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Identity as an interpersonal Exchange. A Challenge for Society

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The author describes the specific difficulties arising from the circumstances of a globalized 'postmodern' society for the developmental task of the formation of identity. Classical contributions to the theory of identity in psychoanalysis are reviewed and the consequences of the 'intersubjective turn' in psychoanalysis for the definition of self and identity are considered. Ammons interpersonal theory of identity and his concept of social energy are described. Consequences from AMMON's theory for the functioning and development of society are drawn.

Keywords: identity, social energy, society, psychoanalysis, Dynamic Psychiatry

Since World War II, the social structure has rapidly changed for the individual. His previous embeddedness in family ties as well as in religious or political traditions and conventions has either changed, or else, these ties have dissolved. The individual is now much more confronted by a discontinuous and fragmented work situation, by a number of choices and by a resulting loneliness as Professor BATTEGAY has put it so poignantly in lecture in Berlin on the topic 'loneliness, addiction, and violence as problems for the individual and society'.

The individual, too, is at risk of 'selfishness, ego-centredness, greed, and hedonism' replacing his ethical values such as loyality, love, caring, and mindfulness etc. as Erich FROMM had already described in 1976 in 'To have or to be'. The consequence is an inner restlessness, an emptiness, and a dissatisfaction with life.

In this context of social change and concomitant instability KEUPP (1999) has conceived identity as an everyday effort, as a project in which the individual has to constantly build and rebuild his identity. This work resembles a patchwork carpet and KEUPP therefore talks about a patchwork identity. He says that for the project of a patchwork identity to succeed material resources and a social network are necessary. He refers to Anthony GIDDENS' 'Runaway world: How globalization is reshaping our lives' (1999), who says, "The most important global

changes in the present concern our private lives—sexuality, relationships, marriage and family."

KEUPP refers in this connect to the following change in the social structure:

- A rapid acceleration and condensation of everyday life,
- people are turning into 'entrepreneurs of themselves',
- dissolution of fixed templates of social roles,
- identity work as an interminable project,
- the anxiety of 'being cut off',
- society's development towards 'measures of security',
- an increasing economization.

This would lead to a 'fluid society', that is, the boundaries are fluid and constants turn into variables.

The essential patterns of such a 'fluid society' are:

- change of values,
- pluralization,
- digitalization,
- disembedding,
- deconstruction of gender roles,
- individualization,
- globalization (compare KEUPP 2009).

Social developments in times of globalization confront us with new demands of identity and new challenges; this means we have to establish new points of view with regard to a post-neo-liberalism politics and society that can counteract the self-alienation of humans, their alienation from fellow-humans and their alienation from nature and their own bodies. What is again crucial in this respect are human contact, social solidarity and democratic social ties with the aim of individual engagement and valuation, of a reduction in bureaucracy, of creating meaning from work and human existence. In this postmodern society there are even more problems that afflict the Ego and human identity. Axel WOLF (1992) points to the 'excessive tiredness' and exhaustion that describe a new 'quiet' illness of our times. This means that the 'postmodern' human being is constantly over-challenged by the demands of work and family and by a pressure to achieve. He is exposed to chronic stress accompanied by a minute structuring of his time and a constant readiness to absorb new competencies and information all of which he cannot

evade.

Even relationships have to be constantly redefined. Thus, the 'post-modern Ego' may be defined as a 'relational Ego' that no longer rests in himself but has to be prepared for constant adaptation and change in his contacts.

Michael WINTERHOFF (2009) also takes issue with the family system as part of the social system in his book 'Warum unsere Kinder Tyrannen werden: Oder: Die Abschaffung der Kindheit'. He says,

> No sooner has a person begun to adapt to a new situation in his social environment, is that situation already outdated and rendered insignificant by a progressive development.
> But people in this society are increasingly overburdened by this development. (2009)

According to him this is a 'development away' from the human being and his real needs with the consequence that the ability to deal with life's reality gets lost, and clearly defined roles are never developed. One's understanding of one's role in relation to children is extremely important for their development, especially with respect to providing a protected space in which children can develop.

If the role of partnership is taken on too early without clearly defined protective boundaries, the development of the child's personality will be at stake.

The absence of meaningful goals in the parents and a certain satiation are the cause that all hope is projected onto the children, who have to serve as partners. What is lost in this development are clear boundaries and the ability to deal with frustration but also the joy that stems from meaningful activities and work. The dependence on an ever-changing technology as well as the affluence that is equally not stable leads to deep-seated anxieties and insecurities. The individual feels overwhelmed, and an exchange of social recognition and affection only exists in a reduced form in society because he is constantly forced to be proactive at the cost of not getting his needs met.

This is where child abuse begins as a way to compensate for the loss of affection. Children are expected to fill the need for partnership, projection and symbiosis. He points out the necessity for engaging with the question of meaning and for facilitating child development by presenting role models for a future oriented society. According to him, nurseries

and schools have an import supportive role in this as the family system is overchallenged in its task to adequately help children in their process of maturity.

Psychoanalytic theorists have only been concerned with the concept of identity since the 1950s, after World War II, in a time of individual and social insecurity. Among the early psychoanalysts Karen HORNEY has to be mentioned. Already in 1937 she has distanced herself from FREUD in her book 'The neurotic personality of our time' in which she points out character deformations, which we have come to understand as personality disorders.

She takes as her premise that pathological family dynamics are the reason for children to develop a 'fundamental anxiety' which makes them feel 'small, insignificant, helpless, abandoned and in danger'. Therefore she understands personality disorders in connection with interpersonal relations. FREUD considers the conflict between individual and society as a certain amount of neurosis that is unavoidable. HORNEY, however, assumes that these conflicts can be overcome and smoothed out by a realization of the self.

In addition, there is ERIKSON, who elaborated on FREUD's psychosexual developmental stages with a special focus on the importance of adolescence for the formation of identity. He talks of identity diffusion if a person does not succeed in developing an ego-identity during the separation from family identifications. ERIKSON includes the social-cultural environment in the dialectical process of identity formation.

Since the 1980s, psychoanalytic theory and practice has tended to move away from intrasubjectivity and towards intersubjectivity. What Günter AMMON has already presented since the 1970s, is now postulated by ALTMEYER and THOMÄ (2006), "That humans feel connected to other humans since birth, and this connection is inscribed in their psychic structure". In this respect TEICHOLZ (1999) says that the displacement from self to subjectivity is a 'postmodern' feature. Subjectivity needs to be understood as a complex and constantly changing process within an intersubjective context. He further says, "The possibility to distinguish between symbol and what is symbolized, and the emergence of language, has turned intrasubjectivity into a mentalized intersubjectivity." (TEICHOLZ 1999)

BOHLEBER (1999, 2006) fears the dissolution of the self in postmodern psychoanalysis. He makes the following recommendation,

> To neither conceive of the unified subject concretely nor to deconstruct it as an illusion, but to understand it as an internal balance of relations, in which the subject emerges as an open system of relationships.
> The child's mirroring in the object of intersubjectivity, that is, the conscious and unconscious fantasies and wishes of the parents about their child, becomes the first real feeling of identity.

BOHLEBER comments on this, "It is a mirroring of one's self in the object in connection with a recognition by the object. Hence, identity is always based in intersubjectivity, and it is also internalized as such a mirroring dialogue." (1999)

As should have become evident by now: the literature presents a largely negative image of society in which the human being has to function.

On the other hand, history proves time and again, as for instance at present in countries in North Africa such as Tunesia, Egypt, and Lybia that people are mobilizing social processes by taking a position, by cooperating and forming a social alliance through which ossified social systems can change, as we were able to witness in countries of the Eastern Bloc in the 1990s.

This kind of confidence in the capacities of the individual, his ability to develop, his ability to take a point of view and create meaning, his creative potential for expression and the power of the group led Günter AMMON to formulate his concept of identity. After his return from America, he left the freudian drive theory more and more behind in the service of developing his own holistic idea of identity. This idea tries to grasp the human being as a whole, that is, the biological, physical, and psychological, and mental qualities are comprehended in a total structure of personality that has more than one dimension. According to him, the development of a person's personality structure is always embedded in group contexts.

AMMON already described the development of identity and emancipation out of groups in 1970 in his book 'Gruppendynamik der Aggression'. In his publication 'Von der spätbürgerlichen Psychoanalyse zur Emanzipation in der Gruppe' ['From a post-bourgeois psychoanalysis to the emancipation in groups'] 1981, he writes, "The prerequisite for a successful adaption is a lively communication between the individual

and the group." [author's translation] A lively communication is 1) that the Ego succeeds in developing and exercising his functions and 2) that the group and, by extension, society at large cooperates in this development. It is in this sense, I think, that adaptation is emancipation. The individual emancipates himself from unavoidable childhood anxieties with the help of the group and achieves an identity free of anxiety. In so far as the group participates and supports this process, it achieves a high level in the ability to communicate and to experience. The group thus enriches its own identity, which enables it to set apart from society of which it is a part.

So, identity is a concept in dynamic psychiatry that is based on an understanding of humans in their various dimensions and in their connections to groups and to the society in which he lives; individuality, both in its physical and mental dimension, cannot be thought apart from groups. Human development always happens in setting oneself apart from and in cooperation with group-dynamic and interpersonal processes and with the aim to integrate these developments into the personality.

AMMON (1982) says here: "Identity and group belong together because only by experiencing one's own personality in the mirror of others and by perceiving, recognizing and valuing others in the group can ego and identity develop." (author's translation)

It is the great merit of AMMON that he has defined and elaborated the principle of social energy (1979, 1982, 1986) as a core group-dynamic principle. By social energy AMMON understands any interpersonal psychical energy; it involves "contact, differentiation, safety, reliability, love, challenges for one's identity, challenges and demands for action, for activity and taking on tasks." (1986) Processes of social-energetic exchange in the primary group are decisive for the development of a personality structure and thus for human identity.

What is crucial in the understanding of social energy in groups is an ethical attitude and the valuation of the concept of a human being that supports a constructive development. This includes questions such as: to what extent are space and time, internal peace, authenticity, ethical values, treatment of work, contact and friendship, tasks, spiritual values and intellectual interests mediated by and lived in a group together with a position on social and political issues?

In Dynamic Psychiatry, social energy, group, identity, personality structure, and the unconscious are entities, which are in constant reciprocal exchange determining human development in a life-long process. The identity of an individual takes center place in this process.

Dynamic psychiatric psychotherapy is therefore called identity and contact therapy. This summons a great challenge for both the individual and the group and society, because to have an identity means to confront questions like 'who am I?', 'what do I want?', what meaningful activity can I pursue in my life?' and it requires one's own point of view. This is also a challenge for society at large as it includes questions such as: which meaningful areas of contact and work, of co-determination, of values can be transferred so that the gap between rich and poor can be closed and the loneliness and emptiness of people be avoided while including a concern for nature and resources.

In his work on society, peace, and aggression AMMON (1986) has been concerned with the connection between anxiety and aggression. Constructive aggression is a necessity for activity, for confrontation and for the capacity to act; constructive anxiety is necessary in order to be able to feel and tolerate anxiety. He, who is not afraid of the open and subliminal threats in the world, is lacking an 'essential human quality' as he calls it. This deficit in anxiety is always related to an endangering of self and other; it leads to destructive aggression. The defence against anxiety leads in the last instance to mental illness.

AMMON, therefore, postulates that anxieties should be openly and genuinely dealt with in education, at work, in the family and in society. To feel anxiety is of crucial importance in times of new social threats, be they economic or political, because only then can solutions be found jointly, solutions that promote a humane understanding and humane actions.

Such an approach is necessary for the emergence of a peaceful and tolerant society. To promote the capacity for peace and peace itself represents a continuous process and a social task for each and every individual. To become a bystander or conformist always involves the danger of resignation, that is, of not really developing an identity and a point of view and of escaping from one's own identity as Erich FROMM has demonstrated in his book 'The fear of freedom' (1942).

AMMON says in this respect,

> This fear and flight from identity marks major parts of our society that I have described elsewhere as a borderline-society. What is characteristic of this borderline illness is the lack of identity and the lack of the capacity for contact and confrontation as well as split-off feelings. ... [He continues,] Today we live in a relatively free and democratic society where we have the possibility to think, talk and write freely; hence, anyone would be an aggressive traitor of life if he did not turn with, all his might, against the perishing of humans due to hunger, thirst, epidemics, and war. (1976, author's translation)

And I would like to add, against the endangering of our environment and living like we can realize in Japan at the moment.

It is here that 'empowerment' has its place in society, that is, to encourage people to perceive their own resources and strengths and use them just as it may be imagined in a realization of ANTONOVSKY's salu-to-genetic model (1979) which states:

- Health and illness form a continuum.
- It is not a question what causes illness but how people succeed in staying well despite various stresses on health.
- Of special importance in health is a person's resilience.
- Of special relevance is the 'sense of coherence', the ability to perceive or create meaning in one's life, that there are goals and projects that are worth pursuing

(quoted by KEUPP 1999).

Huge sums of money are spent on interventions of war or to compensate for massive economic breakdowns, which represent a threat to our opportunities for work. With the 'globalization trap' (MARTIN, SCHUHMANN 2007) poverty is steadily increasing. A 'public' poverty is already felt in social areas such as nurseries, schools, universities, in homes for the elderly and handicapped and in the treatment of mentally ill people as public funds have been withdrawn from these institutions.

It is therefore crucial, then and now, to take a personal point of view towards society. In the 1980s we had a nuclear war threat, in times of globalization, we are threatened by a creeping process that also involves a warlike battle for resources and markets.

AMMON asks each and everyone of us to strengthen our personal ability for peace and erotize, create and energize our life time. Tò accept and confront the challenges of society with our own identity in exchange

with others also means to challenge society in those attitudes that promote the mind, human ethics, peace and nature so that changes can come about.

At the end I want to quote AMMON again, who says,

> To be for peace means spiritual strength, mind, love and non-violence; in the history of mankind it is those qualities that have always won out in the struggle against the power and force of those who rule. (1986)

Or as FOUCAULT (1990) states, "A polis in which everyone would take proper care of himself would be a well-functioning polis. It would find there the ethical principle of its stability."

Zusammenfassung

Seit dem 2. Weltkrieg findet ein beschleunigter Wandel sozialer Strukturen statt, der die Lebensbedingungen des einzelnen Menschen entscheidend prägt und verändert. Die frühere Einbettung des Individuums in familiäre Bindungen, in religiöse oder politische Traditionen und Konventionen hat sich entweder dramatisch verändert und geschwächt, oder ganz aufgelöst. Die fortschreitende Individualisierung mit ihren zahllosen Wahlmöglichkeiten, bei gleichzeitiger Auflösung traditioneller Wertorientierungen, führt zu einer Überforderung des Einzelnen, mit der häufigen Folge von innerer Ruhelosigkeit, innerer Leere, Einsamkeit und allgemeiner Unzufriedenheit mit dem Leben.

In diesem Kontext von sozialem Wandel und damit verbundener Instabilität hat KEUPP (1999) Identität als eine tagtägliche Anstrengung konzeptualisiert, als ein Projekt, bei dem das Individuum permanent seine Identität erschaffen, verwerfen und dann wieder neu gestalten muss. KEUPP spricht in diesem Sinne von einer 'Patchwork-Identität'. Er sieht als Voraussetzung für die tägliche Identitätsarbeit nicht nur materielle Ressourcen, sondern vor allem ein funktionierendes soziales Netzwerk, welches das Individuum in seinem Identitätsprojekt unterstützt.

Die Herausforderungen, welche der gesellschaftliche Wandel den Individuen im Hinblick auf 'Identitätsarbeit' auferlegt, führen auch zu neuen Erkrankungen. So weist etwa Axel WOLF (1992) auf die 'exzessive Müdigkeit' und Erschöpfung der Individuen hin, die eine neue, 'stille' Krankheit unserer Zeit sei. Das postmoderne Individuum ist von Leis-

tungsdruck und chronischem Stress überfordert, gefangen zwischen einer minutengenauen Strukturierung seiner Zeit auf der einen Seite, und der Forderung nach größtmöglicher Flexibilität auf der anderen Seite.

Auch Beziehungen müssen in der postmodernen Gesellschaft permanent neu definiert werden. Dementsprechend kann das 'postmoderne Ich' als 'Beziehungs-Ich' definiert werden, das nicht mehr in sich ruht, sondern zu permanenter Anpassung und Veränderung in seinen Kontakten bereit sein muss.

In der Psychoanalyse begann die Auseinandersetzung mit dem Konzept der Identität erst in den 1950er Jahren, in einer Zeit der gesellschaftlichen und individuellen Verunsicherung. Als Vorläuferin dieser Auseinandersetzung kann Karen HORNEY gesehen werden, die bereits 1937 ein Verständnis von 'Charakterdeformationen' entwickelte, das dem heutigen Konzept der Persönlichkeitsstörung ähnelt. Sie sah Persönlichkeitsstörungen als Folge zwischenmenschlicher Beziehungen. Im Gegensatz zu FREUD ging HORNEY davon aus, dass der fundamentale Gegensatz zwischen Individuum und Gesellschaft durch eine Verwirklichung des Selbst gemildert werden kann.

Ein weiterer Pionier der psychoanalytischen Identitätstheorie war ERIKSON, der die Ablösung aus Identifikationen mit der Primärfamilie als wesentlichen Schritt der Identitätsentwicklung in der Adoleszenz beschrieb und das Konzept der Identitätsdiffusion für jene Fälle beschrieb, in denen die Ablösung aus familiären Identifikationen misslingt. ERIKSON definierte Identitätsentwicklung als dialektischen Prozess zwischen dem Individuum und seiner soziokulturellen Umgebung.

Seit den 1980er Jahren hat sich die Perspektive der Psychoanalyse zunehmend von der Beschäftigung mit intrapsychischen Prozessen weg bewegt, hin zu den intersubjektiven Austauschprozessen. Diese 'postmoderne Wende' der Psychoanalyse vom Selbst zur Subjektivität lässt bei manchen Autoren die Sorge aufkommen, das Selbst könnte sich in der postmodernen Psychoanalyse 'auflösen' (BOHLEBER 2006). Die intersubjektive Fundierung des Selbst in Spiegelungs- und Austauschprozessen muss nach BOHLEBER jedoch nicht zu einer Negation des Selbst führen, erfordert jedoch eine Neudefinition des Selbst, das nun als ein offenes System von Beziehungen zu verstehen sei, das nach einer inneren Balance strebe.

Die intersubjektive Wende in der Psychoanalyse wurde von Günter AMMON bereits in den 1970er Jahren vorweggenommen. Schon in seiner ersten Buchveröffentlichung 'Gruppendynamik der Aggression' (1970) beschrieb er die formative Rolle der Gruppe für die Entwicklung der Persönlichkeitsstruktur des Einzelnen. Als Grundlage erfolgreicher Anpassung des Individuums sah er die lebendige Kommunikation mit der umgebenden Gruppe. Lebendige Kommunikation zeichnet sich dadurch aus, dass a) das Ich des Einzelnen seine Funktionen erfolgreich entwickeln und ausüben kann, und dass b) die Gruppe, und in deren Erweiterung die Gesellschaft als Ganzes, bei dieser Entwicklung mithilft. In diesem Sinne kann Anpassung als Emanzipation verstanden werden. Mit der Hilfe der Gruppe kann sich der Einzelne von den unvermeidlichen Ängsten seiner Kindheit emanzipieren und eine angstfreie Identität erreichen. In so weit die Gruppe an diesem Prozess teilnimmt und ihn unterstützt, kann sie ein hohes Niveau der Kommunikation und der Erfahrungsfähigkeit realisieren. Die Gruppe kann auf diese Weise ihre eigene Identität stärken, wodurch sie sich von der Gesellschaft differenzieren kann, deren Teil sie ist.

Es ist das große Verdienst AMMONS, das Prinzip der Sozialenergie definiert und ausgearbeitet zu haben, das ein grundlegendes Prinzip der Gruppendynamik darstellt. Unter Sozialenergie versteht Ammon jede Form interpersonaler, psychischer Energie. Sie umfasst „Kontakt, Differenzierung, Sicherheit, Verlässlichkeit, Liebe, Herausforderungen an die eigene Identität, Forderungen, zu handeln und Aufgaben zu übernehmen." (1986) Sozialenergetische Austauschprozesse in der Primärgruppe sind entscheidend für die Entwicklung der Persönlichkeitsstruktur und damit der Identität.

In der Dynamischen Psychiatrie werden Sozialenergie, Gruppe, Identität, Persönlichkeitsstruktur und das Unbewusste als Entitäten verstanden, die sich in einem permanenten wechselseitigen Austausch befinden und dadurch in einem lebenslangen Prozess die menschliche Entwicklung bestimmen. Die Identität eines Individuums nimmt in diesem Prozess die zentrale Stellung ein. Diese Sichtweise stellt eine große Herausforderung dar, sowohl für das Individuum, wie auch für die Gruppe und die Gesellschaft. Denn Identität zu haben bedeutet, sich mit Fragen auseinanderzusetzen wie: 'Wer bin ich?', Was will ich?', Welche sinnvollen Aktivitä-

ten kann ich in meinem Leben verfolgen?', und dazu einen eigenen Standpunkt zu finden. Dies stellt aber auch eine Herausforderung für die Gesellschaft dar, da sich dadurch Fragen stellen wie: welche sinnvollen Angebote an Kontakt und Arbeit, an Mitbestimmung, an Wertorientierungen können zur Verfügung gestellt werden, wie kann die Kluft zwischen Arm und Reich überwunden werden, wie können Leere und Entfremdung vermieden werden, unter Berücksichtigung der natürlichen Ressourcen und der Sorge um sie.

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The Value of Psychoanalysis and Dynamic Psychiatry in a Norm-Oriented World

Raymond Battegay (Basel)

To the present day many medical doctors, and among them also psychiatrists and psychotherapists, cultivate the idea of a psyche-soma dualism. On the basis of modern neurophysiological and psychological research, however, we now know that such a concept is an artificial construct. In reality the body and the psyche are inseparable entities, and both are nothing other than two aspects of one and the same human life process. All mental dynamics are at the same time also more or less complex cerebral and thus somatic processes. To a certain degree there already existed an old populär piece of knowledge, namely, that certain emotional states of excitements are often accompanied by physiological reactions.

Keywords. psyche-soma dualism, norm-oriented, neurophysiological, neuro-psychological, conflict-free Ego-sphere

The Nobel Prize Winner Eric R. KANDEL (2000), who at the beginning of his professional career was a psychiatrist and interested in psychoanalysis, later worked in the US National Institute of Health as researcher. He was initially interested in the hippocampus, which plays an enormous role in the processes of memory storage of facts and incidents. He decided to undertake studies on this subject using very simple examples of living beings: the sea-snail Aplisia californica. He discovered their simple nervous system and what is necessary for them to have a protective reflex after having been physically irritated (they retract their breathing organ, the gills, after having been irritated for four days, for more than three weeks). That the result of a habituation training, the physiology of which bears similarities to the protective reflexes of mammals, vertebrates and even humans. With these experiments he proved that repeated somatic irritation in the snail Aplisia californica leads to a process of habituation. Humans generally consider such a habituation as a purely mental process, whereas objectively it is also a somatic one (KANDEL 2006). Despite the great progress made by the possibility to discover the function of the brain and some of the causes of psychic diseases by spectroscopic methods, humans always want to be considered preponderantly

because of their mental capacities. Especially, they expect to be understood with all their inner expectations, hopes and anxieties in treatments by doctors and psychologists.

KANDEL, in the introduction to his book, reports that he was often asked whether his training in psychiatry had a value for his career in neurobiology. His answer was the following (translated from the German version of KANDEL's book).

> My training in psychiatry and my interest in psychoanalysis are central to my thinking. They have given me a perspective on behaviour, which has influenced almost each aspect of my work. Had I skipped my training as medical doctor and had gone to France earlier to work there in a laboratory for molecular biology—of Jacques Monod and François Jacob in Paris—I would have begun my career in molecular biology a little earlier. But the important thoughts for my research, which also initiated my interest for the conscious and unconscious memory, are due to a perspective that psychiatry and psychoanalysis opened up to me.

Sigmund FREUD, at the end of the 19th and the beginning of the 20th century, discovered that humans are directed not so much by their conscious thinking and reflections, as previously thought, but rather by their unconscious dynamics. Through his discovery of the source of our dreams, inspirations and visions he also found the basis of disturbances of our perception, thinking, emotional life, sexuality and communicative capacities. With his method of free association, dream interpretation and analysis of unconscious tendencies as the central points of psychoanalysis, he gave humans the possibility to free themselves of innerpsychic defences and of tendencies to adapt too much to the opinion and judgement of others. Humans can learn to evaluate their own opinions and the positions they want to represent in the world. FREUD, through his psychoanalytic thoughts robbed humans of the illusion that they totally control their psyche; on the other hand, he gave them more freedom to recognize the motives of their dealings, but also allowed a more independent view of public opinions and politics.

In his 'New introductory lectures on psycho-analysis' (1933, p. 80) FREUD writes about psychoanalysis, saying that its intention is to strengthen the Ego in order to make it more independent of the Superego as well as to widen its field of perception and enlarge its organization so that it can appropriate fresh portions of the Id. He summarizes his words in one sentence, 'Where Id was there Ego shall be.' Already from this

quote we can recognize that FREUD saw the aim of psychoanalysis not only in the insight into inner-psychic processes, but also to induce Ego-strengthening in order to deal with social reality. This means that its purpose is, on the one hand, to ameliorate the analysed person's understanding of the unconscious, and on the other hand, to prepare that person's Ego to better respond to or to resist the demands of the outside world. The founder of psychoanalysis, however, directed his interest primarily toward the origins of psychoneuroses und with that dwelled on the past of the people being analysed. This enabled him to get at the psychological sources of neurotic disturbances. Especially in the last two decades, however, people come to seek psychoanalytic help who up until adulthood had no major problems managing their life, but then had difficulties especially with the normative expectations of their personal environment and in their professional life. In our time, in which multiple computerized norms threaten to govern everybody's existence, many people feel unable to adapt themselves to this social and professional reality and begin to suffer from burnout or some other mental or somatic syndrome.

With right the renowned German psychoanalyst Wolfgang LOCH (1960), in an epilogue to the republished book of Heinz HARTMANN ('Ich-Psychologie und Anpassungsproblem' 1939; 'Ego psychology and the problem of adaption' 1958) underlined that FREUD, at the beginning of his work, wanted to compose a comprehensive psychology and to deal the fundamentals of human psyche from his standpoint. As LOCH remarks, only in the 1920s did FREUD in his publications give insight into the genesis and the structure of the Ego, which he saw as decisive for the development of the neuroses as well as for everyday life and drive.

In the publication of Heinz HARTMANN mentioned above, which he first presented in 1937 at the Viennese Psychoanalytic Society, he stated that it is true that the Ego forms itself in the conflicts with Id and super-ego as well as with the environment. But he considered these not to be the unique roots of Ego-development. He wrote

> Not every encounter with the environment, not each process of learning or of ripening to maturity represents a conflict. To this development belongs also the nonconflicting development of perception, intentions, comprehension of facts, thoughts, language, phenomena of repetition, production, the

> well-known phases of motor development, the clutching at a thing, the crawling, the learning to walk and also the maturation and all other learning processes. (HARTMANN 1939; author's translation)

HARTMANN (1939) emphasizes that the processes mentioned, however, are also not totally free of all mental conflicts, especially if there are disturbances in these procedures. But the development of the character or of endowment, which HARTMANN called 'Ego-interests', may not at all be connected with conflicts, but rather correspond in general to the 'conflict-free Ego-sphere'. In my view it is plausible to admit that this sphere is connected with the functions of the mirror neuron system of the ventral premotor cortex of the brain, where, as RIZZOLATTI et al. (1996), RIZZOLATTI, FADIGA et al. (2002), RIZZOLATTI, FOGASSI et al. (2002) discovered , the imitating capacities of the human beings are located. Regina PALLY (2010) of the California University comments in an article with the title 'The brain's shared circuits of interpersonal understanding: implications for psychoanalysis and psychodynamic psychotherapy', while quoting RIZZOLATTI et al. (1996), the functions of these mirror neurons as follows:

> Mirror neurons are brain cells that are activated both when observing someone else perform an action and when performing that same action oneself. The process by which mirror neurons enable one individual to re-create, in his or her brain, the behavior of another individual is referred to as 'behavioral simulation'. (GALLESE 2003; GALLESE et al. 2007; KEYSERS, GAZZOLA 2006; RIZZOLATTI 2001).

In another section of her article PALLY writes, "Because human imitation involves also automatically recognizing the intention of the action, a child can choose to use a different behavior to gain the same goal." We can, therefore, suppose that the mirror neuron system is, at least partly, the cerebral equivalent of the conflict-free Ego-sphere described by HARTMANN (1939).

This conflict-free Ego-sphere, therefore, partly unconconsious and partly conscious, bears the most important mental capacity for the human being to succeed in the norm-oriented world of today. As already mentioned, HARTMANN (1939) concedes that the Ego and with that the conflict-free Ego-sphere may develop themselves, or may be hindered from developing in an adequate manner, by conflicts and deficiency experiences in (early) childhood. Yet, as he underlines, they are not the single origin for them. The human Ego and its capacities grow with the attention

they receive and by taking up challenges, which help to build up an individual's Self and Self-assurance. Social groups, communities and society as a whole represent milieus in which human beings can live out their tendencies and wishes under the condition that they are aware of the written or unwritten norms or written laws.

With their theories Sigmund FREUD (1933) and Heinz HARTMANN (1939) gave humans the possibility to obtain more liberty and strength to establish their abilities and capacities in a world of habitudes, norms and laws which, today under the influence of television, internet and computer, are taking over more and more of people's life. Psychoanalysis can help us to further our Ego-strength and our Self-ascertiveness, to realize our emotional, intellectual, ideological and professional aims, despite the growing number of norms and other hindrances.

Günter AMMON (1986) in his book 'Der mehrdimensionale Mensch' [The multidimensional human being], introduces the term 'social energy', which in his scheme of dynamic psychiatry also activates the formation of the Ego-structure. He writes,

> Social energy may be understood as mental energy, i.e., a motivational factor in the process of human development. This motivation refers to the existence as well as to the behaviour of an individual. Applied to the model of Ego-structure it means that social energy initiates the formation of Ego-structure, which in turn is understood as it were transformed social energy and the identity of an individual as the sum of the experienced social energy in its quantitative and qualitative dimensions. Social energy, therefore, has a transmitter function between the dynamics within a group and the Ego-structures of the personalities of the members of the group. (AMMON 1986; translated from German)

With that AMMON opened up the spectrum of psychoanalysis from the individual-centered aspect to the fact that the human individual is a social being that can be understood only when this social aspect is considered.

Even the infant coming into the world shows this social energy by crying for the presence of the mother. Later, children like to play with others of their own age. In the further stages of life humans always seek out the company or partnership of other individuals. The erotic and sexual life is unthinkable wilhout social energy. As I mentioned elsewhere 'the human being, to realize his or her development, is dependent on the coping and interest of others". (BATTEGAY 2000, p. 37) Martin BUBER (1936, pp.

15-20), in his book 'Ich und Du' [I and Thou] writes that humans get along because of the thou an I. In the light of its group relatedness we can say that the humans become by the we an I. Without groups in which we are integrated we cannot survive. Group psychotherapy, and thus also group analysis, consider the fact that humans are dependent on group contacts. We can, therefore, say that psychotherapy and psychoanalysis gained a wider view by additionally considering the dynamics of social interactions and their value for self-realization.

AMMON , in his book 'Analytische Gruppendynamik' [analytic group dynamics] described the dependence of humans not only on their mother, but also on their social milieu as follows,

> The central problem in the development of the Ego-functions of creativity and constructive aggression lies in delimiting the child from the mother and in a larger sense from the surrounding group. This delimitation, the basis of one's own identity, is not to be understood solely as an individual accomplishment; rather, it is dependent on a helpful mother and an understanding group. Both represent the 'facilitating environment' that supports the child toward the contentment of needs and in the unfolding and experiencing of Ego-functions. (1976, p. 69; author's translation)

Nowadays, in a world in which, as mentioned, humans continually, even in democracies, have to adapt to many norms, a life without desiring self-realization, without a certain self-consciousness, fails to provide humans with satisfaction in their interactions within the groups, communities and states in which they live (BATTEGAY 1977, p.15). The 19th and the beginning of the 20th century was marked by an 'inner-directed society' (RIESMAN 1950, pp. 13-17), in which an altruistic life represented a widely accepted ideal; in the modern 'other-directed society' (RIESMAN 1950, pp. 17-25), in which humans are confronted daily with norms and laws, even young children should be trained to strengthen their self and their self-confidence. When HARTMANN (1939) emphasized the conflict-free Ego-sphere and AMMON wrote about social energy in each individual, these authors were of the opinion that the concentration of the psychotherapist in analytic psychotherapy must not necessarily be directed toward the conflicts of the past of the persons in question, but also toward the development of a conflict-free Ego-sphere and social energy, with the goal of helping the people being treated to gain more self-assurance. Then they will have a greater chance to develop their capacities and to succeed in the struggle with the multitude of norms

governing modern society.

Maria AMMON (2010) in her article 'Identität im Zusammenhang mit gesellschaftlichen Aspekten' [Identity in conjunction with social aspects] considers one of the most important goals of dynamic psychiatry to be the work with the personality structure of the persons being treated. Human beings should be able to be reached in their unconscious nuclei in order to develop from the deficient and destructive parts of their personality constructive, creative, and healthy possibilities of identity and contact with others. She underlines as a central point of dynamic psychiatry, and with that of psychoanalysis in general, the furtherance of the thinking, fantasy and especially emotional realm of the patient as well as learning to deal with anxieties. We therefore can say that, not only in cognitive behavioural therapy, but also in modern analytic psychotherapies, we should encourage people to expose themselves to their anxieties with the purpose of gradually overcoming them. FABIAN (2010) in his book 'Anatomie der Angst. Ängste annehmen und an ihnen wachsen' [The anatomy of anxiety. Accepting anxieties and learning to grow with them] writes,

> Deep psychological therapy is implicitly always one of anxiety, creating trust and contact, bringing things to consciousness as well as diminishing solitude and leading to empathy and essential support. The patient has the experience that his solitude is the result of a deficient development during early childhood, a result of missing empathy, of trauma or neglect, which can be changed by the therapeutic process. FABIAN (2010, p. 281)

All these quotations from representatives of dynamic psychiatry clearly show that analytically oriented psychotherapies help the individuals or groups by working through their inhibitions and with that by overcoming social adversities.

Today, almost all over the world it has become the social norm that both men and women participate in professional life. For many people this fact is simply a clear economic necessity, whereas in most countries of the world it has become a sign of an equalization of the social status of men and women. This development represents a remarkable progress because there is no objective reason to undervalue women in their social position. Yet it must be recognized that, if both parents work, they may no longer have the energy to be consistently at the disposal of their children and to communicate extensively with them. Because their father

and mother are so involved with their professional life and their frequent commitment to cultural and intellectual interests, children may be relatively frequently left alone at home. It is my experience that such children not seldom suffer from not receiving enough attention especially from their mother, but also from their father. That the children, because of the parents' bad conscience, often receive from them expensive presents as a kind of compensation, doesn't in fact ameliorate the situation.

First, the children miss the attention of the parents and, second, these spoiled young people may feel later frustrated when they should be mastering their life independently. In consideration of these facts, we may presume that psychoanalysis and dynamic psychiatry turned their view from concentrating almost exclusively on the past to the present life in order to help patients resolve their adult inner and social difficulties.

A 25-year-old philosophy student sought out my psychiatric help because he was suffering from disturbing compulsive-obsessive symptoms. He lived together with his parents and his younger brother. His father was a medical doctor with many cultural interests, his mother a medical assistant in the father's practice. Because of the parent's many professional obligations, the patient and his brother had as children often been left alone at home. In addition, the parents, because of their cultural interests, visited India and East Africa each spring and autumn. The boys were then taken care of by a grandmother or sometimes by a woman whom they knew only slightly. My patent had shown no visible psychopathological symptoms until the end of secondary school, when he was 19 years old and began complaining that whenever he met up with his father or mother, he had terrible and irresistible thoughts, e. g. that he wished they should die. He was tormented by such involuntary obsessive-compulsive and destructive ideas even toward persons he truly loved. Whenever these thoughts arose, he compulsively repeated them along with actions symbolically linked with them, e. g. taking repeated time-consuming showers. Taking a psychoanalytic approach, I interpreted his thoughts and actions as the result of his aggression toward his parents, who had left him in his early childhood in the hands of people not really close to him. I explained further that the obsessive-compulsive repetitions of his thoughts and actions were also acts of unconscious self-punishment because of his aggressive thoughts toward them and of reactive wishes to

defend himself against them while simultaneously wanting to wash away his guilt. I also said that such aggressions originating in early childhood are understandable and need no later punishment. At the beginning of treatment, however, his obsessive-compulsive and depressive symptoms were so disturbing to him that, parallel to my analytic treatment, I prescribed relatively high doses of neuroleptics and antidepressants.

The gravity of the obsessive-compulsive syndrome gradually diminished in the following years. About eight years later he decided to accompany his father, who in the meantime had developed a severe neurologic disease, and his mother to Thailand for three months' vacation. There he helped his mother to take care of his father, and step by step his obsessive-compulsive and depressive symptoms diminished. After returning with his parents to Switzerland he began suffering once again from his disorder, but in a less severe manner. Apparently his super-ego had become less guilt-inducing after actively having helped his mother to care for his father. Because the parents were leaving to move to another town, he decided to follow them, after twelve years of being my patient. There he sought further treatment with a female psychiatrist, though he remained in occasional contact with me. After further two years he declared that he would go for at least one year to Thailand, where he hoped to lead a normal life and perhaps to find a spouse. I reacted very positively to this project and encouraged him to do so.

This man's example shows in a drastic way how the neglect of a small child, even over a relatively short timespan, can have long-lasting and devastating effects on later development; but that even then a positive attitude on the part of a psychoanalyst toward a patient's plans to revisit a former positively experienced environment may have a beneficial effect on his psychopathological symptoms. As the case of this man with a compulsive-obsessive syndrome also shows, in the analyses of patients modern psychoanalysts and psychodynamicists necessarily have to emphasize the burdens of modern times than used to be the case, with ever more people being born, more norms and laws, and a multitude of temptations. Superficially seen, human life today is easier than in former times, but peopie used to be bound at least to some traditional and religious patterns. Nowadays they often live in the illusion of possessing all possible liberties, which makes it hard for many people to notice that

there are many normative limits that are not always easy to accept or to overcome. Women and men today are frequently tempted to consume the most modern products of fashion or sports, new developments in electronics etc., but in many families not enough cash remains. They have then to take out loans to maintain their standard of living, and often they reach a limit where they are forced to accept the responsibility for their debts. In such situations not seldom people fall into a depression or burnout or a psychosomatic syndrome and come finally to a representative of a psychoanalytic therapy or another psychotherapist.

Recently an article appeared by Stefanie WAGNER et al. (2010) in the German journal 'Zeitschrift für Psychosomatische Medizin und Psychotherapie' [Journal for psychosomatic medicine and psychotherapy] concerning overindebtedness among the German population. They found that seven million people in Germany are affected by being overindebted and/or insolvent, including 4% of the adult population of that country. The study investigated the frequency of financial problems and their effects on physical and mental disorders at a university psychosomatic clinic. A total of 659 patients were assessed for their mental status with the symptom check list SCL-90-R, their physical status with the Gießener Beschwerdebogen (GBB).

The results were the following: 37% of the subjects reported having the mentioned problems. Overindebted subjects reported more physical and mental disorders than those without financial problems. Furthermore, therapists more often recommended more often that patients with such financial problems receive inpatient therapy than patients without these problems. The authors conclude that financial problems should be included in any anamnesis and in therapeutic recommendations for actual therapy of patients in psychosomatic treatment. This study shows clearly that acute problems belong in each psychotherapy, even in psychoanalytically oriented therapies, and should not be neglected. This is true in the psychoanalytic and dynamic treatment of individuals who suffer both in their professional life and in their social environment. They feel constrained by restrictive norms that hinder their self-realisation. Psychoanalysis and dynamic psychiatry, on the one hand, are ideal methods from freeing neurotics and others from their unconscious sources of inhibitions; on the other hand, they also support the analysed per-

sons in their Ego-strength and in their Selves. The same is true for group analysis, which through the participation of other individuals supplies a milieu for insight as well as for social learning. Often a combination of individual analysis with subsequent group analysis seems to have the best therapeutic results, since in classic psychoanalytic therapies narcissistic problems often do not come to the foreground as in therapeutic groups, where rivalry problems can break out and be treated. People who have experienced both kinds of analytic psychotherapy may be best prepared to realise themselves in the norm-oriented world of today.

Summary

To the present day many medical doctors still cultivate the idea of a psyche/soma dualism. As neurophysiological and neuropsychological research has proved, such a concept is artificial. The Nobel Prize Winner Eric C. KANDEL (2006/1979) in his experiments with the sea-snail Amplisia california proved that repeated somatic irritation leads to habituation. Such a process is often considered to only be a mental one, whereas in reality it is also somatic. Such habituation, even of the lowly snail, is the result of training. Its physiology has similarities with the protective reflexes of the mammals, vertebrates and humans.

Sigmund FREUD, robbed humans of the illusion that they govern totally their psyche; on the other hand he gave them more freedom to recognize the true motives of their actions and to obtain a more independent view of public opinions. He summarized his opinion of the goal each psychoanalysis should reach, 'Where Id was, there Ego should be' (1933, p. 80). Heinz HARTMANN emphasized that mental processes are characterized not only by conflicts with the Ego, but also by nonconflictual dynamics directed by the 'conflict-free Ego-sphere'. It is plausible that this sphere can be understood in connection with the mirror neuron system of the ventral premotor system of the brain, which involves not only the human capacity to imitate, but also chooses the behaviour necessary to achieve the same goal (PALLY 2010). This includes humans having not only the possibility to adapt themselves to social conditions, but also possessing a sufficient self and the capacity to oppose social demands.

Günter AMMON (1986, pp. 92-93) in his dynamic psychiatry introduced the term 'social energy', which activates the formation of the Ego-structure. In social energy he sees a transmitter function between the dynamics within a group and the Ego-structures of the group members. To develop one's own identity in AMMON's sense means each individual delimiting himself not only from mother, but also from the surrounding group. In the modern world, in which people continually have to adapt to norms of behaviour and laws, a life without the wish for Self-realisation fails to provide humans satisfaction in their interactions within groups, communities and the state in which they live. Maria AMMON (2010) names, therefore, as one of the important goals of dynamic psychiatry working on the personality structure of the treated persons. According to FABIAN (2010, p. 281) deep psychological psychotherapy is always a treatment of anxiety. This approach should help the treated individuals to defend themselves against hindrances and overcome inhibitions. Analytic psychotherapies in our often traumatically norm-oriented world can no longer concentrate only on the, early, childhood of the treated individuals and the origins of their neurotic symptoms or of signs of other disturbances. Rather, they also have to consider the present burdens of their clients, which are often linked to the social conditions in which they are forced to live (WAGNER et al. 2010).

Zusammenfassung

Bis in die Gegenwart halten viele Ärzte noch an der Auffassung des psychophysischen Dualismus fest. Wie die neurophysiologische und neuropsychologische Forschung nachgewiesen hat, ist dieses Konzept ein Kunstprodukt. Der Nobelpreisträger Eric KANDEL (2006/1979) hat bei seinen Experimenten mit der Seeschnecke Amplisia Californica bewiesen, dass wiederholte somatische Reizung zu Gewöhnung führt. Ein solcher Vorgang wird oft nur als ein psychischer betrachtet, während dieser in der Realität auch ein somatischer ist. Dessen Physiologie hat Ähnlichkeiten mit den Schutzreflexen der Säugetiere, der Wirbeltiere und der Menschen. Sigmund FREUD hat einerseits den Menschen die Illusion genommen, dass sie ihre Psyche total beherrschen. Andererseits hat er ihnen mehr Freiheit gegeben, die wirklichen Motive ihrer Handlungen zu

erkennen und eine unabhängigere Sicht der öffentlichen Meinungen zu gewinnen. Er fasste seine Meinung über das zu erreichende Ziel jeglicher Psychoanalyse zusammen mit dem Satz 'Wo Es war soll Ich werden' (FREUD 1933, S. 86). Heinz HARTMANN (1939) betonte, dass psychische Prozesse nicht nur durch Konflikte mit dem Ich, sondern auch durch nicht-konfliktthafte Dynamik, welche durch die 'konfliktfreie Ich-Sphäre' gesteuert wird, charakterisiert ist.

Es ist naheliegend, dass diese Sphäre im Zusammenhang mit dem Spiegelneuronensystem des ventralen prämotorischen System des Gehirns verstanden werden kann, welches nicht nur die menschliche Fähigkeit zur Nachahmung umfasst, sondern auch das Verhalten auswählt, um das gleiche Ziel zu erreichen. (PALLY 2010) Günter AMMON (1986, S. 92-93) führte in seiner Dynamischen Psychiatrie den Begriff 'soziale Energie' ein, welche die Bildung der Ich-Struktur aktiviere. In der sozialen Energie sieht er eine Übermittlungsfunktion zwischen der Dynamik innerhalb einer Gruppe und den Ich-Strukturen der Gruppenmitglieder. Die eigene Identität zu entwickeln, bedeutet im Sinne von AMMON, dass jedes Individuum sich nicht nur von der Mutter abgrenzt, sondern auch von der es umgebenden Gruppe. In der modernen Welt, in welcher die Menschen sich kontinuierlich an Verhaltensnormen und Gesetze adaptieren müssen, verliert ein Leben ohne Wunsch zur Selbstverwirklichung die menschliche Genugtuung innerhalb von Gruppen, Gemeinschaften und des Staates, in denen, bzw. den sie leben.

Maria AMMON (2010) betont dementsprechend als eines der wichtigsten Ziele der Dynamischen Psychiatrie das Arbeiten an der Persönlichkeitsstruktur einer behandelten Person. FABIAN (2010, p. 281) betont, dass tiefenpsychologische Psychotherapie immer eine Behandlung der Angst bedeutet. Diese Methode sollte dem behandelten Individuum helfen, sich gegen Hindernisse zu wehren und es instand setzen, Hemmungen zu überwinden. Analytische Psychotherapien in unserer oft traumatisch norm-orientierten Welt kann sich nicht mehr nur auf die, frühe, Kindheit der behandelten Individuen oder den Ursprung ihrer neurotischen Symptome oder anderer Störungen konzentrieren. Es müssen vielmehr die gegenwärtigen Belastungen der Klienten betrachtet werden, welche oft mit den sozialen Bedingungen zusammenhängen, in welchen sie zu leben gezwungen sind (WAGNER 2010).

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Psychotherapeutic Work with the Healthy Identity Parts of Patients

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Integrating the resources and the healthy potential of development in psychotherapeutic treatment especially of the structurally early-disturbed patients is increasingly demanded in contemporary scientific literature. At Günter AMMON's Berlin School of Dynamic Psychiatry, the work with the 'healthy parts of the identity' is one of the central treatment paradigms using multifaceted verbal and more non-verbal psychotherapeutic treatment methods in single and grouptherapeutic settings. Starting with the clarification of the term 'healthy parts of the identity' and its concept with its sructural, dynamic and functional process and energetic aspects, the author's is to discuss some of the central prerequisites of treatment and therapeutic interventions, e.g. the therapeutic attitude, the shaping of the therapeutic relationship and structure of the therapeutic process.

Keywords: resources oriented psychotherapy, Dynamic Psychiatry, healthy identity parts, Identity Therapy.

At present there is an interesting discussion worldwide going on about the understanding of health with consequences for new concepts, prevention and health promotion, for clinical practice and finally the health policy. One-dimensional, deficit-oriented disease concepts are replaced in favour of perspectives that take into consideration the comprehensive context of health and integrate positive health-, resilience- and recovery concepts in a holistic sense (AMERING, SCHMOLKE 2007). Currently, there is to observe, also at the psychotherapeutic science and clinical practice, a substantial interest in an integration of resource-oriented, treatment-methodical approaches with the aim to improve the psychotherapeutic treatability of the often severe mentally disordered patients.

Other than the traditional psychodynamic concepts which in former times were more or less deficit-oriented, to work with the constructive identity parts, was the foundation and an integral part of AMMON's work since he developed his Berlin School of Dynamic Psychiatry in the late sixties of the past century (AMMON 1970, 1973, 1976). With formulating

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the term of a 'constructive aggression', seen as an activity aimed at a healthy development inherent in the human nature (AMMON 1970) and by understanding the human being and their groups as open systems with mainly constructively developed identity functions with a flexible social-energetic exchange (AMMON, AMMON, GRIEPENSTROH 1981; AMMON 1982b) between the inner and outer world, the foundation for a constructive understanding of the human being was laid, and as a consequence became the basis of the psychotherapeutic thinking and acting as a whole in Dynamic Psychiatry (AMMON 1979, 1982; BURBIEL, BOTT, FINKE 1982). Identity development (AMMON 1978, 1979a) whether of a person or of whole groups is understood as a lifelong process structural-dynamically internalized in a more constructive, destructive or deficient way depending on the relevant group dynamic conditions of life, especially in the preoedipal time of childhood development.

As a consequence of predominantly constructive group dynamic and social-energetic experiences we can observe, structurally seen, a differentiated, integrated and well regulated identity system with mainly constructively developed identity functions, i. e. constructive aggression, anxiety, demarcation, narcissism, sexuality, and so on.

As the structural result of a predominantly destructive and deficient group dynamic experiences we can observe the development of a deficiency within the central, unconscious core of identity, connected with destructively and deficiently developed identity functions as well as arrested processes of demarcation, differentiation, regulation, and integration of a personality.

Required for the recovery of identity is, structurally seen, a reactivation of the healthy identity structures, an integration of dissociated identity structures, a transformation of arrested, destructive and deficient parts into constructive identity structures, and the development of human potentials in a framework of a constructive, group dynamic, social-energetic, verbal and nonverbal field of relationships.

It is important to elaborate that from the perspective of Dynamic Psychiatry the resources or rather the healthy identity parts are not isolated qualities but in mutual synergistic connection with destructively and deficiently developed parts of a structure. They are integrated in the personality model of the Dynamic Psychiatry, the Human Structure Model

(AMMON 1996, BURBIEL 1998). They are always considered in their dynamics with regard to a patient's identity as a whole (FABIAN 2008).

With these considerations, mentioned above, it is apparent that Dynamic Psychiatric psychotherapy has always to be an 'Identity therapy' (AMMON 1973; 1979a). The Identity therapy, was developed as a mainly structural working and groupdynamic single and group therapy, set on a gliding spectrum of non-verbal and verbal communication possibilities. Identity therapy is therefore especially suitable for patients with early attachment disorders, developmental arrests, and for extreme familial and/or complex traumatised consequential disorders, according to AMMON, for patients with 'archaic identity diseases'.

Identity Therapy as Single Psychotherapy

Identity therapy applied at the single psychotherapy shows fundamental similarities with other psychotherapeutic treatments:

> which work successfully with structurally severe disturbed patients, - even if the core of the effectiveness of their respective technical proceeding is described theoretically and terminologically entirely different. (DAMMANN 2010, p. 69)

According to WÖLLER and KRUSE:

> resource-oriented work is not so much determined by a certain therapy method to be distinguished from a problem-oriented proceeding; it rather represents a different kind of perception and way of thinking, and a different form of therapeutic attitude and basic view. (2010, p. 162).

In principle it is to say that identity therapy is not working directly on the symptoms but with the anxiety of identity, abandonment anxiety and aggression, underlying the symptomatology. In this way, it works with the fundamental deeper-lying central structure of the personality where interpersonal traumatisations of the early childhood have been internalized as destructive and deficient structures.

Vital is the construction of therapeutically stable, security-providing, and reliable therapeutic relations as transparent as possible where the needs of patients for attachment, orientation, control are taken into consideration, where fears, aggressions and tensions are addressed, taken seriously, accepted as legitimate, and can be reduced. To take patients seriously with their desires, needs, questions and experiences and to express those, when indicated, for them as an auxiliary ego, to go into direct con-

tact to them with few transferance interpretations, is the prerequisite for a co-operative attitude of the therapist. A reluctant-reserved therapeutic attitude is usually experienced by patients as rejection.

Any structural-working therapist knows that without including the resources it will be therapeutically very difficult to form a work alliance and secondly is aware that the healthy identity parts as change-relevant are not only seen as the pre-condition for any treatment possibilities of the pathological parts but also as the basis of any therapeutic action.

They are change-relevant, intermittent variables of the therapeutic transformation process and only with their aid the work to integrate the new gained experiences can be made possible. To mention is here Klaus GRAWE, who within the frame of his meta-studies names as the first, empirically entirely supported, therapeutic factor the 'activation of resources.' (1995; 1999)

The awareness, encouragement, strengthening and particularly the appreciation of the healthy identity parts of patients, as well as the discovery of creative potentials plus the not yet used possibilities form a central part of our resource-oriented identity therapy. This includes for instance the strengthening of self-esteem as well as the every day life-competence, the acceptance and appreciation of the constructive qualities of patients as for example their attitude, ethics, solidarity, their sense of responsibility, their social skills, their compassion for other patients, their imaginations, in short, all that what 'makes a person a human being' with their uniqueness, kindness, with their dedication for aims beyond their own narcissistic goals. This includes as well lifestyle concepts, aim and meaning orientations within life, perspectives for the future, coping and defence strategies, but as well the acceptance of one's own boundaries, positive life experiences, and the strengthening of all the forces that help patients to be less 'susceptible' to life crises.

More healthily developed human beings possess enough well integrated identity parts as well as resources at their disposal which they can activate during a crisis for their recovery and healing process; with the aid and assistance of others they are capable to get out of an adverse life condition, even with more strength and more resources than before, that means, with a better ability for resilience (WALSH 1998). Activation of resources and resilience development can not be separated neither in

their genesis nor in their further development from inter-human and group dynamic experiences.

Healthy identity parts are understood as interpersonally developing relation functions always including a:

> personal history of early relations. [... The] positive re-staging of this interpersonal dimension of psychotherapy during the transference/counter transference situation within the frame of the therapeutic relation establishes a relation-dynamically expanded treatment-methodical access to our resource-oriented work. (FABIAN 2010)

To emphasise in particular is that transference and counter-transference has mainly to be focussed on the 'here and now'. The therapeutic work has to be directed at the future, to possible developmental changes, as well as providing hope and courage. That means a solution-oriented work by appealing to the self-responsibility of the patient.

Further it is necessary to articulate already attained achievements and success, to integrate deficiencies and deficits into the context of the personality as a whole, to widen narcissistic narrowed views and memories of experiences through new perspectives and accordingly differentiate the understanding of one's own developments. To give an example: a patient's sense that he was rejected can be qualified after it was worked out that the mother could answer the contact signals of the infant only in an affect-reduced way, due to her depressive structure, and that this affect-reduction was internalised by the child as a rejection. Any information about development occurrences in early childhood as for instance the development of irrational feelings of guilt could as well be very helpful for patients as in general the overcoming of irrational feelings of shame- and guilt.

If possible, it would be essential that also the positive aspects of relation experiences with important attachment figures are worked out and consolidated: With which identity parts the patients could identify themselves positively, with which interests, values, ethical aims, talents, skills, hobbies et cetera of role-model persons in their history of life. Which so-called 'free personality areas' patients could develop, i. e. personality areas that could be developed without pathological prohibitions, limitations and restrictions. With the above said it is apparent that a detailed health diagnosis should be carried out in respect of the utilization of the constructive identity parts but also of the use of construc-

tive relations and stabilizing resources in daily life, the literature speaks here of the 'outer resources' as for instance supporting people or supporting conditions (WÖLLER, KRUSE 2010, p. 263).

For the internalization of newly gained experiences during psychotherapy the previous achievements should be recalled and strengthened time and again with the aim that the patient is capable to integrate these results and experiences also into his daily life. This applies especially to the very important work with separation out of the outpatient and inpatient psychotherapy. During the speration process early, mainly not yet processed loss and separation experiences are mobilized, and seperation resistance are built up, as for instance to revoke already achieved developments.

A successful separation process succeeds by integrating achieved aims of the therapy into the identity of the patient and demarcating not accomplished developments.

Identity therapy as group psychotherapy

If persons can become ill in groups they can also recover in groups. The therapeutic catalysts are the 'emotional correcting' (Franz ALEXANDER 1950) inter-human experiences in the sense to repair and develop the structure of an earlier neglected identity. The internalised group dynamics of the often described pathology of compulsive repetition have to be repeated until they are modified through new group experiences.

Accordingly, the hospital in Menterschwaige as a whole is designed as a multidimensional, group-dynamically and social-energetically structured space for development, where a multitude of unconscious and conscious group dynamics develop in simultaneous and coexisting processes and interconnect into the dynamics of a large group (BURBIEL 1990). In order to facilitate a retrieving identity therapy, this therapeutic space as a whole has to be both, constructively and differentiated structured, and also integrated as a whole system with its multifaceted elements. Among these elements are the different therapeutic methods imbedded in this treatment field.

All these multifaceted therapeutic identification and development opportunities allow the patients to act out and to re-stage their constructive, destructive, and deficient dynamics of relations within a controlled and

manageable group dynamic field, and thus make those accessible for the therapeutic treatment within the 'here and now'.

Of a particular relevance for the resource-oriented therapeutic work in groups are the analytic milieu psychotherapy and the expressive creative group therapies (AMMON 1979; GRIEPENSTROH 1982; REITZ ROSKY, SCHMIDTS, URSPRUCH 2011).

The central therapeutic agent of the milieutherapy is the milieutherapeutic project work. Through focussing on the project and the work on a direct content in the 'here and now' the group resembles anti-regressive. Each patient can contribute with their constructive identity parts and identity themselves with the ressources of other group members. Only if the group is able to identity themself with the project, a creative process will develop. Even unconscious imagination and desires are integrated.

The expressive group therapies are specifically suitable for patients whose illnesses result from early preverbal disorders and who through the medium of painting, dancing, acting or other creative actions are able to communicate in a more 'non-verbal' way out of their 'unconscious'.

The unconscious, according to AMMON, the internalized, mainly unconscious collected inter-human group experiences, is externalized in such therapies. According to AMMON the unconscious is as well the location of the healthy and creatively developed parts of human beings, of their resources, and the not yet developed identity potentials. The unconscious therefore is also the place of creativity (AMMON 1982a; WOLMAN 1982).

That patients are able to internalize new beneficial experiences the leaders have to ensure that the group dynamic process within the groups, and this applies to all groups, develops as constructively as possible. The basis for this work is the analytic group dynamics. (AMMON 1973; 1979c)

The conscious or mainly unconscious dynamics within the group can be recognised and regulated by group dynamically experienced leaders. It becomes apparent that this group dynamic work builds an essential part of the work with constructive identity parts.

The therapeutic dilemma, pictured by Ulrich SACHSSE (2010) between a too strongly supporting, stabilizing, resource activating approach on the one hand, that the "therapies of many traumatized persons are stagna-

ting in a conserving climate of permanent stabilisation" (SACK 2010, p. IX) and on the other hand a too strongly and early trauma-confronting approach with the danger of a 're-traumatisation', is a treatment-methodical challenge for any therapist or therapeutic team.

> Many therapy approaches try to make their work easier by separating through ritualising and institutionalising an adventure and experience room from a work room within their therapy, for instance through imaginations and with elements of play. (SACK 2010, pp. VIII-IX).

The Dynamic Psychiatry works contact- focussed in a regulative way by counting on the group field on the internalized arrested early childhood symbiosis, work on the boundaries of identity, there, where the patient in early childhood was injured, arrested or even not noticed during the demarcation process of the primary group symbiosis. These therapeutic processes are often accompanied by deeps identity anxieties and seperation aggression.

That demands of the therapist and the therapeutic group respectively high degree of 'experience ability' (AMMON 1979e), a careful regulation of the contact quality between regression and the relation with the present. Of particular importance is here the supporting power of the social-energetic field of a group, the mutual adoption of auxiliary ego-functions with which the group members can identify themselves, the possibility to experience supporting symbiotic relations and subgroup formations which allow the treatment of profound group anxieties, especially when the group as a whole is experienced through the transference as the 'persecuting mother'.

There is no claim to a 'total healing' of the personality and the groups but rather to open up individual and groups to other person and groups and to use the interpersonal social energy exchange processes among them for further developmental steps and goals in a regulative way.

Additionally it is necessary to work constantly on the identity of the whole group that it can unfold its constructive repairing processes. Scapegoat dynamics have to be neutralized, arrested role arrangements resolved into role variability, split off subgroups integrated, the work on boundaries intensified and made more flexible, shared solidarity has to be learned and mutual responsibility for each other taken. As methodical equipment it is advisable to resort to the fundamental principles of the analytic group dynamics and their methodological execution

(AMMON 1979c).

At the same time single supervision and supervisory group dynamic work has to be performed. Within the supervision groups, arrested countertransference and resistance processes, but also division and splitting dynamics, problems with the regulation of closeness and distance, and subgroup formations can be solved through mirroring-dynamics within the supervision group.

Identity rejecting processes of the psychotherapists as a defence of their own identity anxieties have to be made transparent, also often unconscious rivalry, jealousy and envy processes toward the patients.

Important is that the psychotherapists are aware that group dynamic arrests and entanglements within therapies are never totally assigned to the patients. Psychotherapists and patients are often entangled in an unconscious 'complicity, in conflict-bearing reproductions and re-enactments, where all participants are involved. The psychotherapist should learn to demarcate own proportions, in order that creative developments are possible. Working with the constructive and creative parts the creativity of the therapists is challenged in particular, to open therapeutic dead ends, to abolish relation-arrests, to encourage new perspetives, hope and optimism instead of helplessness and resignation. Anything blockes has to be animated again, former resources to be activated and used, and new relation areas disclosed that social-energetic exchange processes both, inside the patients and the groups as well as between them and their surrounding are possible.

Psychotherapeutische Arbeit mit gesunden Identitätsanteilen von Patienten (Zusammenfassung)

Gegenwärtig kann man weltweit eine interessante Diskussion über ein verändertes Verständnis von Gesundheit beobachten. Eindimensionale, defizitorientierte Krankheitskonzepte werden abgelöst zugunsten von Perspektiven, die den umfassenden Kontext von Gesundheit berücksichtigen und positive Gesundheit, Resilience- und Recovery-Konzepte in einem ganzheitlichen Sinne einbeziehen (AMERING, SCHMOLKE 2007). Auch in der psychotherapeutischen Wissenschaft und klinischen Praxis

ist ein starkes Interesse an einer Integration, ressourcenorientierter behandlungsmethodischer Ansätze zu beobachten, mit dem Ziel, die psychotherapeutische Behandelbarkeit strukturell gestörter Patienten zu verbessern.

Anders als die traditionellen psychodynamischen Konzepte, die mehr oder weniger defizitorientiert waren, war die Arbeit mit den konstruktiven Identitätsanteilen bei Günter AMMON seit der von ihm weiterentwickelten Dynamischen Psychiatrie in den frühen 60er Jahren des vergangenen Jahrhunderts Grundlage und integraler Bestandteil seiner Arbeit. Mit der Formulierung einer 'konstruktiven Aggression' im Jahr 1970, als einer dem Menschen wesensmäßig gegebenen und auf die gesunde Entwicklung ausgerichteten Aktivität, war die Grundlage für ein konstruktives Menschenverständnis gelegt, das in der Folge Basis allen psychotherapeutischen Denkens und Handelns in der Dynamischen Psychiatrie wurde.

Als Ergebnis vorwiegend konstruktiv gemachter gruppendynamischer Erfahrungen, die einhergehen mit einer sozialenergetisch freundlichen Atmosphäre (AMMON, AMMON, GRIEPENSTROH 1981; AMMON 1982b) innerhalb der frühen Kindheitsgruppen, entwickelt sich beim Menschen strukturell gesehen ein offenes Identitätssystem, das nach innen und außen flexibel abgegrenzt, dynamisch reguliert, differenziert und integriert ist mit hauptsächlich konstruktiv entwickelten Identitätsfunktionen wie beispielsweise die konstruktive Aggression, Angst, Abgrenzung, Narzissmus, Sexualität, Kontaktfähigkeit u.a.. Als strukturelles Ergebnis vorwiegend destruktiv-defizitärer gruppendynamischer Erfahrungen entwickelt sich eine stark ausgeprägte destruktive und defizitäre Identität mit einem entwicklungsbedingten Defizit im zentralen, unbewussten Kern mit destruktiv und defizitär entwickelten Identitätsfunktionen sowie arretierten Abgrenzungs-, Differenzierungs-, Regulations- und Integrationsfunktionen der Persönlichkeit.

Zur Gesundung dieser Menschen bedarf es einer Reaktivierung der gesunden Identitätsanteile, eine Integration von abgespaltenen Identitätsstrukturen, Transformation von arretierten, destruktiven Anteilen in eine konstruktive Identitätsstruktur, einer Kompensation struktureller Defizite sowie die Entwicklung gesunder Potenziale im Rahmen eines vorwiegend konstruktiven, gruppendynamisch-sozialenergetischen, verbalen

und nonverbalen Beziehungsfeldes.

Ressourcen bzw. gesunde Identitätsanteile sind aus der Sicht der Dynamischen Psychiatrie keine isolierten Eigenschaften. Sie stehen in wechselseitig synergistischer Verbindung zu den destruktiv und defizitär entwickelten Identitätsanteilen und werden immer in ihrer Dynamik zur Gesamtpersönlichkeit des Menschen gesehen (FABIAN 2008). Sie werden als zwischenmenschlich sich entwickelnde Beziehungsfunktionen verstanden, die immer eine persönliche frühe Beziehungsgeschichte enthalten. (FABIAN 2010)

Aus den obigen Ausführungen wird deutlich, dass dynamisch-psychiatrische Psychotherapie immer eine Identitätstherapie sein wird. Die von Günter AMMON entwickelte 'Identitätstherapie' wurde als eine strukturell arbeitende, gruppendynamisch- sozialenergetisch fundierte Einzel- und Gruppenpsychotherapie für Patienten mit 'archaischen Identitätserkrankungen' (AMMON 1973, 1979a) konzipiert. Dabei weist die Identitätstherapie als Einzeltherapie mit allen anderen strukturell arbeitenden Psychotherapieansätzen,

> die erfolgreich mit strukturell schwer gestörten Patienten arbeiten, fundamentale Gemeinsamkeiten [auf] – auch wenn sie den Kern der Wirkungsweise ihrer jeweiligen technischen Vorgehensweise teilweise ganz anders theoretisch und terminologisch beschreibt. (DAMMANN 2010, S. 69)

Nach WÖLLER und KRUSE wird

> ressourcenorientiertes Arbeiten nicht so sehr durch eine bestimmte, von einer problemorientierten Vorgehensweise abzugrenzende Therapietechnik bestimmt, vielmehr stellt sie eine Art der Wahrnehmung- und Denkweise und eine andere Form der therapeutischen Haltung und Grundeinstellung dar. (DAMMANN 2010, S. 162).

Entscheidend ist der Aufbau von therapeutisch tragfähigen, sicherheitsgebenden, zuverlässigen und möglichst transparenten therapeutischen Beziehungen, in denen die Bedürfnisse der Patienten nach Bindung, Orientierung und Kontrolle berücksichtigt werden, in denen Ängste, Aggressionen und Spannungen angesprochen, ernst-genommen, als berechtigt akzeptiert und verringert werden. Die Patienten in ihren Wünschen, Bedürfnissen, Fragen und Erlebnissen ernstzunehmen und diese ggf. hilfs-ich-weise für sie auszudrücken, ist Voraussetzung für eine partnerschaftliche Haltung des Therapeuten. Jeder strukturell arbeitende Psychotherapeut weiß, dass eine Verbindung mit den gesunden Identitätsan-

teilen Voraussetzung für den Aufbau eines Arbeitsbündnisses ist. Das Bündnis mit diesen Anteilen ermöglicht es, die in dem Symptom gebundenen Ängste, Aggressionen und Verlassenheitsgefühle der Bearbeitung zugänglich zu machen.

Die gesunden Anteile gelten als veränderungsrelevante, intermittierende Variable des therapeutischen Prozesses, die die Integration neu gewonnener Erfahrungen in die Gesamtpersönlichkeit ermöglichen. Die Bewusstmachung, Förderung, Stärkung und insbesondere Wertschätzung der Ressourcen sowie die Entdeckung kreativer Potenziale und bisher noch nicht genutzter Möglichkeiten, bilden einen zentralen Bestandteil unserer ressourcenorientierten Identitätstherapie. Dazu gehören z. B. die Selbstwertstärkung, die Einbeziehung der den gesunden Identitätsanteilen inherenten positiven Beziehungsgeschichte aus der Vergangenheit in die gegenwärtige Übertragungs-/Gegenübertragungssituation im Rahmen der therapeutischen Beziehung. Ein solches Vorgehen schafft einen erweiterten behandlungsmethodischen Zugang zur Arbeit mit den gesunden Identitätsanteilen. (FABIAN 2010) Die Übertragungs- und Gegenübertragungsprozesse sollten also auf das Hier-und-Jetzt fokussiert werden. Dabei sollte der therapeutische Blick lösungsorientiert immer auf die Zukunft, und auf das Mögliche gerichtet sein bei stetiger Akzentuierung auf bereits erreichte Erfolge. Mängel und Defizite sollten immer in einen Kontext der Gesamtpersönlichkeit eingebettet, narzisstisch eingeengte Sichtweisen und Erlebniserinnerungen durch neue Perspektiven und damit das Verständnis eigener Entwicklungen erweitert werden. Positive Identifikationen der Patienten mit konstruktiven Identitätsanteilen vergangener und gegenwärtiger Beziehungen sollten herausgearbeitet und gefestigt, 'befreite Persönlichkeitsgebiete', d. h. Identitätsanteile, die sich frei von pathologischen Verboten, Begrenzungen und Einengungen entwickeln konnten, diagnostiziert werden. Neben der Diagnostizierung der Pathologie des Patienten sollte also wesentlich eine kontinuierliche Gesundheitsdiagnostik 'innerer und äußerer Ressourcen' (WÖLLER, KRUSE 2010, S. 263) durchgeführt werden.

Zur Verinnerlichung neu gewonnener Erfahrungen während der Psychotherapie sollte das bisher Erreichte immer wieder erinnert und gestärkt werden, mit dem Ziel, dass der Patient diese Erfahrungen auch in den Alltag integrieren kann. Dies gilt besonders für die so wichtige Tren-

nungsarbeit aus der ambulanten und stationären Psychotherapie, wenn es gelingt, erreichte Ziele der Therapie in die Identität des Patienten zu integrieren und nicht erreichte Entwicklungen abzugrenzen.

Die von Günter AMMON formulierte Untrennbarkeit von Gruppe und Identitätsentwicklung je nach der Qualität der sich zwischen den Gruppenmitgliedern entwickelnden bewussten und unbewussten Gruppendynamik und der damit verbundenen sozialenergetischen Qualität der gruppenenergetischen Felder, unterstreicht den hohen Stellenwert gruppenpsychotherapeutischer Arbeit für die Gesundung der Identität der Patienten deutlich: Wenn ein Mensch in Gruppen krank werden kann, kann er in Gruppen auch wieder gesunden. Das therapeutische Agens dafür sind 'emotional korrigierende' zu (Franz ALEXANDER 1950) zwischenmenschliche Erfahrungen im Sinne einer Wiedergutmachung und Nachentwicklung destruktiv-defizitärer Struktur. Die internalisierte Gruppendynamik der Patienten wird in den verbalen und in den mehr nonverbalen therapeutischen Gruppen so lange wiederholt, bis sie durch neue Gruppenerfahrungen verändert werden kann.

Am Beispiel der Klinik für Dynamische Psychiatrie in München-Menterschwaige, die als mehrdimensionaler, gruppendynamisch und sozialenergetisch strukturierter und dynamisierter Entwicklungsraum (BURBIEL 1999) konzepiert ist, werden die dort praktizierten therapeutischen Gruppen in ihrer Bedeutung für die Arbeit mit den gesunden Identitätsanteilen diskutiert. Von besonderer Relevanz für diese Arbeit sind die analytische Milieutherapie sowie die expressiven gestalterischen Gruppentherapien. (AMMON 1979; GRIEPENSTROH 1982; REITZ, ROSKY et al. 2011).

In der analytischen Milieutherapie ist zentrales therapeutisches Agens die milieutherapeutische Projektarbeit. Durch die Fokusierung auf das Projekt und die Arbeit im direkten Kontakt im Hier-und-Jetzt wirkt die Gruppe antiregressiv. Jeder Patient kann seine konstruktiven Identitätsanteile einbringen und sich mit den Ressourcen anderer Gruppenmitglieder identifizieren. Auch unbewusste Fantasien und Wünsche fließen mit ein. In den expressiven gestalterischen Gruppentherapien kommuniziert das Unbewusste der Patienten über das Medium des Malens, der Musik, des Tanzens und des Theaters. Entwicklungspotenziale und Kreativität können sich entfalten.

Damit die Patienten gesundmachende neue Erfahrungen verinnerlichen

können, müssen die Therapeuten dafür sorgen, dass sich der gruppendynamische Prozess (AMMON 1973, 1979c) innerhalb der Gruppen, und dies gilt für alle Gruppen, möglichst konstruktiv gestaltet. Die sich bewusste und vorwiegend unbewusst entwickelnde Dynamik kann durch gruppendynamisch geschulte Leiter erkannt und reguliert werden.

Ressourcenorientierte Arbeit in der Dynamischen Psychiatrie bezieht sich also nicht nur auf die Einzelpsychotherapie, sondern ganz besonders auf die gruppenpsychotherapeutische Arbeit in und mit Gruppen. Sie erweitert die einzeltherapeutisch konzipierten Ansätze der Ressourcenaktivierung durch die Dimension der Gruppe. Dabei ist es notwendig, immer wieder an der Identität der Gruppe als Ganze zu arbeiten, Sündenbockdynamiken aufzulösen, arretierte Rollenübernahmen in eine Rollenvariabilität der Gruppenmitglieder zu überführen, Untergruppen zu integrieren, an den Grenzen der Gruppen so zu arbeiten, dass sie sowohl nach innen als auch nach außen flexibel durch die Gruppe reguliert werden können. Gruppensolidarität und wechselseitige Verantwortung füreinander zu übernehmen. Diese intensive gruppendynamische Arbeit sollte supervidiert werden unter Berücksichtigung der sich innerhalb der Supervisionsgruppe entwickelnden Wiederspiegelungsphänomene. Wichtig ist, dass der Therapeut bereit ist, eigene Selbsterfahrungsprozesse sowohl einzeln als auch in einer Gruppe zu erfahren, eigene Konflikte, Widerstands- und Übertragungsprozesse zu bearbeiten. Psychotherapeuten und Patienten sind oftmals in einer unbewussten 'Komplizenschaft' miteinander verstrickt. Nicht nur der Patient, sondern auch der Psychotherapeut sollte die eigenen Anteile an einer solchen Verstrickung erkennen und verändern.

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Anxiety and Aggression: A Challenge for Today's Youth

Egon Fabian (München)

In our times, characterized by uncertainties and loosening social structures and cultural traditions, anxiety seems to increasingly become part of our culture. Young people are among those particularly affected, since they are extremely sensitive to external influences during their formative years. Part of the existential anxiety may take the form of indefinite aggression. These factors constitute a growing challenge to the identity formation of youths and may thereby be of importance for our future.

Keywords: anxiety; aggression; existential anxiety; adolescence, therapy of anxiety disturbances in adolescence.

Existential anxiety and existential aggression: archaic affects

Anxiety and aggression are archaic, basic affects. Many other affects are secondary and constitute complex varieties and mixtures based on them. Both anxiety and aggression are absolutely essential for the survival of both animals and human beings.

We can differentiate between situational anxiety and aggression on the one hand, and existential anxiety and aggression on the other. In both varieties, anxiety and aggression appear in most situations together and are complementary, like two sides of the same medal.

Situational anxiety and situational aggression represent direct reactions to danger, threats, or conflicts, as well as reactions upon other persons' feelings. They are both conscious and rationally understandable in the context of causality. They both have a direct object: 'He angered me; a certain situation causes fear'.

In contrast, existential anxiety and existential aggression have a primary, unconscious and irrational character that can be traced back to childhood; they mostly lack a direct object, although they may be triggered by such an object. They may be hidden underneath depression, but also under seemingly successful adaptation, being perceptible in feelings of countertransference.

Existential anxiety may manifest itself in the form of chronic, explosive aggression reaching intensive hatred in the cases of people who cannot perceive their deep existential anxiety or find an outlet for their unbearable fears. In the histories of such individuals we find regularly environments which failed to understand and contain the anxieties of the child, or which even denied or actively repressed them. (FABIAN 2010, FABIAN, THOME 2011)

Aggression can better be tolerated than anxiety. It can be directed against someone, who eventually becomes a target for all the accumulated existential anxiety and aggression. The aggression caused by existential anxiety may, in its turn, cause further (secondary) fear and anxiety. Many bordeline-patients for example report fear of 'exploding', of 'losing self-control'. This results again in secondary aggression, and so on, a vicious circle frequently described by borderline patients.

Etiology of existential anxiety

Existential anxiety is part of the human predicament. Due to its extremely long period of physical and psychical dependency, the child is unable to survive without a caring environment. Every step in early development, every separation or abandonment situation, may result in fear of death and anxiety. Certain family dynamics and socio-cultural conditions, however, concur in promoting anxiety. The familial factors are primordial, socio-cultural influences are always filtered by family dynamics.

Common familial factors promoting exitential anxiety in the child are early abandonment, early micro or cumulative traumatizations (M. KHAN 1977), absence of the father and lacking identification figures. An increasing number of divorced parents and of single parents raising their children and too little time and attention for children, both due to poverty and to psychological reasons, like being 'compelled' to raise basically unwanted children, lacking or too rigid boundaries, school stress and overtaxing, lack of ethical values and own identity of the family, as well as unfavorable social conditions like uprootedness as a consequence of migration, are familial factors which directly or indirectly favor existential anyxiety in the child. In todays world, with its basic uncertainty and lack of orientation, its multiple global dangers threatening the existence

of mankind, its vanishing traditions, poverty and criminality following increasing globalization, but also wars, political repression and terror, the fear of 'invisible' lethal weapons and ecological threats, a vague feeling of anxiety may increase the existential anxiety already pre-existing in adverse familial conditions such as those described above. In addition,our gigantic cities with the loneliness of many millions, interpersonal relationships tend to be replaced by the virtual contact of modern elctronic media, enhancing the feeling of abandonment and uprootedness leading to existential anxiety.

Today's school, the great chance for the future, remains conservative in general. It encourages one-sided, cognitive-intellectual learning, basically neglecting intuition and creativity. It furthers individual achievement and competition at the costs of collective responsibility and solidarity.

While positive experiences in school may counteract pathological family dynamics, negative experiences in school, conversely, are apt to potentiate and aggravate destructive dynamics within the primary groups of the children. Thus, negative influences in school constitute a high danger for children coming from problematic familial environments.

On the other hand side, physical and psychical traumatizations, humiliation, over-conformity, as well as repression and exploitation, extreme poverty, and social injustice are additional factors leading to chronical existential aggression. They find an outlet in violence and criminality. The criminals are often youngsters with, not always recognized, borderline or antisocial personality disturbances, usually with similar social backgrounds. They tend to act in violence against others of against themselves, when triggered by crises and in situations involving negative transference constellations. Here, too, the main substrate is the primary group and its dynamics, while social, economical and political factors act as catalyzers. As a rule they do not suffice alone to engender criminal behavior.

Some specific peculiarities of adolescence

Adolescence has at all times been a time of revolt, of discontentment and search for own values to replace those of former generations. At the same time, adolescents striving for their own identity are in a protracted oscillation between autonomy and identification with models of their

own choice. It is a turbulent time which also involves hormonal changes and anxieties linked to unknown perspectives of development including sexuality. Therefore the time of adolescence is a period of continuous uncertainty, augmented by fears connected to global uncertainties concerning their future; to cope with the anxieties caused by these uncertainties, young people have always reacted with protest and aggression. As early as in the 16. century, the Portuguese poet CAMOENS complained about changes becoming more rapid than before (s. Portugiesische Gedichte 1997).

In our times, persisting disorientation is increasing due to the factors outlined above; it particularly affects young people all over the world, in need of some degree of physical and moral security. One strategy to cope with continuous fears caused by threats and uncertainties is trying to dissociate by 'looking for fun, keeping cool, chilling, chatting, and consuming' (WINKELMANN 2010, S. 103), while songs and groups favorized by young people often express rage, hopelessness, or desperate search for meaning. Another strategy, when the home situation corresponds to the outward threats, consists of 'hiding' feelings behind drugs and alcohol.

Generally speaking, for young people in puberty and adolescence, the following factors are of particular relevance:

- intensive search for identification figures,
- search for meaning and the sense of life,
- search for own identity,
- open ego-boundaries,
- enormous group and peer-group boundedness,
- importance of separation processes,
- importance of friendships and sexuality.

Clinical manifestations of existential anxiety and aggression

Generally, the reaction of young people includes discontentment, depressive symptoms, feelings of abandonment, loneliness, of emptiness and senselessness. It expresses itself further in overt or underlying aggression, dependency, envy and jealousy, and a pronounced tendency towards addictions of all kinds. Quick 'overnight' success and fame, above all in financial areas, is a frequent goal concealing hopelessness

and chronic distress. Some 'heroes' with dazzling careers in business, sports or amusement embody the wish to overcome chronic existential anxiety and fill in the vacuum caused by lacking identification models within and without the families.

The spectrum of these signs and symptoms is wide and they are considered to a certain extent as 'normal', 'physiological' expressions inherent to adolescence. In some cases, however, their intensity interferes with socially and individually tolerated limits, and they become pathological. In these cases, clinicians speak of so-called anxiety disturbances, sometimes associated with borderline conditions, psychoses, depression, compulsion, or ADH syndrome. They all have in common deep anxieties underlying the clinical picture.

If we explore the histories of the patients more attentively, we regularly find chronic neglect, abandonment, violence or other excesses in their infancy. The primary groups are characteized by lack of care and interest, abuse, humiliation and other forms of traumatization. The group dynamics in the families display open or hidden animosities and 'cold war' atmosphere in which the children are instrumentalized, or parentification dynamics overtaxing them. Eventually, their position in the families is internalized, and their biographies frequently show repetitions of early dynamics in preschool and school, later also in work and private life (e.g. mobbing). In their partnerships, these young people seek narrow, symbiotic ties, which, however, increase their fear of dependency and often result in abruptly cut-off and again repeated relationships of the same kind. The compulsive repetition of such internalized dynamics may be rendered conscious and changed by consequent psychotherapy.

The therapy of such conditions, beyond all diagnostic categories, must be based on intensive containing including outlet possibilities for protest and aggression, but also clear boundaries within which these can be expressed without damaging themselves or others. Above all, the basic existential anxiety must be perceived and contained by the therapist; without the empathic understanding and support regarding the anxiety of the patient, no enduring therapeutic change can be achieved.

For more severe conditions, inpatient treatment is the therapy of choice; it offers manifold transference and countertransference areas and various media of expression and communication, including verbal, ex-

pressive, and somatic therapies, mainly practised in groups. In the Menterschwaige hospital in Munich, these therapies are interlaced and interact in a therapeutic milieu field centered around group work on common projects enabling the patients to find new contact experiences also through their healthy, creative ressources.

Conclusion and outlooks

Summing up the aforesaid, the following must be emphasized:

- Existential anxiety and aggression are not separate affects, but are complementary, whereas aggression as a rule functions as an outlet for unbearable, or not perceived existential anxiety.
- The psychodynamic and group dynamic approach is instrumental for a deeper understanding of present conflicts and symptoms in adolescents.
- The particular characteristics of adolescents should be kept in mind, as well as their peculiar sensitivities and modes of coping with fears and uncertainties rooted in their familial and socio-political environment.
- Due to these characteristics, young people are particularly sensitive to the open and latent threats and uncertainties of our times.
- Based on this knowledge, and particularly on the empathic understanding of existential anxiety in adolescents, therapeutic, and preventive measures should be made possible whenever necessary; this will result in a decrease of violence and suicides.
- Identity therapy aiming at development of young peoples' deep striving for their own identity should replace solely pharmacological treatment or therapy directed towards alleviation of symptoms.
- Group therapy is particularly efficient, taking into consideration the strong emphasis on adherence to groups displayed by children and adolescents.

Finally, it should again be pointed out that protesting adolescents express more than their own distress and anxieties. They give expression to deep anxieties of a large number of people concerning present instabilities, threats and future dangers overlooked or passively met by politicians and the adult population. Thus, young people should be attentively heard and should become more social and political responsibilities. The sometimes aggressive tone of their protest, ever since the late sixties of the last cen-

tury, is determined by, and reflects, deep underlying existential anxieties. We should not forget that in our days young people hold the key not only for their future in their hands, but also for the future existence of mankind.

Zusammenfassung

Angst und Aggression sind primäre, grundlegende menschliche Affekte. Der Autor differenziert zunächst zwischen situativer und existenzieller Angst bzw. Aggression; die erstere ist unmittelbare Reaktion auf Gefahr, Bedrohungen oder Konflikte, während die letztere primär in der Kindheit entsteht, meist irrationalen Charakter aufweist und kein Objekt hat. Die existenzielle Angst zeigt sich oft als chronische, explosive Aggression, da sie in diesem Fall leichter zu ertragen und gegen ein Objekt gerichtet werden kann.

Existenzielle Angst gehört zum menschlichen Schicksal. Es wird pathologisch, wenn ein Kind Verlassenheit durch Ungewolltheit, Traumatisierungen, mangelnde Identifikationsfiguren, fehlende oder zu rigide Grenzen und andere Faktoren mit ähnlicher Auswirkung der Angst ungeschützt ausgesetzt wird. Soziokulturelle Faktoren wie Armut, Migration, fehlende ethische Werte, Globalisierung, politische Unterdrückung oder Kriege die in der Familie erlittene Verlassenheit noch weiter verschärfen. Leider trägt nicht selten das moderne Schulsystem mit seinen ausschließlich auf Leistung und Kompetition basierenden pädagogischen Methoden zur Verschlimmerung der existenziellen Angst bei Kindern und Jugendlichen, die den dadurch entstandenen zusätzlichen Stress vielfach ohne elterliche Hilfe alleine zu tragen haben, bei.

In der Adoleszenz befinden sich die Jugendlichen in einer Phase hormonaler Umwälzungen und innerer wie äußerer Identitätssuche, die sie in einer Zeit weitgehend fehlender Vorbilder und elterlicher Unterstützung, z. B. durch den physisch oder psychisch abwesenden Vater, die sie im besonderen Maße der existenziellen Angst exponiert. Es ist eine Zeit der Verunsicherung und Desorientierung, der offenen Ich-Grenzen und schmerzhaften Trennungsprozesse, die sich in der Geschichte des Öfteren in allgemeiner Aggressivität und Protesthaltung ausgedrückt hat.

Das Spektrum klinischer Manifestationen reicht bei der Jugend von der 'normalen', 'physiologischen' Unzufriedenheit, Aggressivität und Suche nach engen symbiotischen Bindungen bis hin zu den sog. Angststörungen, Depression, Zwangssymptomen oder ADHS-Störungen, meist im Rahmen einer Borderline-Struktur. Die Behandlung solcher Jugendlichen erfordert intensives Containing mit ausreichenden Möglichkeiten des Ausdrucks aggressiver Gefühle und Ängste, unterstützt durch empathisches Verständnis von Seiten des Therapeuten. Gruppen sind hier von besonderem Wert in ihrer Tragfähigkeit der Angst; in der Klinik in München-Menterschwaige wird dieser Erfahrung durch ein komplexes Netz verbaler und nonverbaler Gruppen bzw. Milieugruppen Rechnung getragen.

Zusammenfassend betont der Autor, dass existenzielle Angst und Aggression komplementäre Affekte sind und dass in der Behandlung von Jugendlichen ihre spezifische psychische Situation und Umgang mit der Angst in einem gruppendynamisch getragenen therapeutischen Milieu im Sinne der Identitätstherapie (AMMON 1986) eine besondere Bedeutung besitzen sollten.

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Strukturdefizit, Affektregulation und Dissoziation: neue Aspekte

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The author refers to Allan SCHORE, who integrates results from attachment research, development psychology, psychoanalysis, and brain research. He suggests that the term dissociation be conceptualized as a central reference for a new etiological understanding of psychiatric diseases. In fact, this concept of dissociate mechanisms and their establishment in the evolving personality helps to understand diverse phenomena such as negative symptoms, numbness of feelings, lack of empathy, mental desorganization and others. The actual insights are brought together with AMMON's structure concept and particularly with his concept of deficient personality development towards a comprehensive idea how psycho-physiological structures and connections are being built up.

Keywords: environment dependent growth of brain, structural deficit, ego regulation, dissociaton

In einer seiner dichten Synopsen, in denen er Bindungsforschung, entwicklungspsychoanalytische Ansätze und Ergebnisse der Hirnforschung zusammenfügt, schlägt Allan SCHORE vor, den Begriff der Dissoziation zu einer zentralen Referenz eines neuen ätiologischen Verständnisses für psychiatrische Erkrankungen zu machen (SCHORE 2002, S. 12). Tatsächlich macht das Verständnis dissoziativer Mechanismen und ihre Verankerung in die sich entwickelnde Persönlichkeit so unterschiedliche Phänomene wie Negativsymptomatiken, Gefühlstaubheit, Mangel an Empathie, mentale Entdifferenzierung u. a. verständlich. Ich will nun neue Einsichten positivistischer Faktizität mit älteren Konzepten, wie sie Günter AMMON für Schädigungen der Persönlichkeitsstruktur annahm, miteinander verbinden und eine psycho-physiologische Begründung wichtiger metapsychologischer Aspekte der ontogenetischen Entwicklung der Herausbildung geschädigter Struktur erläutern.

Die Vorstellung von psychisch-physisch nicht entwickelter Struktur und Funktion und/oder nicht zur Verfügung stehender Struktur und Funktion scheint schwieriger nachvollziehbar zu sein als ihre Verformung und ihre Störung. Die Defizitannahme stieß in der Psychoanalyse

auf ethische Vorbehalte, weil sie sich verdächtig machte, eine therapeutisch-nihilistische Scheidung zwischen entwicklungsfähigen, behandelbaren und nicht behandelbaren Menschen zu befördern oder eine Art Strukturoptimum normativ zu bestimmen.

Bei Vertretern der Objektschulen wie z. B FAIRBAIRN, WINNICOTT oder MAHLER kommt es schon frühzeitig zu Vorstellungen psychisch-struktureller Mängel im Menschen durch mangelnde elterliche Fürsorge und mangelnde mütterliche Empathie. KOHUT (1971) gilt als ein bahnbrechender Vertreter eines Defizitverständnisses (WALLERSTEIN 1992). Er erwägt für die Ätiologie schwerer narzisstischer Störungen die reale frühkindliche Deprivation, d. h. das Ausbleiben für die Entwicklung notwendiger Unterstützung, was dann zum strukturellen Defizit in der Persönlichkeit des Menschen führt. Allerdings beschreibt er diesen Mangel als unzureichende Spiegelung des Kindes und Bestätigung durch die Eltern. Man mag im vielzitierten 'Glanz im Auge der Mutter' die Metonymie oder Symbol gewordene Komplexität des vorwiegend gelingenden präverbalen Miteinanders von Mutter und Kind sehen, er entbehrt aber der dem Gelingen und Misslingen inhärenten Dramatik und Vehemenz.

Dem Begriff eines strukturellen Defizits entgegengesetzt bleibt die Konfliktheorie, die aus unterschiedlichen Gründen und unterschiedlich modifiziert auch für psychiatrische Erkrankungen beibehalten wird. Als Krankheitsursache wird in der Ätiologie der Neurosen ein intrapsychischer Konflikt angenommen, bzw. diese Vorstellung modifiziert, um der Schwere der jeweiligen Erkrankung gerecht zu werden, so z. B. bei Stavros MENTZOS (1982, 1991).

Eine dezidiertes Defizitkonstrukt entwickelte der amerikanische Psychoanalytiker Fred PINE (1994): Für ihn ist das Defizit ein zwischenmenschlicher Mangel in der Beziehung, der sich dann als Defekt in den Ich-Funktionen niederschlägt. Das Defizit wird hervorgerufen durch eine unaufhörliche Traumatisierung, durch Vernachlässigung, demütigende Verhaltensweisen der primären Bezugspersonen und mangelnde Empathie.

Günter AMMON hat seinen Defizitbegriff in den frühen 1970er Jahren dargelegt. Das narzisstische Defizit, wie es AMMON versteht, bedeutet eine reale Schädigung des Ichs, die das Kind in der Phase des frühen

Narzissmus dadurch erleidet, dass die Mutter aufgrund eigener psychischer Beeinträchtigung nur mangelhaft die Äußerungen und Bedürfnisse des Säuglings beantworten kann.

Am Grunde psychiatrischer Erkrankungen, die AMMON als archaische Ich-Krankheiten bezeichnet, liegt, jeweils unterschiedlich modifiziert, ein Defizit:

> Das gemeinsame Kennzeichen dieser Krankheitsbilder ist nach meiner Erfahrung ein in der frühen Kindheit im Rahmen der präödipalen Symbiose von Mutter und Kind erfolgte Arretierung und Verstümmelung der Ich- und Identitätsentwicklung, die dazu führte, dass das Kind im Aufbau seiner Ich-Grenzen und in der Entfaltung seiner primär gegebenen Ich-Funktionen, hier insbesondere der konstruktiven Aggression, nicht adäquat unterstützt wurde und aufgrund früher traumatischer Trennungs- und Vernichtungsängste an der Ausbildung einer kohärenten und flexiblen Ich-Struktur gehindert wurde. (AMMON 1974, S. 202)

Die Symptomatiken bei den archaischen Ich-Krankheiten werden nicht als Resultate von Konflikten eines kohärenten Ichs wie bei der Neurose angesehen, sondern als existenziell notwendige Auffüllung eines strukturellen Mangels des Ichs, der selbst strukturelle Bedeutung zukommt.

Die Symptomatik erhält eine andere als die übliche Prononcierung als ein regressives, entdifferenziertes Geschehen, sie wird in der Dynamischen Psychiatrie als strukturelle Notwendigkeit verstanden und als Schutz vor archaischen Trennungs-, Verlassenheits- und Vernichtungsängsten und als Schutz vor noch größerer Fragmentierung. Anders als das Symptom auf einem neurotischen Strukturniveau

> die Kommunikation des Ich mit der inneren und äußeren Welt [behindert, wird hier das Symptom zum] direkte(n) Ersatz in der defizitären Ich-Struktur. Bezogen auf den interpersonellen Aspekt heißt dies: Das Symptom ersetzt die Kommunikation in einem wesentlichen Erfahrungsbereich durch einen immer wieder fehlschlagenden selbstzerstörerischen Versuch, ein Gefühl der eigenen Identität im Sinne des Schließens der Ich-Grenzen durch das Symptomverhalten zu erleben. (AMMON 1979a, S. 286)

Es sei hier darauf verwiesen, dass es in der ganzheitlichen Neurologie, wie sie Kurt GOLDSTEIN in den 1920er Jahren in Frankfurt und Berlin entwickelt und gelehrt hat, ein analoges Symptomverständnis bereits gab (GOLDSTEIN 1934).

Dieses Defizitmodell steht im Dienst eines therapeutischen Optimismus und soll dem Verstehbarmachen auch scheinbar uneinfühlbar anmutenden Verhaltens dienen.

Das Defizitkonstrukt geht Hand in Hand mit der Vorstellung, der Mensch sei in seinen Entwicklungsmöglichkeiten bis in die primäre Struktur der körperlichen Ausstattung auf eine ausreichend gute mitmenschliche Umgebung angewiesen. Beides steht im Kontrast zu einer biologischen Reifungsvorstellung, die man etwa wie folgt zusammenfassen kann: Wenn der Mensch nicht in seiner Entwicklung gestört wird, entfalten sich die ihm genetisch mitgegebenen menschlichen Möglichkeiten von alleine.

Im Gegensatz dazu nimmt AMMON an, dass, ob ein Mensch geboren wird, wie er geboren wird, ob, wie und welche Möglichkeiten er entwickeln kann, abhängt von der Qualität seiner ontogenetisch frühen mitmenschlichen Beziehungen. Die Entwicklung des Individuums versteht sich in diesem Konzept in keiner Weise von selbst, sondern ist bis in die Biologie des Menschen abhängig von der Gruppendynamik der umgebenden Gruppe, in die ein Mensch hineingeboren wurde. Dieser Einfluss der Gruppe auf die Entwicklung des Menschen ist vorgeburtlich und im frühesten Lebensabschnitt am entscheidensten, weil sich in dieser Zeit die Grundstrukturen im biologischen und im zentralen unbewussten Kern der Persönlichkeit herausbilden. Ist der Säugling Missachtung, Vernachlässigung, Verwahrlosung, mangelnder Empathie, aber auch dem narzisstischen Missbrauch durch seine Bezugspersonen ausgesetzt, entwickeln sich Teile im zentralen Persönlichkeitskern gar nicht, nur rudimentär oder nur als unzuverlässig verfügbare Strukturen und Funktionen. Nach Ammon bilden sich dort Defizite in der Persönlichkeit aus, wo der Kontakt und die Kommunikation und insbesondere die nonverbale Kommunikation über Bedürfnisse, Wünsche ausblieben und das Kind in zentralen Anliegen seiner Persönlichkeit auf kein oder nur ein mangelndes Interesse stieß.

Es gibt unendlich viele Möglichkeiten der Ausbildung defizitärer Momente in der Persönlichkeit in unendlich vielen Variationen mit destruktiv und konstruktiv ausgebildeten Funktionen.

Heute: Das Defizitkonstrukt und die hypostasierte Abhängigkeit der menschlichen Entwicklung von der Umgebung bis in die neurophysiologische Grundausstattung hinein hat in der heutigen wissenschaftlichen Auseinandersetzung um Bindungstheorie und Neurowissenschaften Bestätigung erhalten. Was nur undeutlich als in einer Symbiose mit einer

Mutter verursacht angesehen wurde, die nicht genügend erfahrungsfähig und empathisch im Kontakt mit dem Säugling sein kann, wird heute verständlicher und zum Teil kleinteilig nachvollziehbar als mangelnde Übernahme der Regulation der Ich-Zustände des Säuglings durch die Mutter. Bahnbrechend sind hier die synopsenartigen Arbeiten von Allan SCHORE, der psychoanalytische Entwicklungslehre, Bindungstheorie und Hirnphysiologie zusammenbringt. Der 'psychobiologische Kern' der Entwicklung ist die 'interaktive Regulation', so die Formulierung in einer der jüngsten ins Deutsche übersetzten Arbeiten von SCHORE (SCHORE, SCHORE 2010). Die gelingende affektive Übereinstimmung zwischen Mutter und Säugling wird als das hauptsächliche innere Strukturbildungsagens angesehen. Sie ermöglicht die zunehmende Fähigkeit zu eigener, innerpsychisch/physischer Affektregulation des Kindes.

AMMON (1979b) hielt zwei Vorgänge als an der Entstehung defizitär ausgebildeter Anteile der Persönlichkeitsfunktion der Aggression für möglich: zweifach zurückgewiesene Hinwendung an den anderen, allgemeiner der abgewiesene eigene Existenzausdruck, nochmals mit anderen Worten: zurückgewiesene konstruktive Aggression, deren Frustrationsergebnis, die destruktive Aggression, abermals auf keine Antwort stieß, oder als die andere Möglichkeit: nicht entwickelte Funktion. Heute weiß man, dass es je nach Zeitpunkt und Intensität deutlich destruktiver Einflussnahme auf das Kind oder Vernachlässigung zu nur unzureichend entwickelten neuronalen Strukturen und der dauerhaften Beeinträchtigung metabolischer Prozesse (SCHORE 2001) kommt.

Es gibt zwei Grundmodalitäten der Entäußerung von Verlassenheits-, Vernichtungsangst oder wie der Kinderpsychiater Bruce PERRY sagt 'fear-terror': das eine ist die Übererregung, die den Körper zu Kampf oder Flucht vorbereitet; sie ist sympathikus-abhängig, erhöht die Herzfrequenz und mobilisiert die wichtigen Stresshormone (SCHORE 2003, S. 246ff.). Die andere und spätere Reaktion ist das, was PERRY und SCHORE primäre Dissoziation nennen. Sie entspricht demselben Mechanismus, wie er als pathologische Dissoziation bei traumatischen Einflüssen und Extremtraumatisierung später im Leben beobachtet werden kann. Es finden sich hier in der Aufzählung KAPFHAMMERS (2001) so unterschiedlich anmutende Phänomene wie Gefühlstaubheit, Amnesie, Depersonalisation, Derealisation, Absorption, Euphorie und sexuelle

Erregung.

Der psychophysische Mechanismus, den man als Dissoziation bezeichnet und als grundlegend funktionell sinnvoll bis, je nach Ausprägung, als dysfunktional gelten kann, ist parasympathikus-abhängig, ein Schutzmechanismus, der energiekonservierend, unter Beteiligung von körpereigenen Opioiden vonstatten geht, Schmerzen dämpft und unbeweglich macht, dem Totstellreflex in der Tierwelt entspricht und zum Einsatz kommt, wenn Flucht oder Kampf nicht möglich sind.

Der Säugling, der in seinem Fear-Terror keine Regulation, keine verständnisvolle Beruhigung durch seine Bezugspersonen erfährt, gibt auf und fällt in diese Erstarrung. Bei BOWLBY taucht die Dissoziation als 'profound detachment' auf (n. SCHORE 2003, S. 209). Und wie FREUD das beschreibt, was er Nirwanaprinzip nennt, einer der Grundpfeiler seiner Todestrieblehre, legt auch den Tonusabfall durch die Dissoziation nahe.

Anders als beim schwertraumatisierten Erwachsenen stellt aber die Dissoziation in intensiver Ausprägung beim Säugling ein Störmanöver bei der höchst vulnerablen Entwicklung und Ausbildung von Hirnstrukturen dar, u. a. insbesondere orbitofrontaler Strukturen, die gefühlsmodulierende Aufgaben erfüllen. Es kommt also beim 'relationalen Trauma' je nach Ausmaß und Intensität tatsächlich zur Nichtentwicklung von verschiedenen Strukturen und Funktionen. Es ist mir hier wichtig, die grundlegende strukturbildende bzw. Strukturbildungsprozesse verhindernde Bedeutung des frühen Umfelds des Menschens herauszustellen. Dass es auch später Möglichkeiten in großer Variablität gibt für die Ausbildung defizitärer Funktionen auf anderen Ebenen der Persönlichkeitsentwicklung, ist evident, aber hier nicht Thema.

Der dissoziative Mechanismen erfolgt auf die Nichtbeantwortung von Übererregung, anders formuliert von Verlassenheits-/Vernichtungsangst und Wut:

> Ultimately, the child will transition out of hyperexcitation-protest into hyperinhibition-detachment, and with the termination of protest (screaming), she'll become silent. She will shift out of hyperarousal, and she'll dissociate ... And so not just trauma but the infant's posttraumatic response to the relational trauma, the parasympathetic regulatory strategy of dissociation, is built into the personality. (SCHORE 2001, S. 218)

In den Modellvorstellungen der Dynamischen Psychiatrie würde das Hy-

perarousal bzw. die Chronifizierung des Hyperarousals der destruktiven Ausgestaltung der Ich-Funktionen entsprechen. Die Dissoziation wäre analog zur defizitären Ausbildung von Funktionen zu verstehen. Allan SCHORE schlägt vor die Regulation und die Dissoziation als Hauptreferenzen für ein neues Verständnis psychiatrischer Erkrankungen zu Grunde zu legen, womit es von psychoanalytischer Seite zur Konzeption eines unitären Krankheitsverständnisses käme.

Je nach Ausmaß und Notwendigkeit zur primären Dissoziation in der frühesten Kindheit kommt es zur Verankerung dissoziativer Mechanismen in die Persönlichkeit, was sich in Negativsymptomen, prononcierter Neigung zu dissoziativen Mechanismen wie Amnesie, Depersonalisation und Derealisation u. a. äußert. Anzunehmen ist auch, dass das Vorherrschen der Notwendigkeit zur Dissoziation die Möglichkeit zur sympathikus-abhängigen Übererregung hemmt, d. h. ein anderer überlebensnotwendiger Mechanismus nur unzureichend oder kaum aktiviert werden kann. Dies heißt: Mit dem Mangel an Erregbarkeit geht das reduzierte oder nicht vorhandene Empfinden von Angst und Wut einher und es kommt zum Phänomen, dass oftmals Angst und Wut dem Menschen nicht oder kaum erlebensmäßig zur Verfügung stehen, da er schon den Ansatz von einem Arousal in Dissoziation abführt.

Inwieweit man davon ausgehen kann, dass unter der Dissoziation Angst und Wut in andere Regulationsvorgänge kanalisiert werden bzw. man die Abspaltung von Angst und Wut als eine Art Speichervorgang verstehen muss, wäre eine notwendige Frage. Und wenn sie nicht sowieso schon positiv beantwortet wird, so würde ich hier die Hypothese aufstellen, dass im Vorherrschen defizitärer Funktionen das Arousal und mit ihm Angst und Wut anders kanalisiert und gespeichert sind. Die Möglichkeit des gleichzeitigen Nebeneinanderbestehens von Erregung und parasympathischer Dissoziation muss als mögliche Verknüpfung miteinbezogen werden bei Kindern, die den Irritationen eines chaotischen Bindungsstils ausgesetzt sind bzw. waren, sich also hauptsächlich im Modus des Bindungstyps D befinden. (SCHORE 2003)

In einer anderen Zusammenschau wichtiger neuer Ergebnisse aus Neurowissenschaften, Traumapsychologie und Psychoanalyse kommt der Schweizer Psychoanalytiker Hans HOLDEREGGER in seinem viel beachteten Buch 'Das Glück des verlorenen Kindes' (2002) zu einem Konzept

der 'primären Lebensorganisation', einer angeborenen Basisstruktur der Psyche (S. 51), die auch ein basales Steuersystem für die Regulierung der Emotionalität umfasst. Dies lässt sich mit Sicherheit nicht halten. Hier stellt sich wieder die Vorstellung einer naturwüchsigen Selbstorganisation des Gehirns her, über die Schore schreibt:

> Es herrscht eine allgemeine Übereinstimung, dass das Gehirn ein selbstorganisiertes System ist, aber weniger wird die Tatsache anerkannt, dass die Selbstorganisation des sich entwickelnden Gehirns innerhalb der Beziehung zum anderen Selbst, zu einem anderen Gehirn geschieht. (SCHORE 2003, S. 3)

Structural Deficit, Affect Regulation, and Dissociation: New Aspects

Astrid Thome (Augsburg)

In one of his dense synopses concerning attachment research, developmental psychology, psychoanalysis and brain research Allan SCHORE suggests that the term dissociation can be conceptualized as a central reference for a new etiological understanding of psychiatric diseases. In fact, this concept of dissociative mechanisms and their implementation in the developing personality helps to understand diverse phenomena such as negative symptoms, numbness of feelings, lack of empathy, mental disorganisation, and others.

In psychoanalysis the concept of psychic deficiency was suspected of promoting a therapeutic nihilistic separation between treatable und untreatable people or to define a norm of structural optimum. Since KOHUT (1971) the idea of structural deficiency became more and more accepted (WALLERSTEIN 1992). He proposes the real deprivation during early childhood as the decisive factor in the aetiology of narcissistic disorder. He describes this deficiency as insufficient mirroring and confirmation by the caregivers.

Günter AMMON expounded his deficit model in the early seventies. The narcissistic deficit means a real damage of the ego, caused by the caregivers inability to answer the needs of the baby. AMMON assumes as the common ground of psychiatric diseases, archaic ego diseases, different features of deficit:

> in my experience the common marker of these diseases is a blocked and/or mutilated development of ego- and identity functions within the early symbiotic phase of mother and child, which in consequence restraints the building up of ego demarcation and the other ego functions, especially constructive aggression. Because of early traumatic separation and annihilation anxiety the development of a coherent and flexible structure is disturbed. (AMMON 1974, pp. 202)

The symptoms of the archaic ego diseases are not understood as the results of conflicts of a coherent ego as in neuroses but as existentially necessary attempt to repair a structural deficit of the ego, which attains structural importance in itself.

They are seen as structural necessities and as protection against archaic annihilation anxieties and as protection against on going fragmentation.

This deficit construction is interweaved with the concept, that the ontogenetic process of personality formation including primary biological structure depends on a good enough interpersonal environment. This is in opposition to the idea of maturation, which one can line out as follow: If man is not hindered in his development he is able to bring about his inherent abilities. However AMMON assumed, that the ontogenetic development is not automatic, but right from prenatal life, dependent on the quality of the early interpersonal environment. The group's influence on structure building is decisive during the prenatal and early childhood time, since during this time the fundamental biological and central unconscious structures of personality are formed. In cases in which infants are exposed to neglect and misuse by the surrounding group, parts of the personality do not develop or only in rudimentary form or only as insufficient functions and structures. According to AMMON deficits are developed, where contact and communication concerning needs and wishes, especially non-verbal communication, did not occur or occurred in a distorted manner. There are infinite possibilities of developing deficient structures with infinite variations in destructive and constructive functions.

Today the deficit construction and the hypothesis of environment dependent growth of psycho-physiological structures and functions is confirmed in today's scientific discussions around attachment theory and neurophysiology. The former unclear insufficient symbiotic relationship between the infant and its mother, who because of her own suffering is

unable to establish empathic contact, can be now explained more specifically as failed capability to regulate by psychobiological attunement the infant's ego-states, both stressful negative states and positive emotions. The 'psychobiological core' of development is the 'interactive regulation' (SCHORE, SCHORE 2010). The successful affective attunement between mother and child is seen as the main inner structuring agent. It enables the child to regulate his ego states more and more autonomously.

For the origin of a structural deficit AMMON (1979b) considered two possible alternatives: twice-rejected attempt at contact, more generally: the rejected self-expression. In other words this mechanism consists of rejected constructive aggression which turns into destructive aggression, which in its turn receives no answer. The other possibility he took into consideration was non-developed structure and function. Today we know that depending on the ontogenetic period and intensity, destructive influences or neglect of the child leads to insufficiently developed neuronal structures and the permanent impairment of metabolic processes (SCHORE 2001).

There are two fundamental modalities for the manifestation of annihilation-anxiety or 'fear-terror', the notion the child psychiatrist Bruce PERRY uses: the hyperarousal, which prepares the body for fight or flight; this reaction is a sympathetic activation increasing heart-rate and releasing important stress hormones. (SCHORE 2003, p. 246-252) The other and later reaction is what PERRY and SCHORE call primary dissociation. It is the same mechanism, as can be observed later in life as the petrification reaction by extreme traumatization.

But the dissociative reaction of the infant is a special destructive process as compared with the dissociation of traumatized adults. It disrupts and inhibits the extremely weak development of brain structure, among others the orbitofrontal structures, which modulates feelings. In the 'relational trauma' in fact brain structures and functions were in some parts not developed at all according to the extent and intensity of the disturbances. The quality of the early environment is decisive for the growth or inhibition of structuring biological processes.

In the concepts of Dynamic Psychiatry hyperarousal or the chronification of hyperarousal reactions correspond with the destructive shaping of ego-functions. Dissociation corresponds with the deficient shaping of

functions. According to extent and necessitiy of primary dissociation during the early childhood, dissociation is built into personality, which is shown among others in negative symptoms and in the tendency to dissociative mechanisms. It can also be assumed that the prevalence of dissociation inhibits the capacity of sympathetic hyperarousal. This means that other biological strategies for survival were inadequately activated or hardly at all. This implies: the lack of arousibility is accompanied by the restricted ability to experience anxiety and rage. Anxiety and rage are not then emotionally available, since just this impulse is canalised into dissociation.

If behind dissociation, anxiety and rage are transformed into other regulative functions, or if the separation of anxiety and rage is to be seen as storing procedure, would be an important question. Anyhow, if this question would be not yet affirmed, the assumption would be possible that in the prevalence of deficient functions the arousal and within it anxiety and rage are channelled and stored in other structures.

Although the relation-dependency of brain development and psychophysiological base of personality structure seems to be evident other concepts maintains the idea of an inborn basic structure of the psyche, which includes a basic regulation of emotions. They recapitulate the idea of a natural self-organisation of the brain, about which Allan SCHORE writes,

> There is now widespread agreement that the brain is a self-organizing system, but there is perhaps less of an appreciation of the fact that the self-organization of the developing brain occurs in the context of a relationship with another self, another brain. (2003, p. 5)

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Dankbarkeit als spirituelle Grundhaltung und Narzissmus

Gabriele von Bülow (Berlin)

If the word "'thanks/thank you' would be your one and only prayer, it would be enough." (Master ECKHART) 'Thankfulness is the key for joy' (RUMI). In many religious and spiritual traditions thankfulness plays an important role: buddhism looks at it as a positive energy by which the person strengthens himself and his environment. The difficulty or even the refusal to appreciate the entirety of one's own life in past and presence, and thereby the always limited future possibilities, represents the fundamental narcissistic challenge for our patients. Thankfulness and joy can only be sensed by someone who himself has experienced joy and thankfulness about his existence, which is nothing but a paraphrase of the experience of being loved.

Keywords: thankfulness, narcissism, spirituality

Spiritualität war zunächst ein Wort aus dem katholisch-christlichen Milieu, das in den 1960er Jahren das alte Wort 'Frömmigkeit' ablöste. Heute steht es für die

> Geisteshaltung, aus der heraus ein Mensch handelt, den 'Geist', von dem er sich in seinem Tun und Denken leiten lässt ... In jedem Fall ist der spirituelle Mensch ein bewusst lebender, wacher, an der Wahrheit orientierter, aus dem Hören auf Weisheit heraus denkender und handelnder Mensch. (KÖRNER 2004, S. 71).

Günter AMMON spricht von der 'geistig-ethischen Mitte' eines Menschen: es sind die Werte und Zielsetzungen, das, was einem Menschen bedeutsam ist, seinem Leben Sinn und Orientierung und damit Identität verleiht, was ihn aus den Zwängen eines von reiner Routine und Alltäglichkeit geprägten Daseins zu sich selbst befreit (AMMON 1986). In dieser Sicht kann auch ein sich selbst ausdrücklich als atheistisch verstehender Mensch Spiritualität besitzen. Als Beispiel sei hier aus einem Brief von Rosa LUXEMBURG während ihrer Zeit im Gefängnis im Dezember 1917 in Breslau zitiert; sie schreibt ihrer Freundin Sophie LIEBKNECHT:

> So liege ich ... hier in der dunklen Zelle auf einer steinharten Matratze, um

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> mich im Hause herrscht die übliche Kirchhofsstille, man kommt sich vor wie im Grabe, [...] von Zeit zu Zeit hört man nur ganz dumpf das ferne Rattern eines vorbeifahrenden Eisenbahnzuges oder ganz in der Nähe unter den Fenstern das Räuspern der Schildwache. [...] Und ich lächle im Dunkeln dem Leben (zu), wie wenn ich irgendein zauberhaftes Geheimnis wüsste, das alles Böse und Traurige Lügen straft und in lauter Helligkeit und Glück wandelt. Und dabei suche ich selbst nach einem Grund zu dieser Freude, finde nichts und muss wieder lächeln über mich selbst. Ich glaube, das Geheimnis ist das Leben selbst, die tiefe nächtliche Finsternis ist so schön und weich wie Sammet, wenn man nur richtig schaut. Und selbst im Knirschen des feuchten Sandes unter den langsamen schweren Schritten der Schildwache singt ein kleines schönes Lied vom Leben – wenn man nur richtig zu hören weiß. (Briefe aus dem Gefängnis, n. KÖRNER 2004, S. 65)

Die Fähigkeit, sich verzaubern zu lassen vom Geheimnis des Lebens, Freude erleben und Schönheit empfinden zu können bringt uns in Kontakt mit den Quellen des Lebens, mit seiner 'Tiefe', dem, was wesentlich ist, was bleibt, was allen Versuchen von außen, und auch von innen, 'Versuchungen' in der alten religiösen Sprache, menschliche Integrität und Würde, gar das Leben selbst zu zerstören, trotzt. Es sind immer wieder existenzielle, häufig extreme Grenzerfahrungen, und gerade die Erfahrung des Gefängnisses, in denen Menschen plötzlich Zugang zu einer Kraft finden, die es ihnen ermöglicht, inmitten äußerster Unfreiheit und Bedrohtheit von der unzerstörbaren Schönheit und Kraft des Lebens berührt zu werden.

In Anlehnung an Paul TILLICH, einer der einflussreichsten protestantischen Theologen des letzten Jahrhunderts, soll Spiritualität so auch verstanden werden als die 'Dimension der Tiefe' in allen Lebensäußerungen, das, was

> letztendlich, unendlich, unbedingt [ist, was] uns das Heilige erfahren lässt, etwas, das unberührbar, Ehrfurcht gebietend, letzter Sinn, Quelle des höchsten Mutes ist. [...] Religiös sein heißt, leidenschaftlich die Frage nach dem Sinn des Lebens stellen." (TILLICH 1961)

Und Viktor FRANKL schreibt:

> Wenn die Psychotherapie das Phänomen der Gläubigkeit nicht als ein Glauben an Gott, sondern als den umfassenderen Sinnglauben auffasst, dann ist es durchaus legitim, wenn sie sich mit dem Phänomen des Glaubens befasst ... Sie hält es dann eben mit Albert EINSTEIN, für den die Frage nach dem Sinn des Lebens stellen religiös sein heißt. (1974)

Wir wollen Religion als eine institutionalisierte Ausdrucksform von Spiritualität verstehen.

„Wäre das Wort 'danke' das einzige Gebet, das Du je sprichst, so würde es genügen." (Meister ECKHART) Und der Benediktiner David STEINDL-RAST antwortete auf die Frage nach dem Wesen der Spiritualität: Dankbarkeit (WALTER 2009). „Dankbarkeit ist der Schlüssel zur Freude." (RUMI, Sufi und Dichter des 12.Jh.) Quer durch die verschiedensten religiösen und spirituellen Traditionen kommt der Dankbarkeit eine tragende Rolle zu: im Buddhismus etwa wird sie als eine positive Energie gesehen, mit der sich der Dankende selber wie auch seine Umgebung kräftigt und stärkt. Gerade in Zeiten von Krankheit, Schmerz, Verlust, Trauer und Angst gälte es, sich bewusst zu machen, was trotzdem im eigenen Leben da ist, an inneren und äußeren Reichtümern, die oft als selbstverständlich genommen werden.

Im semantischen Feld von Dankbarkeit liegen Wörter wie Wertschätzung, Anerkennung, Empfangen, Annehmen, Bejahung, Freude.

Der zeitgenössische französische Philosoph André COMTE-SPONVILLE nimmt in seinem Buch von 1996 'Ermutigung zum unzeitgemäßen Leben' die Dankbarkeit auf in sein 'kleines Brevier der Tugenden und Werte', so der Untertitel. Tugenden sind Haltungen, Einstellungen, die sich nicht von selbst verstehen, sie „sind unsere moralischen Werte, sofern sie verkörpert sind, soweit es nur irgend geht, sofern sie gelebt, sofern sie in die Tat umgesetzt sind." (1996, S. 16)

Dankbarkeit ist „Freude über das empfangene Geschenk" (COMTE-SPONVILLE 1996, S. 157) und daher selber ein Schenken, „ausgedrückt mit einem Lächeln oder einem Tanzschritt, einem Lied oder einfach nur mit Glücklichsein." (S. 158) Undankbar sei ein Mensch, „weil er nicht gerne anerkennt, dass er etwas von anderen erhalten hat, ... weil er nicht gerne Dank schuldet, ... weil er nicht gerne teilt, weil er nicht gerne gibt." (S. 158) Dankbarkeit sei letztlich Liebe, Liebe im Sinne der schönen Definition von SPINOZA:

> Liebe ist Freude, begleitet von der Idee einer äußeren Ursache. ... Wenn jemand zu Ihnen sagt: „... Ich verspüre eine innere Freude, und der Grund für diese Freude ist der Gedanke, dass es Dich gibt", dann halten Sie das für eine Liebeserklärung, und zwar mit Recht. Dann haben Sie allerdings auch großes Glück gehabt: nicht nur, weil eine spinozistische Liebeserklärung nicht jedermanns Sache ist, sondern auch und vor allem, weil eine solche Liebeserklärung – welch eine Überraschung – nichts von Ihnen verlangt! (COMTE-SPONVILLE 1996, S. 295)

COMTE-SPONVILLE kommt zu dem Postulat einer

> universale(n) Dankbarkeit, die zwar nicht unterschiedslos wäre (wie könnte man dieselbe Dankbarkeit den Vögeln und den Schlangen gegenüber, MOZART und HITLER gegenüber empfinden?), aber insofern global, als sie Dankbarkeit für das Ganze wäre, von dem sie nichts ausnähme, von dem sie nichts ablehnte, selbst das Schlimmste nicht (also tragische Dankbarkeit im Sinne NIETZSCHES), da die Wirklichkeit wie sie ist anzunehmen ist, da das Ganze der Wirklichkeit die einzige Wirklichkeit ist. (1996, S. 159)

Das sind große Worte, leicht gesagt und schwer getan, für uns alle. Die ungeheure Zumutung, die unsere Conditio humana ganz wesentlich ausmacht, unser Leben, so wie es war und wie es ist, in seiner Gänze anzunehmen, zu ihm 'ja' zu sagen, stellt eine lebenslange Identitätsherausforderung dar. NIETZSCHE sprach von der 'Amor fati', der Liebe zum Schicksal, der Fähigkeit, unser Leben zu bejahen, auch die Vergangenheit, so wie wir sie gelebt haben, auch mit allem, was im Nachhinein als Irrtum und falsche Entscheidung erscheinen könnte. Dadurch adeln wir rückwirkend unser vergangenes Leben.

Ein Analysand sagte mir, er bedauere es 'aus philosophischen Gründen' nicht, viele Jahre als junger Erwachsener Berlin und Deutschland nicht verlassen zu haben, um seiner Mutter Unglück und Ängste zu ersparen. Die Beschäftigung mit NIETZSCHE habe ihn dabei gestärkt.

Von NIETZSCHE stammt auch der Gedanke, dass wir erst durch Leid und Krankheit hindurch gehen müssen, um zu einer 'höheren Gesundheit' gelangen zu können. Leiden heißt übrigens ursprünglich: durch etwas hindurchgehen, es ist verwandt mit 'leiten'. Zu 'tragischer Dankbarkeit' folgende Fallvignette:

Bei einer Patientin in den Fünfzigern wurde nach einem Jahr analytischer Psychotherapie ein lebensbedrohlicher Krebs diagnostiziert. In diesem Jahr hatte sie bereits einige wichtige neue Schritte ins Leben machen können. Die Diagnose machte uns beide fassungslos. Sie erlebte es zunächst wie eine Bestrafung. Aber dann war es gerade diese absolute herausfordernde Grenzsituation, die ihr den Mut und die Kraft gab, sich erstmalig ernsthaft mit ihrer tiefen Ambivalenz zwischen Todessehnsucht und Lebenswunsch auseinander zu setzen. Eine konstruktive Wende in diesem Prozess stellte ein Bild da, das sie nach der Chemotherapie zwischen Wachen und Schlafen hatte: sie sah einen ca. 9-jährigen, sehr lebendigen Jungen. Dieses innere Bild ging einher mit einer sehr körperlichen Empfindung, sehr nahe, ohne die Distanz, die sie sonst immer emp-

fand, wo alles so weit weg von ihr schien. Sie erzählte sehr berührt davon, mit Tränen in den Augen.

Der 'innere Junge' stand für ihre Lebendigkeit und Wildheit, die für ihre depressive Mutter so bedrohlich gewesen war, mit der sie nun zunehmend mehr in Berührung kam. Ihre Krebserkrankung erlebte sie wie einen Sprengsatz, sehr schmerzhaft und zerstörerisch, als ob ihr ganz viel entgleite; gleichzeitig hatte sie eine positive, bejahende Einstellung dem Krebs gegenüber gewonnen: anders sei es ihr nun einmal nicht möglich gewesen, sich so zu öffnen. Durch die Angst, die Bedrohung durch die Krankheit erst sei sie in die Wirklichkeit eingetreten, in neue Erlebniswelten, habe eine sensiblere Wahrnehmung bekommen, habe auch ihren Körper erstmalig als ganz real wahrgenommen. Heute, rezidivfrei und seit drei Jahren beschwerdefrei, laufe sie Gefahr, wieder in den alten Trott zurückzufallen, sie wundere sich, wie schnell das ginge, dennoch sei sie nie mehr so unempfindlich geworden wie vor ihrer Krebserkrankung. Anstelle eines ausgefüllten Fragebogens zum Thema 'Spiritualität', den ich an Patienten verteilt hatte, überreichte sie mir ein Blatt mit Assoziationen von A bis Z wie 'atmen all antlitz arm augen angst ahnen'; 'ja jubel jauchzen joch jahr'; 'stille seele sagen schweigen schauen schwingen summen sinken schlaf schlummer schande schauer schmerz schwelle schwan schwur; zweifel'.

Dass es die Angst ist, eine besondere Qualität der Angst, ich möchte sagen: eine konstruktive Angst ganz hart an der Grenze zur destruktiven, im Sinne einer überwältigenden, überflutenden Angst, die aber zum existenziellen Weckruf werden kann aus einem lebensbedrohlichen Tiefschlaf: das spricht auch Daniel N. STERN in seinem Buch: 'Der Gegenwartsmoment. Veränderungsprozesse in Psychoanalyse, Psychotherapie und Alltag' (2007) aus. Er beschreibt den 'Jetzt-Moment' als einen Gegenwartsmoment, der eine affektiv hoch geladene Grenzsituation innerhalb der therapeutischen Beziehung charakterisiert, in der sich der Therapeut nicht auf routinierte Standardinterventionen zurückziehen kann. „Sowohl im Patienten als auch im Therapeuten wächst die Angst. Sie werden gewaltsam in die Gegenwart hineingezerrt." (STERN 2007, S. 251)

Die Schwierigkeit oder Weigerung, 'das Ganze der Wirklichkeit' des eigenen Lebens in Vergangenheit und Gegenwart, und damit auch in

seinen dadurch begrenzten zukünftigen Möglichkeiten, anzunehmen, es zu bejahen, stellt m. E. das narzisstische Grundproblem unserer Patienten dar, und, natürlich, von uns allen. Wobei die Schwere einer seelischen Erkrankung sich nicht so sehr an dem Ausmaß der Defizite und Störungen bemisst, sondern an der Stärke des Widerstands, an den eigenen Anteilen, die die Krankheit aufrechterhalten, zu arbeiten. Dem pathologischen Narzissmus fällt dabei die entscheidende Rolle zu. Die narzisstische Wunde eines Menschen, der zu Beginn seines Lebens keine oder dramatisch wenig dankbare Freude über seine Existenz von seiner Umgebung widergespiegelt bekommen hat, geht tief.

Freude, Dankbarkeit erleben kann nur ein Mensch, der selber irgendwann in seinem Leben erfahren hat, dass sich jemand über ihn freut, dass jemand dankbar ist für seine Existenz, seine Gegenwart, was ja nur eine Umschreibung ist für die Erfahrung, geliebt zu sein.

Es ist der berühmte KOHUTsche 'Glanz in den Augen der Mutter', der dem Säugling sein Willkommensein in dieser Welt, seine Kraft, qua pure Existenz Freude und Dankbarkeit auszulösen, vermittelt.

Was hindert uns darüber hinaus, dankbare Menschen zu sein? 'Nicht gerne anzuerkennen, etwas von anderen erhalten zu haben', sprich: der pathologische Narzissmus, die Kränkung, sich nicht selber alles zu verdanken zu haben. Auf dem Grund dieser Kränkung findet man bei Patienten nicht selten eine immense narzisstische Wut darüber, die schiere Tatsache des eigenen Lebens den Eltern zu verdanken zu haben, zusammen mit einer umfassenden Macht, wie dem Universum, dem Leben, Gott, sich nicht selbst ex nihilo, aus dem Nichts, geschaffen zu haben. In der Anamnese dieser Patienten treffen wir regelmäßig auf narzisstische Ausbeutung durch Bindungspersonen, auf maligne Abhängigkeitsbeziehungen und/oder das Verweigern der Befriedigung kindgemäßer lebensnotwendiger Abhängigkeitsbedürfnisse.

Auch Verwöhnung erzieht zur Unfähigkeit, Dankbarkeit und Freude zu empfinden, erzieht dazu, Zuwendung, Gaben, Geschenke als selbstverständlich, gewohnheitsmäßig als gegeben hinzunehmen, ohne sich auf eine 'eine äußere Ursache', den oder das Gebende(n), zu beziehen. Verwöhnung verkrüppelt damit schlechthin Beziehungs- und Liebesfähigkeit, die Fähigkeit, für 'Sozialenergie' (Günter AMMON) empfänglich zu sein, häufig nachhaltiger als manifeste Misshandlung, Missbrauch und

Vernachlässigung.

Wir sollten in unseren Therapien neben und in allen professionellen Interventionen darauf achten, dass wir immer wieder mit dem Patienten zusammen einen Raum kreieren, in dem wir uns mit und an dem Patienten freuen können, in dem wir Freude und Dankbarkeit empfinden über die Zeit, die wir mit ihm verbringen.

Thankfulness as a Basic Spiritual Attitude and Narcissism

Gabriele von Bülow (Berlin)

In the first place, 'spirituality' was a word which came from the catholic-christian milieu and replaced the word 'piety' from the sixties.

> Today it stands for the basic attitude by which a person lives, for the 'spirit' by whom he is guided in his acting and thinking ... anyway the spiritual person is one who understands himself as living consciously, orientated by the values of a religion or a philosophy of life, a person who thinks and acts out of his convictions. (KÖRNER 2004, 71).

Günter AMMON (1986) talks about the 'spiritual-ethical centre' of a person: they are the values and aims, what is important for a person, conferring sense and orientation, and therefore, identity and thus setting him free from the constraints of an existence determined by mere routine and banality. From this point of view, even a person who expressly sees himself as an atheist can be said to have a spirituality. The ability to allow oneself to be enchanted by the mystery of life, to be able to experience joy and to feel beauty, brings us in contact with the springs of life, with one's 'depths', with what is essential, with what endures, and defies all attempts from the outside, and also from the inside, 'temptations' in old religious language, which would destroy all human integrity and dignity, even trying to destroy life itself. They are often existential, often extreme borderline experiences and particularly the experience of prison, in which people suddenly find access to a force which allows them to be touched by the indestructible beauty and power of life in the midst of threat and extreme deprivation of freedom.

"If the word 'thank you' were the only that you ever said, it would suffice." (Meister ECKHART). And the Benedictine David STEINDL-RAST responds to the question of spirituality: thankfulness (WALTER 2009).

"Thankfulness is the key to joy" (RUMI, sufi and writer of the 12th century). Across the most diverse religious and spiritual traditions, gratitude plays a primary role: in Buddhism it is seen as a positive energy through which the thankful person empowers and strengthens himself and his surroundings. Especially in times of sickness, pain, loss, mourning, and anxiety, it is effective to become aware of what is still there in one's life, the interior and exterior wealth, which are often taken for granted.

In the semantic field of 'thankfulness', one finds words like 'esteem', 'appreciation', 'receive', 'accept', 'joy'.

The contemporary French philosopher André COMTE-SPONVILLE includes thankfulness in his book of 1996, 'Encouragement for an old-fashioned life', in 'his little breviary of virtues and values', according to the subtitle. Virtues are attitudes which are not to be understood on their own, "are our moral values as long as they are embodied as far as possible, as long as they are lived, as long as they are put into practice"(COMTE-SPONVILLE 1996, p. 16). "Thankfulness is joy over the gift received" (p. 157) and thereby also a bestowing,

> expressed in a smile or a dancing step, a song or just simply by being happy. [A person is ungrateful,] because he doesn't like to admit that he has received something from others, ... because he doesn't like to owe gratitude, ... because he doesn't like to share, because he doesn't like to give. (1996, p. 158)

Gratitude is, in the final analysis, love, love as defined by SPINOZA's beautiful definition:

> Love is joy, accompanied by the idea of an external reason. ... If someone says to you: ...'I feel an inner joy, and the reason for this joy is the thought that you exist', then you see this as a declaration of love, and rightly so. Then you were indeed extremely fortunate: not only because a declaration of love, like that of SPINOZA is not for everyone, but first and foremost because such a declaration of love – what a surprise – demands nothing of you! (COMTE-SPONVILLE 1996, p. 295)

COMTE-SPONVILLE concludes with the postulate of a

> universal gratitude, which would not, in fact, be indiscriminate—how could one feel the same towards birds and snakes, MOZART and HITLER?—but in this respect global, that it is gratitude towards the whole, from which it does not exclude anything, from which it does not refuse anything, even not the worst, therefore tragic gratitude in the sense of NIETZSCHE, because reality has to be accepted as it is, because the whole of reality is the only reality." (COMTE-SPONVILLE 1996, p. 159)

These are grand words, easy to say but hard to do, for each one of us.

The impertinence of which our conditio humana is essentially part, accepting our life, as it was and as it is, saying 'yes' to it, is a lifelong identity challenge. NIETZSCHE talked about the 'amor fati', of the love for our destiny, the ability to accept our life, also the past as we have lived it, including what seems in retrospect to have been a mistake or a wrong decision. In this way we ennoble our past retrospectively.

One patient said, he does not regret 'for philosophical reasons' not having left Berlin and Germany as a young adult for many years, in order to spare his mother fear and insecurity. His occupation with NIETZSCHE had strengthened him in this regard. The thought originates from NIETZSCHE that we first have to go through sickness and suffering, in order to attain a 'higher level of health'. Incidentally, the German word for suffering, 'leiden', means 'to go through something'. In regard to tragic gratitude, here is the following case vignette:

In the case of a patient in her fifties, a life-threatening cancer was diagnosed after a year's analytical psychotherapy. In this year she had managed to take some important steps. The diagnosis stunned us both. To begin with, she experienced it as a punishment. But then it was exactly this absolutely challenging borderline situation which gave her the courage and strength for the first time, to deal with her deep ambivalence between her longing for death and her wish to live. A constructive turning point in this process is represented in an image that she had after chemotherapy between waking and sleeping: she saw a very lively boy, about nine years of age. This inner image was accompanied by a very physical perception, very close, without the distance she usually felt where everything seemed so far removed from her. She recounted it with tears in her eyes, so deeply was she moved by it. The 'inner boy' stood for the liveliness and wildness that had been so threatening for her depressed mother. She was now experiencing her cancer as an explosive charge, very painful and destructive, as if a lot was slipping away from her; simultaneously she had gained a positive attitude towards the cancer: there had been no other way to open up. As a result of the anxiety, the threat caused by the sickness, she stepped for the first time into reality, into new worlds of experience, receiving a more sensitive perception and for the first time experienced her body as totally real. Today, free of any relapse and almost three years without pain, she is in

danger of falling back into the old patterns, she was surprised just how quickly this happened, although she was not as insensitive as before the cancer.

That it is fear, a special quality of fear, I would like to say: a constructive fear, very close to the threshold of being destructive, which keeps us awake and present: this is also expressed by Daniel N. STERN in his book 'The present moment. Processes of change in psychoanalysis, psychotherapy and daily life' (2007). He explains the 'now moment' as a present moment, which characterizes an affective highly-loaded borderline situation within the therapeutic relationship in which the therapist cannot retreat to a standard routine intervention. "Fear increases, both in the patient and in the therapist. They are forcefully dragged into the present." (STERN 2007, p. 251)

The difficulty or refusal to accept 'the whole of reality' of one's own life, past and present, and thus with it one's future limited possibilities, agreeing to this, depicts the narcissistic basic problem of our patients, and, of course, of us all. In saying that the severity of a psychiatric illness is not measured so much on a scale of the deficits and disorders, but on the strength to resist, to work on the portion that is sustaining the illness. The crucial role falls to pathological narcissism. The narcissistic wound of a person, at the beginning of whose existence no, or dramatically little, grateful joy was reflected, goes deep.

Joy or gratitude can only be experienced by a person who has experienced himself at some stage, that someone rejoiced over him, that someone was grateful for his existence, his presence, which is only a description of the experience of being loved.

It is the famous 'brightness in the mother's eyes' (KOHUT), which transmits his being welcome in the world to the infant.

What prevents us from being thankful people? 'Not wanting to acknowledge having received something from others', meaning: the pathological narcissism, the mortification of not having oneself to thank for everything. On the basis of this mortification, one often finds an immense narcissistic anger in patients over the sheer fact of owing their lives to their parents, together with an all-embracing power, like with the universe, with life, God, not having created oneself ex nihilo, out of nothing. In the anamnesis of these patients, we often find narcissistic

exploitation by an attachment figure, malign dependencies or the refusal to satisfy the vital dependant needs of children.

Spoiling also educates a person to be incapable of feeling gratitude and joy, educates to take attention, gifts, presents for granted, as habitual, without relating back to 'an outside cause', the giver or the thing given. As such, spoiling cripples the capability of relating and of loving, the capability of being receptive to 'social energy' (Günter AMMON), often lasting longer than manifested mistreatment, abuse, and neglect. In our therapies, alongside and in all our professional interventions, we should make sure we always create space in which to be glad together with and about the patient, in which we sense joy and thankfulness about the time we spend with him.

(Translation by Karen Spiekerman, St.-Barbara-Str. 23, Warstein)

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Motivational Scenarios of Patients with Bordering Neuro-Psychic Disorders

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The purpose of this research was to create a motivational typology, i.e. scenarios of relationships between a psychotherapist and a patient. Next methods and means were used: Ego structure test by G. AMMON (ISTA) and projective MMI by J. NUTTIN as general methods, method of evaluating psychical health, structural biographical interview and analysis of patient's transference. Results were exposed to qualitative clinical-psychological analysis and statistical method of main components; statistical Kaiser's coefficient of normalizing data was applied. On the base of analyzing 14 motivational scenarios were drawn up. This classification will also help to realize selection of congruous psychotherapist, answering patient's expectations in respect of empathic and personality characteristics.

Keywords: psychoanalysis, motivational scenario, psychotherapy, ISTA, MMI

The importance of experimental researching in the field of psychoanalysis and psychodynamic psychotherapy was emphasized by H. THOMÄ, H. KÄCHELE (1996, p. 776), P. KUTTER (1989, p. 381). We are thoroughly convinced that the relationship between a psychotherapist and a patient (client) are a one of the central themes for research. Psychotherapy as a system of the curing action on psyche and through psyche on an organism (KARVASARSKI 1999, p. 572) can be considered as specially constructed relations between a psychotherapist and a patient. Relationship is a therapy itself (KAHN 1997, p. 224; GILL 1984). Psychotherapeutic approaches, as a matter of fact, suggest different types of relations with patients, and each type of relations possesses certain potential. The determining point of these relations is not only a conscious position of a psychotherapist, following a certain school, but also a patient's desire to create certain relations with a therapist, i.e. his motivation. We can say that there are main motivation lines connected with aims and sense of life (NUTTIN 2004, p. 608). They define general long-time strategy of activity and possibly psychotherapy too (LEONTYEV 2007, p. 512).

E. ERIKSON (1996, p. 344) calls this motivational scenario a guideline

towards the world, for example, basic trusting. Such guideline is available to watching and manifests in behavior (JACOBSON 1964). In the terms of this approach motivation always means unconscious or slightly conscious planning of activity. Also we can say that person's analysis and psychoanalytic psychotherapy are impossible without clearing up motivational forces lying in the base of patient's relations with a psychotherapist (HORNEY 2007, p. 224). Goals set by an individual and peculiarities of his relations with therapist (not always deliberated) by all means reflect his life story as far as his early experience, according to opinion of some researches (ADLER 2003, p. 256; KERNBERG 2000; FREUD 1991, p. 288).

Patients' actions, watched from outside, are not a simple reaction, especially trained or random, on exterior stimulation but they result from necessities, motives and guidelines and settings, which determine behavior and special features of a contact (RUBINSTEIN 2007, p. 720).

One can state, that the base of any psychological analysis is analysis of relations between subject and an objects (MJASISCHEV 1960, p. 425). No doubt that a psychoanalyst is a powerful object for a patient and relations of a patient with him can be studied through consideration of motivation structure. We can assume that as far as psychotherapy means relations, motivation determines the way of patient's attitude towards one of important object, i.e. therapist, and thus we can learn this attitude. Motivation is a preference of certain relations between an organism and environment, and psychotherapy is not an exception. On the base of motivation structure particularly, we can evaluate, what kind of therapy, expressive or supportive, a patient needs at the moment (KERNBERG 2000, p. 464).

WIED points out, that patient's ability to use a certain type of relations, chosen from suggested repertory, is more important than wide spectrum of methods in therapist's possession. The period of establishing contact is very significant for successful treatment; proper forming of therapeutic alliance practically decreases risk ob breaking therapy in two times (WIED 2008, p. 512). On the base of patient's attitude to psychotherapy and psychotherapist it is possible for to make an analysis of patient's actual state and his personal structure (FREUD 1991) and also to choose the proper strategy of therapy (SIFNEOS 1967).

In this context one should mention that patient's motivational peculiarities are extremely dependent on person's organizational, structural and dynamic, features, characteristics of his primary group dynamics (AMMON 1996, p. 200) and system of relations, internalized during the whole life. These factors influence motivational peculiarities more than syndromal diagnosis put down into the base of modern classification ICD, where complex phenomenological pathocharacterological and dynamical structures are totally ignored. And these last often define pathogenesis and form of disorder's duration. The purpose of this research was to create a motivational typology, i.e. scenarios of relationships between a psychotherapist and a patient. To get possible dynamical motivational typology, type of relations between a patient and psychotherapist, investigation was made including 80 patients with border neuro-psychic disorders who were staying at our hospital (modules F4 and F6 in ICD).

The age of patients varied from 25 to 50 years. In this research for obtaining desired aims next methods and means were used: 'Ego structure test by G. AMMON' (ISTA) and projective MMI by J. NUTTIN as general methods, method of evaluating psychical health (MOPH), and structural biographical interview as a clinical psychological method. Results were exposed to qualitative analysis and statistical method of main components; statistical KAISER's coefficient of normalizing data was applied. Next procedures were used: the method of main components as a kind of factor analysis, increasing of matrix contrast range, procedure of rotating, and analysis of contrasting of components, and clinical psychological analysis of statistical results. Statistic matrix is presented in table 1.

a) With a view of the matrix clearness in each of seven types only those indices are presented, which are statistically reliably contrasting.
b) KAISER's criterion of normalizing was used.

On the base of analyzing statistic matrix (table 1), where the main components of each index, components of experimental methods, were singled out, the next motivational scenarios were drawn up:

1. The anxious-collaborating type

A patient is worried both about his actual state and by possible, imaginary consequences of his disease: the risk of lingering illness; fantasies about 'uniqueness and vagueness of his state; the fear of getting possible

somatic defect and become socially inefficient, reflections about unfavorable outcome'. Such qualities of therapist as reliability, efficiency,

Indices of test	**Components (rotated component matrix)**						
MMI test	Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	Type 7
Self						0,661	
S preserv.	-0,401						
Self realiz.				0,721			
Cont. AL	-0,54						
Cont. EG					0,624		
Conflict			-0,700				
Existent.							-0,717
intensive						0,718	
T unlimit							0,676
Explorat.				0,877			
Erotic						-0,484	
ISTA test					0,392		
A1							
A2			0,648				
A3		0,494					
C1	0,611						
C2		0,641					
C3			0,916				
N1	0,656						
N2		0,810					
N3							
O1							
O2					0,716		
O3							
O"1	0,717						
O"2							
O"3							
Se1	0,844						
Se2							
Se3					0,740		
MOPH test							
Ind. Alpha		-0,625					
Ind. Beta	0,749						

Table 1: The matrix of main components.

'correctness', attentive attitude are constantly demanded; the patient will never speak about them directly; it is associated with fear, that relations with psychotherapist can be spoiled on account of doubts in efficiency of treatment.

In the case of psychopharmacotherapy such patient can say great attention to possible side effects, his own feeling from medicines, analyze opinions of other patients concerning therapist and appointed treatment. Situations of confrontation in the course of psychotherapy will produce intensive strain, which a patient will try to conceal deliberately, being afraid to 'quarrel' with a therapist. The main motivational object here is self-preservation. Following this object, a patient can desire to become a 'good and complaisant patient', expecting to receive the same in response and avoid tension during treatment.

As a rule, potential of such patients is rather high in spite of possible sub-depressive feelings. The most important thing in this type is that a patient principally can use contact with psychotherapist, and his close surroundings, for defense from anxiety. To get success in establishing therapeutic relations a psychotherapist should take paternalistic position, clearing up at the very beginning of treatment, that 'quarrels' are inevitable part of psychotherapeutic process and don't lead to a 'catastrophe' in relations. At the first stages psychotherapy should mostly be held in didactic style with informing patient about nature and prevalence of his disorder.

2. The restrictive-evasive type

A patient seeks hyper control of his displays; therapist's attempts of analyzing connection between life situation and displays of illness are exposed to special control. Total dispirity caused by a symptom and defenselessness before incomprehensible state is often declared. Contact with a psychotherapist is constantly worked through, scrolled by patient inside himself; patient is often alerted, a little bit isolated and formal in the contact. As a rule, there is fixation on his own unhealthy feeling which begins to eject from patient's life space alternative objects and feelings; the area of motivational objects becomes narrow. The level of psychic implementation in this case of such patients is low. Control is often expected from the therapist, who can be seen as 'punishing object'

in patient's phantasies; intimacy and openness with respect to him produce intense resistance and fear.

At the same time inside the patient there is nearly constantly a struggle between authority of psychotherapist (and authority requires submission from such patient) and fear of this authority and submission. The former traumatic interpersonal experience of patient and other important persons is repeated in relations with a therapist. A psychotherapist has to be able to control and understand his emotional reactions; they often become a key for understanding, what happens to patient. It is necessary to clear what is the real danger of trusting contact with a therapist for a patient in the situation 'here and now', how his anti-authoritarian reactions favour achieving goals which he defined himself. Including these patients into expressive and non-verbal forms psychotherapy (art therapy, dance therapy) can render much support.

3. The destructive-expansive type

The main tendency of these patients is to percept a therapist as cold, strict, ultimately formal and indifferent to their sufferings. Such patients try to simplify their relations with therapist, denying their curing effect. Externally patients hide such contact with psychotherapist under facade constructions, masking it as 'simple and clear communication with not a bad therapist'. But profundity of contact is not substantial, a patient takes rigid position, avoids attempts of confrontation with his former experience.

Among powerful concealed motivational tendencies with such kind of patients one can sort out: devaluation of therapist and appointed treatment, cynicism in regard to psychotherapy, reasoning, desire to 'deliver preemptive strike'. Such patients feel like destroying therapeutic relations, 'revenge' a therapist for his successes. A patient often describes himself as a man living under the weight of life complexities, other men's mistakes, lack of professionalism of those who helped him; he is aware of directed at him aggression of another people and their 'flimsiness'.

Simplification and devaluation of relations in the case of such patients is a primitive defense from intensive fear of being deserted. A patient often 'deserts' therapist himself not to let therapist 'a chance of doing it

the first'. This type of scenario is mostly characteristic of patients with bordering and narcissistic disorders. Here the risk of developing so-called negative therapeutic reaction, transference, is especially high.

Having destroyed psychotherapist's success, a patient by this very fact gains a victory over him in these fantasies even at the cost of his own failure. The therapist needs a large interpersonality stability, because his and patient's emotional reactions create a powerful intersubjective emotional system with reciprocal influence. One should not take the wish of such patients to interrupt treatment 'at its face value' (in all good faith), here psychotherapist requires great patience to detect the cause of patient's fear to be outcast and of his own incompetence. In the case of negative result of treatment it's reasonable to inform patient, that he can return and continue treatment when he fells more ready to it.

4. The constructive-expansive type

The main motivational object in this case is a self-realization and synthesis of experience (motivation of knowledge). A patient considers psychotherapy as a process of joint creative project with a therapist. In the course of treatment such patient is rather active, able to collaboration and creation of 'therapeutic reality common with a psychotherapist', where the process of therapy will develop. It means, that the disease has not suppressed activity substantially (potential of development is preserved) though it brings suffering, which the patient does not aspire to conceal from himself and people around, including therapist.

Object activity of such patient is high, not limited by the area of disease and methods of its correction. Here it's possible to short-time intensive psychotherapy with active confrontation at earlier stages of work. It's important to understand, that this type doesn't occur very often, though it maximally corresponds psychotherapist's notion about 'ideal patient'.

5. The ambivalent-affective type

Patient's wishes, directed at the objects of wishes are super intensive as a rule. In the case of incompatibility of motivational object and patient's notions about it attitude can change diametrically, and it constantly

happens so. It means that a therapist will be idealized by patient with the same easiness, as he will be destroyed after depreciation.

A therapist himself and treatment, prescribed by him, will be constantly 'put to the test' by the patient, he will 'tempt' a therapist checking his ability to endure impetuous admiration and so impetuous a disappointment. A patient knows, what he wants to possess, but he does not know, what to do with the object of wish. It means that expressing the wish 'to be strong, harmonious, good, happy and honest' a patient sees in such order exclusively estranged from reality characteristics.

A patient 'just wants to be cured' and not to become 'another person' as a result of psychotherapy and realize himself in a new quality; such wish is torn from integral real life. It is reasonable in this case to include an early-stage patient in group kinds of psychotherapy to have opportunity to keep therapeutic relations with his colleagues in the case of devaluation of individual psychotherapist. Group supervision gains peculiar importance for integration of splinted parts of such patients' personality. If there is no such opportunity, a psychotherapist must be able contain contradictory affective states to make patient's relations and senses more integrated.

6. The defensive-manipulative type

A patient is eager to build a strict barrier between a therapist and himself, 'not to allow too close approaching' to him. The more sincerely a therapist is interested in such patient, the stricter is the barrier. As such patient is hardly able to feel compassion to others, in the number of cases he 'is not capable of taking help' from another, when foreign unindifference can be unpleasant. While being in contact with a therapist such patient is affectively constrained, passive and removed. The process of psychotherapy is seen by this patient as a situation of constant confrontation, when the only form of possible relations is 'submission-suppressing'; as a matter of fact, a contact with a therapist is practically one-way. Such relations in patient's mind often come to clearing up the degree of therapist's manipulativeness, how strictly he tries to 'ram his model of disease'.

Due to hyper-control over his emotions such patient can look from the façade as interested and attentive to therapist's words, estimating soberly

and critically the potential of prescribed treatment. During more thorough analysis one can reveal patient's personal desire to manipulate the therapist, evaluate him as 'a resource liable to devastation', and ensure him in complete rightness of his own notions. Such patients more often trust service medical staff and specialists, performing auxiliary psychotherapeutic methodologies. In this case it is better to avoid direct confrontation and give a patient an opportunity to make right conclusions, using stories about other persons, metaphorical modes.

7. The introversive-autistic type

The first place among all motivational objects appears to belong to transcendental, philosophic, and existential ones. A patient is fixed at the questions of loneliness, ultimate sense, internal emptiness; he feels that he is fenced from the world and that his constant inner world prevails over actual changing, and often obscure for him, states of outer environment.

Such patients are often unable to build intermediate links between the object of their wishes and actual time; subjectively they feel it as if the object is unavailable. Among the prevailing tendencies there come forward a desire to exclude personal motivational objects from the context of real time, disturbances in setting goals and planning. Excessive immersion into such experiences complicates therapeutic relations with a doctor, being the certain kind of 'dim glass between self and reality'.

In the number of cases a therapist is expected to possess stability, predictability and accessibility. In the worst case the contact itself is presented as 'a monologue of one of participants' when the patient avoids real interaction, inducing the therapist 'just to speak'. Such patients need a psychotherapist, possessing knowledge enough for keeping up metaphysical dialogue, has good skills in planning and strategy of problem-solving behavior and is capable to realize at the first stages functions of 'auxiliary ego' for a patient, step by step working out the plan of achieving the goal together with him. Milieu therapy can be especially efficient in this case.

A notice should be made, that classification, given above, is undoubtedly not complete. The fact, that separation of pure types is possible only in theory, is also true. However an assumption can be made, that

isolating dominative motivational scenarios (relations) of a patient and psychotherapist can give substantial help in work and improve efficiency of treatment.

For future practical use we recommend to consider in a system results of tests in compulsory context of structural biographic interview, reflecting the history of interpersonal relations of a patient.

Extracted types of motivational scenarios can be useful in practical work. More precise prediction of special features in contact with a patient can be made on the base of them; data can be obtained concerning patient's unique subjective reality. This classification will also help to realize selection of congruous psychotherapist, answering patient's expectations in respect of empathic and personality characteristics. For example, in the case of anxious-collaborating type of motivation more guardian-like therapist must be selected; in the case, when a patient of destructive-expansive type 'wins back' the fear of being abandoned, the therapist must be ready to continue sincere collaboration with him.

Taking into consideration the pattern of scenario, psychotherapist can lay out the strategy of treatment. The sphere of motivation structures is the deepest of all areas, where psychotherapeutic correction is held. By this it's reasonable to satisfy patient's true necessities in interpersonal communication, and only after establishing firm therapeutic alliance with reflex part of patient's 'Ego' it's possible to come to confrontation and using of destructive interpersonal patterns. Though we have a great diversity of methods and techniques for today, the outcome of psychotherapy finally is determined by the fate of contact with a psychotherapist (WIED 2008).

Summary

The importance of experimental researching in the field of psychoanalysis and psychodynamic psychotherapy was emphasized. Psychotherapy can be considered as specially constructed relations between a psychotherapist and a patient. No doubt that a psychoanalyst is a powerful object for a patient and relations of a patient with him can be studied through consideration of motivation structure. The purpose of this research was to create a motivational typology, i.e. scenarios of relationships between a psychotherapist and a patient. In this research for obtain-

ing desired aims next methods and means were used: 'Ego structure test by G. AMMON' (ISTA) and projective MMI by J. NUTTIN as general methods, method of evaluating psychical health (MOPH), and structural biographical interview as a clinical psychological method. Results were exposed to qualitative analysis and statistical method of main components; statistical KAISER's coefficient of normalizing data was applied. On the base of analyzing 14 motivational scenarios were drawn up. This classification will also help to realize selection of congruous psychotherapist, answering patient's expectations in respect of empathic and personality characteristics.

Zusammenfassung

Ziel dieser Untersuchung war es, eine motivationale Typologie zu schaffen, sprich Beziehungsszenarios zwischen einem Psychotherapeuten und einem Patienten. Um mögliche dynamisch motivationale Typologien, Art der Beziehung zwischen einem Therapeuten und einem Patienten, zu erhalten wurden 80 Patienten unseres Krankenhauses mit neuropsychischen Störungen (F4 und F6 Störungen nach ICD) untersucht. Das Alter der Patienten lag zwischen 25 und 50 Jahren. Um die gewünschten Ziele zu erreichen wurde folgende Methodik verwendet: Ich-Strukturtest nach G. AMMON (ISTA), der projektive MMI nach J. NUTTIN als generelle Instrumente, 'Method Of Evaluating Psychological Health MOPH', und ein strukturiertes, biografisches Interview als klinisches Messinstrument.

Die Ergebnisse wurden einer qualitativen Analyse und einer statistischen Hauptfaktorenanalyse unterzogen. Folgende weitere Verfahren wurden genutzt: Die 'method of main components' als eine Art von Faktorenanalyse, 'increasing of matrix contrast range (procedure of rotating)' und 'analysis of contrasting of components', sowie eine klinisch psychologische Analyse der statistischen Ergebnisse.

Sieben motivationale Szenarios wurden aufgestellt. Diese Klassifikation ist zweifelsohne nicht vollständig. Außerdem ist die Isolation von reinen Typen, streng genommen, nur in der Theorie möglich. Trotzdem kann angenommen werden, dass die Extraktion dominanter motivationaler Szenarios zwischen Patient und Psychotherapeut eine beträchtliche

Hilfe bei der Arbeit darstellen kann und dass so die Wirksamkeit der Behandlung verbessert werden kann.

Für den praktischen Gebrauch empfehlen wir die Ergebnisse im Rahmen des obligatorischen Kontextes des strukturellen biografischen Interviews zu betrachten, welches die Geschichte der interpersonellen Beziehungen des Patienten widerspiegelt. Die extrahierten Typen der motivationalen Szenarios können bei der praktischen Arbeit nützlich sein. Genauer gesagt können Vorhersagen über bestimmte Besonderheiten im Kontakt mit dem Patienten, aufgrund der Typologie, getroffen werden; auch Daten bezüglich der einzigartigen, subjektiven Realität des Patienten, können gewonnen werden. Diese Klassifikation wird ebenfalls bei der Wahl eines passenden Therapeuten hilfreich sein, indem die Erwartungen des Patienten bezüglich empathischer und persönlicher Charakteristika erfüllt werden. Psychotherapeuten können anhand des Musters des Szenarios Behandlungsstrategien entwerfen.

Der Bereich der motivationalen Struktur ist die tiefste Ebene auf der therapeutische Korrekturen stattfinden. So erreichen wir, die wahren Bedürfnisse des Patienten in der interpersonellen Kommunikation zu erfüllen und erst nachdem ein fester therapeutischer Bund mit dem reflektierten Part des Ich des Patienten hergestellt worden ist, ist eine Konfrontation und die Nutzung destruktiver interpersoneller Muster möglich. Obwohl wir heute eine große Vielzahl an Methoden und Techniken haben, hängt der Verlauf einer Therapie letzten Endes von der Qualität des Kontaktes mit dem Psychotherapeuten ab.

(Deutsch von Anna Vasilyeva)

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Motivation: An Integrative Paradigm

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This paper is about the relational therapies, Integrative psychotherapy in particular: a therapy model in which the accent of therapy is on contact in therapeutic relationship, as it's relationship focused therapy. It is about needs met, needs neglected and the effect of both to integration of a healthy human being. It's about the repairs of ruptures in early development relationships, about relationship-in-contact: of a client and the integrative psychotherapist. It's about an integrative paradigm of human motivation. Integration occurs in therapeutic contact-focused relationship, within secure and safe, caring, validating, accepting environment, with a strong and dependable therapist who values and acknowledges the client for who he or she is. Needs won't be denied but dealt with.

Keywords: pleasure-seeking, relationship-seeking, contact-in-relationship, relational needs, Integrative psychotherapy

The question about what motivates human behavior is as old and as intriguing as the different schools of psychotherapy and theory of human development. As almost everything else when psychotherapy is in question, this too begun with FREUD: he conceptualized that human behavior is motivated by pleasure seeking, and that the main motivational forces are biological drives: sexuality and aggression, archaic biological instincts that drive human beings basically the same way as they do any other mammal.

FREUD originally used the term 'object' to mean anything an infant directs drives towards, for satisfaction. Drives are of two types: libidinal and aggressive. Accordingly, objects became a key component of FREUD's drive-structural model of the human psyche, and of psychoanalysis as a main stream therapeutic model for a very log time.

Since FREUD, however, many theorists such as FAIRBAIRN (1952), KERNBERG (1980, 1999) and KOHUT (1971), also KLEIN, WINNICOTT, and BOWLBY (SUTHERLAND 1980) have moved, in varying degrees, towards a relational-structural model of the psyche, in which an 'object' is the target of relational needs during human development.

Object relations theory could be seen as a modern adaptation of psychoanalytic theory that believes we are relationship-seeking rather than pleasure seeking as FREUD suggested. Modern object relation theo-

ries believe that humans have an innate drive to form and maintain relationships, and that this is the fundamental human need and behavior motivating force, forming a context against which other drives, such as libidinal and aggressive, gain meaning.

Following the trail of FAIRBAIRN's concept that the ultimate goal of human behavior is establishing relationships, WINNICOTT and GUNTRIP implied that the main course of psychotherapy should be relational rather than interpretative (SUTHERLAND 1980).

Interpretative, classical FREUDian's analysis falls into 'one person psychology' model (STARK 1999): the analyst viewed as a 'blind mirror', an objective and neutral witness to what's going on with the client, working with transference, resistance, denial and conflicts of a client, not being affected or changed by the content of client's ruminations, emotions, needs or affect; countertransference regarded as something to be rid of, the reaction of the analyst to the client that should be dealt with in supervision and be rid of as soon as possible.

We know today that modern psychoanalysis went through many adaptations and changes and even though it borrows freely from 'two person psychology' model (STARK 1999), the fact still stands that it's predominantly one person psychology' in which the client and the analyst practically do not form a contac- focused relationship.

Relational therapies, on the other hand, fall under two person psychology model: a client and a therapist form a contactfull relationship, and through the use of contact within the matrix of that relationship intrapsychic reorganization occurs and old defensive patterns are no longer needed. Even though it's not meant for therapists to benefit out of relationships they form with their clients, and even though it's true that every and any benefit on the part of a therapist is just a 'side effect' of (good) therapy, it would be fair to say that relationship-oriented therapies do change and influence therapists just as much as they do clients, just in a different way. Every relationship is a two way street, even a therapeutic one, where the therapist is in the background and the client in a foreground, using a Gestalt language term, and no therapy, in my opinion, can be called a good therapy if the therapist too, as well as the client, but in a different way, is not affected, changed, influenced. Even though there can not be equality, there can be mutuality to a certain point,

because there can not be a meaningful contact between two people, unless they both feel it. And to feel it, is to be changed. If the therapist is open to feeling it, to being affected by the client, it is virtually impossible not to be changed in one way or another. However, one must always have in mind the benefit for the client and keep the priorities straight: that both the therapist and the therapeutic relationship are there to support the client's well being in the first place.

An integrative psychotherapist works within the framework of such a therapeutic relationship. This is the kind of a relationship that integrative psychotherapy speaks about when postulating that "the underlying and essential element of successful therapy is contact in relationship." (ERKSINE 1999, p. 13) Integrative psychotherapy is a relationship focused therapy. It stands in agreement with other theories which assert that human behavior is relationship-motivated. In fact, it believes that relationship hunger, hunger for contact and for strokes, drives all humans and humans can exist with all their experiences only within relationships with others.

The need for stimuli arises very early in life. Scientific research in past decades show that it exists even during early intrauterine development of the fetus. And when we think of it, is not it true that even the unborn baby is already in contact, in relationship with its mother and not just because it lives within mother's body? Fetal psychology research shows clearly that "the fetus responds to different kind of stimuli, both from the environment outside the womb and within" (HOPSON 1998, p. 44); the amount of tactile stimulation fetus gives to itself is almost amazing: it touches a hand to the face, one hand to the other hand, clasps it's feet, touches it's foot to it's leg, it's hand to it's umbilical cord etc., all that, in exploring it's inner world of warm wetness. Mother's voice is known to sooth and comfort the fetus in the same way as it sooths a newborn baby. It is no miracle than, that newborns, after what seems to be a lifetime of stimuli in mother's womb, seek contact and the same, or more, stimuli after birth. Without the stimuli, without the contact babies do not grow, neither physically nor psychologically. The human self is a product of relationships that are a part of the infant's environment from before birth.

It would be thus fair to say that to be human is to need contact, and to

have needs. Our motivation then is to seek satisfaction of needs through relationships with others, through meaningful contacts. In fact, "the dynamic pattern of experiencing and meeting a need is the essence of contact." (ERSKINE 1999, p. 8)

Relationships are based on needs: if we do not need or want anything from each other, there will be no relationship. Needs are components of everyday relationships that we form with our friends, spouses, children, colleagues. They often emerge from the unconscious at the moment when they are not met, and become more intense, experienced as longing, emptiness or sadness. Further frustration of needs remaining unmet may lead into anger, despair or hopelessness, and eventually into script decision that can be totally destructive and inhibiting for the growth and maturation of a person, preventing further formation of successful relationships.

Even though the 'relational needs' (ERSKINE 1999) are present in every relationship, the therapeutic relationship is special in the sense that the needs of the client always come first, and the relationship is there to serve the welfare of the client. Because the cumulative neglect of needs can be more damaging than any other form of trauma it is essential that therapy provides a contactfull and safe relationship with a therapist sensitive to the relational needs of the client. Since that kind of relationship usually did not exist in client's early life, client comes to therapy not only with the needs belonging to the here-and-now relationship with the therapist, but also with needs not met in the past. To untangle those, to attune to the client's pace for change, to be involved with no expectations, to be curious, and to respond to the relational needs of the client in contact full relationship, meet those that can be met and acknowledge those that can not be met, is the true art of relational psychotherapy.

According to Integrative psychotherapy school eight basic needs arise within any relationship and they are life-long aspects of being humans. The need for safety is probably the most archaic, most basic need: the need for survival. It has to be met before a person can even know or experience any other need, and ERSKINE (1999) describes it as the relational need for security. It is important that we feel the relationship is a safe place where we can be ourselves, accepted and appreciated for who we are, without having to fear that we would lose the other person's love

and respect for us when we drop our defenses and share our emotions, thoughts and dreams. Openness to another human being puts us into a vulnerable position of being fully exposed to the reaction of the other, and it is of utmost importance that we feel secure and safe while sharing ourselves. It is of even greater importance that the client feels this need is met and acknowledged in therapeutic relationship, where clients are invited to share contents hidden for years and be exposed to the reactions of the therapist. Having this need met means having the inner feeling that our vulnerabilities are protected and respected, and that the therapeutic relationship will survive what clients often seem to perceive as their unacceptable, shocking or repulsive inner experiences, thoughts or fantasies.

The need to be valued is also part of every relationship. It means being understood respected and cared for, being valued for what is known about us. It is about appreciating and accepting not just what one does but also why one does it: it is believing that what we do is worthy and important to other people. In the therapeutic relationship this means that the therapist believes in the client's cognitive and emotional processes, believes that what the client is doing, saying, thinking, feeling has an important function and is purposeful, significant and acceptable as well as accepted.

Acceptance is another one of the vital relational needs and it means being respected, loved, and let into other person's life, a life of dependable, stabile, and protective other. This especially applies to the therapeutic relationship, where acceptance of a stabile and reliable therapist is needed in order to re-experience old wounds of needs neglected and unmet, re-experience denied and split off parts of self, and deal with ruptures in early relationships.

The need for mutuality is the need we all have in our everyday relationships, to be in the presence of somebody who understands what we experience because they have been in a similar situation. In a therapeutic situation it refers to the need to be in the presence of a therapist who not only appreciates what the client is going through but who also has a cognitive and affective sense of the experience, who knows what it is really like to be in client's position and to respond to that sensitively and supportively. It does not require that the therapist has had the same experience as the client, "but something that although different on the sur-

face, had the same essential quality as what the client is describing." (ERSKINE 1999, p. 134).

The need for self-definition is the need for 'different-ness', for uniqueness, and for the other person to accept and value that uniqueness. This need is opposite to the need to share the 'same-ness', the need for mutuality. A good balance of those two needs sets healthy boundaries between closeness and separation. In the therapeutic relationship this means that the therapist has to respect and support the client's uniqueness and expression of his or her identity even when the client disagrees with the therapist or the plan of the treatment.

In any relationship, having an impact on the other person is essential. Knowing that we make a difference, that we can cause some change in another human being, in the way they think, act, feel, and to see the effects of those changes is one of the things that define the quality of a relationship. In the therapy situation, the response of the therapist to the client must be dealt with carefully and the expression of it needs to be therapeutically appropriate, with the welfare of the client in mind at all times.

The need for other to initiate contact some of the times is also an important relational need. To be the one who has to initiate all the time can get frustrating and disappointing. We all want the other person to reach out to us and demonstrate that they want to be with us. In the therapy situation, the attuned therapist will know when it is time to follow the client's lead and when to initiate. As ERSKINE said , "effective therapeutic initiation then has two major ingredients: knowing when to initiate and doing so appropriately." (1999, p. 147) Again, the rule of a good therapy applies: as much as needed, and as little as possible.

Finally, there is the need to express love in any close relationship. Feeling love in the presence of another human being is part of our self-definition, of who we are when we are with others. Having not to feel affection, caring or love requires that we push aside our inner experience, and to deny part of ourselves. It's only natural that the client will feel love and affection for the therapist who often turns out to be the most important person at certain periods of the client's life. Not all of those feelings can or should be, accounted for transference: if we have no reason to think differently, most of the times we should take them to be what they seem to be: part of the natural relational need to express caring

for the significant other in the relationship. And as long as we remember that the client is in the foreground and therapist in the background, it is also just as natural that therapists can be pleased about positive feelings from their clients. With that in mind, the therapist can meet this need with comfort and ease, facilitating the integrative processes in client.

Finally to be loved is a need that comes out of all the previous needs as a conclusion: it simply means that all the relational needs are adequately met. Being sensitive to which need is at the foreground at a given time, a relationship is functional and gives the experience of being cared for, appreciated, and respected. Another words: we feel loved.

To not be able to have some or any relational needs meet during childhood, creates the basis for many developmental impasses and scrip decisions that, if left untreated, leave person incomplete, stuck forever with the false Self in one's 'false life'.

Zusammenfassung

Die Frage, was menschliche Wesen ausmacht und was menschliches Verhalten motiviert ist schon immer Gegenstand der Debatte verschiedener Theorien der menschlichen Entwicklung. FREUD ging davon aus, dass wir vor allem nach Lustgewinn streben, also die Triebe, Libido und Todestrieb die motivierenden Kräfte in uns sind. Objektbeziehungstheoretiker hielten interpersonelle Beziehungen für ein fundamentales Bedürfnis des Menschen und damit für die motivierende Kraft (SUTHERLAND 1980).

Der Ansatz der Intergrativen Psychotherapie (ERSKINE 1988, ERSKINE 1999, MOURSUND 2004) geht ebenfalls davon aus, dass menschliches Verhalten durch das Bedürfnis nach Beziehung motiviert ist. Und zwischenmenschliche Beziehungen werden durch Bedürfnisse geprägt. Wenn wir nichts voneinander brauchen und wollen, gibt es keine Beziehung. Nach ERSKINE (1999) gibt es acht Grundbedürfnisse in Beziehungen, die ein Leben lang Aspekte des menschlichen Daseins bleiben Bedürfnisse nach: 1. Sicherheit, 2. Wertschätzung, 3. Akzeptanz, 4. Gemeinsamkeit, 5. Eigenheit (Identität), 6. Austausch/Einfluss auf den Anderen, 7. Kontaktinitiative des Anderen und 8. Ausdruck von Liebe in nahen Beziehungen.

Frühe Beziehungen determinieren unsere Persönlichkeitsentwicklung

und mögliche 'Skript-Formationen', im Sinne von bestimmten geprägten Mustern der Beziehungsgestaltung. Um ein gesundes Leben zu führen und gesunde Beziehungen zu bilden, müssen frühe Störungen in den primären Beziehungen erkannt und es muss mit unterdrückten Bedürfnissen umgegangen werden. Es müssen 'Skript-Entscheidungen', die sich aufgrund kumulierter, verdrängter Bedürfnisse gebildet haben, überwunden werden. Die Integration erfolgt in der Arbeit mit der therapeutischen Beziehung. Die Therapie ist auf den Kontakt zwischen Patient und Therapeut fokussiert. Es bedarf dazu eines sicheren, tragenden, spiegelnden und akzeptierenden therapeutischen Raums mit einem starken und verlässlichen Therapeuten, der den Patienten anerkennt, wertschätzt und in Kontakt mit ihm geht. Bedürfnisse dürfen nicht abgelehnt werden. Wenn sie nicht wahrgenommen werden und nicht mit ihnen umgegangen wird, bleiben sie eine fordernde, nagende Energie, eine bindende Kraft, die die Lebensenergie aufsaugt und uns einsperrt. Man bleibt gefangen, ohne Kontakt mit sich selbst, mit anderen und der Schönheit des Lebens.

(deutsch von Stephanie Zodl)

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'As If' Personalities: Affects, Emotions, Feelings

Anna Maria Loiacono (Firenze)

The 'as if' personality concept refers to people who are prone to having strong identifications, peculiarly imitative in nature, but lack their own personality. This phenomenon is an expression of the human inclination to imitate attractive models, to remain passively waiting for external influences, never reaching, therefore, the capacity of having genuine relationships neither with others nor with their own motivations. By works of DEUTSCH, ABRAHAM, GREENACRE, JACOBSON, KOHUT, ROAZEN the author shows the fact that the problem of 'as if' personalities is a modern reality and treats the 'as if' personalities as a concept of unification in contrast to the current attempts of fragmentation of diagnostic personality disorders, as in many psychoanalytic concepts in relation to the psychiatrization of psychoanalysis.

Keywords: as if personality, countertransference, affect, emotion, feeling

'Feelings of the therapist and the obligations of countertransference': this would be the ideal title for my presentation. The diffusion of scholastic technicisms and the proliferation of orthodoxies requires a critical collocation of the phenomena that constitute the subject of our discussion.

Specifically, I will speak about countertransference as it regards the sociopsychological dimension of the therapist as a person, nowadays.

I begin with the question of 'as if' personalities, which I find paradigmatic: it originates with the psychopathological studies of Helene DEUTSCH, who, in her writings of 1942, associates it with schizophrenia. Later Paul ROAZEN, DEUTSCH's biographer, and executor of her cultural testament, would transport the concept to the social dimension of politics and to the personality of politicians (1989).

Let me clarify my conceptual references, beginning with the distinctions in terminology between emotions, feelings, and affects:

a) the term 'emotion' is limited to the neurobiological component (see E. JACOBSON, 'Depression' 1971);
b) the term 'feelings' indicates those affects linked to the ego, that is, which are attributed to what we feel, articulated through language (SANDLER; LOWENSTEIN).
c) with regard to the term 'affects', my reference will be that of David

RAPAPORT's theory of affects.

RAPAPORT defines 'affect' "a wide variety of phenomena that both in diagnostic and therapeutic work we are in danger of being led astray". (1953, pp.15)

I cite RAPAPORT,

> we also call affects those displays which impress the onlooker as histrionic or affectations, and which certain character-types are prone to produce, either in exaggeration of experienced, or as substitutes for not-experienced affects. It is not quite clear how these are related to the 'as if' affects of those schizoid personalities described by Helene DEUTSCH [1942]. [...] we might add that, on the one hand, neurotic inhibition and ego-limitation cut down the range of intensity and variability of affect-experiences; on the other, regression-processes bring to the fore unbridled and unmodulated affective attacks in which, while intensity is formidable, range and variability are minimal." (RAPAPORT 1953, p. 16).

Next, I cite H. DEUTSCH's definition of the 'as if' personality,

> exteriorly, [the individual] lives as if he had a complete and sensitive emotional capacity. For him there is no difference between his own empty forms and that which others really experience [...] this is no longer an act of repression but a true loss of object investment. (1942, pp. 93-94).

If we consider the concept of affect as undifferentiated energy which may or may not be released, the key element becomes the intensity of this energy and its regulation. This hypothesis constitutes one of the cardinal points of traumatologic prospects currently in vogue.

If, on the other hand, we consider the concept of affect as linked to thought and thus to language, it becomes clear that its representation in the conscious becomes a determining factor with regard to the representation of the ego and of identity. From this point of view, the differentiation of affects manifests itself as feelings which take form through linguistic differentiation.

Today, this prospect is given importance in the connection between psychoanalysis and phenomenology. It is this hypothesis that introduces the 'as if' pitfall, in which speech, the very instrument whose function is to recognize, regulate, and express, becomes, by means of language, an instrument of alienation of the affects themselves.

In this sense, we can refer both to disquisitions on the falsification of language by MUSIL's young Toerless and to the alienation of emotions shown by SALINGER's young Holden, to demonstrate the reintroduction of affects proceduralized as grafted affectivity, by means of a previously

externalized thought. Formal externalizations are reintroduced to the individual who has lost the ability to recognize his own affects and emotions. In this way, we can observe the phenomenon of the grafting of feelings and of affectivity: a sort of guide to what one must experience.

The foregoing remarks represent a preface to the main thesis of my presentation today, that is, to remove the concept of the 'as if' personality from the context of psychopathology, where DEUTSCH elaborates it, transporting it to the sphere of social 'normality' following Paul ROAZEN's conceptualization as articulated in "The 'as if' personality and politics" (1983), and finally reaching the psychoanalyst's office and the core of his analytic activity.

In his essay, ROAZEN characterizes the politician, the leader, as achieving success through social and individual aggressiveness. The process of bonding with the leader is not one of identification but of imitation, therefore it does not transpire at the level of memory and any fixed continuity is excluded because there is no identity that has the persistence to sustain it.

If we continue to apply profound psychoanalytical thought to the comprehension of group behavior, initiated by FREUD in 'Group psychology and the analysis of the Ego' (1921), we cannot help but see that, through the propaganda of the mass media, we are truly being educated to become 'as if' personalities, as interpreted by ROAZEN in the paper cited above.

The question is what can therapeutic work achieve with respect to this social phenomenon? There would have to be therapists who manage to avoid this process, and thus be able to act as the probe necessary to discern certain social phenomena, such as manifestations of massification and alienation of the individual, rendering them available to collective consideration. But such therapists would indeed have to elude conformity and social adaptation themselves in order to be in a position to radically oppose massification.

In general, this is not the case, although, and I emphasize the fact, our profession would have such an ethical duty. It is my feeling that today's therapists indulge in, forgive the term, 'therapeuticism', which they are invited to practice from the very beginning of their formation. Their attention is focused mainly on classifications, on therapeutic results, and

on diagnosis of the patient's pathology with indications for the position one 'should' adopt to treat the case in question. Then there are the indications for what the countertransference 'should' consist of, or at least indications as to the emotional tone that 'should' inform the patient-analyst relationship in order to effect a modification. The ultimate icon is the result of a constant call for authenticity, the definition of which, in terms of content, we are often careful to avoid, while making a great display of prescriptions for what 'should' be done.

In my didactic experience, it has been easy to understand how the fear of 'meeting the other' in the analyst's office reveals the need to follow a format, especially by retracing paths already taken. What I find difficult to comprehend is that the most experienced analysts, those who, like me, are involved in training future colleagues, are the very ones who show a distressing conformism, continuously dishing out methodologies and passing them off as doctrinal truths that risk being transformed into articles of faith.

In this connection, it is indispensable to refer to Erich FROMM's position regarding the conditions to be met if psychoanalytic technique is to be carried out with the maximum efficacy. While FERENCZI finds it sufficient that personal analysis of the analyst be performed at the most profound levels, FROMM goes much further, maintaining the need to consider the social aspect of taboos rather than attributing to them a biologic or natural significance.

In this sense, it is FROMM's belief that the analyst must be capable of totally entering into contact with himself, with the exclusion of any conformism.

The final question, then, is this: to what extent does psychoanalytic conformism represent a collective 'as if' within our profession?

I wish I could say that I have the answer, but indeed I do not.

Concerning FROMM at work, however, I recall an anecdote that is anything but an example of conventional professional conduct. The episode in question, reported by Arno von BLAZER, a psychoanalyst from Zürich, was related to me by a colleague.

A very wealthy widow from Zürich develops a depression marked by feelings of rancor and revenge, which represent the principal, if not only, interest in her life. She consults FROMM, who listens to her for one hour,

at which point he says: 'Sie sind nur eine alte jammerige Frau!' ['You are just a complaining old lady!']. The woman is offended, insults FROMM and leaves his office. She was cured. Can this possibly be a creative act on the part of FROMM, inspired by his art of listening?

I only know that I am uncomfortable with doctrines and that I strive to transmit my passion for research.

I believe that, by pursuing a path in a subdued manner and a low tone of voice, this can be felt and can touch the individual conscience, with no Messianic illusions. Such a pathway can be likened to that of wandering clerics, who once spread the desire for knowledge but without overseeing the fruition of their good intentions. I see my role as somewhat parallel to this. Along this path, I have occasionally felt that I was face to face with myself, and sometimes It has frightened me.

I do not claim to know what should be done, but I have strong convictions about what our past has taught us not to do in order to avoid a repetition of histories without memory.

Summary

The concept of an 'as if' personality is proving to be of particular relevance today. Removed from the context of psychotherapy where it is first elaborated by Helene DEUTSCH, it is then transported to the sphere of social 'normality' by Paul ROAZEN, who characterizes the politician/leader as achieving success through social and individual aggressiveness. The process of bonding with the leader is not one of identification but of imitation and therefore does not transpire at the level of memory. Any fixed continuity is excluded because there is no identity that has the persistence to sustain the process. What emerges from this standpoint is the vision of a general conformism which is present even among the ranks of our own profession, where, ethically, the ability to understand and denounce the manifestations of massification and alienation of the individual should be a priority.

In therapeutic practice, the social phenomenon of 'as if' personalities becomes obvious through the 'therapeuticism' which practitioners are encouraged to exercise from the very beginning of their formation. This results in focussing one's attention mainly on classifications, therapeutic results, and diagnosis of the patient's 'pathology', with indications

regarding the position one 'should' adopt to treat the case in question as well as what countertransference 'should' consist of, or at least indications as to the emotional tone that 'should' inform the patient-analyst relationship in order to effect a modification.

In substance, such psychoanalytic conformism can be seen as the collective 'as if' of our profession, where, despite a constant call for authenticity, there continues to be a great display of prescriptions for what 'should' be done. In this sense, FROMM's belief that the analyst must be capable of remaining constantly in contact with himself and free of any conformism on his part is both notable and timely.

Zusammenfassung

Das Konzept der 'Als-ob'-Persönlichkeit erweist sich heute als besonders relevant. Außerhalb des psychotherapeutischen Kontextes, hier zum ersten Mal von Helene Deutsch beschrieben, wird es anschließend von Paul ROAZEN in die Sphäre der sozialen 'Normalität' transportiert. Letzterer beschreibt den Politiker/Anführer als jemanden der durch soziale und individuelle Aggressivität zum Erfolg gelangt. Der Prozess der Bindung an den Anführer ist nicht durch Identifikation sondern durch Imitation gekennzeichnet und findet somit nicht auf einem Level der Erinnerung statt. Jede feste Kontinuität wird ausgeschlossen, weil es keine Identität gibt, welche die Beständigkeit besitzt, den Prozess aufrechtzuerhalten. Was aus diesem Standpunkt hervorgeht, ist die Vision eines generellen Konformismus, der sogar in den Reihen unseres eigenen Berufsstandes präsent ist. Hier sollte ethisch gesehen die Fähigkeit, die Manifestation der Breitenorientierung und der Entfremdung des Individuums zu verstehen und zu verurteilen, Priorität sein.

In der therapeutischen Praxis wird das soziale Phänomen der Als-ob-Persönlichkeit durch den 'Therapeutismus' deutlich, den praktische Ärzte von Anfang ihrer Ausbildung an, auszuüben angehalten sind. Dieser führt dazu, dass man sich in erster Linie auf Klassifikation, therapeutische Ergebnisse und die Diagnose der 'Pathologie' des Patienten konzentriert, mit Anhaltspunkten bezüglich der Position sollte die Behandlung des betreffenden Falls übernommen werden sowie das, woraus die Gegenübertragung bestehen 'sollte' oder wenigstens Hinweise über die emotionale Tönung, welche die Patienten-Analysanden Beziehung prä-

gen sollte, um eine Veränderung zu erzielen.

Der Sache nach kann solch ein psychoanalytischer Konformismus als das kollektive Als-ob unseres Berufes gesehen werden; abgesehen von dem stetigen Anspruch auf Authentizität, bestehen weiterhin viele Ansichten über Vorschriften darüber, was getan werden sollte. In diesem Sinne sind FROMMs Ansichten, dass der Analytiker in der Lage sein muss immer mit sich selbst im Kontakt zu bleiben und seinerseits frei von Konformismus zu sein, sowohl bemerkenswert als auch zeitgemäß.

(Übersetzung Vanessa Rathert)

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'The Interpersonal Dynamics of Identity. Research, Pathology and Treatment'

Bericht über den 16. Weltkongress der World Association for Dynamic Psychiatry (WADP) und das 26. Internationale Symposium der Deutschen Akademie für Psychoanalyse (DAP) in München

In mehr als 200 Vorträgen und Workshops tauschten sich 130 Wissenschaftler aus über 22 Ländern darüber aus, welche Möglichkeiten und Grenzen einer gelungenen oder störanfälligen Identitätsentwicklung bestehen, mit dem Schwerpunkt der Bedeutung der interpersonellen, gruppendynamischen, kulturellen und gesellschaftlichen Einflüsse darauf. Einbezogen wurden Erkenntnisse aus den Gebieten der Hirnforschung, der Trauma- und Bindungstheorie sowie der Resilienz-, Ressourcen- und auch der pharmazeutischen Forschung. Ein großer Schwerpunkt lag auf den Therapiemöglichkeiten, insbesondere auch im Bereich der ganzheitlichen und kreativierenden Therapien.

„In einer Zeit der Globalisierung und weltweiten Migration, mit ihren sozialen und gesellschaftlichen Problemen und Herausforderungen, erscheinen die Voraussetzungen für eine gelungene Identitätsentwicklung immer schwieriger zu werden", formulierte Maria Ammon, die Präsidentin der DAP in ihrer Einleitung zum Programm. Die Identität der Persönlichkeit sei ein zentrales, aber dennoch bisher unvollständig verstandenes Problem in der Psychiatrie, führte Nikolaj G. Neznanov, der Präsident der WAPD aus. Ihre Erforschung erfordere die interdisziplinäre Zusammenarbeit aller Humanwissenschaften, um die biologischen, psychotherapeutischen und psychosozialen Aspekte in einen ganzheitlichen Ansatz von Behandlung und Forschung integrieren zu können.

Zu Gast war die Tagung in den Räumen der ehrwürdigen Psychiatrischen Klinik der Ludwig-Maximilian-Universität, die bereits 1904 unter dem berühmten Psychiater Kraepelin eröffnet wurde und deren Gründerzeitgebäude unter Denkmalschutz stehen. Optisch eingerahmt wurde der Kongress von den Bildwerken der Kunstaustellung 'Vergangenheit und Gegenwart in der Kunsttherapie', die Werke von Patientinnen und Patienten aus der Maltherapie der dynamisch-psychiatrischen Kliniken in München, St. Petersburg, Orenburg und Kaschenko präsentierte.

Für seine Verdienste in Wissenschaft, Forschung und Therapie erhielt

Raymond Battegay (Basel) am Eröffnungstag die Goldmedaille der DAP. In seiner Key Lecture setzte er sich mit den Möglichkeiten der Psychoanalyse auseinander, das Selbstvertrauen der Patienten zu stärken und sie so in die Lage zu versetzen, in der heutigen, von rigiden sozialen Normen geprägten Gesellschaft einen eigenen Standpunkt zu behaupten.

(Fotos Giancarlo Capezzone)

Maria Ammon (Berlin) beschrieb in ihrer Key Lecture Identität als Ergebnis interpersoneller Austauschprozesse. Sie betonte die Bedeutung der Gruppe für die Identitätsentwicklung und stellte die Herausforderungen für die Identität in der heutigen Gesellschaft in einen breiten Kontext sozialer Entwicklungen und Umbrüche seit dem 2. Weltkrieg.

Die historischen Grundlagen der beziehungsorientierten, dynamisch-psychiatrischen Sichtweise von Identität wurden von Ingeborg Urspruch (München) in ihrem Referat dargelegt. Mit ihrer Analyse der wissenschaftstheoretischen und historischen Wurzeln der Berliner Schule Günter Ammons und ihrer eigenständigen Entwicklung über die letzten 40 Jahre seit der Gründung leistete sie ein wichtiges Stück Identitätsarbeit für die Dynamische Psychiatrie.

In den Ausführungen von Ingeborg Urspruch wurde deutlich, dass die Berliner Schule im breiteren Kontext relationaler Psychoanalyse zu verstehen ist. Diese Verwandtschaft wurde ebenso im Vortrag von Richard Billow (Great Neck, USA), eines prominenten Vertreters des relationalen Ansatzes in der Psychotherapie, deutlich. Auch Billow betonte den Beziehungsaspekt von Identität als zentral für die Behandlung gestörter Identität.

Die interpersonale Grundlage der Identität wurde gleichermaßen von wichtigen Repräsentanten der Bindungstheorie und Bindungsforschung, Klaus Grossmann und Karin Grossmann (Regensburg), betont. In seiner

Darstellung der Entwicklungswege unterschiedlicher Bindungstypen zeigten sich prototypische Verläufe von Persönlichkeitsentwicklung.

Der Entwicklungsaspekt von Identität wurde in mehreren Beiträgen aus unterschiedlichen Blickwinkeln dargestellt, so z. B. aus Sicht der Kinder- und Jugendpsychiatrie von Shmouel Tyano (Tel Aviv). Im Vortrag von Ulrich Rüth (München) wurden die Sichtweisen der Kinder- und Jugendpsychiatrie und der Bindungsforschung, in ihrer Weiterentwicklung als Konzept der Mentalisierung, Gewinn bringend miteinander kombiniert.

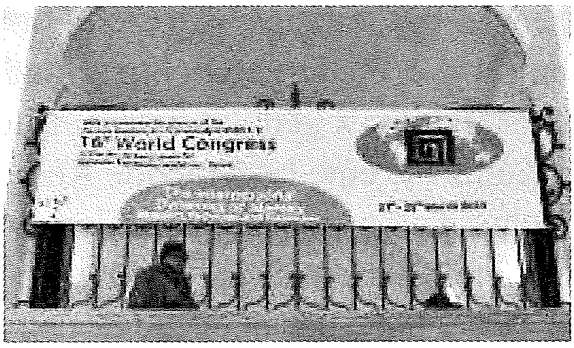
Die Theorie der Mentalisierung war nicht das einzige aktuelle Forschungsgebiet, das von den Vortragenden für die Weiterentwicklung und Vertiefung von Ansätzen des Identitätsverständnisses genutzt wurde. Ein weiteres Forschungsgebiet, das auf dem Kongress eine bedeutende Rolle spielte, war die zeitgenössische Hirnforschung. Ein prominenter Vertreter dieses Fachgebiets soll an dieser Stelle stellvertretend für andere Referenten genannt werden: Joachim Bauer (Freiburg), der über die Bedeutung der Spiegelneuronen für die Identitätsbildung sprach. Bei allem Augenmerk für aktuelle Entwicklungen in der psychologischen und psychiatrischen Forschung kamen aber traditionelle psychoanalytische Themen und Konzepte nicht zu kurz, wie z. B. der Vortrag von Renate Splete (Augsburg) zur Traumforschung zeigte.

Ein zentrales Konzept Günter Ammons für das Verständnis der Identität ist die Mehrdimensionalität des Menschen. Dass sich dieser Ansatz auch bei zeitgenössischen Denkern, die anderen Therapieschulen angehören, finden lässt, konnte man beim Referat von Kenneth Gergen (London), der über die Mehrdimensionalität des Menschen und die therapeutische Beziehung sprach, feststellen.

Ein weiterer zentraler Punkt der Identitätstheorie Ammons ist die Gruppenabhängigkeit der Identität. Mit diesem Thema beschäftigten sich ebenfalls mehrere Vortragende, nicht nur aus der Sichtweise der Dynamischen Psychiatrie, sondern auch aus anderen psychotherapeutischen und gruppendynamischen Denkrichtungen, so z.B. Volker Tschuschke (Köln), der zu den wichtigsten Therapieforschern im Bereich der Gruppenpsychotherapie gehört. Die Sichtweise der Berliner Schule wurde unter anderem von Rolf Schmidts (München) vertreten. In seinem Vortrag über die Bedeutung der Großgruppendynamik für die Identitätsent-

wicklung des Individuums wurde auch die gesellschaftliche Dimension in ihrer Bedeutung für die Entwicklung von Individuum und Gruppe hervorgehoben.

Gesellschaftliche und kulturelle Aspekte der Persönlichkeit wurden in einer Vielzahl von Beiträgen aus unterschiedlichen Blickwinkeln dargestellt. Wiederum stellvertretend für die Referenten, die sich mit diesen Thematiken auseinandersetzten, sei Juan Bar-El (Haifa) genannt, der über die Identitätsaspekte der Zugehörigkeit zu ideologischen Gemeinschaften und religiösen Kulten referierte.



(Fotos Giancarlo Capezzone)

Der Bedeutung spiritueller Dimensionen für die Identität war im Rahmen des Kongresses auch ein eigenes Symposium unter der Leitung von Gabriele von Bülow (Berlin) gewidmet. Die Beschäftigung mit spirituellen Aspekten der Persönlichkeit kann im Kontext einer übergeordneten Thematik gesehen werden, welche die Diskussionen auf dem Kongress in vielerlei Hinsicht prägte, nämlich die Frage nach der Wichtigkeit persönlicher Ressourcen und Konzepten der Gesundheitsforschung. Egon Fabian (München) griff dieses aktuelle und zukunftsweisende Thema in seinem Vortrag auf und skizzierte ein psychodynamisches und gruppendynamisches Verständnis des Ressourcenkonzeptes. Ilse Burbiel (München) beleuchtete das Ressourcenkonzept aus der Sicht der Dynamischen Psychiatrie und bezog sich dabei auf Günter Ammons Ansatz der 'Verbündung mit den gesunden Anteilen des Patienten' in der Therapie.

Die neuesten Ergebnisse der weltweiten Forschung zu den Konzepten von Recovery und Resilienz, insbesondere im Zusammenhang mit der Therapie der Psychosen, wurden von Margit Schmolke (München) in ihrem Beitrag dargestellt.

Das verstärkte Augenmerk auf die gesunden Anteile und Kompetenzen der Persönlichkeit ist ein wichtiger Aspekt übergreifender Entwicklun-

gen, die weltweit in den letzten Jahren darauf hinarbeiten, die institutionalisierte Psychiatrie zu humanisieren und zu individualisieren. Diese Entwicklungen lassen sich unter dem Stichwort einer 'person-zentrierten Psychiatrie' zusammenfassen, wie von Juan Mezzich (New York) in seinem wichtigen Referat dargestellt wurde.

(Fotos Gisela Finke)

Neben den zukunftsweisenden Konzepten einer gesundheitsorientierten und humanen Psychiatrie fand natürlich auch die in vieler Hinsicht verbesserungswürdige Situation der Psychiatrie in der gegenwärtigen gesellschaftlichen Realität Berücksichtigung. So sprachen unter anderem Nikolaj Neznanov und Anna Vasilyeva (St. Petersburg) in ihrem Eröffnungsvortrag zum Thema 'Stigmatisierung und falsche Identität' über die gesellschaftliche Stigmatisierung psychischer Erkrankung, deren Folgen für die Identität der Betroffenen und deren therapeutische Implikationen.

Die Therapie und Gesundung 'erkrankter Identität' war Gegenstand vieler Beiträge. Ein Schwerpunkt lag auf den nonverbalen, kreativierenden Therapien wie der Mal-, Theater-, Musik- und vor allem der Tanztherapie, die Gegenstand mehrerer Workshops war. Ein ganzer Vormittag stand Beiträgen aus der dynamisch-psychiatrischen Klinik in Menterschwaige (München) zur Verfügung, in denen die therapeutische Arbeit im stationären Setting von Mitarbeitern der Klinik aus verschiedenen Blickwinkeln beleuchtet wurde.

Einen praktischen und konkreten Eindruck über diese therapeutische Arbeit konnten sich die Kongressteilnehmer dann beim klinischen Nachkongress machen, zu dem die dynamisch-psychiatrische Klinik in Menterschwaige am Samstag einlud. In einer gemeinsamen Großgruppe von Patienten, Mitarbeitern und Wissenschaftlern aus der ganzen Welt wur-

den Grußworte gesprochen und Gastgeschenke überbracht. Bei einer Klinikführung durch Chefarzt Egon Fabian beeindruckten die Teilnehmer insbesondere die Ergebnisse der milieutherapeutischen Projekte in Haus und in den Außenanlagen. Am Nachmittag führte dann die Theatertherapiegruppe unter der Leitung von Renate Fischer und Stefan Weixelbaumer das Stück 'Die Schneekönigin' auf.


(Foto Giancarlo Capezzone)

Überschattet wurde der Kongress von dem verheerenden Erdbeben, das am 11. März, also wenige Tage zuvor, in Japan stattgefunden hatte und den Ängsten, knapp 25 Jahren nach Tschernobyl, vor einer erneuten atomaren Katastrophe durch die außer Kontrolle geratenen Reaktoren von Fukushima. Dieses Geschehen stand für die Verletzlichkeit menschlicher Existenz, wie auch die Mitbedingtheit von Ängsten und Depressionen durch vermeidbare, von Menschen erzeugte politische und soziale Katastrophen. Das Thema der Abschluss-Panel-Diskussion 'Identität und Solidarität – Herausforderungen für eine zukunftsfähige Gesellschaft' gewann so eine brennende Aktualität.

In einer abschließenden Deklaration gab der Board of Governors der WADP deshalb die 'Münchner Deklaration zum 16. Weltkongress' heraus, in der er an alle Verantwortlichen appellierte: „vermeidbare, von Menschen erzeugte Katastrophen zu verhindern. Nicht nur Naturkatastrophen, sondern auch soziale Katastrophen können psychische Störungen auslösen."

Thomas Bihler (München), Gisela Finke (München)

Nachrichten

Münchener Deklaration zum 16. Weltkongress der WADP

Die auf dem 16. Weltkongress der WADP in München versammelten Wissenschaftler beschäftigen sich mit den Gesundheitsproblemen der Weltbevölkerung. Gesundheitsexperten sagen voraus, dass innerhalb der nächsten 10 Jahre Depression die vorherrschende Krankheit sein wird.

In unseren Gesellschaften begegnen uns vermehrt Angst, Aggression, Resignation und Ohnmacht. Die tragischen Ereignisse in Japan machen uns bewusst, dass als Folge immer wiederkehrender Naturkatastrophen die Angst der Menschen bereits ein hohes Maß erreicht hat. Deshalb sollten wir alles tun, um vermeidbare, von Menschen erzeugte Katastrophen zu verhindern.

Nicht nur Naturkatastrophen, sondern auch soziale Katastrophen können psychische Störungen auslösen.

Daher rufen wir alle Verantwortlichen auf, bevor weitreichende politische Entscheidungen getroffen werden, die möglichen psychologischen und existenziellen Folgen für ihre Mitbürger zu beachten. Gefühle innerer und äußerer Sicherheit der Bevölkerung sollten gestärkt werden, um die aus existenzieller Angst sich möglicherweise entwickelnden Gewalt zu verhindern.

Dazu benötigen wir zwischenmenschliche, gesellschaftliche und politische Solidarität.

Munich Declaration WADP 16th World Congress

The scientists assembled at the 16th World Congress for Dynamic Psychiatry in Munich occupy themselves with the health problems of the world population. Epidemiologists preview that within the next 10 years depression will become the leading disorder in medicine.

In our societies we encounter an increasing extent of anxiety, aggression, resignation and helplessness. The tragic events in Japan make us aware that as a consequence of reoccurring catastrophes of nature anxiety of humans reached already a reasonably high degree. Therefore we should do everything to prevent avoidable further disasters created by humans.

However, not only catastrophes by nature but also social catastrophes can cause severe psychic disturbances.

Therefore we would like to appeal on all responsible persons to evaluate the possible psychological and existential consequences concerning their fellow citizens before taking major political decisions. Feelings of inner and outer security of the population should be strengthened to prevent violence potentially developing through existential anxiety.

Therefore we rely on interpersonal, social, and political solidarity.

Präsident der WADP
Prof. N. Neznanov
(St. Petersburg)

Präsidentin der DAP
Dr. M. Ammon
(Berlin)

München, 25. März 2011

'Identity as an Interpersonal Exchange'

Summarizing Panel WADP Congress, March, 25th 2011: 'Identity and solidarity. Challenges for a society ready for the future.'

Prof. Neznanov:

As a result of our congress we should formulate a declaration. We live in difficult times with lots of tensions in society, in times of catastrophes of different kinds. We have two kinds of catastrophies: Natural disasters like the one in Japan a few days ago, but also so-called social catastrophes that have a serious impact on mental health as we lose interpersonal relations to a great extent. Unfortunately, programmes of mental health are often neglected by governments and officials. Mental health does not get the appropriate attention like Aids and different kinds of infections. It is thought that mental disorders only affect a small minority of people in society. But I do not want to just blame the politicians, it is our problem. We are not active enough in society to make mental health and important issue, we have to change a point of view. Depression is a big topic but it is just one of a lot of problems in mental health. I propose that we try to do our best to change this situation and are active in a movement towards society. Our Declaration of this WADP Congress in Munich will be the first step in the 'movement towards society'.

Prof. Mezzich:

Identity is a necessary concept, without which we would not know who we are as human beings. What comes to mind in regards of the concept of solidarity is the concept of social energy as it has been so poignantly discussed at this conference. When we talk about identity, we are not talking about ourselves but about our concepts. Here I would like to cite the Spanish philosopher Ortega Y Gasset who said that 'I am my circumstance', that is, in identity my context is important. This means that there is a relationship between identity and solidarity. Identity in its definition of interconnectedness is the most promising way forward.

Dr. Fabian:

I would like to build on this last statement. We have to carry the message out into the world that there is an unconscious and that there is a social energy. But to pursue a striving towards identity that reaches from medicine to society that seems like a utopia. Yet, Victor Herzl, the founder of the Jewish state, something that was thought to be a utopia or a dream, has said in 1900, 'if you want it then it will not be a dream.' He meant the dream of solidarity. In our ethical thinking and responsibility in medicine we cannot limit ourselves to our dual work with patients but we need to work with groups and with society at large. We have a responsibility beyond our therapeutic work, a responsibility for the world. There is a consensus that we are multipliers of ideas and so will be our patients. This is a good result of our conference.

Prof. Billow:

I learned a lot about groups from working with adolescents when I was a young guy. These were foul-speaking adolescents just released from jail or mental hospitals. What I found was that once they decided to bond in their groups, the problems in their identity dropped into the background. I also learned about the importance of boundaries. These adolescents would say to me, 'You are the biggest jerk, with four eyes (glasses) and no balls, but I would like you see my parents, they are really crazy and you could help them.' And I said, 'What about confidentiality?' The reply was, 'Don't worry about confidentiality, I'll sue you if you tell them anything!' These adolescents hated their parents and they hated me. But they wanted me to find a way for them to re-bond with their

parents. The longing is for all of us, to be bonded and not to have enemies.

Prof. Rutz:

Psychiatry has to work in a holistic way, not to focus on disease and misery but also on health and well-being. In the question of identity we have to be persons ourselves. In Europe, a medical reductionist model still governs psychiatry. We need to redefine psychiatry go be holistic and be process-minded and person-centered. We need to use professionals from different teams and lead the field of psychiatry into society. We need to move towards a human ecological position and convince our political decision makers of the human ecological impact. There is an ecological movement in Frankfurt, a group called 'Fledermaus' (bat) that has a lobby. We are very quiet in ecological discussions, but we really need to speak about political processes and become public.

Prof. Polozhy:

In speaking about the definition of solidarity and identity, there are two ways of defining them. One is that solidarity and identity are closely connected when we speak of mental health, and the other is in a common human sense. All presentations proved that the development of identity or lack thereof is related to mental disorders. It is also a criteria of mental health to be able to take from the other help and love. The humanistic aspect is that people with a lack of identity also lack the capacity for solidarity. In a society without solidarity there are obstacles for mental health care. However, if there is enough solidarity, then it can also be formed by people with a lack of identity. A society without solidarity also causes problems for identity. For mental health we need a parallel development for identity and solidarity to provide an adequate level of mental health care.

Prof. Gergen:

In the question of identity an important dialogue needs to take place between psychiatry and society. We need to pay attention to 3 movements that have come about over the last two decades if we want to enter this dialogue. Each movement addresses important questions about identity. We have we have to pay attention. The first movement is 'Identity Politics', which is an important movement in various countries. Identity

here not about oneself but depends on joining a group. Identity is defined by which group you join, for instance a racial, sex-orientation group, religious groups. Identity becomes a matter of identifications with and in the group. This means there is a sacrifice of the self for the sake of solidarity. What this shows is that the concept of identity is politically loaded. The second movement is the 'global movement' of large masses of people around the world. In this movement people take on the characteristics of other cultures and relationships with the result that one finds oneself split. The new forms of identity are hybrids. There are multiplications and infusions by various groups to form new ways of thinking about identity. The third movement is 'Social networks' where being located somewhere and a central core of identity becomes a problem. Erik Erikson would turn in its grave because identity is no longer an achievement but the goal is identity diffusion. This makes the very concept of a person problematic. The question 'what is it to be human?' becomes unclear. Also what is the nature of pathology then? We need to reconsider pathology from a historical and cultural perspective. Pathology is Western concept and to share it with other cultures is a form of colonialism. How can we care for people who do not share our concept of pathology?

Dr. Burbiel:

In thinking about identity and solidarity, what came to mind was 'globalisation', but globalisation sounds so global, so comprehensive, yet is has to do with an increase in dualisms, in dissociation, and fragmentation. In our work with patients we notice that many have structural problems. These are patients with discontinuities or with disrupted identities, where there has been destruction that leaves gaps. In these gaps we try to introduce human communication within an identity and between identities. Fragmentation is destruction. This is important for groups that are splintered as well. These are groups that lack social energy. We live with chronic tensions and dualisms such as poor vs. rich, white vs. coloured, hungry vs. wasteful, or tensions between different cultures. This will be our future to work in social frameworks with such tensions. But wherever we work be it in education, in social or clinical settings or as politicians, we should try to reconnect what has been split off. The splitting needs to be bridged by social energy and solidarity. We need to learn to

identify with each other when we are working with patients, so that they can come out of their narcissistic worlds and acknowledge the existence of the other, whom they can support and help, too.

This conference is a sign of solidarity, because where people come together with similar ideas, solidarity is implicit.

Closing Panel

The concept of identity is closely connected with the concept of solidarity as the processes in the formation of identity can only be constructive if they are based on relationships with others and on relationships in groups. Hence, identity has to be re-thought as interpersonal entity and as something that in its formation is dependent on social energy. For the individual, the group is vital, since without the solidarity and support of others identity cannot develop. Mental disorders are always also identity disorders that, for the most part, have their origin in the deficient functioning of family and society. Thus, psychiatry should participate in public relations with a new definition of identity; psychiatry should liaise with sociologists, public institutions and officials in politics in order to influence the health of society. In this sense, psychiatry now has a task that by far exceeds the work with patients. From an ethical point of view and in its medical responsibility, psychiatry has to also deal with society and with global problems as such in order to counteract the fragmentation of persons and groups. Bridges need to be built by therapeutic communications to heal the ruptures in identity. Increasing globalization and virtual networks cause the loss of identity and real solidarity and with it an increase of mental illness. In general, the task should be to put mental health much more into the public and particularly into the political awareness in order to ward off the danger of 'social catastrophes' by means of sufficient mental health care. In the future, psychiatry must participate in political discussions.

In the discussion with the audience it was suggested that an intercultural dimension in the question of identity formation should be included. Different forms of socialization in other cultures may offer new resources; for instance, in families in India and China have a quite different structure. In China, for example, trauma patients are asked whether the respected their parents and teachers, and whether they groomed their

friendships and what kind of positive memories they had of their parents. In conclusion it was stated that in Western countries the family is too weak to carry the whole process of identity formation. Therefore, what is needed are networks that can mediate and support identity with sufficient solidarity. And this is precisely the main point in declaration of this congress, that we need to rely on interpersonal, social and political solidarity.

Zusammenfassung

Der Begriff der Identität ist eng verknüpft mit dem Begriff von Solidarität, da Identitätsprozesse nur über Beziehungen zu anderen Personen und in Gruppen konstruktiv laufen. Identität muss demnach neu gedacht werden als Interpersonalität und als angewiesen auf soziale Energie für ihren Aufbau. Für den Einzelnen ist die Gruppe lebenswichtig, denn ohne Solidarität und Unterstützung durch den anderen kann sich Identität nicht bilden. Psychische Störungen sind immer auch Identitätsstörungen, die zum großen Teil durch Defizite in der Familie und in der Gesellschaft ausgelöst werden. Die Psychiatrie sollte deshalb auch mit einer neuen Definition von Identität in die Öffentlichkeitsarbeit eintreten und sich mit Soziologen, öffentlichen Einrichtungen und politischen Entscheidungsträgern verbünden, um auf eine Gesundung der Gesellschaft Einfluss zu nehmen. Psychiatrie hat in diesem Sinne eine Aufgabe, die weit über die Arbeit mit Patienten hinausgeht. Aus ethischer Sicht und in der medizinischen Verantwortung muss sich die Psychiatrie auch mit der Gesellschaft und Weltproblemen als solchen befassen, um die Fragmentierung von Menschen und Gruppen aufzuheben oder gar zu überwinden. Brücken müssen durch therapeutische Kommunikation wieder geschlagen werden um Risse in der Identität zu heilen. Die immer mehr zunehmende Globalisierung und virtuelle Netzwerke bringen einen Verlust von Identität und realer Solidarität mit sich, und damit eine ansteigende Zahl von psychischen Erkrankungen. Generell muss es Aufgabe sein, die psychische Gesundheit mehr in das öffentliche und insbesondere in das politische Bewusstsein zu bringen, um die Gefahr der 'sozialen Katastrophen' mittels ausreichender Versorgung der mentalen Gesundheit zu bekämpfen wenn nicht zu vermeiden. Psychiatrie muss sich in der Zukunft an politischen Diskussionen beteiligen.

In der Diskussion wurde vorgeschlagen, dass man auch die interkulturelle Komponente in der Frage der Identitätsbildung berücksichtigen sollte. Dr. Verma und Dr. Schmolke sprachen die Ressourcen in der Sozialisation von anderen Kulturen an, z. B. wie Familien in anderen Kulturen, wie Indien und China, strukturiert sind. In China beispielsweise werden traumatisierte Patienten danach gefragt, ob sie ihre Eltern und Lehrer respektierten und ob sie Freundschaften pflegten und welche positiven Erinnerungen sie an ihre Eltern hätten. Abschließend wurde jedoch festgestellt, dass in den westlichen Ländern die Familie zu schwach ist, den Identitätsbildungsprozess zu tragen. Was deshalb nötig ist, sind Netzwerke, die die Identität mit der nötigen Solidarität vermitteln und unterstützen können. Das ist auch der Hauptpunkt in der Deklaration des Kongresses, dass wir uns auf interpersonale, soziale und politische Solidarität verlassen müssen.

(Angelika Rauch-Rapaport, Taufkirchen)

Terminhinweis

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