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Inhalt/Contens

Man as a Multidimensional Being in Health and Illness*

Günter Ammon (Berlin/Munich)

In this paper Ammon points out his conception of multidimensionality of man, concerning the therapeutic consequences and the treatment methods of the Dynamic Psychiatry. He emphasizes that the work with the healthy parts of the patient's personality can overcome the onedimensional diagnostic and therapeutic approach in psychiatry. Essentials of the theoretical conception are the holistic image of man in health and illness, thinking in terms of a group-dynamic and social energetic field and a structural and processual understanding of human development. An integrated spectrum of verbal and nonverbal therapeutic methods within the group dynamic setting of a therapeutic team with heterogeneous personalities and groups, can provide individually for each patient a multidimensional treatment. Thereby, the Dynamic Psychiatric Hospital as a whole is based on the quality of cooperation and communication of the therapeutic team group. In Ammon's concept, every patient is surrounded by a group of different qualified therapists according to the specific needs of the severely ill patient as well as his healthy and creative abilities. The author underlines that any psychotherapeutic method of Dynamic Psychiatry is part of an interwoven system of diagnostics and treatment and that there does not exist any isolated treatment method.

Man as a multidimensional being is a part of our conception of man in general and is related to conceptions of our school such as identity, social energy and androgynity in relation to the groupdynamical influences of man and is in steady development. Multidimensionality is the conception of an individual with all his different gifts, interests, qualifications, achievements and values, all the healthy parts of personality. These healthy parts are subjects to the diagnostic evaluation of man as well as the desintegrated multidimensional pathology like: destructiveness, anxiety, disregulation of ego-boundaries, narcissism, body-image disturbance, thought disorder and phantasy disturbance.

The core of our theory is the social-energetic groupdynamic field conception of man and his lifelong development leading to a specific personality structure dominated by the basic structure of biological, psychological, spiritual and social parts of personality. We conceive different human functions of the above-mentioned structures. For our therapeutic approach it is consequent that we mainly work with the basic structure of personality instead of disturbed functions and symptoms.

The structure of personality is important for our humanstructural work because it is the leading and integrating force of identity. However, we should never forget that all human structures are based on the unconscious and therefore we can understand the methodological need to work with transference, resistance and free association and the application of nonverbal treatment methods providing a multidimensional treatment pro-

* Paper presented at the 10th World Congress of the World Association for Dynamic Psychiatry WADP / XXIIIrd International Symposium of the Deutsche Akademie für Psychoanalyse (DAP), St. Petersburg/Russia, October 25–29, 1994

gram within the milieutherapeutic, socialenergetic and groupdynamic field of the hospital.

Mental illness means to me one-dimensional limitations of the originally multidimensional man or disregulation and desintegration of the multidimensional aspects of a person. I critisize psychiatric thinking in one-dimensional categories and say that the multidimensional potentialities and needs of man and particularly their recognition by the psychiatrist, are more important for the healing process than the causality of the patient's condition. The diagnostic dimension is combined with the dimension of treatment and its multidimensionality, according to the given personality structure and the different symptoms.

The therapist with the need to overlook the wholeness of the patient's personality with the multidimensional healthy and pathological aspects has to use the integrational forces for the treatment of the sick parts of the personality. A general principle for this process is to offer the patient more healthy, creative and satisfying activities in life than the pathology had to offer before. For example, alcohol, drugs or other symptoms have to be replaced by satisfying activities.

The psychotherapist has to be engaged and interested and, to a certain degree, enthusiastic about the offered nonverbal basic program with multidimensional therapeutic methods such as music therapy, dance therapy, theatre therapy, horse-back riding therapy, painting therapy, milieu-project therapy and working therapy. A special offer for more intellectually developed patients are the so-called interest group activities where patients are conducting seminaries, selecting and discussing old movies from a documentary centre, foreign language learning groups and so on. All these non-verbal treatment groups shall lead to the capacity of expressing emotions verbally and to the ability to take part in more formal therapeutic situations such as individual psychotherapy including psychoanalysis and group psychotherapy.

The therapist has to concentrate on his patient as a human being, on his needs, wishes, feelings and anxiety. The therapist has to attempt to reach the person and to offer him new conceptions in the way of thinking, his professional possibilities and so on. In other words, our attempt will be to change the basis structure of a person in its roots instead of being preoccupied with the treatment of symptoms. Sometimes it was helpful to ask the patients at the plenary sessions to report about their therapeutic achievements during the last week and their plans of achievements in the near future as well as their general and far-reaching aim of treatment.

Psychological pathology is in itself multidimensional with different parts of the personality being desintegrated or integrated. Therefore it is necessary to apply therapeutical methods which consider the multidimensional aspects of the patients. Milieutherapy is one of the basic treatment approaches. Milieutherapy can be described as a non-verbal group psychotherapy leading towards verbalization and interpretation. It has to work with different personality functions and structures of the patients. The

therapeutic institution in which milieu therapy takes place is perceived as a social-energetic groupdynamical therapeutic field, where staff and patients are included. In this way the whole group of the psychotherapists are involved in treating the whole group of the patients. Therefore, each patient has a group of therapists treating him multidimensionally with different treatment tools. This group becomes obvious as one group mainly at case conferences and supervision group sessions. This represents a far-reaching therapeutic network where multidimensional therapeutic techniques are reaching a field of multidimensional pathology.

For the patients this means to live in a totally different life situation as at home. While in general the patients shall perceive the whole hospital set-up as a constructive, warm and homelike atmosphere, often the patients experience the whole milieu therapeutic field with all the people like their emotionally disturbed family homes. The slow recognition of the difference is introducing and supporting the healing process.

In our philosophy, life is a process and treatment is a process as well with progressive and regressive periods. Desintegration of the different dimensions of personality means illness, while treatment should be an integrating process. The treatment of milieu therapy is indicated for patients with a so-called split personality, a desintegrated human structure; with so-called archaic humanstructural diseases in general, particularly for borderline patients, patients with psychosomatic and drug problems, but also patients with schizophrenic reaction and depression.

After a careful evaluation of the patient's abilities and inabilities, a treatment program will be composed with the application of nonverbal and verbal therapeutic methods. Qualified and supervised therapists are crucial, as well as additional supervision by case conferences which take place for each patient particularly after the first evaluation of the diagnosis and treatment program and at the end of the hospital treatment.

Thus, the diagnosis may change during the process of treatment and the psychodynamics and group dynamics will also be likely to change in general. *Karl Menninger* used to describe this as a diagnosing process.

On the other hand, we can sometimes observe a patient's totally different behavior in different groups. For example, one patient behaved very demandingly and aggressively in the kitchen, even throwing a plate at the wall. He was, however, absolutely quiet in the formal group psychotherapeutic session, was talking friendly and laughing during the art therapeutic session and was mostly in contact during the horse-back riding through the forest with his horse-back riding therapy group. Through the different behavior patterns of this patient we gained new insight and could understand situations in which he spoke freely like during painting and horse-back riding while he was totally silent during the formal group psychotherapy because of the transference situation. Hence we concluded that he was capable of transference. In the kitchen situation he transferred his infantile oral demands directed towards the mother represented by the

kitchen chietf. Naturally, being on horse-back in the forest there was not much space for transference.

Important in dealing with predominantly non-verbal patients is the interpretation of the dynamics of hostile resistance, of the high degree of anxiety, the high degree of destructive aggression and narcissism. The dynamic relationship between narcissism, destructive aggression and paranoid anxiety dominates the human structure of the group of non-verbal patients, which quite often includes subgroups of acting-out patients. The group of acting-out patients communicates via agitation, thus showing a possibility of reaction in comparison to silent patients. In group psychotherapy those patients stimulate the silent patients.

The therapists have to help the patient to learn to differentiate between the healthy and ill parts of his humanstructure. While at the beginning of treatment he experiences his problems as humanstructurally syntonic, during treatment they become humanstructurally alien and an object for discussion with the therapists. In this way, the concrete thinking of these patients will change slowly into a more reflective, relativating, abstract thinking. This is another important step in the healing process.

The alpha and omega of the psychotherapeutic treatment is our conception of social energy, a form of psychic energy which is developed by interpersonal and groupdynamic relationships, leading to the development of human structure as a whole and of multidimensional humanfunctions. Constructive social energy will be a part of all integrating healing processes in the milieu, while destructive social energy or even deficient social energy is always part of the disturbance of personality structure.

Concluding, it can be said that the hospital as a therapeutic instrument is based on the abilities of cooperation and communication of the therapeutic team. Each patient will be surrounded by different qualified therapists. In this way each patient has a group of therapists treating him multidimensionally. One might add that the patients are receiving social energy directed towards them from this group of psychotherapists. The patients, as well, are giving each other social energy and interpretations of their experiences in the therapeutic milieu.

We would like to emphasize that there does not exist any isolated treatment method, such as milieu therapy. Any psychotherapeutic methods are part of an interwoven therapeutic system.

This conception of treatment offers many new possibilities for therapeutic research as well as for further development of treatment methods. Further research on different human structures, functions and group dynamics should be of interest.

Der Mensch als mehrdimensionales Wesen in Gesundheit und Krankheit

Günter Ammon (Berlin/München)

Das Verständnis vom Menschen als einem mehrdimensionalen Wesen ist Teil des Menschenbildes in der Dynamischen Psychiatrie und steht in enger Beziehung zu Konzepten der Schule wie Identität, Sozialenergie und Androgynität. Es basiert auf gruppendynamischen Entwicklungsvoraussetzungen und dem Verständnis eines Menschen, der sich lebenslang in prozeßhafter Entwicklung befindet. Das Konzept der Mehrdimensionalität umfaßt die verschiedenen Begabungen, Interessen, Leistungsmöglichkeiten und Wertvorstellungen, d.h. alle gesunden Anteile seiner Persönlichkeit. Diese sind ebenso Gegenstand diagnostischer Bewertung wie die desintegrierte mehrdimensionale Pathologie eines Menschen, sein zerstörerisches Potential, seine Ängste, die Unfähigkeit zur Regulation seiner Ich-Grenzen, sein gestörter Narzißmus, seine Denk- und Körper-Ich-Störungen.

Herzstück der Theorie ist die Konzeption eines sozialenergetisch-gruppendynamischen Feldes und das Verständnis vom Menschen als eines sich lebenslang entwickelnden Wesens. Bestimmt durch grundlegende Strukturbedingungen auf biologischer, psychologischer und geistiger Ebene entwickelt jeder Mensch eine spezifische Persönlichkeitsstruktur. Für den therapeutischen Ansatz heißt dies konsequenterweise, statt mit gestörten Funktionen überwiegend mit den grundlegenden Strukturen der Persönlichkeit zu arbeiten. Die Struktur der Perönlichkeit ist entscheidend für die humanstrukturelle Arbeit, denn sie ist die bestimmende und integrierende Kraft der Identität. Dabei sollte man niemals vergessen, daß alle humanstrukturelle Entwicklung auf einem Verständnis vom Unbewußten basiert. Daraus wird die methodologische Notwendigkeit verständlich, mit Übertragung, Widerstand und freier Assoziation zu arbeiten sowie nonverbale Behandlungsmethoden anzubieten. Diese beinhalten innerhalb des milieutherapeutischen, sozialenergetischen und gruppendynamischen Feldes, wie es die Dynamisch-Psychiatrische Klinik Menterschwaige in München anbietet, ein mehrdimensionales Behandlungsprogramm.

Psychische Krankheit bedeuet für *Ammon* eine ein-dimensionale Einschränkung des ursprünglich mehrdimensional angelegten Menschen oder Dysregulation und Desintegration der mehrdimensionalen Aspekte einer Person. Er kritisiert psychiatrisches Verständnis und Denken in eindimensionalen Kategorien und weist darauf hin, daß die mehrdimensionalen Möglichkeiten und Bedürfnisse eines Menschen und ganz besonders deren Anerkenntnis durch den behandelnden Psychiater oft entscheidend wichtiger für den Heilungsprozeß sind als die genaue Ursachenforschung der Erkrankung. Die diagnostische Dimension steht in enger Beziehung zur Behandlungsdimension und zur Mehrdimensionalität, entsprechend der Persönlichkeitsstruktur des Menschen und seiner verschiedenen Symptome. Der Therapeut muß die Persönlichkeit des Patienten in ihrer Gesamtheit mit ihren mehrdimensionalen gesunden und pathologischen

Aspekten erfassen und hat zur Behandlung der kranken Anteile dessen integrierende Kräfte und Möglichkeiten zu nutzen. Ein grundlegendes Prinzip für diesen Prozeß besteht darin, dem Patienten mehr gesunde, kreative und befriedigende Aktivitäten im Leben anzubieten als die Pathologie es bislang vermochte. So sind zum Beispiel Alkohol, Drogen und andere Symptome durch befriedigendere Aktivitäten zu ersetzen.

Der Psychotherapeut muß engagiert, interessiert und bis zu einem gewissen Grad begeisterungsfähig hinsichtlich der angebotenen nonverbalen Behandlungsmöglichkeiten mit ihren therapeutischen Ansätzen auf vielen verschiedenen Ebenen sein, wie etwa der Musiktherapie, Tanztherapie, Theater-, Reit- und Maltherapie sowie der projektbezogenen Milieutherapie und Arbeitstherapie. Ein spezielles Angebot für intellektuell besser entwickelte Patienten liegt in den sogenannten Interessengruppen, wo Patienten selbst Seminare leiten oder Dokumentarfilme auswählen und diskutieren oder sich gegenseitig Fremdsprachen-Unterricht geben. Alle diese nonverbalen Behandlungsgruppen sollen die Fähigkeit entwickeln helfen, Gefühle zu verbalisieren und die Teilnahme an mehr formalen therapeutischen Situationen wie individueller Psychotherapie, Psychoanalyse und Gruppentherapie zu ermöglichen.

Der Therapeut muß sich einstellen auf die Bedürfnisse, Wünsche, Gefühle und Ängste seines Patienten. Er muß den Patienten in der Tiefe erreichen und verstehen und ihm neue Möglichkeiten des Denkens, seiner beruflichen Möglichkeiten usw. anbieten. Das Entscheidende unseres Behandlungsansatzes liegt also im Bemühen, die Persönlichkeitsstruktur eines Menschen an ihren Wurzeln zu verändern anstatt sich auf die Behandlung von Symptomen zu konzentrieren.

Psychologisch gesehen ist Pathologie an sich mehrdimensional mit den verschiedenen Persönlichkeitsanteilen verbunden, welche integriert oder desintegriert sind. Deshalb ist es notwendig, therapeutische Methoden anzuwenden, welche die mehrdimensionalen Möglichkeiten eines Patienten berücksichtigen. Milieutherapie stellt einen der grundlegenden Behandlungsansätze dar. Sie kann beschrieben werden als nonverbale Gruppenpsychotherapie, die schließlich zur Möglichkeit der Verbalisierung und Interpretation verhilft. Die therapeutische Institution, in welcher Milieutherapie angewandt wird, wird verstanden als sozialenergetisch-gruppendynamisches therapeutisches Feld, welches Mitarbeiter und Patienten einschließt. Auf diese Weise ist die gesamte Gruppe der Psychotherapeuten engagiert in der Behandlung der gesamten Gruppe der Patienten. Dementsprechend steht jedem Patienten eine Gruppe von Therapeuten zur Verfügung, die ihn auf mehreren Dimensionen mit verschiedenen therapeutischen Ansätzen behandeln. Als Gruppe wird die Gruppe der Therapeuten hauptsächlich sichtbar bei Casekonferenzen und Supervisionssitzungen. Dies repräsentiert ein weitreichendes therapeutisches Beziehungsgeflecht, wo therapeutische Techniken auf mehreren Dimensionen das Feld mehrdimensionaler Pathologie beeinflussen. Für die Patienten bedeutet dies, gegenüber zuhause in einer gänzlich anderen Lebenssituation zu

leben, wobei ihnen die Klinik insgesamt in einer konstruktiven, warmen und heimischen Atmosphäre angeboten werden soll. Oft erleben Patienten allerdings die gesamte Klinik wie ihre gestörte Familiensituation. Das allmähliche Erkennen des Unterschiedes leitet den Heilungsprozeß ein und unterstützt ihn.

Wir verstehen in unserer Philosophie Leben als Prozeß und ebenso Behandlung als einen Prozeß mit Phasen der Weiterentwicklung und auch mit regressiven Phasen. Desintegration der verschiedenen Dimensionen einer Persönlichkeit bedeutet Krankheit, wohingegen Behandlung einen integrierenden Prozeß darstellt. Milieutherapie eignet sich besonders für Patienten mit sogenannter gespaltener Persönlichkeit, einer desintegrierten Humanstruktur, für sogenannte archaische Ich-Erkrankungen generell, besonders für Borderline-Patienten, Patienten mit psychosomatischen und Drogen-Problemen, aber auch für schizophren reagierende und depressive Patienten. Nach einer sorgfältigen Untersuchung der Fähigkeiten und Schwierigkeiten des Patienten wird ein Behandlungsprogramm mit den verschiedenen verbalen und nonverbalen Behandlungsmethoden aufgestellt. Die Arbeit mit qualifizierten und supervidierten Therapeuten ist essentiell wichtig, ebenso wie die zusätzliche Supervision durch Casekonferenzen, welche für jeden Patienten vor allem nach einer ersten diagnostischen Untersuchung, während der Behandlung und kurz vor der Entlassung stattfinden sollen. So wird eine Veränderung der Diagnose während des Behandlungsprozesses sichtbar und auch die Psychodynamik und Gruppendynamik wird sich vermutlich generell ändern. *Karl Menninger* pflegte dies als »diagnosing process« zu beschreiben.

Immer wieder kann beobachtet werden, wie das Verhalten von Patienten sich in unterschiedlichen Gruppen völlig voneinander unterscheidet. So benahm sich zum Beispiel ein Patient in der Küche sehr fordernd und aggressiv und warf sogar Teller an die Wand. Er war jedoch in der formalen Gruppenpsychotherapie absolut schweigsam, sprach freundlich, lachte während der Kunsttherapie-Sitzungen und war die meiste Zeit im Kontakt mit den anderen Therapiegruppenmitgliedern während der Reittherapie. Durch die verschiedenen Verhaltensweisen dieses Patienten bekommen seine Therapeuten neue Einsichten und können Situationen verstehen, in welchen er während der Mal- und Reittherapie frei sprechen konnte, während er während der formalen Gruppentherapie aufgrund ihres Übertragungscharakters total schwieg. Immerhin kann man daraus schließen, daß er zu Übertragungen fähig gewesen ist.

Entscheidend für den Umgang mit überwiegend nicht-sprechenden Patienten ist die Interpretation der feindseligen Widerstands-Dynamik, des hohen Ausmaßes an Angst und destruktiver Aggression und des gestörten Narzißmus. Die dynamische Wechselbeziehung zwischen Narzißmus, destruktiver Aggression und paranoischer Angst ist bei der Humanstruktur der Gruppe der nonverbalen Patienten vorherrschend. Diese schließt sehr oft Untergruppen von Patienten ein, die zum Ausagieren tendieren. Sie

kommunizieren durch Agitation und zeigen so die Möglichkeit einer Reaktion im Vergleich zu den schweigenden Patienten. Aufgabe der Therapeuten ist es, den Patienten zu helfen, zwischen gesunden und kranken Anteilen ihrer Persönlichkeit unterscheiden zu lernen. Während sie zu Beginn der Behandlung ihre Probleme als zu ihrer Persönlichkeit gehörig (»ich-synton«) erleben, werden sie im Laufe der Behandlung »ego-alien« und Gegenstand der Auseinandersetzung. So wird sich auch das konkretistische Denken der Patienten allmählich wandeln zu einem mehr reflektierenden, relativierenden abstrakten Denken, eine weitere wichtige Stufe im Heilungsprozeß.

Alpha und Omega des psychotherapeutischen Behandlungskonzeptes ist die Konzeption der Sozialenergie, einer Form von psychischer Energie, welche aus dem zwischenmenschlichen und gruppendynamischen Beziehungsgeflecht entsteht. Sie führt schießlich zu einem Wachstum der Humanstruktur als ganzer und der Humanfunktionen auf verschiedenen Dimensionen. Konstruktive Sozialenergie ist ein wesentlicher Teil aller integrierenden Heilungsprozesse im milieutherapeutischen Feld, während destruktive oder gar defizitäre Sozialenergie stets ein Bestandteil gestörter Persönlichkeitsentwicklung ist.

Zusammenfassend kann gesagt werden, daß die Klinik als therapeutisches Instrument auf der Fähigkeit und Bereitschaft des therapeutischen Teams zu Kooperation und Kommunikation basiert. Jeder Patient ist umgeben von unterschiedlich qualifizierten Therapeuten. Auf diese Weise hat jeder Patient eine Gruppe von Therapeuten, die ihn auf mehreren Dimensionen behandelt. Diese Patienten werden also ihre Sozialenergie direkt von der Gruppe der Psychotherapeuten erhalten, wobei die Patienten untereinander sich ebenfalls Sozialenergie geben und sich austauschen hinsichtlich ihrer Erfahrungen im therapeutischen Milieu.

Wir möchten betonen, daß es keine isolierte Behandlungsmethode gibt. Jede psychotherapeutische Methode ist Teil eines untereinander vernetzten therapeutischen Systems. Diese Behandlungskonzeption bietet viele neue Möglichkeiten sowohl für Therapieforschung als auch die Entwicklung weiterer Behandlungsmethoden, auch für ungewöhnliche Patienten. Von besonderem Interesse ist Forschung in Bezug auf die verschiedenen Humanstrukturen, -funktionen und Gruppendynamiken.

Literature at the author

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The Change of Paradigms in Contemporary Medicine**

Modest M. Kabanov (St. Petersburg)*

By the absence of an internationally recognized model of man, the author sees the human psyche as an object of speculations and ideologies. As a good example of the global interference of ideology into the science of man he describes the influence of the communist dogma in the former Soviet Union; hereby psychology has practically not been existing for a long time. The author's understanding of rehabilitation that can be seen as a new paradigm of approaching patient also met a cool reception. In his conception rehabilitation is a dynamic system of interrelated medical, psychological and social components. Its aim, the patient's resocialization and the restoration of his personal and social status, needs the partnership between the therapist and the patient to be realized. Therefore, the author calls for strengthening the therapist's empathic potential by an improved medical training.

Human psychics, due to the complexity of its comprehension, has always been a subject of speculations, both in theory and in practice. The representatives of various pseudo-scientific schools and trends – parapsychologists, »extrasenses«, bioenergists, etc. – are especially successful in this sphere of activities. To a considerable extent, such a situation can be explained by the absence of an internationally recognized »model« of man, as well as by certain difficulties in elaborating the definitions of such notions as norm and pathology, health and illness, organism and personality, finally by the withstanding of biological and psychosocial factors in the development of man and his illnesses. Both an enormous amount of literature and a great number of scientific schools whose efforts are devoted to these problems already exist. The disputes between them sometimes take a scholastic character and as a rule are based on this or that methodology connected with general philosophic conceptions, ideology, and social context.

A good example of the global interference of ideology in the sphere of the science about man, his spirituality, and creative activities, can be provided by the domination of Communist dogma in the former Soviet Union. Evidently, it was not by chance that a decree of the CPSU (then, in 1936, VKP [b]) Central Commitee appeared in the middle of the 30s that was devoted to pedology. This decree spoke of »distortions« in psychology, e.g. the use of standardized methods of human psychics studies (*Wechsler*'s tests, etc.) which were afterwards ostracized. By the way, this was the first official interference of the party officials in Soviet science (many other oases ensued). For many years psychology had been practically nonexistent in this country – research institutes including the Bekhterev Institute were closed, the publication of magazines was stopped, the Society of Psycho-

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logists was dismissed. Psychology as a science lived practically from hand to mouth – it was barely surviving in the furthermost corners of pedagogical institutes where future schoolteachers were being taught the dismembered basics of general and pedagogical psychology. Psychoanalysis was declared a false science, other not orthodox Marxist conceptions of human studies, such as behaviorism, although it was *I.P. Pavlow* who was considered in the West (not without good reasons) to be the founder of this trend of psychology and psychotherapy. By the means of the *Pavlov*ian theory of »top nerve activity« an attempt was made to substitute physiology for psychology. The unconscious sphere of human psyche was rejected as a refuge of ostracized *Freud*ism. Medical psychology has not been mentioned at all in the register of scientific disciplines until the middle 60s, when *V.N. Myasishchev* and *M.S.Lebedinsky* (1966) revived it. Social psychology was either not noticed or portrayed only negatively, since it was considered an invention of bourgeois science incompatible with the so-called historic materialism. This has been the oase for many years. Only gradually did the revival of psychology as a science begin expressing itself, in particular, in its penetration into medical theory and practice. There emerged again an interest in psychoanalysis, psychosomatics, and other non-organism-centered trends in medicine.

During the last two decades attention to psychotherapy has greatly increased – a discipline which, unfortunately, often becomes (due to a number of reasons) a sphere of intensive activities of various quacks and charlatans. It is interesting that an increase of the number of self-proclaimed psychotherapists is being observed in different countries of the world, including the most economically developed ones. It is also worth mentioning that psychiatry in the former Soviet Union was not an object of piety on the part of the officials either. Many psychic discorders seemed not to be noticed or were considered to be »birthmarks of capitalism«, connected with the »pernicious influence of the West« (e.g. alcohol and drug abuse, suicidal and other forms of self-destructive behaviour). Psychological analysis, the medico-psychological and medico-sociological approaches have been considered blameworthy for a long time. Everybody looked for an »organic basis« of an illness. The organism-centered approach dominated not only in psychiatry but in medicine on the whole as well. The consequences of such an approach are visible now in this country, as well as abroad. The influence of psychological and social factors on psychic and other diseases, with some small exceptions (neuroses), was practically ignored by Soviet science. However, there were some efforts to explain the etiopathogenesis of some diseases from simplified standpoints of the so-called cortico-visceral relations (*K. Bykov).*

Physiologist *P. Anokhin, Pavlov*'s apprentice, was one of the first who began to speak (1971) of the system approach as *L. von Bertalanffy* had understood it. I would like to mention that about 20 years ago the employment of the principal items of system approach to medicine in general and

to psychiatry in particular which we suggested faced a strongly negative attitude on the part of the officials. The Board of the All-Union Society of Neuropathologists and Psychiatrists criticized system approach severely as a conception absolutely alien to Soviet materialist methodology.

Our understanding of rehabilitation of the ill and the handicapped also met a very cool reception by the chiefs of the Ministry of Health Care at that time. We considered such rehabilitation to be a dynamic system of interrelated components – medical, psychological, and social – directed not only towards the removal of certain disease symptoms, e.g. pain or delirium syndromes, but also towards the restoration (preservation) of a patient's personal and social status (1969–1972). However paradoxical it may seem, the very term »rehabilitation« put some Soviet psychiatry officials on the alert, and there were attempts to replace it with another word.

It is important to stress the prophylaxis orientation of the contemporary understanding of rehabilitation, despite the fact that many specialists still regard it only as the conclusive stage of treatment, as a patient's adaptation to certain defects, to new everyday life and work efforts of existence – most often, on a reduced level. Such an interpretation narrows incredibly the borders of a very voluminous term »rehabilitation«. Rehabilitation in medicine, as we understand it, is a new ideology (paradigm) of a physician, a psychologist, and other specialists as regards the approach to a patient, including a potential patient who is at the pre-disease stage. Such an understanding brings the methodology of rehabilitation closer to the conception of dynamic psychiatry elaborated by *G. Ammon* and his followers.

One of the basic principles of rehabilitation is our appellation to the patient's personality, an appellation which presupposes the principle of partnership between a physician and a patient. Another basic principle of the conception of rehabilitation is the diversity and the multidirectional character of medical, psychological, and social influences and measures aimed not only at the human organism but at the various aspects of its psychosocial functioning. Not less important is the unity of biological and psychosocial influences in the process of rehabilitation, the unity reflected by still another principle – the existence of several steps (i.e., transitivity) of these influences.

All the above mentioned makes clear the necessity to apply not so much nosological (and even syndromological) as multidimensional and functional diagnostics. In detail the conceptual principles of this diagnostics are discribed in the monograph in the »Clinical and Social Bases of Rehabilitation of the Mentally Ill« that was published in 1980–1981 under my and *Klaus Weise*'s editorship. I would also like to mention that according to the insistence of an official from the former Ministry of Health Care who censored the book the word »social« was replaced with »organizational« as, from his point of view, more appropriate for the Soviet mind. This is a remarkable fact that illustrates the influence of ideology on medical science and practice of health care.

Rehabilitation of mental patients which we have already been involved in for about 30 years has its own peculiarities. The emphasis is put here on the resocialization of patients. However, the general principles of rehabilitation touch upon other fields of medicine as well. Let me remind you that the term »rehabilitation« was used for the first time in its medical sense by the traumatologists and orthopedists from the Anglo-Saxon countries during World War 2. Gradually, rehabilitation became understood as not only the restoration of certain functions (e.g. motional, speaking) but also the restoration, wether full or partial, of the personal and social status of a patient or a handicapped person. The ultimate goal of rehabilitation is the restoration of a patient's personal status, and this is, according to *P. Anokhin,* the systemforming factor. A great concern which we give to the conception of a patient's (or a pre-patient's) rehabilitation poses a set of circumstances in front of a physician or his partner, the medical psychologist, circumstances which are either totally disregarded by traditional (organism-centered) medicine or considered highly superficially and formally. The old slogan »One should treat not the malady but the patient« is, unfortunately, still just a nice word combination at the majority of medical establishments. In connection with a broad dynamic system of rehabilitation of patients and the handicapped being realized, the ethical aspects of medicine, especially in the physician-patient partnership, become exclusively important. It is not only medical-deontological (e.g. the degree and depth of partnership) but also medical-axiological (e.g. value orientation and its correction) problems that require an able solution – so to say, an art, both from a physician/psychologist and a patient. A great concern in rehabilitation, its psycho-socio-therapeutic aspect, is given not only to the dynamics of relationship between a physician and a patient but also to the processes, both conscious and unconscious, taking place in a psychotherapeutic group of patients, and to the correction of family relations. This is where the notion of »evolution-population-based« (ecological) in the establishment of a new medical paradigm originates.

Let us also stress the importance of charisma and a physician's empathic potential – the leading factors in the diad of mutual aid relationship with a patient. (The necessity of empathic potential, though, seems questionable to some therapists). Such urgent rehabilitation problems as labeling and compliance also dictate the necessity of both ethical and psychotherapeutic approaches. The role of a physician's (psychologist's) personality in psychotherapy without which it is impossible to imagine the true process of rehabilitation was practically ignored by official medicine. This is one of the reasons for the success of the above mentioned quacks who ably create the atmosphere of charisma around themselves and elaborate a psychological »arrangement« for their own manipulations bearing in mind the peculiarities of their own personality and the psychology of their clients. It is possible to withstand these »curers«, who are by no means safe for the spiritual and physical health of the people, only by improving the quality

of the future physicians' (especially psychotherapists') and medical psychologists' professional training in colleges and universities. Another means is a more careful selection of entering students where one should pay special attention to their psychological peculiarities (motivation, empathy, etc.).

The reconstruction of medical thinking on the basis of a changing paradigm in medicine is a complex process that requires a lot of time and effort. The Bekhterev Institute as a research and educational centre of the World Health Organization has elaborated a programme of training for specialists in the field of psychotherapy which has already got an approval of the international expertise. We are waiting for an official document from the WHO that would confirm our right to issue proper certificates of postgraduate training, as well as for sponsorship for the realization of, our plans in this sphere.

Five years ago, at an international symposium on social psychiatry that was held at our Institute, Professor *Mitzlaf* said figuratively in his report that we were still sailing in the Mediterranean using ancient Greek maps. He called for the creation of other maps to sail ably in the waves of modern medicine.

Let me express my hope that this Congress of the World Association for Dynamic Psychiatry will bring us all closer to the understanding of human nature. The developing dynamic conception of the rehabilitation of patients is one of the major trends in the holistic approach to the individual and his sufferings, which basically fits the main principles of dynamic psychiatry.

Paradigmenwechsel in der gegenwärtigen Medizin

Modest M. Kabanow (St. Petersburg)

Nach Ansicht des Autors bot die menschliche Psyche sich wegen ihrer Komplexität schon immer für pseudowissenschaftliche Auffassungen und Spekulationen aller Art an. Auch bei der Bestimmung von Gesundheit und Krankheit, Norm und Pathologie kommt es oft zu Schwierigkeiten, da ein allgemein anerkanntes Menschenbild, das zugrunde gelegt werden könnte, fehlt. Vielmehr sind es oft gesellschaftliche Ideologien, die die Wissenschaften vom Menschen inhaltlich ausrichten, wofür nach Meinung des Autors gerade der Kommunismus in der früheren Sowjetunion ein anschauliches Beispiel gab.

Seit Mitte der dreißiger Jahre Vertreter der kommunistischen Partei erstmals in die Wissenschaften eingriffen, existierte in der damaligen Sowjetunion die Psychologie praktisch nicht mehr. Forschungsinstitute wie das Bechterew-Institut wurden geschlossen, Publikationen unterbunden, Fachgesellschaften aufgelöst. Der Psychoanalyse wurde die Wissenschaftlichkeit abgesprochen; ebenso geschah es mit anderen Konzeptionen, die der orthodox-marxistischen Auffassung nicht entspra-

chen wie der Verhaltenslehre. obwohl sie auf einen russischen Physiologen, nämlich *Pawlow*, zurückzuführen war. Die Medizinische Psychologie zählte nicht zu den wissenschaftlichen Disziplinen, bis Mitte der sechziger Jahre *Myasishchew* und *Lebedinsky* sie wieder begründeten. Die Sozialpsychologie wurde entweder nicht erwähnt oder als mit dem historischen Materialismus unvereinbare bourgeoise Wissenschaft abgetan. Auch die Psychiatrie wurde in der früheren Sowjetunion mit Argwohn betrachtet, da viele psychische Störungen wie Alkohol- und Drogenmißbrauch oder Suizidalität auf den schädlichen Einfluß des Westens zurückgeführt wurden. Bei jeder Erkrankung, nicht nur den psychiatrischen, wurde in der Sowjetunion nach ihrer organischen Genese gesucht und – außer bei den Neurosen – der Einfluß psychischer und sozialer Faktoren geleugnet. Die Systemtheorie *von Bertalanffys*, die *Anochin* 1971 aufgegriffen hatte, wurde von der offiziellen psychiatrischen Fachgesellschaft zurückgewiesen, da sie der materialistischen Methodik völlig fremd sei. Die Psychologie kehrte nur allmählich in die Medizin zurück, vor allem in Gestalt der nicht organzentrierten Ansätze von Psychoanalyse und Psychosomatik.

Die Auffassung zur Rehabilitation Kranker und Behinderter, die *Kabanov* in den Jahren 1969 bis 1972 entwickelte, wurden von den damaligen Abteilungsleitern des Gesundheitsministeriums distanziert aufgenommen. Der Autor konzipierte die Rehabilitation als ein dynamisches System, dessen einzelne Komponenten, wie die medizinische, die psychologische und die soziale, darauf ausgerichtet sind, nicht nur Krankheitssymptome zu vermindern, sondern auch die Persönlichkeit des Kranken wieder herzustellen. Für ihn ist Rehabilitation ein umfassendes Paradigma, das beschreibt, wie Ärzte, Psychologen und andere Therapeuten mit Patienten umgehen sollten. Seiner Meinung nach sollten dabei vier Prinzipien Geltung haben (vgl. *Kabanow, Weise* 1981):
– die Hinwendung an die Persönlichkeit des Patienten in einer Partnerschaft von Therapeut und Patient,
– die Anwendung verschiedener und vielfältiger Methoden medizinischer, psychologischer und sozialer Art,
– die Zusammengehörigkeit biologischer und psychosozialer Behandlungsweisen und
– die Abfolge einzelner Behandlungsabschnitte und deren Verbundenheit untereinander während der Rehabilitation.

Bei der Rehabilitation eines Kranken ist nach Ansicht des Autors noch wesentlicher als seine Wiedereingliederung in die Gesellschaft die Wiederherstellung seines persönlichen Status. Dabei kommt der Partnerschaft zwischen Arzt und Patient große Bedeutung zu, denn entsprechend dem bekannten Satz, soll nicht die Krankheit, sondern der Kranke behandelt werden. Daher sind die persönliche Ausstrahlung des Therapeuten und seine Empathiefähigkeit für den Rehabilitationsverlauf sehr bedeutsam. Der Autor fordert deshalb, gerade weil in der herkömmlichen organzentrierten Medizin die Wichtigkeit der Persönlichkeit des Therapeuten vernachlässigt

wurde, daß die Qualifikation der Ärzte und vor allem der Psychotherapeuten verbessert und daß bei der Auswahl der Studenten auf ihre psychologischen Fähigkeiten geachtet werden soll.

Ein medizinisches Denken zu gestalten, das auf einem in dieser Weise geänderten Paradigma beruht, verlangt viel Zeit und Mühe. Das Bechterew-Institut als ein Forschungs- und Ausbildungsinstitut der World Health Organization (WHO) hat dazubeigetragen, indem es ein Weiterbildungsprogramm für Psychotherapeuten geschaffen hat, das internationale Anerkennung erhalten hat. Diese sich entwickelnde dynamische Konzeption der Rehabilitation verwirklicht auch eine der wesentlichen Vorstellungen der Dynamischen Psychiatrie, nämlich einen ganzheitlichen Zugang zu einem Individuum und seinem Leiden zu finden.

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From the Psycho-Soma Dualism to Humans as Bio-Psycho-Social Entities**

Raymond Battegay (Basel)*

In the holistic conception of the author, psychotherapy is also a therapy of the body, in which it is, for example, possible to measure its effects by somatic parameters. Wanting to come to a holistic comprehension of the human being, we therefore have to comprehend, on the one hand, the genetics, the complex biological and pathophysiological processes, and on the other hand, cognitive and emotional experiences as well as the activity of fantasies and thoughts going together with them. Also body language has to be observed: It expresses an actual state and/or a trait of a patient. Four categories of body language are differentiated: 1. Mimic and pantomimic dynamics, posture, skin blood supply, etc. 2. Functional disorders as indicators of unconscious conflicts or mostly deficiency experiences in the realm of narcissism originating in early childhood. 3. Phenomena of hysterical conversion representing symbolic expressions, often of drive conflicts, mostly in the realm of the oedipal triangulation. 4. Serious somatic diseases linked with possible predisposing psychological characteristics. The consequences for the psychotherapy of such a holistic approach are described. The liaison psychiatrist in a hospital setting has to sensitize the physicians, who concentrate on the somatic substrates and functions for the concomitant emotional problems and especially the body language of the patients. Also they have to show them the significance of their own emotions and their somatic expressions in the doctor-/patient interrelationships.

When one works in a University Psychiatric Outpatient Department situated together with all other departments of medicine in a University Hospital and is responsible for organising consultant and liaison services, it quickly becomes apparent that body and psyche are inseparable. The German expression »wie er leibt und lebt« expresses a holistic view and says that humans live and experience themselves in their corporeality and subjectivity. The body is simultaneously a somatic process and a mental experience (*Battegay 1989).* Recently, for example certain behaviors such as an impulsive-aggressive one in major depressions and some cluster B personality disorders according to DSM-III-R 1987 were found to be correlated with lower levels of CSF (cerebrospinal fluid) 5-HIAA (hydroxyindoleacetic acid) (*Soloff* at al., *1994).* Also, high irritability on the Karolinska Scales of Personality in alcoholic violent offenders was correlated with low mean CSF 5 hydroxyindoleacetic acid (5HIAA) concentration. *Linnoila* at al. (1994) found further in alcoholic violent offenders and firesetters a higher mean CSF testosterone concentration compared with healthy volunteers. With antisocial personality disorders the same authors found a low mean CSF ACTH concentration compared with a healthy control group. Such findings led to the assumption that at least some human behaviors are due to special biochemical conditions in the

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cerebrospinal fluid. *Linnoila* at al. conclude that the low central serotonin turnover is associated with the behavioral trait of chronic irritability, and that the CSF free testosterone concentration is positively correlated with interpersonal aggressiveness. We can, therefore, say that the body represents both a somatic process and a personal experience.

Body and soul?

Hearing the voice of a human being or seeing that person, activates through the sense organs a process in our brain. From that a process is triggered in the central nervous system and the rest of the soma, which is also an experience. Similarly, we can say that each psychotherapy is a somatotherapy, since the voice and mimicking as well as pantomimic expressions of the therapist reach the patient through the eyes and ears, which lead in him to a somatic process, which in turn is also a psychological experience. Psychotherapy, therefore, like antidepressants or major transquilizers, affects equally the experience as well as somatic processes, such as those of the immune system, which certainly can be measured by laboratory parameters.

Nevertheless, the old Greek-Platonian division into psyche and soma (*Platon* 1991) is understandable since according to *Jaspers* (1965) in his vital consciousness man does not know about death and does not want to grasp it. He clings rather to his idea of a surviving soul. In a scientific view, however, the body-soul dualism cannot be maintained. The soma is body and soul in the same way as the soul is in the same, the body. An experience apart from the soma is not thinkable, and when a human being dies, the psychosomatic entity has ended its existence. A further existence after death is possible in this view only in the memory of longer existing groups in which an individual has lived and worked, or in a larger sense in the further ongoing of the general life processes in mankind and in nature.

Body language

Therefore, if we want to come to a holistic comprehension of human beings we should not only consider our genetics, the molecular biology, the biochemistry, the pathophysiology and the pathological anatomy; on the other hand we also have to comprehend the psychological processes accompanying them as the cognitive and emotional experiences, the activity of fantasy and thoughts, the perception of organs and body language. The muscle-tendons-skeleton-system, for example, represents not only an apparatus giving man support and enabling him to move, it is at the same time a body system giving expression to the traits of attitude of a human being as well as to the state of his activities in a given situation. The Swiss existential analyst *Medard Boss* (1975) speaks in this respect of man being tuned to his relationship to the world (Gestimmtheit). Important characte-

ristics of a human being, for example, are walking in an upright position or with one's head hanging, expressing with that either an optimistic or a pessimistic view of the world. Whether one moves with heavy tread or soft-footed, or whether one meets others with wrathful appearance or with soft mimic, whether one's muscles are tense as if ready to jump aggressively on other persons or relaxed – these are important characteristics portraying a human being. Body language, however, often allows many interpretations and is not easy for the unexperienced to understand. Even words can distract the view of the essence of what was to be expressed.

The four categories of body language

Body language expresses itself essentially in four categories:
1. Mimic and pantomimic dynamics, posture, skin blood supply, etc.
2. Functional disorders as *indicators* of unconscious conflicts or mostly deficiency experiences, preponderantly in the realm of narcissism originating in early childhood.
3. Phenomena of hysterical conversion representing symbolic *expressions* often of an underlying drive conflict, mostly in the realm of the oedipal triangulation.
4. Serious somatic diseases linked with possible predisposing psychological characteristics.

ad 1) Body language expressing itself in mimic and pantomimic dynamics, posture, skin blood supply, etc.:

Much in the – situative – states and long-terms traits of a personality expresses itself in mimic an pantomimic dynamics, posture, skin blood supply, etc. – mostly without the individuals being aware of it. When, for example, someone enters the examination room of a doctor it is apparent whether he comes with a tense mimic and posture, or whether he enters the room in a relaxed manner. A man can appear in an upright position or with a »broken backbone« (without a physical fracture) which reveals at least his present state. He can, for example, act and react in a resolute way or be extremely inhibited, as is the case in depressives. In schizophrenics, we often observe that in their ambivalence they do not know whether they should approach the doctor or go away from him.

A 29-year-old female patient whose maternal grandmother suffered from a recurrent major depression is separated from her husband. She is linked to a man who is very much bound to his mother. He is a lawyer in a high position in a firm. The patient always feels traumatized by the friend's mother, who works very hard and wants to push her to do at least the same, forgetting the fact that she has to look after two children. She came to the Emergency Service Unit of our University Hospital, in which our Psychiatric Outpatient Department has a Crisis Intervention Ward. The psychiatric consultant, upon seeing her, could recognize her depression. There was

no brightness in her eyes, and at the same time her face was marked not only by depressive despair but also by panic anxiety. Apparently, without even speaking to her, this comorbidity of depression and anxiety was visible. Obviously, the psychiatrist reommended her to stay in the Crisis Intervention Ward and by this offered her the possibility of speaking about her inner experiences. Only in this ward, after she had had the opportunity of finding comprehension in her own French language in which she was only able to express her feelings and after having participated at a word-group psychotherapy meeting, did she feel at least for a moment relieved. In addition, the antidepressant fluoxetine and the major tranquilizer clotiapine were given her to act on her depression and on her panic anxiety. Whereas the medicaments helped only slowly to influence her affectivity, the daily psychotherapeutic sessions of nearly one hour and the group psychotherapeutic sessions of one hour per day in which she participated with all other patients of the ward, as well as the nursing by she staff, helped her in her narcissistic depletion (*Battegay* 1991) to experience this human attention which gave her again a sense of meaning.

This kind of body language represented a signal for the depressive and panic experience of the patient, which enabled the psychiatric specialist to recognize at first glance the patient's suffering. Yet, it further had to be considered that this woman only could feel a sense of support when she had the opportunity to speak in her own verbal language with a therapist in the Crisis Intervention Ward and to take part in a psychotherapy group together with other patients. Since depressive and panic disorders were seen by the staff as bio-psycho-social entities it was indicated that it should be tried to elucidate her mood and to lead to a sedation of her panic anxiety also through psychotropic drugs.

ad 2) Body language in functional disorders as *indicators* of unconscious conflicts or mostly deficiency experiences preponderantly in the realm of narcissism originating in early childhood:

Because of conflictous experiences and/or the absence of adequate attention and love in early childhood, the development of the self is disturbed (*Kohut* 1971, 1977; *Battegay* 1977). That leads not only to a narcissistic hole (*Ammon* 1974) in the experience, but also to a lack of narcissistic investment of the body. If that is the case, there is also an incapacity to be in contact with one's own emotions (alexithymia, *Sifneos* 1973) and one's own body. Whereas *Alexander* (1950) saw the central cause of psychosomatic disorders in aggressions that were inhibited on different levels, I observe in psychosomatic patients that disfunctions and pains in different parts of the body and organs are linked almost regularly with a narcissistic personality disorder, in which not only ego, id and superego, but also the body cannot sufficiently be invested by narcissism. We have, however, no exact findings about the »choice of the organ«. It is certainly dependent on genetic factors, but may also lie in the value given to a certain organ or organ system within a family tradition or in a certain individual.

A man of 62 years had first come to me when he was 55 years old. On the one hand, he complained about extrasystoles and, on the other hand, showed an eye tic which became apparent especially when he then spoke about his wife's rectum carcinoma. No organic causes were found, either for the cardiac symptoms or for the tic. But this man mentioned that he had grown up as a son of a general manager of an insurance company and of an ambitious mother who in his early childhood and later never gave him tenderness and love. His mother could not accept his wife. Following the death of his spouse – when he was 57 – he gave the impression of being seriously hurt by this fact, but he showed no exterior signs of grief. After some months he slowly entered in a new relationship with the widow of a colleague who had recently died. Both of them were formerly also acquainted with his wife. Together they moved into a new house and they lived together peacefully. But he suffers even slightly more now from his extrasystoles and sometimes also from his eye tic. In the psychotherapeutic sessions he talks about the woman he lives with, and that she fears that he like her late husband, could die from heart failure. He speaks of this anxiety apparently without emotion. The extrasystoles and the eye tic, however, seem to have now also a significance in the context of his new relationship. This man, being a translator in a big factory, never had a solid self-esteem and has feared for many years of dying without having accomplished anything, especially not having received any recognition from his mother. His tic sometimes left the impression that he would like to give a sign that, in principle, whatever relationship to a woman he may have, he will remain with his mother inspite of, or because of, the fact that she only had demanded services of him and never had given him love. But it would be to superficial to believe that he would be only bound by oedipal links to his mother. In fact, he hoped to finally receive the narcissistic attention from his mother he sought his whole life for. The further duration of his extrasystoles may indicate that, at least partly, he made a mother transference onto his new womanfriend whom he feared ambivalently to disappoint. The two symptoms showed that he had deep emotional problems that, from their expression, did not directly reveal their content. But they were serious indicators of a basic narcissistic problem linked with his emotionally cool mother and his relationship with his late spouse and his new friend.

ad 3) Body language in hysterical conversion representing a symbolic *expression* often of an underlying drive conflict, mostly in the realm of the oedipal triangulation:

Hysterical conversion consists mainly of innervations or disturbances of innervations not corresponding to the nerve roots or to the peripherical course of the nerves, but to the subjective fantasies of the body functioning of the concerned people. The background of these manifestations is mostly an unresolved drive conflict in the realm of the oedipal triangulation.

A female patient, daughter of a butcher and an emotionally very cold

mother, had helped her mother in the business after the sudden death of her father through myocardial infarction, which took place when she alone was at home in her 29th year of life. Eight months after that she suffered a sensation in the head as if, in her experience, she had been shot from behind into her head. These attacks were accompanied by panic anxiety with tachycardia and singultus. She feared dying. Her paresthesia in her head and her other vegetative symptoms showed, on the one hand, the shock she had suffered by her ambivalently (un)loved father's death in her presence, and on the other hand, the guilt feelings she had since her wishes that father may die had suddenly become cruel reality. In her experience, she deserved to be shot. The eight months she had lived together alone with a mother she had hated since early childhood, not least because she had once menaced at lunch time to »poison« the whole family. Psychoanalytic treatment with her lasted more than 1000 sessions, and despite her gaining a deep insight, she suffered through all these years in situations in which she could have had a good life, from such attacks. Her symptoms were indicative of her growing desire to be punished in her subjective guilt. But through her symptoms she also wanted unconsciously – under the influence of her superego – to punish her mother. It should be added that she had once a dream in which she saw two SS-men of the Nazi time torturing her. At least her tendency for self-punishment came in this way to the foreground.

ad 4) Serious somatic diseases linked with possible special psychological characteristics:

In general it is only asked how the patient is able to cope with a life-menacing disease such as leukemia or a cancer (*Faller* at al. 1992; *Heim* 1988; *Heim* et al. 1978), and what the significance is of the psychosocial factors for the genesis of these diseases (*Buddeberg* 1990; *Eysenck* at al. 1993). But until now, in spite of research done about the »cancer personality« it is not exactly known if there is a typical psychology marking a genetic predisposition for a certain disease, especially a malign one. Often, the cancer personality has been characterized as someone occupying himself preponderantly with his duties, being very conscientious, never complaining, but suffering from hopelessness after life events which cause very serious narcissistic traumata in a realm or concerning a relationship which was very important to him, for example, the loss of a loved one, a professional position and/or the financial resources. In this way *Cooper* and *Faragher* (1993) found that a single major life event was much more damaging than regular exposure to stress situations, particularly if the individual was unable to externalize its emotions and obtain appropriate help and counselling. *Kune* et al. (1991) in their »Melbourne Colorectal Cancer Study« asked 22 psychosocially oriented questions in personal interviews of 637 histologically confirmed new patients with colorectal cancer and 714 age/sex frequency-matched community controls. The authors found that »unhappiness« was statistically significantly more common among the cancer cases, while

»unhappiness with retirement« was similarly distributed among cases and controls. Further, denial and repression of anger and of other negative emotions, a commitment to prevailing social norms resulting in the external appearance of being a »nice« or »good« person, a suppression of reactions that may offend others and the avoidance of conflict discriminated significantly the cancer patients from the controls. The risk of colorectal cancer with respect to this model was independent of the previously found risk factors of diet, alcohol intake and family history of colorectal cancer, but also of other potential factors of the socioeconomic level, marital status, religion and country of birth. As the authors stress, the results must be interpreted with caution. The data, however, are consistent with the hypotheses that this personality type may play a role, as the authors say, in the clinical expression, but, as perhaps may be concluded, in the genesis of colorectal cancer. As *Schwarz* (1993) stresses, the psychosocial findings in cancer patients, however, may be already the result and not the cause of the disease.

In a critical review of the literature, *Levenson* and *Bemes* (1991) found much of the existing research in this field to be based on poor study designs and analyses. *Vetter* (1993) also criticizes *Eysenck* (1993), who has claimed that his and *Grossarth-Maticek's* data from a 14 year follow-up study on which his statistics are based, show that psychosocial data can predict, with considerable accuracy, mortality (from cancer and coronary heart disease) and cause of death 14 years in advance. *Vetter* (1993) supposes that the data were produced with a criterion in mind that made for an unnatural regression relation. Be that as it may, from a holistic point of view it remains impossible to separate the somatic from the psychosocial processes.

A dentist of 55 years, who was known to me because of his alcohol and tranquilizer abuse for many years, worked together with another dentist in the same house. He was held in esteem by his patients because of his intelligence and his diagnostic capacities. But his smoking and drinking patterns always again led to tensions with his colleague. It went so far that the other dentist no longer wanted to cope with this situation and to cooperate with him. In the psychotherapeutic meetings he did not manifest much of a narcissistic injury. Also, he did not speak aggressively about his colleague who disrupted their cooperation. He tried to understand everything and remained on a high level of intellectualization. In the psychological testing he showed in the Hamburg-Wechsler Intelligence Test for Adults, revision 1991, an IQ of 144. In the tests examining his affectivity, for example, the Rosenzweig Picture Frustration Test, newly validated by *Rauchfleisch* (1979), it appeared that this man felt highly affected by social conflict situations, but tried to deny it through defense mechanisms. Nevertheless, I had the impression that he was deeply shocked after the disruption of the professsional relationship with his colleague since now he was really ready and able to omit alcohol. He opened new rooms for his practice and again his waiting room was full. Approximately two years after he had been

forced out of the common practice he had to be operated on because of a lung cancer. He seemed to have recovered, but one month later he began suffering from very servere pains in his throat. He had developed metastases in the thyroid. Again he had to be operated on. Six weeks later he died. Looking back it must be said that we do not know exactly the genesis of the cancer in this patient. But as in many other individuals, the tumor grew in a man, who tried his life long to deny all adverse feelings, after a fundamental narcissistic trauma that had interrupted his ability to exercice his job, which was for him of primary interest. His new beginning in another practice setting at least allowed him to die in honour.

Consequences for psychotherapy

Wanting to treat from a holistic approach, we psychotherapists have to know not only about psychopathology and sociopathology of an individual patient or a disease, but also about the pathophysiology as well as the body language linked with it indicating a disorder or disease. We have to treat each patient in his individuality and individual expression and to try to understand the meaning represented by the four kinds of body language named for a human being in the bio-psycho-social context. Only when a patient can have the justified impression that the psychotherapist does not treat him from a theoretical point of view but rather from the specific and real impression that he as a whole leaves, it is possible for him to open himself to psychotherapy. Often therapists have a more or less rigid system of procedure in mind which may help them to gain security, but no individual likes to be understood only as a prototype of a certain disorder or disease or a certain theory. As important as it is to learn about the named different kinds of body language, so essential is it to consider the individual variations in different patients. If I nevertheless had to define some rules for psychotherapy representing valid general guidelines, I would recommend the following patterns of procedure to increase the patient's compliance:

1. Unconditional comprehension and positive emotional attention:

Like all humans psychotherapists have a more or less selective cognition. Also, the prejudice towards expressive phenomena in our culture leads us sometimes to losing the holistic view. We may then tell a patient that »it's all mental«. But even in neuroses and psychosomatic disorders in which we do not find pathologic-anatomic lesions, the pathogenic factors also are laid down in the somatic structure: No neuroses or psychosomatic disorders can develop without at least the somatic substrate of memory – in which the childhood and later experiences and the accompanying learning processes are stored – and/or without distinct transmitter processes.

The patient in general has a fine sense for the attitude of the therapist towards him and his capacity to encounter him in a holistic way. Whether

he accepts him without prejudice, without considering his origin, his social level, the culture in which he originates, his skin colour or his religion, is decisive for the patient's compliance for psychotherapy. As *Lichtenberg* (1993) stresses, the patient is encouraged »to reveal himself in ever richer descriptions of events and episodes, including those transpiring in the immediate present«, if the therapist's attitude reveals an empathic mode of perception. We may measure the outcomes of different psychotherapies; never, however, we are able to grasp their dependency by the empathic or nonempathic approach of a therapist. From my own experience and that gained in the supervision of colleagues I see how important an empathic-encouraging attitude of the psychotherapist is for the patient's self-experience and his readiness to disclose his fantasies and thoughts.

2. Listening and looking:

Psychotherapy not only means finding the background of the causes of the symptoms; it is also important to let the patient's words and behavior act on us therapists. If a therapist seeks only in a concentrated way for what may be behind a certain verbal expression or an attitude, he may lose much of the essentials. *Sigmund Freud* (1912) spoke in this context of the »free-floating attention«. This means that the therapist is open for all manifestations of a patient. By this attitude he will grasp perhaps a special intonation or a gesture, which may lead him a step further towards the deeper sense and/or the causes of the patient's complaints. Also in nonanalytic psychotherapies it is important that the patient gains the justified impression that the therapist is trying to respect his words and his nonverbal expressions. If there are only standardized questions from the therapist to be answered, the patient may feel he is not being treated as an individual with his specific emotions and cognitions as well as fantasies and ideas.

3. Asking questions:

In spite of what was just said, the patient has to be asked also according to a certain system to find out the kind of disorder or disturbance behind the symptoms. This can even be done partly by a questionnaire, if the patient feels the therapist's empathy. The doctor's questions may give the patient the security that the therapist is taking his complaints and explanations seriously. Further, they may open the patient up for certain connections, which bring him nearer to the background of his suffering and facilitate the therapist's psychological understanding and diagnostic reflections. Questions can also give the patient feedback about what he has stated and lead him to better insight. For example if the therapist repeats a statement of a patient and asks him if that is what he wanted to say, he may be acting in the sense of *Rogers* (1970) as facilitator for an individual to learn »how he appears« to him – or in group psychotherapy also to the other members »and what impact he has in interpersonal relationships«.

4. A clear diagnosis and rarely an early interpretation:

The patient has the right to be given by the physician a clear diagnosis and/or diagnostic considerations. The doctor, however, should not always tell him without preparation the most serious findings. A physician has to direct his orientation according toward the patients. We tell him only step by step, as much as his coping possibilities allow it, about a carcinoma or another serious disease. Honesty for honesty's sake, without considering the ego-strength of a patient, is certainly not the adequate medical attitude. We have above all to refrain from early psychodynamic interpretations. That would only harm the patient. If the patient agrees or wishes it, we may also speak with his relatives, alone or with him together, as desired. If we have not found a distinct somatic disease, we certainly should not tell the patient that we have found nothing and/or that it is only something mental. Rather we should tell him that our examinations today have not yet found an explanation for his symptoms, though as his complaints show, he certainly suffers. We therefore, mention that we will have to know more about his pains and disturbances in order to come to clearer conclusions. If a doctor wants to treat a patient from a holistic point of view, he himself can seek counselling by a psychotherapist concerning the patient to find out what his relationship is with the patient and what the adequate procedure is. He may also follow a case-seminary according to *Balint* (1957) by this having a chance to develop his sensitivity for the adequate psychotherapeutic relationship with a patient.

5. No advice but counselling:

Often doctors try to recommend to their patients a certain life rhythm or, for example, omitting of drugs which could lead to addiction. Sometimes, such advice comes from a caring attitude of the doctor, but it does not correspond to the patients's real situation. Although the concerned individual must be oriented toward the harm that his behavior might cause, for example, cigarette smoking, it is necessary that the patient develop his own motivation for changing his lifestyle. The doctor, in a process of counselling, has to work together with the patient to reach that goal. In emotionally exceptional situations, such as in extreme agitation or in serious depressions, it is, however, necessary to give clear advice or even to take measures to protect the patient against unreflected, possibly aggressive or autodestructive tendencies.

6. Time for reflection concerning the patient and the therapist:

In a holistic approach, it is also essential that the doctor, after ending his work with a patient does not immediately go on to the next patient. A time for reflection after the discharge of an individual is essential. Deeper and

broad diagnostic thoughts as well as a better comprehension of the doctor-/patient-relationship then become possible. Therapy is never a one-sided process: Not only the therapist takes an active role, the patient does as well. It is therefore important that the physician asks himself why the patient behaved at this moment in a certain way, but at the same time why and how he himself had a certain attitude and feeling at a given time. For the doctor, for example, it is important to know that any sympathy for the patient of the other sex may correspond to a transference of emotions valid for former persons of reference or for idealized persons. In other words, he has also to control his own feeling and countertransference especially toward patients of the other sex.

Liaison Psychiatry

In a hospital setting, to reach a holistic approach, it is the task of a liaison psychiatrist to sensitize the physicians, who concentrate mainly on pathophysiology and pathological-anatomic lesions for the emotional problems and especially the body language of the patients accompanying them. He should also show them the importance of their own emotions as well as their somatic expressions in the encounter with patients. The liaison psychiatrist, therefore, ought to help in a team to further the restrictive reflections of the doctors concerning the whole of the patients and their interrelations with their environment.

Vom Psyche-Soma-Dualismus zum Menschen als bio-psycho-soziale Einheit

Raymond Battegay (Basel)

Der Autor, Leiter einer psychiatrischen Universitätspoliklinik mit Konsiliar- und Liaisontätigkeit, erlebt in seiner täglichen Zusammenarbeit mit somatischen Medizinern die Untrennbarkeit von Körper und Seele, die, sprachlich verdeutlicht in dem Ausdruck »wie er leibt und lebt«, eine holistische Sichtweise darstellt. Der Körper ist nach Ansicht des Autors gleichzeitig ein somatischer Prozeß und eine seelische Erfahrung.

Zunächst faßt der Autor die neuesten Forschungsergebnisse auf dem Gebiet des Stoffwechselgeschehens bei psychiatrischen Erkrankungen zusammen. Er stellt dann die Frage nach dem Zusammenhang von Körper und Seele aus philosophischer Sicht und geht dabei auf *Platons* Trennung von Körper und Seele zurück, die er unter dem *Jaspers*schen Gedanken versteht, daß der Mensch aus Angst vor dem Tod die Idee einer unsterblichen Seele entwickeln mußte. Aus der Sichtweise des Autors ist eine dualistische Trennung von Körper und Seele nicht möglich, daher beendet der Tod auch die psychosomatische Einheit eines Menschen. Ein Weiterexistieren nach

dem Tod sieht der Autor nur im Gedächtnis von Gruppen, in denen das Individuum gelebt und gearbeitet hat.

In einer holistischen Sichtweise des Menschen muß auch die Körpersprache als Ausdruck des Seelischen berücksichtigt werden. Dabei zitiert der Autor den Schweizer Existenzanalytiker *Medard Boss,* der von der »Gestimmtheit« des Menschen gegenüber der Welt sprach. Der mimische, gestische und psychomotorische Ausdruck des Körpers muß als Körpersprache ebenso verstanden werden wie die gesprochene Sprache.

Er teilt die Körpersprache in vier Kategorien ein:

1. Mimische und pantomimische Ausdrucksformen, Haltung, Hautdurchblutung etc.
2. Funktionelle Störungen als Indikatoren für unbewußte Konflikte oder Erfahrungsdefizite, vor allem narzißtische Defizite in der frühen Kindheit.
3. Phänomene hysterischer Konversion als symbolischer Ausdruck von Triebkonflikten, vor allem ödipaler Art.
4. Schwere somatische Störungen, die mit prädispondierenden psychologischen Voraussetzungen einhergehen.

Jede dieser vier Kategorien beschreibt der Autor ausführlich und illustriert seine Ausführungen durch ein jeweils psychische und somatische Aspekte beinhaltendes Fallbeispiel, wobei psychoanalytische Behandlung und somatische Therapie parallel zum Tragen kommen. Insbesondere im letzten Fallbeispiel eines krebskranken Mannes wird das narzißtische Defizit deutlich, an dem der Patient hinter der körperlichen Symptomatik litt.

In einem weiteren Abschnitt seiner Arbeit faßt der Autor die Konsequenzen seiner Gedanken für eine holistische Psychotherapie zusammen. Er geht davon aus, daß der einzelne Patient in seiner Individualität behandelt werden muß, wobei der individuellen Körpersprache im bio-psycho-sozialen Kontext große Bedeutung zukommt. Nur wenn der Patient nicht den Eindruck gewinnt, daß er auf der Basis einer Theorie behandelt wird, sondern daß der Therapeut ihn als ganzen Menschen mit dem Gesamt seiner Person behandelt, kann er sich der Psychotherapie öffnen.

Um die Compliance des Patienten zu verbessern, stellt der Autor einige grundlegende Richtlinien für die ganzheitliche Psychotherapie vor, die er für unabdingbar hält:

1. Vorurteilsfreies Verständnis und positive emotionale Beziehung zum Patienten,
2. Richtiges Zuhören und Beobachten (nach *Freud*: »frei flottierende Aufmerksamkeit«),
3. Dem Patienten Fragen stellen,
4. Eine klare Diagnose und selten frühe Interpretationen,
5. Keine Ratschläge erteilen, sondern begleiten,
6. sich Zeit für das Verständnis der Therapeut-Patienten-Beziehung

Liaison-Psychiatrie im klinischen Setting als holistischer Ansatz bedeutet für den Autor, daß alle Ärzte, die mit einem Patienten arbeiten, über den Liaison-Psychiater verbunden, für die emotionalen Hintergründe des Patienten sensibi-

lisiert werden und daß der Psychiater Reflexionen im Team über den jeweiligen Patienten und die Beziehungen im gesamten Feld der Klinik anregen sollte.

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Inpatient Psychotherapy of Borderline Patients: A Pre/Post and Follow-up Study****

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This study presents some recent results of the Munich Catamnestic Project (MKP), which since the early 80ies has been studying the outcome of inpatient dynamic-psychiatric psychotherapy of severe borderline and psychotic disorders with psychological tests. Objective of our study is the development of patients' personality, particularly concerning the human (personality) functions of aggression, anxiety, demarcation and narcissism, changes of psychopathology as well as changes of the life field after human-structural psychoanalytical therapy at the Dynamic-Psychiatric Hospital Menterschwaige (Munich). The results of test-psychological data (Ego-Structure-Test etc.), which were raised at time of admission to the hospital (t1), at time of discharge from hospital (t2) and at follow-up time 1 to 10 years (average 4.5 years) after discharge (t3) indicate short-term (t1/t2) and long-term (t2/t3) positive outcomes of psychotherapy of borderline-patients: The scores of 19 out of 26 scales, which are clinically relevant and sensitive to change, improved significantly between t1 and t2. This development remains stable 1 to 10 years after discharge from hospital, 2 more variables of personality improve in this period (t2/t3). In the second part of the study the results of the borderline-sample are compared with those of a sample of patients with schizophrenic disorders with regard to similarities and differences in their development. Both borderline and schizophrenic patients state, mainly with regard to development of personality, stable improvements of treatment, lasting for many years. Concerning the psychopathology (MMPI) of both diagnostical groups, the borderline-patients seem to profit more from therapy than the schizophrenic group.

This study presents some recent results of the Munich Catamnestic Project (MKP), which since the early 80ies has been studying the outcome of inpatient dynamic-psychiatric psychotherapy of severe borderline and psychotic disorders with psychological tests (see *Burbiel* and *Wagner* 1984, *Burbiel* et al. 1989, 1990, 1992, 1993).

In the first part of the study the results of test-psychological data which were raised at time of admission to the hospital (t1), at time of discharge from hospital (t2) and at follow-up time 1 to 10 years (average 4.5 years) after discharge (t3) are presented as well as the results of an outcome assessment by means of a questionnaire at t3.

Objective of our study is the development of the patients' personality, particularly concerning the human (personality) functions of aggression, anxiety, demarcation and narcissism, changes of psychopathology as well as

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changes of the life field after human-structural psychoanalytical therapy at the Dynamic-Psychiatric Hospital Menterschwaige (Munich).

In the second part of the study the results of the borderline-sample are compared with those of a sample of patients with schizophrenic disorders with regard to similarities and differences in their development.

Sample

For N=74 borderline patients the complete set of test-data at t1, t2 and t3 as well as the questionnaire (KF) at t3 could be obtained. Some characteristics of the sample are shown in table 1.

N of Subjects	74
Average Age	33.5 (s=8.9)
Gender	m= 28 (37.7%) f = 46 (62.3%)
Marital Status Married Single Divorced	 6 (8.9%) 46 (68.7%) 14 (18.9%)
Diagnosis (DSM-III R)	301.00; 301.20; 301.22; 301.70; 301.82; 301.83; 201.60; 301.40; 301.84; 301.90
Duration of Stay at the Hospital (Months)	11 months (s=4.8)
Duration of Outcome (Years)	4.5 Years (s=4.7)

Tab. 1: Characteristics of the Sample N= 74 Borderline-Patients

Instruments

To obtain the relevant data we used the following instruments:

- ISTA (Ich-Struktur-Test nach *Ammon)* Ego-Structure-Test by *Ammon* with the scales Aggression, Anxiety, Inner and Outer Demarcation and Narcissism,
- MMPI by *Hathaway* and *McKinley* in the short version by *Gehring* and *Blaser,*
- Gießen-Test (GT) by *Beckmann* and *Richter,*
- Veränderungsfragebogen des Erlebens und Verhaltens (VEV) by *Zielke* and *Kopf-Mehnert* (Questionnaire of the change of experience and behaviour),
- Outcome-questionnaire (KF) of the Hospital Menterschwaige. It assesses by means of 5-point-rating scales, multiple-choice, and semi-structured questions the following variables: pre-treatment, mode of discharge from hospital, post-treatment, cause for the admission to hospital, development of personality, capacity for social relations, friendship, symptomatology, situation of profession or training, organization of leisure time, situation of housing, general outcome of therapy.

For the statistical examination of the test-result differences of means concerning significant differences between the respective points of measurement t1, t2 and t3 we used the multiple analysis of variance for dependent samples. Testing of significance was done by means of the F-value on a 5%-level. The Scheffé-test measured the significance of differences in the course between the points of measurement t1/t2, t1/t3 and t2/t3.

Results

Interpreting the content of the test scales, the results of our study are as follows:

ISTA		t1	t2	t3	Analysis of Variance F-value	Scheffé-Test p t1/t2	p t1/t3	p t2/t3
AGGRESSION								
constructive	M	9.33	12.51	12.23	24.60	***	***	
	s	4.81	3.80	3.57				
destructive	M	5.23	5.20	4.68	1.06			
	s	3.74	3.07	3.03				
deficient	M	7.36	4.26	4.03	35.85	***	***	
	s	3.72	3.17	3.02				
ANXIETY								
constructive	M	7.16	9.12	9.01	17.57	***	***	
	s	3.11	2.91	2.88				
destructive	M	8.64	6.41	5.54	24.98	***	***	
	s	3.99	4.05	3.80				
deficient	M	6.18	4.46	3.59	34.67	***	***	*
	s	2.84	2.75	2.35				
DEMARCA-TION								
outer	M	4.78	7.11	7.27	31.80	***	***	
	s	3.01	2.97	2.98				
inner	M	6.22	8.39	9.38	21.87	***	***	
	s	3.88	4.32	3.84				
NARCISSISM								
constructive	M	16.44	20.65	21.86	24.04	***	***	
	s	6.43	6.11	5.71				
destructive	M	10.90	6.86	6.48	29.29	***	***	
	s	5.35	4.74	4.53				
deficient	M	7.86	4.58	4.20	31.84	***	***	
	s	4.09	3.40	3.83				

Tab. 2: Analysis of variance over all 3 points of measurement (t1= admission to hospital, t2= discharge from hospital, t3=follow-up 1 to 10 years after discharge (mean 4.5 years, s=4.7) for 74 Borderline-Patients (ISTA), Means M, standard deviation s, level of significance and F-value. Additional Scheffé-test to examine the significances of differences of means between observations at t1, t2 and t3. $p^{***} \leq 0.001$, $p^{**} \leq 0.01$, $p^{*} \leq 0.5$ level.

1. ISTA

Table 2 indicates for all ISTA-scales – with the exception of Destructive Aggression, which does not change over the 3 points of measurement – a significant positive effect of the treatment at the hospital: the constructive scale scores increase between t1 and t2 and remain stable 1 to 10 years after discharge from the hospital. The destructive and deficient scores decrease significantly. The scores of Deficient Anxiety even further decrease after discharge from the hospital.

MMPI		t1	t2	t3	Analysis of Variance F-value	Scheffé-Test P t1/t2	P t1/t3	P t2/t3
Hypochon-driasis	M	121.19	108.06	106.12	4.04		*	
	s	48.53	41.78	35.35				
Depression	M	14.10	9.97	8.58	33.13	***	***	
	s	4.76	5.46	4.82				
Hysteria	M	15.42	11.76	10.30	21.74	***	***	
	s	5.85	5.96	4.92				
Psychopathic Deviation	M	170.97	147.60	140.90	17.33	***	***	
	s	36.34	38.61	42.82				
Paranoia	M	9.22	7.28	6.31	18.28	***	***	
	s	3.86	3.81	3.42				
Psychasthenia	M	207.46	168.88	164.73	33.42	***	***	
	s	47.08	51.51	43.83				
Schizophrenia	M	151.34	118.36	111.04	38.31	***	***	
	s	40.92	41.66	36.87				
Hypomania	M	135.60	136.42	123.88	4.82		*	*
	s	32.23	36.53	35.26				
Social Introversion	M	15.01	12.28	10.60	25.75	***	***	*
	s	5.04	5.48	5.28				

Tab. 3: Analysis of variance over all 3 points of measurement (t1 = admission to hospital, t2= discharge from hospital, t3= follow-up 1 to 10 years after discharge (mean 4.5 years, s=4.7) for 74 Borderline-Patients (MMPI) Means M, standard deviation s, level of significance and F-value. Additional Scheffé-test to examine the significance of differences of means between observations at t1, t2 and t3. $p^{***} \leq 0.001$, $p^{**} \leq 0.01$, $p^{*} \leq 0.5$ level.

2. MMPI

Concerning the MMPI-scales (see Table 3), scores of 7 from 9 clinically relevant scales decrease significantly over the 3 points of measurement. The courses of the tests are similar for all scales, showing significant differences between t1 and t2 as well as between t1 and t3. This is not true for the scales Hypochondriasis, Hypomania and Social Introversion.

Hypochondriasis and Hypomania do not improve significantly during treatment at the hospital but 1 to 10 years after discharge, i.e. there is no short-term change (t1/t2) in these areas but a longterm positive effect (t1/t3). Social Introversion and Hypomania decrease significantly after discharge.

GT		t1	t2	t3	Analysis of Variance F-value	Scheffé-Test p t1/t2	p t1/t3	p t2/t3
Social Resonance	M	40.44	46.06	45.27	8.05	***	*	
	s	12.29	11.80	10.61				
Dominance	M	40.39	36.08	39.98	5.21	*		*
	s	12.99	10.27	6.95				
Control	M	47.39	48.30	46.36	.54			
	s	11.89	11.58	9.45				
Basic Mood	M	64.64	59.73	57.97	12.31	**	***	
	s	10.21	10.40	10.55				
Openness	M	60.30	56.56	53.68	8.33		***	
	s	12.55	12.97	9.08				
Social Potency	M	58.98	52.97	52.76	4.19		*	
	s	12.51	11.88	9.48				

Tab. 4: Analysis of variance over all 3 points of measurement (t1 = admission to hospital, t2= discharge from hospital, t3= follow-up 1 to 10 years after discharge (mean 4.5 years, s=4.7) for 74 Borderline-Patients (GT) Means M, standard deviation s, level of significance and F-value. Additional Scheffé-test to examine the significance of differences of means between observations at t1, t2 and t3. $p^{***} \leq 0.001$, $p^{**} \leq 0.01$, $p^{*} \leq 0.5$ level.

3. GT

The GT (see Table 4) shows a short-term and long-term positive outcome for the scales Basic Mood and Social Resonance (t1/t2; t2/t3). The scales Openness and Social Potency only indicate long-term but no short-term positive outcomes. The scale Control has not changed, i.e. is not influenced by psychotherapy.

4. VEV

In the VEV the borderline-patients assess themselves as significantly improved both at point of measurement t1/t2 and at t2/t3 ($p<0.01$). They experience themselves as more relaxed, composed and optimistic in relation to other persons in various social and achievement-oriented situations.

Rating / Variable	1 (significantly improved)	2 (somewhat improved)	3 (no difference)	4 (somewhat worsened)	5 (significantly worsened)
Symptomatology	60.7	31.0	6.0	2.4	
Development of Personality	11.8	78.8	7.1	2.4	
Capacity for Social Relations	45.8	39.8	8.4	2.4	
Friendships	39.3	44.0	11.9	1.2	3.6
Profession and Training	57.3	28.0	9.8	2.4	2.4
Leisure-Time	32.9	45.1	17.1	1.2	3.7
Housing Situation	47.1	24.7	16.5	7.1	4.7
Outcome of Therapy	43.5	55.3		1.2	

Tab. 5: Percent frequence of the assessment of ratings from 1 to 5 for variables of outcome

5. Outcome Questionnaire

In order to examine how the borderline-patients assess the outcome as a whole and in terms of some variables (see Table 5) the results of the questionnaire (KF) can be interpreted as follows:
71.8 to 91.7% of the patients assess improvements (range 1 and 2) for the variables symptomatology, development of personality, capacity for social relations, friendships, organization of leisure-time and housing-situation. 43.5% assess psychotherapy in the Hospital Menterschwaige as very successful, 55.3% as successful, whereas 1.2% assess the treatment as not successful. Out of 35.6% patients who had taken psychopharmacological drugs before hospital treatment, 17.1% indicated at t3, not to use drugs any more. 2.4% of these patients had lowered their doses at t3. 4.9% only need drugs occasionally, 1.2% take the same or higher dosis.

6. Comparison of Outcomes of Borderline and Schizophrenic Disorders

In Table 6 the results represent the comparison of test data between the diagnostical groups of borderline and schizophrenic disorders by means of multiple analysis of variance. Table 7 summarizes all scales with
a) no differences in the courses of both diagnostical groups, curves are parallel,
b) significant differences in the course of both diagnostical groups with parallel curves,
c) interactions of curves.

Analysis of variance indicates for 16 clinically relevant scales no significant differences. Thus we may assume, that treatment yields no different results for the respective areas for the two diagnostical groups. There are diagnostical differences for 10 scales (see b and c Table 7) especially in the MMPI. We may assume, that the borderline group seems to profit more from therapy than the schizophrenic group in these respective areas. Three scales, namely Deficient Aggression, Paranoia and Schizophrenia indicate interactions of the curves.

Before we shall summarize the results of the study, some qualifying remarks concerning validity and interpretation have to be made. The study is retrospective with a natural design. This means that acquisition of data is not systematically planned (missing data, loss of information and restrictions in interpreting the results because of data not acquired, no controls, only one source of observation). Besides, the results cannot be generalized for all borderline disorders.

ISTA		t1 B	t1 S	t2 B	t2 S	t3 B	t3 S	F-Value p TREATMENT	p INTER	p GROUP
AGGRES-SION										
constr.	M	9.3	8.9	12.5	10.1	12.2	11.6	27.0***	2.1	2.0
	(s)	4.8	3.6	3.8	4.5	3.6	4.1			
destr.	M	5.2	4.3	5.2	4.5	4.7	4.8	0.5	0.8	0.6
	(s)	3.7	3.1	3.1	3.4	3.0	3.6			
deficit.	M	7.4	8.1	4.3	7.2	4.0	4.6	42.7***	3.8*	4.6*
	(s)	3.7	2.9	3.2	4.0	3.0	3.0			
ANXIETY										
constr.	M	7.2	6.5	9.1	7.3	9.0	8.2	18.0***	1.1	3.5
	(s)	3.1	2.5	2.9	3.6	2.9	2.4			
destr.	M	8.6	8.3	6.4	7.8	5.5	6.6	25.7***	1.8	0.6
	(s)	4.0	4.4	4.0	4.4	3.8	4.5			
deficit.	M	6.2	6.0	4.5	5.7	3.6	4.9	35.1***	3.0	1.8
	(s)	2.8	3.0	2.7	3.1	2.3	3.1			
DEMAR-CATION										
outer	M	4.8	5.4	7.1	5.3	7.3	6.5	29.4***	4.8**	1.1
	(s)	3.0	2.9	3.0	2.9	3.0	3.2			
inner	M	6.2	5.9	8.4	7.2	9.4	8.9	27.5***	0.5	0.6
	(s)	3.9	3.6	4.3	4.2	3.8	4.7			
NARCIS-SISM										
constr.	M	16.4	16.2	20.7	18.7	23.9	21.3	28.4***	0.5	0.6
	(s)	6.4	4.9	6.1	6.8	5.7	5.2			
destr.	M	10.9	11.1	6.9	10.1	6.5	7.8	29.6***	2.3	2.4
	(s)	5.4	5.2	4.7	5.5	4.5	6.0			
deficit.	M	7.9	8.5	4.6	7.6	4.2	5.7	32.2*	5.3	5.3*
	(s)	4.1	3.5	3.0	4.5	3.8	4.4			
MMPI										
Hypo-chondria	M	12.1	14.9	10.8	13.3	10.6	13.1	5.7**	0.0	8.5**
	s	4.9	3.9	4.2	4.9	3.5	4.2			
Depres-sion	M	14.1	15.2	10.0	13.1	8.6	11.1	35.5***	0.9	4.2*
	s	4.8	5.1	5.5	6.7	4.8	6.3			
Hysteria	M	15.4	17.5	11.8	16.0	10.3	13.2	26.9***	0.7	6.8
	s	5.8	5.0	6.0	7.2	5.0	6.1			
Psycho-patic deviant	M	17.1	17.7	14.8	16.7	14.1	15.6	19.2***	0.7	2.4
	s	3.6	4.0	3.9	4.0	4.3	4.9			
Paranoia	M	9.2	9.6	7.3	10.7	6.3	8.8	12.5***	3.1	5.6*
	s	3.9	5.3	3.8	6.6	3.4	5.5			
Psychas-thenia	M	20.7	21.9	16.9	20.1	16.5	18.6	37.5***	1.3	4.1*
	s	4.7	5.0	5.2	4.4	4.4	4.9			
Schizoidie	M	15.1	16.0	11.8	15.3	11.1	15.0	31.1***	4.1*	7.3**
	s	4.1	6.6	4.2	5.6	3.7	5.6			
Hypo-mania	M	13.6	12.9	13.6	13.8	12.4	14.0	2.6	2.2	0.2
	s	3.2	3.9	3.7	4.1	3.5	3.1			
Social Introversion	M	15.0	15.9	12.3	14.4	10.6	13.5	24.9***	1.0	2.9
	s	5.0	4.8	5.5	5.1	5.3	4.8			
GT										
Social Resonance	M	40.4	34.9	46.1	35.7	45.3	41.6	9.8***	2.0	5.8*
	s	12.3	9.7	11.8	11.0	10.6	10.0			
Domi-nance	M	40.4	45.9	36.1	48.0	40.0	43.7	3.2**	3.0	8.7**
	s	13.0	12.3	10.3	10.3	7.0	12.4			
Control	M	47.4	41.8	48.3	46.2	46.4	43.3	2.2	0.9	1.7
	s	11.9	10.5	11.6	10.5	9.5	8.5			
Basic Mood	M	64.6	63.0	59.7	60.5	58.0	57.6	13.5***	0.3	0.0
	s	10.2	11.2	10.4	11.7	10.5	8.1			
Openness	M	60.3	51.3	56.6	53.5	63.7	55.9	4.7*	4.0*	1.7
	s	12.6	11.7	13.0	12.9	9.1	11.0			
Social Potency	M	57.0	58.9	53.0	54.2	52.8	55.2	4.8**	0.1	0.7
	s	12.5	11.7	11.9	11.2	9.5	8.7			

Tab. 6: Results of Analysis of Variance of means over 3 points of measurement t1, t2 and t3 (ISTA, MMPI and GT) for N=74 Borderline patients and N=32 schizophrenically structured patients considering the effects of Group (diagnosis), TREATMENTS (course of time) and INTERACTION between group and treatments: Mean M, standard deviation s, F-value and level of significance p (TREATMENT) for course of time and p (Inter) for the effect of interaction between the factors, groups and treatments.

a) No significant differences of courses	b) significant differences of courses with parallel curves	c) significant differences of courses (Interactions)
ISTA Aggression constructive Aggression destructive Anxiety constructive Anxiety destructive Anxiety deficient Demarcation inner Demarcation outer Narcissism constructive Narcissism destructive	Narcissism deficient	Aggression deficient
MMPI Psychopathic Deviation Hypomania Social Introversion	Hypochondriasis Depression Hysteria Psychasthenia	Paranoia Schizophrenia
GT Control Basic Mood Openness Social Potency	Social Resonance Dominance	
Σ Scales:16	8	2

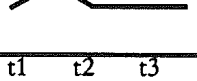
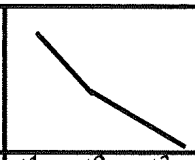
Tab. 7: Comparison of curves between borderline (N=74) and schizophrenic (N=32) disorders

Summary and Discussion of Results

1. The results of this pre/post and follow-up-study indicate short-term (t1/t2) and long-term (t2/t3) positive outcomes of human-structural psychoanalytical therapy of borderline patients in the Hospital Menterschwaige. This is demonstrated in the decrease of psychopathological and symptomatological problems (see Table 8).

The scores of 19 out of 26 scales, which are clinically relevant and sensitive to change, improved significantly between t1 and t2. This development remains stable 1 to 10 years after discharge from hospital, 2 more variables of personality improve in this period (t2/t3). A long-term improvement (t1/t3, t2/t3), but not a short-term change (t1/t2) into the expected direction can be shown of 4 more scales. Destructive Aggression (ISTA) as well as Control (GT) do not change over the 3 points of measurement, both being in the

normal range. Only one scale, Dominance (GT), deteriorates during treatment at hospital, however gets back to the initial score at t3.

Course of curve / Instruments					
	t1 t2 t3	t1 t2 t3	t1 t2 t3	t1 t2 t3	t1 t2 t3
ISTA	Aggression constr. Aggresson deficient Anxiety construc. Anxiety destructive Demarcation inner Demarcation outer Narcissism constr. Narcissism destruct. Narcissism deficient	Anxiety deficient		Aggression destruct.	
MMPI	Depression Hysteria Psychopathic deviat. Paranoia Psychasthenia Schizophrenia	Social Introversion	Hypochondria Hypomania		
GT	Social Resonance Basic Mood		Openness Social Potency	Control	Dominance

Tab. 8: Assignment of scales from ISTA, MMPI and GT for N=74 borderline-patients to t1t2t3 courses of curves

2. The increase of Constructive Aggression and Anxiety, the decrease of Deficient Aggression, Destructive and Deficient Anxiety and increase of Inner and Outer Demarcation in the ISTA, the decrease of Psychopathic Deviation, Social Introversion, Paranoia and Schizophrenia in the MMPI, as well as the increase of Social Potency and the decrease of the schizoid-paranoid attitude in the sense of more Openness in the GT indicate a grown capacity for contacts, relations and positive confrontations as well as an increase of trust into other persons (see Table 9). The patients are able to look for help and to accept it (ISTA: Constructive Aggression, Constructive Anxiety). With the growing of capacity for social relations the perception and assessment of own capacities and limitations (ISTA: Narcissism) as well as self-esteem and self-confidence can be corrected (ISTA: Deficient Aggression, Constructive, Deficient Narcissism, Anxiety; MMPI: Depression, Psychasthenia, Schizophrenia; GT: Basic Mood, Social Resonance, Social Potency).

Variables	Scales
Capacity for social relations	*ISTA:* Aggression constructive, deficient, Anxiety constructive, destructive, deficient; *MMPI:* Psychopathic Deviation, Social Introversion, Paranoia, Schizophrenia; *GT:* Social Potency, Openness
Perception and assessment of own abilities and limitations	*ISTA:* Narcissism constructive, destructive, deficient
Self-confidence, Self-esteem	*ISTA:* Aggression deficient, Narsissism constructive, deficient; *MMPI:* Depression, Psychasthenia; *GT:* Social Potency, Social Resonance, Basic Mood
Ability for demarcation, regulation of social relations, coping with feelings	*ISTA:* Demarcation inner and outer, Aggression constructive, destructive, deficient, Anxiety constructive, deficient; *MMPI:* Depression, Paranoia, Psychasthenia
Readiness and ability for learning	*ISTA:* Aggression constructive, Anxiety constructive, deficient, Demarcation inner and outer, Narcissism constructive, destructive, deficient; *MMPI:* Psychopathic Deviation, Hysteria; *GT:* Social Potency
Reduction of psychopathological symptoms and subjective ailments	*MMPI:* Depression, Hysteria, Paranoia, Psychasthenia, Schizophrenia; *GT:* Basic Mood

Tab. 9: Assignment of personality variables to the scales of ISTA, MMPI and GT

3. The increase of flexible demarcation (ISTA) allows for a better regulation of relations to the outer world as well as to the inner world of feelings and fantasies (MMPI: Psychopathic Deviation). The ability of perceiving and accepting feelings and the increased tolerance of anxiety are connected with a greater ability and willingness of learning (ISTA: Constructive Aggression, Constructive Anxiety, Deficient Inner and Outer Demarcations, Constructive, Destructive, Deficient Narcissism; MMPI: Psychopathic Deviation, Hysteria; GT: Social Potency).

4. The improvements of areas of personality as mentioned are accompanied by a reduction of psychopathological symptoms, ways of experience and behaviour, most distinct in the areas of Depression, Hysteria, Psychopathic Deviation, Paranoia, Psychasthenia, Schizophrenia and Social Introversion (MMPI) (see Table 9). Incidentally, this corresponds with the results, which *Mestel* (1992) has found for borderline patients in another German psychiatric hospital.

5. Most of the examined borderline patients point out, that the development acquired at the hospital has a positive effect on their general development of personality and life situation. They also indicate an improvement in their professional and training situation. Accordingly, most of the patients indicate a positive assessment of success of the treatment at the hospital. They also assess in the Questionnaire of Change of Experience and Behaviour (VEV) the subjectively experienced changes in the following

areas as significantly changed in a positive way: general way of experience, behaviour in social situations as well as experience and behaviour in situations of achievement. This is true for t2 and for t3.

6. Both borderline and schizophrenic patients state, mainly with regard to development of personality, stable improvements of treatment, lasting for many years. Concerning the psychopathology (MMPI) of both diagnostical groups, the borderline patients seem to profit more from therapy than the schizophrenic group. This is also expressed in the schizophrenic group's VEV, which score of change has no significant statistical value at t3.

With these results the MKP is accomplished. For the future we are planning prospective and systematically designed outcome studies, including control groups, also in cooperation with other clinical centers. Qualitative research methods will be incorporated in order to answer specific questions as for example: Which patients are most likely to respond to psychotherapy and why do other patients fail? The results should be considered in the context of that what is now known to be the natural course of the investigated disorders.

Stationäre Psychotherapie von Borderline-Patienten: Eine Prä/Post- und katamnestische Studie

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Die vorliegende Studie stellt einige neuere Ergebnisse aus dem Münchener Katamnestikprojekt (MKP) vor, das sich seit den frühen 80iger Jahren zur Aufgabe gemacht hat, die Wirksamkeit stationärer dynamisch-psychiatrischer Psychotherapie schwerer Borderline- und psychotischer Erkrankungen auf testpsychologischer Ebene zu untersuchen (vgl. *Burbiel* und *Wagner* 1984, *Burbiel* et al. 1989, 1990, 1992, 1993).

Im ersten Teil der Arbeit werden die Ergebnisse einer über 3 Meßzeitpunkte hinweg erfolgten Erhebung testpsychologischer Daten an Borderline-Patienten bei Klinikaufnahme (t1), -entlassung (t2) und ein bis zehn Jahre danach (t3), sowie die Ergebnisse einer katamnestischen Fragebogenuntersuchung vorgestellt. Im wesentlichen interessiert die Frage nach der Persönlichkeitsentwicklung der Patienten unter besonderer Berücksichtigung der Humanfunktion der Aggression, Angst, Abgrenzung und Narzißmus, Veränderungen der Psychopathologie sowie des Lebensfeldes nach erfolgter humanstrukturell-psychoanalytischer Therapie in der Dynamisch-Psychiatrischen Klinik Menterschwaige (München). Im zweiten Teil der Arbeit werden die Ergebnisse der Borderline-Gruppe mit denen einer Stichprobe schizophren erkrankter Patienten hinsichtlich Gemeinsamkeiten und Unterschiede in ihrer Entwicklung verglichen.

Für N=74 Borderline-Patienten liegen die kompletten testpsychologischen Datensätze für alle drei Meßzeitpunkte vor, einige Charakteristika dieser Stichprobe sind in Tab. 1 wiedergegeben.

Zur Datenerhebung sind folgende Verfahren eingesetzt:

- Ich -Struktur-Test nach *Ammon* (ISTA) mit den Skalen Aggression, Angst, Abgrenzung innen und außen und Narzißmus
- der Minnesota Multiphasic Personality Inventory (MMPI) nach *Hathaway* und *McKinley* in der Kurzfassung von *Gehring* und *Blaser*
- Gießentest nach *Beckmann* und *Richter* (GT)
- Veränderungsfragebogen des Erlebens und Verhaltens (VEV) von *Zielke* und *Kopf-Mehnert*
- Katamnestikfragebogen (KF) der Klinik Menterschwaige. Er erfaßt anhand von Punkte-Schätzskalen, multiple-choice- und halbstrukturierten Fragen folgende Variablen: Vorbehandlung, Entlassungsmodus, Nachbehandlung, Aufnahmegrund, Persönlichkeitsentwicklung, Kontaktfähigkeit, Freundschaften, Symptomatologie, Berufs- bzw. Ausbildungssituation, Freizeitgestaltung, Wohnsituation, globaler Therapieerfolg.

Die statistische Überprüfung der Mittelwertsunterschiede der Testergebnisse auf Signifikanz zwischen den Meßzeitpunkten t1, t2, t3 erfolgt mit der multiplen Varianzanalyse für abhängige Stichproben. Die Signifikanz erfolgt über den F-Wert auf dem 5% Niveau. Der Scheffé-Test kann die Signifikanz von Verlaufsänderungen zwischen den Meßzeitpunkten t1-t2, t1-t3 und t2-t3 feststellen.

Die Untersuchung erbrachte folgende Ergebnisse:

1. ISTA

Tab. 2 zeigt für alle Skalen des ISTA, mit Ausnahme der »destruktiven Aggression«, die über alle 3 Meßzeitpunkte hinweg unverändert bleibt, einen signifikant positiven Effekt der Klinikbehandlung: die konstruktiven Skalenwerte nehmen zwischen t1 und t2 zu und bleiben ein bis zehn Jahre nach der Entlassung stabil. Die destruktiven und defizitären Skalenwerte nehmen signifikant ab. Der Skalenwert für »defizitäre Angst« nimmt nach Klinikentlassung (t2/t3) weiter ab.

2. MMPI

Bei den MMPI-Skalen (vgl. Tab. 3) zeigen 7 der 9 klinisch relevanten Skalen über die drei Meßzeitpunkte hinweg signifikante Abnahmen. Die Verläufe sind mit Ausnahme der Skalen »Hypochondrie« und »Hypomanie« für alle Skalen ähnlich und zeigen signifikante Unterschiede zwischen t1 und t2, sowie zwischen t1 und t3. Bei der »Hypochondrie« und »Hypomanie« lassen sich während der Klinikbehandlung keine Änderungen beobachten (t1/t2), wohl aber zwischen t1 und t3. »Soziale Introversion« und »Hypomanie« nehmen nach Klinikentlassung noch weiterhin signifikant ab.

3. GT

Tab. 4 zeigt positive signifikante Kurz- und Langzeitveränderungen für die Skalen »Grundstimmung« und »Soziale Resonanz«. Für die Skalen »Durchlässigkeit« und »Soziale Potenz« zeigen sich langfristige (t1/t3) nicht jedoch kurzfristige (t1/t2) Erfolge. Die Skala »Kontrolle« verändert sich nicht.

4. VEV
Im VEV schätzen sich die Borderline-Patienten sowohl zum Zeitpunkt t1-t2 als auch zum Zeitpunkt t2-t3 als signifikant verbessert ein ($p>0.01$). Sie erleben sich in verschiedenen sozialen und Leistungssituationen als entspannter, gelassener und optimistischer im Umgang mit anderen.
5. Katamnestikfragebogen
71,8 bis 91,7% der Patienten geben für die Fragebogenvariablen Symptomatik, Persönlichkeitsentwicklung, Kontaktfähigkeit, Freundschaften, Berufssituation, Freizeitgestaltung und Wohnsituation Besserungen an (vgl. Tab. 5 Rang 1 und Rang 2). 41,4% stufen die Behandlung in der Klinik Menterschwaige als sehr erfolgreich, 55,3% als erfolgreich ein, während 1,2% die Behandlung als nicht erfolgreich ansehen. Von den 35,5% der Patienten, die vor der Behandlung Psychopharmaka benötigten, geben 17,1% zum Katamnestikzeitpunkt an, daß sie keine Medikamente mehr benötigten. Bei 2,4% hatte sich die Dosis verringert, 4,9% nehmen noch gelegentlich Psychopharmaka und 1,2% nehmen die gleiche oder eine höhere Dosis als vor Klinikaufnahme.
6. Vergleich des Behandlungsergebnisses zwischen Borderline- und schizophren erkrankten Patienten
Die varianzanalytischen Vergleiche zwischen beiden Diagnosegruppen (vgl. Tab. 6) zeigen für 16 klinisch relevante Skalen keine Unterschiede, unterschiedliche Behandlungsergebnisse lassen sich bei 10 Skalen besonders im MMPI beobachten. Tab. 7 faßt in einem Überblick alle diejenigen Skalen zusammen, in denen sich a) keine Unterschiede, b) signifikante Unterschiede in den Testwerteverläufen zwischen den beiden Diagnosegruppen und c) Interaktionen der Kurvenverläufe zeigen.

Bevor die Autoren zu einer abschließenden Zusammenfassung und Bewertung der Ergebnisse kommen, weisen sie darauf hin, daß es sich bei der vorliegenden Studie um eine retrospektive Untersuchung mit einem natürlichen Design handelt. Dies bedeutet, daß Informationsverluste wegen missing data und nicht erhobener Daten hingenommen werden müssen, eine Kontrollgruppe fehlt und die Ergebnisse nur auf einer Beurteilerquelle basieren. Wegen der Stichprobenselektion dürfen die Ergebnisse nicht auf alle Borderline-Patienten generalisiert werden.

Die Ergebnisse der vorliegenden prä-post und follow-up-Untersuchung weisen darauf hin, daß eine humanstrukturell-psychoanalytische Borderline-Therapie in der Klinik Menterschwaige kurzfristig (t1/t2) und auch langfristig (t2/t3) wirksam ist, wenn es um den Abbau defizitärer und destruktiver und die Zunahme konstruktiver Persönlichkeits-, Erlebens- und Verhaltensbereiche (ISTA, MMPI, GT, VEV) und um den Rückgang psychopathologischer Probleme (Symptomatologie, MMPI, GT) geht: Die Werte der 19 von 26 klinisch relevanten und änderungssensitiven Skalen verbessern sich zwischen t1 und t2 signifikant. Diese Entwicklung bleibt für die Untersuchungsstichprobe auch ein bis zehn Jahre stabil bzw. verbessert sich noch in vier weiteren Persönlichkeitsvariablen. Weitere Kurvenverläufe können aus Tab. 8 ersehen werden.

Auf der Grundlage der inhaltlichen Beschreibung der Testskalen (vgl. Tab. 9) können die Untersuchungsergebnisse zusammengefaßt interpretiert werden: die Kontakt-Beziehungs- und Auseinandersetzungsfähigkeit der Patienten nimmt zu, ebenso wie das Vertrauen zu anderen Menschen. Die Patienten sind vermehrt in der Lage, sich Hilfe zu holen und diese auch anzunehmen. Die Patienten schätzen sich selbst realistischer ein in Bezug auf ihre Fähigkeiten und Grenzen. Es erfolgt eine Korrektur im Bereich des Selbstbewußtseins und Selbstwertgefühls.

Die flexiblere Abgrenzungsfähigkeit erlaubt sowohl eine bessere Regulierung der Beziehung zur äußeren Welt als auch zur inneren Welt der Gefühle und Phantasien. Die Fähigkeit, Gefühle wahrzunehmen und zu akzeptieren, sowie die vergrößerte Angsttoleranz sind verbunden mit einem Zuwachs an Lernfähigkeit und -bereitschaft.

Mit der Zunahme an konstruktiven Persönlichkeitsfunktionen geht einher ein Rückgang psychopathologischer Symptome, Erlebnis- und Verhaltensweisen, vor allem in den Bereichen Depression, Hysterie, Psychopathie, Paranoia, Zwang, Schizoidie und Sozialem Rückzug. Ähnliche Ergebnisse hat *Mestel* (1992) für Borderline-Patienten in einem anderen deutschen psychiatrischen Krankenhaus gefunden.

Die meisten der Patienten schätzen die Auswirkungen des Klinikaufenthaltes auf ihre weitere Persönlichkeitsentwicklung und Gestaltung ihrer Lebenssituation außerhalb insgesamt positiv ein.

Sowohl die Borderline- als auch die schizophren erkrankten Patienten konstatieren gleichermaßen stabile, d.h. über mehrere Jahre anhaltende Behandlungsgewinne, insbesondere was ihre Persönlichkeitsentwicklung anbelangt. Was die Psychopathologie beider Diagnosegruppen betrifft, zeigt die Borderline-Gruppe ein insgesamt günstigeres Ergebnisbild als die Gruppe der schizophren erkrankten Patienten. Auch im VEV zeigt die schizophren erkrankte Gruppe zum Zeitpunkt t3 kein signifikant verändertes Bild.

Mit den vorliegenden Ergebnissen sehen die Autoren das MKP als abgeschlossen an. Sie planen für die Zukunft prospektive outcome-Studien mit einem systematischen Design mit Kontrollgruppenvergleich in Zusammenarbeit mit anderen Kliniken im Rahmen einer Verbundstudie. Qualitative Untersuchungsmethoden sollen berücksichtigt werden, um spezielle Fragen anzugehen, wie z.B. warum einige Patienten auf Psychotherapie positiv, andere aber nicht reagieren.

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Integration of Psychotherapy and Pharmacotherapy. Practical and Theoretical Perspectives**

Bela Buda (Budapest)*

The author endeavours to establish a proximity between the apparently opposed directions of psychotherapy and pharmacotherapy for a purposeful cooperation. Buda discusses the indications for pharmacotherapy: on the one hand those rendering the application of drugs necessary in addition to psychotherapeutic treatment, on the other hand indications such as life crises to be overcome, or those which might motivate the patients for a psychotherapy. In the author's opinion the integration of psychotherapy and pharmacotherapy has been examplarily realized in Dynamic Psychiatry.

The relationship of psychotherapy and pharmocotherapy is an issue of interest in psychiatry in the last 25–30 years, practically since the emergence of the potent tranquillizers, anxiolytic and antidepressive drugs. The two main modalities of therapy are considered as rivals or enemies. Pharmacotherapists are critical towards psychotherapy, have doubts about its efficacy and indications and regard psychiatric diseases, and even behavioral disorders, as results of imbalance, deficit or hyperfunction of neurotransmitters and brain messenger mechanisms and believe substitution, inhibition or regulation of these, supposedly causal processes, to be the real cures and therefore regards psychotherapy as a »soft« method of treatment. On the other hand, psychotherapists tend to consider biochemical irregularities connected with diseases mainly as consequenses of disturbance of the personality, and cannot accept simple chemical models of man. Complexes, inner conflicts, structural inadequacies of the ego, communication deficits or lack of proper social skills, cannot be substituted or replaced by molecules, according to psychotherapists. Also, they frequently point out the possibility of misuse and abuse of drugs in psychiatry. Medicaments can be chemical »straitjackets« which put invisible chains on the hands of psychiatric patients, where once Pinel took off the real ones, or erect invisible walls and locked doors, where real doors are seemingly open. Drugs contribute to the re-medicalization of human problems manifested in psychiatric diseases and support a mechanical view of human behavior, and are the basis of a psychiatric philosophy which denies the importance of psychological and social circumstances, with the possible exception of nonspecific sources of stress. A real danger, especially in the eyes of psychotherapists, is the ontologization of symptoms; this can be observed nowadays in the extended use of the diagnostic category of

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depression, which leads to the continuous use of lithium prophylaxis or antidepressive medicaments and thereby creates a label which nobody dares to question later; or in the »depressionalization« of anxiety states or in the creation of such entities as »panic disorder«, where again the »cure« is a lifelong consumption of medicaments with serious side effects.

Dynamic Psychiatry, as conceived in the works of *Günter Ammon (Ammon* 1979, 1980, 1982, 1993), takes also a radical stance concerning the psycho- and sociogenesis of psychiatric diseases and regards, analytically oriented psychotherapy as a form of human-structural psychoanalysis, deployed in multimodal, systemic frameworks, and tries to avoid routine or unnecessary use of psychotropic agents. While other schools of psychotherapy, however, tend to restrain their activities to psychoneuroses and milder manifestations of disorders in behavior and feelings, Dynamic Psychiatry is facing the challenge of the psychoses, borderline syndromes and addictions, too, and the treatment of these serious illnesses which are usually neglected and abandoned in academic psychiatry after the failure of intensive and long-term psychopharmacotherapy is one of its main tasks. Therapy in Dynamic Psychiatry is conceptualized as process of growth of the ego, the strenghtening of ego functions, facilitated by the flow of the social energy in group work and in the systemic effects of the therapeutic milieu. Development fills out deficits and counteracts destructive mechanisms in the ego structure, compensating the harms of the primary group, the early traumas of symbiosis complex in the personality. The nosological theory of Dynamic Psychiatry is an elaborated synthesis of classical psychopathology and psychoanalytic theory, following the initiatives of *Sullivan* and especially *Menninger (Menninger, Mayman, Pruiser* 1963) and the therapy system is a very efficient and advanced approach to the mental disorders.

Accepting severely mentally ill patients and very critical states, Dynamic Psychiatry is concerned with the problem of the place and the values of drugs within psychotherapy treatment regimes. Psychotherapists of other schools working in mental hospitals and outpatient services have to deal with this problem as well. Inevitably, in some very disturbed states tranquilizers have to be used, but only for a short time. In the vast literature of the psychotherapy versus pharmacotherapy dilemma there is a consensus, that severely disturbed behavior of schizophrenically reacting persons, immediate danger of self-destruction, the threat of somatic complications, e.g. in states of delirium, severe mania, intoxication etc., need among other methods also symptomatically acting psychotropic agents. Outwardly directed aggression and some forms of dangerous acting out manifestations can also need pharmacological intervention. Suicidal states might need some chemical restrains, at least for a short time. Psychiatric hospitals also have to treat old and somatically ill persons who can be seriously or fatally harmed by the consequences of some psychopathologically determined mental or behavioral symptoms which need the use of the drugs.

Nowadays, drugs belong to the reality in medical settings and sometimes legal, administrative or social circumstances (for the latter ones consumers' or users' requests can be an example) may force doctors to use medicaments even if they are psychotherapists. Since psychopharmacology has become an ingredient of psychosocial realities of medicine and treatment, patients' and society's expectations, attitudes, cognitive schemas etc. concerning therapy and help have to be taken into consideration, and psychotherapists have to work through and to restructure such motivational patterns or comply with them until the therapeutic relationship becomes a strong alliance or group processes create some insights and changes. The interesting and complex problem of placebo shows that magical expectations, the belief in the power of substances and the strong need of immediate help symbolized by the drug are very strong psychological forces and can exert great effects. An earlier research area of the so-called non-blind placebo trial (*Park, Covi* 1965; *Uhlenhuth, Lilyman, Covi* 1969) demonstrated that inert substances, openly declared as placebos, had nevertheless effects upon target symptoms, such as pain, anxiety and discomfort.

This points to the fact that such fields of psychological forces as using medicaments cannot be disregarded by psychotherapists. One of the main reasons of interest towards such phenomena is that it is obvious that placebo effect is a par excellence psychological, perhaps psychotherapeutical influence, and that it is connected with such facts as confidence, trust, intimacy, encounter with a person of authority and expertise, corrective emotional experience (in the sense of *Franz Alexander*), attention, care, emotional support etc. If a psychotherapist does not want to deal with drugs, this realm of psychological events and processes is neglected. Not only communication with pharmacologically oriented »mainstream« psychiatrists will be difficult, but furthermore position is lost in the dialogue between psychotherapists and psychopharmacologist. An increasing amount of research and publications shows that biological psychiatry or pharmacopsychiatry is not so strong as it declares itself or as the enormous financial investment of the pharmacological industry tends to make believe. Exactly on the spot where it is critical towards psychotherapy, in the issue of efficacy, it has its main weakness. The placebo effect, the factor of suggestion, the influence of the real and symbolic settings are inextricably present in the therapeutic results of drug treatments. Since these subtle and truly psychosocial fields of forces vary in their constellations and intensity, the real impact of pharmacotherapy is keenly discussed, and despite denials and repressions serious doubts are maintained and argumented concerning the high claims of pharmacotherapy (e.g. *Fisher, Greenberg* 1989, *Pam* 1990). If we exclude excesses, misuses and abuses of drugs, the ordinary pharmacotherapy, e.g. the use of sedatives, anxiolytics and other psychotropic drugs, is a real practical and theoretical problem for psychotherapy which merits being studied in depth.

In the practical daily work of the psychotherapists or in the life of a hospital – not to speak now about patients with serious symptoms – this

might mean that experiences and opinions about drugs can be topics of therapeutic conversations. Whatever the patients say can be examined as the manifest contents of the dreams or as texts of free associations. Fantasies, wishes, drives, defense mechanisms, symbols of early traumas, elements of inner struggle for meaning and identity can be detected also in this communication, and interpretations can be based also upon such materials. In a doctor-patient relationship, in individual therapy, the discussion why a drug is given or not given, what is behind a wish or need for or decision against or in favour of a drug might be an important therapeutic step, an operation in the building up of a therapeutic relationship. To give a drug to a patient might serve as a gesture of care and concern, might be a diagnostic tool after probing in the effects of the drug upon feelings and symptoms, can be a symbolic act of cooperation etc. The use of the drug can have a place value, a meaning in the context of the therapeutic work and, if it is verbalized, analyzed, interpreted or worked through, if it is included into a therapeutic strategy and tactic, it can be pure psychotherapy, regardless of the chemical composition or of the textbook indication of the drug. If a medicament is given as a simple response to a complaint or to some clinical observation, it is not psychotherapy (or only in rare circumstances), but if it is an element of a real psychotherapeutic work, if it is thematized and discussed, it can be.

According to my experience, analytically treating situations of pharmacotherapy in the clinical settings can be a useful integration of psychotherapy and pharmacotherapy, an overcoming of the conflict or strain between the two polar orientations, a real synthesis in the sense of the classical Greek logic where synthesis is an integration of a thesis and an antithesis. If a doctor can use drugs psychotherapeutically, a tool is gained thereby which is omnipresent in the situations of the ordinary in- and outpatient care in psychiatry as well as in somatic medicine. Communication difficulties, time shortage, hindering and blocking circumstances can be dealt with by psychotherapeutic,conscious and guided use of drugs, and patients and families can be influenced to seek for and accept proper psychotherapeutic treatment, such as a placement to a hospital of Dynamic Psychiatry or a referral to a psychoanalyst or a family therapist.

The bulk of literature pertaining to the issue of integrating psychotherapy and pharmacotherapy (e.g. *Karasu* 1982, *Goldhamer* 1983) emphasizes this side of the problem, the everyday realities and situations in practice. I would rather stress the role of the drug as a vehicle for communication and interaction, as a means of symbolic encounter between therapist and patient, a field of emotional exchanges, sometimes Ariadne's thread for conducting the patient from the world of traditional medicine to the new territory of the psychological healing. Of course, psychotherapy always remains systemic, interactional, a sequence of relationship and communication, a flow of social energy, a compensatory development of the ego concerning its deficits, but – and it is my main thought or proposition in this short paper – it consists in steps, events, phases and contexts and

in some settings, some stages of relationship (e.g. in stages of transference or resistance, crisis or stagnation, intrusion of outside realities) in which for some reasons and goals drugs might be used as a part of psychotherapy. A much discussed indication is to overcome difficulties of participation at group work, to make the patient accessible to some sort of psychological influences. Drugs might be important in the treatment of psychosomatic patients, and drug effects can be important – e.g. in form of withdrawal symptoms, tapering or antidoting – in the therapy of drug and alcohol patients, a territory of advances in psychotherapy in many countries (*Nizzoli* 1994).

The issue is multifaceted and complicated and an overview of the literature would be urgently needed. These selected aspects of the problem hopefully illustrate that events of pharmacotherapy are worth to be studied also for psychotherapists and that integration can be possible between the two seemingly irreconciliably opposed approaches of psychiatric therapy.

Praktische und theoretische Erwägungen zur Integration von Psychotherapie und Pharmakotherapie

Bela Buda (Budapest)

Der Autor setzt sich zuerst mit der Kontroverse zwischen der Psychotherapie und der Pharmakotherapie auseinander. Die Vertreter der Pharmakotherapie betrachten psychische Krankheiten als Störungen der Transmitterfunktion, die durch Pharmaka beeinflußbar sind, und sie stehen der Psychotherapie kritisch gegenüber. Die Vertreter der Psychotherapie dagegen sehen die Hauptgefahr im Mißbrauch von Medikamenten in der Psychiatrie und meinten, daß psychosoziale Faktoren von großer Wichtigkeit für psychische Erkrankungen sind, die chemisch nicht beeinflußt werden können. Sie kritisieren auch den lebenslangen Gebrauch von Medikamenten mit erheblichen Nebenwirkungen.

In einem zweiten Abschnitt beschäftigt sich der Autor mit der Dynamischen Psychiatrie, die eine psychische und soziale Genese psychiatrischer Krankheiten vertritt und eine analytisch orientierte Psychotherapie entwickelt hat, d.h. eine Form human-struktureller Psychoanalyse, und die die unnötige und routinemäßige Anwendung von Psychopharmaka vermeidet. Im Gegensatz zu anderen Schulen behandelt sie schwere Erkrankungen wie Psychose, Borderline-Syndrom, Sucht usw., d.h. Patienten, die sich oft nach einem Fehlschlagen einer intensiven und langdauernden medikamentösen Behandlung an sie wandten. Der Autor beschreibt die Dynamische Psychiatrie als eine Integration der Psychoanalyse in die Psychiatrie, aufbauend auf Arbeiten von *Sullivan* and vor allem von *Karl Menninger.*

Als nächstes wendet sich der Autor dem Stellenwert der Pharmaka innerhalb der psychotherapeutischen Arbeit zu. Auch Psychotherapeuten

müssen sich dem Problem der Medikamentenverordnung stellen. Krisen und schwere Erkrankungen wie z.B. schizophrene Reaktion, Suizidalität, direkte Aggression u.a. mehr sind Indikationen für deren Anwendung. Medikamente sind eine Realität im medizinischen Setting. Sie können aber auch dem Psychotherapeuten helfen bei der Festigung des therapeutischen Bündnisses oder bis der Gruppenprozeß beim Patienten Einsicht bewirkt hat.

Den nächsten Abschnitt widmet der Autor dem Problem der Plazebogabe und der daraus resultierenden Kenntnis, daß Psychopharmaka auch eine psychische Wirkung haben können, wenn ihre Verordnung oder der Wunsch des Patienten, diese zu erhalten, in der Psychotherapie angesprochen und durchgearbeitet werden, ähnlich wie Träume oder freie Assoziationen. Am Beispiel des Plazeboeffektes zeigt der Autor, daß vor allem die Arzt-Patient-Beziehung das eigentliche Agens der Behandlung ist.

Zum Schluß empfiehlt der Autor eine Diskussion der vielfältigen Literatur und meint, daß eine Integration der beiden scheinbar unversöhnlichen Richtungen der Therapie in der Psychiatrie möglich ist.

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Culture-free Evaluation of Psychotherapy?**

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The author discusses arguments in favour of the necessity and utility of empirical evaluation research in the domain of psychotherapy. He proposes acceptable criteria in four different reference systems: that of patients, that of therapists, a scientific reference system and, fourthly, culture as an important influencing factor. Especially the scientific reference system needs highly developed and elaborated research designs which base on the criteria of objectivity, validity and reliability. These considerations are confronted with the fact that psychotherapy is always a response to psychic problems in a cultural context. Criteria of improvement are dependent on cultural conditions. In the opinion of the author, the global aim of efficiency, which is at the moment largely adopted in western societies, means best improvement with fewest time investment. The cultural relativity of this goal will be discussed and exemplified.

A passionate discussion took place in Western Europe during the last six months concerning the efficacy of psychotherapy. The debate was proved by the book »Psychotherapy in change: from confession to profession« written by *Klaus Grawe* and his co-authors *Donati* and *Bernauer* (1994). Two publications from *Winfried Huber* are at the origin of a similar debate in the French spoken area of Europe. His books »L'Homme psychopathologique et la psychologie clinique« (1993) and »Les psychothérapies. Quelle thérapie pour quel patient?« published 1994 opened a similar discussion in France, Belgium and in the French-speaking part of Switzerland. *Grawe* and *Huber* advocate for a strong evaluation of the effectiveness of psychotherapy, and the debate is running under the label »How to attain and safeguard high quality of psychotherapy?«. They classify the current psychotherapy market on the base of the newest results of metaanalyses in three types of offers: 1. methods that are more or less well evaluated and which can be recommended in function of their effectiveness for certain types of disorders; 2. methods without any scientific research on their effectiveness (such as e.g. the approach of *C.G. Jung)* and 3. methods which have been the object of some scientific evaluation but with negative results. »Evaluation« means for both authors, as for many others, the scientific observation of the changes taking place in patients as an effect of psychotherapeutic intervention. For the prove of a causal relation between psychotherapeutic intervention and the change of symptoms or the change of personality structure, such investigation must respect:
– the scientific criteria of research design,
– criteria for valid and reliable observation and measurement,
– and the criteria for reliable quantitative processing of data.

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However, this recent discussion risks to miss the objectives. Different perspectives are often confounded in the current discussion in Western Europe, and the different inherent presumptions are not explicitly discussed by the critics. I would like to attract your attention to some basic dimensions inherent in this confusing discussion.

Outcome-evaluation needs criteria in every case; and criteria cannot be founded without relation to any specific reference-system. One problem of the current discussion consists of the confusion of different reference-systems. I propose to distinguish the following different frames for criteria:
1. the patients, and groups of patients as reference-system,
2. therapists and groups of therapists as reference-system,
3. science as reference-system, and
4. culture and society as a frame for criteria.

These reference-systems are not independent one from the other, but they should not been mixed up, if problems of outcome-evaluation are discussed. The different reference-systems, respectively the different groups of persons promote not necessarily the same criteria for evaluation. I would like to make a few remarks concerning the different reference-systems. How can they be characterized with regard to evalution-questions?

The patients as reference-system

The keystone of the patients reference-system in the context of psychotherapy is his mental well being. If he or she feels subjectively well with psychotherapy, the patient will evaluate the therapists' intervention positively. Research on this aspects of psychotherapy runs under the name of »consumer satisfaction«. It is indoubitable that the patients' subjective well being is a necessary element in any evaluation. Despite the fact that patients' subjective well being is a necessary condition for successful psychotherapy, we have to remember that this criterion will not be a sufficient condition for the prove of the effectiveness of psychotherapeutic intervention. The patient can positively appreciate the social contact with the therapist and his unconditional positive regard; from such therapeutic intervention may in some cases result a very high consumer satisfaction without serious change of symptoms or of personality structure. If such satisfying social contact with the therapist is not in conflict with economical constraints, it is possible that therapies, which offer this kind of satisfaction of human needs, may profit of high approval by whole social groups or subgroups of society. Therefore, it is allowed to ask the question, in what extent the early stages fo psychoanalysis took profit of such a kind of evaluation.

On the evaluation level of the patients' reference system, all practiced psychotherapies are successful. This level of evaluation works according to the principle of supply and demand. Patients will not achieve psychotherapy

if they are not subjectively satisfied, and if, on the other hand, there are no patients psychotherapeutic methods will disappear. However, the quality of products is neither related to their sale, nor (unfortunately) to their price. The claim of scientific founded psychotherapy is not only to satisfy patients, but also to be the active ingredient for real change on the symptom of the structural level of personality. The reliable observation of the change of symptoms or the change of personality structure and the confirmation of the assumption that the change is caused by the therapeutic treatment, needs other methodological procedures.

The therapist and groups of therapists as reference system

The therapist as reference system for the effectiveness of psychotherapy is related to analogous problems. The therapists' subjective observation of the development of a particular psychotherapy is a necessary and important key element for his conducting and regulation of the process of psychotherapy, but it is not a sufficient criterion for evaluation either. The therapist's observation of the therapeutic process, his collection of information, do not work according to the rationale of controlled systematic observation, and the information-processing does not work according to reliable mathematical rules, but according to subjective cognitive processes. These processes are influenced by emotional and motivational factors and by subjective expectations. They lead to the so-called »clinical judgments«, which are useful for practical purposes, but not sufficient for any reliable evaluation. The therapist is susceptible for social reinforcement as well as his patients. And if he or she is organized in professional associations or societies, it is easily possible that the professional group serves as a social defense system for the therapists subjective needs.

Evaluation needs an other reference-system beyond the perspectives of patients and therapists: Evaluation needs an independent reference-system.

The scientific reference-system

The criterion for the scientific reference-system should not only be the satisfaction of subjective needs but the increase of knowledge about the effectiveness of therapeutic methods. That means that objective, valid and reliable measures based on a powerful research design must serve as the base for the observation of changes of the patients behavior as an effect of the therapist intervention.

From a historical perspective of science one might be tempted to consider the notions of science at a given time as an expression of the particular »Zeitgeist«. Parallel to the collective mentality, the understanding of what mental disorders are and how to treat them best, varies in time. Is psychoanalysis not a system of interpretation that includes many important ideas which were characteristic for the 19th century? Is behaviorism not a late

descendent of English sensualism and empirism? Did not the »cognitive revolution« appear in the shadow of the computer-related spreading of »cognitive sciences«? Is the conclusion of all that, that the scientific reference-system is nothing else than a mirror of the leading collective mentalities of modern culture? Or of some leading subgroups of modern culture that have their nesting places at universities?

Accepting that we can find in all societies the co-existence of different cultures of knowledge, there exists, nevertheless, a broadly accepted minimal consent concerning the common ground of scientific thinking: That is the criterion of knowledge processed by methods which try to respect the criterion of intersubjectivity. That means: The methods to evaluate the processes and effects of psychotherapy have to be objective, valid and reliable.

Scientific research in the field of psychotherapy is in this sense not older than 50 years. *Carl Rogers* was the first, who introduced systematic observation of psychotherapeutic processes by his emphasis on systematic observation of tape recorded therapies. Since this beginning of a scientific analysis of psychotherapy the research possibilities developed considerably. Minimal standards for evaluation research are today the use of control groups, and if single subject studies are at stake, we need special control conditions. For group studies it is indispensable to compare the change measures of an intervention group with the measures of comparable groups without treatment (waiting groups) or with other treatment groups (see Tab. 1)

	R 01	T	02	03
	R 01		02	03
or	R 01	T1	02	03
	R 01	T2	02	03

Tab. 1: Control group design. Campbell, Stanley (1963)

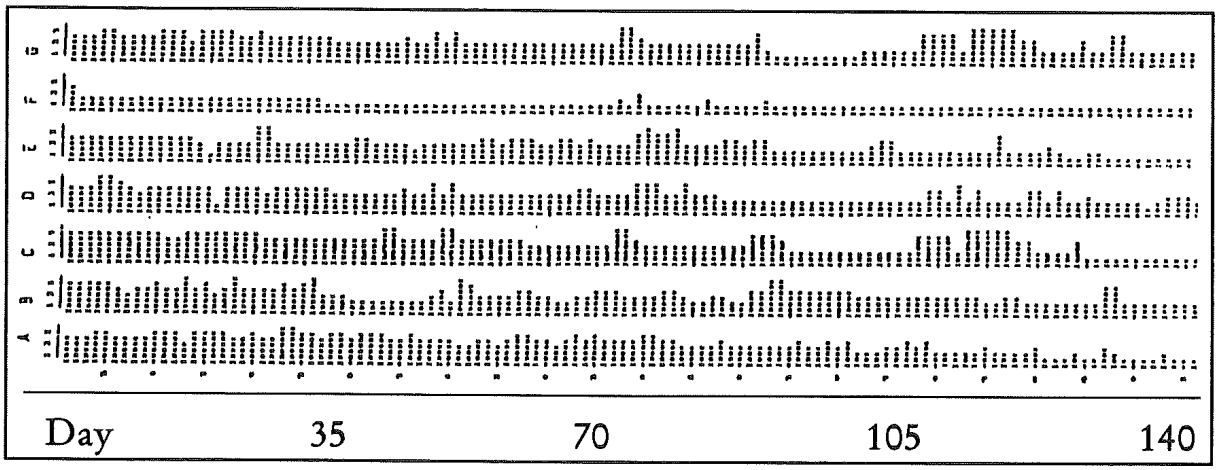
R represents the randomization, 01 and 02 symbolize pre- and post-treatment-measurement, and 03 follow up-measurement, T stands for the treatment or for different treatments (T1, T2).

For single case studies it is not sufficient to have a description of the psychotherapist for evaluating the effects of psychotherapy. That may be helpful for didactic or illustrative purposes, but not for the promotion of well founded knowledge. In this case the reference system of the therapist interferes too obviously with the scientific one.

Single case research designs have been developed during the last 15 years. They allow sophisticated analyses of the therapeutic process, using time series measures or the covariation of therapeutic conditions with patient measures as the bases for analyses. The aggregation of comparable single case studies allows, furthermore, to combine single case-data with group-designs.

We used these complex procedures in different studies. We observed e.g. 15 women after a breast-cancer-operation during 140 consecutive days with self-observation measures and a certain number of test-measures. They took profit from a psychotherapeutic help to improve their coping with the critical life event. The treatment was a *Roger*ian psychotherapy with therapeutic and preventive goals (*Perrez, Wittig, Tschopp* 1989; *Aebischer* 1987; *Wittig* 1992).

The following figures show, how single-case observations can be documented and subsequently aggregated. The patients accomplished every day a well structured diary in form of self-ratings, and at different measurement-points they were invited to respond to objective psychological tests. The computing of several variables shows significant changes concerning subjective self-ratings (Tab. 2: depressive feelings of 7 women) and test-results (Fig. 1: locus of control).



Tab. 2: The course-comparison of the variable »Depressed« indicates a dicrease for all women (A-G; N=7) over 140 days.

Women	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
General mood				.34						.49			.45		
Calm					.65			.64	.63	.75			.46		.39
Cheerful				.37	.61		.68	.61	.61	.64	.29		.69		.39
Gentle			-.54	-.48	.56		.66	.60	.61	.69			.48		.39
Spontaneous				.53	.61	.43	.72	.68	.61	.70	.27		.74		.41
Energetically					.66	.43	.47	.64	.61	.69			.67		.39
Beeing cared		-.53	.54		-.42			.47			.41	-.25	-.47		.41
Condition (physical)	.34			.44				.52		.49			.49		
Powerful	.41		-.53		.59		.46	.61	.55	.76			.53		.52
General well-beeing			-.52		.59	.43		.55	.54	.75			.62		.52
Healthy				.40	.44			.63	.52	.78			.64		.49
Painless		.51			.64		.53	.65	.54	.79		-.23	.32		.61
Rested	.54				.44	.43		.42	.53	.71			.68		.47
Daily total				.47											

Tab. 3: Trend calculations with the time-variable »Day« over 3 months (Level of significance: .05).

Tab. 2 shows the values of the daily self-ratings of 7 women over 140 days. Their depressive feelings decrease over time. We have similar ratings for 7 other feelings (angry, abandoned, etc.). The data were computed for

for every subject first individually. The correlation for the 15 subjects of the variable »time« with the ratings over 90 days (see tab. 3) prove for a majority of subjects and variables an obvious trend for a continous improvement. The subjective data and the results of the objective tests of the case studies were then aggregated (see e.g. fig. 1).

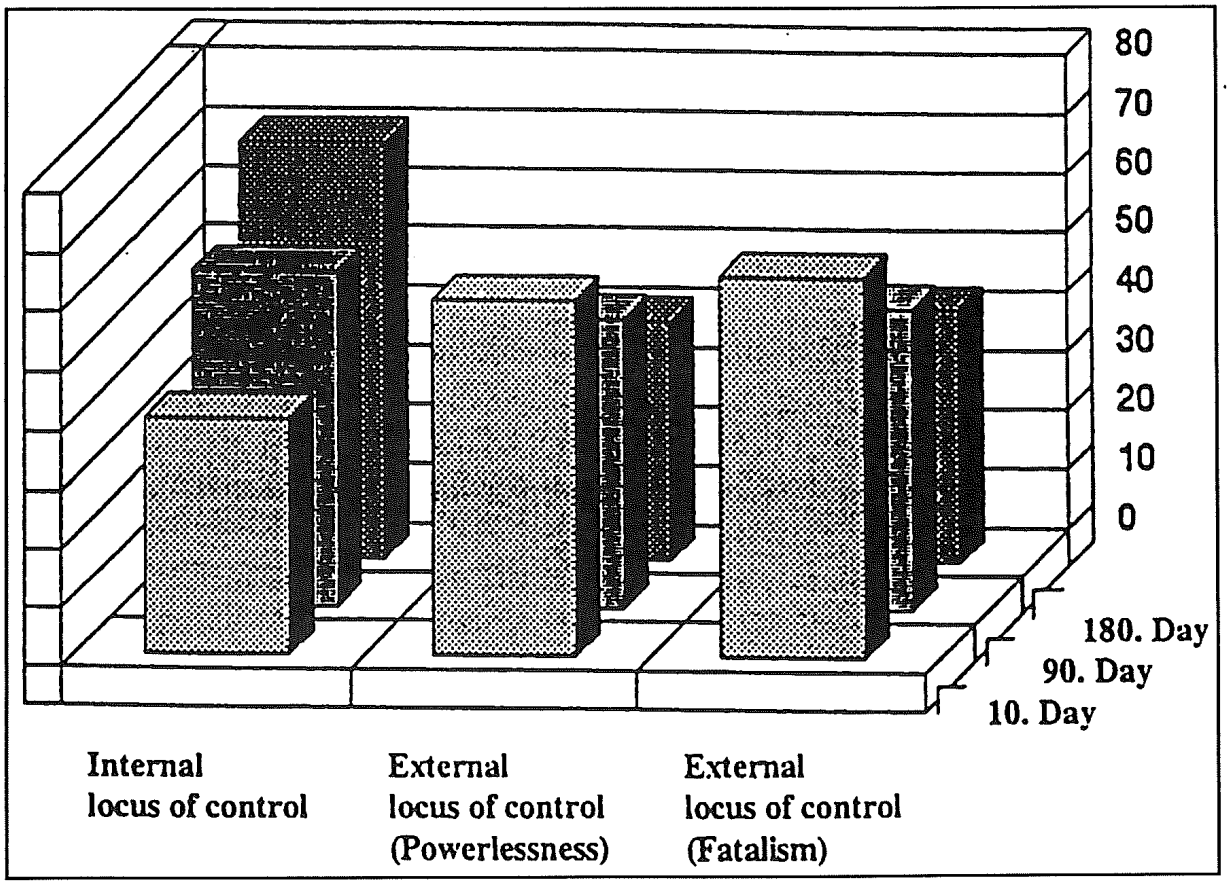


Fig. 1: Means of attribution style »Locus of control« 10, 90 and 180 days after breast-cancer operation (all subjects).

The results manifest a clear increase of the internal locus of control (see *Aebischer* 1987). Analogous results are to observe for the change of the coping strategies on the aggregated level. The documented results prove that there was an improvement in several criteria.

However, this is not sufficient for any prove, that *Roger*ian counseling had any positive effects on the development. As this design lacks a control group. I mentioned that three criteria are necessary conditions for scientific evaluation. Reliable and valid measurement and statistical inference instead of clinical judgement are not sufficient for the prof of that the effects are conditioned by the treatment. For this proof we need a control group to control the internal validity of the study. In this study the possibilities of such conclusions are restricted. Nevertheless, it is possible to correlate the changes with process-measures of the intervention. Not all subjects changed equally. This within-group variance may be related to some psychotherapeutic factors, which were experienced differently between the subjects. The interindividual differences within the treatment group can be correlated with hypothetically assumed predictor variables, such as satisfac-

tion of the patients with counseling, or measures of the therapist on the particular counseling sessions - e.g. his rating of the patients' self-exploration, or measures of tests (see fig. 2).

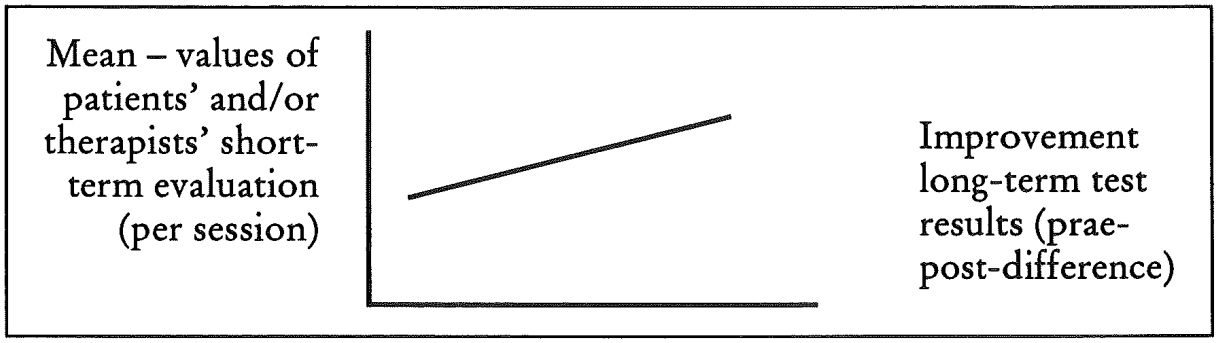


Fig. 2: Correlational design

The traditonal research design for evaluation works with waiting groups, control groups or different treatment groups. Most of the important work done in this field is in accordance with classical designs. The evaluation of our therapy-program for HIV-positive persons (*Perrez, Hüsler, Ewert* 1994; *Perrez, Hüsler, Schmid, Ewert* 1992) also follows this structure (see fig. 3).

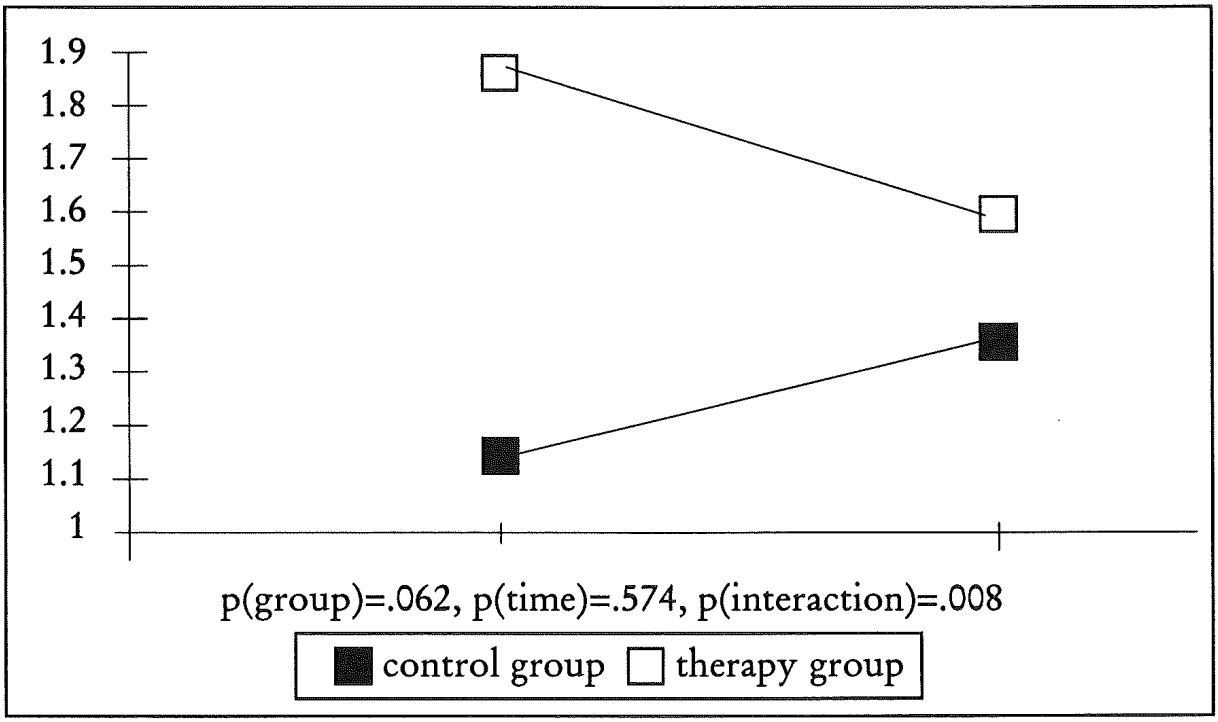


Fig. 3: Change on the scale »evasion in aversive situations« (UBV) over time (M1 to M4)

Fig. 3 shows the change concerning the coping strategy »tendency to escape in aversive controllable situations« instead of »active influence«. From the first measurement to the follow up measurement (M4) one year after (M1) and 4 months after the psychological intervention to improve the coping competence. All subjects were in the phase after HIV-diagnoses. Such an evaluation is of course not indepent of the patients' and therapist's

reference-system. The patients' subjective rating of his mental well being remains one key-stone – not the only one – but one key-stone also for this kind of evaluation. Objective change of symptoms and personality structure has not much sense, if this change is not correlated with the subjective mental well being.

The difference to the evaluation which completely refers to the patients' and therapists' reference-system, is (a) the use of standardized measurement-procedures, (b) the application of a research design, and (c) information processing procedures which allows any judgements and conclusions independently of the interests, motivations and expectations of the therapists. Sophisticated current evaluation designs, like the grid technique of *Kiesler* take into account features of the patients, of the therapist and of the method. They allow to analyse statistical interactions between these factors.

Despite the fact that the scientific reference system for evaluation is better qualified to answer to the question, whether a psychotherapeutic method is really improving psychopathological disorders, it remains related to the cultural reference system.

The cultural reference-system

For the social subgroups achieving psychoanalysis at the first half of this century, time or costs of therapy to improve a disorder, were not relevant. Most of the patients could afford to pay their therapy by their own as members of upper social classes. Some of them were even interested to take profit of this kind of enriching social contact, indepentently of the development of their psychopathological disorder. The mentality of the classical psychotherapy-consumer was shaped for psychotherapeutic encounter in order to change deeper structures of personality. The needed time for such a therapeutic goal was of minor matter. The criterion, whether change was successful, was the patients' and the therapists' reference-system. The values of the concerned patient-groups were in relative accordance with the offer of psychoanalysis.

Our days, persons with mental disorders of all social classes try to take profit of the offers of psychotherapy. Illness insurance fund as an institution of the general population, which has to invest the available money carefully, is obliged to consider this cultural change. As far as the whole community is seeking for the available psychotherapeutic resources, the importance of scientifically proved efficacy increases, and the therapists' reference-system will not be accepted as sufficient for the distribution of public economic resources. We need independent, i.e. scientific evaluation of the benefits of psychotherapy.

The criterion of scientific effectiveness is not only related:
1) to the objective prove that the psychotherapeutic method at stake is the active ingredient for change, but also to criteria such as

2) the time needed for particular effects. That is a culturally satiated criterion. The term used in the US-discussion for the relation of cost and benefits is »efficiency«. More efficiency means not only »more effective« than the group without treatment or with an other treatment, but »effective in fewer time«.
3) Furthermore, in order to save costs, the goals of psychotherapy are discussed: Currently three distinct goals and levels of change are at stake:
- the subjective well being of the patient as an effect of psychotherapy,
- the change of symptoms as an effect of psychotherapy, and
- the change of deeper structures of the personality as an effect of psychotherapy. The priority of the preferred goals is again a culturally biased element of evaluation.

Differently to the beginning and to the first part of this century, the first two levels of psychotherapeutic goals are currently favored by public expectations. They are easier to attain with lower cost. The great study of *Howards* and colleagues (1992) with 1 400 patients, including different therapies, shows that the change of the structure of the personality takes rarely place, and if it happens, it is preceded first by the improvement of the subjective well being and, second, by the change of symptoms – in this temporal order.

Psychotherapy evaluation is not free from subcultural influence. However it has to be free as much as possible from subjective reference-systems, which have more to defend than the validity, reliabilty and objectivity of the evaluation procedure. Society has invented for this task the scientific community.

Ist eine kulturfreie Bewertung von Psychotherapie möglich?

Meinrad Perrez (Fribourg)

Ausgehend von den neuesten Veröffentlichungen über die Effektivität von Psychotherapie (*Grawe* et al. 1994, *Huber* 1993,1994), beschäftigt sich der Autor mit der Frage einer angemessenen Beurteilung derselben. Im Mittelpunkt der neueren Forschungen steht die wissenschaftliche Erfassung von Veränderungen im Patienten als Ergebnis psychotherapeutischer Intervention. Wissenschaftliche Maßstäbe betreffen insbesondere die reliable und valide Erfassung des Gegenstandes sowie die Art der Datenverarbeitung. *Perrez* sieht eine Gefahr in fehlender Objektivität und dem Mangel an nicht expliziter Diskussion inhärenter Vorannahmen im Bereich der Psychotherapieforschung. Um diesem Mangel entgegenzuwirken schlägt *Perrez* vor, Kriterien für eine Ergebnisbeurteilung in den Rahmen von verschiedenen Bezugssystemen zu stellen:

1. Bezugssystem der Patienten bzw. Patientengruppen
Grundlegend für eine Bewertung auf der Patientenebene ist die Frage nach

dem subjektiven psychischen Wohlbefinden des Patienten. Die als »Konsumentenzufriedenheit« bezeichnete subjektive Bewertung stellt eine notwendige, jedoch keine hinreichende Bedingung für eine Überprüfung von Wirksamkeit psychotherapeutischer Intervention dar. Sie sagt nichts aus über eine Symptom- bzw. Persönlichkeitsstrukturveränderung des Patienten.

2. Bezugssystem der Therapeuten bzw. Therapeutengruppen

Ähnlich wie auf der Bezugsebene der Patienten stellt eine subjektive Beobachtung und Einschätzung des Therapeuten ein notwendiges, jedoch kein ausreichendes Kriterium für eine Beurteilung von Psychotherapie dar. In die »klinischen Urteile« fließen emotionale und subjektive Faktoren, wie z.B. Erwartungen usw. mit ein. Möglicherweise fungiert die gesamte Berufsgruppe als soziales Abwehrsystem für die subjektiven Bedürfnisse des Therapeuten. Somit wird ein von subjektiven Faktoren weitgehend unabhängiges Bezugssystem notwendig.

3. Das wissenschaftliche Bezugssystem

Der Maßstab in einem wissenschaftlichen Bezugssystem sollte die Zunahme an Wissen über die Effektivität psychotherapeutischer Verfahren sein. Dies bedeutet, daß objektive, valide und reliable Messungen auf der Grundlage wissenschaftlich fundierter Forschungsdesigns die Basis für eine Bewertung von Veränderungen des Patienten sein müssen. Zum Minimal-standard heutiger Psychotherapieforschung gehört der Gebrauch von Kontrollgruppen und spezielle Kontrollbedingungen bei Einzelfallstudien. Einzelfalldesigns wurden verstärkt in den vergangenen fünfzehn Jahren entwickelt insbesondere durch elaborierte Analysen des therapeutischen Prozesses, der Nutzung von Zeitreihenmessungen sowie durch Veränderung therapeutischer Bedingungen. Die Zunahme vergleichbarer Einzelfallstudien erlauben die Kombination von Einzelfalldaten mit Gruppendesigns.

An zwei Beispielen zeigt der Autor die Anwendung komplexer Verfahrensweisen der Evaluation psychotherapeutischer Effektivität auf, in der qualitative und quantitative Daten kombiniert wurden. Er weist darauf hin, daß zu einer wissenschaftlichen Beurteilung von Psychotherapie immer die subjektive Einschätzung des psychischen Wohlbefindens des Patienten gehören muß sowie das klinische Urteil des Therapeuten.

4. Das kulturelle Bezugssystem

Am Beispiel der Psychoanalyse macht der Autor deutlich, daß kulturelle und soziale Aspekte ebenfalls immer in Beurteilungen miteinfließen und deshalb bei jeder Beurteilung mitzuberücksichtigen sind. Insbesondere in der US-amerikanischen Diskussion spielt der Begriff der »Effizienz« eine bedeutende Rolle. Kriterium ist nicht allein die Effektivität, sondern die »Effizienz«, d.h. die Effektivität in geringerer Zeit. Somit ist der Kostenfaktor von zentraler Bedeutung. Die Zielvorstellung von Psychotherapie, so z.B., das subjektive Wohlbefinden des Patienten, Symptom- oder Persönlichkeitsstrukturveränderung ist ebenfalls kulturell abhängig. Somit kommt der Autor letztendlich zu dem Schluß, daß eine kulturunabhängige Beurteilung von Psychotherapie nicht möglich ist.

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Dynamisch-Psychiatrische Methoden bei einigen durch Sozialstreß ausgelösten psychischen Störungen**

Boris S. Poloshij (Moskau)*

Die gegenwärtige Übergangsperiode in Rußland mit ihrer sozialen, politischen und wirtschaftlichen Instabilität bringt einen Anstieg der psychischen Störungen und der psychischen Desadaptation (Alexandrowski) mit sich. Poloshij bezeichnet dies als Identitätskrisen und unterscheidet vier klinische Varianten: die anomische, die dissoziale, die negativistische und die magische. Er setzt sie in Beziehung zu Ergebnissen aus dem Ich-Struktur-Test nach Ammon in seiner russischen Fassung. Es zeigt sich, daß die destruktiven und defizitären Komponenten der Aggression, Angst, Ich-Abgrenzung und des Narzißmus überwiegen. Für die Psychotherapie dieser Patienten wie für die russische Gesellschaft insgesamt fordert Poloshij den Aufbau konstruktiver sozialenergetischer Felder und Gruppenbeziehungen.

Die Stabilität und fortschreitende Entwicklung jeder Gesellschaft, die Erhaltung und Mehrung ihres intellektuellen und geistigen Potentials hängen in großem Maße vom Zustand der psychischen Gesundheit ihrer Bevölkerung ab. Aus diesem Grund gehören die Erforschung, Pflege und Förderung der psychischen Gesundheit zu den wesentlichen Aufgaben der modernen Psychiatrie. In der dynamischen Psychiatrie, die ihrem Sinn nach humanistisch und auf die Entwicklung der Persönlichkeit und einer konstruktiven Gruppendynamik ausgerichtet ist, kommt Problemen der psychischen Gesundheit sowohl von einzelnen wie auch von Gruppen eine vorrangige Bedeutung zu. Forschung zur psychischen Gesundheit ist eigentlich keine rein medizinische Aufgabe, sondern ein multidisziplinärer Vorgang, zu dem auch klinisch-psychiatrische Forschungsmethoden gehören. Es ist kein Zufall, daß das Thema des X. Weltkongresses der World Association for Dynamic Psychiatry »Medizin und Psychologie im holistischen Verständnis von Gesundheit und Krankheit« heißt und diesen Trend widerspiegelt.

Im heutigen Rußland sind die Aufgaben der Ärzte in der psychiatrischen Versorgung nicht leichter geworden – ungeachtet dessen, daß jetzt die Psychiater bei der Wahl ihres wissenschaftlichen, therapeutischen und methodischen Vorgehens mehr Offenheit und Freiheit haben als während der totalitären Periode. Man kann durchaus behaupten, daß ihre Lage komplizierter wurde. Das ist auf besondere, besser gesagt, extreme Umstände im Rußland der Übergangszeit zurückzuführen. Innerhalb der historischen Entwicklung Rußlands ist die gegenwärtige Epoche einerseits durch so positive Erscheinungen wie die Wiederherstellung von Freiheit und Demokratie, die Wiederanerkennung der russischen Mentalität, die Deideologisierung der Gesellschaft und die Anerkennung der Persönlichkeitsrechte, der Meinungs- und Religionsfreiheit gekennzeichnet. Andererseits

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geht dies mit sozialer, politischer und wirtschaftlicher Instabilität, mit einem Bruch der gewohnten Stereotypien im Alltag, mit dem Verlust einstiger Ideale, mit der Polarisierung der Gesellschaft hinsichtlich der finanziellen Lage und der ideologischen Überzeugungen einher.

Der Moskauer Psychiatrieprofessor *Alexandrowski* versteht all diese Faktoren als Stressoren, die bei einem großen Teil der Bevölkerung zu psychischer Desadaptation (= mangelnde psychische Anpassungsfähigkeit, Anm. d. Übers.) führen. Danach entwickeln sich in jeder Gesellschaft in Zeiten sozialer Spannungen prädisponierende Umstände für die Enstehung psychischer Störungen wie Alkoholismus, Sucht, abweichendes, delinquentes und suizidales Verhalten. Besonders wichtig ist es, daß diese Erscheinungen wechselseitig verbunden sind wie ein »circulus vitiosus«, da der zahlenmäßige Anstieg der Personen mit psychischen und Verhaltensstörungen seinerseits wieder die sozialen Spannungen in der Gesellschaft verschärft. Studien zur psychischen Gesundheit der Bevölkerung erfordern unter diesen komplizierten Bedingungen ein besonderes methodisches und wissenschaftlich-theoretisches Vorgehen. Zur phänomenologischen Beschreibung und für das klinische Verständnis von psychischen und Verhaltensstörungen, die mit Sozialstreß verbunden sind, verwenden wir den in der amerikanischen Psychiatrie anerkannten Begriff der »Identitätskrise«. Darunter wird eine Wahrnehmungsstörung des Selbst verstanden bis hin zum völligen Verlust der Wahrnehmung von sich selbst als Person, die Unfähigkeit, die von der Gesellschaft zugeschriebenen Rollen zu übernehmen oder sich ihnen anzupassen. Die Psyche vieler Menschen erweist sich während einer sozialen Krise und unter der Wirkung einer Art psychologischen Drucks als ungenügend plastisch, um sich den sich rasch verändernden Lebensumständen angemessen anzupassen.

Um den Kern der Identitätskrise und ihre Entwicklungsmechanismen zu verdeutlichen, verwenden wir den dynamisch-psychiatrischen Ansatz und gruppendynamische Prinzipien. Damit ist im gegebenen Fall *Günter Ammons* Konzeption der Sozialernergie und des sozialenergetischen Felds gemeint. Nach dieser Theorie hängen die Entwicklung ebenso wie die weiteren – sowohl gesunden wie auch pathologischen – Funktionen einer Persönlichkeit von der Sozialenergie ab, die im zwischenmenschlichen Kontakt entsteht und weitergegeben wird. Diese Energie kann konstruktiv, destruktiv oder defizitär sein. Das sozialenergetische und gruppendynamische Feld jeder Person umfaßt alle drei Anteile; entsprechend dem jeweiligen Überwiegen des konstruktiven, destruktiven oder defizitären Anteils entwickelt sich die Ich-Struktur und folglich auch der Zustand psychischer Gesundheit bzw. der Charakter der entstehenden psychischen Störungen. Auch wenn man der einzigartigen Individualität jeder konkreten Persönlichkeit Achtung zollt, muß man doch feststellen, daß die Gesellschaft insgesamt zu einem gegebenen historischen Zeitpunkt einige mentale Parameter enthält, die den psychischen Zustand der Nation bestimmen. Ich erlaube mir, an die Worte von *Friedrich Nietzsche* zu erinnern:

»Es kommt selten vor, daß die Zukunft einem Individuum einen Schlag versetzt, sie regiert dagegen ganze Gruppen, Nationen und Epochen.« (Rückübersetzt aus dem Russischen)

Daß sich bei einem großen Bevölkerungsteil Rußlands die Identitätskrise als klinisch-psychologisches Phänomen entwickelte, ist eine Reaktion auf die globalen Veränderungen der gesellschaftlichen Ordnung im Lande, die zu einem Bruch der bestehenden gruppendynamischen Beziehungen führte. Wir verstehen die Identitätskrise als spezifische Form psychischer Desadaptation, die als Antwort auf schnelle und radikale Veränderungen im gesellschaftlichen Leben entsteht. Klinisch manifestiert sich die Identitätskrise durch einen Komplex von Störungen: von der Zuspitzung und Akzentuierung von Charakterzügen bis hin zur Entwicklung oder Dekompensation von psychischen und Verhaltensstörungen. Die vorzufindenden Störungen der psychischen Gesundheit zeichnen sich somit durch klinischen Polymorphismus aus, ihre Manifestationen können sowohl auf vornosolgischem wie auf nosologischem Niveau sein. Die klinische Ausarbeitung der hier vorgelegten Konzeption, die sich auf Untersuchungsergebnisse unterschiedlicher Populationsgruppen gründet, wird noch fortgesetzt. Die vorläufigen Ergebnisse ermöglichen, vier klinische Varianten der Identitätskrise zu unterscheiden, nämlich die anomische, die dissoziale, die negativistische und die magische Form.

Welche Variante der Identitätskrise sich ausbildet, ist abhängig von den im menschlichen Unbewußtem verwurzelten zentralen Ich-Funktionen der Aggression, der Angst, der Ich-Abgrenzung, des Narzißmus und der Ich-Integration der Persönlichkeit. Entsprechend dem Konzept des Synergismus von Bewußtem und Unbewußtem wohnt jeder bewußten Äußerung psychischer Tätigkeit eines Menschen auch ein unbewußter Anteil in unterschiedlichem Maße inne; deshalb spiegelt sich die Ich-Struktur der Persönlichkeit auch in Gedanken, Gefühlen, im Verhalten und in der Spezifik psychischer Störungen wider. Mit Hilfe des Ich-Struktur-Tests nach *Ammon,* ins Russische adaptiert vom Psychoneurologischen Institut Bechterew, St. Petersburg, haben wir die Ich-Struktur bei den verschiedenen klinischen Varianten der Identitätskrise untersucht.

Die erste klinische Variante der Identitätskrise nannten wir die *anomische.* Wir verstehen Anomie hier als Apathie und Entfremdung infolge eines Verlustes der ehemals bedeutsamen Lebensziele. Diese Form der Identitätskrise zeichnet sich durch spezifische Störungen aus: Verlust des Lebensstonus und ehemaliger Interessen, Reduzierung von Aktivität und Zielstrebigkeit, eigenartiges Autistisch-Werden und passives Flüchten in sich selbst. Die Stimmung wird durchgängig ängstlich-depressiv, der Betroffene hat kein Zutrauen zu seinen Kräften, statt dessen ein Gefühl von Bedeutungslosigkeit, hält sich für unfähig, Schicksalsschlägen zu begegnen, er wird ungesellig und verschlossen im Gegensatz zu früher. Dies alles führt zu sozialer Desadaption sowohl im familiären als auch im beruflichen alltäglichen Leben. Diese Personen schwimmen stromabwärts durch den

stürmischen Lebensfluß, indem sie willenlos und passiv erwarten, was am Ende kommt.

Im Ich-Struktur-Test nach *Ammon* (ISTA) ist bei der anomischen Variante der Identitätskrise die Persönlichkeit gekennzeichnet durch defizitäre Aggression, defizitäre innere und äußere Abgrenzung, defizitären Narzißmus und destruktive Angst. Führendes Merkmal, eine Art Visitenkarte der anomischen Variante, ist die defizitäre Aggression, die das Fehlen einer Bereitschaft zu aktiver, zielgerichteter Tätigkeit sowie eine passive Absonderung von den Mitmenschen und von jeglicher Tätigkeit widerspiegelt. Die destruktive Angst trägt dazu bei, daß alle zentralen Ich-Funktionen und insbesondere die Tätigkeit des Menschen gelähmt und desintegriert werden. Der defizitäre Narzißmus gibt dem Patienten keine Möglichkeit, sich selbst, seine eigenen Kräfte und Möglichkeiten adäquat einzuschätzen.

Die zweite Variante der Identitätskrise bezeichnen wir als *dissoziale* bzw. *aggressiv-destruktive.* Bei solchen Persönlichkeiten überwiegt der »Bosheitsaffekt«, und es entsteht absolute Unduldsamkeit gegenüber anderen Meinungen; das Denken bekommt einen überwertigen, in manchen Fällen einen paranoiden Charakter. Diese Personen bilden marginale Schichten unserer heutigen Gesellschaft. Ein Teil von ihnen schließt sich den extremistischen politischen Gruppen und Strömungen an, von der extrem rechten faschistisch-chauvinistischen bis zur extrem linken bolschewistischen Orientierung hin. Gerade diese Personen nehmen an verschiedenen gesellschaftlichen Aktionen wie Meetings, Demonstrationen, Streiks am aktivsten teil und verleihen diesen Aktionen einen kriegerischen, destruktiven Charakter. Es sei betont, daß sich die Personen mit der dissozialen Variante der Identitätskrise durch hohe Suggestibilität auszeichnen und sich aus diesem Grund leicht von einer Führungspersönlichkeit induzieren lassen. Andererseits können sie durch ihr Verhalten und ihr kompromißloses Urteil selbst Menschenmengen stark induzieren, indem sie pathologische Leidenschaften schüren. Übrigens beschrieb der französische Psychologe *Sigale* im 19. Jahrhundert ähnliche Persönlichkeiten als Hauptfiguren der französischen Revolution. Unter unseren gegenwärtigen Umständen sehen wir genügend ähnliche Personen und die Ergebnisse ihres Tuns; es sei nur an die tragischen Ereignisse vom Oktober 1993 in Moskau erinnert. Andere Vertreter der dissozialen Variante füllen die Reihen der Kriminellen und begehen unmotiviert oder aus Geldgier Delikte. Solche Peronen lassen sich von kriminellen Gruppierungen zur Ausübung brutaler und gewalttätiger Verbrechen rekrutieren als Racketeers, Killer, käufliche Mörder usw. Die dissoziale Variante der Identitätskrise entspricht in etwa dem Begriff »sozial erworbene Psychopathie«, den der russische Psychiater *Gannuschkin* in den zwanziger Jahren unseres Jahrhunderts vorgeschlagen hat.

Grundkern der Ich-Struktur solcher Persönlichkeiten ist die destruktive Aggression, die ihren zerstörerischen Verhaltensstil, ihre zwischenmenschlichen Kontakte und das Fehlen der Möglichkeit zur Selbstregulation von

Wut- und Haßgefühlen bestimmt. Die destruktive Aggression wird durch die defizitäre Angst ergänzt und potenziert. Aufgrund dieser nicht gespürten Angst sucht der Betreffende extreme Situationen und Risiken und verliert die Möglichkeit, diese und sich selbst adäquat einzuschätzen. Außerdem kann man bei den meisten Patienten mit dieser Form der Identitätskrise einen hohen destruktiven Narzißmus feststellen, der dazu beiträgt, daß diese Menschen unfähig sind, Kritik zu ertragen und sich selbst und ihre Umgebung realistisch einzuschätzen.

Die dritte Variante der Identitätskrise ist die *negativistische* bzw. *passiv-aggressive.* Bei Vertretern dieser Variante kommt die Aggression in einer passiven Form als Unzufriedenheit, Eigensinn, vorsätzliche Ineffizienz ihrer Tätigkeiten zum Ausdruck. Diesen Personen ist die Entwicklung spezifischer charakterlicher Veränderungen eigen, die sich in Ängsten vor allem Neuen manifestieren und kraft deren sie jede Veränderung und Wendung aktiv ablehnen und deren Ergebnisse skeptisch-pessimistisch einschätzen. Es erscheint ein Affekt ständiger Unzufriedenheit und Mißvergnügens, im Verhalten überwiegen Galligkeit und Murren, die diesen Menschen früher nicht eigen waren. Dabei werden die eigenen Aktivitäten kraß herabgesetzt oder in den ständigen Wunsch zu opponieren verkehrt.

Beispiele für diese Variante der Identitätskrise kann man außer bei klinischen Fällen auch an einigen Mitgliedern des ehemaligen Obersten Sowjets Rußlands beobachten, wenn sie allem ohne Ausnahme, jeder ökonomischen oder sozialen Innovation, entgegenwirken.

Die Analyse der Ich-Struktur passiv-aggressiver Persönlichkeiten erlaubt, als dominierendes Merkmal bei ihnen die destruktive äußere und innere Ich-Abgrenzung festzustellen, mit einer Art psychologischer Schranke und Nicht-Wahrnehmung anderer Menschen und ihrer Bedürfnisse.

Die vierte klinische Variante der Identitätskrise wird von uns als *magische* bezeichnet. Als Hauptmerkmal entwickelt sich bei den Betreffenden ein magisches Denken – im klinischen Sinne dieses Begriffs –, das beginnt, ihre Interesssen, Emotionen, ihr Verhalten und ihre gesamte Lebensweise zu bestimmen. Ein stürmischer Aufschwung des Interesses für alles Unerklärbare, Irrationale, Paralogische und Mystische ist für alle Zeiten von Gesellschaftskrisen und für einen wesentlichen Teil der Gesellschaft allgemein charakteristisch. In den letzten Jahren wurde Rußland von unzähligen Zauberern, Astrologen, Hellsehern, extrasensorischen Heilpraktikern und Beschwörern überflutet, und die Massenmedien versuchen aktiv, von diesem Trend zu profitieren. Es ist bekannt, daß das magische Denken Kindern und primitiven Kulturen eigen ist und als psychopathologisches Phänomen bei schizophrenen und zwangsneurotischen Patienten vorkommt. Die »magische Verseuchung« einer Gesellschaft in Krisenzeiten läßt sich dadurch erklären, daß das magische Denken manchen Individuen als ein psychologischer Schutzmechanismus dient, der es ermöglicht, objektiv existierende Lebensschwierigkeiten subjektiv zu erleichtern. Die

magische Variante der Identitätskrise führt nicht nur zur sozialen und beruflichen Desadaption einzelner Personen, sondern auch zu gefährlichen gesellschaftlichen Entwicklungen. Dies steht im Zusammenhang mit dem Phänomen der Gruppenbildung dieser Persönlichkeiten und ihrer induzierenden Wirkung auf andere. Als Beispiele sollen hier nur die religiösen Sekte »Weiße Gemeinschaft«, die in Rußland und der Ukraine tätig war und von ehemaligen Komsomolzen geleitet wurde, und der Fernseh-'Psychotherapeut' Kaspirowsky angeführt werden.

Es gelang nicht, in der Ich-Struktur dieser Persönlichkeiten irgendein überwiegendes Merkmal an Destruktion oder Defizit der zentralen Ich-Funktionen festzustellen. Dennoch lagen die meisten Ergebnisse außerhalb des Normalbereichs.

Zusammenfassend kann man sagen, daß unter den Bedingungen krasser Veränderungen in allen Bereichen des gesellschaftlichen Lebens in Rußland die psychische Gesundheit der Bevölkerung besonderen Belastungen ausgesetzt ist. Bei einem Teil der Menschen mit einer unharmonischen Ich-Struktur entwickelt sich unter Einwirkung der sozialen Streß-Faktoren eine spezifische psychische Störung, die sich in der Identitätskrise manifestiert. Bei deren Entstehung und klinischen Manifestation nehmen Störungen der zentralen Ich-Funktionen einen wesentlichen Platz ein. Die therapeutische Hilfe für diese Patienten sollte auf Prinzipien der Gruppendynamik und auf Korrektur und nachholender Entwicklung der Ich-Struktur beruhen, mit dem Ziel, ein konstruktives sozialenergetisches Feld zu gestalten. In den Begriffen *Günter Ammons* ausgedrückt, heißt das, daß in der heutigen russischen Gesellschaft insgesamt destruktive und defizitäre soziale Energie noch immer überwiegt. Das erfordert, Gruppenbeziehungen in allen gesellschaftlichen Strukturen konstruktiver zu machen, was eine Grundlage für die Pflege und Förderung der psychischen Gesundheit der Nation darstellt.

Dynamic-Psychiatric Methods in Some Psychic Disturbances Connected with Social Stress

Boris S. Poloshij (Moscow)

Poloshij describes today's situation in Russia: on the one hand, democracy, freedom and human rights are appointed, society is being deiodelogized and the Russian mentality is recognized again. On the other hand, there exists social, political and economic instability, a loss of former ideals, a polarization of society in concern of financial situation and ideological convincements. According to *Alexandrovsky,* a Moscow psychiatrist, all these factors are stressors which may in a great part of the population lead to psychic desadaptation. During social tensions arise predisposing conditions for the development of psychic disturbances. These factors are interconneted like a 'circulus vitiosus', for the increase of disturbed persons itself tightens the social tensions.

The author uses the american psychiatric term »identity crisis« to describe the disturbances related with social stress: it means a disorder of self perception up to its complete loss, the inability to adequately fulfill his roles in society. As a reaction to the global change of life in Russia, which has lead to a break of all groupdynamic relations, a great part of the population developed an identity crisis. *Poloshij* understands it as a specific form of psychic desadaptation, clinically manifested in a polymorphus complex of symptoms.

He is examining several groups of the population. The provisional results allow to discriminate four variants of identity crisis: the anomic, the dissocial, the negativistic and the magic form. Which form is being developed, depends on the developmental state of a personality. For a deeper understanding of the identity crisis he refers to *Günter Ammon's* theory. As *Poloshij* points out, in this dynamic psychiatric approach a person's development and ego-functions, healthy as well as pathological ones, depend on the social energy created and transferred in interpersonal contact. The social-energetic and group dynamic field of each person contains as well constructive, destructive and deficient parts. The ego structure and consequently the state of mental health and the character of disturbances will develop according to the predominating part of social energy.

Which variant of identiy crisis is formed, depends on the central ego functions of aggression, anxiety, ego-demarcation, narcissism and integration rooted in the human unconscious. Every conscious activity, emotion, behaviour and specific of psychic disorders partly reflects the unconscious. The Ego-Structure-Test by *Ammon* in its russion adaptation by the Psychoneurological Bechterev Institute, St. Petersburg, is used by *Poloshij* to examine the ego structure in the different clinical variants of identity crisis.

The *anomic* variant of identity crisis means an apathy and alienation caused by a loss of formerly important aims in life, a reduction of activity and purposefulness, a passive »retreat into oneself«, an anxious-depressive mood, no self-confidence and a feeling of insignificance. »These persons are floating downstream through the stormy river of life, will-lessly and passively awaiting what's coming forth at the end.« The Ego-Structure-Test shows deficient aggression, deficient inner and outer demarcation, deficient narcissism and destructive anxiety. The leading feature is the deficient aggression; the deficient narcissism prevents the patient from adequately estimating himself.

In the personalities with the dissocial or destructive-aggressive variant the »affect of malice« and an absolute intolerance towards others is predominant. In the 20ies the Russian psychiatrist *Gannoushkin* proposed the term »socially acquired psychopathia«. These persons form marginal sections of the Russian society, a part of them joins the extremistic political groups, a part of them become brutal criminals like killers and racketeers. They show a high suggestability and may easily be induced by a »leader«. On the other hand they may, due to their uncompromising behaviour and judgement, themselves induce others, as one could see for example in the tragic events of october 1993 in Moscow. The core of ego structure is the

destructive aggression, which defines the destructive style of behaviour, interpersonal contacts and the missing of self-regulation of feelings of hate and rage. Due to their deficient, i.e. non-experienced anxiety, these persons seek extreme risks and loose the ability of adequately assess themselves. Also a high degreee of destructive narcissism is to be found, therefore they can not stand being criticized.

The negativistic or passive-aggressive variant of identity crisis is characterized by unhappiness, obstinacy, intentional in-efficiency of activities. These persons are anxious towards all new and unknown, they reject every change actively and in a sceptical-pessimistic way. Formerly they did not show this continuous annoyance and grumbling. Their activities are sharply reduced or turned into the wish to oppose. The predominating feature is the destructive inner and outer demarcation, which forms a kind of psychological barreer and non-perception of other men and their needs.

The magic variant is marked by a magic thinking which defines interests, emotions, behaviour and lifestyle of the concerned persons. In the last years Russia experienced a true uplift of the interest in the irrational, paralogic, mystic themes, what has been characteristic for all crisis of a society at all times. The magic thinking serves as a psychological protective mechanism, which alleviates subjectively the existing difficulties of life. Not only social and professional desadaptation, but also dangerous effects in society are linked with this variant of identity crisis and its phenomenon of group formation. *Poloshij* reminds of the religous sect »White Community« which was leaded by former members of Komsomol and the TV-psychotherapist, *Kaspirovsky*. The ego structure of these personalities does not show any specific features of destruction or deficit. Nevertheless most results were found out of the standard.

Poloshij concludes that under conditions of stark changes in all areas of life in Russia the mental health of the population is highly stressed. A part of the persons with an unharmonic ego structure developed an identity crisis. In terms of *Günter Ammon*'s theory, social energy in the Russian society in general is predominantly destructive or deficient. The author postulates to consider group dynamic principles in order to turn group relations more construcitve which he estimates fundamental for the mental health of a nation. The treatment of patients with identity crisis should correct and catch up on the development of ego structure and build up a constructive social energetic field.

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Contributions of the Dynamic Psychiatric Point of View for Social Psychiatric Conceptions and Achievements**

Guilherme Ferreira (Lisbon)*

The author sees Dynamic Psychiatry centered on the concept of conflict. The conception is based among others on the theory of Freud. It was developed in different directions, especially referred the Ego-psychology of Hartmann,the conceptions of Erikson and Rapaport, the opject-relationship theory of the Kleinian school and the Self-Psychology of Kohut. All the different factors, pointed out in these conceptions, are important for the development and organisation of personality. They are included in the biopsychosocial model of the Social Psychiatry. It directs towards prevention and community. We can distinguish between three ways of prevention: primary prevention is linked to hereditarity and the genetic development of individuals. Secondary prevention includes diagnosis and treatment, particularly psychotherapy, the most important sector of application of Dynamic Psychiatry. Tertiary prevention is the rehabilitation and integration especially of handicapped persons in community and working process. In all sectors Dynamic Psychiatry plays an important role. But Social Psychiatry cannot be explained in all its dimensions by Dynamic Psychiatry.

Social Psychiatry is an intervention model in psychiatry, directed towards prevention and community. Its fundamental aim is mental health promotion and its paradigm of human functionment is a biopsychosocial model.

Dynamic Psychiatry is centered on the concept of conflict. The structure of its theory includes the topic, economic and dynamic models. The central axis of this theory is, according to *S. Freud,* the metapsychological point of view. *S.* and *Anna Freud* established the concepts of structure and adaptation, and completed it with the metapsychological points of view. *Heinz Hartmann* developed these conceptions. He established the notions of inborn and aquired structures and he gave to them a central importance in adaptation. This point of view was the basis of the theory of Ego-psychology , according to which metapsychology was a fundamental issue in normal psychology, as well as in psychopathology, in which it was first described.

These conceptions were developed by *Erikson,* who developed an epigenetic psychosocial theory, in which the importance of social and cultural factors in the way in which they influence life cycle manifestations was stressed and the relativity or even the inexistance of a true secondary process was established.

Rapaport systematized the adaptative and psychosocial points of view, established and developed by all the authors above referred, in his metapsychological conceptions.

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The culturalists, now called inter-personalists, contributed to stress the importance of social and cultural factors in psychology and psychopathology (and, consequently, metapsychology).

The Kleinian conceptions, the object relations theory, developed by the English middel group (*Balint, Fairbairn, Guntrip, Winnicott*) and the points of view of the American school of Ego-psychology (*Kernberg*) pointed out the importance of self-object relationships and of interaction phenomena in psychology and psychopathology, giving other aspects to the physical and social environment, influence (seen often today as *Winnicot's* holding) in the individual's evolution and in its personality organisation, through the objects it supplies to him.

In a complementary way, Self-psychology (*Kohut*) sustains, the importance of the individual's own self organisation (consequence of the evolution of its normal and/or pathological narcissism) in its interaction with the physical and social environment above referred and its objects to achieve the same aims (individual's evolution, personality organisation, psychological and psychopathological aspects).

In conclusion, social and cultural unconscious and instinctive factors and self-object relationships are all important for the development and organisation of personality and the eventual appearence and the structuration of psychopathology and they also constitute a central issue to explain the bio-psychosocial model in Social Psychiatry. On the other hand, communication theories (some of them also strongly influenced by psychoanalytic conceptions), namely the Palo Alto School, organized around *Bateson, Watzlawik* and others, showed also the importance of social systems.

As Social Psychiatry is mainly a science of psychiatric intervention, we can use conceptions in primary, secondary and tertiary prevention and consequently in mental health promotion. Life cycle evolution (from the organisation of mother- child-relationship, through the structured oedipal family and the family interaction to the establishment of adult activities in work, sexuality, and leisure, and afterwards, of those characteristic of third age) will influence personality structure organisation, and, naturally, its pathological aspects.

This evolution will consequently contribute to determine personality structure and its way of functionment and, in some cases, the organization of a pathological evolution (neurotics, borderline, psychotics). The appereance of a Balint's basic fault in early phases of life cycle development or of any other disturbance during Evolution will determine the following situations by rising order of seriousness: psychosocial problems, personality disturbance, mental diseases.

These disturbances are more frequent in individual's developmental crises and more serious when they will occur more preconsciously.

Primary prevention (or prophylaxis) of mental disturbance is, generally and fundamentally, linked to hereditarity and inborn or aquired biochemical metabolic errors, to neurological disturbance, – its biological compo-

nent – and to the genetic development, because these are the factors on which we can act. The genetic development is strongly influenced by problems arising in all life cycles, but particularly by those that take place in childhood and adolescence. Education given in these periods of life is particularly important to avoid the development of mental disturbances, constituting perhaps one of the most efficcacious factors in primary prevention. Damaging life styles, on the other hand, should be avoided and substituted by healthy ones, in any period of life this change contributing also to organize and structure primary prevention. As we can foresee, the conceptions of Dynamic Psychiatry are very important in the two last actions referred, particularly in the first one.

Secondary prevention and its two components, preconscious diagnosis and treatment, should be done by the community itself, at least idealistically, through its health (and mental health) technicians, families and self help and volonteer groups. The conceptions of Dynamic Psychiatry can be very useful in both of these actions (diagnosis and treatment), giving to the community and to its agents the possibility of understanding the phenomena occured in mental disturbance and in psychopathology and the ways to correct them. This is its psychopedagogical component. But it is certainly psychotherapy, that constitutes one of the main psychiatric treatments and the most important intervention in Dynamic Psychiatry providing reeducation and the prophylaxis of future crises.

Tertiary prevention (or rehabilitation) should prepare the individuals with handicaps or deficiencies to be reintegrated in community in their own home as in the work universe. It requires also often a previous psychotherapeutic approach in order to strengthen their personality and to prepare them for their reinsertion in it. On the other hand, community should be prepared to accept and support mental deficients. Here again Dynamic Psychiatry conceptions can be used to do this education, as well as to allow the connection as far as possible of the mentally disturbed.

Mental health promotion implies all the actions described above about the prevention of mental disturbance, but it requires also a physical, mental and social state of well being. The educational action, in which these aims are contemplated and in which we should not forget the teachings of Dynamic Psychiatry, should be developed in order to achieve these goals.

The contributions of Dynamic Psychiatry for the prevention of mental disturbance are as following. We can summarize metapsychological conceptions in five points (topographic, genetic, dynamic, energetic and structural). Consequent prevention should be done by paying attention to the following points:

1. The instincts (sexual and aggressive) should be integrated and accepted by the individual. Sexual education is particularly important in this point of view.

2. We should overcome or weaken, particularly in what concerns primary prevention, the infantile trauma, particularly those that are more preconscious in time.

3. We should seek for an equilibrium of narcissistic and objectal investments and weaken the conflicts.
4. We should develop the contact of the Ego with reality and the flexibility of the Super-Ego. In this organisation the ideal of the Ego should become predominant, closer to the individual and less hard to be satisfied.

Concerning the object relations theory, we should stress, in prevention, the importance of the objects in the individual's evolution, through an interactive action and the active position of the subject since its establishment.

On the other hand, Ego-Psychology stresses the importance of psychosocial and adaptative factors on prevention, allowing an adequate integration and adaptation of the indivual to the environment.

Finally, for Self-Psychology it is important to stress the importance of a normal evolution of narcissism, avoiding its pathological development and allowing the normal interaction of the individual with the objects.

The importance of Dynamic Psychiatry in prevention of mental disturbance is as following: Making comprehensive genetic psychology, economical and dynamic equilibrium of the self and social interaction. It explains many of the actions developed in all the prevention levels and it can be based on pedagogical and educational perspectives or on personality reconstruction, based, in its turn, on psychoanalytically oriented psychotherapy. The first ones are more used on primary prevention, the last ones on secondary and tertiary preventions.

Social Psychiatry cannot be explained in all its dimensions by Dynamic Psychiatry. We should point out that the conceptions of the last one can give a very effective support to a great number (if not to the majority) of the actions of Social Psychiatry.

Beiträge des dynamisch-psychiatrischen Standpunktes für Vorstellungen und Errungenschaften der Sozialpsychiatrie

Guilherme Ferreira (Lissabon)

Dynamische Psychiatrie zentriert sich nach der Auffassung des Autors um das Konfliktmodell und basiert letztlich auf den Konzeptionen *Freuds*. Zunächst beschreibt er, auf welche Weise *Freuds* Vorstellungen weiterentwickelt wurden. Dabei erwähnt *Ferreira* insbesondere die Ich-Psychologie *Hartmanns*, die Ansätze *Eriksons* und *Rapaports*, die *Klein*ianische Objektschule, *Kohuts* Narzißmuskonzept und die Kommunikationstheorien von *Bateson* und *Watzlawik*. Diese Modelle bilden für ihn den Kern der Dynamischen Psychiatrie. Er folgert, daß alle hierin genannten Faktoren für die Entwicklung der Persönlichkeit und gleichwohl für die Entstehung von Krankheit bedeutsam sind und alle im biopsychosozialen Ansatz der Sozialen Psychiatrie Aufnahme finden. Ihr Ziel ist letztlich psychische

Gesundheit. Sie richtet sich daher v.a. auf die Prävention und die Integration in die Gemeinde. *Ferreira* unterscheidet drei Arten von Prävention: Zum ersten die primäre Prävention, bei der hauptsächlich Faktoren der Vererbung und Genetik, sowie aller damit im weiteren Sinne verbundenen Vorbeugemaßnahmen eine Rolle spielen. Bei der sekundären Prävention geht es um das Erkennen und Behandeln psychischer Krankheit. Entsprechend liegt hier das Hauptanwendungsgebiet der Dynamischen Psychiatrie. Sie spielt aber auch auf dem dritten Gebiet, nämlich der tertiären Prävention eine gewichtige Rolle, die die Rehabilitation und Integration in Arbeit und Gemeinde meint. Hier soll die Dynamische Psychiatrie zur Veränderung der Persönlichkeit des Rehabilitanden beitragen und ihn beim Knüpfen von Kontakten in der Gemeinde unterstützen. Insgesamt spielt Dynamische Psychiatrie in allen drei Bereichen eine wichtige Rolle. Der Autor resümiert, daß sie nicht das ganze breite Feld der Sozialen Psychiatrie abdecken kann und dies auch nicht beabsichtigt.

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The Holistic Approach of Psychodrama-Therapy and the Significance of its Double Setting**

Grete Anna Leutz (Überlingen/Bodensee)*

The essentials of Moreno's concept of treatment which consists of psychodrama, sociometrics and group psychotherapy, will be shortly described. By the example of a detailed sequence of a psychodrama session the author shows, how in the situation of improvised theater a stable pattern of transference and countertransference reactions can be comprehended in its deeper emotional implications behind its everyday aspects. The author emphazises the significance of switching from the here and now reality of the group to the meta-reality of psychodrama and back again for the separation process from transference feelings and reactions. The verbalization level of the concluding group-psychotherapeutic phase allows for a conscious integration of what the protagonist had experienced during the entire session.

When half a century ago the founder of psychodrama-therapy or more precisely of the Triadic Method Psychodrama, Sociometry, Group Psychotherapy, *J. L. Moreno* (1946) proclaimed: »I move man back into the universe«, this statement has not only been a façon de parler'. It may, indeed, be considered to be the common denominator underlying *Moreno'* s philosophic-anthropologic view of man, his holistic or rather systemic approach, and the specific methods and techniques, developed to have this approach materialized in practice. Therefore, we shall first take a look at the philosophy of the triadic method and then examine the significance of its double setting i.e. of the two different realities in which each psychodrama-session is carried out.

Starting-point for *Moreno* was his awareness of encounter in its universal existential significance. As far as the human dimension is concerned it is equally important to man's prenatal existence, brought about by the encounter of sperm and ovum, as it is to his or her postnatal life and fate. We shall focus on the latter.

Any encounter manifests itself in two interdependent phenomena, namely in interactions and interpersonal relations. By means of their interdependency they constitute situations. After all, situations are the element in which man's life is taking place and in which it is shaped. Next to the genetic code, their respective qualities and duration exert the strongest influence on the individual's wellbeing and bio-psycho-social development.

Thus, it is not surprising that already in his first, still expressionistic publication entitled 'Invitation to an Encounter' *Moreno* (1914), when problems are arising, asks three simple, yet relevant questions which ultima-

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tely have led to treating the patient 'in actu et in situ' i.e. in his system, his universe. Respective questions are:
»– What does the situation consist of?
–What has brought us into this situation?
– What will lead out of the situation?«
They mark the shift from the individualistic paradigm to the holistic one of psychodrama-therapy.

In order to facilitate understanding of the systemic approach of the triadic method I would like to use the ellipsis for illustration. The circumference of this geometric figure is determined by its two foci. It can be altered by changing one or both of them. Correspondingly, the situation of an individual is determined by his or her interactions and interpersonal relations. The situation therefore can also be represented by the circumference of an ellipsis and be altered by changing its determinants, either interaction and/or interpersonal relations.

In view of this fact psychodrama was developed to study and change the patient's interactions and sociometry, to study and change his interpersonal relations. They both bring about group-psychotherapeutic change of the pathogenic or already pathological situation which has been precipitating the patient's symptoms. The pathological situation can be an actual conflict or a crucial situation of the past to which the patient has remained fixated as expressed by his psycho-physical behaviour, psychodramatically speaking by his unconscious re-enactment of roles which are inappropriate in his present life-situation. This neurotic inadequacy causes him (as well as his important others) to suffer by their interaction.

Before the introduction of psychodrama-therapy a patient's life-situation could not actively be dealt with, not 'in actu et in situ', it could only be verbally related to the extent, to which the disturbance or – let's face it – the therapeutic relation permits it. That type of communication takes place in the individual setting or in the here-and-now-reality of the group which both more or less isolate the patient from his life-situation.

Psychodrama-therapy by offering in addition the possibility to unfold one's own life-system according to memory and imagination in the meta-reality of spontaneous scenic play 'moves man back into the universe'. Setting-up the space of a scene and spontaneously moving one's body and mind in it allows the patient to literally reproduce and re-experience scenes of his present life, of the past, or of his fantasy e.g. dreams, hallucinations (*Moreno* 1945) and future projections. The concretization of an anticipated, eventually feared future scene in psychodrama enables the protagonist, to get acquainted whith it, (by role-reversal even from the perspective of the other persons involved), further to investigate it more realistically and to experiment with other possibilities. This use of psychodrama is especially anxiolytic.

All these applications of psychodrama occur in interaction of the patient (now protagonist of the play) with group members he has chosen for the

enactment of his important others and is made possible by psychodramatic techniques such as role-reversal. To the latter we owe the spontaneous flow of the not at all pre-conceived scenic representation of the method's 'via regia' to the unconscious, for according to *Moreno* (1924) »spontaneous acting allows the unconscious to emerge freely, uncensured by the conscious« (»Stegreif läßt das Unbewußte – unversehrt durch das Bewußtsein – frei steigen«). Besides, role-reversal as mentioned before, provides multipolar action-insight, namely from the positions of all partners involved in respective interaction. The 'scenic understanding', to use a term coined by *Lorenzer* (1973) for this psychodramatic experience, corresponds, in the most direct sense of the word, to a recent therapeutic aim of psychoanalysis.

Basis of our psychodramatic work is the double setting, the switch from the here-and-now-reality of the group to the meta-reality of spontaneous scenic play. This meta-reality is and gives the 'Spielraum', the optimal space to meet in imagination and interaction the challenges of outside-life and of its inner representations in free and constructive ways.

The significance of play in general as an easy and cheerful way of life has been commented upon by *Huizinga* (1939), *Rahner* et al. (1949) but also by therapists like *Ekstein* (1977) and *Winnicott* (1973), the latter referring to the space of play as 'the intermediary space'. The 'Spielraum' however, is the essential setting and element in which psychodramatic work takes place and thus becomes 'playful' and easy for the patient.

Example

During the first phase of a psychodrama-session (which always occurs in the here-and-now-reality of the group as setting), a heavy tension between Peter (39) and Linda (28) is noticed. Before the beginning of the session Linda had offered a piece of her favorite chocolate to Peter which he refused so harshly, that Linda felt insulted and asked why for no reason he behaved 'so nasty'. Peter cuts her off: »Stop it, you are a pain in my neck like all women. I had enough of it this morning.«

At this point, the psychodrama-therapist suggests, to show what happened rather than narrating it, and Peter, accepting this, choses a group-member to play his wife Margaret. When at the beginning of the second phase of the session they move from the here-and-now-reality of the group to the imaginary meta-reality of spontaneous scenic play, Peter describes the kitchen where he and Margaret had breakfast. In the following Peter, due to role-reversal now in the role of his wife, offers a piece of cake she had baked and insists that the husband (now played by the group member chosen for Margaret's role) eats it. Back in his own role Peter refuses to take the cake and when his wife keeps insisting he flips out shouting: »Can't you stop pestering me?« Upon Margaret's remark: »I don't want to pester you, I only wish to share my enjoyment over the delicious cake with you«, he

retorts: »Always your enjoyment ... »whereupon Margaret leaves, slamming the kitchen-door.

In this scene Peter's emotional reaction like his previous one to Linda appears inappropriate. Therefore, the psychodrama-therapist steps behind him and, applying the double-technique keeps Peter in his affect by saying: »Why should I share her enjoyment?« And Peter nodding his head continues: »Why can't she let me decide?« Asked by the therapist, whether he knows this upset feeling from former times, Peter (with eyes closed), sees himself as a boy of sixteen accompanying his widowed mother to the theater. Already imitating her voice in spontaneous role-reversal he says: »I shall take you to the most glamorous opera-performance which, I am sure, you will thoroughly enjoy« whereupon Peter, grinding his teeth, in his own role, mutters: »Not at all, not at all«.

In the psychodramatically amplified scene of his youth, suddenly another emotion overcomes Peter. When in the role of his mother he is saying: »Father's death has been so terrible for us, especially for me; now you, Peter dear, are the only close person I have« – a tear is rolling down his cheek. In this situation psychodrama helps Peter to do what he could never do as a boy. On one of two empty chairs, placed in front of him, he imagines the mother he hates for 'sweetly forcing him to share her enjoyments' on the other he 'sees' the mother he loves. Pouring out his feelings to both aspects of the mother, anger on the one hand and love on the other hand, he goes through deep catharsis. This terminates the play-phase of the session. Peter returns with the person acting as his mother (it is Linda he had chosen for the role!) to the here-and-now-reality of the group.

This second switch in the setting, back to the usual reality of the group, is as important as has been the first to the meta-reality of play (*Leutz* 1985). In this usual reality the closure or integration-phase of the session is taking place in form of 'rituals', namely of role-feedback by the players and sharing by group members. Yet, significant above all is the fact that the change in reality also terminates the protagonist's total involvement in the scene he has presented. This change alters his perception of those group members who have just played the roles of his important others. By taking off their roles, the protagonist also liberates them from transferences he had unconsciously projected onto them, but on stage deliberately had acted out with them. Perhaps for the first time he may now see them as the persons they really are. Psychodramatically speaking, he no longer needs them for his unconscious re-enactment of old well-learned roles pertaining to scenes to which he had remained fixated. This is not only control, but already resolution of transference.

Thanks to the re-enactemnt of crucial traumatizing scenes in the meta-reality of psychodramatic play the protagonist can free himself of unfinished business and, back in the usual here-and-now-reality, can consciously integrate this experinece, thus keeping up *Moreno*'s statement of seventy years ago: » Every true second time is the liberation of the first.« (*Moreno* 1924)

According to psychodramatic theory this liberation of unconscious fixations to the past is the basis for a more spontaneous and creative life in the future.

Der ganzheitliche Ansatz der Psychodramatherapie und die Bedeutung ihres Doppelsettings

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Die Begegnung in ihrer universellen Bedeutung, die Begegnung des Menschen mit dem anderen, mit der Welt und mit sich selbst (»I move man back into the universe«, *Moreno* 1946) steht im Mittelpunkt des Menschenbildes von *Jacob L. Moreno,* dem Begründer der triadischen Behandlungsmethodik von Psychodrama, Soziometrie und Gruppenpsychotherapie.

Die Begegnung wird manifest in den zwei Phänomenen der Interaktion und der zwischenmenschlichen Beziehung, deren interdependentes Gefüge den situativen Kontext, die Matrix des menschlichen Lebens ausmacht. Insofern *Moreno* als kleinstes Element immer die Situation, die in ihren pathogenen bzw. pathologischen Anteilen zur Symptombildung des Patienten führt, im Auge hatte, hatte er den individualistischen Ansatz zugunsten eines systemischen aufgegeben. Um die Beziehung zu untersuchen und zu verändern, entwickelte er die Soziometrie und das Psychodrama zur Untersuchung und Veränderung der Interaktion. Die pathologische Situation kann ein aktueller Konflikt sein oder eine Schlüsselsituation der Vergangenheit, an die der Patient fixiert geblieben ist und die er im Wiederholungszwang reinszeniert. Das Psychodrama hat den Vorteil gegenüber der verbalen Vermitteltheit alles Geschehens im einzel- oder gruppentherapeutischen Setting, daß Schlüsselsituationen 'in actu et in situ' sich wiederherstellen und der Bearbeitung direkter zugänglich gemacht werden können. Das Stegreifspiel wird in *Morenos* Konzeption zur 'via regia' zum Unbewußten.

Die Psychodrama-Arbeit, die die Autorin darstellt, vollzieht sich im Doppelsetting von Gruppentherapie und Psychodrama, wobei Beginn und integrierende, abschließende Arbeit im Hier und Jetzt der Gruppe geschieht, dazwischen liegt die Spielsequenz. Sie gibt folgendes Beispiel: Die starke Spannung zwischen Peter (39) und Linda (28) in der gruppentherapeutischen Anfangsphase hatte die Schroffheit ausgelöst, mit der Peter die angebotene Lieblingsschokolade von Linda zurückwies. Dies wird zum Anlaß für Peter, mit einem anderen Gruppenmitglied eine ähnliche Situation, wie sie sich fast tagtäglich mit seiner Ehefrau abspielt, im Stegreifspiel zu reinszenieren, bis, unterstützt durch das Eingreifen des Therapeuten, Schlüsselsituationenen des Protagonisten mit seiner Mutter szenisch agierend erinnert werden. Es wird dem Protagonisten möglich, die Haßgefühle seiner Mutter gegenüber wiederzuerleben, weil sie ihn ständig sachte dazu zwang, ihr Vergnügen zu teilen, aber auch die Liebesgefühle zu ihr. Im

Hier und Jetzt der die Psychodramasitzung abschließenden gruppentherapeutischen Sequenz erfährt dann das kathartische Erleben im Feedback durch die anderen Gruppenmitglieder eine abgrenzende Bearbeitung. In dieser Distanzierung kann der Protagonist möglicherweise zum ersten Mal erleben, wer die anderen Menschen wirklich sind. Erst indem die Realität des Hier und Jetzt der Gruppe hergestellt wird, kann eine Trennung aus Übertragungsgefühlen und -handlungen erfolgen.

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Dreams as Indicators of Unconscious Developmental Processes in Psychoanalytic Group Therapy***

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In the present paper it will be examined by means of the description of a therapeutic group process to what extent the dreams may indicate structural gain of the individual and of the analytic group as a whole. The theoretical basis is provided by Ammon's conception of the dream as an ego- and group-function. Ammon concluded that the dream as a particular form of thinking represents a specific ego-function and indicates the ability of the individual ego to set up its own boundaries. The intention of the authors is to persue the processual course of the group dreams over one year with the underlying hypothesis, that the dream ability and implicitly the demarcation ability from the symbiosis and destructive dynamics leads to a structural developmental process towards one's own identity. The described therapeutic group process exposes the interplay between the symbiotic and the oedipal level in Ammon's conception of analytic group psychotherapy. Within this process, the dreams illustrate and help to render unconscious internalized past destructive dynamics. The sequences of dreams reported in the group make evident the fundamental importance of working through of destructive-aggressive dynamics.

In the present paper we examine to what extent the dream may indicate structural gain of the individual and of the analytic group as a whole. The theoretical basis is provided by *Ammon's* concept of the dream as an ego- and group-function.

While *Freud* (1900) considered the dream as the »via regia to the unconscious« and focussed on function as wish-fulfillment, *Angel Garma* (1966) added to *Freud's* drive conception of the dream an ego psychological dimension. He postulated, that in the dream, early traumatic situations are reactualized, while wish-fulfillment is of secondary importance. Using *Lewins* work on the »dream screen« and *Isakowers* theory on the phenomena of falling asleep, *Garma* concluded the dream content is related to the earliest, preodipal developmental stage. *Freud's* diciple *Stekel* (1935) was the first to emphasize the processual character of dreams: »Dreams must be interpreted in series. Every new dream represents a continuation of a previous one, even though they may be separated by an interval of several days.« Moreover, *Stekel* saw the importance of the inter-relationship between patient and analyst in the interpretation of dreams. *Meltzer* (1988), following *Melanie Klein* and *Bion*, interprets the dream as active, but unconscious thinking, thus continuing *Freud's* understanding: »The dream is basically nothing else but another way of thinking, made possible by the conditions of the sleep state« (*Freud* 1900).

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Ammon (1974) concludes, that the dream, as a particular form of thinking, represents a specific ego-function. He leaves behind *Freud*'s drive conception and attributes to the dream an entirely new importance within his Human Structure Model and his group conception. Thereby, he quotes *Anzieu*'s statement concerning the necessity of a »common group tension«. Further elaborating these thoughts, *Ammon* stresses the signal function of dreams in the therapeutic process: the dream indicates the ability of the individual ego to set up its own boundaries. According to *Ammon,* »a dream brought into the group is always a group dream«. Thereby, the interpretation of the group-dynamic aspects of the dream process should be considered as »an assumption... that the identity conflict staged in the dream must be understood as a conflict in a group in which the dynamics of the primary group, of the present groups and of the therapeutic situation overlap and intertwine. ...The ego function aspects of the dream, the 'ego boundaries' (*Federn*), resp. the 'ego autonomy' (*Rapaport*) are thereby directly connected with the dynamics of the surrounding group« (*Ammon* 1974). The internalizing of coherent group boundaries as well as the dreamers own ego boundaries represent, in *Ammon*'s view, a decisive condition for development of the individual identity.

The initial phase of every therapeutic group process implies, in *Ammon*'s concept, building up flexible and coherent group boundaries on the level of symbiosis, of primary process, which *Spitz* (1955) described as the »world of the primary cavity« – in the sense of *Schindler* (1966), *Foulkes* (1968) and *Ammon* (1971) the »maternal atmosphere«.

As the group process further develops, the interpersonal relations gradually come to the fore on the oedipal level of secondary process, still overlapping with the symbiotic level. It is not, however, before the destructive aggression – i.e. the reactively deformed, originally constructive aggression in *Ammon*'s sense – has been worked through consequently, that a guilt-free demarcation from the symbiosis is made possible.

It is our intention to persue the processual course of the group dreams with the underlying hypothesis, that the development of the dream ability and, implicitly, of the demarcation ability from the symbiosis, leads to a structural developmental process towards one's own identity.

At the beginning of the observation period of one year, the psychoanalytical group counted 12 members, 6 male and 6 female, between 22 and 45 years of age. The structural diagnoses included mainly the borderline spectrum, 3 members had been diagnosed as psychotic structure and one as neurotic. On the primary process level, the group topic was determined by the pregnancy of a group member, involving the issue of the quality of the »maternal nutritive soil«. Besides the pregnant Ms. L., Mr. A. became the group representative of the separation isssue in the last weeks of the initial phase. After having repeatedly disrupted his contact to the group and retired in his home, Mr. A. related a dream in which the pain of separation and birth as well as the pronounced symbiosis with the maternal-feminine:

He dreamed that he was »extracting an acorn (in german synonymous with glans penis) from a fleshy shell. This proved to be more painful than expected«. The free associations of the dreamer and the group members ignored the sexual aspect and focused on his wish of a smooth separation from the »mother group«; however, this was only possible by a painful, forcible act. In reality, Mr. A. broke off the group therapy a few weeks later, while the group was concentrating on the topic of sexuality.

Mr. F., a taciturn man, reported the following oedipal dream: » I find myself in an old bedroom, the woman therapist lies in a large bed, unfortunately covered up to her neck with a beautiful brocate cover. In a cupboard I see a baked, hot meal, which is rotten under its crust. From this meal springs a frog and a snake. Suddenly, there appears a pink-colored, large-eyed cat, which bites the frog in its neck. The snake breaks up in two parts, the front part moves away and turns into a baked eal-like fish«. The patient's and the groups' associations reveal the erotic-oedipal relationship to the woman therapist (mother) and the patient's sexual wishes to a former therapist, which were »under the crust, still quite hot« because he could never separate from her.

In the further therapeutic process, the group was concentrating again on the topic of symbiosis; several birth dreams were reported in anticipation of the immanent birth of Ms. L.'s child. Following the summer vacation, the newborn baby, Anja, was present in the group. The whole group kept working on a concrete level, the resistance being obvious. This resistance was the expression, on the primary process level, of the symbiotic aggression connected to the abandonment feelings experienced during the summer vacation. The group also reacted with jealousy upon the symbiosis of baby Anja with her mother and the attention the group therapists payed to the baby. On the oedipal level, the central conflict developing now in the group concerned the therapists as representatives of parental figures. This is illustrated by a dream of Mr. E.: »I find myself in a large room, connected to the outside by fire latters. I ask a fat therapist where she likes me, while the male therapist, also present in the room, keeps silent. I do not want to have therapy done by people who do not like me and decide to place a complaint with the press«. Working through the dream, E. remembers his being in love with his former, fat lady therapist (mother), whom he left »by the fire ladder« as the topic of sexuality was to be worked through.

At this stage, the topic of autonomy and demarcation from the parental home was brought into the group by two members preparing to leave the group; the unconscious background was supplied by the approaching christmas and new year. Mr. F., who chearished the wish to change important aspects of his life in the beginning new year, dreamed during the christmas holiday that »a dog kept on chain in a burning house was howling as on a tape which his father was playing to him. It was an awful feeling«. It became obvious through his own associations that the howling dog stood for himself with his craving for freedom and erotic experience. The

entire group felt now the ambivalence on the threshold between the symbiotic and oedipal level: the topic of sexuality appeared, but the more familiar, symbiotic level kept recurring, prompted by anxiety.

Oedipal rivalry made its entry again at this point in a dream reported by Mr. E.: »I watched my father with his fat penis in the bathroom surrounded by bare-breasted women (mother and sister), while I must myself bathe alone in cold water outside in the garage«. The son is excluded from sexual pleasure by his own father.

The group recognized during this process that autonomous development and sexuality can only be achieved by separation from the past and its transference dynamics. This development is, however, accompagnied by feelings of anxiety and aggression against the group and mainly its therapists as representatives of the parents.

Consequently, the oedipal aggression against the therapists became more virulent. Mr. H. reported, uneasily, as if being part of an insurrectional party: »I dreamed of four accomplices whose leader looked like a criminal. I charged him to murder my own father. After this had been done, the murderer gave me a plastic bag with the earthly remains of my dead father«. The dreamer himself was touched by his dream; the group phantasized that the plastic bag was containing the cut genitals of his father. The insurgent party was identified in reality among the group members; the aggression against the male therapist could be experienced directly and group-dynamically in the here-and-now of the group situation.

The forty-year-old Ms. K., who had seldom reported dreams up to this time, suddenly burst in tears in one of the following sessions. She became aware of the lost time in her life. Above all, she regretted not having fulfilled her wish to bear children. She dreamed that she was »living in a fabulous house with garden in which children were playing, as a storm was coming up. I took care that all the windows should be closed«. By her associations, it became clear that it had always been her task to check, to watch that feelings should be concealed. The group was sympathetic with her sadness, becoming conscious of the limitedness of human life.

A few concluding remarks: the therapeutic group process described above exposes the interplay between the symbiotic and the oedipal level in *Ammon's* concept of analytic group psychotherapy. Within this process, the dreams help rendering conscious internalized past destructive dynamics and their demarcation. The sequence of dreams reported in the group makes evident the fundamental importance of working through destructive-aggressive dynamics expressed as symbiotic aggression and parallely as oedipal rivalry and jealousy. The therapeutic process reveals, on the other hand, the importance of the time dimension, which *Ammon* understands as actively experienced time. Death – in the sense of a human dimension – means the final demarcation of man. At the border of illness and in conscience of death men may develop identity and even be creative.

In *Ammon's* words: »I believe that it is just the illness that leads man to his limits – such limits as everyone needs. Boundless hedonistic happiness belongs to paradise or to heaven, but it cannot be active and creative, for it lacks the necessary tension« (*Ammon* 1994).

Der Traum als Indikator des unbewußten Veränderungsprozesses in der analytischen Gruppentherapie

Ulrike Schanné, Gerhard Wolfrum (München)

Die Autoren der vorliegenden Arbeit stellen den Gruppenprozeß einer analytischen Therapiegruppe in bezug auf die in der Gruppe berichteten Träume über einen Beobachtungszeitraum von einem Jahr dar. Dabei wollen sie zeigen, wie der Traum als Indikator des unbewußten Entwicklungsprozesses einer Gruppe fungiert und wie sich der zunehmende Strukturgewinn einzelner Gruppenmitglieder und der Gesamtgruppe im Traumprozeß manifestiert. Zugrundegelegt wird dabei *Ammons* Konzeption des Traumes als Ich- und Gruppenfunktion (*Ammon* 1974).

In einer historischen Einleitung gehen die Autoren aus von *Freuds* triebtheoretischer Konzeption des Traumes, den er als »Versuch einer Wunscherfüllung« (*Freud* 1933) verstand. Von *Angel Garma* (1966) wurde *Freuds* Konzept erweitert um eine ich-psychologische Dimension. *Garma* postulierte, daß in allen Träumen frühe traumatische Situationen wiederhergestellt werden und daß die Wunscherfüllung lediglich eine sekundäre Rolle spielt. Neben weiteren Autoren wird ausführlicher die Weiterentwicklung der psychoanalytischen Traumtheoreie durch *Günter Ammon* (1974) dargestellt, der den Traum als Ich- und Gruppenfunktion versteht. *Ammon* geht davon aus, daß der Traum als besondere Form des Denkens eine Ich-Funktion des Menschen darstellt und Aufschluß gibt über den Ich-Zustand und die Ich-Struktur des Träumenden. Durch seine Humanstrukturkonzeption verließ *Ammon* endgültig den Boden der Triebtheorie und gab dem Traumgeschehen innerhalb seiner Theorie einen völlig neuen Stellenwert. *Ammon* betont vor allem den Signalcharakter, den das Auftauchen von Träumen im Gruppenprozeß hat: Es zeigt, daß die Gruppe als Ganze bzw. das Ich des Einzelnen sich abgrenzen kann und daher ein Zugang zur unbewußten Dynamik des Traumgeschehens möglich wird. Die Internalisierung kohärenter Gruppengrenzen als Ich-Grenzen des Träumenden sieht *Ammon* als entscheidende Voraussetzung für die eigene Identitätsentwicklung an.

Im Prozeß einer analytischen Gruppentherapie, wie sie von den Autoren dargestellt wird, bewegt sich die Gruppe von einer archaischen, symbiotisch-primärprozeßhaften Ebene hin zu einer ödipalen, sekundärprozeßhaften Ebene der interpersonellen Beziehungen, der Auseinander-

setzungen um Rivalität und Eifersucht. Nach *Ammon* (1992) ist hierbei die Bearbeitung der destruktiven Aggression von entscheidender Bedeutung, um den Patienten eine schuldfreie Abgrenzung aus der Symbiose-Ebene zu ermöglichen. Die dann einsetzende ödipale Übertragungsdynamik trägt nicht mehr den Charakter einer archaischen Identitätsdiffusion, sondern zeigt Konflikte eines stabilisierten und abgegrenzteren Ichs.

Die Autoren stellen den prozeßhaften Verlauf einer Psychotherapiegruppe und deren Gruppenträume anhand von Sitzungsprotokollen unter der Hypothese dar, daß sich anhand des Wachstums der Traumfähigkeit ein Zuwachs an Ich-Autonomie und Abgrenzungsfähigkeit aus der Symbiose zeigen müßte.

Zu Beginn der Darstellung befindet sich die Therapiegruppe mit 12 Mitgliedern vorwiegend auf der Ebene des Primärprozesses, ausgedrückt durch die Symbiosewünsche im Kontext der Schwangerschaft einer Gruppenteilnehmerin. Die Träume aus dieser Zeit zeigen die Schwierigkeiten der Trennung aus der Symbiose mit der »Mutter Gruppe«. Im Traumgeschehen wird diese Problematik von einem Gruppenmitglied ausgedrückt, das von einer »gewaltsamen Trennung« träumt und tatsächlich bald darauf die Therapie abbricht, ohne sich von der Gruppe zu verabschieden.

Repräsentant zunehmender ödipaler Auseinandersetzung mit dem Gruppenleiter wird ein Patient, der sich als Co-Leiter der weiblichen Therapeutin phantasiert und mit entsprechenden Träumen in die Gruppe kommt. Der damit beginnende Prozeß führt zur Thematisierung von Sexualität und erotisch-ödipalen Wünschen, die in einem langen und bildhaften Traum eines bisher eher schweigenden Gruppenmitglieds ausgesprochen werden. Nach einer Ferienpause wird die Auseinandersetzung mit den Leitern aggressiver, es kommt – gruppendynamisch gesehen – zu einem regelrechten Leitersturzversuch, der sich sowohl im Traumgeschehen als auch auf der direkten gruppendynamischen Ebene des Hier-und-Jetzt beobachten läßt. Nach dieser Phase der mit großer Wut verbundenen beginnenden Trennung aus symbiotischer Abhängigkeit von den Leitern entsteht in der Gruppe Raum für ernsthafte Arbeit mit dem Thema Sexualität und den Zukunftswünschen der Gruppenmitglieder, aber auch Raum für die damit verbundene Angst und Ambivalenz, die in Träumen ausgedrückt werden kann. Die Gruppe beginnt in dieser Phase selbständiger an Träumen zu arbeiten. Anläßlich eines Traums, der die Rivalität mit dem Vater um Mutter und Schwester zum Ausdruck bringt, erkennt die Gruppe, daß man sich von inneren Übertragungsfiguren aus der Vergangenheit trennen muß, um reale neue Beziehungen zu gestalten.

Das älteste weibliche Gruppenmitglied, eine zwanghaft-kontrollierte Patientin, die nur selten Träume berichtet, weint plötzlich. Anhand eines Traumes wird ihr mehr und mehr bewußt, daß sie viel Lebenszeit verloren hat, daß es ihre Rolle im Leben war, auf alles aufzupassen, ihre Gefühle zu kontrollieren, anstatt frei und lebendig zu sein. Die Trauer dieser Patientin

teilt sich der ganzen Gruppe mit, die zeitliche Begrenztheit des Lebens wird für alle spürbar.

Anhand des Traumpozesses der untersuchten Psychotherapiegruppe wird die Dialektik zwischen den Ebenen symbiotischer und ödipaler Dynamiken deutlich. Die kasuistische Darstellung des Gruppenprozesses demonstriert die Anwendung einer modifizierten »Freudianischen« Psychoanalyse auf Gruppenprozesse im Wechselspiel mit *Ammons* Humanstrukturologie und Verständnis von analytischer Gruppenpsychotherapie. Die Bedeutung der unbewußten Traum-Ebene für die Weiterentwicklung des Einzelnen und der Gesamtgruppe ergibt sich aus der Tatsache, daß Fortschritte im Gruppenprozeß jeweils mit entscheidenden »Gruppenträumen« in Verbindung stehen. Über das Medium des Traumprozesses kann in der analytischen Gruppentherapie auch die destruktive Aggression bearbeitet werden, als notwendige Voraussetzung der Trennung aus Symbiose und destruktiven Dynamiken hin zu ödipalen Beziehungskonflikten. Die Arbeit mit Gruppenträumen ermöglicht so durch dauernde Abgrenzungsarbeit langfristig eine Befreiung aus Defiziten und pathologischer Destruktion hin zu einem konstruktiven Aufbau von psychischen Strukturen und individueller Lebensgestaltung.

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Nachrichten / News

»Medicine and Psychology in a Holistic Approach to Health and Illness«

Results on the 10th World Congress of the World Association for Dynamic Psychiatry WADP
in St. Petersburg's Bechterev Institute from October 25 to 29, 1994

The whole man rather than just the illness, is the focus of treatment

For four days more than 200 scientists from over 20 countries met in St. Petersburg's Bechterev Institute. They presented and discussed new results of research and development of theory, as well as the practical conclusions of the integration of psychiatry, psychotherapy, medicine and psychology and other fields of science, necessary for the well-being of both the healthy and the ill person. The well-being of man requires a process of humanization in psychiatry, medicine and other areas of man's life. Science has to serve such humanization.

In the view of Dynamic Psychiatry each science of man has the purpose to create real improvements for human life and – in a wider sense – also to contribute to peace. For the spectrum of topics of the congress, this meant that dealing with ethical, social, and political questions was as relevant as special themes from the fields of prevention, child and family psychotherapy, the treatment of special clinical pictures as neurosis, psychosis, borderline disorders, panic attacks, psychosomatic disorders, questions concering methodology of treatment from a biological, psychotherapeutical and especially from a psychoanalytical point of view; questions concerning integration of methods, contributions from the empirical psychotherapy research and diagnostics.

All scientists agreed that the patient has to be understood as a whole person with his various healthy and ill dimensions of personality, his capacities and needs on the background of his biography and actual life sitution, as well as his developmental potentialities. This view encourages holistic and multidimensional diagnostics and treatment of the personality as a whole, as *Günter Ammon* (Berlin/Munich), President of the congress and the WADP, pointed out in his opening lecture on »Man as a Multidimensional Being in Health and Illness«. »In my opinion psychic disorders are restrictions of the multidimensions characterizing man initially owns, to a few dimensions, or a dysregulation and desintegration of his multidimensional aspects. Besides, the multidimensional potentialities and needs of man, especically as considered by the psychiatrist, are more important for the recovery than the causality of the patient's actual condition.« By means of a multidimensional spectrum of verbal and nonverbal therapies offered to the patients, new therapeutical ways can be found for severely ill and exceptional patients. Thus, the different dimensions of treatment as for example individual and group psychotherapy, in particular milieu therapy,

but also dancing, painting, theatre, music and horse riding therapy should be used, on the basis of a theory of treatment integrating all methods.

The re-integration of the patient's personality also is the declared aim of the therapeutical concept of the dynamic rehabilitation, which has been developed by *Modest M. Kabanov* (St. Petersburg), Vice-President of the WADP and chairman of its Russian branch, host of the congress and director of the Bechterev Institute. Rehabilitation in medicine is a new paradigm for physicians, psychologists and other experts considering the approach to the patient. This also includes potential patients being in a state of pre-illness. As *Kabanov* quoted in his lecture on »Changing the Paradigm in Modern Medicine« – »The old word that one should not treat the illness but the patient, unfortunately still is only a nice play on words in most of the medical institutions«. The role of the psychotherapist's personality, highly important for a real process of rehabilitation has been ignored by the official medicine. In connection with a broad dynamic system of the patient's rehabilitation, ethical aspects of medicine, in particular the doctor-patient-relation, become highly important.

The Psychoneurological Research Institute W.M. Bechterev is the oldest research institution in Russia and one of the world's oldest. It was founded in 1907 by *Vladimir Bechterev* in the framework of the Academy of the Medical Sciences. Its goal was to study man in situtions of normality and pathology. Being the leading scientific institution of the country for problems of medical psychology and psychotherapy, the institute emphasizes psychosocial aspects of rehabilitation.

The Bechterev Institute and the German Academy for Psychoanalysis (DAP) have been scientifically associated for many years. The reason for the mutual interest is – among other things – that for the DAP the Bechterev Institute represents the bridge to Russian psychiatry and psychotherapy and also the fact that the institute has been realizing the post-graduate training of Russian physicians in medical psychology and psychotherapy for many years. On the other hand, the Russian colleagues, are interested in Dynamic Psychiatry, which is more developed in the work with patients who are suffering from severe mental disorder. In 1990 the cooperation of both institutes culminated in a mutual treaty on sicentific cooperation of research, training and scientific exchange. This treaty was also one of the requirements that the 10th World Congress of WADP could take place in St. Petersburg, at the same time being the first international psychotherapy and psychiatry congress in Russia.

The fact that the topic of the congress is of high current interest for the world's psychiatry, was reflected in the participation of leading persons of the world's important psychiatry associations such as *Felice Lieh Mak* from Hongkong, President of the World Psychiatric Association WPA, and *Jorge Costa e Silva* (Geneva), President of the World Association for Social Psychiatry WASP and Director of the Mental Health Division of the World Health Organisation WHO. The congress took place under the auspices of

the WPA and the WASP, as well as the International Health Society (USA) and the Mayor of St. Petersburg *Anatolij Sobtschak.*

At the opening ceremony *Günter Ammon* and *Modest M. Kabanov* welcomed the scientists, expressing their respective views on the current change of the paradigm in medicine and psychology, changing from a scientific model of thinking to a holistic and integrative approach with new ways of considering, developing theories of treatment and research. Among others, *B.D. Karvasarsky, P.Y. Vovin, I. Popov* from the Bechterev Institute, *T.B. Dmitrieva,* Director of the Serbsky National Research Center for Social and Forensic Psychiatry (Moscow), *Y.A. Aleksandrovski, A.A. Churkin* and *B. Poloshij* from the same institute, *A.S. Tiganov,* Director of Mental Health Research Center (Moscow), *V.N. Krasnov* from the Moscow Research Institute of Psychiatry as well as members of centers of different countries followed with opening words. *W. Pashurov* and *N. Lukitchyeva* spoke to the members of congress as representatives of the city of St. Petersburg and its Mayor.

At the opening session the members kept a one-minute silence in memory of *Erwin Ringel* (Vienna), the internationally known scientist, in particular in the field of suicide prevention, who had died in July with 74 years. *Raymond Battegay* (Basel), his scientific friend of many years, honoured *Erwin Ringel* as man, physician and scientist, his path through life, especially by his high commitment for the suffering and for minorities of our society. *Ringel* had not hesitated to argue with politics, art and science of post-war Austria. In particular he argued with the church, being a convinced catholic. He had been chairman of the Austrian branch of the WADP since its foundation in 1981. Since 1974 he had participated in many symposia of DAP. He had wanted to meet *Ammon* again during this year's congress and had submitted a paper on »The Meaning of Medical Psychology for the Medical Training«. This reunion could not take place.

At the end of the opening ceremony – a string quarted of St. Petersbrug providing interludes of chamber music – *Günter Ammon* was presented the DAP's gold medal for his »outstanding services to a humanistic psychiatry and psychoanalysis in theory and practice«. *Rolf Schmidts* (Munich), long-term co-worker of *Ammon,* member of the board of DAP and Chairman of the German WADP branch, honoured in his laudatio the scientific and human life work of *Günter Ammon,* founder of the Berlin School of Dynamic Psychiatry. The great intellectual and therapeutical work of *Günter Ammon* has been developed on the basis of understanding human developement as group process. This view always strives – beyond the limitations of the discipline – to abolish antagonistic dualisms between ill and healthy, old and young, poor and rich, man and woman. »I am glad that Dr. *Ammon,* who as man, therapist and sicentist searched all his life for an integration of opposites, thus striving to pacify the dangerous and often fatal dualisms in the world, is the first scientist of Western Europe, who after the October Revolution in Russia and after *Charcot* and *Kraepelin* received the honorary membership of the St. Petersburg Association for Psychiatry...«.

Following this speech, *Felice Lieh Mak* presented honorary badges of the WPA to the three organizers of the WADP congress (represented by *Günter Ammon),* the Bechterev Institute (*Modest M. Kabanov)* and the DAP (represented by *Maria Ammon* as its president). The members of the congress were informed by *Felice Lieh Mak* about the health policies of Asian countries, seldom represented on Western meetings. *Felice Lieh Mak,* who lives and works in Hongkong, talked in her lecture during the opening session about »Social Psychiatry in the Changing World – the Asian Scene«. She mentioned the rapid changes of population and illness structures in Asia and problems concerned with an adequate health care. She elaborated on special problems such as staff reduction of experts, shortage of financial means, stigmatizing of the mentally ill and lack of coordination. In order to solve the world's problems, she pleaded for the development of common ethics and a common language of psychiatry as well as the development of effective group work.

Focus of the current scientific discussion and research is the therapist-patient-relationship, in which the therapist also must develop more self-criticism and willingness to chance. Recovery is only possible if the therapist trusts in recovery, *Günter Ammon* noted during the first press conference of the congress. In the training of the future therapists the accumulation of facts is not sufficient, but rather work on the whole personality of the therapist is necessary – in the same way as working with the patient. The psychoanalytic method thus requires a psychoanalysis of personality for some years. During this time the future therapist must find an open access to his unconscious. The humanistic attitude of the therapist towards the patient is of great importance for the healing process. Correspondingly, *Costa e Silva* (Geneva) emphasized in his lecture on »The Holistic Understanding of Psychiatry and Treatment Methods of Mental Patients« the fundamental importance of the therapist's attitude towards the patient, characterized by empathy, resepct and support. The active inclusion of the patient in the process of healing must thereby be considered. The cooperation between physician and patient should not only take place between individuals but should also be established in the total health system considering the individual rights of the patient.

Raymond Battegay (Basel) noted that »the patient can open himself towards psychotherapy if he has the justified impression that the psychotherapist does not treat him on the basis of a standard theory but that the therapist relates his therapy on the patient's very special needs as a whole person. In many cases therapists have a more or less rigid way of dealing with the patient, certainly giving them (the therapists) a feeling of security, but no patient likes to be a prototype of a certain disorder or illness or a certain theory«. In his lecture »From the Psychosoma Dualism to Man as Bio-Psycho-Social Entity« *Battegay* emphasized the special meaning of body language for diagnostics and therapy, examining and dividing it in four categories, for example as expression of unconscious conflicts of deficient experiences and predisposed psychological characteristics.

Dynamic Psychiatry determined demand that psychotherapy be given a central position in the treatment of the mentally ill, therefore, most of the representatives of Dynamic Psychiatry and colleagues from other centers of the world, especially from the St. Petersburg Bechterev Institute, from Moscow and other parts of Russia dealt with theoretical and practical problems of treatment concerning different therapeutical approaches from a holistic point of view.

Mental disorders, understood as restriction of the basically multidimensional human being or as dysregulation and desintegration of a personality's multidimensional aspects, needs in the view of Dynamic Psychiatry an integrated spectrum of treatment integrating not only non-verbal methods but also verbal methods as individual and group psychotherapy (*Günter Ammon).*

Rolf Schmidts (Munich), Chief of staff of the Hospital Menterschwaige Munich, presented in his contribution the human-structural music therapy which he himself had developed. It uses the free improvisations of the patient as expression of human potentialities understanding them on a groupdynamic level of communication. In his second contribution, »Group Dynamics of the Plenary Group Meetings in the Dynamic Psychiatric Hospital Menterschwaige« *Rolf Schmidts* demonstrated the important integrative mode of operation of this group, in which all events, information, rights and duties, rules of therapy and ethical values existent in the hospital are discussed. Structure and dynamics of the plenary group integrate in a special way verbal and nonverbal therapeutic methods in which the groupdynamic processes of the whole hospital are realized and dealt with on a higher level. *Egon Fabian* (Munich), assistant medical director of the Dynamic Psychiatric Hospital Menterschwaige, examined in his contribution »Psychosomatics and Psychosis – a Structural Approach« the human-structural intertwining of psychosomatics and psychosis. In *Ammon's* concept both diseases are placed on a gliding spectrum of archaic ego-disorders. In particular, the author discussed structural points of view, which play an important role in organic and mental disorders, illustrating this with case histories.

In a survey of *Gabriele von Bülow* (Berlin) the whole spectrum of treatment of Dynamic Psychiatry was illustrated in the intertwining of inpatient and outpatient psychotherapy and the various facts of verbal and nonverbal therapeutic methods. There were examples of nonverbal psychotherapy by *Georg Kress* (Munich, art therapist of the Hospital Menterschwaige), on processes in the course of painting therapy. *Claudia Friedsam* (Munich) reported on horse-riding therapy. *Monika Dworschak* (Munich) spoke about principles of human-structural milieutherapy, as further developed by *Günter Ammon* with the groupdynamic principle, in order to help patients with most severe disorders. The integrative aspect of the case conference in an inpatient setting, was described to the last detail by *Günter Ammon, Margit Schmolke* and *Monika Dworschak* (Munich).

The case conference allows a differentiated diagnostical description of personality of the respective patient in his healthy and ill aspects. It also allows the planning and testing the course of treatment as well as the development of a future outlook for the patient. An important characteristic is the patient's active incorporation into the process of the case conference. In the Dynamic Psychiatric Hospital Menterschwaige there are also treated elderly patients. *Bernhard Richarz* (Munich) presented a case history of a male patient suffering in a severe Alzheimer's disease. On the basis of psychodynamic and groupdynamic aspects of this disease, he presumes that Alzheimer expresses a lack of social energy because of an identy deficit which lasted in the whole life and influenced the neurophysiological structures of the brain in a bad way.

Gertraud Reitz (Munich) presented an interesting contribution from the field of outpatient psychotherapy, dealing with the development of body-ego-identity and sexuality in the framework of human-structural dance therapy. This was illustrated with examples of video recordings of a patient's developmental process during dance therapy. The author used various levels of data as basis of her examination, for example the Ego-Structure-Test-data, qualitative interviews and group protocols.

Ingeborg Urspruch (Munich) established in her lecture a link between human-structural theatre therapy and the tradition of the Russian Theatre School of *Stanislawski,* in both cases the working with the actors being of great importance. Theatre therapy helps the patient to create fantasies, to make the unconscious perceptible and to make desires and feelings accessible through the theratre as a medium. The contribution »Dreams as Indicator of Unconscious Developmental Processes in Psychoanalytic Group Therapy« by *Ulrike Schanne* and *Gerhard Wolfrum* (Munich) demonstrated the changes of dream contents of the individual patients in the course of group therapy and the fluctuation between symbiotic and oedipal levels. More contributions from co-workers of the Berlin Training and Research Institute were by *Rita Primbas* on »Therapeutical Techniques in the Treatment of Paranoia in the Framework of Dynamic Psychiatry« and by *Reinhard Hochmuth* on »System-theoretical Concepts in Psychology and Dynamic Psychiatry«, as well as by *Bianca Hohl* and *Monika Braun* on »Groupdynamic Processes of a 10-Day Groupdynamic Experience in Paestum (South Italy)« and by *Irma Schindler* on »Handling Destructive Aggression in School Classes«. *Astrid Thome* (Munich) analyzed *Ammon's* conception of freedom which must always be seen as a dialectic process between identity and group. Freedom means leaving symbiosis and its internalized pathological family dynamics to become a self-determined individual.

Two examples of working with therapeutic communities were presented at the congress: *Gertraud Reitz* lectured on »Therapeutic Communities and their Importance in the Treatment Spectrum of Dynamic Psychiatry«. The communities are not only used as prophylaxis for psychic disorder and

as aftercare following inpatient psychotherapy. Rather the residents should be encouraged to find a new perspective in life and living own life style. *Martin Urban* (Esslingen) spoke in his paper »Practical Experience and Theoretical Thoughts on the Longtime Treatment of Personality Disturbances« about his long experience with Borderline patients in supervized communities with special attention to symbiotic and narcissistic transference manifestations.

The demand to include the unconscious into psychotherapy, in particular by nonverbal psychotherapy methods – especially the human-structural dance therapy – was greeted with positive resonance. A workshop demonstrating this form of dance therapy given by *Maria* and *Günter Ammon* found great interest. The Swiss ethnologist and dancer *Renato Berger* (Zürich), specialized in Afro-oriented dance styles emphasized the communicative meaning of dance as an integration of body and mind relations.

As during preceding WADP congresses there was an exhibition of paintings from patients of the Hospital Menterschwaige, along with work from patients of the Israel Center for Rehabilitation (Tel Aviv) under the supervision of *Heli Rosenblum.* Togehter with *Vadim S. Rotenberg* and *H. Somekh* (Tel Aviv) they presented their rehabilitation concept on the basis of expressive therapy forms, such as dance-movement therapy, music and art. All these therapy forms should lead to an integration of somatic, verbal and visual areas. It was also possible to win *H. Rosenblum* for an active membership in the Israeli WADP branch.

For the internationally known successor of *Moreno, Grete A. Leutz* (Überlingen), the therapeutic setting is of special importance. In her contribution about »The Holistic Approach of Psychodrama Therapy« she emphazised the importance of combining working through of the here-and-now-reality with the meta-reality of spontaneous scenic play in the group. The psychotherapeutic approach which was developed at the Bechterev-Institute under the guidance of *B.D. Karvasarsky* (St. Petersburg), President of the newly founded Russian Society for Psychology, must also be noted. *Karvasarsky* and *G.L. Isutina* spoke about the personality-oriented (reconstructive) psychotherapy. Personality-oriented psychology is a continuation of the so-called »Myasishchev's pathogeneous psychotherapy« and is based on Object Psychology. Psychotherapy consists in the psychological correction of the personality, the restoration and improvement of the disturbed system of relationships of the patients. *Karvasarsky,* together with *V.D. Wied* and *V.A. Taschlikov,* also compared Dynamic Psychiatry with the Russian Object Psychology. The concept of »social energy« in Dynamic Psychiatry and the »significant relationships« in *Myasishchev's* conception proceed from the acknowledgement of the importance of psychosocial needs of man in emotional relations with the surrounding world. *T.B. Dmitrieva* (Moscow) investigated in her contribution about »Social Psychiatry: History and Contemporaneity« the different meaning and notions of the »Social Psychiatry« represented by various authors. She

regards Social Psychiatry as a separate branch of general psychiatry because it possesses its specific subject, goals, methods and techniques. She pleads for the development of a social psychiatry of catastrophes and crises.

The cooperation between the experts was very profitable in the development of theories as well as on the practical side of the therapeutic work. This became obvious in the projects of many colleagues who presented their dynamic psychiatry concept at the congress. *Luiz Miller de Paiva* (São Paulo) whose lecture on »The Basic Principles of Human Structurology within *Ammon's* Dynamic Psychiatry« must be mentioned as being very meticulous in dealing with *Ammon's* theory of illness of the archaic ego-disorders, which he related to the literature of a number of other authors. In his twelve topics he presented the narcissistic deficit under which the patient suffers and gave an indication as how the psychotherapeutic relational situation should be created. *Boris S. Poloshij* from the Moscow Serbsky Institute, who became acquainted with the practiced Dynamic Psychiatry during his visit of some weeks to the Hospital Menterschwaige, spoke about »Dynamic Psychiatric Approaches to Social Stress-Related Disoders«. According to *Poloshy,* a transformation of destructive and deficient expression of parts of human structure into a constructive development by means of psychotheray promises a higher efficiency and better social adjustment.

Marius Erdreich (Haifa) presented in his contribution on »The Dynamic Relation between *Ammon's* Human-Structurology and Psychotraumatology« the basic characteristics of both concepts as well as their relations and demonstrated how both concepts can be used in a useful, complementary way. One aim of his contribution is to apply the psychotraumatological approach and psychodynamics not only to individuals but also to large populations being influenced by societal changes, sometimes by tragedies of wars. *G. Ferreira* (Lisbon), member of the Board of Trustees of the World Association for Social Psychiatry WASP, presented in detail common factors of Dynamic Psychiatry and Social Psychiatry in the field of prevention, mental health promotion and treatment in his paper about »Contribution of Dynamic Psychiatry for the Intervention in the Field of Social Psychiatry«. For many years *Ferreira* has been interested in Dynamic Psychiatry and he took part on several WADP-congresses. In the course of this long scientific connection the Portuguese Branch of WADP under his chairmanship was created at the St. Petersburg congress. Whereas *M. Ruiz-Ruiz* (Malaga) spoke about »Convergence and Divergence of Ecological and Dynamic Psychiatry«, *Metin Özek* (Istanbul), new chairman of the WADP's Turkish branch, was concerned in his lecture about the connection of experienced isolation, psychic and physical torture and *Ammon's* concept of deficient and destructive social energy. In order to make this clear, he outlined in an involved and moving way examples of his own sorrowful experiences as a political prisoner.

Abb. 1: Prof. Dr. med. Modest M. Kabanow (St. Petersburg), Direktor des Psychoneurologischen Instituts W.M. Bechterew, Vizepräsident der WADP und Chairman ihres russischen Zweiges, (stehend) bei der Eröffnung des 10. Weltkongresses der WADP / XXIII. Internationalen Symposiums der DAP; sitzend v.l.n.r.: Dr. med. Rolf Schmidts (München), Dolmetscherin, Dr. med. Günter Ammon (Berlin/München)

Abb. 2: Während der Eröffnungszeremonie Blick ins Auditorium

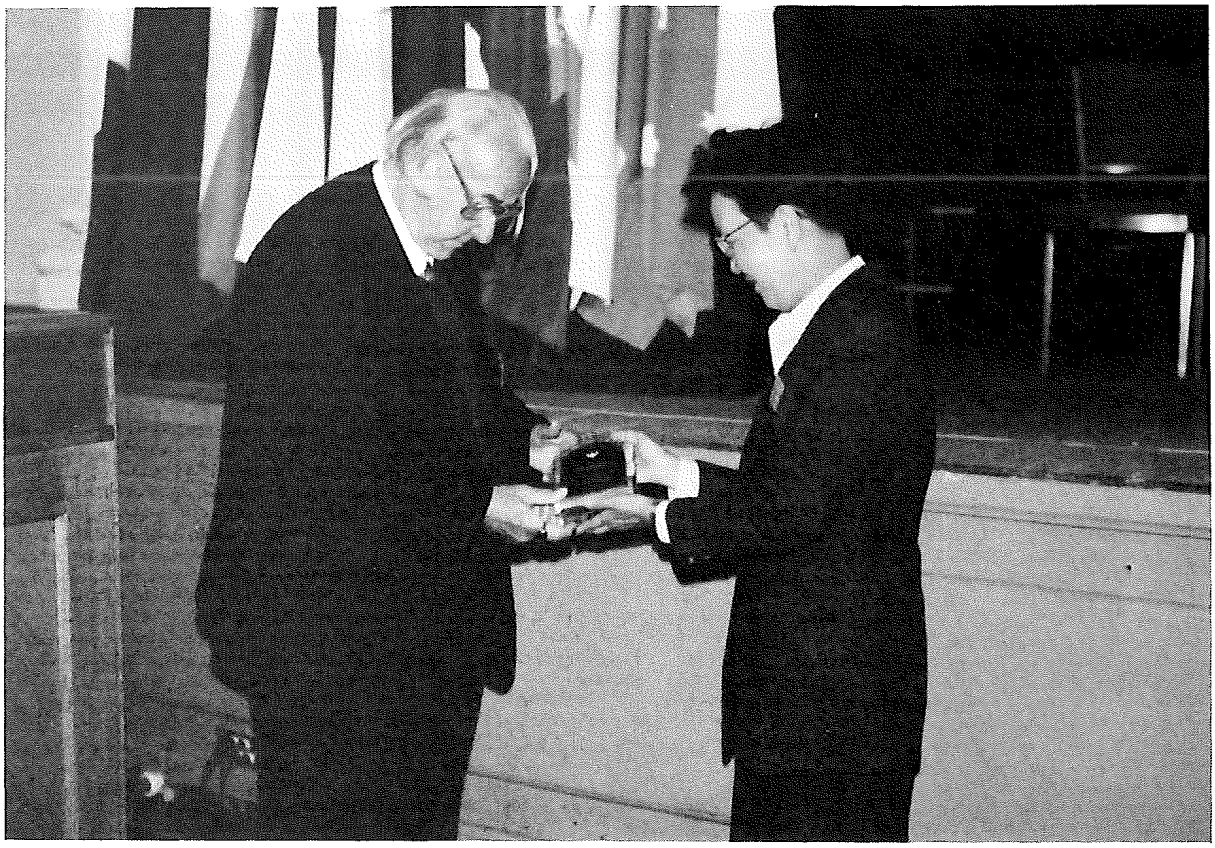

Abb. 3: Prof. Dr. med. Felice Lieh Mak (Hongkong), Präsidentin der World Psychiatric Association WPA, überreicht Dr. med. Günter Ammon, Präsident der WADP, die Anerkennungsplakette der WPA.

Abb. 4: Prof. Dr. med. Jorge A. Costa e Silva (Genf), Präsident der World Association for Social Psychiatry WASP und Leiter der Abteilung für psychische Gesundheit in der WHO, bei seinen Grußworten.

Bei der Eröffnung der Malausstellung mit Bildern von Patienten der Dynamisch-Psychiatrischen Klinik Menterschwaige München, des Israel Center for Rehabilitation und des W.M. Bechterew Instituts.

Abb. 5: Dr. med. Heli Rosenblum (Israel) und Dr. med. Günter Ammon

Abb. 6: Dr. med. Egon Fabian (München), Dipl. Psych. Maria Ammon (Berlin), Präsidentin der DAP, Dipl. Psych. Astrid Thome (München); im Hintergrund links: Dr. med. Bela Buda (Budapest), Vizepräsident der WADP und Chairman ihres ungarischen Zweiges.

Bei den Pressekonferenzen

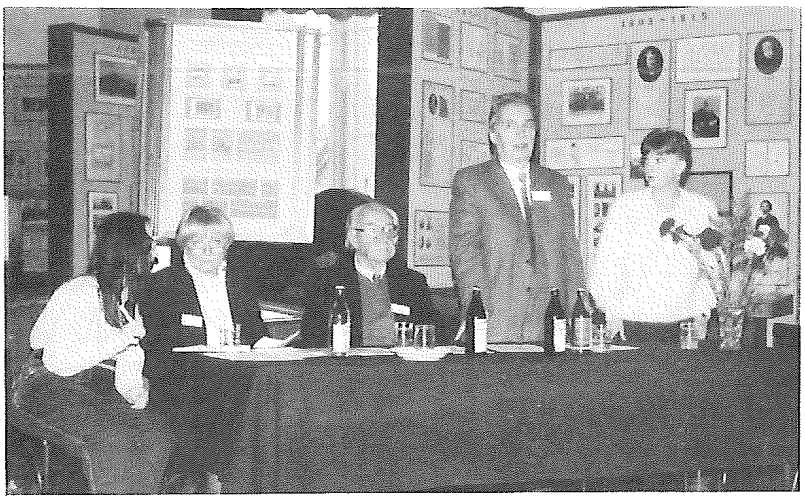

Abb. 7: v.l.n.r.: Dolmetscherin, Dipl. Psych. Dr. phil. Ilse Burbiel (München), Pressereferentin der WADP, Dr. med. Günter Ammon, Prof. Dr. med. Modest M. Kabanow

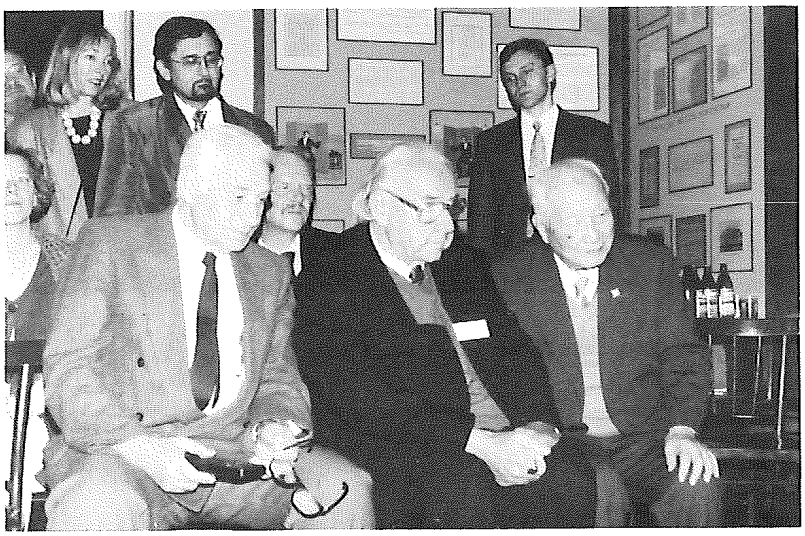

Abb. 8: v.l.n.r.: Prof. Dr. med. August Schereschewski (St. Petersburg), Dr. med. Günter Ammon, Prof. Dr. med. Wu-Chen I (Shantou), Chairman des Chinesischen Zweiges der WADP.

Abb. 9: v.l.n.r.: Prof. Amnon Carmi (Haifa), Präsident der Society for Medicine and Law in Israel, Präsident der World Association for Medical Law und Präsident des Israelischen Zweiges der WADP, Dr. phil Madeleine Jeannau (Umea), Prof. Dr. med. Jerzy W. Aleksandrowicz (Krakau), Prof. Dr. med. Felice Lieh Mak.

Abb. 10: Prof. Dr. med. Boris Poloshij (Moskau) im Gespräch mit Dipl. Psych. Margit Schmolke (München)

Abb. 11: Prof. Dr. med. Raymond Battegay (Basel) im Gespräch mit Prof. Dr. med. Metin Özek (Istanbul)

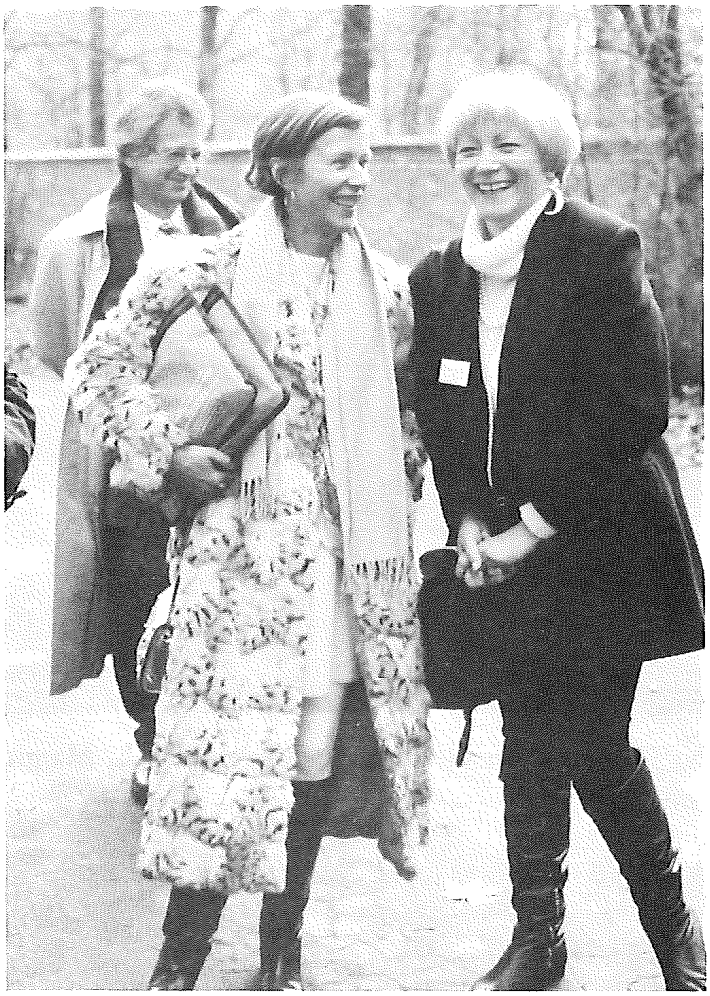

Abb. 12: v.l.n.r.: Dipl. Psych. Gerhard Wolfrum (München), Dipl. Psych. Maria Ammon, Dipl. Psych. Dr. phil. Ilse Burbiel

Abb. 13: v.l.n.r.: Dr. med. Günter Ammon, Prof. Dr. med. Guilherme Ferreira (Lissabon), Chairman des Portugiesischen Zweiges der WADP und Board of Trustees der WASP, Dipl. Psych. Maria Ammon, Frau Ferreira.

Abb. 14: Der Tagungsort des 10. Weltkongresses der WADP, das festlich geschmückte Psychoneurologische Forschungsinstitut W.M. Bechterew in St. Petersburg.

Abb. 15: Referenten, Teilnehmer und Organisatoren des 10. Weltkongresses der WADP/ XXIII. Internationalen Symposiums der DAP.

Schizophrenic patients make it necessary for both scientist and therapist to change basically their way of understanding their illness and unusual ways of treatment, as *Günter Ammon* pointed out in his preface of the congress program. The contribution of *Milos Kobal* (Ljubljana) was to be the representative work for this change of paradigm in understanding schizophrenia. Exemplarily, he contributed his model of »Metarepresentation« to the discussion. »Metarepresentations«, higher brain activities, are seen as representations of second order, which can be understood as »missing link« of a holistic activity in the brain. *Maria Ammon's* (Berlin/Munich) lecture represented an important result for the understanding of the development of the schizophrenic disorder on the background of the family's group dynamics and social energy. By means of qualitative interviews with schizophrenically structured patients and their families, she gave a meticulous analysis of the symbiotic group dynamics which are differently organized in the respective family groups and are differently experienced by the familiy members. *B. Karon* (Michigan), disciple of *Rosen,* showed in his lecture »The Fear of Understanding Schizophrenia« from a different point of view a basically human understanding of schizophrenic patients and their openness to a psychodynamically oriented treatment. *A. Giovannoni* and his coworkers *C. Lucii, F. Tozzi, C. del. Ministro* and *A. Addabbo* (Sienna) dealt with the problem of long-term patients becoming chronic, especially those with schizophrenic disorders. They pointed out that in the course of rehabilitation rigidity of the relation between patient and institutions of the health system has to be avoided. *Wu-Chen I* and *Sheng-Chang Giuo* (Guangdong) emphasized in their contribution the importance of a therapeutical attitude characterized by warmth, authenticity, honesty and devotion. Four important principles should be strictly observed: the well-being of the patient, the development of social awareness, the regaining of the patient's dignity, his legal rights and human respect as well as – to a certain degree – the exoneration of the state's responsibility. With schizophrenia, AIDS and »handicap« as examples, *C. Veil* and *C. Veil-Barat* (Paris) discussed in their lecture »The Psychosocial Construction of Disease and Handicap« different factors, influencing the definition of disease and »handicap«. Interesting contributions on psychosomatic disorders, in particular on emotional patterns and social and ecological factors of aetiology, were presented by *D. Isaev, A. Podporin, L.D. Bogomolova, V.L. Philipov* (St. Petersburg) and *P. Sidorov* and *A. Solovyov* (Arkhangelsk).

As a consequence of the various efforts to understand the mentally ill, the congress demanded the reinforcement of the use of preventive measures in the work with children and their families. *Gertraud Reitz* and *Dorothee Doldinger* (Munich), both experts in the supervision of the Munich Psychoanalytic Kindergarten, analyzed in their contribution the pivotal factors of groupdynamic psychoanalytical work in Kindergarten. The travel of a children's group of the Kindergarten, serving as an example, they described important steps of development of the children as well as of the parents and

co-workers of the Kindergarten. In his contribution »Child in Crisis: 'Cry for Help'-Syndrome in the Child-Centered Family Therapy«, *Sandor Bollok* (Budapest) pointed out that the child, being the carrier of the symptom, expresses the whole family conflict, and that the symptoms shown in public have to be understood as consequence of destructive family dynamics. Therapy has to start from the whole family group. The aim is to work on the unconscious problems of the family. *L. Krasojevič* (Belgrade) too, spoke about the family and its meaning for rehabilitation and resocialization of mentally ill patients. In their paper »Positive Family Psychotherapy – A Holistic and Transcultural Approach« *H. Peseschkian* (Wiesbaden) and *D.A. Avdeev* (Moscow) presented the conflict-centered short-therapy concept founded by *Nossrat Peseschkian.* This specific psychotherapy encourages the patient to see his own capabilities and establish a balance in his daily life through development of his physical, intellectual, socio-emotional and spiritual capabilities. Through the use of positive interpretations and stories as well as examples from other cultures, the selfhelp potential of the patient can be mobilised. Based on *Ammon's* group and identity concept, *D. Harbisch* and *S. von Wallenberg* (Solingen/Düsseldorf) examined the process of development and differentiation of symbiosis between parents and their newborn children, including the prenatal period. Taking a group of pregnant women and their partners as example, they analyzed the emerging group process as »inner symbiotic protective space« into which children are born. The infants are further supported until their third year of life and their groupability is examined.

Another demand of the congress was the empirical examination of treatment and methodology with regard to results of psychotherapy, including not only subjective, but also objective outcome criteria, as the well-known psychotherapy investigator *M. Perrez* (Fribourg) demanded. In his lecture on »Cultural Dependency of Evaluation Research« he went beyond this view, outlining that the definition of therapy outcome is dependent on cultural conditions. For example, in the Western societies, »efficiency« is connected with »improvement with the least time investment«. *Ilse Burbiel* and her co-workers *R. Apfelthaler* and *G. Sandermann* (Munich) reported on new results of the Munich Catamnestic Project studying short and long-term effects of Dynamic Psychiatric treatment of Borderline patients in the Hosptial Menterschwaige. They could demonstrate that up to 10 years after discharge from hospital not only the patient's symptomatology but also their personality functions could be changed significantly, especially aggression, anxiety, ego-demarcation and narcissism. Finally they discussed similarities and differences in the outcomes of borderline and schizophrenic patients. In her comprehensive study *Maria Ammon* described the results of psychic expression of 10 patients of the human-structural dance therapy group (Hospital Menterschwaige). The results are based on biographical interviews, a qualitative evaluation of the TAT and a qualitative and quantitative evaluation of video tapes. The author could observe changes in the

experience of the body of the patients, the approach to the group, the approach to the patients' own feelings, the ability to express and to verbalize feelings. The outcome results of the Swedish group of *Bengt-Ake Armelius* (Umea) on milieu therapy and psychotherapy in small treatment units for psychotic patients were as positive as those of the so-called Soteria project, which was presented by *Elisabeth Aebi* (Bern) in her lecture on »Going through Psychosis: Aspects of Therapeutic Treatment and Appropriate Research«. The Soteria project, started by *Luc Ciompi,* is based on psychoanalytic development psychology, including concepts as »holding function« (*Winnicott*), »containing« (Bion) and »checking back« (*Mahler*). *Jerzy W. Aleksandrovicz* (Cracow) discussed in his work on the »Effectiveness of Neurosis Psychotherapy« the results of a long-term study with neurotic patients who were treated with different models of psychotherapy.

A special symposium on empirical psychotherapy research concerning particularely the psychoses was held under the chairmanship of *Victor D. Wied* (St. Petersburg) and *Gerhard Wolfrum* (Munich). With the exception of *Rainer Dahlbender*'s and *Horst Kächele*'s (Ulm) lecture all contributions of this symposium came from the Bechterev Institute (St. Petersburg). The following questions were examined: the »Symbolic Feedback in Analysis with Mentally Ill Patients« (*G.V. Bourkovsky, Y.N Levchenko),* the »Symbiotic Family Relationships of Psychotic Patients and the Psychotherapeutic Target« (*V.Y. Alekseyev, J.S. Lukina)* and »Dynamic Psychiatric Principles in Psychotherapy of Autistic Children with Participation of Co-Therapists« (*A.S. Lomachenkov, L.S. Jeleznyak, J.B. Karvasarskaya, N.E. Martsinkevich, O.V. Utochkina).* Concerning the cooperation in diagnostics and psychotherapy resarch with the Russian colleagues, the contribution »Results of the Clinical Application of the Russian Version of Ammon's Ego-Structure Test« under the guidance of *Y.Y. Tupitsyn* with his co-workers *V.V. Bocharov, T.V. Alkazova, S.L. Solovyova* and *M.V. Tsvetkova* was of special interest.They compared samples of inpatient neurotics, psychotics and alcoholics. As a main result the structure of correlations of scales was different in the subgroups. *Boris S. Frolov* presented his »Method of Computerized Current Mental State Assessment«. *Rainer Dahlbender* and *Horst Kächele* (Ulm) in their lecture spoke about »Internalized Relationship Patterns in Psychotherapy and Research«, concerning the CCRP (Connected Central Relationship Patterns) which was developed in Ulm and which is a structured version of *L. Luborsky*'s CCRT-method (Core Conflictual Relationship Theme). The authors described the approach and some clinical and research applications of the CCRP, which was created in order to identify internalized patterns of relation in psychotherapy.

The quality of the results in psychotherapy research are among other factors dependent on the quality and adequacy of methods of sampling data as developed for diagnostics and change. The Ego-Structure Test by Ammon (ISTA), which has been successfully used in diagnostics and research for more than 10 years, was presented in a revised version by

Günter Ammon and his co-workers *Gisela Finke* and *Gerhard Wolfrum.* The scales of aggression, anxiety, ego-demarcation and narcisssism were extended by the scale of constructive, destructive and deficient sexuality. Scale- and item analysis of the new scales led to good results. Correlations with aggression, anxiety, demarcation and narcissism were directed as experienced. The valid form of the ISTA, as used so far, has been translated into several languages and has been adapted as test psychological measure, recently for Russia at the Bechterev Institute under the guidance of *Yuri Tupitsyn,* who lectured together with his co-workers on the results of the clinical use of the Russian version. *Anatoly Podporin* of the Bechterev Institute reported on the particularities of the emotional pattern of psychosomatic patients examined with the »Basic Emotional Structuring Test« (*H. Calehr*). Both, the relation between anger and joy and disturbances of the ego-ideal seem to be responsible for the development of psychosomatic disorders. Two contributions of the congress focused on the importance of the diagnostics of past and present interpersonal dimensions of relation for understanding human personality: *R. W. Dahlbender, P. Buchheim* and *H. Kächele* (Ulm) used three generations of first interviews to demonstrate the development of the level of examination, starting from a phenomenological to a psychodynamic formulation (first generation e.g. »Dynamic Interview« by *Gill, Newman* and *Redlich;* »Psychiatric Interview« by *Sullivan* etc.). The second generation (e.g. »Structural Interview« by *Kernberg)* includes the inner organization of psychic structures. Today systems are more generalized, connecting clinical examinations and empirical research (third generation »Relationship Anecdotes Paradigm Interview« by *L. Luborsky,* which identifies repeating patterns of relations). *Rolf Holmquist* (Umea) examined in his contribution »Psychiatric Diagnosis and Countertransference Reactions« different emotional reactions of psychiatric milieu therapists towards different diagnostic groups. A »Feeling Word Checklist« had been used as diagnostic instrument. The author found a close relationship between the feelings of the therapist and the patient's diagnosis.

Sleep and brain research as well as holistically oriented approaches in the understanding of neurobiological processes and processes of higher brain activity were particularly important for the theme of the congress, since the joint of psyche and brain illustrates the necessity overcoming dualistic thinking in psychiatry. *Robert Cancro* (New York) in his lecture entitled »Necessity of Going Beyond Dualism in Conceptualizing Mental Disorder« advocates a change in understanding neurobiology, proceeding from the assumption that the biological part of the individual as well as the quality of his experiences are unique. Particular events are of very personal importance to the individual's way of experience and therefore exercise a specific influence on the person's nervous system. For many years the sleep structures of different groups of patients have been investigated in the Menterschwaige Hospital under the guidance of *Ulrich Köppen* and *Astrid Thome* (Munich). The results of their work are published in

their paper on »Sleep Structure in Depression, Schizophrenia, Psychosomatics, Borderline Syndrome and Anorexia Nervosa: A Comparison«. The statistic comparison of the sleep structure of five diagnostic groups (narcissistic depression, schizophrenia, psychosomatic diseases, borderline personality disorder, anorexia nervosa) against control subjects shows that the most number of patients, independent of diagnosis, has an increased activity level of night sleep. The increased activity level is similar for all patient groups. This is understood as a developmental deficit within the regulative systems of ascending and descending activation, in terms of the humanstructural model as an expression of increased destructive aggression and destructive and deficient anxiety, which cannot be integrated within the adaptive-regulative system of night sleep and can thus not be integrated into the personality. The well-known sleep and brain researcher *Vadim S. Rotenberg,* who for many years has regularly presented the results of his research on WADP-congresses, this time together with *A. Elizur* (Tel Aviv), discussed the »Right Hemisphere Insufficiency and Illness in the Context of Search Activity Concept«. *Rotenberg's* conception of »search activity« is a general psychobiological mechanism which provides for the individual's development and protects somatic and psychic health. The right hemisphere has a significant meaning for the search activity by its ability to produce a polysemantic context in dreams. The function of dreams is to restore decreased search activity. That means that normal adaptation in the polydimensional world can be maintained. *Inge Gorynia* (Berlin) investigated »Signs of Latent Laterality according to Luria« in right-handed psychotic patients compared with right-handed healthy controls. Marked differences occured only with males: while in the healthy male controls more signs of unilaterality were evident, in psychotic patients more signs of crossed laterality could be established.

Empirical research in the field of psychopharmacotherapy was given an own Symposium under the chairmanship of *Yuri C. Nuller* (St. Petersburg) and *Bernhard Richarz* (Munich). Its aim was to investigate the effect of different kinds of psychopharmacological drugs and substrates on the development of symtpoms, whereby the works of *Y. Nuller* (»Role of Anxiety in the Structure of Mental Disorder«), of *A.P. Muzychenko* (Moscow) (»Current Psychoactive Remedies in Treating Mental Disorders of Different Levels«) and of *V.A. Tochilov* (St. Petersburg) deserve particular attention. In his paper »Application of Psychoactive Remedies with Directed Action for Investigating the Structure of Schizoaffective Attacks«, *Tochilov* studied the small effect of classical neuroleptic and antidepressive drugs on non-typical affective psychoses. He recommended the application of benodiazepines, which in addition deliver diagnostical and prognostical information. The second part on this symposium on »Empirical Investigations on Psychopharmacotherapy« dealt among other things with experiences and investigations concerning a combination of psychopharmacotherapy and psychotherapy, presented by *A.S. Tiganov* (Moscow), *A.B. Smule-*

vich and co-authors (Moscow) in view of cardiophobia, and by *L. Mikhelune* (Tartu) regarding depressive states. *R.Y. Vovin* (St. Petersburg) held his lecture on the »Correlation between Psychopharmacotherapy and Psychotherapy in Different Stages of Treatment of the Mentally Ill«. He emphasized that a »primary condition of the efficiency of psychotherapy in mental disorders is the use of different psychotherapeutic interventions according to stages of a psychopharmacologically induced setback of symptoms«. *V.N. Krasnov* (Moscow), President of the Russian Psychiatric Association and Director of the Moscow Research Institute for Psychiatry, discussed the different ways of applying psychotherapy, which are dependent on the various states of depression development. *Bela Buda* (Budapest), Vice-President of the WADP and lecturer in Communication Sciences at the University of Budapest, dealt with problems of integrating psychopharmacotherapy and psychotherapy. The author discussed specific indications of temporary pharmacotherapeutic treatment beside psychotherapy, particularly in order to stop destructive forces in the patients, to prevent suicides, threatening acting out manifestations, but also to overcome crises, existential problems, to make patients responsive to psychotherapy etc. The main principles of Dynamic Psychiatry, however, should be namely growth and development of personality of constructive ego-functions of the patient.

One symposium dealt with the »Investigation of the Process and Efficiency of Psychotherapy of Borderline-Conditions and Psychososmatic Diseases«. In this symposium *V.S. Chudnovsky* and *Y.M Shikin* (Stavropol) presented their paper about »Self-Consciousness and its Role in the Mechanism of Borderline Disorders in Children and Teenagers under Conditions of Family Deprivation«. Another paper came from *V.A. Tashlykov* (St. Petersburg) about »Coping Mechanisms as Reflection of the Psychodynamics of the Internal Disease Picture of Neuroses«, and *E.G. Eidemiller* (St. Petersburg) contributed on »Pathology-Inducing Social Inheritance in Neuroses: Optimistic Paradigm of Dynamic Psychiatry«.

A further important result of the congress was the fact that the psychotherapist, the patient and the group cannot be regarded as isolated from their relations with the health and social system. *Y. Tupitsyn (*St. Petersburg) and *A.A. Churkin* (Moscow) discussed this aspect in their papers on »Modern Problems of Organization of Psychiatric Care« and on »New Conceptual Approches to Mental Health« respectively. While *Tupitsyn* analyzed the main factors being responsible for deterioriation of psychiatric care in Russia, *Churkin* discussed the necessity of a conceptual basis for mental health protection which should be oriented not at the patient but at the healthy person, suggesting detection of risk factors, complex evaluation of the individual's functional condition, prevention, early diagnosis and effective correction of premorbid conditions.

Researchers from Israel, Russia and Germany delivered lectures on ethical, legal, family and socio-political problems of modern psychiatry: *Amnon Carmi* (Haifa), Supreme Judge of Haifa and President of the Inter-

national Society for Medical Law and Ethics, considered in his paper the Russian Law »On Psychiatric Care and the Saveguarding of Citizen's Rights in the Dispensing of Such Care«, which has been formulated in 1992, to be a great step towards international humanistic ideas and concepts. Nevertheless, this law does not consider man's fundamental right for active and equal participation in the therapeutic process. *Yuri V. Popov* (St. Petersburg), who also regards the new law as a step towards more humanity in Russian psychiatry, discussed some possible collisions between legal and ethical standards, which the psychiatrist is exposed to and which he must solve. *I. Y. Gurovich* (Moscow) also dealt with the »Russian Legislation of Psychiatry and its Realization«. *Thomas Hessel* (Munich) investigated in his capacity as a lawyer the mutual influences between the altered family structures of the last two centuries and family legislation. He concerned himself particularly with the development of the law of divorce under dynamic psychiatric points of view. While *Yigal Ginath* and *Michael Ritsner* (Jerusalem) and *Aleksei N. Krasniansky* and *Peter V. Morozov* (Moscow) dealt with the »Psychological Adjustment among Emigrants – The First Three Years« and with »Posttraumatic Stress Disorders of Afghan Veterans«, *Helmut Volger* (Berlin) concerned himself with »Nationalism and the Protection of Minorities – Group-dynamic Considerations concerning the Present Integration Problems in the Different States«. In order to overcome problems regarding nationalism, minorities and other kinds of group desintegration, the author demands, from a group-dynamic point of view, total responsibility on the part of greater state communities and intensified democratizing processes, taking into consideration civic right movements.

The efforts of the congress members for a scientific integration of the many theoretical, therapeutical and research approaches as demonstrated in discussions, scientific meetings and in particular in three press conferences, made clear over and over again that dynamic-psychiatric science with its strictly holistic approach of thinking and treatment may represent one possible level of integration, including not only different field of research, but also different human sciences. Liberating human being, science and politics from dualistic thinking in categories of friend/enemy, good/evil, young/-old, healthy/ill, east/west etc., could represent a great step towards a peaceful society in this world. Certainly it is not by chance that this congress took place in St. Petersburg, a city situated at a joint line between east and west and being at the same time the gate to the west for Russia and the gate to Russia for the west. The congress was terminated on the third press conference on which the participants expressed their wish that they may apply the results of the congress in their scientific and therapeutic field of work for the sake of the healthy as well as the ill human being.

Ilse Burbiel, Margit Schmolke, Monika Dworschak (Munich)

Message of Greeting from The White House

The White House
Washington October 14, 1994

Dr. M.M. Kabanov
Chairman
World Association for Dynamic Psychiatry
Bekhterev Street 3,
193019 Saint Petersburg
Russia

Dear Dr. Kabanov:
Thank you so much for your letter requesting that the President and First Lady serve as Honorary Presidents for the World Association for Dynamic Psychiatry's Tenth World Congress.
It is a great honor to be considered for such a role, and the President and First Lady sincerely appreciate your interest. Unfortunately, they are unable to accomodate your request at this time and cannot lend their names to your cause.
President and Mrs. Clinton do, however, wish you the greatest success in your efforts. Thank you again for your interest.
Sincerely,

James A. Dorskind
Special Assistant to the President
Director of Correspondence and
Presidential Messages

Ansprache von Dr. med. Rolf Schmidts anläßlich der Verleihung der Goldmedaille der DAP an Dr. med. Günter Ammon

Meine Damen und Herren, lieber Dr. *Ammon,*

ich habe die große Freude, Dr. *Günter Ammon* hier in St. Petersburg auf dem 10. Weltkongreß der World Association for Dynamic Psychiatry die Goldmedaille und die Urkunde der Ehrung der DAP zu überreichen. Die Überreichung der Goldmedaille der DAP an verdiente Förderer unserer Arbeit hat bereits eine lange Tradition. Geehrt wurden bisher: *Apollon E. Sherozia, Edward J. Dehné, Erwin Ringel, Gisela Ammon, Gustav Hans Graber, Friedrich S. Rotschild, Béla Buda, S.H. Foulkes, Rita Rogers,* Patienten und Team der Dynamisch Psychiatrischen Klinik Menterschwaige, *Ilse Burbiel.* Einem einstimmig gefaßten Vorstandsbeschluß der DAP

gemäß wird Dr. *Günter Ammon,* dem Begründer der DAP, für seine hervorragenden Verdienste um eine humanistische Psychiatrie und Psychotherapie in Theorie und Praxis die goldene Medaille der DAP am heutigen 26. Oktober 1994 verliehen.

Ich freue mich umso mehr, als diese Ehrung an einem Ort wie St. Petersburg erfolgen kann, weil St. Petersburg für den Westen ein Tor zum Osten, für den Osten ein Tor zum Westen darstellt und als genius loci einer umfassenden Integration von Gegensätzlichem wie geschaffen ist, einen internationalen Kongreß über etwas scheinbar so Unterschiedliches wie Natur- und Humanwissenschaften zu beherbergen. Ich freue mich, daß Dr. *Ammon,* der Zeit seines Lebens als Mensch, Therapeut und Wissenschaftler die Integration gesucht hat im Bestreben, die gefährlichen, oft tödlichen Dualismen dieser Welt zu befrieden, als erster westeuropäischer Wissenschaftler nach der Oktoberrevolution von 1918 und nach *Charcot* und *Kraepelin* auch die Ehrenmitgliedschaft der St. Petersburger Gesellschaft für Psychiatrie und Nervenheilkunde erhalten hat. Sein fundamentaler Wille zur Integration, und damit ein Wille zu völker- und menschenverbindender Verständigung, wird an keinem Ort greifbarer als hier.

Das in *Ammons* Denken zentrale humanistische Anliegen beschreibt er selbst bereits in einem programmatischen Artikel des ersten Heftes der Zeitschrift »Dynamische Psychiatrie / Dynamic Psychiatry« (1968). »Dynamische Psychiatrie ist eine Psychiatrie, in der die Psychoanalyse als Grundlagenwissenschaft zur vollen Anwendung kommt; somit verstehe ich unter Dynamischer Psychiatrie eine Psychiatrie, die das Unbewußte wie auch das gegenwärtige, vergangene und in Zukunft mögliche soziale Feld des leidenden Menschen miteinschließt. ... Eine Dynamische Psychiatrie verwaltet den Patienten nicht und begnügt sich auch nicht mit einer ... Diagnose, sondern versucht, die gesamte Dynamik des Krankheitsgeschehens sowohl von der psychischen und soziologischen als auch von der somatischen Seite in ihrem Wechselspiel zu verstehen. Auf diesem Verständnis, das auch die konstruktiven Aspekte des Patienten, seine Begabungen, Interessen sowie sozialen und psychischen Möglichenkeiten umfaßt, versucht die Dynamische Psychiatrie ein Behandlungsprogramm aufzubauen«.

Lieber *Ammon,* überblickt man allein Deine im Rahmen der jährlichen Kongresse der DAP und später auch der WADP gehaltenen Schlüsselvorträge in ihrer Gesamtheit, so wird die enorme geistige Arbeit, in der Du internationale Kompetenz um Dich versammelt und Deine Themen organisch als gruppendynamischen geistigen Prozeß entfaltet hast, unübersehbar. Über die Entwicklung der Behandlungsmethodik, die Theorieentwicklung im engeren Sinne sowie die Entwicklung eines übergreifenden Menschenbildes hinaus hast Du schließlich das außerordentlich fruchtbare Humanstrukturmodell formuliert.

Bereits der erste Kongreßvortrag von 1969 enthält die »Ausarbeitung eines tragfähigen und therapeutisch fruchtbaren Gruppenkonzeptes«, das

als zentralen Leitgedanken für die Weiterentwicklung in Theorie und Praxis die Zurückweisung aller reduktionistischen Verengungen im Verständnis des Menschen beinhaltet: Der Mensch als Gruppenwesen, der in Gruppen lebt, arbeitet und sich entwickelt, aber auch in Gruppen krank wird und in Gruppen geheilt werden kann – das ist der Boden, aus dem *Ammons* Lehre gewachsen ist und zur Herausbildung eines neuen Menschenbildes und dem zentralen Begriff der Identität geführt hat. Als bedeutsame Stationen bis dahin möchte ich die Ablösung des *Freud*ianischen Triebkonzeptes mit *Ammons* Neufassung der Aggressionslehre und seinen Grundbegriff der konstruktiven Aggression erwähnen, das positive Verständnis des Unbewußten als Potential menschlicher Möglichkeiten und das sozialenergetische Prinzip als neuer Zugang zum Problem psychischer Energie. Daß es dabei um intensive Austauschprozesse zwischen Menschen ging, fand schließlich in Deiner zukunftweisenden Arbeit »Das Prinzip der Sozialenergie im holistischen Denken der Dynamischen Psychiatrie« ihren konzeptionellen Niederschlag.

Angesichts Deines zentralen therapeutischen Anliegens, nämlich der Behandlung schwerstkranker bis heute weitgehend unverstandener psychotischer und psychosenaher Patienten, war der Aufbau Dynamisch Psychiatrischer Kliniken eines Deiner wichtigsten Ziele. 1969 hast Du die Tagesklinik für intensive Gruppenpsychotherapie in Stelzerreut mit teilstationärem Charakter aufgebaut. Nach einer Vorläuferklinik 1975 hast Du schließlich 1979 die Dynamisch-Psychiatrische Klinik Menterschwaige gegründet und im Sinne eines gruppendynamischen sozialenergetischen Feldes strukturiert. Dazu kamen teilstationäre Einrichtungen wie die therapeutischen Wohngemeinschaften mit jeweils unterschiedlicher Struktur.

Dein »Paradigmenwechsel in der Wissenschaft vom Menschen« fand hier seine praktische Bestätigung. Besonders in Deiner Arbeit »Zur humanstrukturellen Verwobenheit von Psychosomatik und Schizophrenie in einem ganzheitlichen Krankheitsverständnis« 1988, hast Du diesen Gesichtspunkt hervorgehoben, indem Du die psychiatrische und psychoanalytische Krankheitslehre auf ein Verständnis der Gesundheit stutzt, womit Deine therapeutisch optimistische Haltung und Ethik sinnfällig ihren Ausdruck findet. Interessanterweise kam es gerade in diesem Zusammehang 1988 zu der so fruchtbaren Begegnung mit der russsischen Delegation des W.M. Bechterew Psychoneurologischen Institutes unter der Leitung von Prof. *Modest Kabanow.*

Voraussetzung für den Aufbau der oben genannten Institutionen war eine neue Strukturierung der Lehre und ihre Institutionalisierung sowohl in Fachverbänden wie der Deutschen Akademie für Psychoanalyse DAP, der Deutschen Gruppenpsychotherapeutischen Gesellschaft DGG, der Deutschen Gesellschaft für Psychosomatische Medizin DGPM als auch in den Lehr- und Forschungsinstituten der DAP in Berlin und München. Gerade in den Lehr- und Forschungsinstituten hast Du hunderte von Ärzten, Psychologen und auch Laien ausgebildet; Du hast freigiebig Deine jahrzehnte-

lange Erfahrung, die Du auch unter Entbehrungen gesammelt hast, weitergegeben und Gruppen fruchtbarer wissenschaftlicher und praktischer Zusammenarbeit aufgebaut. In diesen lebendigen Zentren geistiger Auseinandersetzung hast Du die methodologischen und wissenschaftstheoretischen Gesichtspunkte unserer Disziplin herausgearbeitet und auf den inzwischen schon 23 internationalen Kongressen der DAP, die Du vorbereitet, strukturiert und getragen hast, einer breiten Öffentlichkeit zur Diskussion gestellt. Es geschieht auch heute mit Deinem Eröffnungsvortrag »Man as a Multidimensional Being in Health and Illness«.

Die Mitglieder und der Vorstand der DAP möchten Deine heutige Ehrung zum Anlaß nehmen, Dir für Deinen enormen Einsatz für Deine Schüler und vor allem für Deine Patienten von ganzem Herzen danken, vor allem aber auch für die Lebenszeit, die Du uns gegeben hast.

Pressestimmen zum 10. Weltkongreß der WADP

We live in a crazy society but it will not at all be cured by tablets

Today, the Xth Congress of the World Association for Dynamic Psychiatry is opening in St. Petersburg. During three days more than 300 scientists and clinicians from 27 countries will be discussing actual problems of medicine and psychology »in an holistic approach to health and illness«.

The concept of the Dynamic Psychiatry developed by the prominent German scholar *Günter Ammon* assumes that the links between medicine and psychology have dynamic character and express the unity of human biological and psychosocial origins.

Being a follower of *Freud,* he and his collective in Munich, in treating the gravely mentally ill people, are focusing on personality's psychosocial potential. And they develop it actively through treatment by the music, dances, art (the Congress participants will be able to see wonderful pictures by patients). The labour therapy is essential, too, but the patients are not involved in primitive activity (e.g. pasting together cardboard boxes); they work creatively, according to the project which is interesting for them and useful for the society. »Let us find still more unusual methods and ideas for our unusual patients«, – urges Dr. *Ammon* his colleagues stressing that this Congress, which takes place in Russia for the first time, is demonstrating at the same time new political holism of our world.

Really, still 10 years ago, such forum would be impossible in our country, because the Soviet psychiatry was in the service at the Soviet politicians and psychotherapy in the totalitarian state could be only directive, slogan bound (»act in such way and it will be good for you«).

Yet the transition from totalitarism to democracy is taking place extremely painful in our society. In direct and indirect meaning of this word.

According to data of sociologists, 80% of school children have various nervous and mental disorders. The picture is not much better in adults, too. Therefrom stem conflicts, frustration, nervousness. We are living in a madhouse – the professionals are stating. But the solution they see not at all in the total use of drugs.

In modern medicine, so Prof. *Modest Kabanov,* Director of the Bekhterev Institute, change of paradigms is taking place: from Pasteurian (physiological) to personality oriented one. Such psychotherapy presupposes first of all hightening of each personality's creative potentiality, development of independence and ability to consciously solve most difficult problems.

Today, the society needs not just performers but creators, activity and independence are popular at last but the success will depend only on efforts of every concrete human being.

Tatiana Chesanova (»rush-hour«, St. Petersburg, 26.10.94)

In St. Petersburg findet der X. Kongreß der WADP statt

Liebe und Verständnis anstelle von Beruhigungsmitteln

An den Wänden grelle, ungewöhnliche Gemälde, nicht immer verständlich, aber den Blick zum Verweilen bewegend... Im Prozeß des Schaffens verläuft ein fortwährender Kampf gegen die Schizophrenie.

In den Mauern des Bechterew-Instituts findet gegenwärtig der X. Weltkongreß der Weltgesellschaft für Dynamische Psychiatrie statt. Er versammelt Forscher aus 27 Ländern der Erde. Man kann schwer die Bedeutung des Vertrauens überschätzen, welches uns die Weltspezialisten auf dem Gebiet der Psychiatrie und der Psychologie, insbesondere der Begründer der Konzeption der Dynamischen Psychiatrie, der berühmte deutsche Wissenschaftler Dr. *Günter Ammon,* schenkten. Das Thema des Kongresses – »Medizin und Psychologie in einem holistischen Herangehen an Gesundheit und Krankheit« (von dem griechischen Wort »holos« = Ganzheit) – ist ziemlich einfach zu beschreiben: Diese zwei Wissensgebiete – Medizin und Psychologie – sind zwei Seiten eines Ganzen und müssen in einer Einheit betrachtet werden.

Nach der Theorie *Günter Ammons* sind im Menschen ebenfalls eine biologische und eine psychosoziale Grundlage vereint. Für die Psychiater und Psychotherapeuten bedeutet das die Möglichkeit, die Biologie des Menschen durch seine psychische Sphäre zu beeinflussen und dabei auch nicht all das außer acht zu lassen, was ihn in dieser Welt umgibt.

Günter Ammon studierte bei Nachfolgern *Freuds* am Berliner Psychoanalytischen Institut und ging danach in die Forschung, wo er die Prinzipien der Dynamischen Psychiatrie auf die Behandlung schwerer psychischer Erkrankungen anwandte.

»Wir sehen den Menschen in einem ständigen Entwicklungsprozeß, sowohl in Gesundheit als auch in Krankheit, wobei sich diese Entwicklung durch den Einfluß psychotherapeutischer Methoden ergibt«, meint Dr. *Ammon.* »Die Menschen leben in Gruppen, und diese Gruppen mit ihrer Dynamik, mit ihrer Sozialenergie und ihrer kulturellen Verpflechtung mit größeren gesellschaftlichen Vereinigungen bestimmen das Leben des Menschen... die Dynamische Psychiatrie ist eine verstehende Psychiatrie.«

Auf die Frage, was das Gemeinsame und was die Unterschiede im Herangehen an das Problem im Vergleich zwischen unseren und den europäischen Wissenschaftlern seien, antwortete Dr. *Ammon* so: »Uns vereint eine humanistische Konzeption, aber uns trennt, daß die europäischen Spezialisten von der Psychoanalyse *Freuds* ausgehen«. Wie bekannt, löste sich unsere einheimische Psychiatrie von der physiologischen Schule *Palows* ab, in derselben Zeit, in der im Westen die Schule *Freuds* ihren Aufschwung begann. Nicht zufällig ertönte auf der Pressekonferenz kurz die Frage nach der Entwicklung der Theorien und Methoden der Psychoanalyse in Rußland, auf die Professor *W.D. Wied* folgendermaßen antwortete:

»Wenn man es kurz machen will — Psychoanalyse gibt es bei uns nicht, ebenso wie es keinen einzigen Menschen gibt, der eine genügende psychoanalytische Ausbildung hätte. Es wird das praktiziert, was wir eine »wilde Analyse« nennen, so daß sich sehr scharf die Frage nach der Professionalität unserer Spezialisten stellt. Gefährlich ist, daß die Ärzte sich die Methoden aneignen, aber nicht die Konzeption übernehmen«.

Am Kongreß nehmen die angesehensten Vertreter der modernen Psychiatrie teil: Die Präsidentin der DAP, *Maria Ammon,* die Präsidentin der World Psychiatric Association *Lieh-Mak,* der Präsident der Spanischen Assoziation für Analytische Psychiatrie *Ruiz-Ruiz,* der Direktor des Bechterew-Instituts Prof. *M.M. Kabanow,* die Direktorin des Zentrums für Sozial- und Gerichtspsychiatrie Prof. *T.B. Dmitrijewa* und andere (insgesamt mehr als 150 Teilnehmer aus dem Ausland und mehr als 100 aus dem Inland).

Auf die Frage nach dem praktischen »Ergebnis« der Ideen der Kongreßteilnehmer antwortete Prof. *Kabanow:* »Wir können neue Krankenhäuser bauen, und natürlich müssen wir dies tun. Wir können neue Medikamente entwickeln, womit wir uns ständig beschäftigen. Aber das Wichtigste: Solange sich die Mentalität unserer Ärzte nicht ändert, werden uns die modernsten Medikamente nicht helfen. Wir können zu einem elementaren »Feldscherismus« gelangen. Seit uralten Zeiten sprechen die Ärzte davon, daß es notwendig ist, nicht die Krankheit, sondern den Kranken zu heilen. In unserer einheimischen medizinischen Praxis war dies lange Zeit lediglich eine Deklaration. Wenn wir uns wie früher an der Analyse von Blut, Urin und Liquor orientieren und unsere Aufmerksamkeit nicht der Persönlichkeit des Patienten, seinen Beziehungen zur Familie, den Mitmenschen und sich selbst, sowie den Problemen seiner Weltanschauung widmen,

geraten wir in eine Sackgasse. Vielleicht hört sich das nach einer Predigt an, aber tatsächlich gehen die Leute heute nur deshalb zur Geistheilern und Gesundbetern, weil sie den Ärzten nicht vertrauen. Die Ärzte sind nicht in der Lage, mit den Menschen zu reden. Wir beschäftigen uns seit mehr als einem Vierteljahrhundert mit den Problemen der Rehabilitation und wenn ich gefragt werden, was heute für uns das Wichtigste ist, dann antworte ich: Nicht das Herauspressen von Geldern aus dem Ministerium oder dem Rathaus, nicht die Suche nach fehlenden Medikamenten und erst recht nicht Probleme der Diagnostik. Das Wichtigste ist, das ärztliche Denken zu verändern«.

In den Vorträgen, die von den bedeutendsten Wissenschaftlern des Weltniveaus gehalten werden, scheinen Themen der Prophylaxe, der Kinder- und Familienpsychotherapie, der Behandlung spezieller Krankheitsbilder (Neurosen, Angstanfälle, Psychosen und Psychosomatische Erkrankungen). Und noch ein mehr globales und nicht weniger wichtiges Thema, welches auf dem Kongreß angeschnitten wurde, ist die Integration der Medizin und der Psychologie. »England und Amerika trennt, daß sie dieselbe Sprache sprechen« — dieses Sprichwort ist auch auf die zwei Wissenschaften anwendbar, die so viel Gemeinsames haben: die Psychologie und die Psychiatrie.

Zweifellos hat der Kongreß auch eine wichtige politische Bedeutung. Eines der Treffen der Teilnehmer ist den Problemen des Einflusses der Psychiater und Psychologen auf die Prozesse in der großen Politik, auf die Überwindung der Kosten »feindlichen« Denkens gewidmet. Zum Glück ist die Vergangenheit vorbei, über die Prof. *Karwasarski* (Präsident der neu gebildeten Russischen Psychotherapeutischen Gesellschaft) erzählte:

»Als in den 70er Jahren ein Professor aus Frankreich den Generalsekretär der Kommunistischen Partei und die übrigen Partei- und Regierungsfunktionäre aufforderte, in die Theorie des »Unbewußten« einzudringen, um besser die Motive ihrer Handlungen zu verstehen, erschien es mir, daß gleich zwei Menschen in Zivil hereinkommen und den Professor bitten würden mitzukommen. Alle diese Leute lebten ja ein Doppel- oder Dreifachleben. . . »

Müssen die Fachleute die Sprache der Politiker sprechen? Prof. *T.B. Dmitrijewa* aus Moskau sprach über ihre Zweifel mit einem bekannten deutschen Juristen, und dieser antwortete: »Wenn Sie sich nicht mit Politik beschäftigen, wird sich die Politik mit Ihnen beschäftigen«. Amerikanische Psychiater erzählten über Forschungen zu Problemen nationaler Minderheiten und wie unter der Diskriminierung nicht nur kleine Gruppen leiden, sondern auch die Mehrheit, die notgedrungen aggressiv gegenüber anderen ist.

Einheimische Psychiater wiesen auf Veränderungen in der Persönlichkeits(Identitätskrise) der Patienten als Antwort auf die stürmischen Veränderungen in der russischen Gesellschaft hin. Mit Hilfe der Methodik der Schule Dr. *Ammons* gelang es, bei unseren Patienten eine Neigung zur

Aggressivität und destruktive Ängste festzustellen. In der Behandlungsmethodik ist es unerläßlich, psychologisches und psychotherapeutisches Herangehen zu vereinen.

Das Wichtigste, was auch ein Nichtspezialist verstehen könnte, der diesen repräsentativen Kongreß besucht: Es lohnt nicht, alle Hoffnungen auf Tabletten und Skalpell zu setzen.

Und noch ein nicht weniger wichtiges Ergebnis: Psychiater aus allen Enden der Erde — aus Amerika, Deutschland, Israel, Polen, China und Rußland fingen endlich an, in *einer* Sprache zu sprechen.

Augenzeugin *Alla Borisowa*
(»Newa-Zeit«, St. Petersburg, 29.10.94)

Auszüge aus Dr. Ammons Briefwechsel zum 10. Weltkongress der WADP

The World Association for Medical Law
President: Prof. A. Carmi

Haifa, November 6, 1994

Dr. Günter Ammon
Meierottostraße 1
1000 Berlin 15
Germany

Dear Dr. Ammon,
First of all, I would like to congratulate you for the big scientific success of the Congress at St. Petersburg. I look forward to your active involvement in all activities which are so dear to you.
Please give my best regards to Maria and all our good friends in Berlin and in Munich.
Wishing you all the best,
Sincerely yours,
Prof. Amnon Carmi

Ingo Hartmann, Dipl. Psych.
Psychoanalytiker

Düsseldorf, 25.11.94

Lieber Ammon,
nachdem nun der erste Streß der Kongreßnachbearbeitung bewältigt ist, möchte ich Ihnen mit diesem Brief noch einmal herzlich danken, daß Sie mit Ihren Mitarbeitern einen so großen und bedeutenden Kongreß veranstalten konnten und daß Sie mich dazu eingeladen hatten. Was die

Humanwissenschaften angeht, ist wieder einmal mehr deutlich geworden, daß die Berliner Schule an der vordersten Front der Entwicklung steht; fast scheint es manchmal, als ob viele Länder in ihren bisherigen Systemen so gefangen sind, daß sie der Humanstrukturologie gar nicht folgen können. Man wird also noch viele solcher Kongresse durchführen müssen.
Ich wünsche Ihnen unbedingt Gesundheit und tausend lange Leben
Ihr
Ingo Hartmann

Shantou University
Add: Shantou Guangdong
People's Republic of China

November 24, 1994

Dear Dr. and Mrs. Ammon:
I was so much honored to be invited to attend the 10th Congress of WADP in St. Petersburg. It was such a wonderful opportunity not only to meet you and other old German friends, but also to learn a great deal from the conference which gave me a lot of inspiration to the future development of psychiatry in China. We hope very much that both of you will be able to arrange a visit to China at your convenience. I will be much honored if you will give us some lectures here.
Respectfully yours,
Wu Chen-I

From the World Association for Social Psychiatry

The minute of the Executive Council of the World Association for Social Psychiatry has been sent by its General Secretary, *Pierre F. Chanoit*, Paris. It informs about the proceedings held during the XIVth World Congress of Social Psychiatry in Hamburg under the presidentship of *Jorge A. Costa e Silva.* He resumes the decisions taken, among which the most important are:
1. Cutting short his own mandate on account of the new responsabilities he assumes, such as the lead of the Division for Mental Health of the WHO;
2. The inauguration of the bilingual (English-French) International Journal of Social Psychiatry to be issued quarterly;
3. The legal registration of the Association in France;
4. The adhesion of new members, and
5. The organization of the XVth Worldwide Congress of the W.A.S.P., which will take place during September, 5-10 1995 in Rome.

Ending his presidential mandate with the Congress in Rome, *Costa e Silva* will be replaced by the Vice-President *A. Petiziol* (Italy), until the President-Elect *Eliot Sorel* (USA) will assume the presidency in 1996. The next General Assembly of the W.A.S.P. will take place preceeding the Congress in Rome.

Kongreß über kulturelle und ethnische Probleme im Gesundheitswesen vom 13. bis 15. Dezember 1994 im Serbski National Research Centre for Social and Forensic Psychiatry Moskau

Bemerkenswert an diesem ersten internationalen Kongreß des Moskauer Serbski-Institutes waren mehrere Punkte: Die Offenheit, mit welcher zusammen mit ausländischen Fachvertretern und Referenten des Moskauer Gesundheitsministeriums innerrussische ethnische Problemstellungen diskutiert wurden, die Kunst, angesichts noch immer drängender wirtschaftlicher Probleme eine Vielzahl von Fachvertretern aus den entlegensten Gebieten der russischen Föderation an einen Tisch zu bringen und schließlich die Brisanz der diskutierten Thematik angesichts des damals gerade beginnenden und mittlerweile eskalierten Tschetschenien-Krieges.

Eingeladen hatte die etwa 250 Gäste aus sieben Ländern die Direktion des »Serbski National Research Center for Social and Forensic Psychiatry«, Frau Professor *T.B. Dmitrieva.* Ins Zentrum stellte sie die politische Aktualität der Veranstaltung und die Frage nach der Rolle des Psychiaters in der Gesellschaft: »Wenn wir als Psychiater uns nicht um die Politik kümmern, wird sich die Politik um uns kümmern« — eine These, die auch in den Diskussionen immer wieder aufgegriffen wurde. Professor *Boris Poloshij*, Chef der Abteilung für ökologische und soziale Probleme im Gesundheitswesen, eröffnet den Kongreß, der auch viele Mitarbeiter des Instituts anzog, mit einem bemerkenswerten Grundsatzreferat »Mental Health in Russia: Current Ethnical and Sociocultural Aspects«. Er analysierte die derzeitige Situation der russischen Gesellschaft, die sich seiner Meinung nach nicht nur in einer Übergangsperiode, sondern auch in einer tiefen Identitätskrise befindet. Er beklagte die zunehmende Tendenz, Gewalt als Mittel für Konfliktlösungen einzusetzen, fragte nach der Bedeutung der Religion für das Land und zitierte zentrales Gedankengut der Dynamischen Psychiatrie *Günter Ammons*. Er plädierte vehement für ein strukturelles Denken jenseits von Kategorien und Diagnosen, verwies auf die Arbeitsprinzipien des Ich-Struktur-Tests nach *Ammon* (ISTA) und demonstrierte dessen Anwendungsmöglichkeiten für ein strukturelles diagnostisches Verständnis. Er stellte im Hinblick auf gesellschaftliche Prozesse vier Varianten der Identitätskrise vor und bediente sich ihrer zur Erläuterung der Begriffe von Humanstrukturen und Funktionen. Er sprach von der passiv-aggressiven Haltung von weiten Teilen des russischen

Volkes und der hohen Präferenz der Russen für Magie, Mystik und okkulte Phänomene als einer Möglichkeit, der noch immer bitteren Alltagsrealität zu entkommen.

Der bekannte amerikanische Aggressionsforscher Professor *Eliot Sorel* (Washington), President-Elect der World Association for Social Psychiatry, zeichnete in seiner Präsentation über Gewalt in Amerika und die kulturellen Hintergründe psychiatrischer Diagnostik profund und ausführlich ein düsteres Bild der Gewaltbereitschaft der amerikanischen Gesellschaft. Die von ihm vorgetragene amerikanische Kriminalstatistik demonstriert, daß es sich sowohl bei den Opfern von Gewalt als auch bei der Tätergruppe um soziale Randgruppen handelt. *Sorel* wies auf die historische Bedeutsamkeit dieser Stunde angesichts eines im Süden des Landes beginnenden Krieges mit seinen noch unabsehbaren Folgen hin.

Als Vertreter der World Association for Dynamic Psychiatry wies Professor *Modest Kabanow*, Direktor des St. Petersburger Bechterew-Instituts, wo nur wenige Wochen zuvor der erste psychoanalytische Kongreß der WADP auf russischem Boden sehr erfolgreich durchgeführt worden war, auf die Bedeutsamkeit der Aggressionslehre *Ammons* hin, die wesentlich zum Verständnis sozialer und ethnischer Konflikte beiträgt. Als weitere WADP-Vertreter aus St. Petersburg sprachen Prof. *Popow* über die Rolle der Psychiatrie bei religiösen und ethnischen Konflikten in einer sich wandelnden Gesellschaft, Prof. *Wied* über transkulturelle Untersuchungen kognitiver Defizite bei älteren Menschen.

Dipl.-Psych. *Gerhard Wolfrum* trug als Vertreter der Deutschen Akademie für Psychoanalyse (DAP) die Arbeit von *Ammon* »What is Dynamic Psychiatry« vor, welche Grundpositionen der Humanstrukturologie *Ammons* darlegt und vor allem im Hintergrund viele Fragen und eine lebhafte Diskussion auslöste.

Eine Fülle weiterer epidemiologischer und kasuistischer Beiträge zeigte das breite Spektrum einer Nation mit 22 verschiedenen Ethnien und der daraus resultierenden Konfliktmöglichkeiten. Die Notwendigkeit einer gemeinsamen Verständigung wurde evident — ein Aspekt, der in den Diskussionen immer wieder vor allem von Professor *Kabanow* betont wurde. Notwendig sei eine gemeinsame Sprache, die Zusammenarbeit und Verständigung mit den Psychologen und anderen Disziplinen, die verbindliche Festlegung auf gemeinsame Definitionen wichtiger Begriffe, etwa des Aggressionsbegriffs im Sinne von *Ammons* Aggressionslehre.

Unter anderem stellte Professor *Semke* aus Tomsk eine detaillierte Untersuchung über die besonderen und extremen Lebensbedingungen der Tschuktschen vor, gefolgt von einem Beitrag des russischen Emigranten Professor *Leiboy* (Sparta) zur transkulturellen Diagnostik und schließlich kasuistischen Beiträgen der deutschen Professoren *Bauer* (Offenbach) und *Kunze* (Kassel) sowie des Schweizer Klinikdirektors Professor *Böker* (Bern).

Eröffnung des Kongresses durch Frau Professor Dmitrieva (stehend), Leiterin des Moskauer Serbski-Institutes zusammen mit Professor Poloshij (links), einem Vertreter des Moskauer Gesundheitsministeriums und Professor Kabanow (ganz rechts), Leiter des St. Petersburger Bechterew-Instituts

Teilnehmer der internationalen Konferenz zu kulturellen und ethnischen Fragen des Gesundheitswesens. Von links: Prof. Karpow, Vertreter des Gesundheitsministeriums, Prof. Semke, Tomsk, Prof. Popow, Bechterew-Instiutut, St. Petersburg, Prof. Alexandrovski, Vizepräsident des Serbski-Instituts Moskau (zweite Reihe)

Dipl.-Psych. Gerhard Wolfrum bei der abschließenden Round-Table-Diskussion mit seinem Statement über die Notwendigkeit, gruppendynamische Aspekte in der Psychiatrie zu berücksichtigen

Die abschließende Round-Table-Diskussion unter Leitung von Frau Professor *Dmitrieva* zeigte noch einmal das breite Spektrum der unterschiedlichen kulturellen, sozialen, religiösen und ethnischen Konfliktmöglichkeiten und die Dringlichkeit einer Integration und Berücksichtigung der Besonderheiten der jeweiligen Bevölkerungsgruppen. Wesentliche Diskussionspunkte waren die Frage nach der Rolle des Psychiaters in der Gesellschaft, die ungenügende Ausbildung der Ärzte, die unterschiedlichen und meist unintegrierten therapeutischen Ansätze, die zunehmende psychiatrische Unterversorgung der Bevölkerung sowie das neue Psychiatriegesetz. Gefordert wurde ein Umdenken, weg von psychiatrischem Kategoriendenken, ein neues Verständnis, nicht mehr Krankheiten zu behandeln, sondern erkrankte Menschen, ethische Normen zu berücksichtigen und die Notwendigkeit, praktikable theoretische Ansätze zu entwickeln. Vor allem sollte ein Dialog zwischen Psychiatrie und Gesellschaft geführt werden, die Psychiatrie sich als gesellschaftsrelevante und politische Disziplin begreifen, die Angst vor dem Psychiater abgebaut und unbewußte wie gruppendynamische Apsekte stärker berücksichtigt werden. Der Vertreter des Gesundheitsministeriums forderte Psychiatrie und Psychiater zu mehr Selbstkritik, Infragestellung eigener Positionen und zu einem stärkeren Dialog mit Politik und Medien auf. Ob diese Konferenz historische Bedeutung bekomme, könne nur die Zukunft zeigen.

Bedeutsam für uns als Gäste des Moskauer Serbski-Instituts wurde auch die anschließende Einladung durch Professor *Kudryavtsev* in sein psychologisches Laboratorium, wo in intensivem Austausch die unterschiedlichen diagnostischen Methoden des Serbski-Instituts und der Klinik Menterschwaige diskutiert werden konnten. Die herzliche Einladung in die Borderline-Abteilung der Klinik von Professor *Alexandrovski* und die fundierte Darstellung der diagnostischen Arbeit durch Frau Dr. *Sobtschik* rundeten das Bild einer engagiert arbeitenden Psychiatarie ab und ließ auch zu den jüngeren Kollegen eine freundschaftliche Beziehung entstehen. Die Einladung zu einer Ballettvorstellung im Kongreßpalast des Kreml im Rahmen des großzügigen Kulturprogrammes, ein Prokojew Konzert in der Philharmonie von höchster künstlerischer Qualität und eine private Einladung bei Professor *Poloshij* und seiner Familie unterstrichen die persönlichen Freundschaftsbeziehungen.

Gerhard Wolfrum, Sylvelin Römisch (München)

Gastseminar von Dr. Tisera am Münchner Lehr- und Forschungsinstitut der DAP

Am 21. Januar 1995 hat in München Dr. med. *Gregorio Tisera*, Psychiater und Musiktherapeut der Universität Rosario, Argentinien, zum zweiten Mal ein Musikselbsterfahrungsseminar am Lehr- und Forschungsinstitut der DAP durchgeführt. Das Seminar stieß auf reges Interesse. Eine theoretische Einführung leitete das Seminar ein, praktische Übungen in Form freier Improvisationen einzelner Individuen und kleiner Gruppen mit *Orff*schem Instrumentarium sowie Kongas und anderen Instrumenten demonstrierten, wie in kürzester Zeit Kontakt entstehen kann und Konflikte ausgetragen werden können. Interessant war dabei die Konstituierung einer zweiten Untergruppe, die das musikalische Geschehen zu beobachten und zu beurteilen hatte und die ein außerordentlich differenziertes Feedback für die Spieler gab. Sehr anregend war das Experiment, dieses Feedback musikalisch bzw. pantomimisch oder tänzerisch darzustellen. Die reiche Erfahrung von *Dr. Tisera* brachte auch diesmal vielfältige Anregungen und Anstöße für unsere eigene Musiktherapie bzw. Musikselbsterfahrung.

Ein Vortrag von Dr. med. *Rolf Schmidts*, Chefarzt der Dynamisch-Psychiatrischen Klinik Menterschwaige, zur Musiktherapie in der Dynamischen Psychiatrie war dem Gastseminar vorausgegangen und hatte zu lebhaften Diskussionen geführt.

Egon Fabian (München)

Ankündigungen / Announcements

Congrés Européen Adolescence 1995
Organizer: Ligue Bruxelloise Francophone pour la Santé Mentale
Theme: Le franchissement d l'adolescence ... au risque de se perdre
Location: Palais de Congrés, Bruxelles, Belgique
Date: 30 mars - 1 avril 1995
Information: Lique Bruxelloise Francophone pour la Santé Mentale, 53 rue du Président, 1050 Bruxelles, Belgique

94. Gruppendynamische Tagung der Deutschen Akademie für Psychoanalyse (DAP) e.V.
Veranstalter: Deutsche Akedemie für Psychoanalyse (DAP) e.V.
Leitung: Dr. med. Rolf Schmidts
Ort: Tagungszentrum der DAP in Paestum (bei Salerno/Süditalien)
Zeit: 10.-20. April 1995
Information: Lehr- und Forschungsinstitute der Deutschen Akademie für Psychoanalyse (DAP) e.V., LFI Berlin, Kantstraße 120/121, 10625 Berlin, Tel. 030 / 3 13 26 98; LFI München, Goethestr. 54, 80336 München, Tel. 089 / 53 96 74, Fax 089 / 5 32 88 37

International Symposium on »Recent Advances in Care of the Elderly«
Organizer: Sarah Herzog Memorial Hospital, Jerusalem
Theme: Recent Advances in Care of the Elderly
Location: Jerusalem, Israel
Date: 23-27 April 1995
Information: Ortra Ltd., 2 Kaufman Street, P.O.B. 50432, Tel Aviv 61500, Israel

Kongreß der Schweizerischen Gesellschaft für Kinder- und Jugendpsychiatrie/ VI. Genfer Symposium über Kinder- und Jugendpsychiatrie
Organisation: Schweiz. Gesellschaft für Kinder- und Jugendpsychiatrie
Thema: Eltern-Kleinkind-Beziehungen und ihre Störungen
Ort: Geneva International Conference Center, Genf, Schweiz
Zeit: 11.-13. Mai 1995
Information: Symporg S.A., Av. Pictet-de-Rochemeont 7, CH-1207 Genf, Schweiz

Jahrestagung 1995
Veranstalter: Deutsche Arbeitsgemeinschaft für Jugend- u. Eheberatung e.V. (DAJEB)
Thema: Beratungsarbeit 2000
Ort: Augsburg
Zeit: 25.-27.Mai 1995
Information: DAJEB, Neumarkter Str. 84c, 81673 München

29. Montecatini-Kongreß 1995 mit Psychotherapiewochen in der Toscana

Veranstalter: Landesärztekammer Brandenburg
Ort: Montecatini Terme (Toscana, Italien)
Zeit: 25. Mai - 10. Juni 1995
Information: Dipl. med. päd. D. Piesker, Landesärztekammer Brandenburg, Referat Fortbildung, Postfach 10 14 45, 03014 Cottbus, Tel. 03 55 / 7 80 10 24

95. Gruppendynamische Tagung der Deutschen Akademie für Psychoanalyse (DAP) e.V.

Veranstalter: Deutsche Akademie für Psychoanalyse (DAP) e.V.
Leitung: Dr. med. Günter Ammon
Oer: Tagungszentrum der DAP in Paestum (bei Salerno/Süditalien)
Zeit: 2.-12. Juni 1995
Information / Anmeldung: Lehr- u. Forschungsinstitute der DAP e.V., LFI Berlin, Kantstr. 120/121, 10625 Berlin, Tel. 030 / 3 13 26 98; LFI München, Goethestraße 54, 80336 München, Tel. 089 / 53 96 74, Fax 089 / 5 32 88 37

28. Internationales Trainingsseminara für Gruppendynamik

Veranstalter: Österreichischer Arbeitskreis für Gruppentherapie und Gruppendynamik
Ort: Alpbach, Österreich
Zeit: 10.-15. Juni 1995
Information: Alpbach-Sekretariat, Dr. Th. Hartwig, Kreuzstraße 13, A-4040 Linz-Urfahr

2nd Baltic Sea Conference on Psychosomatic Medicine

Organizer: Swedish Association of Psychosomatic Medicine
Location: Ronneby, Sweden
Date: June 11-14, 1995
Information: Institute for Psychosomatic Medicine, Ga Lv6, Kvibergsv. 5, 41505 Göteborg, Sweden

13th European Audiovisual Immersion Course

Organizer: The Swiss Institute for Intensive Short-Term Dynamic Psychotherapy
Theme: Technical and Metapsychological Roots of the Process of Unlocking the Unconsious
Location: St. Gallen, Switzerland
Date: June 22-24, 1995
Information: Sekretariat Immersion Course, Stadelhoferstraße 28, CH-8001 Zürich

Forum Rehabilitation

Veranstalter:	Referat »Psychosoziale Rehabilitation«, Deutsche Gesellschaft für Psychiatrie und Nervenheilkunde (DGPN), World Association of Psychosocial Rehabilitation
Thema:	Brennpunkte in der Psychiatrie
Ort:	Congress Centrum, Hamburg, Germany
Zeit:	23.-24. Juni 1995
Information:	Forum Rehabilitation CCH-Congress Organisation, Postfach 30 24 80, D-20308 Hamburg, Tel. 040 / 3569 - 2341, Fax 040 / 3569 - 2343

World Congress of Behavioural and Cognitive Therapies

Veranstalter:	WCBCT c/o DIS Congress Service, Herlev Ringvej 2c, DK-2730 Herlev
Ort:	Lyngby, Denmark
Date:	July 10-15, 1995
Information:	DIS Congress Service, Herlev, Ringvej 2c, DK-2730 Herlev

World Federation for Mental Health — 1995 World Congress

Title:	Time for Reflection
Location:	Dublin
Date:	August 13-18, 1995
Information:	WFMH World Congress, 10 Hagan Court, Lad Lane, Dublin 2, Ireland, Tel. 353-1-6618904, Fax 353-1-6785047

Baden-Badener Tage für Tiefenpsychologie

Leitung:	Dr. Thomas Kornbichler
Thema:	1895-1995: 100 Jahre Psychoanalyse
Ort:	Baden-Baden
Zeit:	21.-26. August 1995
Information:	AKM Congress Service GmbH, Obere Schanzstraße 16, D-79576 Weil am Rhein, Tel. 0 76 21 / 79 19 64, Fax 0 76 21 / 7 87 14

96. Gruppendynamische Tagung der Deutschen Akademie für Psychoanalyse (DAP) e.V.

Veranstalter:	Deutsche Akademie für Psychoanalyse (DAP) e.V.
Leitung:	Dr. med. Günter Ammon
Ort:	Tagungszentrum der DAP in Paestum (bei Salerno/Süditalien)
Zeit:	21.-31. August 1995
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