of resolving conflicts, a somatising person experiences their body as a "defect or mistake" or focuses on physical symptoms in order to avoid an unbearably stressful situation. Theories relating to developmental learning observe that children may learn that illness or symptoms are likely to be rewarded by attention and sympathy or, similarly, that this can be a mechanism of avoiding conflicts and responsibilities. Consequently, somatization becomes a style of conflict management and attention seeking. Studies suggest that children exposed to physical illness and pain behaviour of other family members are at higher risk of developing somatization (10,11). Precipitating factors include life events and situations (e.g. painful losses, physical illness and injuries, separations, relationship breakups, etc.) (11).

The treatment of persons suffering from so-called somatoform disorders is complex, time-consuming and arduous and demands a broad spectrum of psychiatric skills. However, it rarely yields positive results.

The objective of the case study: To demonstrate that a conflicting situation at work, experienced as a narcissistic injury, can trigger a dramatic clinical picture in the form of somatization in a female patient with a histrionic personality disorder.

CASE STUDY

A patient in her 50s is admitted to a psychiatric ward due to extremely severe anxiety and psychomotor agitation following a number of medical examinations and diagnostic screenings that failed to detect any physical disorder or illness.

PRIKAZ BOLESNICE

Bolesnica u dobi od 50 godina primljena je na odjel zbog visokog stupnja anksioznosti te izrazitog psihomotornog nemira nakon opsežnih i opetovanih tjelesnih pregleda i pretraga kojima nije nađen tjelesni poremećaj ili bolest. Kod prijama zapomaže, hvata se za glavu, sjeda na pod tijekom intervjua te na dramatičan i teatralan način iznosi niz somatizacija koje hipertrofira i na koje je fiksirana. Žali se da je "boli i peče mozak", posebno oko lijevog uha, navodi "užasnu" fotofobiju, strašno joj se povraća, ima neizdrživu bol i kočenje u vratu koji se spuštaju niz kralješnicu i ne spava tjednima.

Intervju je vođen tijekom nekoliko dana nakon što je sedirana anksioliticima. Pacijentica je rastavljena, majka odraslog sina s kojim živi, radi u struci kao upravna pravnica, paralelno studira politologiju na kojoj je apsolventica. Svoju primarnu obitelj opisuje korektnom, no odnosi su oduvijek bili "hladni", otac je počinio suicid. Za sebe kaže da je oduvijek bila perfekcionist. Navodi da su se bolovi prvi puta počeli javljati nakon "akustičke traume" na radnom mjestu kada joj je nadređeni svom snagom zalupio slušalicu nakon verbalnog konflikta putem telefona. Do tada je imala „odličan" odnos s nadređenim, opisuje ga „idealnim", smatrala je da ju cijeni i poštuje i ona se je trudila biti što bolja na svom poslu, a tome je i težila u svom životu. Nije mogla ni pomisliti da bi nadređeni reagirao na taj način. Nadređeni joj je izgovorio da nije sposobna razumjeti ni najjednostavniji ugovor, koji je sačinila prema njegovim uputama. Ona se uvijek trudila sve napraviti što je više moguće dobro, jer smatra da jedino tako dobro funkcionira. Kada mu je pokušala reći da je ugovor napravila kako je on tražio, nadređeni je počeo na nju vikati, „doslovno urlati i svom snagom je zalupio telefonsku slušalicu". Napravila je jaki trzaj glavom, tresak slušalice joj je "odjeknuo kao eksplozija u glavi" te je osjetila jaku bol u lijevom uhu, nestabilnost i

Prior to admittance, she calls for help, grabs her head, sits on the floor during the interview and reports a number of somatizations on which she is fixated, and she exaggerates dramatically and theatrically. She complains about "a burning and aching sensation in her brain", especially in the area of the left ear, she talks about an "unbearable" photophobia, she feels nauseous, feels like vomiting, describes an excruciating pain and stiffness in the neck area radiating down the spine and also talks about sleeping problems that have bothered her for weeks.

The medical interview takes place over the course of several days following sedation with anxiolytic drugs. The patient is a divorced mother of a grown-up son with whom she shares her household. She works as a paralegal and simultaneously she is a graduate student at the Faculty of Political Sciences. She describes the family she grew up in as fairly normal, but "reserved and emotionally cold." Her father committed suicide. She says that she has always been a perfectionist. She states that the first time she felt pain was after the "acoustic trauma" she experienced at work when her boss abruptly hung up the phone following a verbal conflict over the phone. She claims that until then she had an "excellent" relationship with her boss. She describes him as the "ideal boss." She sincerely believed that he had felt nothing but respect for her and she was doing her best to provide excellent performance at work. Similarly, she has been a perfectionist in other aspects of her life. It never occurred to her that her boss could react in such a way. He told her that she could not understand even the simplest contracts, e.g. the one she drafted following his instructions. She was devoted to excellence at work since she was convinced that this was the only way for her to function. However, when she tried to explain that she had strictly followed his instructions, he started shouting at her, "literally, he shouted his head off and then hung up the phone." At that moment she moved her head in an awkward way, and the echo of the slammed phone reverberated in her head "like a detonation." Immediately, she felt severe pain in her left ear, as well as unsteadiness. She staggered while walking. The pain in her ear intensified with time and on several occasions, over the course of 2 years following the traumatic

zanošenje u hodu. S vremenom se intenzitet bolova u uhu pojačavao te je višekratno obrađivana od neurologa, otorinolaringologa, oftalmologa (obilna medicinska dokumentacija) u razdoblju od dvije godine. Često je posjećivala hitne medicinske prijame. Nakon niza pregleda otorinolaringolog je utvrdio "akustičku traumu" te je započeto liječenje klonazepamom. Međutim, unatoč terapiji tegobe su se intenzivirale i proširile na bolove u želucu, kralješnici, itd. Socijalno i radno funkcioniranje pacijentice bilo je izrazito oštećeno i bila je na višemjesečnom bolovanju.

Na početku liječenja nije uopće bila suradljiva i zbog izrazite anksioznosti liječenje je započeto anksioliticima i antidepresivom uz suportivni pristup. Ne prihvaća emocionalnu i psihološku etiologiju svojih smetnji. Zabrinuta je za tjelesno zdravlje te inzistira na nizu tjelesnih pretraga. Fiksirana je na pažnju vlastite sestre, zahtijeva njezin dolazak navodeći minorne razloge.

Smatra da nema mentalnih tegoba te da su uzrok sniženom raspoloženju i nesanici jedino bolovi. Ne priznaje događaj na poslu kao glavni uzrok svojih tegoba, a neprihvatljive osjećaje "premješta" na razne dijelove tijela za što nalazi niz racionalnih objašnjenja. Psihijatrijsko liječenje doživljava kao osobni poraz.

Odrastala je u obitelji koja je bila emocionalno hladna, osobito majka koja je bila distancirana, često joj je prigovarala ako ne bi postizala uspjehe u školi ili općenito u nekim drugim aktivnostima. Znala ju je i fizički kažnjavati uz verbalna omalovažavanja. Starija sestra je bila favorizirana jer je bila bolja učenica od nje i činilo se da joj sve polazi za rukom. Često ju je majka uspoređivala sa sestrom, koja je bila usmjerena na postizanje uspjeha. Čini joj se da je s ocem imala bolji odnos, on je bio seduktivan, nju je favorizirao i čini joj se da je to dodatno frustriralo majku. Majka je bila hladna i prema ocu, a on je bio usmjeren na svoju karijeru. Nakon što je doživio otkaz na poslu nakon

experience, a neurologist, an otorhinolaryngologist and an ophthalmologist (she provides well-documented medical records) examined her. She sought urgent medical assistance at emergency facilities on many occasions. After a number of medical examinations, the otorhinolaryngologist diagnosed her with an "acoustic trauma" and prescribed her clonazepam. However, despite therapy, her condition deteriorated and now she had symptoms in the stomach, the spine, etc. Her performance of social and occupational roles was seriously compromised, and she had been prescribed a several-month sickness leave.

The patient's lack of cooperativeness marks the beginning of the treatment. Furthermore, due to heightened anxiety, the treatment includes anxiolytics and antidepressants along with a supportive approach. She refuses to accept the emotional and psychological etiology of her condition. She is worried about her physical health and she demands a thorough physical check-up. She seeks her sister's attention intensely and keeps finding trivial reasons to ask her to visit her.

Moreover, she denies any possibility of psychological distress or emotional disturbance claiming that the physical pain she feels is the sole cause of her low mood and insomnia. She does not recognize her experience at work as the main trigger of all her problems. In addition, she unconsciously "converts" unacceptable feelings she feels into physical sensations in various parts of her body and offers a number of rational explanations for them. She experiences the psychiatric treatment to which she is subjected as a personal failure.

She was brought up in an emotionally cold family. Her mother was especially emotionally detached. On top of that, she criticised her when her school performance was not up to the expectations or generally when she was not successful in other activities. Sometimes she even punished her physically. She also had a habit of belittling her verbally. Her older sister was her mother's favourite because she was a better student and generally seemed more of an achiever in a number of ways. Her mother habitually compared her to her sister, a success-oriented person. She feels she had a better relationship with her seductive father and that

uspješne karijere, u njezinoj dobi od 7 godina je počinio samoubojstvo. To ju je izuzetno pogodilo i nakon toga smatra da više nije mogla vjerovati muškarcima. Obitelj je imala oskudnu komunikaciju izvan vlastitog obiteljskog sustava, držali su se kao da vrijede više od ostalih. To je majka često znala isticati, a nakon očeve smrti komunikacija se još više prorijedila. Nije ostvarivala emocionalne veze sa suprotnim spolom zbog toga što smatra da im se ne može vjerovati. Udala se na drugoj godini fakulteta, nakon što je ostala trudna s kolegom s godine. Veza je započela na jednom tulumu i završila njenom trudnoćom, koju je teško prihvatila, kao i brak, koji je trajao svega nekoliko mjeseci. Prekinula je studij politologije, htjela je biti novinarka. Prebacila se na studij upravnog prava, koji je uspješno završila i zaposlila se. Studij politologije je nastavila nakon što je sin odrastao.

Otvoreno izražava hostilnost prema muškarcima, govori da su oni osobe kojima se ne može vjerovati, ali unatoč toga ostvaruje odnos na odjelu s jednim pacijentom. Sa sinom ima izrazito hladan odnos. Tijekom hospitalizacije on ju ne posjećuje dok ona istovremeno traži maksimalni angažman od sestre.

Postavljene su dijagnoze somatizacijskog poremećaja komorbidnog s histroničkim poremećajem ličnosti.

Terapijski ciljevi su bili ograničeni i usmjereni na razvoj mogućnosti introspekcije, stjecanje uvida o utjecaju histrionskog ponašanja na okolinu, učenje toleriranja negativnih emocija, postavljanje jasnih granica u odnosima i redukciju ovisničkog ponašanja. Psihoterapijsko liječenje bilo je moguće započeti tek nakon redukcije početne anksioznosti, histrionskog načina reagiranja i somatizacija. Bolesnica postupno i samo djelomično stječe uvid u psihološku etiologiju svojih smetnji u smislu psihološke nadgradnje. Prihvaća konfliktnu situaciju sa šefom kao jedan od mogućih uzroka za nastanak njezinih tegoba. Nakon otpusta nije došla na do-

she was his favourite. She also feels that this was an additional source of her mother's frustrations. Her mother's relationship with her father, a career-oriented man, was also emotionally cold and detached. Despite her father's successful career, his work contract was terminated abruptly, and he committed suicide when she was seven. This was a devastating experience for her that made her lose trust in men. From then on, she believed she could not trust them. Since a sense of superiority had prevailed in her family, they had not nurtured many relationships outside their family. Her mother had a tendency to emphasize this illusory superiority and after her father's death, communication outside the family became even rarer. She did not engage in emotional relationships with the opposite sex because she firmly believed that men could not be trusted. She married when she was a sophomore, after becoming pregnant by a fellow student. Their relationship started at a party and ended with her pregnancy. She struggled to come to terms with her pregnancy, as well as her short marriage that ended after several months. She dropped out of the Faculty of Political Sciences. She wanted to become a journalist. She enrolled in the Public Administration College from which she graduated successfully and found a job immediately after. When her son grew up, she returned to the University and finished her studies.

She does not hesitate to show her hostility towards men openly, to say they cannot be trusted. However, she starts a relationship with a patient in the same ward. Her relationship with her son is emotionally cold. He does not come to the hospital to visit her. At the same time, while at the hospital, she demands a maximum involvement from her sister in her treatment.

She is diagnosed with a somatization disorder comorbid with a histrionic personality disorder.

The treatment goals are limited to and focused on the development of her introspection potential, as well as on raising awareness about the histrionic behaviour's impact on the environment. In addition, the goal is to learn skills to tolerate negative emotions, to learn to create healthy boundaries in relationships and to reduce addictive behaviours. The psychiatric treatment starts after reducing the

govorenu kontrolu, tek je naknadno došla na jedan (ujedno i posljednji) kontrolni pregled.

RASPRAVA

Unatoč histrionskoj strukturi ličnosti, koja se na razvojnom kontinuumu kod pacijentice nalazila u području granične organizacije ličnosti, funkcionirala je na relativno zdravoj razini sve do doživljene narcističke povrede, nakon koje je razvila somatizacije i disfunkcionalnost (10). Histrionska obilježja njezine ličnosti su se očitavala u sklonosti teatralnosti, dramatizaciji, preuveličanom izražavanju osjećaja, površnoj i labilnoj afektivnosti, traženju pažnje, neadekvatnoj zavodljivosti, egocentričnosti, priželjkivanju priznanja, lakoj povredljivosti i samougađanju uz manipulativno ponašanje prema okolini.

Osobe s histrionskom organizacijom ličnosti imaju teškoće u self-percepciji sebe i drugih (doživljavanje sebe i drugih na stabilan, integriran, kompleksan i ispravan način), interpersonalnim odnosima (uspostavljanju stabilnih emocionalnih veza i odnosa), afektivnoj regulaciji, testiranju realiteta te imaju krhku ego i superego integraciju uz korištenje nezrelih obrambenih mehanizama osobito u stresnim situacijama (12). Takve osobe su preokupirane temama spola, seksualnosti i moći te nesvjesno na sebe gledaju kao na slabe, manjkave, obezvrijeđene, a osobama suprotnog spola zavide i vide ih kao moćne i prijeteće (13).

Dosta je istraživanja posvećeno histrionskom poremećaju ličnosti u kojem su obrasci ponašanja relativno dobro poznati i definirani. Etiologija samog poremećaja ostaje do kraja nerazjašnjena, a terapijske mogućnosti su ograničene (14).

Postoji nekoliko teorija o razvoju histrionskih crta ličnosti: neurokemijske (hiperaktivnost autonomnog živčanog sustava kao uzrok afektivne nestabilnosti), biosocijalne (naučeno

level of anxiety, histrionic behaviour responses and somatizations. The patient gradually and only partially gains insight into the psychological etiology of her condition where the constitution of the psychological superstructure is concerned. She recognizes the conflict with her boss as a possible underlying cause of her condition. After being discharged from the hospital, she does not show up for her scheduled follow-up. Subsequently, she shows up for a control visit that was also her last visit.

DISCUSSION

Notwithstanding the histrionic personality structure that was in the category of borderline personality organization along the developmental continuum, the patient functioned relatively well until the conflict with her boss, which she experienced as a narcissistic injury. Only then did she start somatising and her performance of expected occupational and social roles was compromised (10). The traits of her histrionic personality were visible in her tendency to be theatrical, to dramatize, to overplay emotions, to display shallow and labile affect, to seek attention, to act seductively in inappropriate situations, to be self-centred, and to seek gratification, as well as in her vulnerability, her self-indulgence and her inclination to be manipulative.

Persons with a histrionic personality organization frequently struggle with the accuracy of their self-perception and their perception of other people (namely, their perception of themselves and other people in a stable, integrated, complex, and accurate way), with interpersonal relationships (keeping stable emotional relationships) and also with affect regulation and reality testing. Furthermore, the integration of their egos and superegos is fragile and they are inclined to use immature defence mechanisms, especially in stressful situations (12). Such persons are preoccupied with topics of gender, sexuality and power and unconsciously perceive themselves as weak, defective, worthless. At the same time, they envy persons of the opposite sex and perceive them as powerful and dangerous (13).

Although a number of studies identify and elaborate on behavioural patterns of histrionic per-

ponašanje – ispunjenje želja manipulativnim ponašanjem), sociokulturne (češće kod naroda koji teže izravnom iskazivanju emocija) i psihodinamsko-razvojne teorije (14). Prema psihodinamskim objašnjenjima glavni etiološki čimbenici su: "odsutnost majke" - hladnoća i osuda u odnosu, zavodljiva očinska figura, visoka razina stresa tijekom odrastanja, nepovoljna seksualna klima – izrazito stimulirajuća ili pak ozračje koje uči potiskivati seksualnost, izmjena uloga – poticaj da dijete preuzme roditeljsku ulogu i socijalna izolacija – traženje gratifikacija unutar obitelji (15,16). Osobe sa značajnim histrionskim crtama često imaju prisutan strah od iskazivanja pravih emocija od kojih se brane nezrelim obrambenim mehanizmima: potiskivanjem, poricanjem, disocijacijom, premještanjem i racionalizacijom (17). S psihodinamskog aspekta kod pacijentice nalazimo opisane karakteristike u njezinoj razvojnoj anamnezi koje se odnose na obilježja histrionskog poremećaja ličnosti. Svoje istinske osjećaje je potiskivala, imala je nesvjesnu želju za dobrom majkom, koja bi se konfrontirala s očevom seduktivnošću. Kod takvih osoba, kao i pod pacijentice, prema Johnsonu (15) na libidinoznoj strani često postoji nesvjesno rivalstvo, strah od osvete, žudnja za novim ocem, novim muškarcem koji će preuzeti brigu o njoj i spasiti je. Na anti-libidinoznoj strani otac je često doživljen kao zavodnik i oskvrnitelj, razvratan i pokvaren. Postoji ogromna nesvjesna hostilnost prema muškarcima zbog osjećaja eksploatiranosti. Ovaj osjećaj hostilnosti i mržnje je u osnovi zdrav i proizlazi iz libidinoznog selfa, dok je na anti-libidinoznoj strani selfa doživljen kao tajni odnos što rezultira u histeričnim osjećajima da je učinjeno nešto loše, odnosno osoba se doživljava zavodnicom. Iako, bolesnica govori o muškarcima kao osobama kojima se ne može vjerovati, prema kojima izražava verbalnu agresiju, traži gratifikaciju u odnosima s muškarcima o kojima razvija neku vrstu ovisničkog odnosa. Njezini odnosi su površni jer kontakt nije siguran. Odnos sa šefom je bio

sonality disorder, the etiology of the disorder still remains unexplained, and therapeutic approaches limited (14).

There are several theories relating to the development of the histrionic personality traits: the neurochemical theory (the hyperactivity of the autonomous nervous system as a cause of affective instability), the biosocial theory (learned behaviour – manipulation as a model of getting what they want), the sociocultural theory (more common among cultures that value uninhibited display of emotions) and the psychodynamic developmental theory (14). According to the psychodynamic explanation, the main etiological factors are: the "absent mother" – emotionally cold and judgemental mother; a seductive father figure; a high level of perceived stress in formative years; an unsupportive sexual climate in the family of origin (especially stimulating or, in contrast, an environment teaching a repressive approach towards sexuality); encouragement of a child to take on a parenting role; and social isolation – seeking gratification within the family (15,16). Persons with strongly pronounced histrionic personality traits are commonly reluctant to express their true emotions and are inclined to use immature defence mechanisms (namely repression, denial, dissociation, displacement and rationalization) to block them (17). From the psychodynamic point of view, the above-mentioned traits of the histrionic personality were identified in the developmental history of the patient, notably her tendency to repress her true feelings, her subconscious yearning for a "good" mother that would stand in the way of her father's seductiveness. According to Johnson (15), unconscious rivalry, fear of revenge, yearning for a new father, a new man that will take on responsibility for her and save her are common traits on the libidinal side of persons with histrionic personality disorder and this was also true for the patient. On the antilibidinal side, such persons/patients often experience their fathers as seducers and sacrilegists, as well as corrupt and perverse persons. Additionally, since these patients feel they have been victims of abuse, there is an unconscious heightened sense of hostility in them directed towards men. In its core, this feeling of hostility and hatred is healthy. It

infantilan i po ovisničkom modelu s transfernom relacijom idealizirane očinske figure. Njezin seksualni život je konfliktuozan, a odnos s muškarcima je manipulativan.

Narcistička povreda događa se kada osoba s narcističkim obilježjima doživi da je njezin „pravi self“ otkriven, što je prijetnja samopoštovanju i vrijednosti osobe s narcističkom strukturom (18-20). Traumatsko iskustvo u komunikaciji sa šefom pacijentica je doživjela kao narcističku povredu. Njezina nemogućnost suočavanja s narcističkom povredom selfa, s obzirom na njezinu primarnu strukturu ličnosti karakteriziranu histrionskim poremećajem, dovela je do somatizacija kao načina rješavanja problema.

Osobe koje imaju izražena narcistička obilježja u svojoj strukturi ličnosti, pokušavaju održati idealiziranu sliku o sebi kao nepobjedivoj osobi i perfekcionistu te takvu sliku nastoje projicirati prema drugim osobama. Njezina se idealna slika o sebi „raspala“ nakon reakcije nadređenoga što je dovelo do gubitka sigurnosti, jer je izgubila kohezivnost slike o sebi, koja se temeljila na njezinom krhkom samopoštovanju i osjećaju nesigurnosti, od kojega se branila potrebom za divljenjem i nedostatkom empatije za druge zbog infantilnog osjećaja vlastite važnosti. Njezin odnos s majkom je bio traumatičan (hladna, emocionalno odsutna i kritizirajuća majka, koja ju je fizički kažnjavala i verbalno omalovažavala), dok ju je otac kojega je doživljavala bliskim zbog njegove seduktivnosti, i kojem se divila razočarao počinivši samoubojstvo. Narcističke obrane (svjesno poricanje, projekcija, nesvjesna represija, distorzija) koje uključuju preuveličavanje ili umanjivanje, racionalizaciju, ovisničko ponašanje i traženje pomoći od osoba koje će podržati njihov iskrivljeni pogled na svijet, rascjep (engl. *splitting*), gdje se ljudi i situacije vide kao dobri ili loši, odnosno u crno bijelim pojmovima) razvijaju se kako bi se sačuvali idealizirani aspekti selfa i porekla ograničenja koja u poza-

arises from the libidinal-self. However, at the same time, the antilibidinal-self feels that it is engaged in a "forbidden" relationship. This triggers hysterical feelings, feelings driven by a sense that something unacceptable has been done. In other words, this person experiences him/herself as a seducer. While the patient talks about men as persons that are not to be trusted and displays aggression verbally, she seeks gratification in her relationships with men and even develops a form of addictive behaviour. Her relationships with men are superficial because she feels vulnerable. Her relationship with her boss was infantile. She created paternal transference by turning her superior into an idealized father-figure. Her sexual life was marked by conflict and her approach to men manipulative.

A narcissistic injury happens when a narcissistic person feels that their "true self" has been disclosed. Such a disclosure represents a direct threat that has the potential to undermine narcissistic self-respect and self-worth (18-20). The patient experienced the traumatic telephone conversation with her superior as a narcissistic injury. Since the histrionic personality behaviour was a trait of the patient's primary personality structure, her inability to accept and resolve the narcissistic injury triggered somatization as a mode of managing the problem.

Persons with pronounced narcissistic characteristics in their personality organization struggle to preserve their idealized indestructible and perfect self-representations and they have a tendency to project them onto other people. Her ideal self-representation became fragmented when her superior reacted in such an abrupt way that she lost cohesiveness of her self-representation, which was built on low self-esteem and fragile sense of security from which she defended herself by seeking attention and admiration and by failing to show compassion because of a prevalent infantile sense of self-importance. Her relationship with her mother was traumatic (her mother was emotionally cold and detached, overly critical and did not refrain from punishing her physically and abusing her verbally) while her seductive father, with whom she was close, betrayed her when he committed suicide. Narcissistic defence mechanisms

dini imaju često svjesne ili nesvjesne osjećaje srama i krivnje (18,21).

Konflikt sa šefom je bio dodatno traumatizirajuće iskustvo za nju s obzirom da ga je idealizirala, kao i oca. Njezina vrijednost reakcijom šefa je bila dovedena u pitanje, osjetila se bezvrijednom, s obzirom na njeno krhko samopoštovanje, koje je ranjivo i na najmanju dozu kriticizma. Njezina se fragilna idealizirana slika o sebi kao perfektnoj osobi fragmentirala, odnosno raspala u komadiće i od emocionalne boli izazvane narcističkom povredom se obranila somatizacijama (9-11) koje su dovele do somatizacijskog poremećaja. Prema psihodinamskim objašnjenjima tjelesni simptomi su odraz mentalnog stresa i imaju simboličku vrijednost. Kod pacijentice od tjelesnih simptoma najizraženija je bila „akustička trauma" (oglušila je nakon šefova omalovažavanja čime na simboličan način više ne čuje ono što ne može prihvatiti). Somatizacijama se je obranila od neprihvatljivih self-objektnih reprezentacija i ujedno „razriješila" nesvjesni konflikt povezan s rascjepom na dobre i loše self-objektne reprezentacije (18). Dodatno je mogući izvor njezine velike anksioznosti prigodom prijama bilo okretanje agresije prema sebi u obliku autodestrukcije zbog identifikacije s ocem koji je doživio profesionalni neuspjeh nakon kojega je počinio samoubojstvo. Njezina velika narcistička investicija bila je u profesionalni self, i u tom segmentu svojega identiteta je najbolje funkcionirala, koji je destruiran reakcijom šefa i njezinim mogućim doživljajem da ne valja ni u ovome segmentu svojega identiteta u kojega se najviše investirala.

Somatski simptomi su psihološka obrana protiv mentalne nestabilnosti i kao drugi mehanizmi obrane, somatizacija smanjuje intrapsihički distres (22). Ovo se još naziva i primarna dobit (2) koja služi da održi psihološki ekvilibrij, ali se pri tome iskrivljuje i narušava realnost. Pažnja se usmjerava na simptome koji se prezentiraju i stvarni problem, odnosno izvor mental-

(e.g. conscious denial, projections, unconscious repression, distortion), including exaggeration or undermining, rationalization, addictive behaviour and an inclination to seek help from people that will, most likely, support her distorted views, splitting (polarization of people and situations into good-bad, black-white) develop as a defence system to protect idealized aspects of self and to deny limitations often related to conscious or unconscious feelings of shame and guilt (18,21).

The conflict with her superior was especially traumatizing since she idealized him in the same way she idealized her father. Not only did her boss' reaction jeopardize her sense of self-worth, but since her fragile, vulnerable, and sensitive self-esteem was as insubstantial as a house of cards, she now felt worthless. Her fragile idealized self-representation, an image of a perfect person, became fragmented, it broke into pieces, and somatizations became the first line of defence against emotional distress inflicted by the narcissistic injury (9-11). Consequently, she developed the somatization disorder. According to the psychodynamic explanation, physical symptoms are symbolic manifestations of mental distress. In our case study, the "acoustic trauma" ("hearing loss as a consequence of her boss' reaction" symbolically represents her inability to hear things she cannot accept) was the most prevalent physical symptom. Her somatizations became defence mechanisms against unacceptable self-object representations and also a way for her to "resolve" the subconscious conflict relating to splitting the self-object representations into good and bad (18). In addition, it is possible that her self-destruction (possibly a result of identification with her father whose suicide was a consequence of his inability to accept his professional failure) triggered heightened anxiety at the moment of hospitalization. Her professional-self was her major narcissistic investment and a segment of her identity that functioned the best. However, her boss' reaction may have made her realize that she was "no good" even in the segment of her identity that was her major narcissistic investment and that she felt most confident about.

Somatic symptoms represent psychological defence mechanisms against mental instability. Sim-

ne nestabilnosti je blokiran i ne bude stvarno doživljen ili je doživljen samo djelomično (21). Pacijentica nije mogla prihvatiti psihološku odnosno emocionalnu podlogu svojih tegoba te je tijekom dvije godine odlazila na brojne tjelesne pretrage. Na aktualnu hospitalizaciju je došla na nagovor sestre nakon brojnih negativnih tjelesnih nalaza.

Jednom kada se simptom ili simptomi pojave mogu se svjesno koristiti da se postignu optimalne interpersonalne koristi i to se naziva sekundarnom dobiti (2). U somatizaciji je osnova psihički poremećaj, koji je prijetnja mentalnoj stabilnosti i prijetnja mentalnom integritetu, i koji dovodi do anksioznosti koja između ostaloga mobilizira somatizaciju kao obrambeni mehanizam (17,23). Ovaj proces je nesvjestan, a somatske obrane dovode do neorganskih tjelesnih (somatskih) simptoma i konvertiraju psihičku, odnosno emocionalnu bol u tjelesnu. Takve osobe „koriste“ svoje somatske simptome u interpersonalnim postignućima da dobe najviše što mogu od svojih smetnji i to predstavlja sekundarnu psihološku dobit (pacijentica je zadobila sestrinu pažnju, koja ju je u protekle dvije godine stalno obilazila i pomagala u organizaciji pretraga, ali i svakodnevnog života). Ovakvi pacijenti se osjećaju i vjeruju da su bolesni i nisu svjesni svojeg bazičnog psihičkog poremećaja ili traumatskog psihološkog iskustva, odnosno motivacije koja pobuđuje simptome. Oni isto tako nisu svjesni da su njihovi simptomi lažni (1) i najčešće reflektiraju pacijentovo shvaćanje koncepta bolesti tako da često puta opisi simptoma budu bizarni i atipični (bolesnicu “boli i peče mozak”, posebno oko lijevog uha, navodi “užasnu” fotofobiju, strašno joj se povraća, ima neizdrživu bol koja se spušta niz kralješnicu, kočenje u vratu, ne spava tjednima, itd.).

Postavljeni terapijski ciljevi kod pacijentice tijekom hospitalizacije su bili vrlo ograničeni zbog visoke razine njezine anksioznosti, koja je bila preplavljujuća.

ilar to other defence mechanisms, somatization reduces intrapsychic distress (22). This phenomenon is also called a primary gain (2) that serves as an agent sustaining the psychological equilibrium. However, this equilibrium comes at a price – a distorted reality. Attention becomes focused on the reported symptoms and, consequently, the actual problem or the source of mental instability and distress is blocked, and the person is unable to experience the stressful event, or they experiences it only partially (21). Since the patient could not accept the psychological (emotional) cause of her physical illness, she subjected herself to a number of medical examinations over the course of 2 years. However, medical examinations and screenings failed to establish a connection between her symptoms and an organ impairment, so her sister insisted on psychiatric help and her insistence made the patient agree to be hospitalized.

The moment a symptom or symptoms appear, they can be consciously used for optimal interpersonal gain, also known as a secondary gain (2). Intrapsychic distress is the root cause of somatization. It is a psychological condition that represents a threat to the mental stability and integrity of a person. It triggers anxiety that, among other things, unconsciously mobilizes somatization as a defence mechanism (17,23). Furthermore, somatic defence mechanisms trigger physical (somatic) symptoms and convert psychological (emotional) pain into physical illness. People diagnosed with somatization disorder have a tendency to “use” their somatic symptoms for their interpersonal gain in order to attain as much as possible from their physical illness. This represents a secondary gain (the patient attracted her sister’s attention; over the course of 2 years her sister visited her regularly, helped her organize medical examinations and also assisted her in her everyday life). Such patients do not feel physically well, and they honestly believe they are sick. Simultaneously, they are not aware of their primary psychological condition, the traumatic psychological experience or, in other words, they are not aware of the underlying psychological motivators of the physical symptoms. Similarly, they are not aware that their symptoms are false (1) and that they, most commonly, reflect the patient’s understanding of the concept of illness. Consequently, descriptions

Neliječeni pacijenti često postanu ogorčeni, ljuti, nepovjerljivi, "zakazuju" u svakodnevnim aktivnostima. Prigodom liječenja je važno identificirati točan uzrok, tj. okidač (engl *trigger*) koji je doveo do nastanka poremećaja i važno je suočiti pacijenta s psihološkom i emocionalnom etiologijom tegoba. Postoje različite terapijske mogućnosti, iako često s vrlo ograničenim rezultatima. Vrlo često je potrebna psihofarmakološka terapija s obzirom na visoki stupanj anksioznosti, ali i komorbidnih anksioznih i depresivnih poremećaja (pacijentica je dobivala anksiolitik i antidepresiv) (1,8). Što se tiče psihoterapijskog liječenja ono može biti: etiološko s psihodinamskim (17) i integrativno-psihoterapijskim pristupom (24), koji su usmjereni na rješavanje emocionalnih konflikata u podlozi somatizacije ili simptomatsko, najčešće kognitivno-bihevioralni pristup (25), koji je usmjeren na identificiranje negativnih misli, rad na impulzivnom ponašanju, učenje vještina rješavanja problema. Dodatne terapijske mogućnosti su uključene u grupni psihoterapijski rad (26,27).

Teškoće u verbaliziranju emocija, razlikovanju između tjelesnih senzacija i različitih emotivnih stanja, zbunjenost i frustracija kada se pokušava razgovarati o emocionalnom doživljavanju zbog aleksitimičnih karakteristika (28,29) čine komunikaciju s ovim pacijentima otežanom i napornom. Odsustvo simboličkog razmišljanja i siromaštvo fantazija izraženi su do te mjere da kod terapeuta kontratransferno uzrokuju osjećaj praznine i dosade.

S obzirom na česte somatizacije ove osobe nerijetko prolaze niz nepotrebnih medicinskih pretraga uzrokujući frustraciju liječnika i medicinskog osoblja. U većini slučajeva psihoanalitički orijentirana psihoterapija ne dovodi do poboljšanja tako da se kod ovih pacijenata mogu, pored suportivne psihoterapije, kombinirano koristiti različiti terapijski postupci poput kognitivno-bihevioralnih postupaka, metoda primijenjene psihofiziologije (engl.

of symptoms are often bizarre and atypical (e.g. the patient's "brain burns and aches", especially in the area of the left ear, she also describes "unbearable" photophobia, she feels like vomiting, an excruciating pain is spreading down her spine, her neck is stiff, she does not sleep for weeks, etc.).

In the case of the patient, identified therapeutic goals during hospitalization were limited due to prevalent heightened anxiety.

It is common for untreated patients to feel bitter, angry, distrustful and not be capable of running everyday errands. Where treatment is concerned, it is important to identify the accurate cause – the trigger that caused the problem in the first place. Furthermore, it is of greatest importance for patients to be confronted with the psychological and emotional etiology of their problems. A number of therapeutic approaches are available, but the results attained are often limited. Most commonly, therapeutic approaches include psychopharmacological therapy to decrease heightened anxiety, but also to treat comorbid anxiety and depressive disorders (the patient was prescribed anxiolytics and antidepressants) (1,8). Where psychotherapeutic treatment is concerned, there are various approaches: etiological combined with psychodynamic (17) and integrative-psychotherapeutic approach (24), aimed at solving underlying emotional conflicts that trigger somatizations. Another possibility is a symptomatic cognitive-behavioural approach (25) aimed at identifying negative thoughts, modifying impulsive behavioural patterns, learning problem-solving skills. Additionally, a group-work approach is also recommended (26,27).

The alexithymic traits (28,29) of somatising patients, namely difficulty in articulating and identifying feelings and distinguishing between feelings and the bodily sensations, as well as confusion and frustration that arise in conversations focused on their emotional experience make communication with patients difficult and demanding. A lack of symbolic reasoning and restricted imagination are so pronounced that, countertransferentially, the therapist may begin to feel emptiness and boredom.

As a consequence of frequent somatizations, somatising patients commonly subject themselves

biofeedback), autogenog treninga, farmakološkog tretmana, uključujući i modificirane oblike psihodinamske psihoterapije. Grupna terapija može biti dobra alternativa ili dodatak individualnoj psihoterapiji. U tretmanu primarne aleksitimije, ali i osoba s aleksitimičnim karakteristikama, koje se javljaju i kod somatoformnih poremećaja, prisutna je nesposobnost prepoznavanja i izražavanja emocija, stoga se mogu primijeniti razni oblici suportivne psihoterapije dok se za sekundarnu aleksitimiju može koristiti modificirana psihodinamska psihoterapija (28,30).

U zaključku se može reći da je pravovremeno prepoznavanje somatizacija, kao psihološke obrane od emocionalnog distresa, nužno zbog izbjegavanja nepotrebnih dijagnostičkih postupaka i preveniranja socijalne, radne i drugih oblika disfunkcionalnosti takvih osoba, a ujedno i ublažavanja njihovih patnji.

to a number of unnecessary medical examinations. This can trigger frustration in physicians and medical personnel. In most cases, psychoanalytically oriented psychotherapy does not yield positive results. This is why medical professionals combine supportive psychotherapy with various therapeutic approaches, namely, the cognitive-behavioural approach, applied psychophysiology (e.g. *biofeedback*), autogenic training, pharmacologic treatment, and modified forms of psychodynamic therapy. In this particular segment, group therapy represents an acceptable alternative or addition to individual psychotherapy. Since difficulties in identifying and describing feelings often mark the treatment of the primary alexithymia, as well as the treatment of persons with alexithymic personality traits that are also common in the so-called somatoform disorders, it is advisable for medical professionals to use various modes of supportive psychotherapy. Modified psychodynamic psychotherapy (28,30) is recommended for the treatment of secondary alexithymia.

In conclusion we can say that timely identification of somatization as a defence mechanism against intrapsychic distress is necessary to avoid unnecessary diagnostic procedures and to prevent compromised performance of the patient's social and occupational roles and to alleviate their suffering in the process.

LITERATURA / REFERENCES

1. Hurwitz TA. Somatization and conversion disorder. Can J Psychiatry 2004; 49(3): 172-8.
2. Lazare A. Current concepts in psychiatry. Conversion symptoms. New Engl J Med 1981; 305(13): 745-8.
3. Wool AC, Barsky JA. Do women somatize more than men? Gender differences in somatization. Psychosomatics 1994; 35(5): 445-52.
4. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: American Psychiatric Association, 2000.
5. World Health Organization. ICD-10 Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization, 1992.
6. Jukić V, Arbanas G. (ur.) Američka psihijatrijska udruga. Dijagnostički i statistički priručnik za duševne poremećaje - peto izdanje (DSM-V). Jastrebarsko: Naklada Slap, 2014.
7. Servan-Schreiber D, Kolb NR, Tabas G. The somatizing patients: part I. Practical diagnosis. Am Fam Physician. 2000; 61(4): 1073-8.
8. Somatization disorder. U: Encyclopedia of Mental Disorders. Preuzeto 10. svibnja 2018. http://www.minddisorders.com/Py-Z/Somatization-disorder.html
9. Tony I, Duckworth PM, Adams EH. Somatoform and factitious disorders. U: Sutker BP, Adams EH, (ur.) Comprehensive Handbook of Psychopathology. New York: Kluwer Academic/Plenum Publishers, 2001, str. 211-258.
10. Alliance of Psychoanalytic Organizations. Psychodynamic Diagnostic Manual (PDM). Silver Spring, MD: Alliance of Psychoanalytic Organizations, 2006.
11. Lipowski ZJ. Somatization: The concept and its clinical application. Am J Psychiatry 1988; 145(11): 1358-68.

12. Novais F, Araújo A, Godinho P. Historical roots of histrionic personality disorder. Front Psychol 2015; 6: 1463.
13. Horowitz MJ. Hysterical personality style and the histrionic personality. Lanham, Maryland, USA: Jason Aroson Inc, 1991.
14. Kohut H. Thoughts on narcissism and narcissistic rage. Psychoanal St Child 1972; 27: 360-400.
15. Miller JD, Lynam DR, Hyatt CS, Campbell WK. Controversies in Narcissism. Annu Rev Clin Psychol.2017; 13: 291-315.
16. Topić Lukačević S, Bagarić A. Teorijski koncepti narcističkog poremećaja ličnosti. Prikaz narcističkog poremećaja ličnosti u grupnoj analizi. Soc psihijat 2018; 46(3): 285-306.
17. Alper G. Self Defence in a Narcissistic World: The New Everyday Addiction to Power Trips. Lanham, Maryland, USA: University Press of America, 2003, str. 10.
18. Vaillant GE. Theoretical hierarchy of adaptive ego mechanisms: A 30-year follow-up of 30 men selected for psychological health. Arch Gen Psychiatry 1971; 24(2): 107-18.
19. Gabbard GO. Psychodynamic Psychiatry in Clinical Practice, Third Edition. Washington, DC: American Psychiatric Press, 2000.
20. Gregurek R, Ražić Pavičić A, Gregurek R, ml. Anksioznost: psihodinamski i neurobiološki dijalog. Soc psihijat 2017; 45(2): 117-24.
21. Histrionic personality disorder. U: Encyclopedia of Mental Disorders. Preuzeto 10. svibnja 2018. http://www.minddisorders.com/Flu-Inv/Histrionic-personality-disorder.html
22. Johnson SM. Theory of character formation. Johnson S (ur.). Character Styles. New York, NY: WW. Norton & Company Inc, 1994, str. 3-6.
23. Trimble M, Reynolds EH. A brief history of hysteria: From the ancient to the modern. Handb Clin Neurol 2016; 139: 3-10.
24. Evans KR, Gilbert MC. An introduction to integrative psychotherapy London, UK: Palgrave Macmillan, 2005.
25. Allen LA, Woolfolk RL, Escobar JI, Gara MA, Hamer RM. Cognitive-behavioral therapy for somatization disorder: a randomized controlled trial. Arch Intern Med 2006; 166(14): 1512-18.
26. Lidbeck J. Group therapy for somatization disorders in general practice: effectiveness of a short cognitive-behavioural treatment model. Acta Psychiatr Scand 1997; 96(1): 14-24.
27. Tschuschke V, Weber R, Horn E, Kiencke P, Tress W. Psychodynamic short-term outpatient group therapy with patients suffering from somatoform disorders. Z Psychiatr Psychol Psychother 2007; 55: 87-95.
28. Sifneos PE. The Prevalence of 'Alexithymic' Characteristics in Psychosomatic Patients. Psychother Psychosom 1973; 22(2): 255-62.
29. Kušević Z, Marušić K. Povezanost aleksitimije i morbiditeta (The relationship between alexithymia and morbidity). Lijec Vjesn. 2014; 1-2: 44-8.
30. Kozarić-Kovačić D, Frančišković T. Suportivna (podupiruća) psihoterapija. U: Kozarić-Kovačić D, Frančišković T (ur.). Psihoterapijski pravci i tehnike. Zagreb: Medicinska naklada, 2014, str. 411-19.