ISSN 0012-740 X

Dynamische Psychiatrie

Herausgegeben von Günter Ammon

Dynamic Psychiatry

Internationale Zeitschrift für Psychiatrie und Psychoanalyse

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Györgyi Körmendy
DerBegriff der Sozialenergie
Günter Ammon/Monika Dworschak/Margit Schmolke
The Case-Conference as an Integrative Moment in Diagnostics and Psychotherapy
Yuri V. Popov
Ethics and Professional Duty of a Psychiatrist – Conflict and Intervention
Vadim S. Rotenberg
Right Hemisphere Insufficiency and Illness in the Context of the Search Activity Concept
Jerzy Aleksandrowicz
Effectiveness of Neurosis Psychotherapy
Hamid Peseschkian/Dimitri A. Avdeev
Positive Family Therapy – A Holistic and Transcultural Approach
Martin Urban
Longterm Treatment of Borderline Personality Disorders – Practical Experiences and Theoretical Considerations
Rita Primbas
Therapeutic Techniques in the Treatment of Paranoia in the Framework of Dynamic Psychiatry (with Case Study)
Sarantis Thanopoulos et al.
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Buchbesprechungen

28. Jahrgang
1./2. Heft 1995

150/151

»Pinel« Verlag für humanistische Psychiatrie und Philosopie GmbH München

Dynamische Psychiatrie / *Dynamic Psychiatry*
Internationale Zeitschrift für Psychiatrie und Psychoanalyse
Organ der Deutschen Akademie für Psychoanalyse (DAP), der
World Association for Dynamic Psychiatry WADP, der
Deutschen Gruppenpsychotherapeutischen Gesellschaft (DGG), der
Deutschen Gesellschaft für Psychosomatische Medizin (DGPM), der
Dynamisch-Psychiatrischen Klinik Menterschwaige, der
Deutschen Gesellschaft für Dynamische Psychiatrie (DGDP) und der
Psychoanalytischen Kindergärten

28. Jahrgang, 1./2. Heft 1995, Nr. 150/151

Inhalt/Contens

Nachruf Prof. Dr. med. Friedrich S. Rothschild 1

Wu Zhen-Yi (Shantou)
A Chinese Dynamic Concept of Psychiatric Rehabilitation 3
Ein chinesisches dynamisches Konzept zur psychiatrischen Rehabilitation 6

Milos Kobal (Ljubljana)
Metarepresentations (Representations of Second Order) as the Essential Part of Mentality in the Holistic Approach to Health and Illness 8
Metarepräsentationen (Repräsentationen zweiter Ordnung) als zentraler Bestandteil der Geistestätigkeit im Rahmen einer ganzheitlichen Herangehensweise an Gesundheit und Krankheit 15

Luiz Miller de Paiva (Sao Paulo)
Neutral Disease (Part I) 19
Gleichgültigkeit – ein Krankheitsbild (Erster Teil) 27

Alexander A. Churkin (Moscow)
New Conceptual Approaches to the Mental Health Protection in Russia 29
Neue konzeptionelle Ansätze zum Schutz der psychischen Gesundheit in Rußland 32

Györgyi Körmendy (Budapest)
Der Begriff der Sozialenergie 35
The Concept of Social Energy 40

Günter Ammon (Berlin/Munich), *Monika Dworschak, Margit Schmolke* (Munich)
The Case–Conference as an Integrative Moment in Diagnostics and Psychotherapy 43
Die Case-Konferenz als integratives Moment in Diagnostik und Psychotherapie 46

Yuri V. Popov (St. Petersburg)
Ethics and Professional Duty of a Psychiatrist – Conflict and Intervention 50
Ethos und Berufspflicht des Psychiaters – Widerstreit und Wechselwirkung 52

Vadim S. Rotenberg (Tel Aviv)
Right Hemisphere Insufficiency and Illness in the Context of the Search Activity Concept 54
Insuffizienz der rechten Hirnhemisphäre und Krankheit in Verbindung mit dem Konzept der Suchaktivität 61

Jerzy Aleksandrowicz (Cracow)
Effectiveness of Neurosis Therapy 64
Wirksamkeit von Neurosenpsychotherapie 73

Hamid Peseschkian (Wiesbaden/Moscow), *Dimitri A. Avdeev* (Cheboksary/Moscow)
Positive Family Therapy – A Holistic and Transcultural Approach 75
Positive Familientherapie – Ein ganzheitlicher und transkultureller Ansatz 83

Martin Urban (Esslingen)
Longterm Treatment of Borderline Personality Disorders – Practical Experiences and Theoretical Considerations 86
Langzeitbehandlung von Borderline-Persönlichkeitsstörungen – praktische Erfahrungen und theoretische Überlegungen 93

Rita Primbas (Berlin)
Therapeutic Techniques in the Treatment of Paranoia in the Framework of Dynamic Psychiatry (with Case Study) 96
Therapeutische Techniken in der Behandlung der Paranoia im Rahmen der Dynamischen Psychiatrie (mit Kasuistik) 101

Sarantis Thanopoulos, G.V. Margherita, E. Cocozza di Montanara, G. Di Petta, S. Di Paola, B. Merola, A. Colao, F. Sarnacchiaro, G. Lombardi (Naples)
Psychological Aspects of Resistance to the Treatment of Feminine Hyperprolactinaemia 104
Psychologische Aspekte der Therapieresistenz weiblicher Hyperprolaktinämie 110

Buchbesprechungen / Book Reviews 113 128

Nachruf Prof. Dr. med. Friedrich S. Rothschild 17.12.1899 - 6.3.1995

Am 6. März 1995 verstarb *Friedrich S. Rothschild* in seinem 96. Lebensjahr. *Rothschild* hat mit seinem Lebenswerk einen eigenständigen Beitrag zur Überwindung des dualistischen cartesianischen Denkens geleistet durch die Schaffung einer neuen Wissenschaftsdisziplin, der Biosemiotik, die die Leib-Seele-Einheit neu deutet in einer umfassenden Theorie, die das Modell der Zeichentheorie auf alle Formen der psychophysischen Relation anwendet.

Wir schauen zurück auf den beeindruckenden Lebensweg eines Menschen, der im besten Sinne des Wortes ein deutscher Gelehrter war, aber in seiner ganzen Denkweise auch Jude war, so daß in seiner Person jüdische und deutsche Gelehrsamkeit eine fruchtbare Synthese eingingen.

Friedrich S. Rothschild, Psychiater, Neurologe, Psychoanalytiker – er war Lehranalysand von *Erich Fromm* und Assistent von *Frieda Fromm-Reichmann* – und Philosoph in der Tradition der Ausdruckswissenschaft *Ludwig Klages* und der Phänomenologie *Edmund Husserls*, richtete das Hauptaugenmerk seiner Forschung auf das menschliche Gehirn als dem höchstentwickelten psycho-somatischen Kommunikationsorgan. In einem seiner bedeutendsten Werke, der »Symbolik des Hirnbaus« von 1935 (Neuauflage 1989), beschreibt *Rothschild* Struktur und Funktionen des zentralen Nervensystems als symbolischen Ausdruck der seelischen und geistigen Prozesse, die durch dieses Organ vermittelt werden. Ihre Aktualität beziehen seine Forschungen nicht zuletzt aus der Betonung des Stellenwerts der funktionalen Asymmetrie des menschlichen Gehirns, lange vor den Arbeiten von *Sperry* und anderen. In vielen folgenden Veröffentlichungen konnte *Rothschild* überzeugend nachweisen, daß die enorme Komplexität des menschlichen Gehirns und seiner geistigen Leistungen nicht auf physikalisch-chemische Funktionen reduziert werden kann. Sie ist ihm vielmehr Ausdruck eines geistigen,

schöpferischen, der Evolution erst ihren Sinn gebenden göttlichen Prinzips. Sein viele geistes- und naturwissenschaftliche Einzeldisziplinen integrierendes Alterswerk von 1986 »Die Evolution als innere Anpassung an Gott« trägt so auch zur Überwindung des Dualismus von religiösem Glauben und wissenschaftlicher Erkenntnis bei, indem es die metaphysische Dimension in seine Erkenntnismethodik mit hineinnimmt.

Nach Jahren der neurologischen Arbeit in Deutschland – so unter *Kurt Goldstein* am Neurologischen Institut der Universität Frankfurt – emigierte *Rothschild* 1936 nach Palästina, wo er im selben Jahr Frau Dr. med. *Margot Helmuth* heiratete, die ihm bis zuletzt treue Lebensgefährtin und Mitarbeiterin war.

Seit 1948 arbeitete *Rothschild* an der neugegründeten Universitätsklinik »Hadassah« in Jerusalem als Lehrender und Oberarzt der Psychiatrischen Abteilung. 1955 wurde er Professor für Psychiatrie an der Medizinischen Fakultät der Hebrew University in Jerusalem. Im gleichen Jahr wurde er Corresponding Fellow der American Psychiatric Association. 1961 erfolgte eine Einladung der »New York Academy of Sciences«, deren Mitglied er wurde. Hier sprach er zum ersten Mal von der »Biosemiotik« als einer neuen Wissenschaftsdisziplin.

1976 begegneten sich *Friedrich S. Rothschild* und *Günter Ammon* auf einem Kongreß der Hebrew University und entdeckten ihr gemeinsames Interesse für die Struktur und Dynamik des Ichs – Auftakt für einen beide Seiten anregenden wissenschaftlichen Austausch. *Rothschild* nahm an vielen Symposien der Deutschen Akademie für Psychoanalyse (DAP) und Kongressen der World Association for Dynamic Psychiatry (WADP) teil, war Mitarbeiter der Zeitschrift »Dynamische Psychiatrie/Dynamic Psychiatry«, in der er zahlreiche Arbeiten veröffentlichte. 1981 erhielt *Rothschild* die Goldmedaille der DAP und übernahm die Leitung des israelischen Zweiges der WADP, deren Ehrenpräsident er bis zu seinem Tode war. Zu Ehren seines 90. Geburtstages fand 1989 ein Symposium am Berliner Lehr- und Forschungsinstitut der DAP statt: »Von der Kausalität zur Kommunikation – Die Biosemiotik *Friedrich S. Rothschilds*«. Beeindruckend für alle Teilnehmer war die konzentrierte geistige und kreative Atmosphäre, die von dem jugendlich lebendigen »Geburtstagskind« ausging. Vor zwei Jahren erschien ein Buch über sein Werk: »Schöpfung durch Kommunikation. Die Biosemiotik *Friedrich S. Rothschilds*«, das auf breite interessierte Resonanz stieß.

Die Begegnung mit dem Menschen und Wissenschaftler *Rothschild* bedeutete und bedeutet eine geistige Herausforderung ebenso wie eine ethische: Ist in seinem Denken doch dem Menschen die Aufgabe der Verwirklichung der Schöpfung übertragen und damit die volle Verantwortung für die Fortsetzung der Evolution. Bis kurz vor seinem Tode konnte *Rothschild* das Geschenk körperlicher und geistiger Frische erleben.

Wir trauern um *Friedrich S. Rothschild.*

Gabriele von Bülow

A Chinese Dynamic Concept of Psychiatric Rehabilitation**

Wu Zhen-Yi (Shantou)*

The author pleads for the development of a Chinese way to solve the psychiatric rehabilitation problem which should be effective and tolerated everywhere in China. He suggests four basic ideas for the realization of this rehabilitation concept: 1. For the benefit of the patients, the welfare and happiness in every respect should be considered as much as possible, 2. To promote the restoration of their social consciousness, patients should go back as early as possible to their social community, 3. Try to regain the patient's dignity, legal rights and human respects, and dedicating them to social construction and economic progress, 4. Release a certain amount of governmental responsibility and activate the potential of society and group organizations. In order to achieve these goals it is necessary for psychiatric professionals to change their old conception of man from a biological point of view and to build up a bio-psycho-social dynamic model of orientation.

Since the founding of the People's Republic of China in 1949, mental health services have witnessed tremendous changes, and also a number of twists and turns have made remarkable achievements. These accomplishments, though far from meeting the present demands of the society, should nevertheless give a fair appraisal when put against the background of past.

According to incomplete statistics, we have a very high prevalence rate of psychiatric patients in China, among which chronic patients may play a major part. That is why the problem of psychiatric rehabilitation and treatment of chronic cases becomes a great national concern as well as a matter standing in urgent need of investigation and solution by our psychiatrists.

However, because of differences in historical and cultural background, customs and habit, education, cultural, social and political systems, in order to solve this problem, we should try to work out a special way of our own, that is, a typical Chinese way which our people can tolerate and accept everywhere in China, especially in poor and undeveloped districts. Thus, Chinese psychiatrists have to take this target as our main goal to make great efforts and keep it as basic requirement and sacred duty.

In order to achieve it, there are four basic ideas as prerequisites to be clarified and accepted by our psychiatrists:

First, it is necessary to set up our own understanding or notion of psychiatric rehabilitation as a general consent. This term does not only mean to realease the physical and mental disorders of the patients, but it is even more important to improve and restore their abilities to reestablish the normal social consciousness, to go back to the society and live adequately

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** 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

with family and social groups. It is also necessary to train them in certain social skills and professional abilities, so that they will be able to live independently on their own, to enjoy their personal legal rights, fortune, dignity and stay harmoniously with the group as ordinary people do. It is through these requirements that patients will also be able to build up their own self-esteem, self-confidence, self-reliance, self-respect, and maintain a normal level of social activities.

Second, to be a psychiatrist, it is extremely important to set up a strong faith in serving the people whole-heartedly. It is not a slogan, but a moral standard and holy doctrine that every medical person should keep in mind. Besides, it is extremely important to help us build up a good rapport between doctors and patients which may greatly facilitate the psychotherapeutic effect by this doctrine, we may be able to overcome a lot of difficulties as misunderstandings about discriminations and stigmas against mental patients, which we are always confronted with in the psychiatric career especially in our country.

Third, nowadays in China, it is extremely important to take it as an item of reformation for our colleagues to change their old conception of man from a biological point of view in medical practice and to build up a bio-psycho-social dynamic model of orientation. Otherwise one can hardly imagine how we shall be able to accomplish our task properly.

Fourth, in recent years there has been developed a new requirement in China which should call for our attention. We call it the socialization of psychiatric rehabilitation. Through years of practice, gradually we realize that this work cannot only rely on the government economically, but it is even more important to consider it therapeutically. It is especially so since we adopted the opening policy, and the outside world became for us more and more complicated. It caused a lot of problems for our patients. Whenever they are discharged from the hospitals, we have to consider beforehand what will be the better way to stabilize the therapeutical effects, to prevent recurrence, and to live more closely and peacefully with the group. Through years of practice, we found that it will be much better to be taken care by the society or group organizations. Besides, it is also more adequate to mobilize the public opinion to eliminate the psychiatric stigma, to obtain better understanding and due respect, love and care, to strive for a better social environment in which they may lead a normal life.

Now this problem is becoming one of the most important issues that we should face.

For the reasons mentioned above, I propose the following motto to be our guidance of treatment: »A combination of psychotherapy, taken as the fundamental measure, together with occupational, recreational, vocational, behavioral, sport, and family therapies as the dominant measures, and medical treatment as the subsidiary if necessary.«

In accordance with the above considerations, I recommend the following four principles to be followed and taken in consideration during treatment:

(1) Viewing the problem from the angle of social construction:

So far, China is still a developing country in need of improvement in every field to develop the level of science and technology, industrial and agricultural productions, education and hygiene. So it is necessary for every one of us to bring into full play the potential of his or her efforts in social construction. If the chronic mental patients will be also mobilized to take part according to their capabilities and participate as much as they can in this constructive process, it will be as our old Chinese proverb says: »Every grain of sand when put together may build a pagoda.« So there is not doubt that they will bring their own contribution.

(2) Viewing the problem from the angle of economic benefits:

Through the last 15 years of reformation and opening policies, our economic condition has improved to a certain extent. But, as a whole, because of our high rate of population with rather low level of production, we are actually still very poor. The majority of the people has not yet got rid of poverty, especially in the central regions. In case the patients may engage in certain productive works as far as their general conditions permit, it may not only promote therapeutic effects and physical health, but may also release economic burdens to a certain extent, and possibly raise some money for their own work.

(3) Viewing the problem from the angle of therapeutic effect and welfare of the patients:

As far as our present understanding goes, we cannot rely on medicine as the only tool to treat chronic mental patients. Our experience proves that only rehabilitative measures may give them some real therapeutic satisfaction. We found that through different measures, such as breeding fishes, pigs, chickens, cows, planting fruits and flowers, patients may also obtain better food as well as better living facilities.

(4) Viewing the problem from the angle of socialization and after-care:

It is even more important to consider the after-care of the patients, especially after they leave the hospitals. We found it preferable to lead patients back to society as early as possible. It is very important to help them restore the social consciousness and enjoy normal group life. Besides, we should always keep in mind the possibility of recurrence and consider seriously the better way to reduce or avoid its occurrence. According to our experience, it is also better for the patients to be taken care of by the society. Now we are working earnestly to establish a better system of our own to perform this kind of socialization everywhere in China.

Regarding our concrete design or plan for rehabilitative work, we found it will be more acceptable and tolerable in China today to suit different measures to different condition, and utilize every possible facility to work with, so that we may be able to initiate and carry out rehabilitation whenever necessary.

In summary, it is important to work out our own Chinese way of rehabilitation. Morever, it is necessary to establish the four prerequisites and to follow the four important principles as our guides.

Ein chinesisches dynamisches Konzept zur psychiatrischen Rehabilitation

Wu Zhen-Yi (Shantou)

Der Autor hebt die positiven Veränderungen der psychiatrischen Einrichtungen seit Gründung der Volksrepublik China 1949 hervor, obwohl sie nach wie vor noch nicht den gegenwärtigen gesellschaftlichen Anforderungen genügen. Die Prävalenzrate psychiatrischer Erkrankungen, insbesondere chronischer, in China ist sehr hoch. Deshalb steht das Problem der Behandlung und Rehabilitation besonders stark im Vordergrund. *Wu Zhen-Yi* betont die historischen, kulturellen, sozialen und politischen Besonderheiten in China und plädiert für die Entwicklung eines Rehabilitationskonzeptes, das auf die Charakteristika der sozialen Strukturen in China zugeschnitten ist.

Der Autor nennt vier Grundprinzipien, auf denen ein solches Konzept basieren soll:

1. Ziel psychiatrischer Behandlung soll nicht nur die Beseitigung körperlicher und psychischer Störungen sein, sondern die Entwicklung bzw. Wiederherstellung eines gesunden sozialen Bewußtseins, das das Zusammenleben in den Familien und in der Gemeinschaft ermöglicht. Dazu gehört die Wiedererlangung von sozialen und beruflichen Fähigkeiten, persönlichen Rechten, Würde, Selbstwert und Selbstachtung des Einzelnen.
2. An die Professionellen in der Psychiatrie werden hohe ethische Anforderungen gestellt. Sie sollen ernsthaft und überzeugt an der Seite des Patienten stehen und eine gute Beziehung zu ihm herstellen, was die psychotherapeutische Wirksamkeit deutlich erhöht.
3. Erforderlich ist ein grundlegender Einstellungswandel bei den Psychiatern, d.h. Abkehr vom biologischen hin zu einem dynamischen bio-psycho-sozialen Erklärungsmodell.
4. Rehabilitation soll nicht mehr ausschließlich staatlich finanziert, sondern zunehmend von gesellschaftlichen Verbänden und Gruppen getragen werden.

Der Autor betont die Notwendigkeit, Vorurteile in der Gesellschaft gegenüber psychisch Kranken abzubauen und sich mehr für deren Verständnis und Achtung einzusetzen.

Aufgabe nach Entlassung aus der stationären Behandlung ist die Stabilisierung der erreichten Veränderungen durch die Therapie, die Rückfallprophylaxe, sowie ein friedliches Leben in der Gemeinschaft. Kernelemente der Therapie sind eine Kombination von Psychotherapie mit Beschäftigungs-, Freizeit-, Arbeits-, Verhaltens-, Sport- und Familientherapie und, wenn nötig, medikamentöse Therapie.

Der Autor weist auf folgende Aspekte bei der Verwirklichung des von ihm konzipierten Rehabilitationskonzepts hin:

a) Mobilisierung der Potentiale chronisch psychiatrischer Patienten beim Einsatz in unterschiedlichen Bereichen (wie z.B. Landwirtschaft, Industrie, Technologie) als gesellschaftlicher Beitrag;

b) Teilnahme an produktiver Arbeit nicht nur aus therapeutischen, sondern auch aus ökonomischen Gründen (Armut in der Bevölkerung, insbesondere in der ländlichen, ist weit verbreitet);
c) reale Veränderung und Verbesserung der konkreten Lebensbedingungen (z.B. der Ernährung) durch therapeutische und rehabilitative Maßnahmen;
d) frühzeitige Wiedereingliederung der Patienten in die Gesellschaft, um soziales Bewußtsein und Gemeinschaftsfähigkeit wiederherzustellen.

Wu Zhen-Yi plädiert für eine Differenzierung rehabilitativer Arbeit, die auf die spezifische Situation des einzelnen Patienten zugeschnitten ist. Dabei gilt es, den eigenen chinesischen Weg zu finden, den die Menschen überall in China akzeptieren können, insbesondere in den armen und unterentwickelten Gebieten.

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Metarepresentations (Representations of Second Order) as the Essential Part of Mentality in the Holistic Approach to Health and Illness**

Milos Kobal (Ljubljana)*

The merits of the Russian physiologists (Bekhterev, Pavlov) are in discovering and experimental reiteration of certain brain reflexes with psychic relvance, Instead of equating »reflexes« in the complex of »higher nervous activity« with the mentality as whole, the author postulates the »repetitive reflexion«: by the repetition of un- and conditional reflexes in appropriate brain structures a new cognitive (and emotional) activity is formed. As a synonym the authors uses the term »second order representation (SOR)«. To the author, the metarepresentations signify the final and for the time being the missing link of the holistic brain activity. That is to be extended from unconsciousness beyond basic cognitive engrames as representations of the first order and superimposed by »special mental mechanism« (Frith), by which the metarepresentations are formed. The author uses schizophrenia as model to demonstrate the value of his ideas. He finally states that the concept of metapresentations will be helpful in conquering the boundaries between physiology and psychoanalysis.

Introduction

The holistic approach to a healthy person presumes the integrity of his personality ranging from unconsciousness, consciousness as the basic phenomenon of vigilance up to self-awareness. The description of the holistic man was made by those describing the physiology of the nervous system on one hand and by the representatives of psychoanalysis on the other. The latter, although using a symbolical language, incontestably made a better approach to the real man.

Psychoanalytical theories and the respective data have become almost innumerable. Whichever we follow or try to interrelate, we always strive for the holistic model. Right within the scope of human structurological concepts (*Ammon* 1993) it is possible to proceed »from primarily organic structures to central human functions located in the unconscious, predominantly determining the behaviour, capabilities and skills of a person« (*Ammon* 1993).

Both anthropological trends endeavoured to support their discoveries with some objective background, independent of subjective experience and subjective interpretation. The *Descartes'* reflex was quite suitable for describing the ascendental flow of the impulse in the brain. However, it does not explain the active component of mentalization. This component was added gradually. Let us remember *Sechenov* and his representations of the reflexes of brain (»golovni mozg«), in Russian physiology the

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** 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

predecessor of such important discoveries as the reflexology by *Bekhterev* and the theory of unconditioned and conditioned reflexes by *Pavlov*. These were important building stones of objectivity in psychophysiology.

To the western experts who adopted the notion of conditioned reflex and used also the term of conditioning (*Blackman* 1974), the idea of reflex basis of the psychical denoted too little. *Lausch* (1972) expressed, in the name of many others, the prudence towards absolutisation of conditioned reflexes for the state of mind by saying: »It can be maintained with certainly that the conclusions of certain investigators, who believe to have found the key for the whole mental activity through conditioned reflexes, are premature«.

We were of the same opinon although at the same time we were asking ourselves how to establish a bridge between the state of mind as a whole and the reflexes of the brain without recourse to reductionism and subjective interpretation. Several observations and investigations have led us to the discovery that the reflected should be re-reflected at least once or even several times (*Kobal* 1950) if more highly organized beings were to develop new mental qualities.

Thereby it is also characteristic for such investigations of behaviour, capabilities and skills of a person that all functions, in particular those described hereafter in connection with a holistic person, are groupdependent (*Ammon* 1993).

Repeated Reflection

Our concept of repeated reflection (*Kobal* 1950) is based on the observation ot the behaviour of four dogs subject to training. The golden retrievers did their task perfectly well: they kept bringing a particular object form across the river. Yet, when using the increasing speed of the flow of the river we moved the target on the other bank of the river towards the place where the water streams over the dam, two dogs changed their mind half-way of the rapid river and returned to the river bank. They again plunged into the river from a higher spot on the river bank than the first one and they reached the goal by swimming diagonally. Thus, the observers unexpectedly discoverd that the dogs performed their task »through own reflection«. The ramaining two dogs, having seen the first two, immediately set out for diagonal swimming from a higher spot without having ever practised such striving against the stream. In our opinion the behaviour of these dogs reflected their previous training, i.e. the conditioned reflexive behaviour with a new mental substance.

Even more indications of non-reflexive building of the state of mind were manifested at investigation of schizophrenia. It is a tragic natural experiment by itself, although it is as well observed as negative picture of the normal state of mind. The negative covers one part of the patient's behaviour. It is manifested in such behaviour where the habitualized, i.e. the conditionally and unconditionally reflexive mental status gives rise to a dif-

ferent new form of pathological mind. In the then symbolic language the creation of such relations was referred to as »repeated reflexion«. The conditioned and unconditioned reflexes would accordingly give rise to such mental activity whereof the contents are at the same time dependent and independent of the objective world. The resulting contents are in a subject-to-object metapostion, which the subject recognizes as the state of self-awareness. This re-reflected mental activity could also be labeled as abstractive: it is adequate to objects, their properties and interrelations, but at the same time independent thereof.

Representations and Metarepresentations

The investigators of the cognitve process in the brain define the respective records as representations instead of reflexes. Certain records represent the basic data about the world and its objects as well as the knowledge stored in the long-term memory, wherefore they belong to first order representations include all basic reflexes and conditioning whereas on the emotional level they include the basic anxiety.

A special problem involves conditioning as a mental phenomenon and as definition. We believe that with reference to its formation and role in mentalization it is different from the group of naturally and/or artificially created conditioned reflexes. Since our opinion differs from that of some experts from the respective domain we will explain our attitude to conditioning when following further destine of representation in the mental process.

Already *Jackson* in the far-off 1884 maintained that individual motorical functions of the central nervous system were, though represented in the medulla, gradually re-represented or even re-re-...represented in higher brain structures.

A similar idea can also be used at re-representation of records of psychic quality, accordingly at transition of first order representations into second order representations and probably also into representations of higher orders.

The adherents of the theory of mind pursued this hypothesis. *Leslie* (1987) wittily noticed in his mental experimentation that the basic cognitive record of a certain object, e.g. in the child's imaginative playing (»the banana in child's hands becomes the telephone«) requires decoupling from the original representation and raising for expression in its metaposition. Thereby the object passes into its own metarepresentation. It does not any more correspond to physical reality but rather represents some new and/or different knowledge of previous knowing. Already in the child's imaginative playing and even more with a healthy adult there develops new thinking with the recognition that other people, too, are thinking and even what they are thinking.

These terms have not yet been completely established. Nevertheless this paper would use the term metarepresentations because by speaking of

second order representations the extent of representation in self-awareness might be excessively limited.

Then the metarepresentation is both a dependent and independent relation to the object. It represens new thinking about the original mental record. It offers the possibility to comprehend and to predict, thereby taking into account other people's thinking.

Metarepresentations in Schizophrenia

Already many decades ago schizophrenia was pragmatically taken as the model where the »negative of the normal« can serve for demonstration of the characteristic of »repeated reflection«.

Recently *Frith* (1992), an English neuropsychologist, elaborated an useful model of schizophrenia explaining why and how the disorders in self-awareness change the schizophrenic patient's thinking (language).

Considering the *K. Schneider*'s division into symptoms of the first and the second order, the symptoms of the first order (from the voice of the thought to inserted and controlled will) share a common basis that the patient experiences them as alien, i.e. independent of his own will. According to *Frith* and *Done* (1989) it is a self-monitoring disorder affecting the internal dialogue. Patients with paranoid delusion and delusion of reference indicate also disorders in monitoring the intentions of others. Accordingly, the disorder affects the possibility for appropriate thinking about other people's thinking.

In the whole spectrum of disorders of willed action with schizophrenic patients we can also observe its impoverishment, perseverations and inappropriate action. In particular perseverations can be quite persuasive for confirmation of this theory: the patient cannot stop his routine activity (speech, drawing) although its continuation is not necessary. According to *Frith* all these are only special cases of a more general mechanism. This mechanism ensures the capacity for self-awareness and production of metarepresentations. In schizophrenia the production of the latter is disturbed or even omitted. Patients with negative symptoms can be recognized as those where the general mechanism for the production of metarepresentations failed.

In our investigation of schizophrenic thinking (language) (*Kobal* 1993) the above principles of formation and non-formation of metarepresentations were examined on a large number of schizophrenic patients divided into three schizophrenic syndromes. The first syndrome denotes distortion of reality. A large part of distorted reality is, of course, »group dependent«. They may be without significant problem related to similar, yet controlled experience of healthy people: acquired in the group, yet useless for the group, such experience mostly remains private or it ends in internal dialogue. It may represent the basis for unconscious experience and the ensuing symptomatics: It may appear as an attempt of recognition of other

people's thinking. In schizophrenic patients the metarepresentations of this kind are also correct with reference to their form and contents, but when appearing as illness, the patient looses the control of its communicational dimension. He does not enter into usual contacts with other people because mentally sane people, also due to their group-dependence, experience them as unreal and strange.

With disorganizational syndrome, thinking is distored in contents and mostly in form (consequently also in communication). Distortions may show extraordinary quantitative differences. Disorganized thinking (language) in a simpler form may still be converted into usual words. However, we may also come across such changed form of thinking that can only be understood by the patient himself.

Patients with psychomotorical impoverishment, specified also as patients with negative symptoms, make contacts through first order representations only. Metarepresentations are not produced at all, whereas those from the previous cognitive processing make part of first order representations through conditioning. Yet, these, too, are used in reduced extent.

In the first and the second case self-monitoring does not work properly nor does the monitoring of other people's intentions. However, the intention of will is on the decrease as well; in schizophrenic patients suffering from psychomotorical impoverishment it practically falls down to the bottom.

Relation of Metarepresentations to Brain Structures

Warrington and *Weiskrantz* (1982, cited after *Frith* and *Frith* 1989) have precluded, also from experiments on animals, that first order representations as typical records of posterior parts of the brain are pre-frontally switched into metarepresentations. In their own symbolical language they speak of »cognitive mediational memory system«. This system should enable additional representation of long-term information from posterior association cortex in the frontal system. It should be presumed that the formation of metarepresentations requires an intact frontal lobe as well as its connections with the temporal lobe.

However, it is difficult to believe that the definitely formed metarepresentations appearing in sequences on the final mental pathway would originate from the cortical activity only. Thereby it is schizophrenia which reveals that at the formation of pathological metarepresentations the internal control of interrelation of impulses and the resulting substances has failed. According to the experimental data relating to animals and with reference to the findings derived from lesions, the central monitoring is probably related to hippocampus and to ther parahippocampal area (*Gray* 1982). Thereby the circle of cortical and subcortical structures, important for metarepresentations, is closed.

Some details about these mechanisms may also be detected from the peculiarities expressed in the behaviour of people with organic frontal syndrome.

However, since in our approach the pathological metarepresentations are so closely related to schizophrenia, their (non)-formation should be attributed to the pre-frontal cortex, if we are to confirm those issues that look for the reasons of schizophrenia in this molecular, biological and structural area.

In this respect, the group gathered around *Goldman-Rakic* (1983) is particularly propulsive; it maintains that schizophrenic patients show abnormalities in neuronic links of the frontal lobe.

However, other approaches to schizophrenia exist, of which we should mention the adherents of the filter hypothesis. The essential reason for dysfunction of the filter should be located in thalamus (*Carlsson* 1991). Otherwise, contrary to the numerous proofs of dysfunction of the frontal lobe in schizophrenia, such as based on neuropsychological methods (also in comparison with the persons showing frontal lobe syndrome), there appear individuals who have not discovered any frontal dysfunction with schizophrenic patients submitted to neuropsychological testing (*Ishikawa* et al. 1989).

Since at the moment there is a common practice in science that hypotheses are not subject to confirmation but rather to the search of reasons for their rejection, this controversy will require the search of differences in methodological and conceptual approaches to the etiology of schizophrenia. The respective literature is hardly surveyable.

Still under the impression of importance of the model of schizophrenia for understanding the formation and processing of metarepresentations, let us make a short introduction into cortical links which *Swerdlow* and *Koob* (1987) believe to be decisively involved into schizophrenic processes: »The cortical areas, traditionally related to the limbic system, cooperate with infracortical structures including nucleus accumbens, ventral pallidum and dorsomedial nucleus of thalamus«. Transferred to the transmitter level, both authors propose such model of schizophrenia which originates in hyperactivity in the DA system of the frontal cortex, which results in the loss of lateral inhibitory interaction in the nucleus accumbens. Consequentially, it comes to a desinhibition of the palidothalamic afferent links, which in its turn causes quick changes and loss of corticothalamic activities in those cortical structures that control cognitive and emotional processes.

At some other place *Wu* et al. (1990) conclude that each PFC dysfunction may introduce a certain disorder into higher order processing of sensorial input and motoric output information. For these very reasons they propose that the DA modulation of the GABA-ergical inhibitory circulation be viewed as the critical factor for certain psychotic symptoms and motoric disorders.

Lidlle (1990), who together with his assistants specified the above three schizophrenic syndromes, showed through PET on patients of these three

die Psychoanalyse dem wirklichen Menschen besser angenähert habe, wie z.B. in dem ganzheitlichen Modell des humanstrukturologischen Konzepts von *Günter Ammon.* Er betont die Leistung russischer (Neuro-)Physiologen wie *Setschenow, Bechterew* und *Pawlow* bei der Entdeckung der unbedingten und bedingten Reflexe, zitiert aber auch zustimmend *Lausch* (1972), daß darin nicht der Schlüssel für die gesamte geistige Aktivität liege. Anliegen des Autors in dieser Arbeit ist es, seinen Ansatz vorzustellen, der eine Brücke schlagen soll zwischen Geist und Gehirnreflexen, ohne in Reduktionismus und rein subjektive Interpreatation zurückzufallen: das Konzept des wiederholten Reflexes, das *Kobal* seit 1950 entwickelt hat.

Die Erforscher kognitiver Hirnprozesse begreifen die Aufzeichnungen des Gehirns als Repräsentationen anstelle von Reflexen. Repräsentationen erster Ordnung umfassen die Basisdaten über die Welt, das im Langzeitgedächtnis gespeicherte Wissen sowie, auf der emotionalen Ebene, die Grund-Angst. Metarepräsentationen stellen ein neues Denken über eine ursprüngliche mentale Aufzeichnung dar, eine Leistung, wie sie uns bereits im imaginativen Spiel des Kindes begegnet, für das z.B. eine Banane zu einem Telefonhörer wird. Sie eröffnen die Möglichkeit, zu verstehen und Voraussagen vorzunehmen, wobei sie das Denken anderer Personen einbeziehen.

Der Autor bezieht sich auf Arbeiten der Neuropsychologen *Frith* und *Done,* die die schizophrenen Symptome erster Ordnung nach *Kurt Schneider* wie Stimmenhören, Fremdbestimmung des Willens bzw. paranoide Wahnvorstellungen und Beziehungswahn als Störung der Selbst-Überprüfung (monitoring), die den inneren Dialog beeinträchtigt, bzw. als Störung der Überprüfung der Intentionen anderer interpretierten. In der Schizophrenie sei die Produktion von Metarepräsentationen schwer gestört oder falle völlig aus wie im Falle der Patienten mit negativen Symptomen wie der psychomotorische Verarmung. Eigene Untersuchungen des Autors bestätigen diese Ergebnisse (*Kobal* 1993). In ihnen werden drei schizophrene Syndrome unterschieden: die Verzerrung der Realität, die zu formal korrekten Metarepräsentationen führt, über deren kommunikative Dimension aber das Individuum die Kontrolle verliert; das Desorganisations-Syndrom, das in einer Sprache resultiert, die nur noch für den Patienten verständlich ist; schließlich die Patienten mit psychomotorischer Verarmung, die nur noch mit Repräsentationen erster Ordnung Konatakt aufnehmen.

Die Bildung von Metarepräsentationen erfordert einen intakten Frontallappen sowie dessen Verbindungen mit dem Schläfenlappen. Der Autor erwägt darüber hinaus die Beteiligung subkortikaleer Strukturen wie des Hippocmapus. *Liddle* (1990, 1993) fand bei der Anwendung von Positronenemissionstomographie bei schizophrenen Patienten mit einem »Realitätsverzerrungssyndrom« einen erhöhten zerebralen Blutfluß im linken Schläfen- und Frontalbereich und eine etwas reduzierte Aktivität in der rechten Hemisphäre. Das Desorganisationssyndrom kann in Beziehung gesetzt werden zu einem erhöhten Fluß im linken unteren Frontlappen und

das Verarmungssyndrom mit dem höheren Teil des Frontlappens, eher links als rechts.

Abschließend betont *Kobal* die Bedeutung von Metarepräsentationen für das Selbst-Bewußtsein und die Persönlichkeit als Ganze. In seinen eigenen Untersuchungen hat der Autor sich vor allem mit Metarepräsentationen des emotionalen Typs als einer besonderen Form des Selbstbewußtseins beschäftigt. Er schlägt vor, die Konzepte der Dominanten von *Uhtomski* und der Einstellung von *Uznadze* in einer Theorie des Unbewußten zu integrieren. Das Wissen über die Metarepräsentationen und die Mechanismen, die zu ihnen führen, so die Einschätzung des Autors, werde zu einem Kristallisationspunkt werden, um die noch bestehenden Schranken zwischen Physiologie und Psychoanalyse zu überwinden.

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Neutral Disease**
(Part I)

Luiz Miller de Paiva (São Paulo)*

The author introduces a clinical picture, which he calls »Neutral Disease«, i.e. indifference towards life, characterized by emptiness, inertia and anesthesia. He differentiates this disease from schizophrenic disorders and from depressive as well as borderline states, although it may appear in them. It is a state of negative narcissism and nihilism, the causes of which the author sees in a fragile ego (ontological insecurity), induced by a mother that will favor the petrifying of the child's ego through a lack of holding and filicidal phantasies towards the child. After presenting a case-study of a patient with neutral disease the author discusses its psychdynamics on the theoretical background of Kleinian object school.

> *»Life is hollow, the soul is hollow, the world is hollow.*
> *All of the gods die a death greater than death. All is*
> *emptier than a vacuum. All is a chaos of nothingness«.*
> *Fernando Pessoa.*
> (Livro do Desassossego (The Book of Disquiet), pg. 46, 1931)

The death instincts can, from our viewpoint, reduce vital tensions to zero and reappear, reborn, as in the myth of the Phoenix. It is the analysand that symbolically kills bad internalized parents, exorcises them, and becomes redivivus to begin a new life once more, for »to bear being alive is the first duty of every living being«.

Freud (1915) says: »Our unconscious is as inaccessible to the representation of our death, as avid for the murder of The Other, as divided (ambivalence), in relation to the loved person, as was man in primeval times.« Not always does non-pleasure substitute pleasure, but sometimes it is the Neutral. It is not on depression that we must dwell here, but on aphanisis, on the anorexia of living, on asceticism and on emotional indifference. The metaphor of a return to inanimate matter is stronger than it is thought, for this petrification of the ego aims at anesthesia and at inertia of a psychic death – it is but an aporia (hesitation). It is the living death characteristic of certain schizophrenic states. To become aware of the Neutral is to be indifferent to human passions. The Neutral is the area of this impartiality of intellect that *Freud* (1938) invoked when he postulated the existence of the death instincts.

Like depression, which is more commonly found in M.D.D., the neutral is more frequent in schizophrenia, in schizomorph neuroses and in the »borderlines«, but at times, it is a special disease. Negative narcissism (*Green* 1988) seems to me different from masochism; in the latter, there is a painful state that aims at pain and its maintenance as the only form of existence and, inversely, to anesthesia, to emptiness, to white (neutral). This

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

white does not invest affection (indifference), nor representation (negative hallucination) and much less thought (white psychosis.

We know that one of the greatest obstacles to communication is narcissism. It would be untrue to say that to be born is a trauma – conditions so close to intrauterine life are soon built up outside – hence the importance of holding, that is no more than an external intrauterine fixation on the part of the child (*Stone* 1988). Another birth (second birth, *Green* 1988) is loss of the breast that allows for the birth of the ego. Indiviuals that have been subject intensely to *Balint's* basic lacks (*Balint* 1968) may suffer from asexuality (*Lacan* 1966), aphanisis or indifference.

They do not wish to have sex – a defensive position and one of neutrality of fantasy, built up with the aid of all of the resources of untemperate narcissism that bears the marks of absolute despotism of an ideal of a tyrannical and megalomaniac ego: »Since I cannot have all and be all, I will have, I will not be anything« (*Green* 1988).

This fantasy can be elaborated on the perception of the maternal fantasy that wishes that its child be neither sexual nor alive – the salvation of the child takes place through the existence of the neutral gender (a sign of obedience and, at the same time, vengeance against her) – it is the aspiration for Nothing (Nihilism). Negative narcissism may seldom lead to suicide.

The libido is a negativity where nothing is incarnate and where desire takes place as the triumph over the death of desire – the silence of the death instincts (*Laplanche* 1985). The chaotic state is the primary disorder of autoregulation.

Winnicott (1960) draws our attention to very precocious traumas that affect the baby before he can become aware or elaborate what happened, as if there were emptiness, a state of expectancy of something that does not actually occur. In this fault, there remains a dead object (mother without affection, living-dead, petrified and without internal representation in the child), that may manifest itself later through the living experience of catastrophic fear. This sense of annihilation may, when adult, be manifest by terrifying dreams about wild animals (*Begoin* 1989). They become hypersensitive, »raw flesh« or lacking in »psychic skin« in the absence, in their internal world, of a good mother. Psychic suffering must be separated from anguish because the deeper aspects of suffering remain latent and hidden through defense mechanisms. Hence, it is understood that certain negative therapeutic reactions must be reactions of survival of a desperate subject.

Absence is of the symbolic order and comes forth after a relationship, whereas emptiness is real disorder of the »thing in itself«, equivalent to the internal space where the possibility of the appearing of a representation of the object is annulled (*Malpique* 1993). According to *Malpique* (1993), living out emptiness may be the equivalent of an oceanic feeling to annul space-time, reaching the hallucination of immortality, to attain the anguished states of »depersonalization«. In the words of *Hartocollis* (apud *Malpique*), when time is experienced without affection, affection is experienced with-

out time, hence the feeling of strangeness and emptiness (space peopled by inanimate things – living-dead mother).

Depressive emptiness would manifest itself when the elaboration of the depressive position is precarious and the self threatened by abandonment, becoming extremely dependent on the external object (without the capacity to be alone), hence an excessive dependence on the analyst, as occurs in the disease of the neutral (the analyst becomes, therefore, an idealized object in his absence, but when present, is devalued and depreciated) – a breast filled with absence and emptiness, hollow and useless when it is offered. This is an attempt, according to *Malpique* (1993) to maintain the imagos in animation (living-dead, neither dead so as not to live the guilt, nor alive so as not to love them and thereby to miss them).

A feeling of depression is the place where an object (the breast for example) was (out goes the object, in comes depression). It is the so-called spatium (from the new theory of structuralism) (*Miller Paiva* 1987). Without an object, there remains an empty space and this emptiness, thus, superposes depression – it is an existential emptiness. Mental space is like the kantean, incognizable, thing – itself, that can, nevertheless, be represented by thoughts; without thoughts (or even without good thoughts) there remains a vacuum.

Therefore, only the beta-elements should be evacuated, which explain the escape from the vacuum thought, of hallucinatory delirium, all to escape from existential emptiness. The thought which does not produce alpha elements will not even be classified as thought. We found that replacing thought would occur through somatization – a defense, therefore, in order not to succumb and to continue living, despite the frustrations in life (absence of the good breast).

Emptiness is, clinically, subjective suffering, described as a deep feeling of internal emptiness, absence, basic lack, of no courage (the patient will say: »I feel dead inside«), of meaninglessness, corresponding to psychic nonelaboration. In Zen Buddhism, emptiness is sought through non-thought (as in Moslem Sufi practices) (*Penalver* 1993), which renders the practice of these difficult to westerners. To these patients, the end of a session, a weekend, of holidays are experienced as abandonment, as anguish that, at times, they deny by asking for medicine, books, etc. In *Freud*ian thought this feeling of strangeness, not recognizing his own image, etc., would be a rupture of mental thought, a type of depersonalization. Emptiness is, therefore, of double perspective: one in the origin of thought, and the other as the center of a pathology. In the latter case, emptiness of the basic lack, the non-breast is converted »because the breast is with my father«, the phantom of the primary scence whose combined figure is invariably persecutory (*Botella* 1988). According to *Lopez Penalver* (1993), the transitional object is the paradox of presence-absence, for it represents a magic step to substitute emptiness or absence of the mother, it is through failure of the transitional object that we can understand not only certain pathologies, but mainly this emptiness and its terrible consequences.

A person with a primitive emotional disorder may become hypersensitive to day-to-day annoyance – a deregulation of affection, producing mania, depression, panic, and shame. According to *Grotstein* (1991), these circumstances are the result of the onset of »noise« which is meaningless nothing. The primary nothing initiated with or without primary sense (meaninglessness) would be the rudiments of preconceptions and preperceptions expecting postnatal fulfillment and would define primary nihilism.

Secondary nihilism would be the result of negative hallucinations (there being no breast, it would remain in the »black hole«). In this case, the discourse on the self and on meaningless objects, is distorted and bizarrely alters that which is contained with secondary meaninglessness – the chaotic state (primary disorder of self-regulation):

We had a patient, N.A.* who, in the absence of »reverie« of the parents (living-dead mother and indifferent father) and a strong feeling of having been rejected, could not love. He married through insistence of the bride (two daughters), had little genital contact and could never give affection to his wife. He was, nevertheless, efficient in his job as an engineer. He did his work, however, mechanically. The family lived in another town, and he saw his family only at weekends. He felt as if he were living-dead, did not enjoy himself, nor was he happy (but he did not suffer from depression); he felt inert, apathetic (four years without genital contact), with chronic fatigue. He took a discreet delight in contesting, though without much conviction and this only in dealing with emotions, with loss of apetite for food – in fact, in aphanasis, or in effect, a case of disease of the neutral or of indifference.

Patient N.A. could not love anyone because he might, later, be disappointed. He could not fall in love with any woman, since he was afraid he would become overdependent. In describing childhood problems, patient N.A. showed a picture of resentment and of hostility and the perception that something that he really wanted was lacking at home. Lack of reverie or fillicide fantasy of the mother seems to have led to a feeling of disappointment. The patient's struggle was against being dependent on the analyst and on his job, as also on his wife's, or on his parents' past. His wish to be completely independent was based on his fear of being disappointed and disillusioned as occurred in contact with his mother. He would say: »... pleasure ran like sand through my fingers, just as happiness did at the weekend«.

The patient said (during a session): »When I am in an extraneous state I can not belong essentially to a thing. This produces in me a feeling of insecurity (similar to dizziness, half-sleep). All objects (trees, streets, sky, etc.) seem to be gloomy with smut. Sometimes the whole of São Paulo city is in a kind of dusk; I think of death only, of buried life (but I don't think of suicide). Recently my aunt died. She was like a mother to me. I liked

* Similar cases (Neutral Disease) were presented in the meeting of the Soc. Brasil Psicanal. S. Paulo by Leila Cintra (Nov 20, 1993); M. La Puente (April 30, 1994) and Ricardo Pelosi (Oct. 1993, Grupanalise Congr., Portugal).

SCHIZOPHRENIA	DISEASE OF NEUTRAL	MELANCHOLIA
Introverted.	Introverted (discreetly)	Extroverted (periods)
Not doing so well at school	Studious.	Not doing so well at school
Decrease in affectivity (cold) indifferent to misfortune and joys of others. Ambivalent love. Diminished libido.	Indifference to love and to misfortune of etc. (cold) Lack of sexual interest.	Suffers too much with suffering of others. Cries easily. Sexual desire diminished.
Wears different clothes.	Disreet in dress.	Wears loud clothes.
Paradoxical (ex. sudden interest in philosophy).	Lack of interest in everything (no enthusiasm), no paradoxism. Loss of self-esteem.	Unstable. Loss of self-esteem.
Opposition and hostility to family and to all of its ideas.	Indifferent to what family thinks. Quarreling without conviction.	Accepts or suffers through not accepting family adversity
Less appetite for food and strange. Loss of sexual interest.	Indifferent to food (no enthusiasm in tasting food).	Increase in appetite. Less sexual desire.
Conflict between impulse and prohibition. Absurd aggression.	Indifferent to conflicts. Argues with no emotion. Is not aggressive.	Any conflict generates guilty feelings. Becomes irritable.
Tendency towards isolation.	Discusses tendency towards isolation.	Indifferent to family and friends.
Unsociability. Expression of fear.	Does not seek new friendships, but receives them well. Bouts of insatisfaction.	Difficulty being sociable or state of periodic agitation
Taciturn and passive. Loss of initiative.	Passivity. Diminished initiative.	Sociable in excess with retiring periods. Loss of initiative is cyclic.
Neurocirculatory asthenia only in simple cases and spells of hebephrenia.	Neurocirculatory asthenia (growing chronic fatigue).	Asthenic depression.
Obsessive characteristics (rigid, ironic oppositional dogmatics).	Correct, is not miserly, enjoys a discussion, but without much conviction. No tendency towards alcoholism.	Tendency towards alcoholism.
Suicidal raptus.	No (makes an effort to live).	Frequent ideas of suicide
Deliria (paranoid, feeling of strangeness and hallucination).	No.	Rarely.
No dementia but blocked thought	No (difficulty in accepting the interpretation of the analyst, without hope, although apparently desirous of being understood).	No.
Mutism. Answers »sideways«, stupor.	No (compulsive repetition of conflicts).	No (only in depressive states).
Word salad. Neologisms.	No.	No.
Strange writing.	No.	No.
Negativism. Catatonia and cenestopathies.	No.	No (psychotic negativism).
Depersonalization. Mental automatism.	Sometimes.	Rarely.

Tab.: Distinction between schizophrenia, depressive states and the disease of the neutral

her very much, but I did not cry. I did not feel sad because I am »living-dead« already. In the newspaper I saw the word »seduction«, which upset me a lot as it reminded me of the analytical interpretation associated to seducing and to the guilt of not having an intercourse with my wife...« The patient seemed calculated in communicating or in giving vent to despair and to a feeling of despair both concerning himself and the analyst, although, apparently, desiring comprehension. He seemed to derive satisfaction from punishing himself, from arriving late to sessions and repeatedly went over the same incidents with subtle use of derision, sneering, and contempt of the interpretation. He was attracted, however, to life and towards sanity, had no thoughts of suicide, but was fond only of complaining, both in analytical dialogue, and in family and social life. He used manic defense of negation, never suspecting there might be the possibility of unfaithfulness on the part of his wife, although there had been no sexual contact for four years. There was no evidence of infection to account for fatigue; tests of neurocirculatory asthenia were positive (increased lactic acid, decrease in blood calcium, urinary phosphate loss) with the exception of hypoglicemia, also the endogene depressive tests (dexamethasone, fenfluramine, prolactine and lactate) were negative.

The table (p. 23) will give a distinction between schizophrenia, depressive states and the disease of the neutral.

A child is born into a world of hereditary credit inherent to preconceptions and according to the attachment that will lend him support for development and maturity. The task of the parents consists in being not only good nutritioners but in the ability to enable the child to adjust to life, with the forming of a precocious and primitive somatopsychic alter ego (second self). Should the child fail or be incapable of receiving help, he will suffer a flaw in self-authorization with foreclosure, where the corporal ego disappears, being left only what remains of the abandonment: a total victim of self-abnegation, with the death of the soul as a whole (schizoid fate – the pact of Faustus, a terrible alliance of »beta primary elements«). This condition originates a satanic superego or super-superego.

Hulak and *Lederman* (1992) refer to patients with a special profile: a fantasy of not inhabiting their own body, carrying a false existence that was imposed on them, with a lack of creativity, severe somatization , although desiring treatment and being alive; brought up by a mother that was little affective, begotten unwillingly or by accident. One of his patients says: »The greatest pain there is, is the pain of knowing that I lost what I never had«.

These patients present a false self that these authors classify as: 1) supposed false self, that must keep up this situation through secondary gains and with somatization to a lesser extent; 2) imposed false ego, that lives the tragedy of not being himself and struggles to be another person whose somatizations are severe (in the sense of expelling bad objects), entering into chaos, but may, if well treated, lay hold of regenesis, that is, to try and

restore the libido once more to the id in order to obtain a chance for yet another rebirth.

The internal »noise« of a newborn is digested by the capacity for reverie on the part of the mother. Should there be no reverie, there will be splitting, that is, there will be no internal representation of »noise« to keep up a good structure. If the projective identification is dealt with malignantly, there will be permanence of the beta element, impoverishing mental life and exacerbating the psychotic personality. Failure to connect experiences with corresponding emotions to reach meaning is a sign of failure of the alpha function (bizarre object, product of the inversion of the alpha function). The individual seems prepared, phylogenetically, to receive information and be responsible for preconceptions (*Bick* 1970). We are, in this way, prepared to receive experiences. There is, in the newborn, a series of disruptive psycho-physiological states of conscience that demands harmonic interaction on the part of the mother.

In the narcissistic personality, there is a deficiency of self-esteem that the individual overcompensates by using grandiosity. Loss of self-assurance may be seen in the following light: Example: A 2-years-old child with a temperature dreams that there are snakes in his bed, goes to his mother's room and cuddles close to her belly. This is the need for contact (skin identification) (*Bick* 1970). *Anzieu* (1989) refers to the skin of the ego of a person without self-assurance who eventually experiences the plunge into the black hole of nihilism – a state of chronic panic as is the case in hebephrenia, which is demonstrated by a biochemical alteration (*Miller Paiva* 1991). In all of these cases, filicidal feelings, sadness of the mother and her diminishing interest in the child are first and foremost. The fact is that, at that moment, the individual experienced a catastrophic change, a real mutative change in the behaviour of the maternal imago, that is experienced by the child as a catastrophe (lost love – narcissistic trauma – loss of meaning), mainly when the child feels lost between a dead mother and an inaccessible father, engendering a depressive state or disease of the neutral or of indifference.

This is deinvesting in the maternal object and unconsciously identifying with a dead filicidal mother. This person will experience a great deal of difficulty in atoning to the maternal figure; at most, there may be mimicry, for not being able to possess the object, but in continuing to try possess it, becoming not like it but actually becoming it itself. These persons show a tendency towards obsessive neurosis with an intense capacity for compulsion towards repetition, repeating former defenses.

What is wholly unconscious is an identification with the living-dead mother hence the anancastic ceremonials or somatizations such as neurocirculatory asthenia or chronic fatigue, characteristic of the disease of the neutral. This condition gives rise to consequences such as hate, maniac sadism, where the purpose is to overpower the object, to defile and exact revenge from it, leading personal relationships to desperate levels.

Our patient N.A. had a sudden thought: »I should like to murder 783 poeple. I'll be damned! How crazy can you get«. Later, reflecting on the cabala of this number, he came to the conclusion that: »I want to kill myself, for that was my number at military school«. This insight showed how former murderous hate was now directed towards himself.

These cases also experience subsequent autoerotic excitation not necessarily accompanied by sadic fantasies, but rather by reticence in love for the object – blocking love, aphanisis. Finally, this person brought up by a living-dead filicidal mother is frantically engaged in a game with the obligation to win – to win the mother-good-breast, mainly because he has no love for his professional life. He may also have an intellectual obligation, that is an obligation to think so as not to feel the living-dead mother or in the search for a means of resurrecting from the living-dead mother and thus putting an end to the curse of the living-dead and of psychic pain.

This type of patient cannot tolerate a lasting relationship, tends to destroy the good work – nursing at the breast – as also the analyst representing the mother – his envy, giving rise to damaging rivalry.

The pulse of life does not predominate to the extent that the patient may trust in his love. The patient who does not suffer pain is incapable of »suffering« pleasure, according to *Bion* (1970). Pain is not only anxiety: It is associated to a greater perception of the self, and is therefore associated to a feeling of existing separately. Some artists could transmit anxiety and death in sublime forms of art. If these patients suffer from neutral disease, they are more profoundly analyzed, make progress, and experience changes from anxiety into »pain«. The slow rupture of this mode of internal relationship leads to very deep feelings of pain in the periods of absence of the analyst and of friends. It seems to involve a fantasied project of the self into the mind or the body of the analyst; proximity is of this type and means neither relationship nor contact. They do not realize this and believe they have a very positive attitude and admiration for the analyst – that proves far from true. The feeling of fetalization (*Miller de Paiva* 1971) is, at times, intense, mainly if it is profoundly identified with the foetus, that feels it is being pulled or torn from the body of the mother, thereby giving rise to claustrophobia.

There is a type of very malignant slef-destruction, addicted to the quasi-death in the words of *Beti Joseph* (1992). From our view-point, living-death dominates life for these patients. The internal object is felt and maintained as an object paralysed (full of lethargy) neither dead, nor live, a state of suspension of the vital functions – the living dead, the disease of the neutral.

The commitment between life and death can be seen in the condition of paralysis, of suspension of vital functions. Its object is paralysed just as he himself is, to a great extent, emotionally paralysed. What makes the problem insoluble is that there is no real integration or any real mitigation of hate for love, so there is no progress, but only compulsive repetition.

These patients with the neutral disease cannot face the ambivalence and guilt and therefore, cannot attain and elaborate the depressive position;

they withdraw from it by the use of defenses pertaining to the schizoparanoid position. Their particular method of cision and fusion with the idealized object offers protection from psychosis; however, their incapacity to tolerate ambivalence, conflict and, therefore, integration, prevents the possibility of normality.

Gleichgültigkeit – ein Krankheitsbild (Erster Teil)

Luiz Miller de Paiva (São Paulo)

Der Autor präsentiert in seiner Arbeit einen pathologischen Zustand, der ihn an *Freuds* Vorstellung eines Todestriebs gemahnt, an dessen Bild von der Rückkehr zur unbelebten Materie: die Krankheit der Gleichgültigkeit. Er definiert sie als eine Anorexie, die das ganze Leben betrifft, eine Versteinerung des Ichs, die sich in Gefühllosigkeit, psychischer Trägheit und tiefster Ratlosigkeit äußert – eine Indifferenz gegenüber menschlichen Gefühlen und Leidenschaften, die auch Asexualität beinhaltet. Er grenzt diesen Zustand ab gegenüber der Depression sowie der Schizophrenie, schizoformen Neurosen und Borderline-Zuständen. Bei den genannten Erkrankungen finde sich häufig pathologische Indifferenz, darüber hinaus postuliert *Miller de Paiva* sie aber als ein eigenständiges Krankheitsbild.

Als krankheitsverursachend sieht *Miller de Paiva* eine stark ausgeprägte Grundstörung im Sinne *Balints*, die immer mit einem pathologischen Narzißmus einhergeht. Zustimmend wird *Green* 1988 zitiert: »Weil ich nicht alles haben kann und sein kann, will ich nichts haben und sein«. Diese Phantasie entwickelte sich aus der Wahrnehmung der mütterlichen Phantasie, die sich das Kind weder lebendig noch als sexuelles Wesen wünscht. Die Rettung für das Kind besteht darin, sich in ein neutrales Geschlecht zu flüchten und das Nichts anzustreben – zugleich Gehorsam gegenüber der Mutter und Rache an ihr. Die Mutter selbst bleibt ein totes Objekt ohne Affekte, versteinert und ohne innere Repräsentanz in dem Kind, so daß sein innerer Raum zu einer existentiellen Leere wird.

In ihrem verzweifelten Kampf ums Überleben wehren diese Patienten ein wirkliches Leiden ab. In der Therapie wird der Analytiker zu einem idealisierten Objekt in seiner Abwesenheit, wird aber abgewertet und mißachtet, wenn er anwesend ist – aus einer großen Angst heraus vor Enttäuschung und Abhängigkeit.

Diese Aspekte demonstriert der Autor anschließend an einem Fallbeispiel eines Patienten, der, bei äußerlicher sozialer Angepaßtheit, unter chronischer Apathie, Müdigkeit, Asexualität und Fremdheitsgefühlen litt, sich selbst als »lebenden Toten« beschrieb.

Es schließt sich eine tabelarische Übersicht über die Unterschiede von Schizophrenie, Depression und krankhafter Gleichgültigkeit an. Bei letzterer konnte *Miller de Paiva* u.a. keine Suizidalität feststellen, als wesent-

liches differentialdiagnostisches Kriterium gegenüber Depression und Schizophrenie.

Den psychogenetischen Hintergrund der pathologisch-narzißtischen Persönlichkeitsentwicklung dieser Patienten sieht der Autor in den feindseligen, vernichtenden Phantasien und Gefühlen der Mutter, deren mangelnden Interesse an dem Kind von Anfang an, oder auch in einer, vom Kind als katastrophal erlebten Veränderung des mütterlichen Verhaltens. Der Verlust der Liebe wird so zu einem narzißtischen Trauma, das einen weitgehenden Sinn- und Bedeutungsverlust nach sich zieht. Diese Dynamik wird verstärkt, wenn sich das Kind verloren fühlt zwischen einer gefühlsmäßig »toten« Mutter und einem unzugänglichen Vater. Es kommt zu einer unbewußten Identifizierung mit der abweisenden Mutter und deren Todesphantasien gegenüber dem Kind. Bei diesen Patienten entwikkeln sich häufig starke zwangsneurotische Tendenzen, wobei sie im Wiederholungszwang auf frühere Abwehrmechanismen zurückgreifen. Es können aber auch Somatisierungen das Bild beherrschen, wie Asthenie oder chronische Ermüdung.

Die an Teilnahmslosigkeit Leidenden können keine kontinuierliche Beziehung ertragen, so neigen sie auch dazu, die Beziehung zum Analytiker zu zerstören, vor allem durch ihre starken Neid- und Rivalitätsgefühle.

Der erste Teil dieses Artikels endet mit einer metatheoretischen Reflexion des Autors auf dem Hintergrund der Kleinianischen Objektschule: die beschiebenen Patienten sind unfähig, Ambivalenz- und Schuldgefühle zu ertragen, können daher die depressive Position nicht erreichen und verbleiben so in der schizo-paranoiden Position. Ihr besonderer Mechanismus der Verschmelzung mit dem idealiserten Objekte schützt sie vor der Psychose, verwehrt ihnen aber auch die Möglichkeit eines normalen, gesunden Lebens, das Integrationsleistungen von ihnen fordern würde.

(Wird fortgesetzt)

Literature with part two.

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New Conceptual Approaches to the Mental Health Protection in Russia**

Alexander A. Churkin (Moscow)*

In his paper the author points out the problems of mental health protection within the Russian population as well as a lack of a generally accepted concept of mental health, clear-cut evaluation criteria and methods of prevention and recovery. He stresses the changed socio-economic conditions under which psychiatric service is working in today's Russia and the request for a new adequate method of psychiatric help. Therefore, he suggests, the conceptual basis for mental health protection should be the development of a national program, which is mainly oriented not at the diseased, but at the healthy person. It should comprise detection of risk factors, complex evaluation of the individual's functional condition, prevention, early diagnostics and effective correction of premorbid conditions.

The socio-economic changes, having taken place in Russia during recent years are connected with the aggravation of vital problems, one of which is the problem of mental health protection within the population. In consequence, the tendencies, recently observed in social life lead to the spreading of mental disorders. The social crisis, the economic changes combined with a decreasing level of existence in population, the changes of values and ideological ideas, international conflicts, natural and technogenic disasters affecting the migration of people, the breaking of living stereotypes – all these aspects are significantly reflected in the mental conditions of the members of a society, causing stress, frustration, anxiety, feelings of insecurity and depression.

In 1993 the psychiatric and narcological help of the state institutions of health protection of the country was given to approximately 7 million people, which represent 4,7% of the population. 0.9 million of them were children which represent 2,7% of the country's children population, 0,3 million of them were adolescents which represent 4,6% of the country's population of adolescents and 5,7 million of them were adults which represent 5,3% of the adult population of the country. Among those, who adressed for psychiatric help, these were 2,4% of the entire Russian population which had mental disorders and 2,3% which showed narcological pathology. According to information, received by native specialists of different branches of industry and agriculture, 20%–60% of the population are suffering from different mental disorders, who need special help, but most of these people stay beyond the psychiatric field of activities.

The strong increase of the original morbidity indexes in mental disorders is obvious in the period 1985 to 1993, it increased by 27%, suicides

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** 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

increased by 23% during 1993. The original invalidisation among mental patients increased by 70% during the period of 1985–1993. The degree of invalidisation also aggravated – in 1993 among the disabled mental patients 6,4% i. e. 668,100 people had the third invalid group. Along with the mentioned changes, the recent years are characterized by the spreading of alcoholism, narcomania and other forms of self-destroying behaviour as well as by the increasing number of children with mental retardation. A great number of crimes are commited by people with mental abnormalities. All these phenomena represent the significant social problem.

Simultaneously, the number of mental disorders which are caused by social factors are increasing. Borderline states, neurotic and neurotropic disorders, psychosomatic diseases, abnormal personal development can be mentioned in this respect. In particular the increasing number of neurotic and psychosomatic disorders has to be regarded. Only in 1993 the number of people with originally diagnosed neuroses increased by 30,0% and the number of people with originally diagnosed psychosomatic disorders increased by 65,8%.

The following figures underline the aggravating situation of the narcological contingent. In 1992, compared to 1991, the number of patients with originally diagnosed alcoholic psychoses increased by 25,7% (from 10,5 to 13,2 per 100,000 of population) and the contingent of patients with alcoholic psychoses increased by 19,9% (from 18,6 to 22,3 per 100,000 of population). The number of alcoholics who are in remission for more than one year, decreased by 5,6% during one year, and patients with narcomania decreased by 8,7%. The entire number of hospitalized narcological patients in 1992, compared to 1991, increased by 9,4%, the number of patients with alcoholic psychoses increased by 27,4%, the number of patients with intoxicative psychoses increased by 27,5%.

Most problems of mental health protection are connected with the false conception of health care in general and mental care in particular. Proceeding from the ideology of false understanding of humanism, the health care system in our country was exclusively oriented to sick people for many years, providing them with practically all social and medical resources. The health care system struggled with diseases, but did not deal with the protection of health. The prophylactic approach within medicine, proclaimed throughout the years in connection with non-infectious diseases, including mental ones, had not been realized, first of all because of the wrong reason-conditionality in appeareance of diseases.

Results of the equalizing-consuming attitude to the health of population and the imperfection of the socio-legislative sphere in health protection are the circumstances of the preferred security of sick people compared to the healthy ones and the conditions of those who get ill occasionally; for example, those who get sick are provided with free out- and in-patient service, they are paid 100% salary while staying ill at home, the privileged resource treatment, etc. Under these circumstances the authorities of com-

panies have a sort of interest for their workers to be sick, because they have an economy in the salary funds.

Epidemiological, ecological-hygienic and clinical-social investigations allow to confirm the following hierarchy of facts, influencing the state of health of the population, including mental health:

- conditions and way of peoples living 50–55%,
- conditions of the environment 20–25%,
- genuine facts 15–20%,
- activities of health care institutions 10–15%.

Thus, the influence of the health care system on the population's health can be increased no more than 30%, the remaining 70% of influence are to be exerted by the state and other departments. This means that the conception of health lies far from the frames of medical responsibility. Since there is no official concept of mental health today, the exact criteria of its evaluation, the principles for a person's mental health have not been worked out, the ways and methods to keep and reconstruct mental health potential have not been identified either. So, the psychiatric service lacks objective possibilities of mental health evaluation in a wide field of the population and moreover, it lacks the possibility to functionally correct the status of pre-sickness, leading to the development of mental illness.

The stimulus for intensifying the treatment process of patients and the stimulus to increase the preventive efficacy are absent. The criteria of efficacy evaluation of the activities of psychiatric institutions are based exclusively on the indexes of working with already ill people, while the indexes of the mental health of the entire population of a certain area are not at all taken into consideration.

Finally, the changed socio-economical circumstances under which the psychiatric service is working nowadays (decentralisation, marketing economics, unemployment, unstable budget financing, the syndrome of postantipsychiatric stress that psychiatrists have, etc.) require new adequate organizing forms and methods of psychiatric help to be worked out.

A reorientation of social consciousness and state bureaucracy according to the problems of mental health is essentially connected to the foundation of dominant socio-ethical mental health protection of the healthy person. For prevention as a system and a service this means that in the centre of attention there has to be the healthy mother and father, the healthy child, the healthy working individual, a healthy way of living, working activities and venerable age.

In addition to the previous information we have to provide for the individual's mental health at his/her working place in the process of working activities. Here we speak of a primary prophylaxis, if it is possible to reveal not only the mental pathology, but also the levels of mental health in connection with a prognosis of decrease, which is dependent on the particular professional activities. The main goal is not only the treatment of already existing mental disorders, but banning the sicknes by way of active

regeneration of a person's psychoprophylactic resources, providing for a clear balance between organism and environment, for an adequate reaction to changing stereotypes, for resistance to extreme circumstances.

The given concept can be realized practically in the presence of constitutional and legislative requirements to employers, which have to provide for the regeneration of the employee's health by socially-oriented economical policy. Thus, the strategy of mental health protection is to direct social mechanisms to prophylactic and mental help.

To summarize the information above, the conceptual basis of mental health protection of the Russian population can be defined as follows:
– working on a national program of mental health protection of the population, which is to be oriented not to the sick indiviual, but to the healthy person, with the intention to reveal risk factors, to a complex evaluation of the individual's functional condition, early diagnostics and effective correction of premorbial conditions;
– working on mechanisms (legislative, economical) of law realization regarding psychiatric help and guarantee for people's rights and founding a legislative basis, providing for the interests of the state, the society and in particular of the individual person to keep up the mental health and the working ability of each individual;
– creating a positive image of mental health protection, service and specialists working in it, by the work of mass media structures, integrating medical services into mental health services, constructing a material and technical basis for psychiatric and psychoneurological institutions according to modern requirements, by an intensive training of personnel;
– founding a branch system of centres for the regeneration of mental health, providing for multiple medical, working, social and psychological rehabilitation for the purpose of recovering and using the remaining working ability of each person, suffering from psychic disorder.

Neue konzeptionelle Ansätze zum Schutz der psychischen Gesundheit in Rußland

Alexander A. Churkin (Moskau)

Die sozialen und wirtschaftlichen Veränderungen, die in den vergangenen Jahren in Rußland stattfanden, haben dazu geführt, daß sich die existentiellen Probleme im Lande wesentlich verschärft haben. Die soziale Krise, der verringerte Lebensstandard, der Wertewandel und verschiedene internationale Konflikte haben Streß, Angst, Unsicherheit und Depression in der Bevölkerung hervorgerufen. Es enstand dadurch die Frage, wie die psychische Gesundheit der Menschen am besten geschützt werden kann, da die Zahl psychiatrischer Erkrankungen in den vergangenen Jahren deutlich zugenommen hat.

Im Jahre 1993 nahmen 7 Millionen Menschen psychiatrische und Suchtkrankenhilfe von staatlichen Institutionen in Anspruch; das entspricht 4,7% der Bevölkerung. Davon waren 0,8 Millionen Kinder (2,7% der Kinder im Land), 0,3 Millionen Jugendliche (4,6% der Jugendlichen), 5,7 Millionen Erwachsene (5,3% der Erwachsenen). 2,4% der gesamten russischen Bevölkerung litten an psychischen Störungen, 2,3% an Störungen aus dem Suchtbereich. Von 1985 bis 1993 stieg der Morbiditätsindex für psychische Störungen um 27%, die Suizidrate um 23%. Die Rate der Arbeitsunfähigkeit aufgrund psychischer Erkrankungen stieg im selben Zeitraum um 70%. Ebenso nahmen in den vergangenen Jahren Alkoholismus, Medikamentenabhängigkeit und andere Suchterkrankungen erheblich zu. Gleichzeitig stieg die Anzahl psychischer Störungen, die mit sozialen Faktoren in Zusammenhang gebracht werden können, vor allem von neurotischen und psychosomatischen Erkrankungen. Erwähnenswert ist auch, daß von 1991 auf 1992 die Zahl alkoholischer Psychosen um 27,4% und die intoxikativer Psychosen um 27,5% angestiegen sind.

Aufgrund epidemiologischer, ökologisch-hygienischer und klinisch-sozialer Untersuchungen kann vermutet werden, daß folgende Faktoren die Gesundheit, auch die psychische, der Bevölkerung beeinflussen:

- Lebensbedingungen und Lebensweise 50–55%
- Umweltbedingungen 20–25%
- persönliche Anlagen 15–20%
- Maßnahmen zur Gesundheitspflege 10–15%.

Nur in geringem Maße hängt der Gesundheitszustand der Bevölkerung also von medizinischen Maßnahmen ab.

Das Hauptproblem beim Schutz der psychischen Gesundheit liegt in einem falschen Konzept der Gesundheitsfürsorge, denn sie war lange Zeit auf die Bedürfnisse des erkrankten Menschen ausgerichtet und bezog die Prävention nicht mit ein. Es fehlt bis heute eine offiziell anerkannte Vorstellung, was psychische Gesundheit bedeutet, und eine Konzeption, wie sie erhalten bzw. wiederhergestellt werden kann. Die Kriterien zur Beurteilung der Effektivität psychiatrischer Einrichtungen beziehen sich ebenfalls ausschließlich auf bereits erkrankte Personen, während dabei der Grad der psychischen Gesundheit in bestimmten Gegenden überhaupt nicht berücksichtigt wird. Das Hauptziel aller Maßnahmen zur Förderung der psychischen Gesundheit sollte darin liegen, die jeder Person eigenen Kräfte und Ressourcen aktiv zu stärken, um auf diese Weise ein gutes Gleichgewicht zwischen dem Organismus und seiner Umgebung und eine Widerstandsfähigkeit gegen extreme Belastungen zu erreichen. Besondere Bedeutung kommt dabei der Prophylaxe am Arbeitsplatz zu, die dem Arbeitgeber gesetzlich auferlegt werden sollte.

Zusammengefaßt gesagt, sollte die Vorsorge für die psychische Gesundheit der Bevölkerung in Rußland auf folgenden Punkten beruhen:

- Ausarbeitung eines nationalen Programmes für die psychische Gesundheit der Bevölkerung, das sich an der gesunden Person ausrichtet;

– Ausarbeitung einer gesetzlichen Grundlage für die psychiatrische Hilfe, welche auch die Rechte der Menschen gewährleistet, was gleichermaßen im Interesse des Staates, der Gesellschaft und vor allem des Individuums ist, um Gesundheit und Arbeitsfähigkeit zu erhalten;
– Schaffung eines positiven Images der Maßnahmen zur Vorsorge der psychischen Gesundheit, z. B. durch Einsatz der Massenmedien, wozu auch die Einbeziehung des psychiatrischen Gesundheitsdienstes in den allgemein-medizinischen gehört, sowie die Sicherstellung der materiellen Grundlagen der Institutionen und die Personalschulung;
– Gründung von eigenen Zentren zur Wiederherstellung psychischer Gesundheit.

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Der Begriff der Sozialenergie**

György Körmendy (Budapest)*

Aufbauend auf den Grundpositionen der Dynamischen Psychiatrie Günter Ammons stellt die Autorin den Begriff der Sozialenergie als einen Begriff dar, der bekannte Methoden zu integrieren in der Lage ist. Sie betont dabei die »primäre Interpersonalität« des Menschen, die Bedeutung verinnerlichter Gruppenerfahrungen und das Verständnis von Persönlichkeit als manifestierter Sozialenergie. Sie zitiert dabei Ammon ausführlich in seinen wesentlichen Aussagen zum Konzept der Sozialenergie und verweist auf die Anfänge dieser Begriffsdefinition auf dem Kongreß über Sozialenergie 1982 in Lübeck/Travemünde. Sie unterstreicht vor allem, daß sich Ammons Lehre mit diesem Konzept erneut von der orthodoxen Trieblehre entfernt. Sie versucht am Beispiel des Begriffs der konstruktiven Aggression, am Verständnis von Kreativität jenseits von Sublimierung und am Begriff des Symbiosekomplexes und des symbiotischen Widerstandes die grundsätzlichen Unterschiede zur orthodoxen Lehrmeinung aufzuzeigen. Sie betont die großen Vorzüge dieses Theorieverständnisses für die Behandlungspraxis, vor allem hinsichtlich ihrer Arbeit in ihrer kinderpsychotherapeutischen Praxis in Ungarn. Gerade das Verständnis des Symbiose-Komplexes sowie von konstruktiver, destruktiver und defizitärer familiärer Gruppendynamik in Verbindung mit dem Konzept des sozialenergetischen Feldes trägt wesentlich zum Verständnis und zur Behandlung schwerer erkrankter Kinder und auch deren Familien bei.

Ein neuer Begriff, der die alten Methoden integrieren kann, der Begriff der Sozialenergie.

Der Begriff der Sozialenergie wurde von der Berliner Schule der Psychoanalyse ausgearbeitet. Er ist das Leitprinzip der humanstrukturellen Persönlichkeitstheorie, die als Resultat der Verknüpfung von Psychoanalyse, Gruppendynamik und Forschungsergebnissen der Münchener Dynamischen Psychiatrischen Klinik Menterschwaige entstand. Das Wesen des Menschen wird dabei als primäre Interpersonalität verstanden seine Ich-Funktionen sind von verinnerlichten Gruppenerfahrungen bestimmt und seine Persönlichkeitsstruktur ist als manifestierte Sozialenergie zu begreifen.

»Die humanstrukturelle Psychoanalyse (Humanstrukturologie) hat sich im Laufe der Jahre von der *Freud*ianischen Libidotheorie getrennt und setzt an ihre Stelle das Konzept der Sozialenergie, d.h. der Mensch ist kein Triebwesen, sondern ein Sozialwesen. Sozialenergie als psychische Energie steht immer in Abhängigkeit von zwischenmenschlichen und gruppendynamischen Bezügen, von der Umwelt des Menschen und gesellschaftlichen Faktoren. Sozialenergie haben heißt nichts anderes, als Verständnis zu entwickeln, Interesse zu haben an anderen und der Gruppe, sich mit einem anderen auseinandersetzen und den anderen Menschen ernstzunehmen mit seinen Freuden, Leistungen, Interessen, aber auch mit seinen Sorgen und Schwierigkeiten. Sozialenergie entsteht durch Kontakt, durch Forderungen an die Identität, durch Aufforderung zur Tätigkeit und zur Aufgabe.

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** Vortrag gehalten auf dem 4. deutschsprachigen Kongreß für Gruppenpsychotherapie und Gruppendynamik vom 25.–28. August 1994 in Kassel

Menschen, die zu wenig gefordert werden, sind verlassene Menschen mit Sozialenergie-Defiziten. Sozialenergie dient dem Ich-/Human/Struktur-Aufbau und der Entwicklung der einzelnen Ich-Funktionen. Die Humanstruktur kann sozusagen als manifestierte Sozialenergie betrachtet werden und unterliegt lebenslang sozialenergetischen Einflüssen. Dabei wird das Strukturmodell der orthodoxen Psychoanalyse, wie auch der Ich-Psychologie, das in seiner Begrifflichkeit von Ich, Es und Über-Ich einen hypothetischen Chrarakter hat, zugunsten eines Strukturmodells aufgegeben, das versucht, die Ausbildung und Interdependenz der Ich-Funktion, als Spiegel einer internaliserten Gruppenerfahrung zu verstehen und in der Interaktion mit dem Therapeuten und der therapeutischen Gruppe gezielt zu beeinflussen.

Unter Struktur versteht die humanstrukturelle Theorie die gesamte Persönlichkeitsstruktur des Menschen, wo sie zur Identität der Gesamtpersönlichkeit wird. Man kann unterscheiden hierbei auch die Großstrukturen des zentralen unbewußten Ichs, wie die Struktur des sekundären Verhaltens-Ichs und des primären biologischen Ichs. Dieser Strukturbegriff ist ein dynamischer: die Strukturen sind in ständiger Entwicklung und Beziehung untereinander und formen Substrukturen, z.B. die Identität, in die alle Funktionen in dynamischer Beziehung einfließen. Im Verständnis der Dynamischen Psychiatrie mit ihrer Humanstrukturologie hat die Schizophrene Erkrankung (und die archaische Erkrankung im allgemeinen) ihre Wurzeln in einer nicht gelungenen Abgrenzung aus der frühkindlichen, präödipalen Symbiose mit der sozialenergetischen, gruppendynamischen Gestörtheit innerhalb der Primärgruppe. Diese führt zu einer Arretierung der psychischen Persönlichkeit, zu einem »Loch im Ich« in der Humanstruktur/Persönlichkeitsstruktur...

In ... der Behandlung ist es wesentlich, alle konstruktiv und aktiv gewesenen Humanfunktionen der Patienten zu fördern. Im Sinne einer echten nach-holenden Persönlichkeitsentwicklung gilt es dann, zu der Leere der zentralen Humanfunktionen, dem 'Loch im Ich' vorzustoßen, und dort die Identität allmählich aufzubauen (*Ammon* 1982).

Im Jahre 1982 fand ein Symposium der Weltgesellschaft für Dynamische Psychiatrie und der Deutschen Akademie für Psychoanalyse in Lübeck statt, mit dem Titel: Das sozialenergetische Prinzip in der Dynamischen Psychiatrie. Der wissenschaftliche Leiter des Symposiums war *Günter Ammon,* ich zitierte vorher von ihm. Hier wurde klar, daß die Sozialenergie ein integrativer Begriff ist, der keine biologische-physikalische Größe mit entsprechender Gesetzmäßigkeit sein kann und immer gruppen- und personenbezogen zu sehen ist. Die Referenten haben über die Erscheinung eines neuen Paradigmas in der Wissenschaft gesprochen. Hier wurde auch klar, daß die Sozialenergie in drei Erscheinungsformen betrachtet werden kann: sie kann konstruktiv, defizitär und destruktiv sein. Es wurden Vorträge gehalten über die sozialenergetischen Felder in stationärer Psychotherapie, über die ambulante Mileutherapie, über die neuro-

physiologischen Zusammenhänge der Sozialenergie und über andere wichtige Themen aus sozialenergetischer Sicht, z.B. Kinderpsychologie, kinderärztliche Praxis, forensische Psychologie, Psychosomatik, Balint-Gruppenarbeit, pränatale Psychologie usw.

Mit diesem Symposium wurde die Möglichkeit gezeigt, wie sich die Psychoanalyse von der einseitigen Trieblehre losmachen kann. Ich möchte drei Punkte als Beispiele kurz hervorheben, an denen ich die Abweichungen der humanstrukturellen Psychoanalyse von der orthodoxen Psychoanalyse demonstrieren will. Es sind: 1) Aggression, als Ich-Funktion und die konstruktive Aggression, 2) Kreativität, als genuine Ich-Funktion, Möglichkeit zur konstruktiven Kreativitätsentwicklung ohne Sublimierung, 3) Symbiosekomplex und symbiotischer Widerstand.

Die orthodoxe Psychoanalyse geht von einem angeborenen destruktiven Aggressionstrieb aus. Ein Strukturgewinn des psychischen Apparates entsteht nur durch die notwendige Leistung, Triebenergien zu neutralisieren und umzuwandeln, um sie den Forderungen der Realität anzupassen. *Thomä* stellt schon fest, daß die Aggression kein Trieb im Sinne der Definition *Freuds* ist, sondern nur eine Reaktion. Wir können aber daraus nicht wissen, was sie eigentlich ist.

Dagegen ist die Aggression bei *Ammon* eine genuin konstruktive, gruppendynamisch bestimmte Ich-Funktion, die sich in fließender Interaktion mit der Mutter und der Primärgruppe entwickelt. Wenn das sozialenergetische Feld der Familie nicht entsprechend strukturiert ist, das heißt defizitär oder destruktiv ist, kann sich die ursprüngliche konstruktive Aggression durch schädigende oder mangelnde Beziehungserfahrungen in Richtung destruktiv oder defizitär verändern. Hinter den kindlichen Wutausbrüchen oder den detruktiven Akten der Erwachsenen kann man immer schwere Identitäts-Frustrationen finden. Die defizitäre Form der Aggression entspricht dem Zustand, – wer nichts will, will auch nicht leben, – und aus diesem Zustand herauszukommen ist im allgemeinen mittels destruktiver Durchbrüche möglich.

Die orthodoxe Psychoanalyse hält die Kreativität für ein Ergebnis von Sublimierung. Der kreative Akt ist aber immer Gruppenprodukt, auch wenn der Künstler allein arbeitet. Er schöpft für die anderen Menschen oder für die Menschheit. Die konstruktive Sozialenergie kann in großem Maße das künstlerische Produkt erhöhen. Die Humanstrukturologie behauptet, daß »die Kreativität nicht ein Problem von Abwehr von Triebbedürfnissen ist, sondern ein Problem der Abgrenzung des Kindes aus der Symbiose und seines aktiven Hervortretens«.

Die Mutter-Kind Symbiose, die von dem Vater und der Familie unterstützt werden soll, kann auch konstruktiv, destruktiv oder defizitär sein. Bei der Symbiose von konstruktivem Charakter, wo das Kind von der Mutter und der Familie genügende Zuwendung und Sorge bekommt, seine emanzipatorischen Schritte unterstützt werden, kann es aus dieser symbiotischen Beziehung leicht heraustreten und es bringt für das Leben eine konstruktive

Aggression mit, damit es leben, seinen Partner finden und in seinem Beruf sich entfalten kann. Die anderen Ich-Funktionen, hauptsächlich seine Identität entwickeln sich ebenfalls gesund. Bei einer kranken Mutter, oder einer Mutter, die ohne Unterstützung und ohne umgebende Gruppe alleine steht, bekommt das Kind keine notwendige Wärme und Zuwendung, eventuell gibt es auch Mängel in der Pflege. Diese krankmachende Symbiose verhindert dann eine schuldfreie Loslösung aus der frühkindlichen Abhängigkeit. Mit realen Schädigungen in der Ich- und Identitätsentwicklung wird das Kind, auch als Erwachsener lebenslang eine Mutter oder Mutterersatz suchen. Dieser Zustand ist von *Ammon* als Symbiose-Komplex bezeichnet worden. Dieser erscheint bei archaischen Ich-Kranken in der Patienten-Therapeuten-Beziehung als symbiotischer Widerstand.

In meiner kinderpsychotherapeutischen Praxis in Ungarn habe ich den schwersten zu behandelnden Wiederstand in der Familie in ihrer symbiotischen Fixierung zum Kind angetroffen. In der Erziehungslage der zur Beratung angemeldeten Kinder haben wir vier Typen vorgefunden: Die Kinder befanden sich in normaler, problematischer wegen Mangel an Erziehungskenntnissen, problematischer wegen »verborgener Gefühlsvernachlässigung« und in bedrohender Familienerziehungslage. Die Ergebnisse dieser Untersuchungen wurden im Jahre 1970 publiziert. Nachdem ich den Begriff der sozialen Energie und die ganze Persönlichkeitstheorie von *Ammon* kennengelernt hatte, fand ich, daß der Inhalt der obigen Typen den konstruktiven, defizitären und destruktiven Varianten der familiären Gruppendynamik und des sozialenergetischen Feldes in den Familien entspricht. In der kinderpsychotherapeutischen Behandlung ist es von besonderer Bedeutung nicht nur mit der ödipalen Problematik, sondern auch dem Symbiose-Komplex zu arbeiten und den wegen der verlängerten Symbiose entfalteten starken Widerstand der krankmachenden Familie zu bearbeiten. In meiner kinderzentrierten familientherapeutischen Methode habe ich anstatt Psychoanalyse Relationenanalyse gemacht, wobei die thematischen Besprechungen über die Beziehungen der Familienmitglieder diagnostiziert und auf diese Weise für die Behandlung vorbereitet wurden. Wir haben so gesehen, daß die destruktive, von Generationen zu Generationen sich übertragende, krankmachende Familiendynamik als eine Volkskrankheit zu sehen ist, und darum nicht nur die Psychiater, sondern auch die Kinder- und Familienärzte eine Ausbildung in dieser Richtung machen sollten. An den von unserer Vereinigung für Dynamische Psychologie und Psychiatrie eingerichteten Lehrgängen haben auch diese Fachleute teilgenommen, und sie machen schon Familiendiagnostik und Therapie auf diese Weise. Ich kann sogar erwähnen, daß ich für die Lehre der Sozialenergie und für die humanstrukturelle Persönlichkeitstheorie auch in populärwissenschaftlichen Vorträgen ernsthaft Interesse erfahren habe. Es wurde ein Lehrgang z.B. auch für die Jugend gehalten, deren Teilnehmer begeistert waren über diese für sie auch verständliche Persönlichkeitstheorie.

Mit Hilfe dieser Sicht können auch therapeutische Gemeinschaften organisiert, milieutherapeutische Gruppenarbeit und nonverbale Therapie-

sitzungen durchgeführt werden. Das Wesen der Hypnose und des Psychodramas, der Wirkungseffekt in der Bewegungstherapie für die schwerverletzten Kinder im Pethő Institut sind menschliche Begegnungen, die Kontakt, Körperkontakt, systemische Kommunikation, zusammenfassend: Sozialernergie-Austausch bedeuten.

Szönyi (1993) stellt, wie er sagt, mit Unzufriedenheit fest, daß wir Psychotherapeuten für die Gruppenarbeit bisher kein Theoriesystem haben, im Gegensatz zu den Therapien mit Einzelnen bei den verschiedenen Richtungen. Eine Gruppenpsychotherapie-Theorie sollte – sagt er – in einem kohärenten System die Theorie der Persönlichkeit, der Krankheit, der Interpersonalität, der Gruppe, des Prozesses, und der Technik enthalten. Die Gruppenanalyse kann mit der Libidotheorie nichts anfangen. Verschiedene Theorien, z.B. Gedanken von *Winnicott* oder *Foulkes* sind sehr nützlich, aber zu wenig. Ich wollte ihn und die Kollegen auf die *Ammon*sche Theorie aufmerksam machen, darüber handelt dieser Vortrag. *Béla Buda*, der die Entwicklung dieses Theoriesystems kritisch, aber stetig in seiner Studie über die systemtheoretischen Züge der Humanstrukturologie von *Ammon* beobachtet, stellt die Hauptcharakteristika des systhemischen Denkens dar. »Systemmodelle kann man auf verschiedene Größenordnungen anwenden, man kann hierbei mit Sicherheit rechnen, daß es zwischen ähnlichen Elementen und Prozessen auf verschiedenen Systemniveaus Gleichheiten und Zusammenhänge gibt (*Buda* 1993). Seine Gedanken fortsetzend, können wir sagen, daß Persönlichkeit, Gruppe und Gesellschaft die drei Systemniveaus sind, die in diesem Sinn gedeutet werden sollten. Die Sozialenergie-Theorie und das *Ammon*sche Persönlichkeitsmodell begreift diese drei Bereiche. Das Unbewußte bei *Ammon* ist eine Sammlung verinnerlichter Gruppenerfahrungen, während die zentralen Ich-Funktionen, wie: Identität, Aggression, Angst, Abgrenzung, Kreativität, Sexualität auch als Gruppencharakteristika erscheinen. Die menschliche Persönlichkeit ist als manifestierte Sozialenergie zu begreifen. In den gesellschaftlichen Verhältnissen können wir die konstruktive, destruktive oder defizitäre Erscheinung beobachten und in einigen Therapieformen auch schon lenken.

Der Begriff der Sozialenergie kann als ein Geschenk der Psychotherapie für die Menschheit am Ende des Jahrhunderts betrachtet werden. Wir müssen uns von der einseitigen Isolation der Libidotheorie losmachen und uns in unserer Tätigkeit öffnen. Mit diesem Begriff und der ganzheitlichen Theorie von Persönlichkeit, Gruppe und Gesellschaft können wir unsere Arbeit öffentlich darstellen und dem leidenden Menschen als Partner begegnen.

The Concept of Social Energy

Györgyi Körmendy (Budapest)

The concept of social energy has been developed as a milestone of *Günter Ammon*'s Berlin School of Dynamic Psychiatry. It is a consequence of the integration of the results of psychoanalytic and group-dynamic work as well as of the research in the Dynamic Psychiatric Hospital Menterschwaige in Munich. It is based on the understanding of man as a primarily interpersonal being, whose growth and development is a result of internalized group experiences, and on the understanding of personality structure as internalized social energy.

Ammon's human structural psychoanalysis has replaced *Freud*'s libido theory by the concept of social energy. This implies, that man is not a being governed by drives, but a social being: »To give social energy means nothing else than to develop understanding and interst for others and for the group, to solve interpersonal conflicts and to understand other persons in their joys, achievements, interests, but also in their preoccupations and difficulties. Social energy is the consequence of contacts, of demands upon another persons identiy, of the requests of activity and tasks. Persons from whom too little has been demanded are abandoned persons with social energy deficits. Social energy builds up ego/human structure and leads to the developments of the single ego functions...« (*Ammon* 1982).

On the occasion of the symposion on »The Social Energetic Principle in Dynamic Psychiatry« in Travemünde, 1982, *Ammon* emphasized that social energy is not to be understood as a biological-physical quantity subject to physical laws, but rather as an integrative notion which must always be considered in relation to persons and groups. Taken as a new paradigm, social energy may express itself by a constructive, destructive or deficient quality. In this context, the concept of group dynamic-social energetic fields is of particular importance in the inpatient psychotherapy, the inpatient and outpatient milieu therapy, in the connections between social energy and neurophysiology, child psychology, in pediatric practice, in forensic psychology, in psychosomatics, prenatal psychology and in the work of Balint-groups. The symposion on social energy could point out remarkable possibilities to renounce to the onesided concept of psychoanalytical drive theory.

Three examples may illustrate the departure of human structural psychoanalysis from the orthodox psychoanalysis:

1. The concept of aggression as an ego function and as constructive aggression
2. Creativity as a genuine ego function with the possibility of constructive creativity without sublimation
3. The symbiosis complex and the symbiotic resistence.

While traditional psychoanalysis proceeds from an innate destruction drive, *Thomä* points out, that aggression is not a drive, but rather a reaction.

Ammon postulates aggression to be genuinely constructive and determined by group dynamics; its development must be seen in relation to the mother and the primary group. Depending upon the quality of the social energetic field in the family, the originally constructive aggression will be distorted by damaging or deficient experiences into destructive or deficient forms. The rage of the infant and the destructive acting out of the adults must thus the understood as severe identitiy frustration. The deficient form of social energy can be considered as the most pathological state, which may only be overcome by detructive bursts.

While orthodox psychoanalysis considers creativity as a result of sublimation, *Ammon* sees a creative act as related to the group and as a result of an active detatchment from symbiosis, i.e. of a demarcation ability of the child. The quality of the symbiosis, determined by father, mother and surrounding group, may be thereby constructive, destructive or deficient. In the favourable constructive case, the child receives enough attention and support to undertake emancipatory steps and be able to step out of the symbiotic relationship. It will later be equipped with sufficient constructive aggression to realize its own aims in profession, partnership and its own identity. A pathogenic, soical-energetically insufficient symbiosis prevents the guilt-free detachment from infantile dependence. As a consequence of real damage in the ego and identity developments in childhood, the adult will repeatedly seek for the mother or a mother subsitute.

In her experience as a child psychotherapist in Hungary the author could observe the symbiotic fixation to children as the most severe therapeutic resistence. She could also differentiate several types of normal to severely ill children and families, which could be well understood and treated on the basis of *Ammon*'s concept of social energy with its constructive, destructive and deficient variants in the group dynamics and the corresponding social energetic field of the family. Therefore, the therapeutic work not only with the Oedipus complex, but particularly with the symbiosis complex, above all in the case of pathologically arrested symbiosis, is of paramount importance in the practice of child psychotherapy. Thereby, the treatment and analysis of the relationships of the family members to each other, is crucial.

Szönyi (1993) points out with dissatisfaction, that up to the present, group psychotherapists had no useful and coherent theoretical system at their disposal to offer a theory of personality, of illness, of interpersonality, of the group and its processes, and of therapeutic technique. *Ammon's* personality model integrates these aspects including the social dimension and proves to be an extremely efficient tool for the therapeutic work and, therefore, for helping the suffering patients.

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The Case-Conference as an Integrative Moment in Diagnostics and Psychotherapy***

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In the Dynamic Psychiatric Hospital Menterschwaige, the case-conference is the central tool for diagnosis and therapy planning. It takes place for each patient at least once during the inpatient treatment. The aims of the case-conference are the integration of all diagnostic and therapeutic findings about the patient, to access not only the patient's symptomatology and pathology, but also his healthy functioning with his creative and constructive parts of the personality, to differentiate, or if necessary to change the diagnosis, to reflect the therapeutic process of the patient, to plan a more differentiated treatment program, and to discuss perspectives for the patient's future. Of special importance is the active involvement of the patient into all diagnostic procedures and into the case-conference. To be confronted with the own life history, behaviors, abilities and difficulties means for the patient that the case-conference has also a therapeutic function. The procedure of a case-conference will be discribed by the authors.

The Dynamic Psychiatric Hospital provides an intensive therapeutic field with a treatment program with various non-verbal and verbal therapeutic methods. Beginning with his admission, the patient is surrounded by a variety of persons, co-patients, therapists and different coworkers of the hospital. In the course of this treatment the patient develops a network of relationships, in which he is involved in a specific way. I.e., in his co-patients, the patient will find important partners to discuss various problems and exchange common interests, especially in those groups where he actively participates. The patient will contact different therapists as well as coworkers in administration, kitchen, caretakers, etc. Altogether, the therapeutic field in the hospital can be regarded as a milieu therapeutic, social-energetic, and groupdynamic field (*Ammon* 1994).

The group of therapeutic team members determines the individual treatment program and finds an individual therapist for the patient. Individual therapist and patient should be well matched concerning their personality structures; i.e. there should exist an interest for each other and the therapist should understand the patient's problem in principle. *Ammon* emphasizes the significance of the first encounter between patient and therapist which will be decisive for a successful psychotherapy.

The treatment program is composed individually according to the patient's abilities and needs and can be changed during the treatment process if necessary. Thus, the patient involves himself actively into the field of the hospital and can be observed in various facets of his personality.

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*** 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

Moreover severely ill patients often are unable to verbalize conflicts and have so the chance to communicate their unconscious and non-verbal aspects into the therapeutic field.

The assessment of the multidimensionality of each individual patient emphasizing the healthy and creative parts is characteristic for the dynamic psychiatric diagnosis. Of special interest are the patient's abilities (i.e. languages, skills, intellectual abilities, creative talents, social capacities, life experiences).

The patient will be examined at the beginning of this hospital treatment with detailed diagnostic and anamnestic investigations. They include a detailed anamnestic interview by the psychiatrist and social worker (including the life history) and a physical assessment by an internist. A detailed psychological testing especially includes the unconscious part of the personality with tests like ISTA (Ego-Structural Test by *Ammon*), Wartegg and other drawing tests. Personality tests such as MMPI Saarbrücken and Gießentest as well as different intelligence tests are applied. Additional examinations with the Autokinetic Light Test (AKL) and in the sleep and dream laboratory are carried out.

All these diagnostic procedures take place at the beginning of treatment, on the frame of the case-conference and shortly before discharge. All test results are intensively discussed together with the patient. He is an active partner in the diagnostic process. All therapeutic findings about the patient are important hints for the diagnostician and vice versa all diagnostic results are helpful for the therapists. Finally we can say that the diagnostic situation simultaneously is a therapeutic one. For both, the diagnostician and psychotherapist, direct observations of the patient's daily life and behavior in several treatment groups are important, such as his dressing style, his facial expression, his gestures, his room decoration, the ability to be responsible, his pecularities.

It is also important to study manifestations of transference and counter-transference in different areas of the hospital, as *Ammon* pointed out in his opening lecture. Those transference and counter-transference phenomena can be understood by recognizing mirror processes in various therapeutic groups as well as in the therapeutic team. Mirror dynamics are formed »when the patient acts into groups with his entire identity and we can use the mirror dynamics for the understanding of the patient's unconscious family dynamics«. (*Ammon, Burbiel* 1992).

The observations mentioned above lead to the case-conference usually taking place once during the treatment process, and is conducted and coordinated by the chief-consultant of the hospital, who is psychiatrist and psychoanalyst. Participants in the case-conference are all therapists and coworkers being involved in the patient's treatment: individual psychotherapist, group psyhotherapist, milieu therapist, diagnostician, social worker, and the therapists of the non-verbal methods, such as the art therapist, horse-back riding therapist, dance therapist.

All participating team members report about the patient's development from their point of view. The potentialities, strengths and capabilities in the sense of a »health diagnosis« are of special interest, especially concerning the future perspective of the patient after discharge. In order to evaluate the course of the treatment process it is necessary to understand stagnations, arresting points, ruptures, as well as improvements. Significant questions are: Has the treatment setting been sufficient? Are changes necessary? Has the patient been understood in the core of his personality? Has it been possible to establish a true therapeutic relationship between patient and therapist?

The first diagnosis at the time of admission will be evaluated, discussed, and changed if necessary. *Ammon* has characterized it as »diagnostic process« (*Ammon* 1959). The theoretical assumption is that the dynamic psychiatric treatment results into a structural change, not only in an improvement of symptoms. The treatment has been conceptualized by *Ammon* as »identity psychotherapy« (*Ammon* 1982), that means that the patient is touched in his central unconscious part of personality. It also means to ask the patient for his needs, wishes and goals in life.

The actually developing group dynamics in the team group of the case-conference is useful for drawing conclusions from the unconscious dynamics of the patient. For example, a warm, friendly, and permissive atmosphere will arise with various ideas for planning the patient's future, or the atmosphere will remain cool and reserved. Sometimes, the staff members fall into a stormy, vehement, and passionate argument with each other and everybody insists in his own perception of the patient.

In a next step, the patient will be called into the case-conference, usually supported by some co-patients who are important for him. In some way, the co-patients represent the healthy and ill aspects of the patient. For example, there was one patient who was accompanied by some patients: one of them represented his erotic dimension, one his creative aspects, another one his unability to verbalize his feelings, and another one his intellectual skills. First of all, the therapists will ask the patient about his present condition and his future plans. The co-patients give their comments as well. The comments, ideas, phantasies of the co-patients contribute additionally to an intense diagnostic information.

Every single case-conference is unique according to the patient's individuality. Some patients are rather concerned about their case-conference, others are glad to get special attention and care, and still others prepare themselves in a special way, for example bringing artistic products or showing their dance videos from the humanstructural dance therapy group. Almost all patients give an insight into their unconscious processes by a variety of paintings explained and interpreted by the art therapist.

The case-conference as a whole has a therapeutic function for the patient. Very often it is a turning point in the course of the therapeutic process. By assembling all information about one patient and reflecting this information back to him, he will be confronted with himself in an intensive and direct

way. This is like a mirror in which the patient encounters with himself by the perceptions of the therapists.

The inteview style varies according to the patient's condition, his psychopathology and the therapeutic process. For example, a schizophrenic patient at the beginning of treatment will need more support, empathy and hope than a borderline patient reacting with a variety of defenses to avoid personality development. This borderline patient will be more directly confronted with his destructive and hostile behavior, provided that the patient-therapist-relationship is stable enough.

Concerning the future planning, the quality of life including the professional development is of central importance. Requirements of the society as well as special needs, possibilities and limitations of the patient should be considered for the life planning after discharge. For further development after the hospital treatment the patient needs to conceptualize a healthy and supporting environment in the sense of a social-energetic field, mostly in connection with a continuing ambulant psychotherapy in order to stabilize the inpatient treatment progress. Some patients need to live in a therapeutic living community which is connected with the hospital. The results of the case-conference will be actively integrated into the different field of our hospital treatment such as individual therapy, group psychotherapy, milieu therapy.

Summarizing, the case-conference in the Dynamic Psychiatric Hospital Menterschwaige is a central integrative moment in which all observations and findings about one patient are focussed. In our understanding, the case-conference is a highliy communicative process in which the patient is an active participant. The principle of Dynamic Psychiatric psychotherapy and diagnosis is to use the healthy aspects of the patient and to strengthen and to support the creative potentialities more and more until the illness looses its life-restrictive meaning.

Die Case-Konferenz als integratives Moment in Diagnostik und Psychotherapie

Günter Ammon (Berlin/München), Monika Dworschak, Margit Schmolke (München)

Die Dynamisch-Psychiatrische Klinik bietet mit dem nonverbalen und verbalen Behandlungsprogramm ein intensives therapeutisches Feld. Der Patient ist ständig von vielen Personen umgeben und entwickelt ein Netz von Beziehungen: Mit seinen Mitpatienten diskutiert er und teilt Interessen, vor allem in den Gruppen, an denen er sich aktiv beteiligt; er hat Kontakte zu verschiedenen Therapeuten und den Mitarbeitern in Verwaltung, Küche, Reinhaltung etc.

Die Gruppe des therapeutischen Teams legt entsprechend den Fähigkeiten und Bedürfnissen des Patienten den individuellen Behandlungsplan fest und findet einen Einzeltherapeuten. *Ammon* betont die Bedeutung des Erstkontakts zwischen Patient und Therapeut als entscheidend für eine ge-

lingende Psychotherapie, beide sollten Interesse aneinander haben und der Therapeut sollte das Problem des Patienten prinzipiell verstehen. Der Patient ist aktiv in das therapeutische Feld der Klinik involviert und kann in seinen verschiedenen Persönlichkeitsaspekten beobachtet werden, was besonders bei schwerer kranken Patienten wichtig ist, die nicht verbalisieren können und so die Chance haben, ihre unbewußten Aspekte ins Feld hinein zu agieren.

Charakteristisch für die dynamisch-psychiatrische Diagnose ist, die Mehrdimensionalität eines Patienten zu erfassen bei Betonung seiner gesunden und kreativen Anteile. Von besonderem Interesse sind die Fähigkeiten eines Patienten (soziale und intellektuelle Fähigkeiten, Sprachen, Fertigkeiten, kreative Begabungen, Lebenserfahrungen etc.). Bei der Aufnahme wird der Patient detailliert diagnostisch und anamnestisch untersucht: Anamnestische Interviews durch Psychiater und Sozialarbeiter inklusive der Lebensgeschichte, körperliche Untersuchung durch den Internisten, ausführliche psychologische Testdiagnostik, die besonders die unbewußten Bereiche der Persönlichkeit erfaßt mit dem Ich-Struktur-Test nach *Ammon* (ISTA) und Zeichentests wie Wartegg und anderen, ergänzt durch Persönlichkeitstests (MMPI, Gießentest) und Intelligenztests. Hinzu kommen der Autokinetische Licht-Test und Untersuchungen im Schlaf- und Traumlabor. Diese gesamte Diagnostik wird bei Aufnahme, im Rahmen der Case-Konferenz und kurz vor der Entlassung durchgeführt. Alle Ergebnisse werden ausführlich mit dem Patienten als aktivem Partner besprochen. Die therapeutischen Erkenntnisse über den Patienten bilden wichtige Hinweise für den Diagnostiker und umgekehrt, so daß die diagnostische Situation zugleich eine therapeutische darstellt. Sowohl für den Diagnostiker wie für den Therapeuten sind direkte Beobachtungen des Alltags und des Verhaltens in verschiedenen Behandlungssituationen wichtig, wie Kleidungsstil, Gesichtsausdruck, Gestik, Zimmerdekoration, Fähigkeit, Verantwortung zu übernehmen, Besonderheiten etc. Ebenso wichtig ist es, Übertragungs- und Gegenübertragungsmanifestationen in den verschiedenen Bereichen der Klinik zu erkennen. Sie können als Spiegelungsprozesse sowohl in den therapeutischen Gruppen als auch im Team verstanden werden.

Alle obengenannten Beobachtungen münden in die Case-Konferenz, die überlicherweise einmal während der Behandlung stattfindet. Sie wird geleitet und koordiniert vom Chefkonsiliar der Klinik, der Psychiater und Psychoanalytiker ist. Teilnehmer daran sind alle Therapeuten und Mitarbeiter, die in die Behandlung eines Patienten involviert sind: Einzeltherapeut, Gruppentherapeut, Milieutherapeut, Diagnostiker, Sozialarbeiter, Kunst-, Reit-, Tanztherapeut usw. Alle berichten aus ihrer Sicht über die Entwicklung des Patienten. Die Potentiale, Stärken und Fähigkeiten im Sinne einer »Gesundheitsdiagnostik« sind von besonderem Interesse im Hinblick auf die zukünftige Perspektive des Patienten nach der Entlassung. Stagnation, Brüche, Besserungen, Arretierungen müssen verstanden werden,

um den Behandlungsprozeß zu evaluieren: Reicht das Behandlungssetting aus, wurde der Patient im Kern seiner Persönlichkeit verstanden, existiert ein echtes therapeutisches Bündnis zwischen Patient und Therapeut?

Die anfängliche Diagnose bei der Aufnahme wird evaluiert, diskutiert und wenn nötig verändert. *Ammon* (1959) spricht vom »diagnosing process«. Theoretisch nehmen wir an, daß die dynamisch-psychiatrische Behandlung zu einer strukutrellen Veränderung führt, nicht nur zur bloßen Symptombeseitigung (»Identitätstherapie«, *Ammon* 1982), so daß der Patient im zentralen unbewußten Kern seiner Persönlichkeit berührt wird. Die aktuell sich entwickelnde Gruppendynamik in der Teamgruppe der Case-Konferenz erlaubt Rückschlüsse auf die unbewußte Dynamik des Patienten. Z.B. kann eine warme, freundliche, gewährende Atmosphäre entstehenden oder sie kann kühl und reserviert bleiben oder die Mitarbeiter verfallen in eine vehemente, leidenschaftliche Diskussion miteinander, bei der jeder auf seiner Sicht des Patienten beharrt.

Im nächsten Schritt wird der Patient in die Case-Konferenz gerufen, normalerweise begleitet von ihm wichtigen Mitpatienten. In gewisser Weise repräsentieren sie die gesunden und kranken Anteile seiner Person; z.B. die erotischen oder die kreativen Aspekte, ein anderer die Unfähigkeit, Gefühle zu verbalisieren, ein anderer die intellektuellen Fähigkeiten. Zunächst fragen die Therapeuten den Patienten nach seinem gegenwärtigen Zustand und seinen Zukunftsplänen. Auch die Kommentare der Mitpatienten tragen zur intensiven diagnostischen Information bei. Jede Case-Konferenz ist – entsprechend der Individualität des Patienten – einzigartig. Manche Patienten sind über die Case-Konferenz sehr besorgt, andere freuen sich, spezielle Aufmerksamkeit und Fürsorge zu erfahren, andere bereiten sich besonders vor, z.B. indem sie künstlerische Arbeiten mitbringen oder Videos aus der Tanztherapiegruppe zeigen. Fast alle Patienten geben einen Einblick in ihre unbewußten Prozesse über ihre gemalten Bilder, die vom Kunsttherapeuten erklärt und interpretiert werden.

Die Case-Konferenz insgesamt hat therapeutische Funktion für den Patienten und ist oft der Wendepunkt im therapeutischen Prozeß. Er wird durch die Reflektion aller Information über ihn intensiv und direkt mit sich selbst konfrontiert. Dies wirkt wie ein Spiegel, in dem sich der Patient durch die Wahrnehmung der Therapeuten sieht. Der Stil des Interviews variiert mit der Befindlichkeit und dem therapeutischen Prozeß der Patienten. Zum Beispiel braucht ein schizophrener Patient anfangs mehr Unterstützung, Einfühlung und Hoffnung als ein Borderline-Patient mit einer Vielzahl von Abwehrformen zur Vermeidung von persönlicher Entwicklung. Letzterer wird direkter mit seinem destruktiv-feindseligen Verhalten konfrontiert, vorausgesetzt, die Patient-Therapeut-Beziehung ist stabil genug. Für die Zukunftsplanung ist die Lebensqualität einschließlich der beruflichen Entwicklung von zentraler Bedeutung. Anforderungen der Gesellschaft müssen ebenso wie spezifische Bedürfnisse, Möglichkeiten und Grenzen des Patienten berücksichtigt werden. Der Patient braucht für

seine weitere Entwicklung nach der Klinikzeit eine gesunde und unterstützende Umgebung im Sinne eines sozialenergetischen Feldes, meist in Verbindung mit einer fortgesetzten ambulanten Psychotherapie. Die Ergebnisse der Case-Konferenz werden in die verschiedenen Behandlungsfelder der Klinik integriert wie Einzel-, Gruppen- und Milieutherapie.

Zusammengefaßt ist die Case-Konferenz in der Dynamisch-Psychiatrischen Klinik Menterschwaige ein zentrales integratives Moment, in dem alle Beobachtungen und Erkenntnisse zu einem Patienten zusammenfließen. Sie ist ein hochkommunikativer Prozeß, an dem der Patient aktiv teilnimmt. Prinzip der dynamisch-psychiatrischen Psychotherapie und Diagnose ist es, die gesunden Anteile des Patienten zu nutzen und seine kreativen Potentiale mehr und mehr zu stärken und zu unterstützen, bis die Krankheit ihre lebenseinengende Bedeutung verliert.

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Ethics and Professional Duty of a Psychiatrist – Conflict and Intervention**

Yuri V. Popov (St. Petersburg)*

The author draws attention to the chance and the challenge of the new law of psychiatric care adopted in Russia. For him it allows to humanize psychiatric care as much as possible and to avoid those problems that took place in Soviet psychiatry. In a historical and an ethical perspective he considers possible collusions that can arise in consequence of professional duty which strictly obliges a physician to implement law and ethic standards. Specially, he sees the psychiatrist standing in the field of tension between moral principle, law of the state and the economical difficulties of a society. The author comes to the conclusion that the implementation of the new Russian law of psychiatric care is extremely difficult. It requires that for the patients' benefit the relationships between ethic standards and professional duty of the psychiatrist are transferred out of conflict towards a sphere of interaction.

The law of psychiatric care, as adopted recently in Russia, allowed to humanize psychiatric care in our country as much as possible, creating a foundation to avoid those misuses by psychiatry which were so much discussed during the last years of USSR existence. But even the best law cannot and must not precisely regulate the whole variety of relations between people. Especially relations between mentally ill persons and people surrounding them, i.e. society, cause some problems.

Surely some people may not agree with one of the main propositions of dynamic psychiatry which considers mental diseases not only as biological disorders but as a response of a personality towards various life situations. But it is impossible to neglect the immense influence of social factors on mental disease. Undoubtedly, this influence can be either useful or harmful for a patient. And taking into consideration the relativity of the notion »good« and »evil« as well as the fact that these notions are used by real persons having their own, sometimes very peculiar, understanding of what is good and what is evil, a law of psychiatric care is of special importance.

Unfortunately, psychiatric diagnosis is less determined than diagnostics in other fields of medicine. Thus psychiatry which takes a lot of subjective factors into consideration, remains most vulnerable for misuse of different kind. During all historical times and in all cultures stigmatization of a man as »mad« and diagnosis of a psychiatric disease sometimes were applied without justification. Reasons for that could be either personal motives including mercenary ones or political considerations. Sometimes this did not contradict the law. (Such abstract formulation as »disturbance of socialist community regulations« could be a reason for being admitted to a psychiatric hospital in the USSR.) But in any case it was an ethic breach, i.e. a

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** 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

breach of the whole complex of moral principles. Unfortunately, complete correspondance of moral principles and law clauses was in general not possible.

Law in jurisdiction is the highest manifestation of state power, i.e. establishing obligations (norms) of power, which are obligatory for everybody. As it is known, periodically power changes in any state. In accordance with this fact, laws are also changed including the Constitution as a fundamental law of a state. Laws are valid only legally; the more frequently they are changed, the less they lead to accustomed forms of the citizens' behaviour and activities. Ethics as manifestation of moral principles are less prone to alterations. Though from a historical point of view, the theory of ethics – I emphasize just theory – has undergone various changes in history. Remember *Plato,* for whom ethics and morals were divine issues; or further remember Aristotle, who considered a person's striving for delight and happiness as initial manifestations of morals. In his opinion it was the mind which gave highest happiness; and finally remember *Epicurus* with his utmost materialistic approach to the idea of happiness, ethics and morals.

All these standpoints – I repeat – only reflected historical changes of morals and ethic norms. A masterpiece of the theoretical development of ethics was the creation of Marxist-Leninist ethics as an outburst of revolutionary thoughts. In Marxism-Leninism, it is a classical point of view, that everything which promotes and supports the final goal – the victory of communism – is moral. Theory of ethics thus changed, but the main moral principles and norms of human behaviour practically remained unchanged during centuries. Russians will remember very well the existence of the moral code of communism, which repeated in most respects in an utmost concentrated form those ideas which are also expressed in the commandments of the Old Testament and in the Sermon on the Mount of the New Testament.

As for professional ethics, i.e. the whole complex of principles and behavioural norms for certain professional groups, also remained unchanged. This can be demonstrated in the field of medicine. The ancient text of the Hippocratic oath has been preserved, and each word of it can be confirmed by any modern physician. This is evident, because moral principles or ethics of behaviour were not »invented« by only one person. We may assume, that *Hippocrate* formulated and preserved the professional doctors' ethics as they had already been created before in the medical world. It would be naive to believe, that before *Hippocrate*'s formulations medicine was without any moral.

Only those moral principles and ethical norms which had turned out to be helpful for each individual and for society remained. The rest was eliminated during the long history of human existence. It was a sort of »natural selection« of man's norms for communication and social behaviour, serving everybody's welfare.

Undoubtedly, there exist some differences of these norms, depending on religious and ethnical factors, but this is a reflection of those cultural, climatic and even geographical variables by which populations differ. The principle is common to all: only that consideration or behaviour which helps man and society is consolidated in moral and ethic norms.

This fact may lead every professional doctor into a complicated situation: the conflict between his own wishes and emotions determined by his moral standpoint and the duty to be a citizen who obeys law. Another point of view which I highly respect is the fact that a physician, especially a psychiatrist, is the representative of a particular profession dealing with man and his soul. That is why he is obliged to implement moral principles and ethical norms. This may lead to an external conflict with the existing law. Fortunately, these situations are scarce. Mostly, a doctor has not to make a choice between these two poles in his practical work. When necessary, man usually chooses the »golden mean«. By the way, for Aristotle, the mid of extremes signified the embodiment of virtue. In his view, virtue has the purpose to strengthen a state, and a state should try to educate virtuous people.

The proposition that only a strong state is able to provide strict implementation of its laws and its steadiness can hardly be doubted. This is of special importance for Russia, where obedience of laws never was a main characteristic of the citizens, not even in times of high prosperity of the state. Without considering the various reasons of this phenomenon, one must mention one fact which promotes this non-obedience. In Russia, individual power always ranges higher than power of law. The solution »by conscience« of any conflict and not by law has always been considered as optimum. Partially due to this reason, Russian people always have been longing for religion which offered moral and spiritual laws. This was particularly true for those times, when lawlessness was most obvious in Russia. By the way, orthodoxy has preserved christianity in a most invariable condition.

As for the law of psychiatric care, its full implementation is extremely difficult at the present time. Let me emphasize: how can a psychiatrist fully provide human right and security if in some psychiatric hospitals there is room of less than two square meters for one mentally ill person? As proclaimed by law, the right of the mentally ill persons to »appeal« against all actions of health care bodies which infringe their rights and legal interests – either in procurator's offices or in court (article 22) – only exists in a certain degree. In this situation, doctor's morals and professional ethics – besides *Hippocrate*'s oath and ancient doctors' maxime »first of all do not injure« – are the most important starting points for the articles of law which have to be observed. Only interaction of professional ethics and a doctor's duty can provide the adherence of the patients rights and interests.

Ethos und Berufspflicht des Psychiaters – Widerstreit und Wechselwirkung

Juri W. Popow (St. Petersburg)

Das neu in Kraft getretene Psychiatriegesetz in Rußland ermöglicht eine Humanisierung der psychiatrischen Versorgung und schafft die Voraussetzungen, einen Mißbrauch der Psychiatrie zu verhindern, wie er in den letzten Jahren der Sowjetunion viel diskutiert wurde. Das Verhältnis

zwischen psychiatrischen Patienten und der Gesellschaft bleibt dennoch spannungsvoll. Auch wenn nicht jedermann bereit sein mag, die Annahme der dynamischen Psychiatrie zu übernehmen, wonach psychische Erkrankungen eine individuelle Antwort auf die Belastungen der jeweiligen Lebenssituation sind, kann der Einfluß sozialer Faktoren auf psychische Erkrankungen nicht übersehen werden. Da bei der psychiatrischen Diagnostik zudem die persönliche Einstellung eine große Rolle spielt, kam es nicht nur in der Sowjetunion, sondern in allen Zeiten und in allen Gesellschaften zu einem Mißbrauch der Psychiatrie zu politischen oder wirtschaftlichen Zwecken. Deshalb ist die gesetzliche Regelung der psychiatrischen Versorgung besonders wichtig.

Auf die Arbeit des Psychiaters wirkt sich auch aus, daß Moral und Gesetz nie vollständig übereinstimmen. Gesetze ändern sich zudem immer wieder in Abhängigkeit der Machtverhältnisse in einem Staat. Ethische Überzeugungen sind Änderungen weniger unterworfen; was sich jedoch wandelt, ist die Form, in der sie unterwiesen werden, wie ein Blick auf die Philosophie von *Plato, Aristoteles* oder *Epikur* zeigt. Auch der berufliche Ethos des Arztes blieb durch die Jahrhunderte hindurch nahezu unverändert; der Eid des *Hippokrates* hat bis heute für jeden Arzt Gültigkeit. Allgemein läßt sich sagen, nur was den Menschen und einer Gesellschaft hilft, schlägt sich in ethischen Normen nieder. Doch durch die nie aufzuhebende Kluft zwischen Gesetz und Moral kommt gerade der Arzt in einen Zwiespalt zwischen seinen ethischen Vorstellungen und seiner Pflicht als Staatsbürger; in noch größerem Maße gilt das für den Psychiater. Normalerweise kann er in solchen Fällen die »goldene Mitte« wählen, aus der nach Aristoteles die Tugend erwächst.

Bei der Einführung des neuen Psychiatriegesetzes in Rußland nun ist in Betracht zu ziehen, daß sich russische Bürger noch nie durch einen einfachen Gesetzesgehorsam kennzeichnen ließen: Immer stand die persönliche Macht über dem Recht, immer hatte die Entscheidung nach dem Gewissen eine höhere moralische Gültigkeit als die nach dem Gesetz. Zudem ist die Verwirklichung der Menschenrechte in der Psychiatrie erschwert, wenn derzeit in manchen psychiatrischen Einrichtungen den Patienten weniger als zwei Quadratmeter zur Verfügung stehen. Unter diesen Umständen kann nur ein Zusammenspiel von Ethos und Berufspflicht des Psychiaters – und nicht angeordnete Wahrung von Rechten – die größtmögliche Einhaltung der Interessen der Patienten gewährleisten.

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Right Hemisphere Insufficiency and Illness in the Context of Search Activity Concept**

Vadim S. Rotenberg (Tel Aviv)*

The author summarizes his concept of search activity as a general psychobiological mechanism which provides individual's development and discusses its theoretical and clinical implications. In the framework of his concept he sees psychic and psychosomatic disorders caused by a renunciation of search or by a misoriented search activity. As dreams, being a function of the right hemisphere, can restore the decreased search activity, a functional insufficiency of the right hemisphere displays a general predisposition to psychic and psychosomatic pathology. In his opinion, the restoration of search activity is based on the particular ability of the right hemisphere to produce a polysemantic context. The author suggests that psychoanalysis and other psychotherapeutic methods activate right hemisphere functions and that hereby their effectiveness can be explained.

According to the definition, search activity is oriented to change the situation or the subject's attitude to it in the absence of the precise prediction of the outcome of such activity, but by taking into consideration the accomplished outcomes at all stages of activity (*Rotenberg* 1984, 1993). The concept of search activity has initially been proposed in order to explain the complicated relationships between behavior, emotional state and body resistance. It was shown (*Rotenberg, Arshavsky* 1979) that flight and fight as well as self-stimulation of the emotionally positive brain zones display a tendency to block different forms of artificial pathology in animals (for instance experimental epilepsy, anaphilactoid edema, cardiac arrythmia etc.), while passive self-stimulation and freezing intensify all these forms of pathology.

It was necessary to identify some factors that determine the opposite effect ot these two groups of behavioral patterns on body resistance. It was not the difference between positive and negative emotions because passive and active self-stimulation both represent the positive emotional state, while fight, flight and freezing are related to the negative emotional state. It was also not the difference between general activity and passivity, because panicky behavior, accompanied by motor irritation, has a negative outcome for body resistance, while the inhibition of motor activity in a form of adaptive passive avoidance or startle reaction does not cause somatic disorders.

I have suggested that it is search activity and renunciation of search that determine body resistance and somatic health. Behavior of fight and flight types is classified as search behavior because in such behavior an attempt is

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** 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

performed to overcome or to avoid the obstacles, but the outcome of such attempt remains doubtful. Self-stimulation also acquires features of search behavior, for it is search for positive experience in the absence of a priory confidence in the success caused by the negative emotional component of active self-stimulation (*Grastyan* 1976). Self-stimulation is often produced from the same brain regions as exploratory behavior and positively correlates with such behavior (*Panksepp* 1982).

It is worth to emphasize that the positive outcome of search activity on body resistance and adaptation is determined by the process of search activity rather than by the pragmatic result of this activity, i.e. by the goal achievement. The final goal even not being achieved, the positive influence of the process of searching on the body health is present in any case. Such a positive outcome of search activity is a biological encouragement of this behavior.

Constructive aggression (*Ammon* 1970, 1993) is a manifestation of search activity, while psychosomatic disorders are characterised by the deficiency of the constructive aggression, i.e. by renunciation of search. According to *Ammon* (1993) the deficiency of constructive aggression depends on the early experience of hopelessness and helplessness caused by the lack of parental emotional support, which represents social energy, in early childhood.

The search activity concept can explain some clinical paradoxes. For instance, it is possible to explain the nature of the diseases of achievement. According to the concept, such diseases appear as a result of an abrupt decrease of search activity after achievement of a very meaningful goal. Another paradox which can be solved is the ambiguous role of type A behavior in the development of the coronary heart disease. Type A behavior was considered to be a behavioral predisposition to the ischemic heart disease. However, recent investigations do not confirm this assumption: restlessness, time urgency, unlimited activity (all components of the type A behavior which resemble search activity) are not related to the ischemic heart disease. Only the high competition, which is combined with other typical components of type A behavior in a part of all cases, is a real determining factor of ischemic heart disease and myocardial infarction. Competition can lead to the renunciation of search if the subject's attempt to be the best is unsuccessful, and such renunciation can be especially harmful if giving up is following a hard long-lasting activity. At the same time type A behavior without competition can have even a protective effect on heart: time urgency and emotional arousability are the inverse predictors of mortality in women with a premature acute myocardial infarction, while the relaxed type B behavior which is characterized by the low time urgency increases the risk of death in these patients (*Ragland, Brand* 1988; *Powell* et al. 1993). The authors are speculating that the absence of time urgency may be a marker of depression, but it is more reasonable to suggest that it is a marker of the reduced search activity.

Although every high-developed animal is born with the genetic prerequisites for search activity, its development depends very much on the experience in early childhood. The opposite situations appear to be equally unfavourable for the development of search activity: conditions, in which all actions of the subject provoke invariable resistance, and conditions, in which all desires are immediately satisfied without any efforts of the subject.

In animals search activity is accompanied by the hippocampal theta-rhythm and this rhythm is very good expressed in REM sleep. According to the search activity concept, REM sleep (which is associated with dream experience) is a psycho-biological mechanism that permits compensation for the biologically and psychologically harmful state of renunciation of search and ensures the restoration of search activity. All arguments for such a point of view are present in my previous publications (*Rotenberg* 1984, 1993).

The dreams of healthy subjects represent a very specific kind of search activity, however it fits in the definition of this notion. A subject is usually active in its dreams, but at the same time it is unable to make a definite probability forecast according to dream events. In face of it, the dream does not fit only in that part of the definition of search activity which emphasizes the permanent consideration of the behavioral outcomes. However, it is true only if the dream is not self-reflective and does not include self-control, if the activity in the dream is chaotic. According to the recent investigations (*Purcell* et al. 1993) in the vast majority of spontaneous dream recalls the dreamer is moderately self-reflective and partly effective in the dream control.

The dream presents a good opportunity for additional search activity after having given up during wakefulness. First of all, during the sleep the subject is separated from the reality, also including those aspects of reality which caused renunciation of search. Thus, the subject can start its search activity as from the beginning. Secondly, in its dream the subject is very free in its »behavior«: it can solve its actual problem in a metaphoric way, or it can solve another problem which displays the actual one, because the main restorative factor is the search process itself.

Moreover, in the dream subject is not restricted by the logical and conventional rules in the process of handling the problem. It is able to use right-hemispheric image thinking which is polysemantic in its nature and more flexible than logical thinking. It was confirmed in some investigations that the right hemisphere dominates during REM sleep (*Hirshkovitz* et al. 1979). However, it does not mean that all dream-like experiences are related to the right hemisphere. Some dream reports can be received even after callosal disconnection. But it is a problem for future investigations, whether »left-hemispheric« dreams are equal in their functions to right-hemispheric dreams.

According to my conception (*Rotenberg* 1979, 1985, 1993, 1994) the difference between the two strategies of thinking (which is commonly

associated with the function of the left and right hemispheres) is reduced to the opposite modes of organizing the contextual connection between elements of information. Left-hemispheric, or formal logical thinking, organizes any sign material (whether symbolic or iconic) to create a strictly ordered and unambiguously understood context. Its formation requires active choice from among innumerable real and potential connections between the multiform objects and phenomena of few definite connections. Such thinking will not create internal contradictions, will be most natural, and facilitate an ordered analysis. Such a strategy of thinking makes it possible to build up a pragmatically convenient, but simplified model of reality. It is based on the probability of forecasting and on the search for concrete cause-and-effect relations.

In contrast, the function of right hemispheric, or image thinking, is organized to simultaneously capture an infinite number of connections and to form an integral, but ambiguous context. In such context the whole is not determined by its components, since all specific features of the whole are only determined by interconnections between these parts. On the contrary, any concrete element of such context bears a determining stamp of the whole. The perception of each concrete moment is brought in correspondence with the entire past experience, with the already shaped picture of the world, which impacts to such activity the status of thinking. Individual facets of images interact with each other on many semantic planes simultaneously. The advantages of this strategy of thinking manifest themselves only when the information itself is complex, internally contradictory and basically irreducible to an unambiguous context.

As I have stressed in many previous publications, the right hemisphere and the polysemantic way of thinking play a crucial role in the psychological defense mechanisms (*Rotenberg,* 1982; *Rotenberg, Elizur* 1992):

1. All information is grasped by the right hemisphere before its conscious realization.
2. The self-image which integrates the human's behavior is based on the right-hemispheric image thinking and represents the conscious behavioral attitudes in the kingdom of unconsciousness.
3. A polysemantic context provides an opportunity for a more flexible handling of information, in comparison with a monosemantic context which is the basis of ordinary consciousness.

As a result, problems can be presented and solved in a very bizarre way, by using those relationships between objects and events which are not obvious and which are usually ignored by the consciousness. It is what typically happens in dreams and what makes them meaningful and remarkable. In healthy subjects, and especially in emotionally sensitive healthy subjects, the dream contents after awaking in REM sleep are extensive, rich and polysemantic. It provides an opportunity to find a new way for search activity. In addition, the formation of the polysemantic

context is less expensive for the human brain because it does not require the additional activation of the braain (*Rotenberg, Arshavsky* 1991). As a result, search activity in dreams can start in physiological conditions a relative decrease of brain monoamine activity (*Rotenberg* 1984, 1994) – which are inappropriate for search behavior during wakefulness.

However, in mentally ill persons (patients with depression, neurotic disorders, anxiety etc.) as well as in patients with psychosomatic disorders (*Rotenberg* 1988) the number of dream reports is decreased, the dream contents become linear and simple and they are loosing their polysemantic feature. Such simplification of dreams, their »exhaustion« up to the total disappearance of the contents, reflects, from my point of view, a functional deficiency of the right hemisphere to produce a polysemantic context and to perform all the above mentioned tasks which are so important for the psychological adaptation.

Another sign of the functional inability of the right-hemispheric image thinking is alexithymia. Alexithymia is characterized by the difficulty in distinguishing between feelings and bodily sensation, by the inability to express feelings, as well as by the lack of fantasy life, for instance reduced daydreaming etc. (*Rubino* at al. 1991). Subjects with alexithymia are not open to experience, they have impoverished fantasy. It is not a result of repression (*Newton, Contrada* 1994). It is worth to take into consideration that a human's emotions and feelings are polysemantic in its nature – it is impossible to explain the state of love exhaustively in a monosemantic unambiguous way, as well as other emotional states. Thus, the impoverished fantasy and poor imagination can be a natural reason of the main symptoms of alexithymia, i.e. the inability to feel and to express emotions.

This conclusion is in a good agreement with the numerous investigations which are displaying the role of the right hemisphere in perception and in processing of emotional experience (*Wittling, Rosenmann* 1993). It was shown (*Sackheim* et al. 1978) that emotions are expressed on the left side of the face: Left side composites were judged by healthy testees to be more emotionally intense than right side composites (*Sackheim, Gur* 1978). The conjugate lateral eye movements in response to the emotional questions are directed to the left, reflecting the activation of the right hemisphere (*Hugdahl, Carlgren* 1981).

During recent years the phenomenon of alexithymia has been discussed in the context of the interhemispheric transfer deficit (*Miller* 1986; *Zeitlin* et al. 1989; *Henry* et al. 1992). However, there are some direct evidences that alexithymia is related not to the interhemispheric transfer deficit of information, or at least not only to such deficit, but also to the functional inferiority of the right hemisphere. It was shown that alexithymia correlates with the right direction of the conjugate lateral eye movement (*Parker* et al. 1992). This is a sign that alexithymia is associated with the left cerebral lateralization and the dysfunction of the right hemisphere. It corresponds with the preoccupation with the details of external events in alexithymic subjects.

According to modern investigations, alexithymia characterizes not only psychosomatic disorders (*Alkin, Alexander* 1988), but also depression (*Parker* et al. 1991), bulimia nervosa (*Jimerson* et al. 1994), neurotic and psychotic disorders (*Rubino* 1993), posttraumatic stress disorders (*Henry* et al. 1992). Thus, it is possible to conclude that alexithymia, as well as the functional insufficiency of dreams, is the common feature of the wide rank of mental and psychosomatic disorders. It means that the dysfunction of the right hemisphere may be a general pathogenetic mechanism of these disorders. I have proposed this hypothesis in 1973, and the recent investigations are going to confirm it. These recent investigations are also in a good agreement with the statement (see *Ammon* 1993) that structural common features are to be found in psychosomatics, depression and schizophrenia, and the shifting of symptoms may occur in the course of these diseases. The inability to form a polysemantic context which is very much related to the Hole in the Ego (*Ammon* 1973) is the most common feature of these diseases.

In previous publications (*Rotenberg* 1993, 1994) I have suggested that the functional deficiency of the right hemisphere, the inability to produce a polysemantic context, may be caused by the lack of emotional relationships between the child and the parents. Such emotional relationships, being polysemantic in their nature, stimulate the development of the right hemisphere functions and correspond to these functions as a key to the lock. If these emotional relationships are insufficient, the right hemisphere will become inefficient, its contribution in psychological defense mechanisms and emotional stabilization will be lost, and it will be a general predisposition to the subsequent mental and psychosomatic disorders. All these suggestions are in line with the ideas of *Ammon* (1986) that the deficient parental emotional support predisposes subjects to the mental and psychosomatic disorders in future. The lack of the positive social energy in childhood is the main reason of the subsequent Hole in the Ego (*Ammon* 1973) which characterizes alexithymic persons. Some recent investigations confirmed this approach: the best predictor of alexithymia is having grown up in families with a lack of positive emotional communications (*Berenbaum, James* 1994).

If right hemisphere functional deficiency is a crucial point in the predisposition to different mental and psychosomatic disorders, it will be reasonable to suggest that different forms of psychotherapy are effective due to the restoration of image thinking, in parallel with the restoration of search activity. We have already discussed this topic previously (*Rotenberg, Arshavsky* 1987) and we have come to the conclusion that the importance of the emotional relationships between psychotherapist and client can be explained by the restoration, in the process of such relationships, of the right hemispheric activity. In this way the emotional relationships in the process of psychotherapy are covering the initial deficiency caused by the lack of emotional relations in early childhood.

Speaking about the different forms of psychotherapy, it is necessary, first of all, to stress the increasing role of art therapy in modern psychotherapy. Art therapy is addressed to the right hemisphere and is using right-hemispheric skills. Dance therapy and creative self-realization are successfully used in *Ammon*'s school of Dynamic Psychiatry as well as in the Israel Center of Rehabilitation through the Functional Art. All of them are related to the right hemisphere activity and stimulating its function. The therapeutic use of metaphors (*Trad* 1993, *Sledge* 1977) can partly be explained according to the same approach because metaphors are processed by the right hemisphere (*Winner, Gardner* 1977). Moreover, even the therapeutic effect of psychoanalysis can be explained according to the conception of the activation of the right hemisphere functions. The typical features of psychoanalysis – working with free associations, concentration on dream contents, flexible game with images and metaphors – they all correspond to the right hemisphere activity. It is very natural that the positive effect of psychoanalysis, as well as the positive effect of other psychotherapeutic methods, correlates with the restoration of spontaneous dream reports, which are related to the sufficient right hemisphere functions. In addition, in psychoanalysis the patient is trained to become an objective supervisor of his own problems, conflicts and mental processes, and this position helps to maintain search activity.

Thus, in conclusion I want to stress, that the functional insufficiency of image thinking predisposes subjects to different disorders (mental and somatic) by itself because it prevents the restoration of search activity.

Insuffizienz der rechten Hirnhemisphäre und Krankheit in Verbindung mit dem Konzept der Suchaktivität

Vadim S. Rotenberg (Tel Aviv)

Um den Zusammenhang von Verhalten, emotionaler Befindlichkeit und körperlicher Widerstandsfähigkeit zu fassen, hat *Rotenberg* den Begriff der Suchaktivität geprägt. Damit werden die Versuche bezeichnet, die ein Individuum unternimmt, um eine Situation oder zumindest seine Einstellung ihr gegenüber zu ändern, ohne das Ergebnis der Bemühungen genau vorherzuwissen. *Rotenberg* und *Arshavsky* (1979) konnten zeigen, daß bei Tieren die Aufnahme von Suchaktivität Krankheiten unterbinden kann, während der Verzicht auf Suchaktivität zu körperlichen Störungen führen kann. Es kommt dabei nicht darauf an, ob die Suchaktivität einen Erfolg erzielt, allein der Vorgang des Suchens stärkt die körperliche Gesundheit. Eine Ausdrucksform von Suchaktivität ist die konstruktive Aggression (*Ammon* 1970), wohingegen die defizitäre Form der Aggression einem Suchverzicht nach *Rotenberg* entspricht und von *Ammon* (1993) ebenfalls in Zusammenhang mit der Entstehung körperlicher Erkrankung gebracht wird. Daß manche Menschen nach Erreichen eines Zieles erkranken, kann

mit diesem Konzept als ein plötzlicher krankheitsbedingender Verzicht auf Suchaktivität erklärt werden. Auch wenn die Vorraussetzungen für die Suchaktivität genetisch gegeben sind, ist davon auszugehen, daß ihre Ausgestaltung von den Erfahrungen der frühen Kindheit abhängt.

Nach dem Konzept der Suchaktivität beinhaltet der REM-Schlaf und das damit verbundene Traumgeschehen die Möglichkeit, den biologisch und psychologisch schädlichen Suchverzicht zu kompensieren und die Suchaktivität wiederaufzunehmen (*Rotenberg* 1984, 1993). Denn im Traum befindet sich eine Person außerhalb der Realität, also auch außerhalb des realen Erlebens, das den Suchverzicht hervorrief, und in einem Zustand, der es ermöglicht, Probleme auf metaphorische Weise zu lösen. Zu diesen günstigen Wirkungen des Traumes hinsichtlich der Suchaktivität trägt ferner bei, daß während des REM-Schlafes die Aktivität der rechten Hirnhemisphäre überwiegt, also bildhaftes, polysemantisches Denken vorherrscht; gerade komplexe und in sich widersprüchliche Information kann dadurch besser verarbeitet werden.

Einhergehend mit einer herabgesetzten Aktivität der rechten Hirnhemisphäre ist bei Patienten mit Depressionen, Neurosen, Angstzuständen und psychosomatischen Beschwerden der Traumgehalt vermindert und vereinfacht. Ebenso sind bei psychisch Kranken Phantasie und bildhaftes Denken verarmt, was unter dem Begriff der Alexithymie zusammengefaßt wird. Auch für die Alexithymie wird eine verminderte Aktivität der rechten Hemisphäre angenommen. *Rotenberg* (1973) hat vorgeschlagen, die Insuffizienz der rechten Hirnhemisphäre allgemein als pathogenetischen Mechanismus dieser Erkrankungen anzunehmen. Diese Insuffizienz ist möglicherweise in der Kindheit durch eine gestörte emotionale Beziehung zwischen den Eltern und ihrem Kind entstanden. In einer Untersuchung konnte unlängst gezeigt werden, daß ein Mangel an emotional freundlicher Kommunikation in der Kindheit das spätere Auftreten von Alexithymie am besten voraussagen läßt (*Berenbaum, James* 1994).

Wenn die Annahme stimmt, daß eine Insuffizienz der rechten Hirnhemisphäre entscheidend für die Entstehung psychischer Erkrankungen ist, liegt es nahe, daß psychotherapeutische Verfahren wirksam sind, die bildhaftes Denken und Suchaktivität wiederherzustellen helfen. Die Beziehung zwischen Therapeut und Patient vermag dabei die emotionale Mangelsituation der Kindheit zu überwinden. Kunsttherapie und Tanztherapie beispielsweise, wie sie in der modernen Psychotherapie praktiziert werden, sei es in der Dynamischen Psychiatrie *Günter Ammons*, sei es im Israel Center of Rehabilitation, tragen wesentlich dazu bei, die rechte Hirnhemisphäre zu stimulieren. Dasselbe tut die Psychoanalyse mit ihrem Ansatz der freien Assoziation, der Traumdeutung und dem Umgang mit Bildern und Metaphern. Es ist deshalb naheliegend, daß ein Erfolg einer psychoanalytischen Behandlung mit einer Zunahme von Träumen einhergeht. Indem ein Patient lernt, sein eigenes inneres Erleben zu beobachten und zu verstehen, wird auch seine Suchaktivität angeregt.

Diese und andere therapeutische Verfahren vermögen es, die Insuffizenz der rechten Hirnhemisphäre aufzuheben und dadurch den Heilungsprozeß zu bedingen.

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Effectiveness of Neurosis Psychotherapy**

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After discussing the critical methodical aspects of psychotherapy and psychotherapy outcome research of the last 40 years, the author presents his criteria to make outcome research transparent and understandable. They are: – limiting the examination or unit of examination to only one disorder; – a clear definition of the notion of psychotherapy; – standardized measuring methods for change of the disorder. Methodology and results of an examination over a period of 10 years, according to these criteria, are presented and discussed. Two groups of neurotic patients have been examined: 947 patients, who have been treated in »open« psychotherapeutical groups, and 515 patients, who have participated in »closed« group therapies. Patients of closed groups (starting and finishing of therapy simultaneously for all members) have significant more breaking offs of therapy and less positive outcomes than open groups with starting point and end of therapy not being regulated.

Nearly 100 years have passed since the publication of the first psychoanalytical book (*Freud* 1895), and more than 40 years of discussion provoked by *Eysenck*'s famous paper on psychoanalytical psychotherapy ineffectiveness (1952) – at what point are we now, in 1994? Do we have one real evident proof of psychotherapy effectiveness?

In some moments of the past forty years, most papers concerning psychotherapy evaluation seemed to convince us that every psychotherapy is equally effective, mainly due to the curative influence of the correct patient-doctor relationship. In the explanation of this influence, the factors described by *Jerome Frank* (1961) as »nonspecific« as well as the healing factors of group dynamic processes defined by *Irving Yalom* (1975) were considered the most important. However, such approach, explaining simultaneously psychotherapy mechanisms and effectiveness, presents psychotherapy as a completely unspecific procedure, an element of every – professional or nonprofessional – healing activity. As a consequence, the question »Does there exist something specific and particular, named psychotherapy?« arises.

As another consequence, this approach supports the idea that psychotherapy can be helpful to people in different areas of human existence; i. e. in personal development and in interpersonal relations improvement, in sport competition, in business management and so on, even in solving social and international conflicts. Shortly – psychotherapy is considered effective not only in treatment of some disorders but also in making people richer and happier. As psychoanalysis some decades ago, psychotherapy was more and more pushed out from medicine, starting to be more psychological or unprofessional than medical business.

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** 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

Another answer to the question of psychotherapy effectiveness says that different procedures named »psychotherapy«, based on different theroretical approaches, are – in general terms – equally effective, though in different groups of patients. At first glance, this assessment sounds very good. It reminds of the obvious medical truism that in different illnesses triggered by different etiology, and having different mechanisms of disease, different treatment procedures must be used. Clear and reasonable formulation of the process' goals, existence of agreement between the patient and the psychotherapist as regards such goals and the way to achieve them, and so on, were considered as conditions of such effectiveness. Yet, this assessment stressing differences is rather far from recognizing the patients' psychopathology as the main frame of reference. Moreover, once more in the notion of »psychotherapy effectiveness«, »psychotherapy« is used in general terms, it occurs as a universal concept, in the global, general sense, and always an efficient procedure (*Bergin, Garfield* 1994).

Only very few papers present opposite data indicating, for instance, that only psychodynamic psychotherapy or only psychodynamic and behavioral psychotherapies are really effective, while others – like, e.g., gestalt or bioenergotherapy – are neutral or even harmful. In some of those papers the authors consider psychotherapy (especially psychodynamic psychotherapy) a very specific process, based on specific procedures – e.g. those leading to insight – effective only in treatment of psychogenic disorders. In other papers some forms of psychotherapy are presented also as effective in complex, more or less somatogenic disorders, e.g. psychodynamic psychotherapy in »psychosomatic« or cognitive approach in affective and schizophrenic disorders.

The difficulty of research and the discrepancy between the results obtained is sometimes considered as a result of the impossibility to decide one common set of criteria for measuring psychotherapy effects. It is obviously a very important problem. However, the postulate of measuring all psychotherapy results with the same measuring instruments seems to me unrealistic, not only because of the researchers' aspirations to construct their own methods. The idea of evaluating »psychotherapy effectiveness« seems to be false in general. Nobody tries to discuss »effectiveness of pharmacotherapy« in such general terms. Our conviction about effectiveness of pharmacotherapy is a sum of particular experiences concerning effectiveness of some drugs in certain illnesses – e.g., effectiveness of one antibiotic in one infectious disease. It might be more reasonable to learn from such medical experience and to postulate, for instance, a common battery for measuring effectiveness of different therapies in a chosen form of affective disorders, and not the effectiveness of one form of therapy in different illnesses. Since the variability of the psychotherapists' behaviour is evidently greater than that of drugs, such way might lead to the general conclusion on the psychotherapy effectiveness.

On the other hand, the current status of our knowledge is a result of the specificity of the most commonly used methodology of effectiveness

evaluation: meta-analyses. This procedure seems to be a great effort to compare the incomparable, moreover, using the methodologically doubtful notion of »average«. Different meanings of »improvement« and differences between the methods of measuring it, differences between the diseases treated by means of different psychotherapies and by psychotherapists having different skills and experiences, make all treatment results »average«. Inevitably, this must lead to the conclusion that all psychotherapies are equally effective. Yet, it seems important to recall that looking on »average« value is a very good scientific procedure for avoiding the error of measurement if we measure, for instance, the weight of one object. Yet, it is not so well justified, though commonly accepted, if we try to define differences between some traits of the examined groups. *Quetelet's* paradigma, formulated at the end of the 19th century and stating that differences between traits of objects constituting different groups can be determined with the use of the same method, proves good only to a very limited extent.

Perhaps one additional social factor also plays an important role in our tendency to estimate all psychotherapies effective. Such assessment is the only »politically correct« one. On the psychotherapy market we find different groups – »minorities«: medical doctors, psychotherapists, psychologists, priests, different groups of people (mostly former patients) devoting themselves to help suffering people, and so on. On this market we also have different schools, frequently led by charismatic leaders who fascinate people. The assessment of their activity effectiveness is not only the question of pure science, it is also the information about the right of those groups to be present on the market. To consider their activities generally equal also seems to be a condition of relative peace and quiet in the professional milieu.

I guess, like a hundred years ago, we can only believe in psychotherapy effectiveness, we cannot prove it. I think that there is nothing strange in it. What is more, both socio-economical reasons and methodological choices mentioned above render the chance of any real progress very doubtful. On the other hand, however, our scientific curiosity as well as exigencies of assurance companies induce us in repeated attempts to answer these questions.

It seems possible, though under certain methodological conditions.

It becomes more and more evident, for instance, that it is unreasonable and unjustified in the research on psychotherapy effectiveness to recognize different diseases treated by psychotherapy like one undifferentiated whole, one global variable. Just the opposite, current knowledge on psychopathology presents this area differentiated, both in clinical picture and in pathomechanisms of the illnesses. This leads to the paradigm of directing the therapy at a change within those factors which lead to the occurrence and duration of particular dieseases and to treat these changes as a criterion of effectiveness.

There is no other reason to use »psychotherapy« as a global variable either. There exists great variability in the psychotherapists' behaviour and

their experiences, »therapeutic ideologies« and aims. This promotes procedures offering an opportunity of analyses of multiple interfering variables, not only the differences between average values.

In my opinion, looking for a proper methodology, we must first reformulate the definition of psychotherapy – or rather come back to its genuine meaning. Psychotherapy is a therapy of the ill person by specific psychological means, changing selectively those psychological factors which are responsible for the disease. No other activities, not even those which are also a form of influencing the subjects' psyche and using psychological means – e.g., leading to personal growth, social skills improvement or to creativity – can be called psychotherapy. Contradictory to the different popular theories, from the point of view of clinical pathology, those factors can hardly be recognized as the causes of the person's disease. Not all human suffering or problems like lack of the sense of life or lack of certain performances, not all sadness and inadequate behaviour, are symptoms of an illness.

Thus, the frames of psychotherapy should be designated by our current knowledge of psychopathology and an individual psychodynamic diagnosis. As far as this knowledge is realistic and adequate, we can formulate what is really curative. This means that we have no right to estimate all positive (secondary) benefits from psychotherapy as a positive treatment results – neither the growth of personal freedom nor well-being based on feeling proud of certain symptoms or positive valuation of some extraordinary behaviour. Only those changes, which are evidently and directly connected with improvement of the patients' health condition deserve to be named therapy effects.

Unspecific treating factors, being a powerful aspect of every treatment, have a lot in common with so defined psychotherapy, but they are not specifically oriented (excluding some particular situations) at the change of particular traits of psychopathology of the person, defined as the source of illness.

At this point, it seems important to differentiate psychotherapy from psychological help in treatment. It is a very important addition not only to the specific medical treating procedures. To help someone incurably ill to endure suffering or to find her/his place in the world, to diminish anxiety and/or loneliness, is sometimes more valuable than medical procedures. To assist a severely ill or dying person is undoubtfully one of the most dramatic of such tasks. Thus, we have to consider different forms of psychological help as a very important aspect of treating procedures. They cannot be named, however, a therapy.

To introduce some order in our thinking on the different activities named psychotherapy seems to be the second condition, making the construction of effective methodology of treatment results possible.

The consecutive step is to find or construct instruments for measuring changes in those main pathology features. Those instruments must be of

course different in the treatment of different diseases – e.g. in the case of neurotic disorders other than in the case of affective disorders, schizophrenia, disfunctions caused mainly by psychogenic factors – like hypertonia, and so on. Using such standardized and normalized instruments before and after treatment we can evaluate some changes being therapy effects.

Normalization of those measuring instruments offers a very important opportunity: a chance to assess the state of cure (if the outcome results of measurement are like those obtained in the group of »normal« subjects). One of the crucial points is to replace the notion of »improvement« by the notion of »cure«. This postulate can be interpreted as over-optimistic expectation of our treating opportunities. We frequently do not take into consideration however, that even a significantly improved patient still remains ill! The evaluation of treatment effects in terms of different levels of improvement (or lack of change or deterioration) says nothing about the real therapy effectiveness.

In this, the patients' self-assessment as well as the therapists' (subjective or »independent judge«) assessment of therapy effects seems not so valuable a source of information as we commonly believe. Most of the patients describe their results better than it is shown by intermediate measurement results (e.g. questionnaires). The patients' opinions depend upon different factors: wishful thinking, relation with the therapist, perception of different aspects of change (not only connected with the illness and its therapy) and so on. The therapists' assessments are also hardly consistent with the intermediate, objectivized measurement. Even »independent judge« impressions depend on his/her theoretical approach and »therapeutic ideology«, on the personal relationship with the therapist, the patient, and institutions, etc. – and, last but not least, on his/her salary.

It also seems unreasonable to evaluate effects in follow-up studies. Such investigations provide good information about the patients' state after treatment or the stability of results, but not about the particular therapy effectiveness. Most of the patients who do not improve in one therapy, look for another therapy within 2 months after outcome.

Those methodological rules of studying psychotherapy effects are tested in our department from some 10 years (*Aleksandrowicz* et al. 1989). The subject were the neurotic diseases treated by complex programme, based on psychodynamically oriented group psychotherapy. The background of the measuring effects was the theoretical assumption that neurotic disorders are a particular illness, in which the occurrence of the various dysfunctions of psychic, somatic and behavioral aspects of the person's global activity, is a result of particular personality disorders, mainly deficits. This means that this person's ego defences and/or coping mechanisms are insufficient to cope with the current (in the chronic states – average) exigencies of reality. Assuming the social role of an ill person, such individual can find a temporary solution of his problems (though

paing for this by suffering) as well as an opportunity to communicate the content of his/her unconscious problems, using the symbolic meaning of the symptoms. This induces the individual to use a particular form of language – in which symptoms play the role of words – in communication with other subjects – »poles« in his/her psychosocial field (*Aleksandrowicz* 1984).

Following such understanding of neurotic diseases, two main parameters of the patients' clinical state seem to be of primary importance: the presence and intensity of symptoms (presence of neurotic language) and the personality disturbances, making it necessary to use this language (*Aleksandrowicz* 1984). This concept of neurotic disorders psychopathology is compatible with the notions of DSM-IV axis I and axis II. Consecutively, two relatively dependent criteria decide on the therapy effects assessment: 1. The change of symptoms' quantity and intensity; 2. The change of chosen personality traits.

For measuring changes in neurotic symptoms we use a symptom checklist, derivative on SCL-90, but more specific by exclusion of psychotic and paranoid items. Scoring the answers »no symptom« as 0, »weak discomfort provoked by symptom in the past 7 days« as 4 points, »moderate discomfort« as 5 and »severe discomfort« as 7 points, we calculate a simple sum of points – »Global Severity Index«.

The most commonly used form of this SCL consists of 138 items, and its norm for women is from 0 to 200 points, for men from 0 to 165 points (normalisation on the 2026 patients and 800 untreated persons). This means that under 200 points (for female patients) and under 165 (for males), symptoms can be not neurotic or only »psychophysiological«, not forming this particular entity – the neurotic syndrome.

As regards particular personality traits, a certain method to measure them, at least intermediary, was established experimentally. Examining neurotic patients' populations by different personality tests – like MMPI, ACL, Thurstone and others, we find interesting data in 16 PF Cattel Test (see table 1). In 13 from 16 scales 30% or more of neurotic patients present the extreme (low or high) results. Patients with other disorders – e.g., personality disorders – have such extreme values in scales or areas other than neurotic patients. This offers the opportunity to determine two »indexes« – NDI (Neurotic Disintegration Index) and GDI (Global Disintegration Index) (see table 2). NDI was normalized on the population of untreated persons and verified on the population of patients. Both indexes offer some opportunity of diagnostic and comparative, i.e., treatment effects, assessment.

16 PF CATELL																	
FACTORS:	A	B	C	E	F	G	H	I	L	M	N	O	Q1	Q2	Q3	Q4	normal distribution
%	18	15	1	6	7	22	6	49	33	37	8	71	4	14	5	69	
10	•	•	•	•	•	•	•	▒	▒	▒	•	▒	•	•	•	▒	2%
9	•	•	•	•	•	•	•	▒	▒	▒	•	▒	•	•	•	▒	5% 16%
8	•	•	•	•	•	•	•	▒	▒	▒	•	▒	•	•	•	▒	9%
S 7	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	15%
T 6	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	19%
E 5 %	60	50	30	62	57	64	53	46	58	60	57	28	62	60	63	30	19% 68%
N 4	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	15%
3	•	▒	▒	▒	▒	•	▒	•	•	•	▒	•	▒	•	▒	•	9%
2	•	▒	▒	▒	▒	•	▒	•	•	•	▒	•	▒	•	▒	•	5% 16%
1	•	▒	▒	▒	▒	•	▒	•	•	•	▒	•	▒	•	▒	•	2%
%	22	35	69	32	36	14	41	5	9	3	35	1	34	26	42	1	

Tab. 1: 16 PF CATELL Test (n = 560); black: »neurotic areas« of results

$$\frac{(\text{INDEX VALUE* BEFORE TREATMENT} - \text{VALUE AFTER TREATMENT})^2}{\text{GREATER VALUE x MAXIMAL VALUE}}$$

*VALUE of Symptom-Checklist GLOBAL SEVERITY INDEX
or
Personality Test NEUROTIC DISINTEGRATION INDEX

as well as the degree and direction of change, indicated by those calculations results:

between	0,99	and	0,1	– significant improvement
between	0,099	and	0,01	– moderate improvement
between	0,0099	and	–0,0099	– lack of improvement
between	–0,01	and	0,099	– worsening
between	–0,1	and	–0,99	– significant worsening

Cure: at the moment of outcome or follow-up measurement results of GSI like in the control (untreated) population and results of NDI like in the control population.

Tab. 2: Comparing the GSI and NDI before and after treatment, we can evaluate the degree and direction of change

Such methodology makes possible different comparative studies. The sample of those opportunities and their use may be a comparison between »open« and »closed« groups effectiveness.

Group psychotherapy is led mainly in the form of »closed« groups, where patients start psychotherapy together on the same day and end therapy on another day, after a certain number of sessions. Dynamic processes of such groups are more clear and relatively easy to control, therapists have to work with the same persons for a longer time, so there are numerous reasons for preference of such procedure. On the other hand,

great percentage of patients drop-out from such groups at different moments, especially in the second part of the contracted time.

The question is, which method is more effective: the »closed« groups psychotherapy or the »open« one, i.e. accepting new patients in place of the persons ending their therapy. In the investigated groups those exchanges were one patient a week on the average.

Symptom improvement

	»open« groups 947 ss.		»closed« groups 515 ss.		stat.sign.	
		%		%		
cure	432–	45,6%	176–	34,2%	x = 7,61	p<0,01
significant improvement	145–	15,3%	72–	14,1%	stat. negligible	
moderate improvement	171–	18,1%	128–	24,8%	x = 6,16	p<0,05
lack of improvement	121–	12,8%	90–	17,5%	x = 4,41	p<0,05
worsening and significant worsening	78–	8,8%	49–	9,5%	stat. negligible	

Personality change in 16 PF Cattell Test

	»open« groups 929 ss.		»closed« groups 451 ss.		stat.sign.	
		%		%		
cure	360–	43,7%	112–	24,8%	x = 20,03	p<0,001
significant improvement	146–	17,6%	69–	15,3%	stat. negligible	
moderate improvement	133–	16,0%	121–	26,8%	x = 13,94	p<0,001
lack of improvement	95–	11,5%	82–	18,2%	x = 8,25	p<0,01
worsening and significant worsening	95–	11,5%	67–	14,9%	x = 4,9	p<0,05

Tab. 3: »Open« and »closed« psychotherapy groups effectivity in neurotic disorders

We had a chance to compare therapy effects of 947 patients treated in open groups and 515 patients treated in closed groups in the same day hospital, in ca. 10 years (mean value of treatment time: 10 weeks, 150 hours/ combination of family therapy, individual and group psychotherapy). Obviously, the therapeutic staff changed during this period, and in some periods more patients were treated mainly in closed or in open groups, which made the therapy effects dependent also on the staff members' experience and other traits. The main style and theoretical background of the therapy remain unchanged however, so the comparison of the influence exerted by »openness« and »closeness« of the therapy system seems to be possible.

In some cases the lack of information concerning personality change is a result of drop-outs (in such cases, information concerning symptoms intensity comes from the last Monday before drop-out). This leads to the first evident observation: the number of unfinished treatments is significantly greater in the closed groups (12,4%) than in the open ones (1,9%)!

The second, and perhaps more important observation, is the difference between percentage of cured patients. In the open groups such percentage is greater (statistically significant difference in symptoms change as well as in the personality change dimensions) than in the closed ones.

Moreover, the percentage of moderate symptom improvement and lack of improvement is greater in closed groups. As regards personality changes: moderate improvement, lack of change and worsening percentages are greater in those groups.

Those results could have evident interpretation. Due to the different time needed to cure, in the closed groups only a few need for cure exactly as much time or as many sessions as was presumed before therapy and agreed in the therapeutic contract. Some patients stay in treatment longer than necessary (e.g., for the benefit of the whole group), for most of them therapy is usually interrupted at the moment of outcome. In the case of open groups, the end of treatment is decided upon flexibly, and mainly directed by the patient's progress in therapy. This, from the very beginning, makes the treatment conditions in closed groups less favourable than in open groups.

Such conclusion could be formulated theoretically, without any research, but in the clinical practice it is not so easy to realize even such simple facts. The result of research helps not only to realize the presence of such conditions but also the degree of their influence on the treatment effects. To obtain this kind of data, methodology and methods presented above could be very helpful.

This system is still far from precision. It surely must and will be evaluated in the future. Especially, the personality change measurement could be more specifically oriented at the traits connected with neurotic personality. This, however, requires the construction of a new, really specific »neurotic personality« test. Symptom checklist construction also seems to have some

weak points, and the first step to make it more reliable has already been desribed. But the need of developing instruments is clearly evident.

The hard work of creating similar systems of measuring effects, appropriate to different clinical unities, seems to be an interesting challenge. The aim of this paper is to present the main methodological rules of constructing such systems rather than to promote described proof of its application for measuring the effects of neurotic disorders psychotherapy.

Wirksamkeit von Neurosenpsychotherapie

Jerzy Aleksandrowicz (Krakau)

Kritische Einwände gegen einen Großteil der üblichen Psychotherapie- und Psychotherapieeffizienzforschung der letzten 40 Jahre sind u.a.:
– eine globale und generalisierende Begrifflichkeit, die u.U. keine Klarheit gibt über die eingesetzten psychotherapeutischen Verfahren;
– die Unmöglichkeit, Konsens darüber zu erreichen, was als Therapieerfolg zu verstehen ist und vergleichbare Kriterien zu entwickeln;
– die Nivellierung einer Vielzahl interferierender Variablen auf eine Mittelwertsebene bei Metaanalysen und
– häufige Undurchsichtigkeit des Zwecks der Studie.

Um die Transparenz und Nachvollziehbarkeit von Forschungen zur Psychotherapieeffizienz zu ermöglichen oder zu erhöhen, sollten folgende Kriterien Berücksichtigung finden: Je eine Untersuchungseinheit soll sich auf ein Krankheitsbild beziehen. Der Begriff der Psychotherapie muß definiert sein: Psychotherapie ist eine Therapie der kranken Person, die speziell diejenigen psychologischen Faktoren verändern soll, die für die Erkrankung verantwortlich sind. Nicht einbezogen in diesen Begriffshorizont sind Maßnahmen, die beispielsweise über Verhaltenstraining oder dem Training sozialer Fertigkeiten auf eine Veränderung der psychischen Befindlichkeit abzielen und auch psychologische Hilfe bei schwerer körperlicher Krankheit. Zu berücksichtigen ist ebenfalls, daß nicht allen Beschwerden Symptomwert zukommt und nicht alle positiven Veränderungen während des therapeutischen Prozesses Veränderungen im Sinne dieser Definition bzw. Heilung sind. Meßinstrumente müssen zum Einsatz kommen oder entwickelt werden, die standardisiert sind und Veränderungen in der Psychotherapie differenziert erfassen. Die Einschätzung des Therapieerfolgs durch den Patienten und den Therapeuten sind keine Kriterien zur Beurteilung der Effizienz.

Der Autor stellt aus seiner Arbeit eine nach diesen Kriterien konzipierte Therapieeffizienzstudie an neurotischen Patienten vor, die im Durchschnitt in einer Tagesklinik 10 Wochen bei insgesamt 150 Stunden Psychotherapie (Familien-, Einzel-, Gruppentherapie) behandelt wurden. Die Untersuchung bezieht sich auf 947 Patienten, die an einer sog. offenen Gruppen-

psychotherapie teilgenommen haben, und auf 515 Patienten einer sog. geschlossenen psychodynamisch orientierten Gruppentherapie. Die Diagnosekriterien entsprechen DSM IV (Achsen 1 und 2).

Zwei voneinander abhängige Kriterien werden zur Beurteilung des Therapieverlaufs herangezogen, nämlich die Veränderung in Ausmaß und Intensität der Symptome und Veränderungen der Wesenszüge (traits) der Persönlichkeit. Zur Messung der Symptome dient eine modifizierte Form der SCL 90. Zur Persönlichkeitstestung wurden Verfahren wie der MMPI, ACL, Thurstone u.a. herangezogen, wobei Ergebnisse des 16 PF Cattell-Tests in 13 von 16 Skalen Extremwerte für neurotische Patienten aufweisen. Der NDI (Neurotic Disintegration Index) und der GDI (Global Disintegration Index) wurden zur Veränderungsmessung herangezogen. Unter geschlossener Gruppe ist zu verstehen, daß Beginn und Ende der Gruppentherapie für alle Teilnehmer der gleiche Zeitpunkt ist, unter offener Gruppe ein fließender Wechsel in Aufnahme neuer Gruppenmitglieder und Beendigung der Therapie.

Der Vergleich zwischen beiden Gruppen zeigt:

1. Es finden signifikant mehr Abbrüche in der geschlossenen Gruppe statt (12,4%) als in der offenen (1,9%).
2. Ein mittlerer Grad der Verbesserung und das Fehlen einer Besserung ist in der geschlossenen Gruppe größer, gleiches gilt für die Persönlichkeitsveränderung.

Gründe hierfür dürften darin liegen, daß die Dauer der Therapie vorgegeben ist und sich nicht daran mißt, was der Patient braucht, wodurch manche zu lange in der Gruppe sind und für andere die Beendigung einen Abbruch bedeutet. In der offenen Gruppe ist der Zeitrahmen dagegen flexibel und abstimmbar auf die individuellen Fortschritte der einzelnen Patienten.

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Positive Family Therapy – A Holistic and Transcultural Approach***

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Positive Psychotherapy and Positive Family Therapy, founded by Nossrat Peseschkian, is a conflict-centrated short-therapy which belongs to the humanistic psychologies. This method bases on three pillars: The positive concept means that man is good by nature, and that through the use of positive interpretations and stories, the self-help potential of the patient can be mobilised. Examples from other cultures are used for broadening of the perspective. The balance model looks at man as a unity of body, mind, emotions and soul. Positive Psychotherapy encourages the client to see his own capabilities and establish a balance in his daily-life through the development of his physical, intellectual, socio-emotional and spititual capabilities. The five-stage-integral therapy encourages the patient to become a therapist for his own environment and family. Here he learns communication and consultation techniques how to get from the conflict to its solution. The use of other psychotherapeutical methods helps to be flexible and to orient to the needs of the patient. Positive Psychotherapy and Family Therapy has been introduced in more than 60 countries, and beside the headquarters in Germany, there are 20 centres and an association for Positive Psychotherapy now existing in Russia and other former Soviet Republics.

»If you think of a year, then plant a seed.
If you think of a decade, then plant a tree.
If you think of a century, then educate a human-being.«

(Oriental Wisdom) (from: *H. Peseschkian* 1993)

A few years before the transition into the next millennium, our society finds itself in a deep worldwide crisis. It is a multidimensional crisis whose facets influence every aspect of our life – our health and life-styles, our economics, technology, ecology and politics. It is a crisis with intellectual, moral and spiritual dimensions, unique in world history. This crisis faces us with enormous conflicts on the one hand, and with unique opportunities and challenges on the other. This new situation challenges psychotherapists in a very special way – we have to search for new approaches and concepts for life during this transitional period, or, as stated by *Günter Ammon* in his welcoming words to the 10th World Congress, »...let us find unusual thoughts and methods for our unusual patients«.

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*** Short version of this article was presented as a lecture 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

The situation in psychotherapy today requires the development of methods which are both economical and effective. Positive Psychotherapy and Positive Family Therapy want to contribute with their holistic and transcultural approach in psychotherapy to some of the needs of today's clients and patients. This method of therapy and self-help has been developed by *Nossrat Peseschkian* since 1969 and is based on his researches in more than 20 countries, and it belongs to the so-called Humanistic Psychological Methods. This conflict-centred short-term method has been officially accepted by the State Medical Chamber in Hessen/Germany for the postgraduate training of medical doctors in psychotherapy and psychosomatics (»Zweitverfahren«), only about 10 methods out of approximately 250 have this status in Germany. The aim of the present authors is to acquaint the reader with some of its basic principles based on our experiences in applying this concept to the needs of the people in Russia.

The Positive Image of Man

In the above mentioned welcoming address, *Günther Ammon* asks: »...can we change the human personality structure?« This leads us to the question, who is man and what are the different aspects of our humanness. In psychotherapy and psychiatry this question is directly linked with the image or concept of man of the therapist himself and of the method he uses. Traditional psychotherapy derives its view of man from psychopathology. Thus, the object of its investigation are illnesses. The goal of the treatment is to remove these symptoms and disorders. While many of the existing psychotherapeutic procedures take as their starting point the disturbances and illnesses, prophylactic preventive medicine and psychotherapy require another approach, which starts with a person's developmental possibilities and capacities instead of the disturbances.

Positive Psychotherapy has a new, positive image of man, based on the conception that every human-being has two basic capacities: The capacity to love, and the capacity to know (see graphic no. 1).

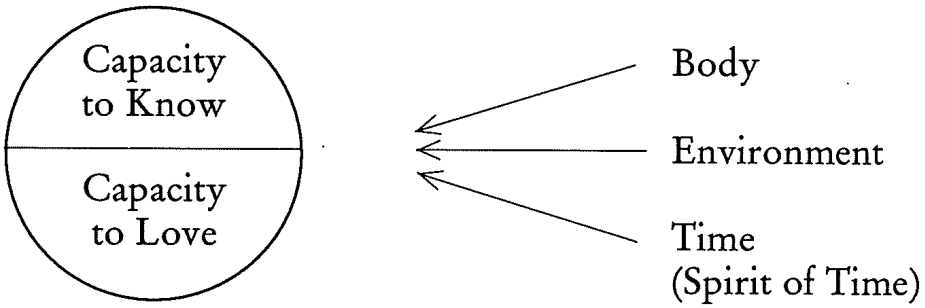

Fig. 1: The basic capacities and their conditions for development

These two basic capacities are already existing in man at his birth, but they have to be developed trough education and socialisation. The capacity

to know represents the rational part of man, and the capacity to love the emotional one. Because every human-being without exception possesses these two basic capacities, we say that man is essentially good by nature. This concept of man has now far-reaching consequences; it means that psychiatric patients, mentally or physically ill persons, even a murderer, have these capabilities and potentials. Besides being a great encouragement for every patient, this new concept of man plays an important role during the whole treatment and therapy. It further means that every human-being consits besides his body, of a mind and an immortal identity, which we call soul or human spirit. Whereas body and mind can be afflicted by illnesses and disorders, the soul, being non-material by its nature, cannot. But mental illnesses can afflict the mind in a way, that the soul cannot show its full capabilities anymore. As every worldview is based on some philosophical and ideological teachings, so is this concept. This image of man of Positive Psychotherapy has been inspired by the principle of the Bahá'i Faith, that »man is like a mine rich of gems of inestimable value«. Every person has at his disposal the two basic capacities which open up to him a broad range of possibilities. In accordance with the conditions of his body, of his environment, and of the time in which he lives, these capacities are differentiated and lead to an unmistakable structure of essential traits. This positive image of man influences now the concept of Positive Psychotherapy in different ways.

The Positive Approach in Positive Family Therapy

Positive is meant here in its original sense, i.e. Latin: positum, the factual, the given. And given are not only the illnesses and disorders of a patient, but also his capabilities. His capability to deal with the illness, to become healthy again, and all the other creative and constructive parts of man. Often patients do not suffer only because of their illness, but because of the hopelessness introduced through the diagnosis. One could say, that symptoms can be looked upon as the pique of an eisberg, whereas the main part, which as we know, is often unconsciously, exists of conflicts which led to the symptoms. Whereas in traditional medicine we concentrate often on the symptoms of our patients, and the aim of the treatment is the removal of the symptoms, in Positive Psychotherapy we try to leave the symptoms and to get to the contents of the conflicts. This approach of a holistic understanding of illness is very close to that of *Ammon*'s Dynamic Psychiatry (*Ammon* 1979).

This is achieved through the positive interpretations of illnesses and disorders, whether of psychiatric or somatic genesis:

- Depression is interpreted as the capabiltiy to react with deep emotions on conflicts.
- Frigidity is the capabiltity to say no with one's own body.
- Fear of loneliness is the desire to be with other people and the wish for social contacts.

- Schizophrenia is the capability to live in two worlds at the same time. To escape into another world (of fantasy), not caring for what other people think and say.
- Diabetes mellitus: To give oneself the warmth, one does not get from others.

This positive approach helps the patient to change his point of view, and is a basis for the therapeutic co-operation with the patient which helps to deal with the existing problems and conflicts. With the help of stories, parables, anecdotes and mythologies, the patient's door to fantasy is opened, and new approaches can be tried of which the patient was unaware earlier. The stories are applied in Positive Psychotherapy individually, and they are used in nind different ways (*N. Peseschkian* 1982).

The transcultural approach in Positive Psychotherapy is based on the two questions:

- What do all people have in common?
- By what do they differ?

With the help of examples form other cultures – each family actually has its own culture – the patient is confronted with new ways how to face a certain situation and problem, and this leads him to change of his own perspective and stand point. Transcultural in this sense means, how do people form another cultural background deal with the same problem or situation. The patient learns the relativity of his own behaviour and sees new potential approaches. So, the transcultural approach has also a wider consequence in the political sense. Through it we learn to understand other people and cultures better, and this can lead us to the abolishment of prejudices of different kinds.

The Balance Model and its Four Aspects of Life

We had compared the human capabilities with diamonds and gems. To stay with this example, we could state further that as gems need some endeavour and work in order to become very precious, the same is with our human potentials which have to be developed through a processs which we call education in the broadest sense. Researches of *Nossrat Peseschkian* et al. in different cultures have shown that there are four ways how people react to conflicts, and four spheres of life in which we invest our daily time and energy. This Balance Model (see graphic no. 2) is based on the holistic concept of man and his capabilities (*N. Peseschkian* 1987).

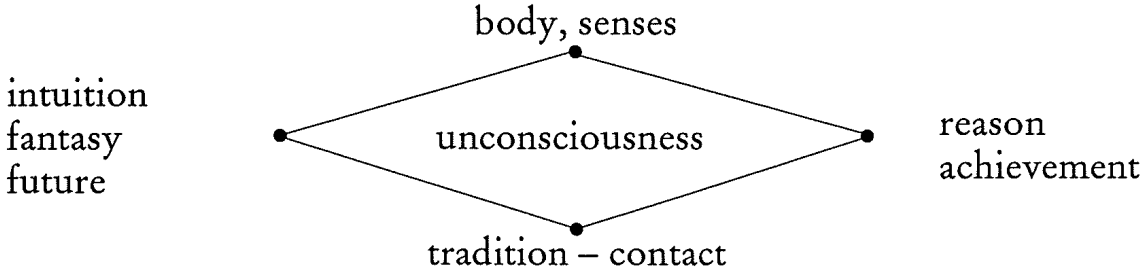

Fig. 2: Model functions in the development of the four modes of the capacity to know

In this sense, we speak about the physical (biochemical, genetical), intellectual, socio-emotional and spiritual capabilities of man. Everybody has them latent in himself, and according to our education and culture some are more developed and emphasized than others. Disorders or illnesses are caused by some imbalance in this model, and the aim of the therapy is to help the patient to develop those potential capabilities, which he has not developed up-to-now. So, we do not give the patient something new, but we help and encourage him to develop by himself his potiential. In conflict situations, we react either through our body with illnesses or much physical activity, through our achievement with too much or too less work, through our sphere of contact with a lot of contacts or escape into loneliness, or through escape into our fantasy or creativity. According to Positive Psychotherapy a person is healthy over the long run, if he puts his energy – not necessarily his time – in all these four aspects, and tries to be more or less in balance. Of course, the individual's situation must be bear in mind, so, balance has for everyone an personal meaning. But the basic idea is, that by neglecting one or more of these spheres, one sooner or later, suffers and becomes ill. Our transcultural researches have shown that people in different cultures react in a quite different way to problems. Whereas in countries such as Germany, the most energy is invested in the spheres of physical health (body) and job (achievement), in Oriental countries most of the energy is spend for guests (contact) and questions about the future, the purpose of life and spiritual questions (fantasy). In Russia now, a country which is not only geographically but also psychologically between East and West, we found out that most of the energy is put into daily work (achievement) and contacts with family, guests and friends (contact) (*H. Peseschkian* 1993).

The Balance Model is not only used in the treatment, but also in the prevention of illnesses and problems. And also the whole therapy in Positive Psychotherapy orients at these four aspects of life. Therefore we include in our therapy body-oriented methods, rational approaches, different kinds of sociotherapy, and methods such as logotherapy which are oriented towards the purpose of life and future. The positive image of man of Positive Psychotherapy also greatly influences the attitude towards the future of the patient. Whereas some methods concentrate mainly on the past experiences made by a person, we concentrate during our treatment about 20% on the past of the patient, 30% on his present situation, and more than 50% on his future life and plans. This itself is encouraging the client that he is responsible for his own life and happiness, and that he can be very creative for his own future.

In Positive Psychotherapy the patient gets already from the very beginning a very active role and is being encouraged to become a »therapist« for his own family and environment. Through a therapeutic strategy the patient is already in the first interview and later during the therapeutic sessions assisted and encouraged to give up his passsive role, and to develop

by himself all his potentials. The involvement of the family and the patient's environment is of paramount importance, if we bear in mind that our patient is often not the »real« patient, who is often »sitting« at home. Our patient is often just the bearer of the symptoms.

The Five-Strategy of Therapy and Self-Help

In the frame of psychotherapy and self-help, Positive Psychotherapy uses a five-stage-approach, which consists of the stages of observation/distancing, inventory, situational encouragement, verbalisation and broadening of goals. In each stage stories and anecdotes are introduced, in order to help the patient to leran the deeper meaning of the stage and to apply its meaning in his life. Besides this, the stories are functioning as small »psychotherapists« for the patient, due to their prolonged effect, and so he can apply them outside of the therapeutic chamber – in his daily life.

1. Stage of Observation and Distancing:
The aim of the observation is an analysis of the patient's situation. This is to help him to proceed from an abstract to a concrete descriptive level. The patient gets a chance to step back from his own situation (distancing). Here the patient writes down those situations in which his symptoms appear or worsen. Already at this stage a process of differentation begins and the patient learns to describe the contents of the conflict.

2. Stage of Inventory:
In the therapy session, the assignment consists primarily in clarifying the learning history with regard to the individual actual capacities and modes, as well as making the background of the consepts and misunderstandings transparent to the patient. The attitudes, which as a rule seem to the patient to be unchangeable and bound up with his personality, are relativised on the basis of their presuppositions in the life story. Through the help of the Differentiation-Analytic Inventory (DAI) (*N. Peseschkian* 1987), the patient's experience or that of his partner is grasped as positively and negatively valued attributes. The differentiation, which the therapist accomplished in the first interview mainly for diagnostic reasons, is carried out by the patient and deepened in the therapeutic dialogue, with inclusion of the specific basic conflict. The first and second stage are actually included in the first interview, which is a half-structured interview.

3. Stage of Situational Encouragement:
At this stage, the patient is directly employed as therapist of his milieu, and especially of his conflict partner. Instead of critisizing the conflict-partner, the patient learns to encourage him, because of the positive capabilities the other has, and which have been made conscious to the patient through the prior two stages.

4. Stage of Verbalisation:
Here the patient is encouraged to talk on a more mature level than before with his conflict-partner. He is taught different tools and techniques of com-

munication and consultation, with which he starts the conversation at home. The concept of the family or partner council (group) is introduced at this stage, and the family members are included into the therapy.

5. Stage of Broadening of Goals:

This stage actually accompanies the patient during the whole therapeutic process. It means nothing less then the question: »What are your plans after you will have solved all your present problems?« The patient acquires the ability to himself develop activities, to enjoy them and to develop all his capabilities and to put emphasize on all the four spheres of life. This prevents the repetition of the neurotic concept of the past, and avoids that the problem becomes the centre of life. The patient learns to shape his life anew and to envision goals which he has not pursued before because of his neurotic behaviour and which were driven into the background.

Positive Psychotherapy uses now elements of other psychotherapeutic methods in all the above mentioned stages. Psychoanalysis is used, for example, in the stages 2 and 4, elements of logotherapy in the 3rd and 5th stage, different methods of relaxation in the 3rd stage, behaviour therapy in the 3rd and 4th stage, psychodrama mainly in the stages 2, 3 and 4, and gestalt therapy in the stages 2 and 4 – just to name a few methods (interdisciplinary approach) (*N. Peseschkian* 1987). This means, that Positive Psychotherapy does not not understand itself just as a new psychotherapeutic method, but it tries to offer a basis on which different methods can cooperate and work together (metatheoretical approach).

Positive Family Therapy Beyond the Year 2000

Like the world as a whole, the family is in transition. In every culture, families are disintegrating, fragmenting under pressure of economic and political upheavals and weakening in the face of moral and spiritual confusion. Therefore many experts are looking for new solutions and approaches – some are looking for new concepts of partnership, such as the concept of life-stage-partners, others speak about the death of the family, and others are looking for a new family concept. All this is understandable, if we look at today's family situation., of which the increasing divorce rate is just one example: In Germany the divorce rate is around 33%, in the USA around 50%, in Russia 62%, and in Moscow 75% (dates from 1922). We can see this crisis as a sign of humanity's struggle toward a new age in its collective development, an age of maturity. The family, as the most basic unit of society, must in this process be remoulded and revitalised according to the same principles that are reshaping civilisation as a whole. The family concept of Positive Family Therapy is based on the belief, that the familiy is an institution of human society which has always existed and will always exist. But it has to undergo some fundamental changes, if it wants to meet the needs of today's individuals. We have to get from the old power-based family concept to a new more unity-based concept, which is based on the

equality of the marriage partners. *H. B. Danesh* /1944) speaks in this connection about the violence-free family. Besides the principles of unity and equality, the partners have to solve their daily affairs and problems throuch the power of consultation. Within the framework of the Five-Stage-Therapy, the patient learns tools of communication, and how to establish at home a regular hold family council or family group. The positive family concept also implies that no individual should undergo psychotherapy without the involvement of his family into the therapeutic process. Holistic, in this sense, means to understand the patient within his own surroundings and micro-culture.

Conclusion

Coming back to the question of human personality and its possible change, we can say that according to the concept of Positive Psychotherapy, the purpose of the therapy is to help the patient to recognize and to develop all his inborn capabilities. Through the broadening of his own capabilities, he develops the capacity to react on conflicts in different ways, and enlarges by this his own possibilities and reactions. So, we can say that a good marriage is not the one in which there are no problems and conflicts, but rather the one in which there exists readiness to talk over and consult on the problems in a frank and loving manner, and to cope with them.

The concept of Positive Psychotherapy has been received very warmly in Russia, since 1989, when this method was first introduced there. In the mean-while more than 40 one-week-training seminars have been held for more than 3,000 doctors, psychologists and psychotherapists, and more than 350 persons have finished a 100-hour-training program. There are now more than 20 local and regional »Centres for Positive Psychotherapy, Transcultural Psychiatry and Psychosomatic Medicine« existing in Russia and other former Soviet republics, and in 1993 the Russian Association for Positive Psychotherapy was founded in Kazan. A magazine called »Positum« has been published by this association, and several books on Positive Psychotherapy have either been translated or published into Russian. It might be that the main aspect of this encouraging response is due to the humanistic concept of this method, which is based on a holistic and transcultural approach, which is so near to the peoples of Russia.

About the Courage to Risk a Challenge – An Exemple for the Positive Approach

A king put his court to a test for an important post. Powerful and wise men surrounded him in great numbers. »You wise men«, said the king, »I have a problem, and I want to see who of you is able to solve it.« He led the men to a huge door, bigger than anyone hat ever seen. The king explained, »Here you see the biggest and heaviest door in my kingdom. Who among

you can open it?« Some of the courtiers just shook their heads. Other, who were counted among the wise men, looked at the door more closely, but admitted they could not do it. When the wise men had said this, the rest of the court agreed that this problem was too hard to solve. Only one minister went up to the door. He checked it out with his eyes and fingers, tried many ways to move it, and finally pulled on it with a hefty tug, and the door opened. It had just been ajar, most completely shut, and nothing more had been needed but the willingness to realize that and the courage to act boldly. The king spoke, »You will get the position at the court, for you do not rely just on what you see or hear; you put your own powers into action and risk a challenge.« (Persian story in: *N. Peseschkian* 1982).

Positive Familientherapie – Ein ganzheitlicher und transkultureller Ansatz

Hamid Peseschkian (Wiesbaden/Moskau), Dimitri A. Avdeev (Tscheboksari/Moskau)

Die derzeitige Situation in der Psychotherapie erfordert die Entwicklung von Verfahren, die ebenso ökonomisch wie effizient sind. Außer der technischen Frage der psychotherapeutischen Prozedur wird dabei die inhaltliche Frage wichtig, nach welchen Kriterien der bestehende Konflikt beschrieben und durchgearbeitet wird. Die Positive Psychotherapie (nach *Nossrat Peseschkian)* als »beachtenswerte Synthese von psychodynamischen und verhaltenstherapeutischen Elementen« (*G. Benedetti)* ist eine konfliktzentrierte Kurzzeittherapie, welche ein Rahmenmodell darstellt, in welchem verschiedene psychotherapeutische Richtungen miteinander arbeiten können. Die Positive Psychotherapie beruht auf drei Säulen, nämlich dem positiven Ansatz, dem inhaltlichen Vorgehen und der fünfstufigen Selbsthilfe.

Der Begriff des Positiven, der in der Positiven Psychotherapie besonders hervorgehoben wird, bezieht sich darauf, daß die Therapie nicht primär darauf ausgerichtet ist, eine bestimmte Störung zu beseitigen, sondern zunächst versucht, die vorliegenden Fähigkeiten und Selbsthilfepotentiale zu erfassen und zu mobilisieren. Positiv bedeutet hier entsprechend seiner ursprünglichen Bedeutung (lat.: positum) das Tatsächliche, das Vorgegebene. Tatsächlich und vorgegeben sind nicht nur die Störungen und Konflikte, die eine Person oder eine Familie mit sich bringt, sondern auch die Fähigkeiten mit diesen Konflikten umzugehen. Während ein Großteil der psychotherapeutischen Richtungen von den Störungen, den Krankheiten und damit vom Negativen ausgeht, sehen wir die menschlichen Fähigkeiten als das Primäre und Wesentliche. Hierbei ergeben sich viele Parallelen zur Dynamischen Psychiatrie von *Ammon.*

Dem Konzept der Positiven Psychotherapie liegt die Auffassung zugrunde, daß jeder Mensch ohne Ausnahme zwei Grundfähigkeiten besitzt: Die Erkenntnisfähigkeit und die Liebesfähigkeit. Beide Grundfähigkeiten

gehören zum Wesen eines jeden Menschen. Je nach den Bedingungen seines Körpers, seiner Umwelt und des Zeitgeistes, werden sich diese Grundfähigkeiten differenzieren und zu einer unverwechselbaren Struktur von Wesenszügen führen. Diese Hypothese der Grundfähigkeiten bedeutet nichts anderes als: Der Mensch ist seinem Wesen nach gut. In diesem Sinne werden Erkrankungen und Störungen als Fähigkeiten angesehen, mit deren Hilfe, der Patient Unbewußtes ausdrücken möchte. Krankheitsbilder werden somit in diesem Sinne positiv interpretiert. Das positive Vorgehen führt zu einem Standortwechsel, der die Basis für die therapeutische Zusammenarbeit darstellt. Man kommt somit vom Symptom zum Konflikt. Durch die Anwendung von Märchen, Sprachbildern und Weisheiten wird die Phantasie des Patienten angesprochen und mit Hilfe der Intuition neue Wege gesucht. Hierbei werden auch Beispiele von Menschen anderer Kulturen angeführt, um einen Standortwechsel des Patienten herbeizuführen (transkultureller Ansatz).

Untersuchungen von *N. Peseschkian* haben ergeben, daß es vier Medien der Konfliktverarbeitung gibt, die man auch als die vier Qualitäten des Lebens im Rahmen der Ganzheitsmedizin bezeichnen kann: Körper, Leistung, Kontakt und Phantasie/Zukunft. Durch einseitige Über- oder Unterbetonung einzelner Bereiche kommt es zu Störungen und schließlich zu Erkrankungen. Im Laufe der Therapie lernt der Patient seine ihm innewohnenden Fähigkeiten zu erkennen und an ihrer Realisierung selbst aktiv zu arbeiten. Das Ziel der Therapie besteht in einem Gleichgewicht der Alltagsenergie in diesen vier Bereichen. Im Rahmen eines mehrstufigen Vorgehens werden die Konflikte des Patienten auf- und durchgearbeitet. Hierbei werden auch Elemente verschiedener anderer psychotherapeutischer Verfahren im Sinne eines interdisziplinären Vorgehens angewendet.

Die Positive Familientherapie geht davon aus, daß die Familie in menschlichen Gesellschaften schon immer existiert hat und weiterhin existieren wird. Doch sie muß in einigen Punkten entscheidend geändert werden, um den Bedürfnissen der heutigen Menschen gerecht werden zu können. Die Familienmitglieder müssen lernen, auf der Grundlage ihrer Einzigartigkeit und Gleichheit ihre alltäglichen Angelegenheiten durch die Macht der gemeinsamen Beratung zu lösen. In der Positiven Familientherapie werden den Menschen auch Kommunikationstechniken vermittelt, um z.B. selbst einen Familienrat abhalten zu können. Das Positive Familienkonzept beinhaltet auch die Auffassung, daß sich kein einzelner einer Psychotherapie unterziehen kann, ohne daß seine Familie in den Prozeß miteinbezogen wird.

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Longterm Treatment of Borderline Personality Disorders – Practical Experiences and Theoretical Considerations**

Martin Urban (Esslingen)

The author reports his experiences as a psychotherapist in a therapeutic living community with nine places, founded by him six years ago. 24 of totally 38 patients suffered from Borderline Personality Disorders. Urban gives fundamental principles for their therapy derived from the structural understanding of borderline pathology by Kernberg (1975) and Ammon (1979) and from examinations of his patients with the Ego-Structure-Test by Ammon (ISTA). Finally he compares outpatient and inpatient psychotherapy to the reality-prone setting of therapeutic living communities.

1. The History of the Institution

Six years ago I was a member of the therapeutic staff of a psychosomatic unit of the communal hospital of Esslingen – a nice old town near Stuttgart, in southern Germany.

Many patients with psychosomatic disorders have a rather neurotic personality structure: after discharge from the clinic they live at home like before – with less or sometimes even the same symptoms and problems. But there were some patients, on the other hand, who could not live at home again – either they had become more sensitive to for the problems in their environment (even due to the therapy), or they had no home at all, no intact family, no solid social connections. And they often had too many self-destructive tendencies as to be successful in managing their lifes. Many of them had great difficulties to separate from the hospital where they had found positive familiarity perhaps for the first time in their life, and more than one committed suicide.

So I tried to find a way of prolonging the therapeutic relation outside the frame of the hospital (which is overfeeding and leads to hospitalism, as we know); a way of treatment that would be more sustaining and helpful in the practical problems of daily life than a usual outpatient psychotherapy could be. My idea was to install psychotherapeutic living-communities. (This was long before I met the Hospital Menterschwaige in Munich and the German Academy for Psychoanalysis of *Günter Ammon.)*

For everything you do in Germany, you need a category, a paragraph or title in law. Unfortunately, for therapeutic living-communities there is no paragraph in the German social law. It is not an outpatient psychotherapy, and so the health insurance companies do not pay for it. The social depart-

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** 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

ment, on the other hand, said: Yes, we have living-communities for mentally ill people, but we do not pay the salary for psychotherapists in these institutions. Finally, we found a paragraph, named »supervised living for young people« (Betreutes Jugendwohnen): Boys and girls living in a social institution and learning to live by themselves, may live in supervided communities, or even in a single appartment, and a social worker is looking after them. The intensity of supervision is twice as good as in the living-communities for the mentally ill people. It was a long struggle, but at the end the social department of our district administration agreed to use this paragraph, this title of social law for financing my institution of »therapeutic living-communities«. But indeed, until now it is a matter of diplomacy, or even of legal quarrel, to get the agreement – and the payment – in each single case.

2. *Diagnostical Classification of the Clients. Some Problems with the Diagnosis »Borderline Personality Disorder«*

Actually we have nine clients who live in our house and in two appartments near Esslingen. They stay with us one or two years, some of them maintain a stronger connection with us even years after. 38 persons now have been treated since the beginning of my institution. Most of them come immediately from one of the psychiatric hospitals around Stuttgart. What kind of disorders did they offer, and what happened with them?

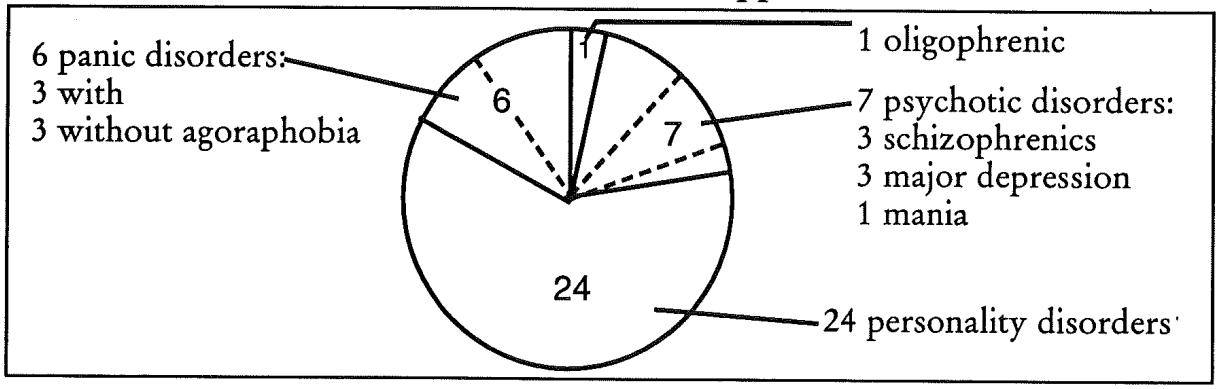

Figure 1: Diagnostical classification of all 38 clients

As you see, most of them have »personality disorders« (24 persons). Classifying them according to the DSM-III R, we get the following subgroups:

DSM-Nr.	Diagnosis	Frequency
301.00	Paranoid Personality Disorder	1
301.20	Schizoid Personality Disorder	4
301.22	Schizotypic Personality Disorder	1
301.40	Anancastic Personality Disorder	2
301.50	Histrionic Personality Disorder	1
301.60	Dependent Personality Disorder	1
301.70	Antisocical Personality Disorder	3
301.81	Narcissistic Personality Disorder	1
301.82	Self-inconfident Personality Disorder	5
301.83	Borderline Personality Disorder	4
301.84	Passiv-aggressive Personality Disorder	1
	Total	24

Tab. 1: Diagnostic classification according to DSM-III R

But I have some problems in using this classification, especially with the use of the term »Borderline Personality Disorder« (BPD). In this system, it is the name of one of the 11 subgroups of Personality Disorders. It is described as follows:
»A general pattern of instability in the areas of mood, interpersonal relations, and self-representation... Five of the following (8) criteria must be fulfilled:
– A pattern of instable but intensive relations, changing between overidealization and devaluation,
– Impulsivity in at least two selfviolating activities,
– Affective instability,
– Excessive anger or incapacity of controlling anger (explosions),
– Repeated threat or attempts of suicide or self-mutilation,
– Disturbance of identity – in self-representation, sexual and professional orientation etc.,
– Chronical feeling of emptiness or boredom
– Desperate efforts to avoid loneliness.« (Shortened by the author.)

This is a quite different meaning of »Borderline Personality Disorder« than it is used in the pschoanalytic literature. *O.F. Kernberg* (1975) defines BPD as »a certain and stable level of (pathological) personality organization«; it is not a symptomatical but a structural diagnosis. The borderline personality organization is settled between the neurotic and the psychotic structure. One can show it as follows:

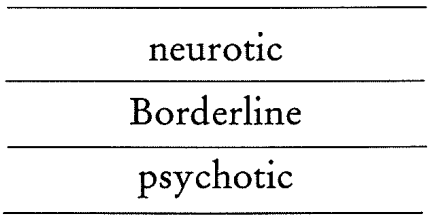

Figure 2: Three levels of personality organisation, according to *Kernberg* (1975)

Otherwise he defines five degrees of pathological narcissism (*Kernberg* 1975)

1.–3. Narcissistic Personalities (in several stages)
4. Borderline Personality Disorders
5. Psychotic Personalities

One can assume that the concept of »Borderline« in this sense is as wide as those of neurosis or psychosis, and may have very different phenotypes, including e.g. the schizoid or the passive or self-inconfident type. Even patients with panic disorder mostly seem to be »borderliners« in this sense.

Fortunately there is a new instrument of test diagnostics, the Ego Structure Test by Ammon (ISTA). In addition to other instruments, e.g. the MMPI, it gives very useful informations especially in the diagnosis of Borderline Disorders in this structural sense. I demonstrate a very typical example.

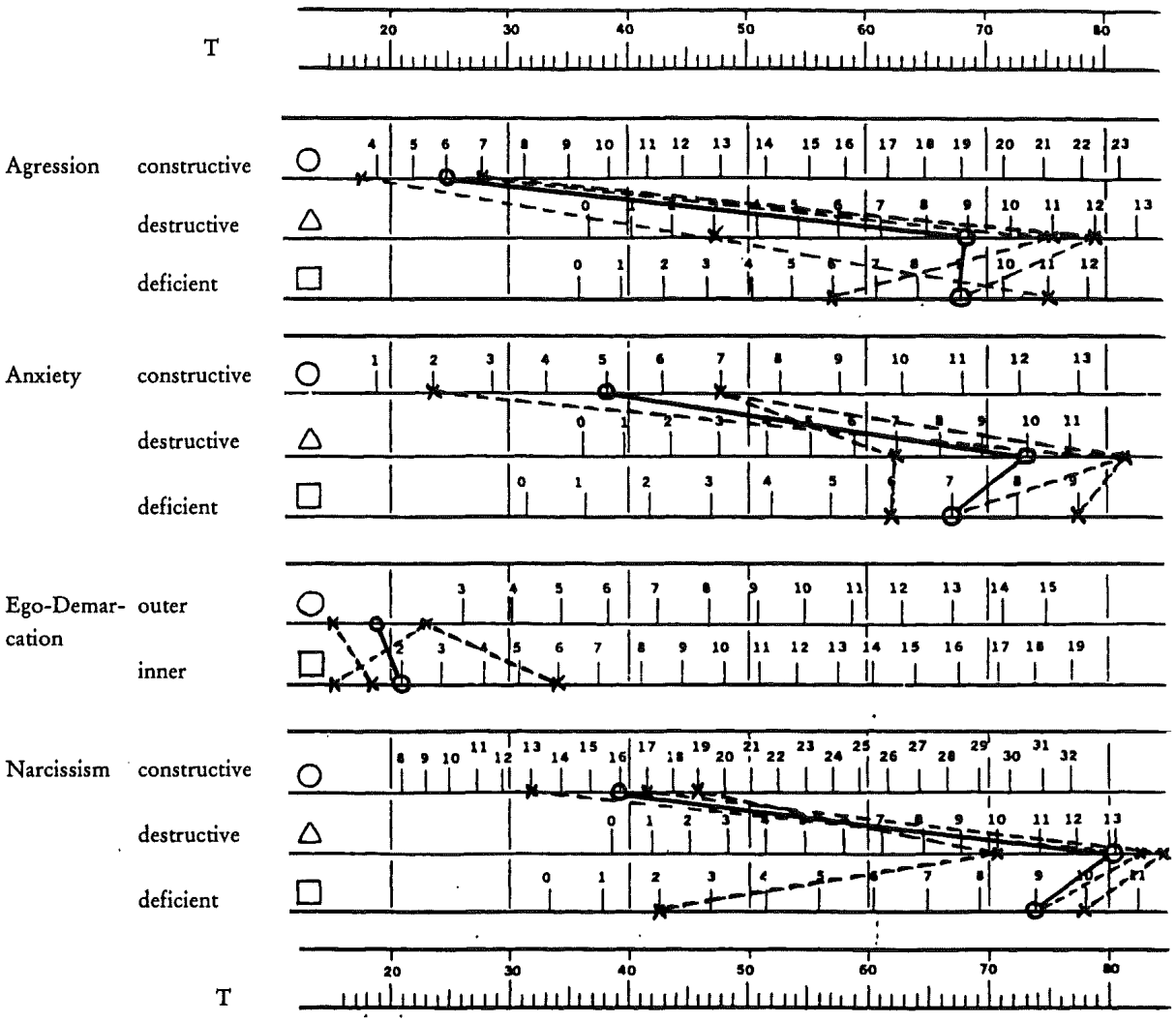

Figure 3: Three ISTA profiles of different borderline phenotypes (---) with averaged profile (—)

As you see, the test patterns of the three persons are very similar over all scales, although the patients are quite different in their symptomatics. One of them showed a classical Borderline Personality Disorder with transitional psychotic phenomena, another one was rather schizoid, with anancastic traits and several attempts of suicide, and the third one had a classical panic disorder and was formerly diagnosed as »anxiety neurosis«. All three of them are females.

On the scales of ISTA, they all show the same pattern of inability to manage their basic emotions: anger and fear (low scores for the constructive form, high scores for the destructive and the deficient form). They all have a very weak Ego-demarcation towards inside and towards outside; this is valid even for the schizoid type. And they all have dramatical deficits in narcissism.

My experience confirms that these four are the essential dimensions of borderline pathology, in the structural sense of *Kernberg*, independently of the phenomenal type.

3. Success and Failure in Our Treatment

It is difficult to answer the question of outcome in a quite new institution. We have no formal follow-up study. From the 38 clients, 9 are still in treatment. About the remaining 29 clients one can say that
– 15 went out successfully (more than 50%). They are socially integrated in one way or another.
– 6 persons changed to other institutions, mostly hospitals some of them to Menterschwaige in Munich. I assume you would agree that it cannot be seen as a negative outcome if a very disturbed person, e.g. with severe problems in contact, could be motivated to undergo an inpatient psychotherapy;
– 8 clients finished with negative outcome (27%); in detail:
– 2 decompensated with psychosis (1 schizophrenic, 1 depressive),
– 1 had to be dismissed because of dealing with illegal drugs,
– 1 went to prison (where he was before he came to us),
– 2 broke off the treatment by themselves,
– 1 left us, incriminating us as being misused sexually (what was irreal, of course),
– 1 died by suicide. This was the most shocking event I ever had. The client was very depressive, rather mutistic, with ideas of grandiosity, full of hate against his parents who brought him into the hospital first. I tried to motivate him to go to Menterschwaige; he died one week before he should have his first interview.

Now you may imagine the problems we are dealing with. Nothing is perfect on earth, and also therapeutic living-communities cannot provide the solution for all problems of mentally severe ill persons. But a good part of them profited from our treatment, and we saw examples of astonishing personal growth and development.

4. The Dimensions of ISTA Providing Basic Treatment Rules

What do we do with our clients? It is not a therapy on the chair or even on the couch, it means rather accompanying persons along their way when they start their own lives, after hospital and after the shock of falling mentally ill. They mostly lost their job, they often need new professional orientation, they seek for new personal relations, for the old ones mostly were negative, they often have not learned to manage their daily life, including money, hygiene, eating. And most of them have severe problems in contact, so that the desirable community-life in our »living-communities« sometimes is rather sparse.

My main thesis is: The treatment has to start from the crucial points of disturbance. And if it is true that the dimensions of ISTA are the essential traits of borderline pathology, then we may start here:
1. They have to learn to grapple with their aggressions. And aggressivity is a largely known phenomenon in our living-communities, not only between

the inhabitants but also between clients and therapists. They fall in anger when they should keep clean the kitchen or bathroom and one asks them why they did not, or if they should pay their telephone bill and they have no more money because they spent it for cigarettes or for new clothes. We have to help these persons not to deny their anger, not to aim it against the wrong person, or against themselves, but to admit this feeling, even against the therapists. It is allowed to feel anger. Then we have to help them to find out where their frustration was coming from, and what they have to do in order to get their reasonable needs fulfilled. E.g. we have to encourage them to speak with their boss or comrades on the job, who hurt them. That means, in practice, to change destructive into constructive aggressivity.

2. In similar manner, they have to grapple with their anxiety. We have to help them talk about their fears, and encouraging them to go foreward with little steps against and through their anxiety.

3. Ego-demarcation or ego-boundaries may best be learned in group therapy. (We have group therapy sessions once a week.) Very often one takes the problem of another as being his own, and we can correct him. They have to learn to say: » Das ist mein Bier, und das ist dein Bier.« (This is my glass of beer, and that is yours.) Improving the sense of ego-boundaries means to improve the process of individuation.

4. Last not least, narcissism is a crucial point. For all who work with early disturbed persons it is necessary to be most careful with the utmost vulnerable sense of self-esteem, more: with the suspicious expectation that you will be one of the many people that will hurt them. They jealously observe how long you speak with somebody, and how long with his comrades. It is not possible to be always »just«, giving everyone truly the same, but everyone should get the basic-feeling that you respect him, even if he is wrong in his thinking or wishes.

With these four rules we have already a good foundation for our daily contact with borderline persons in our living-communities. Psychoanalysis is a »high-tech« form of treatment, but following these simple rules, you can already achieve very much.

5. Theories of Borderline Personality Disorders and Therapeutic Consequences

How do the theories of Borderline Personality Disorder help us for improving our treatment?

Borderline persons have not – or not yet – stable object relations; these are splitted into a good and a bad object. For the therapist it means he will be one day overidealized and next day he will be seen totally negative. We had clients that did not speak with us for two or three weeks. They felt so disappointed. But afterwards we talked together again, and the client was very thankful that were this patient. So he can learn object-constancy, one of the promotors of personality development.

According to *Kernberg,* borderline states are the fourth degree of narcissistic disorders. The therapist therefore has to be very careful handling the vulnerated self-esteem of the patients, as we said above. But a second point is important: These persons have a strong need of narcissisistic transference. That means, they need us, and they use us as idealized self-images of figures of identification. We have to imagine that they had not had these good objects before. They need us as models of adult, self-confident and competent persons. And they need to be accepted by this idealized person.

Early disturbed persons always have had an unsufficient or distorted symbiotic phase in their childhood. And so they seek a symbiotic object again and again. *Ammon* speaks of the »symbiosis complex«, and in therapy it means that they will develop a sort of symbiotic transference. This is a fact even in schizoid persons: it was a striking experience for me to see very introverted or even paranoic persons in the longer process of staying in our living-communities developing a strong and unexpected need of contact and nearness. They even seek »mother and father«. I think this is one of the great chances in this form of longterm treatment with borderline persons: We become mother and father, but we do not leave them on the children's playground; we accompany them on their way to independent life.

6. Comparison of Three Therapeutic Settings

In conclusion I will show a scheme comparing the therapeutic milieu of living-communities with the setting of stationary treatment and outpatient psychotherapy.

	inpatient therapy	therapeutic livingcommunities	outpatient psychotherapy
time	3–12 months	1–2 years	open
frequency	»around the clock«	variable 2–6 per week	1 per week
intensity of treatment	high (too high for some pat.?)	middle (variable)	low
hospitalisation	yes	no	no
relation to real life	distant	therapy »in the middle of the life«	rather distant
real conflicts pat.-therap.	yes (chance for reality-close therapy!)	yes	no
narcissistic support	+	++ (by real success in daily life)	+
symbiotic regression	very high	high	low
problems with separation	high	low (slow transition)	low
process of individuation	+/– (overadaptation to the group?)	+	+

Tab. 2 Comparison of psychotherapy as outpatient, inpatient and in living communities

The main point is that both inpatient treatment and outpatient psychotherapy are rather distant to real life, while the living-communities provide a therapy »in the middle of the life«.

Shortly: The clinic is quasi a »therapeutic intensive-care unit«; it is necessary in certain circumstances, or stages in the patient's life. The therapeutic living-communities for the clients are quasi a »school of emotional learning and mastering their lifes«. And outpatient psychotherapy accompanies patients to their own way of live from a distant point – in the manner of a remote control.

All three of them are necessary in their realm and complement each other. All three of them are needed.

Langzeitbehandlung von Borderline-Persönlichkeitsstörungen – praktische Erfahrungen und theoretische Überlegungen

Martin Urban (Esslingen)

Vor sechs Jahren gründete der Autor eine psychotherapeutische Wohngemeinschaft aus der Erfahrung heraus, daß viele psychosomatische Patienten nach der Klinikentlassung nicht in ihre frühere Wohnsituation zurückkehren können, sei es, daß sie durch die Therapie sensibler für die Probleme ihrer Umgebung geworden sind, sei es, daß sie kein Zuhause haben, sei es, daß ihnen die Trennung aus der Geborgenheit der Klinik schwerfällt. Da psychotherapeutische Wohngemeinschaften in der deutschen Sozialgesetzgebung nicht vorkommen, muß bis heute für jeden Einzelfall die Finanzierung erkämpft werden; immerhin gelang es dem Autor, über »Betreutes Jugendwohnen« eine relativ sichere Bezahlung der psychotherapeutischen Versorgung zu erreichen.

Derzeit leben neun Patienten für ein bis zwei Jahre in drei Wohnungen nahe Esslingen bei Stuttgart. Bisher wurden insgesamt 38 Personen behandelt, 24 von ihnen hatten die Diagnose »Persönlichkeitsstörung« nach DSM-III R (s. Tab. 1). Diese Klassifikation hält der Autor allerdings für problematisch, denn im DSM-III-R wird die Borderline-Strörung als »allgemeines Muster von Instabilität in den Bereichen Stimmung, interpersonelle Beziehung und Selbstrepräsentanz« definiert. Dies unterscheidet sich fundamental vom Verständnis der Borderline-Persönlichkeitsstörung in der Psychoanalyse. *Kernberg* (1975) bezeichnet mit diesem Begriff ein »bestimmtes stabiles pathologisches Niveau der Persönlichkeitsorganisation«. Borderline-Persönlichkeitsstörung stellt also nicht eine symptomatische, sondern eine strukturelle Diagnose dar, angesiedelt zwischen neurotischer und psychotischer Struktur (Abb. 2). Demnach wären viele weitere Patienten als Borderline-Kranke zu verstehen, selbst schizoide, passive oder selbstunsichere Persönlichkeiten, die sich lediglich nach dem Grad ihres pathologischen Narzißmus unterscheiden *(Kernberg* 1975).

Der Ich-Struktur-Test nach *Ammon* (ISTA) liefert – zusammen mit anderen Testinstrumenten wie dem MMPI – nützliche Informationen für die Diagnose. *Urban* zeigt drei typische Testprofile, die sich trotz großer Unterschiede in der Symptomatik der Patientinnen sehr ähnlich sind. Bei allen drei fällt die Unfähigkeit auf, mit den Grundemotionen der Aggression und der Angst angemessen umzugehen; sie haben schwache Ich-Grenzen nach außen und innen und hohe Defizite beim Narzißmus. Nach *Urbans* Erfahrung stellen die vier ISTA-Skalen – unabhängig von der Phänomenologie – die wesentlichen Dimensionen der Borderline-Pathologie im strukturellen Sinne dar.

In dieser jungen Institution gibt es keine Follow-up-Studie. Neun Patienten befinden sich noch in Behandlung; von den übrigen 29 Behandelten beendeten 15 die Therapie erfolgreich und sind sozial integriert, neun wechselten in andere Einrichtungen vorwiegend psychotherapeutische Kliniken wie die Klinik Menterschwaige. *Urban* sieht es letztlich als Erfolg, die nötige Motivation zu weiterer Therapie aufgebaut zu haben. Acht Patienten verließen die Wohngemeinschaft mit negativem Erfolg (zwei reagierten psychotisch, einer kam ins Gefängnis, einer handelte mit Drogen, drei brachen ab, einer starb durch Suizid).

Die Therapie muß nach *Urban* an den Brennpunkten der Krankheit beginnen. Ausgehend von den ISTA-Skalen als wesentlichen Dimensionen der Borderline-Pathologie leitet er vier Prinzipien ab:

1. Die Patienten müssen lernen, mit ihrer Aggression umzugehen; d. h. Ärger und Wut weder zu verleugnen noch destruktiv gegen sich selbst oder andere zu richten, sondern zu spüren, die Ursachen zu verstehen und ihre Bedürfnisse angemessen zu befriedigen. In der Praxis bedeutet dies die Veränderung von destruktiver in konstruktive Aggression.
2. Ebenso sollten sie lernen, mit ihrer Angst adäquat umzugehen.
3. Die Ich-Abgrenzung zu verbessern, bedeutet, den Prozeß der Individuation zu stärken. Dafür bietet sich die Gruppentherapie an, die einmal pro Woche stattfindet.
4. Jeder Patient sollte das Gefühl haben, daß er respektiert wird. Jeder, der mit frühgestörten Patienten arbeitet, muß sorgfältig mit ihrem äußerst verletzlichen Selbstwertgefühl bzw. ihrer unausgesprochenen Erwartung, erneut verletzt zu werden, umgehen und so die Entwicklung eines gesunden Narzißmus fördern.

Aus den Theorien zur Borderline-Störung, insbesondere *Kernberg* (1975) und *Ammon* (1979) leitet *Urban* folgendes für die Behandlung ab:

1. Borderline-Patienten haben keine stabilen Objektbeziehungen, sie spalten auf in gutes und böses Objekt. Um die Persönlichkeitsentwicklung voranzutreiben, müssen sie Objektkonstanz erlernen.
2. Borderline-Patienten haben eine großes Bedürfnis nach narzißtischer Übertragung, d.h. sie brauchen den Therapeuten als idealisiertes Selbstbild oder Identifikationsfigur für eine erwachsene, sich selbst vertrauende und kompetente Person.

3. Frühgestörte Patienten hatten stets eine unzureichende oder verformte symbiotische Phase in ihrer Kindheit. *Ammon* spricht vom »Symbiosekomplex«. Sie zeigen eine symbiotische Übertragung, laut *Urban* entwickeln selbst sehr introvertierte oder paranoische Personen im Prozeß ihrer Behandlung ein unerwartet starkes Bedürfnis nach Nähe und Kontakt. Zugleich ist dies die spezifische Chance dieser Form von Langzeit-Therapie: Die Therapeuten stellen sich als Mutter bzw. Vater zur Verfügung, begleiten die Patienten aber auf ihrem Weg in die Unabhängigkeit.

Abschließend vergleicht *Urban* die Settings von stationärer und ambulanter Psychotherapie mit der psychotherapeutischen Wohngemeinschaft (Tab. 2). In letzterer findet seiner Meinung nach die Therapie »mitten im Leben« statt, während die Klinik für ihn eine »therapeutische Intensiv-Einheit« ist, die für bestimmte Lebens- oder Therapieumstände nötig ist. Die psychotherapeutische Wohngemeinschaft sieht er als »Schule des emotionalen Lernens und der Lebensbewältigung«. Die ambulante Therapie dagegen begleitet den Patienten auf seinem weiteren Weg mit größerer Distanz. Alle drei Behandlungsformen ergänzen einander.

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Therapeutic Techniques in the Treatment of Paranoia in the Framework of Dynamic Psychiatry (with Case Study)**

Rita Primbas (Berlin)*

Paranoia is one of the most frequent symptoms with patients suffering from archaic ego-diseases. It represents a treatment problem which is rather difficult to handle. By means of the case study of one patient, who shows a Borderline personality structure, the essential treatment methods of out-patient human-structrural psychotherapy are presented . They aim at significantly decreasing paranoic symptomatology. Moreover, essential theoretical concepts of Dynamic Psychiatry are outlined that are necessary for the understanding of the phenomenon of paranoia. The following points are discussed as central therapeutic techniques of the therapist: unconventional personal approach towards the patient; direct pointing out the problems of the patient in the here and now; listening; taking the patient's individuality serious; empathy with a certain distance; establishment of a therapeutic alliance with the healthy ego-parts of the personality; evasion of the paranoic defense.

The two central mechanisms of the paranoic defense were described by *Freud* 1911 in the case study of Schreber. He wrote that all the main symptoms of paranoia is the opposition to the phantasy »I love him«. For men the main conflict of paranoia is the opposition to the phantasy to love a man, that means to his homosexuality. This opposition leads to the following inversion: »I don't love him, I hate him« (*Freud* 1911). The mechanism of projection transforms this sentence into: »He hates me« (*Freud* 1911).

Ammon's theory of paranoia has assimilated these basic mechanisms: the projection and the inversion. But his interpretation of paranoia essentially differs from *Freud*'s understanding, as described above. *Ammon* accentuated the following mechanisms:

1. On a psycodynamic level paranoia is decribed as a defense against a persecuting mother. On the same level paranoia is an exteriorization of the internalized destructive experiences of the primary group (*Ammon* 1979).
2. On a humanstructural level, paranoia is a compensation of the very deficient ego-boundaries of the patient.

The theory of the Berlin School of Dynamic Psychiatry of *Ammon* provides a very important contribution for the understanding and the treatment of patients with severe psychic diseases, by *Ammon* (1979) named archaic ego-diseases. Dynamic Psychiatry has developed new ways of therapeutic approaches towards these illnesses. The treatment methods have to correspond with the patient's needs.

Paranoia is one of the central symptoms of patients suffering from archaic edo-diseases as Borderline syndrome.

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** 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

In the following I would like to point out the essential treatment methods of out-patient humanstructural psychotherapy of paranoia which aim at significantly decreasing paranoic symptomatology:
1. Unconventional personal approach towards the patient,
2. Listening of the therapist,
3. Direct pointing out the problems of the patient in the here and now,
4. Taking the patient's individuality serious,
5. Establishment of a therapeutic alliance with the healthy ego-parts of the personality,
6. Empathy, but with a certain distance,
7. Evasion of the paranoic defense.

Case Study

The patient T. came into out-patient psychoanalytical individual therapy after he had left a four-months in-patient treatment in the Dynamic Psychiatric Hospital Menterschwaige because of severe paranoia and the fear of psychic decompensation. The patient, 31 years of age, but looking younger, complained at the beginning of the treatment about nervosity, restlessness, compulsive brooding. He had not been able for years to cope with reality and he said that he felt observed and threatened by other people most frequently, especially at his working place. He told me that he was afraid to enter the department store because he felt watched and controlled there as well. He had always had insufficient self-esteem.

He was brought up as a second child of a family in a German city together with two sisters being three years older and eight years younger. He described his parents as fearful, cautiously withdrawn, petits bourgeois who always tried to get social recognition by adaptation. His father had always cared about his reputation of orderly citizen. The most important contact partner in his family had been his mother, who had given up her job as a nurse after the birth of the first child in order to dedicate her time completely to the children. »The care for the children« was »her life«, said the patient. She had been »fanatically fond of children, self sacrificing, very soft, with slight power of self-assertation. She could defend only with great efforts in particular against her husband, an office worker, and she could not set limits to the patient.

His father had been very strict, impatient and had beaten him frequently. The threat to beat him had been the central principle of his father's education. The father had suffered from depression since the age of 30 and had taken psychotropic drugs for a long time, among others antidepressiva. He was very discontent with his job and his life in general, at the age of 35 he had made a suicide attempt by drowning.

He had withdrawn himself from his family, had given his daughters a better treatment and had rejected the patient constantly, had controlled and

tyrannized him by his constantly changing moods. The parents had not given him any support at school and in his job. During school time he had always suffered from learning disturbances. With great pain and an effort of will he had finished secondary school and had successfully completed vocational training in a trade. But his job had not given him any real pleasure.

Course of Treatment

At the beginning of the treatment, the patient seemed to me depressive, rather suspicious, at a loss, intimidated, and under great tension. He could not establish any eye contact, he spoke monotonously and appeared all the time turned inwards. The out-patient treatment lasted two and a half years and has not been completed yet.

1. Unconventional personal approach towards the patient:

The essential criterion of humanstructural therapy is that not symptoms but the whole person is placed in the center of therapy. Therefore the establishment of contact is of central importance. For this aim it is important for the therapist working within the framework of Dynamic Psychiatry that »the Borderline therapist should not follow general rules but should face the patient with his whole personality and should establish a relationship. At a given moment he frees himself from the wisdom of books and is able to reach the patient through his ego-structural working« (*Ammon* 1979).

Because of his immense contact anxiety, being accompanied by the subjective experience to be threatend and controlled by me, the patient felt often the need to determine the frequency of the therapeutic sessions to postpone them or to cancel them. Often he managed to get his treatment on the phone. Through this being detached on the phone, he feld freer and could tell his experiences and thoughts more easily than in his ordinary session. To this desire for flexibiltiy, I have answered positively quite often. My acceptance of this desire was one way to convey to the patient that I understood his contact anxiety, his tendency to break off contact, his desire for contact and his great loneliness.

For the beginning of the treatment i.e. for the phase of establishing trust (approximately one year), this therapeutic approach was more important than all verbal statements of the therapist.

2. Listening:

Of decisive importance for my contact to the patient there was in the first phase of the treatment a great reserve on my sight, in the verbal as well as in the nonverbal communication and interventions, i.e. essential restriction to a very patient, but also very alert and interested listening. The patient seemed to have a listener who was interested in his person for the first time

in his life. He obviously enjoyed the attention and being taken serious, that is the narcissistic supply (compare *Ammon* 1979). This process represents the therapeutic attempt to fill the narcissistic deficit of the patient.

Very slowly but perceptibly he developed a feeling of being accepted that manifested itself in a increasing friendliness and opening towards me.

3. Direct pointing at the problems of the patient in the here and now:

At the beginning of the therapy, the patient was occupied with problems with neighbours and with the few acquaintances he had. He felt watched by all of them, controlled, not seen, not understood and partly exploited. These problems were considered and treated a long time from the subjective perspective of the patient.

To treat the paranoic element, which was rather obvious, as a pathological perception would not have made sense in this early phase, because at that time the humanfunction of reality-testing was still very weak in the patient. The paranoic defense was seen as a necessary protection against psychic desintegration and, therefore, I tried to leave it untouched.

4. Taking the patient's individuality serious:

It was always impressive for me how strongly the patient insisted on his very subjective experience in view of people and events and how existentially important seemed to be for him my aggreement in this context. I have seen this as an expression of an existential need to have his personal individuality accepted by me, to take him serious and to mirror his individuality.

In this context, his immense deficit in childhood with regard to the reflexion of his identity became apparent. In the sense of the retrieval of ego-development which is regarded by Dynamic Psychiatry as central for the treatment of archaic ego-diseases, the therapeutically compensating fullfilment of his need for reflexion was regarded as essential in the patient's treatment.

I would like to say that the following remark of the patient to me has been like a red thread in the whole two and a half years lasting therapeutic process and is the most important question of the patient in general: »I ask myself again and again whether you have an interest in me and whether you take me serious.«

5. Establishment of a therapeutic alliance with healthy ego-parts of the personality:

Of basic significance for the establishment of a therapeutical relationship for a dynamic psychiatrist is the establishment of a working alliance with the healthy ego parts in the personality.

So it was most important within the therapeutic process to take up the patients craft skills, his earlier sports achievements as well as his ability of a

differentiated intuitive perception of the personality features of other persons, to emphasize these points and regard them as healthy and faraway from pathology. It was clearly perceptible how relieved the pateint felt to be accepted as a person with healthy personality parts.

6. Empathy, but with a certain distance:

The therapist's intuitive understanding of the emotional situation of the patient also is a fundamental characteristic of borderline therapy.

In view of the immense affect lability of the patient the therapist's attitude of detached empathy was in my understanding the best instrument to perceive the momentary emotional situation of the patient. It was the basic precondition for the emotional contact with the patient, who would be otherwise very restricted, unclear and distored in his verbal and non-verbal communication.

7. Evasion of the paranoic defense:

In the school of Dynamic Psychiatry, or more specifically Humanstructurology, the symbiotic transference and the symbiotic restistance are the basic dynamics in the understanding of archaic ego-diseases.

Within the course of an increasing symbiotic transference of the patient, he reacted to slight events of disappointment and insult with archaic fears of desertion and archaic anger. These feelings were manifested in paranoic delusions. For instance, the patient called me a jew who wanted to take revenge on the Germans for the sufferings in the Third Reich and who therefore wanted to destroy the patient's personality. Another paranoic idea of the patient was that I tried to convey him a politically leftist ideology and that I used therapy only as a means for ideological indoctrination. The symbiotic desires for fusion were defended by the patient most aggressively and manifested themselves in the form of severe fears of dependence.

Résumé

I would like to point to the stress which the out-patient therapy of a Borderline patient means for the therapist. The out-patient therapy of this patient provoked severely stressful countertransference reactions in the therapist caused by the severe structural deficits of the patient, his immense frustration intolerance as well as the existential feelings mobilized by the symbiotic transference. To put up to this stress was only possible through the support of continous relieve of the emotional strain within the framework of individual supervision, control supervision and through the understanding and the support of the therapy within the group of the co-workers and therapists of the institute I work in.

In the treatment of this paranoic Borderline patient the greatest problem was the handling of the immense anxiety and distrust of the patient. Therefore, in the first phase of the treatment all therapeutic techniques had the

aim to establish and to keep a therapeutic alliance. This purpose served the contact to the patient, the respect of his indivuality and the acceptance of his signs of life as important bridges of communication. By means of the therapeutic alliance which is successful – it is essential to establish a friendly symbiosis – in contrast to that the patient failed symbiosis in the past – and which is therapeutically effective in the sense of the retrieval of ego-development.

In the second phase of treatment the way out of symbiosis can be attempted. The therapeutic process of the patient presented here is now in the beginning of this second phase.

Therapeutische Techniken in der Behandlung der Paranoia im Rahmen der Dynamischem Psychiatrie (mit Kasuistik)

Rita Primbas (Berlin)

Die Autorin beschäftigt sich in der vorliegenden Arbeit mit der ambulanten humanstrukturellen Therapie eines schwerkranken Patienten mit Borderline-Persönlichkeitsstruktur im Rahmen der Schule der Dynamischen Psychiatrie nach *Ammon.* Anliegen dieser Kasuistik ist der Umgang mit der Paranoia, die als ein sehr häufig auftretendes Symptom aller archaischen Ich-Krankheiten gilt und sich durch starkes Mißtrauen, Gefühle der Bedrohung durch andere Menschen und durch massive Kontaktängste auszeichnet.

Einleitend werden die zentralen Mechanismen, auf die *Freud* die Paranoia im Fall Schreber zurückführte, vorgestellt. Für das männliche Geschlecht nahm er die Abwehr der latenten Homosexualität als psychodynamischen Hauptmechanismus an. Es geht um den Abwehrmechanismus der Umkehrung: »Ich liebe ihn nicht, ich hasse ihn«, dem der Abwehrmechanismus der Projektion, nämlich »Er haßt mich« folgt. Die Dynamische Psychiatrie nach *Ammon* hat die *Freud*schen Mechanismen der Umkehrung und Projektion als grundlegend für das Verständnis der Paranoia in ihre Theorie integriert. Deren Interpretation der paranoischen Symptomatik unterscheidet sich jedoch von den *Freud*schen Annahmen. Folgende Hypothesen liegen ihr zugrunde:

1. Auf der psychodynamischen Ebene sieht *Ammon* im Gegensatz zu *Freud* den Kern der Paranoia in der »Abwehr der als Verfolgerin erlebten, eigene Ich-Abgrenzung verbietenden Mutter« (*Ammon* 1979). Dies gilt sowohl für die weibliche wie für die männliche Paranoia. Auf der gleichen Ebene ist Paranoia weiterhin eine »Veräußerung der verinnerlichten destruktiven Erfahrungen der Primärgruppe« (*Ammon* 1979).
2. Auf der humanstrukturellen Ebene ist Paranoia ein Kompensationsmechanismus der sehr brüchigen Ich-Grenzen des archaisch Ich-kranken Patienten.

Zentrales Anliegen der Behandlung des vorgestellten Patienten war die Herstellung und die Aufrechterhaltung des therapeutischen Bündnisses, um damit als erste Phase der Behandlung eine freundliche Symbiose und damit eine nachholende Ich-Entwicklung zu ermöglichen. Diesem durch die Paranoia ständig gefährdeten Zielen dienten folgenden sieben in der Arbeit ausführlich dargestellten methodischen Vorgehensweisen der Therapeutin:

1. Unkonventioneller Umgang mit dem Patienten,
2. direktes Ansprechen der Probleme des Patienten im Hier und Jetzt,
3. Zuhören,
4. Ernstnehmen der Individualität des Patienten,
5. distanzierte Empathie,
6. Herstellung eines Arbeitsbündnisses mit den gesunden Ich-Anteilen der Persönlichkeit,
7. Unterlaufen der paranoischen Abwehr.

Die Arbeit gibt zunächst eine Beschreibung des Patienten, seiner paranoischen Symptomatik mit abgrundtiefer Angst vor der Therapeutin, heftigem Mißtrauen, von ihr bedroht und kontrolliert zu werden. Weiterhin gibt sie die wesentlichen Aspekte der Lebensgeschichte und der Dynamik seiner Primärgruppe wieder. Im zweiten Teil der Arbeit werden die oben angegebenen wichtigsten therapeutischen Maßnahmen anhand des Verlaufs der ersten zweijährigen Phase der Behandlung, d.h. der Herstellung und Aufrechterhaltung einer freundlichen Symbiose, dargestellt. Wie ein roter Faden zieht sich durch die Beschreibung des schwierigen und für den Patienten und die Therapeutin belastenden therapeutischen Prozesses die von *Ammon* erarbeitete und geforderte Haltung des Therapeuten durch: »Der Borderline-Therapeut darf sich nicht auf Faustregeln verlegen, sondern muß sich immer mit seiner ganzen Person dem Patienten stellen und in Beziehung zu ihm treten »(*Ammon* 1979). Für den im Rahmen der Dynamischen Psychiatrie arbeitenden Therapeuten sei es nach *Ammon* am wichtigsten, »daß er sich im gegebenen Moment frei macht von Lehrbuchweisheit und in dem Augenblick, wenn er humanstrukturell arbeitet, den Patienten erreichen kann«. Nur ein sehr flexibles therapeutisches Setting konnte den sehr wechselnden Bedürfnissen des Patienten nach Nähe und Distanz gerecht werden.

Der Patient schien das erste Mal in seinem Leben einen an seiner Person interessierten Zuhörer zu haben, was er immer wieder in Zweifel zog und testete. Das Gefühl des Angenommenseins, das sich sehr langsam entwickelte, ermöglichte zunehmend ein Unterlaufen der paranoischen Abwehr und eine freundliche Symbiose. Die paranoische Abwehr wiederum wurde in der ca. zweijährigen Anfangsphase des therapeutischen Prozesses als notwendiger Schutz vor psychischer Desintegration von der Therapeutin gesehen und deshalb nicht interpretiert. Weiterhin wurde in dieser Phase der Symbiose die Befriedigung des Bedürfnisses des Patienten nach Spiegelung seiner Individualität und seiner subjektiven Realität für existentiell wichtig erachtet.

Die Autorin möchte mit dieser Arbeit die Bedeutung des direkten menschlichen Kontaktes und des Vertrauens zwischen Patient und Therapeut für den Heilungsprozeß schwerkranker Patienten zeigen.

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Psychological Aspects of Resistance to the Treatment of Feminine Hyperprolactinaemia

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Assuming that emotional or stress factors influence prolactin secretion, the authors inquire into psychological aspects of feminine hyperprolactinaemia, resistant to therapy. They study the emotional reactions and psychodynamics in seven women aged between 18 and 35 by individual interviews and group meetings. In identifying the psychological implications which determine the resistance they find a previous narcissistic wound to the women's feminity which characterizes the entire group and which will be reopened by the endocrinological recovery. The authors suppose that the subjects' tendency to establish a static relationship with the illness reflects an ambivalent relationship with the mother figure and the conflict of becoming her rival or remaining incomplete in order to defend her.

Introduction

It is well known that emotional or stress factors can influence prolactin secretion. The function of prolactin, in fact, is connected with a very important field which concerns the whole emotional structure in every person: sexual potency in males and procreative capacity in females. The presence of idiopathic hyperprolactinaemia and the different forms of resistance to surgical or pharmacological treatment suggest the possibility that psychological factors, that is basic emotions organized on complex interior experiences, could condition the relationship between the body and prolactin secretion. In our research we specifically examined the relationship between resistance to therapy in sterile women, who were affected by hyperprolactinaemia and psychological dispositions connected with female identity.

Methods

Emotional reactions in seven women aged between 18 and 35 affected by hyperprolactinaemia resistant to therapy were studied. Two of them were married and two others had a steady partner. The remaining three had no partner. The highest levels of prolectinaemia recorded fluctuated between 100–550 ng/ml. Three women had previously undergone transphenoidal surgery without a normalization of prolactin levels.

We used individual interviews and group meetings as the means of conducting our study. Every subject was interviewed twice and we held ten

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group meetings led by two trainers, a woman and a man respectively. Six subjects participated in those group meetings, two of whom participated in all the meetings. In conducting the group we utilized Gestalt therapy techniques, psychodrama, music therapy and psychoanalysis. As we were interested in identifying the psychological implications which determined resistance and not the psychotherapeutic treatment of resistance, we used eclecticism in the choice of techniques to stress the experimental and diagnostic aspects.

To evaluate the forms of resistance we based our study on a comparison between the anamnestics endocrinological data and the diagnostic data which was derived from the psychological investigation. These data were obtained independently from each other (in double blind) and then analyzed together for the purpose of our investigation.

Results and Discussion

Psychological Features

A clear relationship between hyperprolactinaemia and psychiatric disorders was not found. In the last few years a hypothesis of an increase of prolactinaemia in depressed subjects has been put forward, but the data appear to be extremely controversial (*Kasper* et al. 1988, *Kitamura* et al. 1988, *Klein* at al. 1984, *Linkowski* et al. 1989, *Maes* et al. 1989, *Rubin* et al. 1989). In any case, the variations supported by documentary evidence are minimal in comparison with the prolactin levels found in the women who were the subjects of our research. We excluded at the outset the possibility that psychiatric disorders in these women could be the result of hormonal trouble, and the possibility that such disorders could be the direct cause of the high prolactin levels.

As a matter of fact, only in one subject there was made a diagnosis of dysthymia, according to DSM-III-R. In the other subjects a clear psychiatric disorder was absent. However, this absence was linked to the presence of psychological conflicts which, without producing a real clinical picture according to DSM-III-R criteria, nevertheless conditioned the emotional and relational dynamics of the subjects in a more or less evident way.

Beginning with the initial diagnostic phase, two kinds of psychological typologies began to emerge in the course of our research: subjects with prevalent hysterical aspects and subjects with prevalent depressive aspects. In subjects with relational dynamics mostly of hysterical kind the internal implications were organized around emotional schemes of contra-position between fear and desire and between excitement and censure. In this context the demand for help and protection appeared ambivalent and manipulative in order to control the relationship. Instead, in those subjects with depressive relational dynamics, the emotional management of the relationship tended towards control of the ambivalent feelings. The diffi-

culty of integrating tenderness with anger and loving with bitter aspects was clear, and was much more evident when musical instruments were used.
Hysterical and depressive aspects combined variously with each other, but, except for the subject who was affected by dysthymia, in four subjects the hysterical emotional dynamics were prevalent and in the other two the depressive dynamics were prevalent.

Profiles and Forms of the Resistance

In the three cases subjected to adenectomy the level of prolactinaemia was much higher than normal: 110, 119 and 125 ng/ml. In any case the inefficiency of the surgical operation had no bearing on the subsequent evolution of the clinical picture.

Only in one case, concerning the subject who was affected by dysthymia and who had already undergone surgery, the resistance to the pharmacological treatment (based on bromocriptine and other dopaminergic agonists) persisted with continuous amenorrhea, and the values of prolactinaemia fluctuated between 80–150 ng/ml. In the other subjects we noticed phases of relatively good response to therapy with phases of total or partial resistance.

The resistance also showed itself indirectly with a greater sensitivity to side effects which regularly required the interruption of treatment (four cases), and, in the other three cases, the amenorrhea persisted periodically, while prolactinaemia levels were more or less normalized.

Finally, in two subjects, the prolactin levels had become normal, but during our investigation, there was a reaction of anxiety, which partially regressed afterwards. This anxiety reaction temporarily raised questions concerning the results of the endocrinological therapy.

On the whole, the direct resistance to pharmacological treatment was stronger in subjects with more evident depressive aspects, while the increase in sensitivity to side effects and the anxiety reaction to the hormonal normalization was typical of the subjects with hysterical emotional dynamics. The resistance concerning menstrual cycle occurs in both psychological typologies.

In table 1, we report the data concerning the kinds of resistance and correlated them with the psychological diagnosis and various parameters such as age, partner relationship, years passed since the first diagnosis, and frequency of participation in the group experience.

Subjects	Age	Partner relationship	Years passed since the first diagnosis	Age of menarche	Surgical treatment	Participation in the group experience	Psychological diagnosis	Kinds of resistance	Biological parameters
1	33	No	18	13	Yes	constant	Dysthymia (DSMIIIr)	emotional reactions, treatment resistant hyperprolactinaemia	PRL 150 ng/ml amenorrhea
2	26	Yes	14	12	No	constant	prevalent hysterical aspects	partial treatment resistance of PRL, emotional reactions, side effects sensibility	PRL 19 ng/ml regular menstruation
3	31	No	18	13	Yes	periodic	prevalent hysterical aspects	partial treatment resistance of PRL, periodic amenorrhea not related to PRL levels, side effects sensitivity	PRL 10.2 ng/ml amenorrhea
4	34	Yes married	13	13	No	frequent	prevalent hysterical aspects	partial treatment resistance of PRL	PRL 32.3 ng/ml regular menstruation
5	21	No	6	18	Yes	frequent	prevalent depressive aspects	partial treatment resistance of PRL, periodic amenorrhea not related to PRL levels	PRL 30 ng/ml amenorrhea
6	18	Yes married	4	12	No	periodic	prevalent hysterical aspects	partial treatment resistance of PRL, side effects sensitivity	PRL 35 ng/ml regular menstruation
7	32	Yes married	17	13	No	---	prevalent depressive aspects	partial treatment resistance of PRL, periodic amenorrhea not related to PRL levels	PRL 30 ng/ml regular menstruation

Table 1: Data about the kinds of resistance correlated with the psychological diagnosis and various parameters.

Relational Conflicts

The relational implications of the subjects we examined are organized around two main figures: the mother and the partner (be she/he real or imaginary).

Mothers represent the privileged interlocutors of their daughters' »secret« because the daughters tend to hide their situation from their partners by only partially informing them. A relationship of complicity forms between the daughter, who tries to get rid of her anxieties by partially projecting them on to her mother, and the mother, who in her turn tends to identify herself with the daughter and assumes a function of support and comfort. This relationship seems to remain on a superficial level, leaving the deeper trouble uncovered. As a matter of fact, the understanding the daughter has with the mother expresses, in its emotional implications, in the women we examined, a fear of being different (*Sobrinho* and *Almeida-Costa* 1992 speak of a symbiotic, malignant relationship) more than a possibility of real communication.

Instances of aggressiveness constantly interfere with the demand for motherly support, thus giving rise to a relationship of strong ambivalence which is in singular symmetry with the unconscious symbolic perception of hyperprolactinaemia. Prolactin and the tumour which secretes it are represented in fantasies elaborated in free association in the group through ambivalent images which are centred on »nutritious« aspects, »body flooding with milk«, »a bunch of grapes«, »mozzarella«, »ever-flowing fountain«. The strong determination of our patients to »attack and destroy« prolactin reflects, at an unconscious level, the envy towards the maternal capacity of nourishing. In this sense the nearly obsessive interest towards the prolactinaemia levels (in contrast with the denial of the illness) involves,

in some respects, the same process of control through which anger towards a very important motherly function is neutralized but changed into envy.

In relationships with partners, the emotional dynamics are dominated by the figure of an absent father constantly sought after and avoided at the same time. The relationship with the partner appears to be oriented towards a principally weak male figure whose value is at the same time protected and lessened. Hysterical relational aspects prevail over ambivalent feelings, that is: aggressiveness towards the man (which has its origins in the dominant Oedipal frustrations) takes a back seat compared with the feeling of inadequacy and the fear of exposing themselves without protection in an exciting, but at the same time, uncontrolled relational field. As a consequence at a level of unconscious Oedipal valences the relationship with the man is organized around the complementary figure of brother-partner who proposes a rearranged but reassuring relationship.

The Feelings of Maternity and Female Identity

In our patients the perception of their maternal qualities is full of depressive feelings. Free fantasies worked out in a group demonstrate this: »something dead«, »empty cylinder«, »vase of trash«, »ash-tray«, »butterfly«, »puddle«, »falling leaves«. The feelings of depression are connected with an unconscious feeling of rivalry with the procreating capacity of the mother whose figure takes on aggressive nuances. The scene is ruled by the perception of an aggressive relationship between mother and child which translates into an unconscious attack against pregnancy. The image of the internal feminine space, which is diminished in value, becomes associated, in terms of projective identification (*Klein* 1946), with the image of the maternal womb aggressively emptied, giving origin, on the rebound, to feelings of emptiness and loneliness.

The feelings of rivalry and envy towards the maternal womb are reflected in the feeling of ambivalence concerning children, these feelings were particularly evident in the two patients with prevalently depressive aspects. These feelings, which fluctuate between the feeling of a mother in difficulty and that of a neglected daughter, show a desire for possession and hyperprotectiveness together with elements of coolness or destruction.

In hysterical subjects femininity is associated with fantasies of lust and madness which are opposite to fantasies of chastity and wisdom. In the group the search for a balance between the two opposite tendencies, constantly reproduces, behind an apparent variety and mobility, the two initial poles of the contradiction, leaving the conflict unresolved.

Conclusions

At the pathogenetic level, the psycho-dynamic data obtained show the existence of a narcissistic wound in the perception of their femininity

typical of the whole group of people we examined. Such a wound may be linked to the difficulties of identifying with the feminine mother image, in the ambit of the Oedipal relationship which are peculiar to the immediately pre-Oedipal phase in infancy or with feelings of inadequacy and vulnerability towards the father figure within the area of triangular Oedipal relationships.

In this psychological context, the depressive instances which we found, although at variable rates in all of our patients, represent, in terms of defence, the mediation between the latent feelings of envy and rivalry and the narcissistic identification with the mother, self-object (*Kohut* 1971), who allows in infancy the partial reconstruction of the damaged female identity. Hysterical instances, instead, express the tendency to compensate the feelings of vulnerability and uncertainty with the control of emotional dynamics in the sexuality area.

Recovery from the endocrinological disease re-establishes, at an organic level, the parameters of femininity, the procreating capacity and the menstrual cycle, and heals the emotional uneasiness caused by their alteration. In the presence of previous psychological conflicts, the endocrinological recovery runs the risk of bringing out the old wound of femininity, so that the subject passes through a crisis because she had found in the organic disease the possibility of making concrete a psychological disablement, filling its vacuum and justifying it. The resistance rises in this field of use of the organic disease and expresses opposition to every change which would leave the narcissistic wound uncovered again. The feminine integrity at an organic level in these conditions, makes the psychological disorder more intense, without however justifying it. In this way the feminine integrity excites the dangerous conflicts of ambivalence again and reproposes the dangers connected with the hysterical relational modalities.

The psychological inclination of women who resisted the hyperprolactinaemia treatment to remain in a condition of sterility gives rise to a static relation (at a conscious level) and to a high maintenance (at an unconscious level), of the levels of prolactinaemia. This tendency reflects, in the field of her ambivalent relationship with the mother figure and her own femininity, an attempt to control the opposite desire to be like the mother and compete with her, or to remain incomplete and defend her.

The psychogenic resistance to the treatment of hyperprolactinaemia makes itself clear at more than one level: at the level of anxious manifestations which are independent from the biological circuit of the hormone and exclusively connected to psychological elaboration; at the level of peripheral action of prolactin with the persistence of amenorrhea or dysmenorrhea even after the normalization of the secretion of the hormone (persistence that in part may even be an expression of a somatization); and finally, at the level of a direct interference of psychological and conflictual elaboration on the prolactin secretion.

The interference of complex emotions with the secretion of the pituitary hormone, which derives from the hypothalamus-pituitary axis and its con-

nections with the limbic system, gives to the endocrinological and psychiatric research a refined task of exploring that field of stratified functioning of the human bio-computer. In this ambit emotions and endocrinological functions intersect at different levels of complexity which involve our entire repesentational system and not simply elemantary, emotional reactions.

Summary

The psycho-dynamic study of seven hyperprolactinaemic women, resistant to pharmacological treatment, revealed, a previous narcissistic wound to their femininity which was characteristic of the entire group. An endocrinological cure would increase, in these conditions, their psychological discomfort which is linked to the disturbance of their feminine identities, but which is more justified by organic lesion. The resistance arises in this field of secondary psychological gain of the organic illness, in opposition to any change which would reopen the narcissistic wound. These subjects' tendency to establish a static relationship with the illness (in which the conscious attempt to lower the levels of prolactin in the blood is cancelled by the unconscious desire to keep them high) reflects an ambivalent relationship with the mother figure and the conflict of becoming her rival or remaining incomplete in order to defend her.

Psychologische Aspekte der Therapieresistenz weiblicher Hyperprolaktinämie

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Emotionale Faktoren beeinflussen bekanntermaßen die Prolaktinsekretion. Das Vorkommen einer idiopathischen Hyperprolaktinämie und die gelegentlich zu beobachtende Resistenz gegen chirurgische oder pharmakologische Behandlungen lassen darüber hinaus vermuten, daß auch psychologische Faktoren die Prolaktinsekretion beeinflussen können. Um diese These zu belegen, untersuchten die Autoren sieben Frauen im Alter von 18 bis 35 Jahren, bei denen eine therapieresistente Hyperprolaktinämie vorlag. Vier von ihnen lebten in fester Partnerschaft, bei drei von ihnen war erfolglos eine transphenoidale Operation durchgeführt worden. Jede der Frauen wurde zweimal interviewt und nahm bis auf eine Ausnahme an bis zu zehn Gruppensitzungen teil, in denen Techniken verschiedener psychotherapeutischer Verfahren angewandt wurden, um psychologische Befunde erheben zu können, die Rückschlüsse auf die Therapieresistenz erlauben könnten.

Zwar fand sich nur bei einer Frau ein entsprechend DSM-III-R klassifizierbares Krankheitsbild, doch bestanden bei allen starke psychische Kon-

flikte, die ein Teil eher hysterisch, der andere Teil eher depressiv verarbeitete. Es fand sich ein Zusammenhang zwischen psychischer Reaktion und medikamentöser Behandlung, nämlich daß die Therapieresistenz bei depressiv Reagierenden größer war, während bei hysterisch Reagierenden verstärkt Nebenwirkungen auftraten. Als untersucht wurde, in welchen Beziehungsdynamiken die Versuchspersonen standen, fand sich eine symbiotische Beziehung zur Mutter, die oft als einzige der Angehörigen die Krankheit genau kannte, mit der aber tiefergehende Schwierigkeiten nicht besprochen werden konnten. In der Partnerwahl wurden schwache Männer bevorzugt, wobei die Beziehung oft aggressiv unterlegt war, worin die Autoren eine Wiederholung der enttäuschenden Beziehung zum abwesenden Vater sehen. Als die Frauen zu ihrer Selbstwahrnehmung hinsichtlich weiblicher Identität und Mutterschaft befragt wurden, hatten die gemachten Äußerungen eine eindeutig depressive Qualität. Bestimmt vom Erleben einer aggressiven und von Rivalität gekennzeichneten Beziehung zur Mutter, bestand im Unbewußten eine Ablehnung der Schwangerschaft und Eifersucht und Neid auf die Geborgenheit des ungeborenen Kindes. Die Frauen selbst teilten Gefühle von Einsamkeit und innerer Leere mit.

Die erhobenen Befunde lassen sich nach Ansicht der Autoren dahingehend zusammenfassen, daß alle sieben Frauen an einer schweren narzißtischen Wunde litten, die ihre Weiblichkeit betraf. Eine erfolgreiche medizinische Behandlung würde das Leid vergrößern, das sich zwar aus der Störung der weiblichen Identität ergab, das aber durch die organische Schädigung mehr gerechtfertigt erschien. Im Sinne eines sekundären Krankheitsgewinns entstand die Therapieresistenz, da jede Besserung der Hyperprolaktinämie die narzißtische Wunde neu eröffnen würde: Dem bewußten Bemühen, den Prolaktinspiegel im Blut zu senken, stand der unbewußte Wunsch, ihn erhöht zu halten, entgegen. In dieser zwiespältigen Haltung, die zu einem unveränderlichen Zustand der Erkrankung führte, sehen die Autoren zum einen die ambivalente Beziehung der untersuchten Frauen zu ihrer Mutter widergespiegelt und zum anderen den unbewußten Konflikt ausgedrückt, entweder deren Rivale zu werden oder sie auf Kosten eigener Verletztheit abzuwehren.

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Buchbesprechungen / Book Reviews

Jorge Alberto Costa e Silva, Carol C. Nadelson (Hrsg.)
International Review of Psychiatry, Vol. 1

American Psychiatric Press Inc., Washington, London 1993, 690 Seiten

Mit dem vorliegenden Buch eröffnet die World Psychiatric Association (WPA) eine neue Reihe wissenschaftlicher Publikationen, die dem Turnus der WPA-Kongresse folgend in dreijährigem Abstand mit weiteren Bänden fortgeführt werden soll. Wie *Juan J. López-Ibor* in seinem Vorwort schreibt, ist der Entschluß der WPA, ein solches Periodikum zu schaffen, Ausdruck der in den vergangenen Jahren zugenommenen Internationalisierung der Psychiatrie, wie sie mit den ersten psychiatrischen Weltkongressen begonnen habe, und des anhaltenden Bemühens, eine international anerkannte und geteilte Fachsprache zu schaffen. Die einzelnen Bände sollen jeweils Themen von besonderer Wichtigkeit aufgreifen, welche von verschiedenen Verfassern unter unterschiedlichen Gesichtspunkten dargestellt werden sollen.

Im ersten Abschnitt, bearbeitet von *Juan E. Mezzich* und *Miguel R. Jorge,* werden Fragen der psychiatrischen Nosologie behandelt, welchem die beiden Herausgeber eine kurze historische Übersicht der psychiatrischen Klassifikation vorangestellt haben. Autoren aus Ägypten, Dänemark und Bulgarien, Brasilien, Guatemala und den USA befassen sich mit Grundfragen psychiatrischer Diagnostik, wobei der Bedeutung psychosozialer und kultureller Faktoren für eine multiaxiale Diagnostik breiten Raum eingeräumt wird. Die gegenwärtige Forschung ist dabei, ein weiter differenziertes Diagnoseschema zu entwickeln, um sowohl die Symptomatik eines Patienten als auch seinen kulturellen und persönlichen Hintergrund kategorisieren zu können.

Als zweites Thema werden die jüngsten Entwicklungen der klinischen Psychopharmakologie dargestellt, nämlich zum einen neue Medikamente für die Akutbehandlung von depressiven Zuständen und von Schizophrenie, von Angststörungen und von dementiellen Prozessen, zum anderen aktuelle Strategien zur Langzeitbehandlung von affektiven und schizophrenen Psychosen. Die Autoren der beiden letztgenannten Artikel, *Ellen Frank, David J. Kupfer* und *Michael Thase* bzw. *Samuel J. Keith* und *Nina R. Schooler,* empfehlen jeweils eine Langzeitbehandlung mit Psychopharmaka, da ihrer Ansicht nach die bisherigen Vergleichsstudien zur Wirksamkeit von Psychotherapie und Schizophrenie eindeutig zugunsten letzterer ausgefallen seien. Kritisch ist m. E. dabei anzumerken, daß den zitierten Studien ein eingeschränktes Verständnis von Psychotherapie zugrunde liegt, wonach z.B. die Behandlung nur wenige Stunden pro Woche umfaßt hat und sie nicht auf einem psychodynamischen Krankheitsverständnis beruhte. Ferner scheint mir bei dieser Gegenüberstellung von Psycho-

therapie und Pharmakotherapie die Berücksichtigung der Nebenwirkungen der Psychopharmaka zu fehlen, die bei vielen Patienten die Lebensqualität erheblich beeinträchtigen.

Der dritte – und ausführlichste – Abschnitt des Buches ist der Neurobiologie gewidmet. Seine Kapitel über moderne bildgebende Darstellungen des Gehirns, psychiatrische Genetik, Neurotransmitter, Neurophysiologie und Neuropathologie sind für den klinisch tätigen Psychiater geschrieben. Sie geben einen prägnanten Einblick in den gegenwärtigen Wissensstand, zumal die beschriebenen Befunde jeweils auf die wichtigsten psychiatrischen Krankheitsbilder bezogen werden. Die Beiträge regen zur Diskussion an: Sind die Befunde über die pathologischen Reaktionsweisen des Gehirns die Mechanismen, die psychische Erkrankungen hervorrufen, wie *Andreasen* und *Sato,* die beiden Herausgeber dieses Abschnitts, in ihrem Vorwort vermuten? Oder inwieweit drückt sich in ihnen eine zum morphologischen Substrat gewordene und lebenslang erfahrene Psychodynamik aus? Es sind Fragen, die die Psychiatrie während ihrer ganzen Geschichte beschäftigt haben und zu ebenso erbitterten wie fruchtbaren Auseinandersetzungen zwischen »Psychikern« und »Somatikern« geführt haben.

Der vierte Abschnitt schließlich wendet sich dem weltweiten Problem des Alkoholismus zu, wobei im Mittelpunkt die therapeutischen Möglichkeiten sowohl psychologischer wie medikamentöser Art stehen. In einem unter psychotherapeutischen Gesichtspunkten sehr interessanten Beitrag stellt *Marc Galanter* aus New York die »Netzwerk-Therapie« von alkohol- und drogenabhängigen Patienten vor: Der Therapeut baut mit dem Patienten zusammen ein Netzwerk von Beziehungen auf, in dem dieser menschlichen Halt finden soll, wenn er ansonsten zu einem Suchtmittel gegriffen hätte. Dieses Modell, das von der Überlegung ausgeht, daß man dem abhängigkeitskranken Patienten etwas Besseres als die Droge anbieten muß, um ihm helfen zu können, ist m.E. sowohl auf Industrienationen wie auf die sich entwickelnden Länder der Dritten Welt gut übertragbar.
Der von *Jorge Alberto Costa e Silva* und *Carol C. Nadelson* hervorragend edierte erste Band einer »International Review of Psychiatry« wird seinem Anspruch gerecht. Man darf auf die weiteren Bände gespannt sein.

Bernhard Richarz (München)

Antonio Lambertino
Psychoanalyse und Moral bei Freud

Bouvier Verlag, Bonn 1994, 394 Seiten

Erst 1994 ist das Werk des italienischen Psychoanalytikers und Moralphilosophen *Antonio Lambertino* »Psicoanalisi e Morale in Freud«, das 1987 in Italien veröffentlicht wurde, in deutscher Sprache erschienen. Diese und die ähnlich ausführliche und umfangreiche Arbeit des amerikanischen Psychoanalytikers und Philosophen *Ernest Wallwork,* »Psychoanalysis and Ethics« (London, New Haven 1991), dürften die bisher einzigen Versuche sein, *Sigmund Freuds* Werk nicht nur in Teilaspekten mit Blick auf sein Ethik- und Moralverständnis zu lesen und zu interpretieren.

Lambertino schließt an eine genaue Untersuchung der philosophischen, wissenschaftsgeschichtlichen und naturwissenschaftlichen Bedingungen des *Freud*schen Denkens eine gegenstandgeleitete Exegese an, die das ganze Werk umfaßt und den Schwerpunkt der Abhandlung auf Entwicklung und Verständnis des Gewissens-Konzepts in den metapsychologischen und kulturanthropologischen Schriften und die Frage nach der menschlichen Freiheit und Autonomie legt. *Freuds* Konzeption des Gewissens, zugehörig dem im wesentlichen unbewußten Über-Ich, schließt eine ethische Instanz im Menschen aus, der virtuell Autonomie zukommt. Das Gewissen ist die Verinnerlichung des von der elterlichen Autorität gebotenen Triebverzichts, Resultat der Angst vor dem Verlust der elterlichen Liebe, Resultat von Kastrationsangst, Umwandlung der gegen den Elternrivalen gerichteten Aggression gegen sich selbst. Anhand von »Das Ich und das Es« (1923) und »Das ökonomische Problem des Masochismus« (1924) arbeitet *Lambertino* heraus, daß mit Einführung des Todestrieb-Konstrukts das Gewissen einen weiteren verschärften Akzent erfährt, insofern es gänzlich Funktion des Destruktionstriebs wird: »Das Gewissen wäre somit die lebende Verkörperung des menschlichen Bedürfnisses, sich selbst zu zerstören und wäre somit auf einen masochistischen Instinkt zurückzuführen. Es würde damit zu folgendem widersprüchlichen Verhalten führen: bei der Introjektion der Aggression und deren Erhebung zur Instanz des Über-Ichs gegen die Triebe dekretiert das Ich seinen eigenen Tod, es hat sogar einen *Hang* zum Tod.« (*Lambertino* S. 228) Gemäß den Antinomien von Todestrieb und Libido werden dann Entwicklung und Vorhandensein von die Gemeinschaft regulierenden Wertsetzungen dem Wirksamsein der Libido zugerechnet, Vernunft verdankt sich dem Eros. In seinen theoretischen Grundpositionen ist für *Freud* der Mensch in seinem Naturzustand antisozial, daß er sich bemüht, ethische Prinzipien zu verwirklichen, verdankt sich utilitaristisch wirksam werdender Vernunft, die auf die Libido zurückführbar ist, ihrerseits wiederum dem Todestrieb unterworfen.

Lambertino zeigt insbesondere im letzten Kapitel zum Freiheitsbegriff die Widersprüchlichkeit in *Freuds* Denken auf, das Verfangensein in mechanistisch-deterministischem Denken, das beibehalten wird, obwohl

die Behandlungspraxis der Psychoanalyse die Virtualität menschlicher Freiheit impliziert. Es findet auch hier eine strikte Polarisierung statt zwischen dem Begriff der Freiheit als etwas Unbedingtem und Absolutem und dem »durchgängige(n) Determinismus alles seelischen Geschehens« (»Zur Vorgeschichte der analytischen Theorie«, 1920), dem *Freud* den Willen und alles menschliche Handeln unterworfen sieht. Dem steht entgegen, daß die Psychoanalyse als Therapie aus dem Wiederholungszwang herausführen, Fixierungen aufheben und »dem Ich des Kranken Freiheit schaffen soll, sich so oder anders zu entscheiden« (»Das Ich und das Es«, 1923).

Der *Freud*schen Konzeption von Ethik und Moral als einem reaktiven psychischen Geschehen, als einem Defizienzmodell ethischen Bewußtseins setzt *Lambertino* eine Positivformulierung der wesensmäßigen Möglichkeit des Menschen zu einem »reifen Gewissen« entgegen, entlang einer philosophisch hermeneutischen Darlegung. Der Autor geht von naturethischen Vorstellungen aus, wonach der Mensch das »immanente, innere, seiner Konstitution als Mensch angepaßte Vermögen« (S. 289) hat, das Gute vom Bösen zu unterscheiden, geht also genau von der Prämisse aus, die *Freud* ablehnte, ablehnen mußte, so meint *Lambertino*, weil er die Unterscheidung, die der Philosoph *Brentano* – den *Freud* hörte – in diesem Zusammenhang zwischen »angeborenem« und einem Vermögen, das die »aktive Beteiligung und den freien Gebrauch der Vernunft« erfordert, machte, nicht nachvollzog, sondern konkretistisch den Begriff natürlich mit angeboren gleichgesetzt habe (S. 288).

Die Reifung eines moralischen Bewußtseins wird von *Lambertino* als Teil eines wiederum dem Menschen inhärenten Entwicklungsprinzips angesehen, der Selbsterfüllung, die sich »in Zusammenhang mit der Realisierung des Interpersonalen vollzieht« (S. 331). So gerne wir *Lambertino* folgen würden, zu welch' widersprüchlichen Schlußfolgerungen und Aporien *Freud* auch immer gekommen sein mag, so merkwürdig nimmt es sich aus, daß der Autor in der Hauptsache lediglich andere ontologische Positionen einnimmt und bei seiner hermeneutischen Begründung hinter das psychoanalytische Bemühen zurückgeht, die komplexe Vermitteltheit menschlicher Entwicklung transparent zu machen. So führt *Lambertino* als Hinweis für ein genuines moralisches Bewußtsein im Menschen beispielhaft an, Kinder hätten bereits frühzeitig ein Gefühl für gerechtes und ungerechtes Handeln. Der Autor generalisiert ein Einzelphänomen, zieht nicht in Betracht, daß es u.U. besonderer Umwelt- bzw. gruppendynamischer Bedingungen bedarf, damit sich überhaupt die Fähigkeit wahrzunehmen und zu unterscheiden entwickelt, und mißachtet, daß es wiederum unabhängig sein kann von der Ausbildung dieser Fähigkeiten, ob beispielsweise ein Mensch dann nicht doch ein Leben lang in pathologischer, unbewußter Treue dem Unrecht tuenden Elternteil hörig bleibt.

Wiewohl es geboten sein mag, einen neuen oder erweiterten Entwurf einer psychoanalytischen Ethik zu machen, der *Freud* korrigiert, neue Ansätze

musanalyse zurück. Das Moment, das *Wallwork* bei *Freud* würdigt und für die philosophische Ethik reklamiert, das Subjekt in der Bedingtheit seines Handelns, seiner Motivation und unbewußten Intentionalität verstehen zu wollen, um ihm die Möglichkeit der Emanzipation zu eröffnen, wird bei *Lambertino* der Analyse von *Freuds* denkerischen Grundpositionen geopfert. Es erhebt sich die Frage, ob nicht ein solches Unterfangen einem Irrtum aufsitzt, nämlich konkretistisch ein 'work in progress' in die statische Systematik zu zwingen, die es unterläuft.

Astrid Thome (München)

Jörg Wiesse (Hg.)
Chaos und Regel. Die Psychoanalyse in ihren Institutionen

Vandenhoeck & Ruprecht, Göttingen 1992, 217 Seiten

In den 80er Jahren setzte eine intensive Auseinandersetzung mit der Geschichte der Psychoanalyse in der Zeit des Nationalsozialismus ein, ihren Verstrickungen und bis zur Selbstaufgabe reichenden Anpassungen in dem verzweifelten Versuch, »die Fackel der Psychoanalyse durch die dunkle Nacht des Nationalsozialismus« hindurchzuretten, wie *Freud* es gegenüber *Felix Böhm* und *Carl Müller-Braunschweig* formuliert hatte. *Böhm* war seit Sommer 1933 Vorsitzender der Deutschen Psychoanalytischen Gesellschaft (DPG) in der Nachfolge von *Eitingon*, der als von den Nazis unerwünschter Ausländer von der DPG veranlaßt wurde, den Vorsitz niederzulegen. Zahlreiche Verhandlungen *Böhms* und *Müller-Braunschweigs* mit den politisch Verantwortlichen des NS-Regimes führten zur Integration des Berliner Psychoanalytischen Instituts in das Deutsche Institut für Psychologische Forschung und Psychotherapie.

Der vorliegende Band stellt eine Sammlung von Originalbeiträgen von – überwiegend zeitgenössischen – psychoanalytischen Autoren dar, die Formen der institutionellen Zusammenarbeit der Psychoanalyse mit dem NS-System untersuchen, darüber hinaus aber auch den Prozeß der Institutionalisierung der Psychoanalyse seit dem 2. Psychoanalytischen Kongreß 1910 in Nürnberg sowie Voraussetzungen und Konsequenzen der Spaltung in DPG und DPV im Nachkriegsdeutschland.

Regine Lockot, bekannt geworden durch ihr 1985 erschienenes Buch »Erinnern und Durcharbeiten. Zur Geschichte der Psychoanalyse und Psychotherapie im Nationalsozialismus«, sieht in ihrem Beitrag in dem frühen Tod von *Karl Abraham* (1925), der zentralen Kristallisations- und Integrationsfigur der Anfänge der Psychoanalyse in Deutschland – 1910 gründete er zusammen mit *Eitingon, Hirschfeld* u.a. die Berliner Ortsgruppe der soeben in Nürnberg ins Leben gerufenen Internationalen Psychoanalytischen Vereinigung (IPV) – den »ersten entscheidenden Bruch in der

psychoanalytischen Bewegung in Berlin« (S. 132). Schon vor 1933 kam es zu einem Exodus von bedeutenden Pionieren der Psychoanalyse wie *Melanie Klein, Sandor Rado, Franz Alexander* und *Karen Horney,* die nach England bzw. den USA gingen und dort eigene theoretische und therapeutische Ansätze entwickelten. *Schultz-Hencke*, der sich zu weit von der herrschenden Lehrmeinung entfernt hatte, erhielt bereits ab 1929 am Berliner Institut Lehrverbot. »Vielleicht«, so die Autorin, »hat eine gewisse, aus dieser Vorgeschichte entnehmbare »Prämorbidität« der Gesellschaft (der DPG; G. v. B.) zu dem Mangel an Solidarität mit den später ausgewiesenen Juden geführt« (S. 133).

Die Autorin skizziert anschließend die Mechanismen der »Selbstgleichschaltung«, mit denen die »reichsdeutschen« Psychoanalytiker versuchten, Arbeitsbedingungen herzustellen, unter denen die Fortführung psychoanalytischer Behandlungen und die formale Existenz der DPG gesichert wäre – die DPG wurde 1938 aufgelöst! Sie beschreibt anschließend »die Auswirkungen des Nationalsozialismus auf die Gruppenbildungen« (so der Titel ihres Aufsatzes), sowohl unter der NS-Herrschaft – sie führt aus, daß Analytiker wie *Schultz-Hencke* und *C.G. Jung* die neuen nationalsozialistischen Machtverhältnisse als Vehikel für ihre eigenen Interessen benutzt hätten – als auch in der Nachkriegszeit in dem von ihr so bezeichneten »kalten Krieg« zwischen den beiden Berliner Gruppen um *Müller-Braunschweig* und *Schultz-Hencke.*

Der Titel des Buches »Chaos und Regel« umreißt das grundsätzliche Dilemma, in dem sich nach dem Herausgeber *Jörg Wiesse* alle psychoanalytischen Institutionen befinden: das »kreative Chaos«, das durch die Entfesselung des Unbewußten in der Analyse zu Tage trete, stehe in einem grundsätzlichen Reibungsverhältnis zu den reglementierenden und verdrängungsfördernden Prozessen der Institutionalisierung. Er selbst geht in seinem Aufsatz über den Nürnberger Kongreß den historischen Anfängen der Psychoanalyse nach. Für *Freud* selber bedeutet dieser Kongreß von 1910 mit seiner Gründung der IPV das Ende der »Kindheit« der psychoanalytischen Bewegung.

In dem Band sind zwei historische Texte enthalten von *Karen Horney* und *Hanns Sachs* anläßlich des zehnjährigen Bestehens des Berliner Psychoanalytischen Instituts im Jahr 1930 zu Fragen der Organisation und der Lehranalyse.

Andere Beiträge beschäftigen sich mit dem Einfluß unterschiedlicher Organisationsformen der Psychoanalyse auf die Identitätsentwicklung des Analytikers (*Tobias Brocher*) und mit einer kritischen Analyse hierarchischer Ausbildungsstrukturen innerhalb der DPV (*Johannes Cremerius*).

Die ausführlichste und mit reichem Quellenmaterial belegte Arbeit von *Bernd Nitzschke*, beschäftigt sich mit der Ausgrenzung *Wilhelm Reichs* aus der IPV.

In seinem Aufsatz »*Sigmund Freud* und die Politik« bezeichnet *Rudolf Ekstein* die psychoanalytische Bewegung als eine geistige Revolution, »als

eine unvollendete Revolution, als eine Bewegung, die nur lebendig bleibt, wenn sie weitergeht, wenn sie nicht stillsteht und sich nicht in sentimentaler orthodoxer Vergangenheit aufhält« (S. 213).

Die Unauflösbarkeit des Widerspruchs von Psychoanalyse und Institution, die der Tenor vieler Beiträge dieses Buches ist, basiert freilich auch auf dem Festhalten an der *Freud*schen Negativ-Konzeption des Unbewußten als dem Verdrängten sowie einem spürbaren mangelnden Vertrauen in die Kraft von kreativen Gruppierungen, ihre eigenen gruppendynamischen Prozesse zum Gegenstand der Reflexion und zum Motor von Entwicklung zu machen.

Gabriele von Bülow (Berlin)

Andrea Huf
Psychotherapeutische Wirkfaktoren

Psychologie Verlags Union, Weinheim 1992, 264 Seiten

Die Autorin untersucht in ihrer Literaturarbeit die Wirkfaktoren von Psychotherapie, speziell der Psychoanalyse, Gesprächspsychotherapie und Verhaltenstherapie, wobei sie die jeweiligen Schulrichtungen hinsichtlich ihrer zugrundeliegenden Persönlichkeits- und Störungstheorie, ihrer Therapietheorie, Therapieziele und Indikatoren analysiert. Ziel ist die Beantwortung der Fragen, ob die »Effektivität von Psychotherapie durch die Wirksamkeit schulenspezifischer Variablen (spezifische Wirkfaktoren) oder durch schulenübergreifende Komponenten des therapeutischen Prozesses (unspezifische Wirkfaktoren) bedingt (wird) und in welchem Verhältnis (diese) spezifischen und unspezifischen Wirkfaktoren zueinander» stehen. Aus der vergleichenden Psychotherapieforschung wählt die Autorin als methodischen Zugang zur Behandlung ihres Anliegens die wichtigsten bisher existierenden Meta-Analysen zum Effektivitätsvergleich unterschiedlicher Therapieformen, wie beispielswiese die Meta-Analysen von *Luborski,* von *Singer* und *Luborski,* von *Smith* und *Glass,* von *Wittkamm* und *Matt* sowie die Berner Therapievergleichsstudie von *Grawe, Caspar* und *Ambühl,* die die interaktionelle Verhaltenstherapie in Gruppen und einzeln, die normale verhaltenstherapeutische Breitspektrumtherapie und die Gesprächstherapie einander gegenüberstellt. Hinzu kommen noch die beiden Meta-Analysen zum Effektivitätsvergleich unterschiedlicher Therapieformen von *Durlak* und von *Gunzelmann, Schiepek* und *Reinecker.*

Die Effektivitätsvergleiche der in den Meta-Analysen untersuchten Therapierichtungen brachten keine grundlegenden quantitativen Wirkungsunterschiede, »differenziertere Auswertungen des Therapieverlaufs«, so die Autorin, »verweisen jedoch auf qualitativ voneinander abweichende Veränderungsmuster«. Grundlage für diese Schlußfolgerung sind empirische

Untersuchungen zum Einfluß unspezifischer Wirkfaktoren und Patienten-Therapeuten-Interaktionsvariablen auf den Therapieerfolg. Die Befunde weisen darauf hin, daß eine vertrauensvolle Therapeut-Patient-Beziehung (unspezifische Wirkfaktoren) eine wichtige Voraussetzung dafür bildet, daß die verschiedenen therapeutischen Methoden (spezifische Wirkfaktoren) ihre Wirkung erst entfalten können. Dabei ist die Abstimmung der eingesetzten Techniken auf die individuellen Bedürfnisse des Patienten von wichtiger Bedeutung. Als Konsequenzen aus diesen Ergebnissen empfiehlt die Autorin die Kombination von Therapieelementen aus unterschiedlichen Schulen, d.h. das eklektische therapeutische Arbeiten, beispielsweise die Zusammenarbeit verschiedener Therapeuten in Gemeinschaftspraxen, allerdings auf der Grundlage von noch zu entwickelnden integrativen Metatheorien und Handlungsmodellen für ein begründbares eklektisches Vorgehen. Ob allerdings dieser eklektisch orientierte Lösungsansatz eine Zukunftsperspektive für die Weiterentwicklung der Psychotherapie darstellt, ist fraglich. Es besteht die Gefahr, daß einem unreflektierten und unüberprüfbaren Eklektizismus Vorschub geleistet wird, zumal es fraglich ist, ob und wann die Entwicklung eines einheitlichen, integrierten Therapiemodells gelingen kann. Die bislang vorliegenden, von der Autorin auch diskutierten Versuche z.B. von *Garfield, Lazarus, Bastine, Deneke* und *Dietrich* befinden sich allesamt noch in den Anfängen.

Insgesamt ist die umfassend zusammengestellte und akribisch analysierte Arbeit von *Andrea Huf* nicht nur für den Psychotherapieforscher, sondern auch für den praktizierenden Therapeuten sehr anregend. Sie läßt sich in die übergeordnete Diskussion nach der Gültigkeit der beiden großen in der Psychologie und Medizin diskutierten Hauptströmungen, des naturwissenschaftlich-quantitativen und des geisteswissenschaftlich-hermeneutischen Zugangs zum Menschen ein. Die Autorin schließt sich hier dem zunehmend auch in anderen Wissenschaften geforderten Trend nach einem grundlegenden Paradigmenwechsel in der Psychologie und Psychotherapie an, der den Menschen in seinen Bezügen und übergeordneten Zusammenhängen, auch seinen sozialen Bezügen versteht und untersucht. »Damit verändert sich die Gewichtung naturwissenschaftlicher und hermeneutischer Methoden: Gesprächsführung, teilnehmende Beobachtung, Gruppendynamik und Hermeneutik werden zu Basismethoden, während Statistik, Epidemiologie und experimentelle Methoden diese ergänzen und differenzieren«. Nicht nur hinsichtlich dieser, sondern auch hinsichtlich der Forderung nach einer ganzheitlichen und integrativen Sicht des Menschen in Diagnostik und Psychotherapie vertritt die Autorin einen Standpunkt, den die humanstrukturelle und gruppendynamische Psychoanalyse *Ammons*, ausgehend von dem *Freud*ianischen, ich-psychologischen und objekttheoretischen Ansatz, seit vielen Jahren prozeßhaft zu einer eigenen Richtung weiterentwickelt hat.

Etwas bedauerlich ist daher, daß sich die Autorin in ihrer Untersuchung psychoanalytischer Wirkfaktoren auf die *Freud*schen Theorieentwicklungen

beschränkt und andere psychoanalytische Richtungen unberücksichtigt läßt. Für die Bewertung der bisher vorliegenden Ergebnisse aus der psychoanalytischen Psychotherapieforschung und der daraus abgeleiteten Schlußfolgerungen wäre eine solche Analyse von großem Wert. Trotz gemeinsamer konzeptioneller Behandlungselemente, wie beispielsweise der Arbeit mit Übertragung, Gegenübertragung und Widerstand gibt es zwischen den verschiedenen psychoanalytischen Richtungen große Unterschiede in Menschenbild, Persönlichkeits- und Krankheitstheorie, Behandlungstheorie und -praxis, so daß die Forschungsergebnisse nicht unmittelbar miteinander vergleichbar sind.

Ilse Burbiel (München)

Dieter Sandner (Hrsg.)
Analytische Gruppentherapie mit Schizophrenen

(Beiheft 22 zur Zeitschrift Gruppenpsychotherapie und Gruppendynamik – Beiträge zur Sozialpsychologie und therapeutischen Praxis. Herausgegeben von Anneliese Heigl-Evers, Dieter Eicke und Hannes Friedrich)

Verlag für Medizinische Psychologie im Verlag Vandenhoeck & Ruprecht, Göttingen 1986, 198 Seiten

Da die Therapie mit »Schizophrenen«, wie sie kategorisch genannt werden, auch heute noch als Novum mit der Frage nach Praktikabilität und Effektivität behandelt wird, erscheint es uns sinnvoll, an dieser Stelle auf ein Buch hinzuweisen, das zu diesem Thema vor annähernd zehn Jahren erschienen ist. Obwohl manche der Arbeiten zur analytischen und analytisch orientierten Gruppentherapie mit schizophren reagierenden Patienten sowohl aus dem ambulanten als auch aus dem stationären Bereich fast eine Dekade später eher historisch zu verstehen sind, enthält das Buch eine immer noch anregende Sammlung von Beiträgen zur Behandlungstechnik. Die Autoren, im wesentlichen zentriert um die inzwischen aufgehobene Forschungsstelle für Psychopathologie und Psychotherapie der Max-Planck-Gesellschaft in München, kommen zu dem Schluß, daß Gruppentherapie mit »Schizophrenen« möglich, ja sogar eine gemeinsame Therapie mit Neurotikern erfolgreich ist – sofern sie ein Minimum an Behandlungsdauer von wenigstens drei Jahren überschreitet und der behandelnde Gruppentherapeut zu flexibler Behandlungstechnik in der Lage ist.

Dem Herausgeber geht es verdienstvollerweise darum, das immer noch weit verbreitete Vorurteil gegen eine psychotherapeutische und erst recht gruppentherapeutische Behandlung schizophren Reagierender abzubauen und faßt hierzu Erfahrungen verschiedener, z.T. prominenter Autoren mit unterschiedlichen Erfahrungen und Arbeitsweisen zusammen.

Detlev von Zerssen etwa sieht in seinem 1964 erschienenen Erfahrungsbericht die therapeutischen Erfolgsaussichten auf gruppentherapeutischer Basis eher pessimitisch, macht aber vor allem auf viele ungünstige Behandlungsbedingungen aufmerksam: Homogenität der Gruppenzusammensetzung – z.B. nur junge, nur weibliche, nur schizophrene Patientinnen, ein einzelner Therapeut. Er diskutiert hier zurecht die Frage der Gruppenzusammensetzung, der Größe der Gruppe, des institutionellen Rahmens, der Behandlungsdauer und des Umgehens mit Übertragung und Gegenübertragung. *Dieter Eicke* (1967) schätzt die gruppentherapeutischen Möglichkeiten für schizophren Reagierende optimistischer ein, spricht sogar von möglichen »strukturellen Änderungen des schizophrenen Prozesses«. Er mißt dabei der analytischen Deutung durch den Gruppenleiter große Bedeutung bei und plädiert u.a. für die Interpretationstechnik der Gruppe als Ganzer im Sinne von *Bion*, aber vor allem für flexibles Vorgehen vonseiten des Therapeuten. Ein weiterer Beitrag (*Greve* 1977) diskutiert die Frage der gemeinsamen Behandlung von Schizophrenen mit Neurotikern und kommt trotz kurzer Sitzungsdauer (45 Minuten) und häufigem Patientenwechsel in seiner Vier-Jahres-Studie zu positiven Erfahrungen. *Sandner* (1980) schließt sich dem Ansatz der gemeinsamen Behandlung an und betont die Wichtigkeit der Gesamtinterpretation von Gruppenprozessen, stellt aber auch fest, daß eine Behandlung kürzer als von zwei Jahren Dauer eigentlich nichts bringen kann. Ein weiterer Beitrag (*Mattke*) diskutiert die Erfahrungen eines niedergelassenen Psychotherapeuten, wo die Frage der Gruppenzusammensetzung und der anderen Behandlungsbedingungen besondere Bedeutung erhalten. Er plädiert weniger für eine Modifizierung gängiger gruppentherapeutischer Behandlungstechniken, sondern vielmehr für Integration einer kleinen Gruppe schizophren Reagierender in eine Neurotikergruppe. Sehr indirekt wird bei *Poppe* die Frage der Aggressionsbearbeitung abgehandelt, wo sich die Autoren wundern, daß nach einer langen »harmonischen Mittelphase« vermehrt Abbrüche bis zur Beinahe-Selbstauflösung der Gruppe stattfinden und sie dann in der Konsequenz für frühzeitige Entidealisierung der Therapeuten und Bearbeitung der symbiotischen Wünsche plädieren. *Schwarz* (1982) schließlich plädiert für die differenzierte Behandlung von eher schizoaffektiven und eher paranoiden Psychosen, wohingegen der Herausgeber (*Sandner* 1983) die Bedeutung der Schaffung einer tragfähigen Beziehung zum Therapeuten, die Wichtigkeit des Umgangs mit negativer Übertragung und die Bedeutung der Kontinuität für derartige Gruppen betont. Grundsätzlich plädiert er für die Festlegung von Grundfragen der Behandlungstechnik bei gemeinsamer Behandlung unterschiedlicher Krankheitsbilder, aber modifiziertem Umgang je nach Überwiegen der vorherrschenden Symptomatologie. Eine weitere Arbeit (*Klug*) beschäftigt sich mit der Kooperation zwischen stationärer und ambulanter Therapie für Patienten, die im Sinne einer »Stufentherapie« mehrfach stationär aufgenommen werden müssen. *Battegay* und *von Marschall* (1982) stellen schließlich eine katamnetische Langzeit-Untersu-

chung einer halboffenen analytischen Gruppe mit schizophrenen Patienten unter zusätzlicher neuroleptischer Medikation vor, die deren Überlegenheit gegenüber der ausschließlich medikamentösen Behandlung zeigt. Vermutet werden sogar mögliche strukturelle Veränderungen bei den Patienten, allerdings nur bei einer Behandlungsdauer von wenigstens drei Jahren oder länger. Ein Befund, den auch der Herausgeber (*Sandner* 1983) in einem Modellversuch bestätigt: Schizophrenietherapie ist nur bei einer längeren Behandlungsdauer sinnvoll und effizient, die gemeinsame Behandlung mit neurotischen Patienten nicht nur sinnvoll, sondern sogar notwendig. Der Hinweis, schizophren kranke Patienten seien in einer Neurotikergruppe wie das »Salz in der Suppe«, wirkt etwas zynisch.

Die Einzelbeiträge zur Gruppenpsychotherapie mit »Schizophrenen« sind vor allem historisch gesehen interessant hinsichtlich eines veränderten Behandlungsverständnisses. Unangenehm ist das Überwiegen von Kategorien-Denken, ein Denken in Strukturen fehlt. Ein Hinweis auf menschliche Einzelschicksale, welche die Diagnose zweitrangig werden lassen, scheint den Autoren fremd. Auch das Bedenken unbewußter Prozesse und eine partnerschaftlicheBeziehung kommt zu kurz. Dennoch zeigen die Beiträge das Bemühen um einen Weg zur Behandlung dieser schwer zu behandelnden Patienten. Daß *Ammon* weder als Autor noch als einer der erfahrensten Schizophrenietherapie-Pioniere irgendwo auftaucht, ist schwer einfühlbar.

Gerhard Wolfrum (München)

Winfried Rief und Wolfgang Hiller
Somatoforme Störungen: Körperliche Symptome ohne organische Ursache

Verlag Hans Huber Bern, Göttingen, Toronto, Seattle 1992, 186 Seiten

»Hauptmerkmale dieser Gruppe von Störungen sind körperliche Symptome, die eine körperliche Störung (daher somatoform) nahelegen. Es lassen sich für diese Symptome jedoch keine organischen Befunde oder bekannte pathophysiologische Mechanismen nachweisen, und es ist evident bzw. liegt der Verdacht nahe, daß psychischen Faktoren oder Konflikten Bedeutung zukommt.« So definieren die Autoren auf Seite 24 in Anlehnung an DSM-III-R das interessante Thema ihrer Arbeit, die somatoformen Störungen. Beide kommen aus der klinischen Praxis, denn sie arbeiten unter Leitung von *Manfred Fichter* in der Medizinisch-Psychosomatischen Klinik Roseneck am Chiemsee.

Ihrer kurzen theoretischen Einleitung am Beginn des Buches folgt das wohl mit Abstand interessanteste Kapitel zum Thema der Diagnostik. Mit viel Sachkenntnis und in gut verständlichem Stil stellen die Autoren dar, wie somatoforme Störungen in den beiden verbreitetsten psychiatrischen Diagnosesystemen, dem amerikanischen DSM-III-R und der neuen ICD-10 der

Weltgesundheitsorganisation, eingeordnet sind. Dabei wird gezeigt, wie die ICD-10 viele Kriterien des DSM-II-R übernommen hat, so auch den Begriff der somatoformen Störung. Einige nicht ganz unwichtige Unterschiede gibt es aber doch: Beispielsweise wird diskutiert, daß die Konversionshysterie im DSM-System selbstverständlich zu den somatoformen Störungen gerechnet wird, während sie in der ICD von ihnen getrennt verschlüsselt wird. Gerade wer damit beginnt, Diagnosen zu erstellen und eines der Diagnosesysteme zu verwenden, wird im vorliegenden Buch wertvolle Anregungen finden. Es ist laut Vorwort nicht zuletzt als Überblickswerk für Studierende geschrieben und mit Tafeln und Übersichten didaktisch gestaltet.

Im dritten Kapitel erhält der Leser Hinweise auf standardisierte Interviews zur Diagnosefindung, ferner auf Checklisten für die tägliche, klinische Praxis, die die Differentialdiagnose erleichtern sollen, sowie auf Fragebögen.

Der vierte Abschnitt widmet sich der interessanten Frage der sogenannten Komorbidität – also des gemeinsamen Auftretens – von psychischen Krankheiten und somatoformen Störungen. Es werden epidemiologische Untersuchungen vorgestellt, aus denen hervorgeht, daß stationär behandelte, depressive Patienten oft auch somatoforme Störungen aufweisen, ja oft wegen dieser ursprünglich medizinische Hilfe aufgesucht hatten. Die Häufigkeit der somatoformen Störungen wird in den verschiedenen Untersuchungen zwischen 25% und 74% angegeben. Zu einer Diskussion dieser widersprüchlichen Befunde kommt es leider nicht. Hier stößt die deskriptiv epidemiologische Sichtweise der Autoren an ihre Grenzen. Wir finden lediglich die etwas befremdliche Erklärung, man müsse die verschiedenen Einzugsgebiete der einzelnen Untersuchungen beachten, da ja bekannt sei, daß »... in einfachen, sozialen Schichten oder bei Personen aus weniger entwickelten Ländern« somatoforme Störungen häufiger aufträten (S. 74). Ebenso wenig Substantielles erschließt sich dem Leser aus den Erörterungen über die Zusammenhänge zwischen somatoformen Störungen auf der einen Seite und Angststörungen, Borderline-Erkrankungen oder der neuen, amerikanischen Modediagnose Multiple Persönlichkeit auf der anderen Seite.

Weitere Teile des Buches befassen sich mit der Epidemiologie somatoformer Störungen, mit deren gesundheitspolitischer Relevanz und ihrem Auftreten in allgemeinärztlichen Praxen, was ich für sehr wichtig halte. Es folgen verschiedene Bedingungsfaktoren für die Entstehung somatoformer Störungen, die jedoch insgesamt kein integriertes Modell, sondern lediglich eine eklektizistische Ansammlung altbekannter Konstrukte darstellen. Angefangen von genetischen und neuropsychologischen Faktoren, geht es über kognitive Ansätze der Einstellungen zu Gesundheit und Krankheit, der Selbstbeobachtung und verstärkten Wahrnehmung von Körperprozessen bis hin zu Konzeptionen der Alexithymie, Lebensereignisforschung und der Coping-Strategien. Lediglich psychoanalytische Vorstellungen fristen

ein Mauerblümchendasein. Selbst wenn man sie nicht teilt, wären sie bei ihrer praktischen Verbreitung einer Erwähnung wert gewesen. Das Buch endet mit seinem schwächsten und kürzesten Teil: Er behandelt eine verhaltensmedizinisch orientierte Therapie somatoformer Störungen.

Die Stärke des Buches liegt in der Deskription und der Darstellung der Einordnung somatoformer Störungen in die gängigen Diagnosesysteme. Hier kann der Praktiker viele Hinweise erhalten. Eine anregende, spannende Diskussion der vielen, brennenden Fragen, die das Thema aufwirft, habe ich leider vermißt. Nicht einmal der nicht unproblematische Begriff »somatoforme Störung«, der ja bereits im Buchtitel steht, wird kritisch hinterfragt. Schließlich ist es durchaus die Frage, ob nun dieser Begriff oder verwandte Begriffe, wie psychosomatische oder funktionelle Störung, das Leib-Seele-Wechselspiel dieser Erkrankungen besser verkörpern.

Thomas Abel (Berlin)

Helmut Junker
Nachanalyse – Ein autobiographisches Fragment

edition diskord, Tübingen 1993, 184 Seiten

»Nachanalysen sind selten, noch seltener Berichte über sie« schreibt der Verlag in seiner Werbung zum Buch des Kasseler Universitäts-Dozenten und Lehranalytikers der Deutschen Psychoanalytischen Vereinigung (DPV/IPV). Entsprechend neugierig ging der Rezensent an die Lektüre »des außergewöhnlichen Buches, wo der Therapeut als Patient zur Sprache kommt« (Verlagswerbung). Natürlich dachte der Rezensent an den wichtigen nachanalytischen Prozeß, der in der Regel nach einer abgeschlossenen großen Analyse noch einmal wichtige Einsichten und Prozesse ermöglicht. Doch Enttäuschung machte sich breit, denn das Buch stellte sich als Neuauflage bzw. Wiederaufnahme einer möglicherweise unzureichenden Erstanalyse heraus, als streckenweise interessanter, dann wieder langatmiger und sicherlich für den Betroffenen wichtiger Therapiebericht, wo sich der Autor selbst als gespalten zwischen seiner Rolle als Patient und Autor bzw. Therapeut fühlt. Interessant die Beschreibungen der »in Symptomen versteinerten Kindheitserinnerungen«, die sich in massiver Asthma-Symptomatik, einer vom behandelnden Lehranalytiker als »Lungenwelt« bezeichneten Weltansicht und einer dahinter liegenden Depression äußern. Weniger interessant und eher banal anmutend die Problematik von Ehescheidung, Verlustangst, Anklammerung an Freundin und Töchter. Ein bißchen weit hergeholt wirkt der Versuch, diesen ausladenden und sehr persönlichen Therapiebericht aufzuhängen an der Äußerung *Freuds*, »jeder Analytiker sollte periodisch, etwa nach fünf Jahren, sich wieder zum Objekt der Analyse machen, ohne sich dieses Schrittes zu schämen« (1937).

Größeren Nutzen hätte der Leser, wenn der Autor nicht die bereits 1974 exhibitionistisch anmutenden »Lehrjahre auf der Couch« von *Tilman Moser* kopiert hätte, sondern die Problematik und Symptomatik des Patienten auf einer theoretischen Ebene aufgearbeitet und interpretiert hätte, wie dies etwa *Freud* in seinen Krankengeschichten oder der »Traumdeutung« getan hat. Die Frage bleibt nur, wem dies zu persönlich geworden wäre – dem Autor oder dem Patienten?

Gerhard Wolfrum (München)

Helmut Volger
Die Vereinten Nationen

R. Oldenbourg Verlag München Wien 1994, 229 Seiten

Anschaulich und voller Details stellt der Autor die Arbeit der Vereinten Nationen vor, wie sie mit dem Ziel der Friedenssicherung auf verschiedenen Gebieten erfolgt. Die Vereinten Nationen, nach dem Zweiten Weltkrieg gegründet, damit sich ein so furchtbarer Krieg nicht wiederholt, in den ersten 40 Jahren ihres Bestehens durch die anhaltenden Spannungen der Supermächte in ihrer Wirksamkeit beeinträchtigt, stehen nun seit dem Ende der Sowjetunion vor einem neuen Abschnitt ihrer Geschichte.

Es war die Politik *Gorbatschows*, die auch bei der UNO neue Wege eröffnete: Seine im September 1987 in einem Prawda-Artikel gemachten Vorschläge zur effizienteren Gestaltung des UN-Systems veranlaßten die USA nach anfänglicher Zurückhaltung, ihren Rückzug aus der UNO aufzugeben. Durch die sich entwickelnde Zusammenarbeit der Großmächte wandelten sich die Handlungsmöglichkeiten der UNO von der einfachen Stationierung von UN-Truppen zur Sicherung eines bereits ausgehandelten Friedensschlusses zur mitwirkenden Konfliktfrüherkennung, Friedensstiftung und Friedenskonsolidierung.

Im einzelnen beschreibt *Volger*, auf welche Weise die UNO im Golf-Konflikt, in Jugoslawien, in Somalia und in Kambodscha Einfluß zu nehmen suchte, um ihrer Aufgabe, dem Frieden in der Welt zu dienen, gerecht zu werden. In Erweiterung ihres bisherigen Selbstverständnisses waren die Vereinten Nationen in Kambodscha am wirtschaftlichen und sozialen Wiederaufbau eines vom Bürgerkrieg zerstörten Landes beteiligt und bemühten sich in Somalia, den Zerfall einer staatlichen Ordnung zu verhindern. Dabei zeigt *Volger* auf, daß die Vereinten Nationen nur dort erfolgreich wirken können, wo zwischen den Kriegsgegnern Gesprächsbereitschaft vorhanden ist, und daß sie dort scheitern müssen, wo sie fehlt. Der anhaltende Krieg in Jugoslawien ist für ihn nicht auf ein Versagen der UNO zurückzuführen, sondern Ausdruck des fehlenden und trotz aller Bemühungen nicht zu schaffenden Friedenswillens der verfeindeten Par-

teien. Langfristig strebt die Politik der UNO nicht den verstärkten Einsatz von eigenen Truppen an, da dadurch die Konflikte nur eskalieren können, sondern sie will versuchen, durch im voraus vermittelnde Gespräche einen Konflikt erst gar nicht entstehen zu lassen. Darüberhinaus möchte die UNO erreichen, wie ihr Generalsekretär *Boutros-Ghali* in seiner »Agenda für den Frieden« vom Juni 1992 darlegte, daß die Staaten sich zu einem Verzicht auf Gewaltanwendung bereiterklären und daß sie sich verpflichten, ihre Konflikte vor dem Internationalen Gerichtshof auszutragen.

Mit dieser Entwicklung einher, so *Volger*, geht eine Ausweitung des Friedensbegriffes. Im Verständnis der UNO meint Frieden nicht mehr nur die Abwesenheit von militärischen Konflikten, sondern innerhalb der Vereinten Nationen setzt sich zunehmend die Auffassung durch, daß der Frieden auch gefährdet ist durch eine ungerechte Weltwirtschaftsordnung und durch Umweltprobleme. Aus diesem Grund verstärkten die Vereinten Nationen ihre Bemühungen auf diesem Gebiet durch die Organisation zahlreicher Konferenzen wie der Klimakonferenz in Berlin oder durch den Aufbau von innerhalb des UN-Systems eigenständig arbeitenden Sonderorganisationen; entscheidend waren sie auch bei der Erstellung einer neuen Weltwirtschaftsordnung beteiligt. Als eine der veränderten Konstellationen der Großmächte zeigt sich hier, daß sie ihre Zusammenarbeit häufig zum Nachteil der Entwicklungsländer gestalten.

Wie der Autor ausführt, liegt die Möglichkeit der UNO als von den Staaten unabhängige, aber gleichwohl anerkannte Institution darin, Anregungen zu geben und Zielvorstellungen auszuformulieren, auf die sich kleinere Nationen berufen können, um damit ihre Position zu stärken, wie es auch tatsächlich immer wieder mit Erfolg geschieht. Folgerichtig wird derzeit in der UNO auch überlegt, das Recht auf eine intakte Umwelt, das Recht auf ausreichende Ernährung und das Recht auf Entwicklung als unveräußerliche Menschenrechte festzuschreiben, zu deren Verwirklichung die Staaten sich verpflichten sollen.

Volgers Darstellung veranschaulicht eindrucksvoll die Grenzen und Möglichkeiten, innerhalb derer die Vereinten Nationen vor allem als geistige Kraft wirken, um eine friedvollere Welt zu schaffen. Auch wenn sie oft an das Tagesgeschehen gebunden bleiben, schaffen sie auch immer wieder Werte, auf die Menschen, aber auch Staaten sich berufen können. Gerade dadurch, daß sie bei der Verwirklichung ihrer Ziele nicht über Machtmittel verfügen, sondern auf Gespräch und Beziehung setzen müssen, liegt ihre Stärke. Mit ihrer aus innerer Autorität betriebenen Politik wirken sie vorbildhaft für die internationale Staatengemeinschaft, worin ich eine der wichtigsten impliziten Aussagen von *Volgers* überaus lesenswertem Buch sehe.

Bernhard Richarz (München)

Ankündigungen / Announcements

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
Information / Anmeldung: Lehr- u. Forschungsinstitute der DAP e.V., LFI Berlin, Kantstr. 120/121, 10625 Berlin, Tel. 030 / 3 13 26 98; LFI München,

12th International Congress of Group Psychotherapy

Title: Groups on the Treshold of a New Century
Location: Centro Cultural Gral, San Martin, Sarmiento 1551, Buenos Aires, Argentina
Date: August 27 - September 1, 1995
Information: Paraguay 2475 (1121), Buenos Aires, Argentina, Tel. 54-1-792-5986, Fax 54-1-963-5075

Münchner Nuklearmedizin Symposium

Veranstalter: Nuklearmedizinische Klinik und Poliklinik der Technischen Universität München und Klinik und Poliklinik für Nuklearmedizin der Ludwig-Maximilians-Universität München
Ort: München
Zeit: 15.–16. September 1995
Information: PROKOM GmbH, Oberstraße 21, D-41460 Neuss Tel. 02131-21067, Fax 02131-21404

2. Internationaler Kongreß für Hypnose und Psychotherapie nach Milton H. Erickson

Veranstalter: Milton Erickson Gesellschaft für klinische Hypnose e.V.
Ort: München
Zeit: 3.–7. Oktober 1995
Information: Milton Erickson Gesellschaft für Klinische Hypnose e.V., Konradstr. 16, D-80801 München, Tel./Fax 089 / 33 62 56

Kongreß Klinische Psychotherapie

Veranstalter: Verein zur Förderung der wissenschaftlichen Forschung an der Universitätsklinik für Psychiatrie Graz
Thema: Psychotherapie in der Psychiatrie
Ort: Graz, Österreich
Zeit: 19.-22. Oktober 1995
Information: Universitätsklinik für Psychiatrie, Auenbruggerplatz 22, A-8036 Graz, Tel. 043-316-385-3634, Fax 043-316-385-3556

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Impressum

Verlag, Sitz und Geschäftsstelle/Publishing House, seat and office:
»Pinel« Verlag für humanistische Psychiatrie und Philosophie GmbH München, Goethestraße 54, D-80336 München, Tel. (089) 53 96 74, Fax (089) 5 32 88 37
Verlagsleitung und Hauptgeschäftsstelle/Head Office:
Kantstraße 120/121, D-10625 Berlin, Tel. (030) 3 13 28 93, Fax (089) 3 13 69 59
Geschäftsführer des Verlages: Dipl. Ing. Werner Schütz, Kantstraße 120/121, D-10625 Berlin
Druck: Alfa-Druck GmbH, Buch- und Offsetdruckerei, Levinstraße 9a, D-37079 Göttingen
Herausgeber/Editor: Dr. med. Günter Ammon, Meierottostraße 1, D-10719 Berlin (verantwortlich für den wissenschaftlichen Teil)
Buchbesprechungen/Book reviews: Dr. med. (Univ. Tel Aviv) Egon Fabian, Asamstraße 18, D-81541 München
Nachrichtenteil/News: Verantwortlich Dr. phil. Ilse Burbiel, Presse- und Informationsreferentin im Executive Council der World Association for Dynamic Psychiatry WADP, Schwindstraße 1, D-80798 München;
Rechtsanwalt Thomas Hessel, Justitiar und Schatzmeister im Executive Council der World Association for Dynamic Psychiatry WADP, Arcisstraße 59, D-80799 München
Anzeigen/Advertising Manager: Dipl. Psych. Maria Rettenberger, Schmellerstr. 17, D-80337 München (verantwortlich)
Abonnentenabteilung/Subscription management: Dipl. Ing. Werner Schütz, Kantstraße 120/121, D-10625 Berlin
Manuskripte nehmen entgegen/Manuscripts should be sent to:
Hauptschriftleitung: Dr. med. Günter Ammon, Kantstraße 120/121, D-10625 Berlin

Anschrift der Redaktion/Address of the editorial staff:
Kantstraße 120/121, D-10625 Berlin

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Dynamic Psychiatry is published bi-monthly. Annual subscription rate $ 78, for WADP-members $ 62,–, for students 42,– (plus postage charge $ 8,–), per individual copy $ 13,–. Air mail delivery with additional payment on special request. The subscription is prolonged for one year, if it has not been cancelled four weeks before the end of the year. The annual subscription rate should be paid by the 1st of April. The money should be remitted on the account of »Pinel« Verlag für humanistische Psychiatrie und Philosophie GmbH Berliner Volksbank (BLZ 100 900 00) Kto.-Nr. 24 011 208.