

Dynamische Psychiatrie

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Certain Aspects of Leadership and Employees' Psychological Development in
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„Interdisciplinarity” from the view of Dynamic Psychiatry. What does it imply?

Ilse Burbiel (München)

Based on the pivotal process of the development of groups and identities of the dynamic psychiatry the author conceptualizes a systemically oriented theoretical framework for interdisciplinarity and names the factors which warrant or impede a constructive vibrant cooperation. The author reflects the necessary preconditions of an interdisciplinary cooperation on the example of the Dynamic-Psychiatric Hospital Meterschwaige in Munich. This takes place through group dynamic and self-reflective processes within various groups of the clinical system as for instance the regular group-dynamic sessions of the team. By means of a case study it will be discussed what essential significance this self-reflective work has for a successful psychiatric-psychotherapeutic treatment of seriously mentally ill patients.

Keywords: Multidisciplinarity, Interdisciplinarity, interdisciplinary team approach, group-dynamic teamsupervision, Dynamic-Psychiatric Hospital Meterschwaige

1. Introduction

Dynamic Psychiatry per se stands for the integration of psychoanalytic science and treatment in psychiatry. Thus, from the beginning, dynamic psychiatry has been an interdisciplinary science. Against the background of biological, psychical, mental, social and cultural perspectives that shaped a holistic view of the human being, Günter Ammon expanded Sigmund Freud's psychodynamic view of the psyche with the dimension of group-dynamics, that is, he added the interpersonal dynamics as well as the unconscious dynamics in interactions. 'Analytic group-dynamics' became the fundamental science of his Berlin School of Dynamic Psychiatry, and today it is still part of all foundational concepts, theories and treatments approaches. With his concept of group dynamics, AMMON 'dis-mantled' the drives as an inherent source of energy in the individual and replaced the Freudian destructive drive and the destrudinal energy with the concept of 'constructive aggression' as an essential, innate life activity. Later he substituted for libidinal energy what he called 'social energy' (AMMON et al. 1981, AMMON 1982a).

He conceived his science as an 'open system' that allows for the results and methods of other schools to represent intradisciplinary results and for

extra- and interdisciplinary results from other human sciences, such as medicine, psychology, biology, philosophy, anthropology, education, neurobiology and others, to become integrated.

The selection criteria for the findings of other schools and disciplines were their ‘usefulness’ for either the understanding or the therapeutic elaboration of a problem. AMMON considered the human being himself as the most important ‘unit in integrating methods’ (AMMON 1982b, p. 34) because it is the human being that stands in the center of any knowledge and treatment. All efforts have to be orientated on the human being and not the other way round. The human being is not to adapt to any theory or treatment method. Here we can see the links to the ‘person-centered’ (MEZZICH 2007) and the ‘human-based’ approaches (MUSALEK 2005) in recent psychiatry and medicine.

Regarding the question of selection of intra- and interdisciplinary findings, we might add another question: What ‘function’ should multi- or interdisciplinarity take on for the ‘original discipline’ in our Dynamic Psychiatry? Should it ‘validate’ the knowledge of Dynamic Psychiatry, i.e. confirm or falsify or ‘complement’ it by adding to it or ‘clarifying’ it and thus expanding the understanding of a phenomenon? (cf. MERTENS 2011, p. 819f). What seems to be crucial is what form of collaboration is wanted, in other words, the way in which intra- and interdisciplinary results and findings are linked with the ‘original science’. This question has taken on such significance that it has been made the decisive criteria for differentiating between the concepts of multidisciplinary and interdisciplinarity.

2. ‘Multi- or interdisciplinarity’?

According to the free encyclopaedia on [German] Wikipedia (2014), ‘multidisciplinary’ is defined as the „incidental elaboration of a scientific question or study of a research subject by scientists from independent disciplines, where no significant methodological, terminological or conceptional exchange between the disciplines takes place”. In contrast to ‘interdisciplinarity’, regarding a synthesis „there is no uniform conceptual frame, nor is there any work on common strategies for solving problems ...” these are merely established as aggregates. Thus, ‘multidisciplinary’ represents „the weakest form of cooperation with regard to content in subject-transcending work” ([German] Wikipedia, 2014). In our theory of science, the individual disciplines are related in a mutually determining

dynamic which means that we ought speak of a more coherent ‘interdisciplinarity’. What is at stake is a frame of work that allows for interactive and reciprocal activities as opposed to working side-by-side.

3. The concern of the paper

Using the structural-dynamic model of ‘identity’ and ‘group’, I would like to propose for our science such a ‘structural frame’ for ‘interdisciplinarity’ in theory and practice, regardless of the level on which interdisciplinary processes would then take place. From such a ‘structural frame’, more general theoretical consequences ought to be derived for constructive interdisciplinary and interprofessional connections. I will discuss the practical application of such interprofessional collaboration in the example of a groupdynamic team supervision in the Dynamic-Psychiatric Hospital Meterschwaige in Munich at the end of my paper.

4. The dynamic-psychiatric understanding of identity, group and development

With its two central concepts of ‘identity’ and ‘group’ and their inseparable unity (BURBIEL et al. 1982c) Dynamic Psychiatry offers a theoretical model for interdisciplinarity and interpretation, based on a central principle, the holistically formulated image of man. According to AMMON, all life and anything vital is a process of continual development and change. For the human being it is the striving for identity and a purpose in life – throughout one’s whole life.

The development of an individual identity is seen as a process of ‘internalizing’ the consciously and unconsciously evolving group dynamic in the various external groups into which a person is born and in which he lives and works.

‘Psychodynamics’ becomes an internalized ‘experienced group dynamic’ when the external ‘interpersonal’ is transformed into the intrapsychical personality structure. Here the ‘transmitter’ between inside and outside is taken to be a basic energy, a ‘social energy’ that determines intrapsychical processes of exchange between inside and outside and thus it leads to the structural formation, the expansion and change of identity.

From this perspective, the structure of identity can be considered as a ‘manifested social energy’ (AMMON 1982a).

In the reverse sense, structure gets ‘energized’ by interpersonal encoun-

ters in the group and facilitates further dynamic processes of regulating intersubjective communication. Every member of the group, with its own specific identity, contributes to the social-energetic quality of the group, its atmosphere, group-dynamics and group identity. „Identity and group belong to each other because only through the experience of one's own personality, mirrored through other people as well as through recognition, respect and awareness regarding other persons within the group, ego and identity development can take place.” (AMMON 1982a). The group thus stands for the ‘interconnectedness’ of the people in the group; the group develops in the process of forming such connections and shapes a particular formation of human beings.

In ‘group analysis’ by FOULKES (1964) this formation is called ‘networks’ by taking into account the unconscious process of a ‘group matrix’, by Günter AMMON by paying attention to unconscious processes of energetic exchange within groups and between groups which AMMON calls ‘group-dynamic/social-energetic fields’ (AMMON 1982a).

It is here that it becomes evident that our theory, if considered from a meta-theoretical perspective, can be articulated as a system. Systems are ‘structured entities’ whose elements relate in a certain order to one another, and among them there is an exchange taking place „whereby the state [of being] of each element is determined by the state of the other elements” (CIOMPI, 1981, p. 68)

‘Identity’, just as the group, can be articulated systemically, as a system of bio-psycho-social conscious, pre-conscious and unconscious functions, which can be attributed to three subsystems. Unfortunately, due to shortage of time, I cannot elaborate on the system-theoretical approach and instead will refer you to the respective literature on this topic (v. BERTALANFFY 1937, 1945, 1974; GOLDSTEIN 1939; MILLER 1955, 1975).

5. ‘Structural frame’ for interdisciplinarity in Dynamic Psychiatry

The basic principles of ‘connection’, ‘differentiation’, and ‘integration’ as processes in the development of identity and group, are inherent in the theory and practice of Dynamic Psychiatry. Therefore a systemic form of representing the structures and dynamics lends itself to the conception of a ‘structural frame’ for arriving at a dynamic-psychiatric understanding of ‘interdisciplinarity’.

„To make a joint effort in achieving something together is, at the end of the day, the basic form of every human activity ... To communicate with one another about common goals and ways of achieving them, including which steps to take next, is a fundamental condition for intentional developments.” (MEYER-ABICH 2007, p. 9)

I suggest that we interpret what Meyer-Abich calls the ‘joint effort’ as an interdisciplinary collaboration. In this way we can regard interdisciplinarity as an open total system whose elements or sub-elements (different schools, methods, disciplines, professions, care-units) are positioned in reciprocal relationships. What is important is the type of relationship that determines the specific function of the interdisciplinary total system. What we should not forget, of course, is that sub-systems themselves are also working systemically.

6. Criteria for constructive systems

In multidisciplinary fields or better ‘spaces’ you often end up with immensely complex structures, dynamics and processes. „Working on communication” through which one becomes more familiar with one another (MEYER-ABICH 2010, p. 11) can be more or less successful and depends on a number of factors that are interdependently linked up with one another.

We could speak of a vital, constructive system if the individual subsystems of the total system are prepared for by engaging in a joint effort at communication concerning

1. the goals that connect them and the function of their collaboration.
2. an overarching theory or conception of the subject the subsystems are working on, in our case: the patient. Here the bio-psycho-social model (BPS-model) could offer such an integrative theory. But, for various reasons, the BPS-model until today has not sufficiently been made the foundation of scientific work on the human being. „If one regards for instance the developments in the field of psychiatry, then one sees clearly that a primary biological orientation (‘the decade of the brain’, ‘the decade of the genome’) has forget its way, accompanied by a marginalization of the social-psychiatric perspective” (PAULS 2013, p. 20). And, what is more: „In the area of psychotherapy we find in part a loss of the social perspective because many experts are giving up the psycho-social origins by replacing them with concepts of ‘disorder specific’ and ‘dosage’ of therapy applications, thus ‘medicalizing’

psychotherapy” (ibid., p. 20). According to KEUPP (2000), there is a considerable ‘assemblage’ of ‘plausible’ research results from various disciplines that support the BPS-model. Even the WHO report of 2010 summarized several studies „on the mutual determination of integrative levels of health in the BPS-model” (PAULS 2013, p. 22).

3. the manner and form in which subsystems can collaborate depending on their respective function, i.e. the organisational structure.
4. the design of a communication structure.
5. the emphasis on the ‘interfaces’, that is, the point of encounter between the various subsystems.
6. with regard to the installation in the total system of coordinating, regulative and, above all, integrative systems, which are responsible for an efficient collaboration as well as the removal of potential conflicts and barriers. The group subsystems as well as the total systems need to be guided by a ‘central figure’ (REDL 1942) or a group of leaders, or coordinators. The leader should be positioned at the boundary of the group, between the inside and its outside. With regard to the inside, he is “probably the most important variable because he decides the level and the spirit of the group” (FOULKES 1978, p. 13). With regard to the outside, he has to fulfil wishes and expectations of the other subsystems.

To be sure, the above aspects are quite complex if they are to serve as prerequisites for a successful collaboration. But I am of the opinion that quite a few failures in multi-disciplinarity could have been prevented if those responsible for the planning phase of new projects had spent more time on the preparatory ‘work on communication’.

On the whole, required is: as much common work as possible by linking up the subsystems, even though there should also be as much differentiation from one another as needed.

What needs to be considered and included into the interdisciplinary process is:

1. the specific identity of the subsystems, what and who they are, their self-understanding and their understanding of others.
2. their personal, social, cultural and professional qualifications.
3. the different points of view and theories from which they perceive, investigate and treat their objects.
4. with what methods they pursue their goals.
5. how they integrate their results into the total system.

6. where and how their cognitive potentials and limits are likely to be. Vital interdisciplinary systems are in a constant reciprocal exchange directed towards the inside and outside; in our terms, they are in a ‘social-energetic exchange’, which means vital systems are continually changing. According to AMMON, the continuous development takes place at the boundaries of encountering systems, at the limits of their identity. Whether these encounters are successful depends on the social-energetic quality or the ability of the subsystems for making contact with each other.

The quality of social-energetic exchange processes can be more or less constructive, that is to say, either they foster development and change, or they are destructive and prevent development, or else they are totally deficient with no development happening; however, the transitions between these qualities are often indistinct. If the multidisciplinary collaboration is more constructive, the subsystems are communicating with each other and are engaged in a constructive social-energetic exchange. Yet the subsystems are not melding into one another but maintain their limits around their respective identities in order to absorb and integrate what is communicated between them. Important is the subsystems’ ability to be flexible in opening and closing their boundaries in order to regulate communication and social-energetic exchange processes. It is in this way that subsystems and the total system will change. Thus, constructive interdisciplinarity can be qualified by features such as connectedness, flexibility, regulation, communication, and energetic exchange as well as integration and differentiation. In this kind of collaboration, it can of course happen that conflicts, crises, and limit situations occur that cause a resistance to development. But, in constructive systems these developmental blockades can at last be overcome and systems emerge from those crises as ‘changed beings’.

Destructive systems are notoriously characterized by a broken connection, rigidity, dysfunctional communication and blocked social-energetic exchange, but also by destructive (i.e. split off) integration and differentiation. These kinds of destructive systems turn into so-called ‘closed systems’.

For every ‘constructive joint effort’ its ‘purpose’ is crucial as HÜTHER, ROTH and BRÜCK (2013) – each from their own scientific perspective – reflect in their little book entitled „For thinking to have a purpose”. The authors comply with our demand for ‘purpose’ in all our efforts by taking into account our concept of human nature and identity. For example, in

their introduction they write: „Everything is linked to everything else. However, our analytical thinking has now arrived at a point, despite much progress, where its limitations have become frightfully evident. Thus we have to make an effort to catch the loose ghosts and integrate them into a common horizon of meaning, which can provide a reliable basis for action in a global world.” (2013, p. 8) In our human sciences, a holistic and multidimensional view of the ill person – also intended by the BPS-model – will free a person from being reduced to a ‘carrier of disease’, and hence his individuality and dignity will be returned to him!

In conclusion, I would like to emphasize that my rather complex above developed model of a possible interdisciplinarity should merely serve as an intellectual perspective, that is, as a guiding idea or even as a kind of utopia to be realized in different ways. Hence my model is not meant to design a concrete measure to be put into practice. Rather, this model might serve us as a structural model and frame of orientation for analysing the dysfunctionality of interdisciplinary processes as well as suggest necessary interventions. Utopias are meant to open up possibilities for thought and action in the future; they create potential for development and inspire creativity.

7. The interdisciplinary team approach and treatment at the Dynamic-Psychiatric Hospital Mengerschwaige

As mentioned before, interdisciplinary fields tend to evolve into highly complex structures, dynamics and processes. An example is our dynamic-psychiatric hospital, Klinik Mengerschwaige in Munich. The hospital Mengerschwaige was founded on the basis of our holistically oriented treatment concept, as a multi-professional, multimodal and multidimensional treatment space shaped by group-dynamics and social-energy. It was conceived of as a ‘space for development’, a space in which a multitude of unconscious and conscious group-dynamics develop in simultaneous and coexisting processes that interconnect into the dynamic of the ‘large group’. Here the subsystems are the various formal and informal groups of patients and therapists with their respective functions, for instance the various psychotherapeutic methods and groups as for instance the milieu therapy, the analytic dance therapy, theatre-, music-, painting-, art-, sport-, body-, horse-toach-riding therapies, special interest groups and especially the large group of all patients and the team.

For the clinical care this means the involvement of the whole team into the treatment process, including nurses, psychotherapeutically trained psychiatrists, doctors and psychologists, social-workers, milieutherapists, therapists for the expressive therapies, as well as the administration and kitchen personnel into treatment as parts of the social-energetic field.

Interdisciplinary team approach for person centred clinical care implies,

1. that all people and professions involved in the interdisciplinary healing process cooperate in the various designated groups on the basis of a commonly shared holistic image of man and, derived from it, a model of personality and a common understanding of health, illness, healing and development.
2. Since the goal of dynamic-psychiatric treatment is to open up patients by emotionally corrective and new experiences so that they will regain their health, it is important that the total system, the hospital, as well as its subsidiary group systems are structured and dynamized as spaces for constructive interaction, as much as possible. It is therefore the daily task of the leader group and of the team to reflect and regulate both conscious and unconscious group-dynamics that develops within and between the various groups, including the dynamics of the ‘large group’. Obviously this group-dynamic work plays an essential part within the hospital work. It is necessary to constantly work on the identity of the whole groups so that their constructive repairing processes can unfold. Scapegoat dynamics have to be neutralised, arrested role arrangements resolved and changed into role variability, split-off subgroups integrated, the work on boundaries intensified to make those more flexible; moreover, shared solidarity has to be learned and mutual responsibility taken. In terms of such methodological equipment, it is advisable to resort to the fundamental principles of the analytic group dynamics and their methodological execution (AMMON 1979a).
3. Furthermore, that it is the task of the hospital leadership to worry about maintaining and fostering the supportiveness and capacity for mentalization of their staff. Why? Since FONAGY conceptualized ‘mentalization’ as the capacity that enables one „to think of mental states as explanations of behaviour, in oneself and in others” (2008), mentalization can be seen as the basis for any psychotherapy.

Hence, one could conceive of Hospital Mengerschwaike as a multi-di-

mentionally structured and dynamized ‘space for mentalization’.

SPERRY expanded on the concept of mentalization by adding the ‘inter-subjective’ component and describing the capacity for mentalization as a variable entity dependent on the surrounding relational context. Mentalization „is constantly shaped by the relational context. (...) It is influenced by the dynamic interplay between that person’s capacity and the capacities of the other members of that person’s relational world” (SPERRY 2013, p. 683) Consequently, „therapists have to mentalize themselves in order to maintain and promote mentalizing in their patients.“ For hospitals, but also for any organization, „the promotion and the maintenance of mentalizing in co-workers is a crucial prerequisite for a functioning collaboration in the treatment team” (SCHULTZ-VENRATH 2013, p. 21).

This happens essentially through self reflection and reflection on others in the ‘multi-professional cooperation’ of the hospital leadership and the leader group as well as in the control group of the team, the team supervision, and in all uni-professional supervisions. The goal is to reflect on the conscious, but particularly on the unconscious, processes in communication on various levels so that these won’t „evolve into a disturbing subterranean dynamics in the process” (GFÄLLER 2010, p. 41).

In detail the praxeological consequences of the above mentioned principles for an integrated interdisciplinary team approach can be realized by

a) weekly interdisciplinary team meetings for each patient.

That means the different team members meet and bring together the different treatment methods which are applied for a patient. It is always the objective to integrate the various therapeutic strategies in order to enable the patient to integrate his various experience and to solve splitting processes. Every patient receives in this way an individual space for being brought together the different personality and treatment aspects like achievements and difficulties. The developments within the different therapeutic approaches will be pointed out, the individual therapeutic plan together with the therapeutic aims of the patient and the diagnosis will be charged, the biological and physical aspects will be considered, splitting processes, transference and counter transference will be discussed. But also group-dynamic and contact aspects, interests, life concepts and social realities, cultural and religious needs, family dynamics and the work situation and the coping with reality demands have to be discussed and brought together. All these aspects have to be

- considered for further treatment consequences and development and also the aspects of the life after separation from the hospital.
- b) individual integration conference especially at the end of the treatment.
 - c) everyday network meetings of the team, where the daily processes are brought together.
 - d) the plenary group (once a week) with all patients and most of the team.
 - e) the uni-professional single- and group supervisions.
 - f) the interprofessional supervision group (control group of the team, twice a week) in which all co-workers involved in the treatment of a particular patient or patient group try to get a picture of the status and the process of the patient's development in light of the dynamic-psychiatric model of personality and treatment. The team is working with transference, countertransference and resistance processes and establish so an internal contact with the patient in his absence.

In this kind a 'dynamic of mirroring [the patient]' evolves and unconsciously, relational dynamics are occurring in the control group that contribute to the psycho- and group-dynamic understanding of the patient while the team is reflecting on him. Corrections in the treatment or consequences for the treatment are often the result.

In the relational spaces between patient and co-worker, there are not only the patient's psychical parts and his dynamics but also parts of the co-workers' selves and dynamics that are brought to the table, and these may either be conducive or interfering in the interpersonal dynamic and work on the relationship with the patient. Reflection on the patient has to be supplemented therefore by the 'self reflection' of the team members.

These self-reflective processes in team supervisions are supposed to help the staff become aware of destructive and deficient parts in themselves and to verbalise and reflect on them. One's own negative feelings, among them, sorrow, rage, anxiety, etc. as well as one's own destructive or deficient qualities, lacking abilities, social incompetence, problems in setting boundaries, projections onto the patient, fixations in the counter transference and projective identifications, 'triggered' traumatic experiences in one's own life but also, personal and inter-professional conflicts (say, rivalries, jealousy and envy within the team) are all parts that need to be made conscious. Because the team is willing to identify those parts as their 'own', it is accepting the 'responsibility' for their own dynamics. This acceptance helps the patient or patient groups because they don't

have to bear or act out the parts of the team or its dynamic. The intersubjective distance and the boundaries between team and patients are thus re-established with the aim of improving the staff's capacity for making contact, for mentalization and containment, as the following example of an interdisciplinary team supervision shows.

8. Example of group-dynamic team supervision

At the beginning of August the hospital team was meeting for team supervision under the leadership of one of the authors. Over the last few months the team had to say 'Goodbye' to a few very experienced, older colleagues whose places were filled with new staff. The Head physician of the hospital and several co-workers were on holiday. In addition, the leading milieu therapist was in the process of leaving. In the meeting, there was a leaden heaviness that spread across the room-silence. The consultant psychiatrist was the last member to enter the room and was beckoned by the team to take his seat next to the right of the teamsupervisor. Playfully the supervisor took up this 'enactment' and talked about the Fantasy of a 'marriage' between the consultant and her. But why did she say that? From the fantasies of the staff she gathered (a) the wish for a strong, central leadership of the hospital, and (b) also the vote of confidence on the consultant whether he could steer the (hospital) ship well enough with the chief physician being gone into holiday. In a slightly changed fashion from BION (1971), I was interpreting the 'wish for pair building' (BION 1971) as the team's demand for a strong parental couple out of fear that otherwise the team might fail. After my interpretation, the tension in the room relaxed. The group could then turn to the immanent leaving of their well-liked colleague, the milieu therapist. Feelings of sadness, separation anger, threats to one's identity, and fears of failure, were being voiced, but also feelings of powerlessness and resignation in the face of the fact that, despite all these feelings, because the colleague would indeed leave.

The supervisor was working in an anti-regressive manner, and made interpretations: whenever powerlessness and resignation was the prevailing feeling, because this is a sign that the team was moving in a group-dynamic, infantile state that prevented them from perceiving their competence; hence I was working with the team's resources, their multitude of experiences. The team reacting to this anti-regressive boundary positively and beginning to open up. It was to be expected that now also the new

members could complain that they were not being supported by the older ones, and hence they felt abandoned. On the one hand, the team reacting to this complaint in self defence; on the other hand, they offering support. In the process of the meeting, the conflict was solved, and the complaining co-workers could be integrated.

This group session demonstrates how anxiety and massive emotional stress fuels regressive processes in the team. Such regressive tendencies reduce the ‘intra-psychical space’ of the hospital team and their capacity for containment. When parts of the self are embedded in the relational context of the team group, self-reflection can push these parts back within the boundaries of one’s own identity; thus, they can be isolated from the intersubjective context of a symbiotic relationship with the patients.

„Moving from an enactment to a mentalizing process requires that (the group) ... self-organize and develop interactional patterns that facilitate and support mutual reflection on their relational process.” (SPERRY 2013, p. 691)

Everybody is sitting in the same boat. The development of a self-reflective community in the team supervisions represents the actual inter-professional ‘work on communication’, lifting professional barriers and boundaries.

The joint work on communication and differentiation between patients and team changes everyone who participates in this process, and thus it facilitates the hospital as a total system to again become a creative environment for change. If we understand interdisciplinary processes as creative processes that not only tend to push their limits but also try to overcome those limits by creating something new, then interdisciplinarity can indeed become a realistic way of professional interaction.

Zusammenfassung

Dynamische Psychiatrie steht per se für eine Integration psychoanalytischer Wissenschaft und Behandlung in der Psychiatrie. Dynamische Psychiatrie ist daher von Anfang an eine interdisziplinäre Wissenschaft. Vor dem Hintergrund eines, die biologischen, psychischen, geistigen, sozialen und kulturellen Aspekte umfassenden, ganzheitlich orientierten Menschenbildes erweiterte Günter AMMON die durch Sigmund FREUD konzeptionalisierte psychodynamische Betrachtungsweise der Seele um die Dimension der Gruppendynamik, d. h. des dynamisch Zwischenmensch-

lichen und hier ganz besonders des unbewusst Dynamischen.

Er konzipierte die Dynamische Psychiatrie als ein ‚offenes System‘, das erlaubt, die Ergebnisse und Methoden sowohl anderer Schulrichtungen, d. h. intradisziplinäre Ergebnisse, als auch extra- oder interdisziplinäre Ergebnisse aus anderen Wissenschaften vom Menschen wie z. B. der Medizin, Biologie, Philosophie, Anthropologie, Neurobiologie zu integrieren. Auswahlkriterium für die Befunde aus anderen Schulrichtungen und Disziplinen war und ist deren ‚Nützlichkeit‘ für das Verständnis oder die therapeutische Bearbeitung des Problems. Als die wichtigste „methoden-integrativ wirkende Einheit“ (AMMON 1982, p. 34) sieht Ammon den Menschen selbst, der im Mittelpunkt einer jeden Erkenntnis und Behandlung stehe. Alle Bemühungen haben sich an ihm zu orientieren, auf keinen Fall geht es darum, den Menschen an die Theorie und Behandlungsmethodik anzupassen. Hier sehen wir inhaltliche Übereinstimmungen mit den „person-centered-“ (MEZZICH et al. 2010) und „human-based“-approaches (MUSALEK 2013) in der jüngeren Psychiatrie und Medizin.

Dynamische Psychiatrie postuliert über ihre beiden zentralen Konzepte von ‚Gruppe‘ und ‚Identität‘ und deren „untrennbare Einheit“ (Burbiel et al. 1982) grundlegende Voraussetzungen und Möglichkeiten menschlicher Entwicklung und Kreativität. Dabei wird die Identitätsentwicklung des Individuums als ein Prozess der ‚Verinnerlichung‘, d. h. Internalisierung der äußeren bewusst und unbewusst sich entwickelnden Gruppendynamik der verschiedenen Gruppen postuliert, in die der Mensch hineingeboren wird, lebt und arbeitet.

Die grundlegenden Prinzipien von ‚Verbindung‘ und ‚Differenzierung‘ als Prozesse der Identitäts- und Gruppenentwicklung sind der Dynamischen Psychiatrie in Theorie und Praxis immanent. Daher bietet sich die systemische Darstellungsform von Strukturen und Dynamiken für eine Konzeptionalisierung einer ‚Rahmenstruktur‘ für ein dynamisch-psychiatrisches Verständnis von ‚Interdisziplinarität‘ an.

„Gemeinsam etwas zustande zu bringen ist letztendlich die Grundform jeder menschlichen Tätigkeit (...) Sich auf die miteinander anzustrebenden Ziele, Wege und über die nächsten Schritte jeweils zu verständigen ist eine Grundbedingung aller beabsichtigten Entwicklungen.“ (MEYER-ABICH 2010, p. 9)

Fassen wir das ‚Gemeinsame‘, von dem MEYER-ABICH spricht, als das interdisziplinäre Zusammenwirken und die Zusammenarbeit auf, so kann dieses, das ‚Gemeinsame‘, als ein offenes Gesamtsystem aufgefasst wer-

den, deren Elemente oder besser Subsysteme (Schulrichtungen, Methoden, Disziplinen, Professionen, Care-Units) miteinander in wechselseitigen Beziehungen stehen. Dabei kommt es auf die Art der Beziehungen an, wodurch die spezifische Funktion eines interdisziplinären Gesamtsystems definiert wird.

In multi- oder interdisziplinären Feldern oder besser ‘Räumen’ kann es zu ungeheuer komplexen Strukturen, Dynamiken und Prozessen kommen. Die ‘Verständigungsarbeit’, in der man ‘aneinander vertrauter’ wird (MEYER-ABICH 2010, S. 11), kann mehr oder weniger gut gelingen und hängt von zahlreichen Faktoren ab, die interdependent miteinander verbunden sind.

Lebendige interdisziplinäre Systeme stehen in einem ständigen wechselseitigen Austausch nach innen und außen, bei uns in einem ‘sozialenergetischen Austausch’, d. h. lebendige Systeme verändern sich fortwährend. Dabei findet bei AMMON die Weiterentwicklung an den Grenzen der sich begegnenden Systeme, an deren Identitätsgrenzen statt. Ob diese Begegnungen gelingen, hängt von einer Fülle von Faktoren ab, wesentlich aber von der sozialenergetischen Qualität oder der Kontaktfähigkeit der Subsysteme.

Die Qualität sozialenergetischer Austauschprozesse kann mehr oder weniger konstruktiv, d. h. entwicklungs- bzw. veränderungsfördernd, destruktiv, d. h. entwicklungsarretierend und defizitär, d. h. ohne Entwicklung sein, wobei die Übergänge zwischen den Qualitäten ‘fließend’ sind. Bei einer mehr konstruktiven multidisziplinären Zusammenarbeit kommunizieren die Subsysteme miteinander und stehen in einem mehr konstruktiv-sozialenergetischen Austausch miteinander. Gleichzeitig verschmelzen die Subsysteme aber nicht ineinander, sondern grenzen sich in ihrer je spezifischen Individualität immer wieder voneinander ab, um das Kommunizierte aufnehmen und integrieren zu können. Wichtig ist hier also die Fähigkeit der Subsysteme zur flexiblen Öffnung und Schließung ihrer Grenzen und damit zur Regulation der Kommunikation und der sozialenergetischen Austauschprozesse. Damit verändern sich die Subsysteme und so das gesamte System. Konstruktive Interdisziplinarität kann also durch die Merkmale Verbundenheit, Flexibilität, Regulation, kommunikativer und energetischer Austausch, Integration und Differenzierung qualifiziert werden.

In der Zusammenarbeit kann es immer wieder zu Konflikten, Krisen und Grenzsituationen und damit zu Entwicklungswiderständen und -ar-

retierungen kommen. Konstruktiven Systemen gelingt immer wieder eine Überwindung der Arretierungen und sie gehen als 'Veränderte' aus diesen Krisen heraus. Destruktive Systeme sind gekennzeichnet durch abgebrochene Verbundenheit, Starrheit, dysregulierte und arretierte Kommunikation und sozialenergetischen Austausch, destruktive, d. h. abgespaltene Integration und Differenzierung. Sie können als 'geschlossene Systeme' qualifiziert werden.

Entscheidend für jedes 'konstruktive Miteinander' ist dessen 'Sinnhaftigkeit', wie HÜTHER, ROTH und VON BRÜCK in ihrem Buch *Damit das Denken Sinn bekommt* (2013) aus ihrer je spezifischen wissenschaftlichen Perspektive heraus reflektieren. Die Autoren kommen unserer Forderung nach 'Sinnhaftigkeit' aller unserer Bemühungen vor dem Hintergrund unseres Menschen- und Identitätsverständnisses sehr nahe, wenn sie schreiben: „Alles ist mit allem verwoben. Unser analytisches Denken zeigt bei allem erreichten Fortschritt nun auf erschreckende Weise seine Begrenztheit, und wir werden uns anzustrengen haben, die Geister wieder in einen allgemeinen Sinnhorizont einzufangen, der eine verlässliche Basis des Handelns in einer globalen Welt sein kann“ (S. 7-8). In unseren Wissenschaften vom Menschen befreit beispielsweise eine ganzheitlich ausgerichtete mehrdimensionale Betrachtung den erkrankten Menschen von seiner Reduziertheit zu einem 'Krankheitsträger' und gibt ihm seine Vielfalt und damit seine Würde wieder.

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Motivation, Empathy, Aggression: How Neurobiology Adds to Our Understanding of the Psyche

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Successful interpersonal relationships are of paramount importance for the biological systems of the human body and thus for the health of human beings. Dynamic psychiatry has already known this for decades but during recent years this insight has also found its way into modern neuroscience. This article sets out to provide an overview of some recent neuroscientific findings that show how a newly formed field of modern brain research, the so called „social neurosciences“, can further a deeper understanding of the human psyche.

Keywords: neurobiology, interpersonal relationships, empathy, aggression, stress, mirror neurons, social neurosciences

1. The influence of social experience on the activity of genes

Even today, the genome often is still depicted solely as an autonomous system that single-handedly determines all biological processes. This is a lopsided view, as genes, in fact, are not autistic actors at all. On the contrary, the activity of genes is regulated by numerous, from the perspective of the gene, external stimuli. Among the stimuli that influence gene regulation are not only nutrition, the extent of our sporting activities, or the quality of our ecological environment, but also what kind of interpersonal relationships we experience. All social experience, whether pleasant or not, is constantly evaluated by the limbic system in our brain and translated into biological responses. As the activity patterns of numerous neurotransmitter systems continuously change in response to what we experience, the brain, if you will, converts psychology into biology every minute we are out and about socially.

Numerous studies have shown that social experience has effects on regulatory sequences in many genes. The experience of stress activates stress genes such as the CRH gene. If we're exposed to „good“ stress, that is, if we're confronted with challenges we can manage, this not only activates stress genes but also genes for nerve growth factors. Unhealthy stress, on the other hand, especially traumatic experiences, where humans become

victims of violence in conjunction with a total loss of control, activates gene cascades that can result in the demise of nerve cells.

Genes are not only regulated by social experience „right here, right now”. Numerous studies from recent years have shown that social experience can influence the accessibility of genes in the medium and long run. This is where so called „epigenetic” mechanisms come into play: cells can block or unblock, i.e. make accessible, a gene’s regulatory sequences or „gene switch”, for the long-term, by attaching side groups, usually methyl residues. Michael MEANEY’s research group was able to show that the regulatory sequences of the glucocorticoid receptor gene are epigenetically blocked in newborn mammals – and we humans are mammals, too. The glucocorticoid receptor gene is an important anti-stress gene that is instrumental in an organism’s ability to downregulate, that is, quiet down the stress axis again after it has been activated. As already mentioned, in newborn mammals – humans included – the genetic switch in this important antistress gene is blocked. The antistress gene only becomes unblocked, that is enabled, by the stimuli acting on the newborn during maternal care. Evolution has apparently worked in such a way that small mammals only become capable of calming down their stress system once they have de facto experienced a protective environment. Studies by Moshe SZYF and his colleagues have shown that in suicidal adults who were victims of childhood abuse the epigenetic blockades of the mentioned anti-stress gene had only been insufficiently removed. Persons whose epigenetic blocks in the region of the regulatory sequences of the glucocorticoid receptor gene have not been properly removed during childhood and adolescence, apparently carry a higher risk for depression.

In summary, we see that genes are not autistic but are molecular communicators, if you will, that react to stimuli from the organism’s social environment.

2. The vital importance of interpersonal affection: the neuronal motivation system

Modern neuroscience not only teaches us that the experience of social relationships really has biological effects but that we also know *what kind of relationship experiences* humans need to stay biologically energetic and healthy. A number of studies show that experiencing interpersonal affection and social support activates biological systems that ensure that we

feel vigorous and enjoy life.

In an elegant study, French and Italian researchers generated so called „knock-out” mice with a disabled endogenous opioid system. The all-female research group inactivated the opioid receptor gene in these mice. Wild-type newborn mice react with ultrasonic isolation cries if separated from their mother. The investigators’ hypothesis was that the mother’s presence had the effect of an opiate on the pups. Newborn mice *without* a functioning endogenous opioid system indeed do not react with the typical vocalizations but remain relatively calm when separated from their mother. Maternal closeness is apparently embodied in the pups’ opioid system. In another study, this time in adult humans, persons suffering from experimentally induced pain not only showed a significant subjective reduction of their pain but also a massive production of beta-endorphin, an important endogenous opioid, in response to social affection.

The opioid system is not the only biological system that reacts to interpersonal affection. Four year old children, who exchange small caresses with their mothers, react with an increase in their endogenous oxytocin levels. Oxytocin, which was discovered many years ago as a hormone relevant during childbirth, also is a highly potent „mind-altering” drug as many recent publications have shown. It attenuates the stress response, lowers blood pressure and increases the readiness to behave empathically and cooperatively. As already mentioned, four-year olds with a normal social biography react with a clear increase in their endogenous oxytocin levels after tender interaction with their mothers. Children, on the other hand, who during their first 12 to 16 months of life have lived in an infant nursery under conditions of neglect, show a clearly reduced response capacity of their oxytocin system even years later. Early experiences of social neglect apparently leave a sort of biological scar in humans’ oxytocin system.

The most important vigor-related transmitter in humans is dopamine, which is produced by the so called mesolimbic system in the midbrain. Because it elicits pleasant feelings, dopamine has also come to be known as „happy hormone” in lay publications. In fact, addictive drugs such as alcohol, nicotine or cocaine do not unfold their disastrous addictive effects per se but by inducing the release of dopamine. The ability of dopamine to trigger pleasant feelings is the reason why any behavior and experience that is tied to the release of dopamine has a motivating effect on human behavior. One of the most important insights of modern neuroscience

is that interpersonal recognition, affection and the experience of social appreciation activate the endogenous dopamine system.

All sentient beings seek pleasurable feelings, an insight we owe to Charles DARWIN. Sigmund FREUD adopted DARWIN's realization and later called it the „pleasure principle“ („Lustprinzip“). This is the reason why humans intuitively seek experiences that activate their dopamine, opioid, or oxytocin system. One possibility of activating these systems and thus experience pleasurable sentiments consists in obtaining caring human affection, social recognition and appreciation. Humans are willing to go out on a limb to reach this goal. Not least, it is this goal that drives us humans to go to work. At this point, let me mention that sports and music, like social acceptance, are able to activate the human motivation system.

In summary, results from numerous investigations document that social recognition and attachment are, from a neurobiological standpoint, most desirable for humans. Thomas INSEL, director of the National Institute of Mental Health (NIMH), ironically likened social bonding to a sort of addiction in humans. Humans crave social recognition and connectedness but this, in no way, implies that humans are by nature morally „good“. As a matter of fact, humans are willing to not only do good but also bad things to reach their goal of social inclusion. This prominently shows in unattached young men who crave nothing more than social appreciation and to belong. If a society cannot provide adequate opportunities to their young people, e.g. in the form of institutions of education, recreational offers, sports facilities or participation in meaningful social projects, then these young people may instead turn to fanatical-religious or radical political groups or join criminal gangs in their desire to be part of a community.

Studies have shown that an adequate degree of social recognition plays a big role in workplace health. If effort and reward at work do not balance out, i.e. if a so called „Effort-Reward-Imbalance“ exists, the proportion of those with stress-related health problems, be it orthopedic problems, nervous dysfunction, disordered sleep, gastrointestinal complaints or heart diseases, increases.

Meta-analyses from recent years have shown that social connectedness not only has a significant influence on health but also on the life span of humans. Abstaining from alcohol and tobacco, exercising or losing weight all have an effect on the probability of a long life but so does social attachment – even to a higher degree than all of the other factors, as this study impressively demonstrates. The reason for this is not humanitarian con-

victions but is the structure of the human brain which is geared towards good social relationships.

3. The neurobiological foundation of intuitive understanding and empathy: the mirror neuron system

The human brain not only requires social recognition but evolution has equipped humans with a neurobiological tool without which mutual understanding, empathy and, consequently, social connectedness could hardly be achieved: the mirror neuron system. It is now generally known that this system was discovered by an Italian research group around Giacomo RIZZOLATTI. One could characterize the mirror neuron system as a neuronal resonance system. A tuning fork, which is struck and caused to vibrate, can induce a second tuning fork to vibrate via the sound waves it emits. In other words, it causes the second tuning fork to resonate. In principle, a very similar process can also occur between two human brains. Certain aspects of a brain's state can be related to a second brain – through language or body language. Numerous experiments have convincingly demonstrated this.

Guitar students were placed a functional magnetic resonance imaging scanner. The young test persons observed the movements of their guitar instructor's hand on a screen. The students who lie in the scanner see how the teacher's hand repeatedly plays a specific chord on the guitar's fret board. While watching this, not only the visual cortex in the observers' brain becomes active – as expected –, but motor neurons are co-activated as well. Even though the observing students do not move their hands, motor networks that would be capable of making the hand move show a mirror-like co-activation. One could say that the viewers' brains are simulating the observed action. This way, their brains probably make the observing students gain a sort of comprehension of the observed activity. When the students are asked to memorize the chord they are about to see, so as to later be able to play it on the guitar themselves, then the mirror reaction becomes stronger the very moment they are watching.

Neuronal mirror reactions can not only be observed in the area of the motor system but also in the limbic system. As the brain itself feels no pain, neurosurgical procedures on epileptic patients can be performed under local anesthesia in conscious patients. The Canadian neurosurgeon William HUTCHISON took advantage of this particular situation to examine

nerve cells in the anterior cingulate cortex (ACC) – with consent from the patients and the (relevant) local ethics board. He examined neurons that belong to the so called pain matrix in the human brain. William Hutchison's group identified nerve cells in the area of the ACC that always reacted when the experimenter quickly pricked the patient's finger pad with a mini lancet. However, the same pain-activated nerve cells in the ACC also discharged when the patient himself did not suffer any pain but when he observed how the experimenter pricked his/her own finger pad with the lancet. Tania SINGER and colleagues used functional magnetic resonance imaging (also known as nuclear spin tomography) to confirm William HUTCHISON's findings: neuronal networks in the pain matrix, which encompasses parts of the ACC but, additionally, parts of the insula complex as well, react not only to pain we experience ourselves but also to pain we observe.

Additional experiments by Tania SINGER show that the brain's readiness to let its own pain matrix resonate in response to the pain observed in another person, is reduced if the observed other person previously behaved unfairly towards other fellow human beings. Female observers show a significantly reduced mirror reaction in the insula region when they watch how pain is inflicted on persons who have previously acted unfairly. Male observers show an even stronger decrease in their neurobiological empathy reaction than women. Experiments like these explain why the leaders of nations who intend to ready their own people for war, spread information that aims at dehumanizing the people in the country they want to wage war against. The empathy barrier which would prevent normal humans from hurting others can be overcome by creating the reasonably convincing impression – e.g. via mass media – that those who are the target of an intended aggressive intervention behaved unfairly.

Let us briefly sum this up: Mirror neurons are nerve cells that not only become active if oneself acts or feels something. They also react when a person merely observes or witnesses another human acting or feeling something. Mirror neurons convert an observation into an internal personal experience. They create an internal simulation in the observer, if you will. This way, mirror neurons let us intuitively understand what other humans are doing or feeling. But there's more. Mirror neurons also set up unconscious actions. Moreover, mirror neurons are the biological foundation for the phenomenon of emotional contagion: they can, so to say, infect us with other humans' emotional states.

Against this backdrop, it becomes clear that the mirror neuron system is of enormous importance for the physician-patient relationship, and of downright paramount importance in psychotherapy. On one hand, the therapist's „charisma” generates effects of contagion, because doctors and therapists invariably trigger resonance in their patients – whether they want it or not. On the other hand, the therapist also feels a resonance that the patient induces in him. Mirror neurons are the neurobiological substrate of the effect we know as counter-transference. The resonance induced in himself allows the therapist to intuitively understand his patient. In some cases, the therapist's process of comprehension precedes that of the patient. Sigmund FREUD was the first to recognize this. In 1912 he wrote: The psychoanalyst „must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver [is adjusted to the transmitting microphone]. Just as the receiver converts back into sound waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations.”

4. The neurobiology of aggression

While Sigmund FREUD's genius is undisputed, we must realize that modern neurobiology is unable to confirm all of his concepts. Especially the aggression drive Freud postulated could not be substantiated. Directing unprovoked aggression towards others is unrewarding from the perspective of the motivation systems in the human brain, which I talked about at the beginning. In this sense, modern neurobiology agrees with Charles DARWIN who did not posit an aggression instinct but described human aggression as a – while biologically founded – yet (merely) reactive behavioral program. Inflicting pain is the most reliable trigger for aggression in all mammals including humans. If you step across another human's pain threshold, you will provoke aggression or depression.

Naomi EISENBERGER, an American neuroscientist, realized that parts of the pain matrix in the human brain, especially the anterior cingulate cortex ACC, not only react to pain that is physically inflicted but also to social rejection and humiliation. The pain matrix clearly reacts more sensitively to an acute experience of social exclusion in humans who generally have

had little social support in their lives than in persons embedded in strong social networks. Furthermore, it is interesting that our brains' pain matrix not only responds when we experience social rejection ourselves but also when we observe how others are (being) excluded – which brings us back to the (previously mentioned) mirror mechanism.

Let us summarize: For the human brain, social exclusion and humiliation „feel” just like physical pain. This is why social rejection and humiliation cause aggression, just like physical pain does. Interpersonal bonds and social support attenuate the reaction of the pain matrix (and the resulting aggressive tendencies) to an acute experience of exclusion.

In this paper, I will not go into detail on some other important aspect of human aggression which I have covered extensively in my book „The pain threshold” („Schmerzgrenze”). These include, for example, the role of the memory of aggression, the role of displaced aggression and the influence of experiencing violence on a person's tendency to act aggressively him-/herself. At this point, I would simply like to add that underdogs living in countries where extreme poverty collides with immense wealth, experience their situation as social exclusion. We have already learned that social exclusion activates the neuronal pain matrix and promotes violence. Many independently performed studies have in fact demonstrated that a country's homicide rate correlates with the unequal distribution of income and wealth.

From a neurobiological perspective, the ability of humans to control their own aggression can be described as a process that strives to balance a neurobiological „bottom-up drive” against a neurobiological „top-down control”. The „bottom-up drive” is embodied in the Corpora amygdalea (fear centers), parts of the Insula, parts of the hypothalamus and the brain stem. Together, these systems represent the „bottom-up drive” of aggression and react whenever humans experience physical or social pain. The so called „frontolimbic loop” forms a central element of the human aggression system. This loop consists of nerve projections that connect the Corpora amygdalea (fear centers) to the prefrontal cortex OFC, that is with the frontal lobes. The prefrontal cortex contains networks in which the human brain stores information on what the things we ourselves do look like to our fellow human beings. The basis for the prefrontal cortex's ability to perform this important function, are years and years of a dialog process we call „education”. As the existence of the prefrontal cortex proves, teaching children to consider the perspective of other humans is not a project that

goes against a child's „nature". On the contrary: whoever fails to invest time and effort into this dialog process, is guilty of compromising proper biological maturation of a child's brain. The consequence may be juveniles with narcissistic, dissocial or even psychopathological disorders.

Zusammenfassung

Gelingende zwischenmenschliche Beziehungen sind von erstrangiger Bedeutung für die biologischen Systeme des menschlichen Körpers und so für die Gesundheit von Menschen. Die Dynamische Psychiatrie hat dies bereits seit Jahrzehnten erkannt, aber während der letzten Jahre hat diese Einsicht auch ihren Weg in die moderne Neurowissenschaft gefunden. Dieser Artikel gibt eine Übersicht über einige neuere neurowissenschaftliche Ergebnisse, die aufzeigen, wie ein neu entstandenes Feld der modernen Gehirnforschung, die sogenannten „sozialen Neurowissenschaften“ das tiefere Verstehen der menschlichen Seele vorantreiben kann.

Soziale Anerkennung und Wertschätzung sind Schlüsselmotivationen für das menschliche Verhalten. Menschen sind allerdings nicht nur bereit, Gutes zu tun, sondern auch Schlechtes, um ihr Ziel der sozialen Zugehörigkeit zu erreichen. Soziale Ausgrenzung oder Demütigung aktiviert die neurobiologische Schmerzmatrix und fördert Aggression (oder Depression). Menschen besitzen ein neuronales System für intuitives Verstehen und Empathie. Dieses System, das Spiegelneuronen-System, lässt uns nicht nur intuitiv verstehen, was andere Personen tun oder fühlen. Es fördert auch bestimmte (unbewusste Tendenzen für) Handlungen und erklärt, warum Menschen sich von den emotionalen Zuständen ihrer Mitmenschen anstecken lassen. Der präfrontale Kortex befähigt Menschen, die Perspektiven anderer Personen zu reflektieren und aggressive Impulse zu kontrollieren. Vorbedingung für eine ausreichende biologische Reifung des vorfrontalen Kortexes ist der Prozess der Erziehung. Gute zwischenmenschliche Beziehungen sind, so die zentrale Erkenntnis der „sozialen Neurowissenschaften“, eine entscheidende Voraussetzung für das biologische Wohlergehen von Menschen.

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The Role of Treatment Adherence in Psychotherapy

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The concept of 'treatment adherence' in psychotherapy is discussed in the light of recent meta-analyses and research results from a major naturalistic study in Switzerland. The results of the research support the conclusions in the literature. Eight different psychotherapy approaches were investigated empirically by objective ratings of therapists' intervention techniques in 81 psychotherapy cases. Nonspecific interventions were much more often used than concept-specific interventions. Although different psychotherapy concepts seem to work significantly different with regard to their conceptually prescribed techniques, therapists from all eight investigated concepts remained far below expected levels of specificity. It could be shown that the degree of therapists' professional experience as well as patients' degree of severity of psychological problems impacted the level of therapists' treatment fidelity.

Keywords: treatment adherence, specific therapeutic factors, nonspecific therapeutic factors, treatment alliance, professional experience, severity of psychological problems

How specific is psychotherapy?

Treatment integrity in psychotherapy is considered to be a major point in judging the scientific credibility of a particular psychotherapy approach (BARBER, GALLOP, CRITS-CHRISTOP ET AL. 2006; BOSWELL, CASTONGUAY, WASSERMAN 2010; PEREPLETCHIKOVA, CHEREJI, HILT et al. 2010). It comprises treatment adherence and a competent delivery of the psychotherapeutic treatment. However, most researchers in psychotherapy have neglected the securing of treatment integrity so far since most studies have not controlled for treatment competence of therapists and not controlled for therapists' adherence to treatment protocol. There are only very few adherence-outcome studies providing little evidence that treatment fidelity in fact impacts treatment outcome substantially (BALDWIN, IMEL 2013; WEBB, DERUBEIS, BARBER 2010).

However, it seems to be premature to fully draw the conclusion that the therapists' degree of treatment adherence does not play a crucial role in psychotherapy outcome.

AS ORLINSKY, RØNNESTAD, WILLUTZKI'S (2004) Generic Model of Psychotherapy suggests (figure 1), there is a wide diversity of the many variables, specific and nonspecific therapeutic factors, contributing to the psychotherapeutic process and its outcome which are hypothesized to surmount the theory-specific factors by far (LAMBERT 2013).

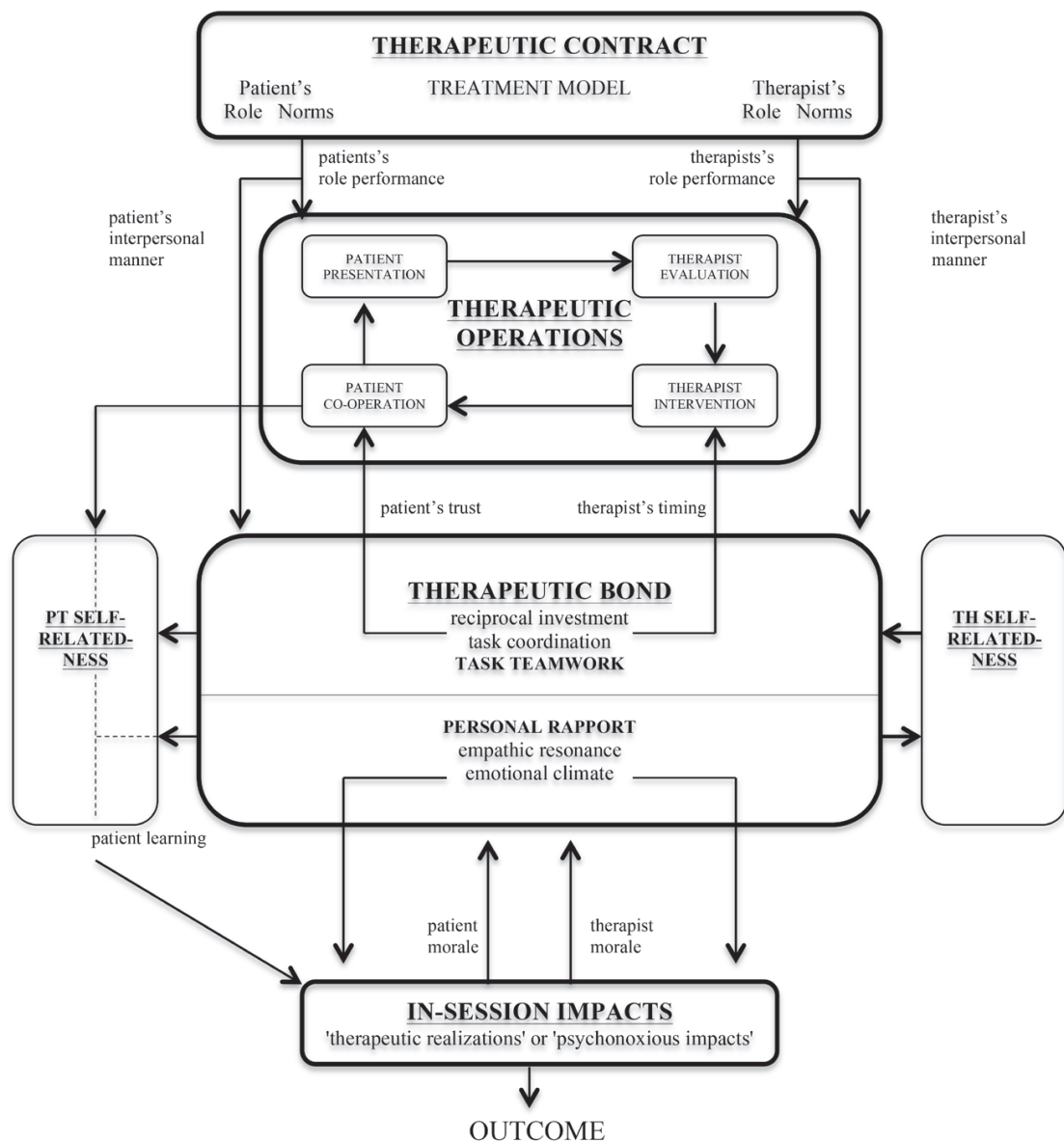


Figure 1: Generic model of psychotherapy (ORLINSKY et al. 2004; p. 321) (short version)

ASAY and LAMBERT (2001) (figure 2) summarize the research by suggesting that approximately 30% of the outcome variance might be explained by the quality of the therapeutic alliance, approximately 40% of the outcome variance by the patient's personality and extratherapeutic factors, approximately 15% of the outcome variance by expectation (placebo) effects, and only approximately 15% of the outcome by concept-specific therapeutic factors (therapists' interventions in the 'Generic Model'). WAMPOLD (2001) even concludes that only 1% of the explanation of outcome variance may be due to specific or concept-related factors.

Therapeutic relationship (nonspecific), appr. 30%	Factors and extratherapeutic changes or challenges (nonspecific), appr. 40%
Expectation (placebo) effects, appr. 15% (nonspecific)	
Concept related factors 1% - 15% (specific)	

Figure 2: Four classes of therapeutic factors in psychotherapy and explanation of outcome variance (ASAY, LAMBERT 2001; pp. 49)

As can be seen from ORLINSKY et al.'s 'generic model', the therapeutic interventions are only one of many aspects that work in a complex manner together in psychotherapy. The technical interventions of the therapist again are only one aspect within the cluster of therapeutic operations and the cluster of therapeutic operations in turn is only one of many other clusters.

A major other cluster is the therapeutic bond. This grouping is also described as therapeutic alliance and is seen as a common or nonspecific therapeutic factor of essential importance in psychotherapy as has been shown by numerous research studies (MURAN, BARBER 2010). Only very few studies have investigated the relationship between treatment adherence and therapeutic alliance. BARBER et al. (2010) found that patients with a lower therapeutic alliance led therapists to adhere more closely to their treatment protocol than patients with a higher alliance did. In our study we found just the opposite: The more the therapeutic alliance was stressed, for example by patients' severity of psychological problems, the less the therapists adhered to their treatment protocol and the more they lowered their degree of treatment adherence (TSCHUSCHKE, CRAMERI, KOEHLER et al. 2014). These results suggest that treatment adherence might be not a thing per se but rather a variable that might be influenced by other relevant factors. Therapist x patient features may play a more prominent role than evidence-based studies using a RCT-design suggest (TSCHUSCHKE, FREYBERGER 2014).

Most of the empirically supported treatments (EST) in psychotherapy used a RCT-design. These studies rely on the assumption that therapists realize the treatment approach under study in a pure manner, which means

that therapists stick very closely to the intervention techniques of the treatment concept which is currently investigated, for example in comparison to another concept.

Unfortunately, most EST studies do not control for treatment adherence of the therapists (PEREPLETCHIKOVA et al. 2010). In general, there is very sparse research with regard to adherence-outcome studies in psychotherapy (BALDWIN, IMEL 2013, WEBB et al. 2010).

The EST research is suffering from too many blind spots. The RCT design makes a point of evidence by testing concepts against each other, and neglects all other variables which altogether seem obviously more relevant than the treatment concept itself. Moreover, RCT studies do not even know what the therapist really does and whether it is in the product what the advertisement promises.

Treatment Adherence in Several Theoretical Concepts

The ‘Practice study outpatient psychotherapy – Switzerland‘ (PAP-S) (TSCHUSCHKE, CRAMERI, KOEMEDA 2010; VON WYL, CRAMERI, KOEMEDA ET al. 2013) conducted by the Swiss Charta for Psychotherapy investigated ten different therapeutic approaches empirically. The main goal of the PAP-S is to compare different types of psychotherapy with regard to specific and nonspecific therapeutic factors.

A first preliminary report compared eight different therapeutic approaches. 81 therapies were investigated by objective ratings of audio-taped therapy sessions, three to five sessions were drawn by chance for objective ratings of the full sessions out of each therapy. We developed a new rating system (TSCHUSCHKE, KOEMEDA, SCHLEGEL 2014) that allows objective identification of each intervention by the therapist with regard to treatment fidelity, use of nonspecific interventions, and use of intervention techniques stemming from other therapeutic approaches than own.

Figure 3 gives an overview of psychotherapists’ average amounts of treatment adherence, nonspecific interventions, and interventions from approaches other than their own across eight different approaches. Treatment adherence was relatively low across all eight treatment approaches. It ranged from 4.2% at the low to 27.8% at the high end. Nonspecific intervention techniques were used much more often by the therapists; they ranged between 49.6% and 72.9%. Interventions from approaches other than the therapist’s own ranged from 15.9% to 26.9%.

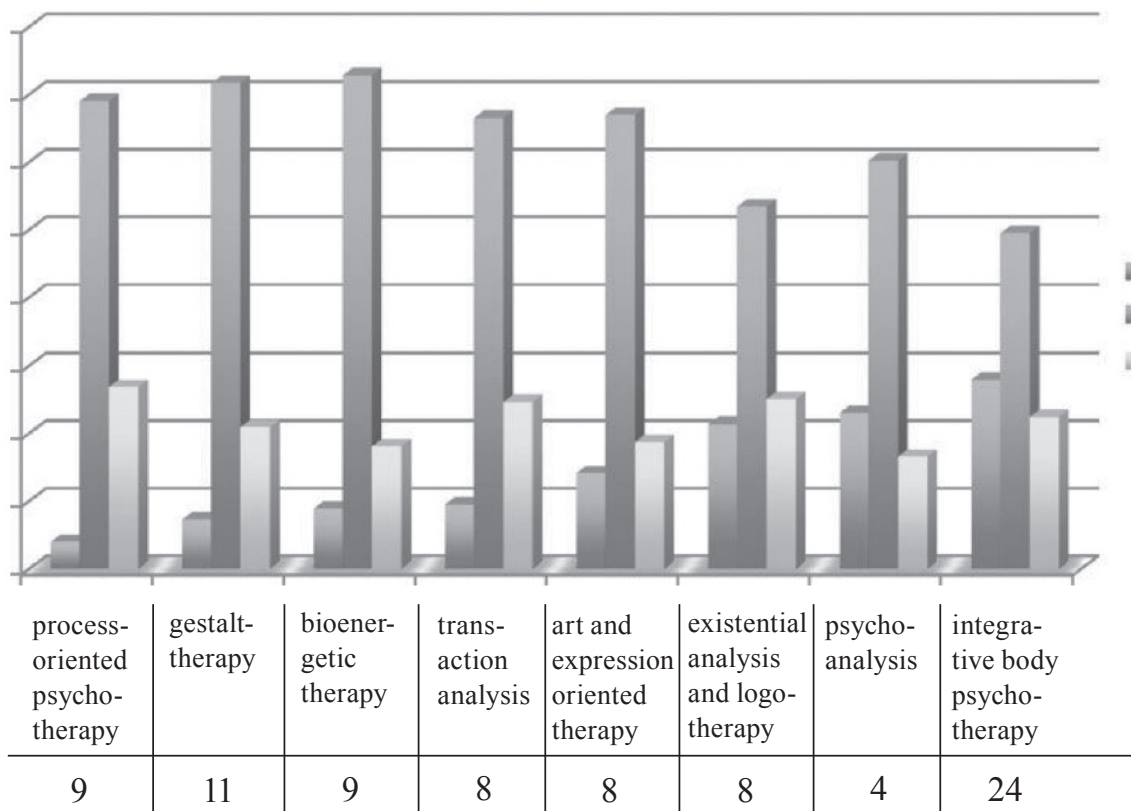


Figure 3: Eight types of psychotherapy: specific, theory-specific, interventions (treatment adherence; middlegray), nonspecific, common interventions (dark), and interventions from psychotherapy schools other than the therapist's own (bright: mean percentage across all therapies using each psychotherapy concept) and numbers of rated therapies per concept in the bottom line (TSCHUSCHKE, CRAMERI, KOEHLER et al. 2014; p. 3).

In a mixed model calculation, taking into account several cases from the same therapists, the degree of treatment adherence did not play an important role with regard to treatment outcome. Other, nonspecific therapeutic factors, such as the severity of patients' psychological problems at treatment entry as well as therapists' degree of professional experience, in years, predicted significantly treatment outcome. Highly experienced therapists working with patients with more severe problems achieved highly significantly better treatment outcomes. Thus, professional experience of therapists as well as a higher psychological burden of patients play an important role in psychotherapy, but the combination of therapists' professional experience and severity of patients' psychological problems explain even more outcome variance than both variables alone do.

Therapists of the eight treatment approaches that were investigated differed significantly in their degree of treatment adherence. It appears that

different psychotherapy approaches tend to be more specific than others, notwithstanding the fact that the degree of adherence is not correlated with treatment outcome and that the percentages of concept-specific technical interventions remained low compared to the degree of non-specific interventions in all eight concepts.

Another result was that therapists lowered their degree of treatment fidelity when patients with a higher severity of psychological problems stressed the therapeutic alliance, although the therapists were already working on a relatively low level of treatment adherence. Also, the same psychotherapist showed a considerable variation in treatment adherence from patient to patient. This is a result from research that has already been reported elsewhere: ‘within therapist variation’ (BALDWIN, IMEL 2013).

Conclusions

There are several relevant implications of this research for clinical practice as well as for the theoretical discussion regarding the significance of theoretical concepts in psychotherapy.

- As the available research shows, a strict adherence to the treatment concept or to the prescribed treatment protocol does not apply in psychotherapy or seems to be counterproductive in some cases, respectively.
- Technical interventions in psychotherapy cannot occur isolated from the mood of the patient/client, the quality of the working alliance, the very moment in a session or the phase during treatment.
- Thus, the degree of treatment adherence in psychotherapy varies for a number of reasons and from case to case: ‘within therapist variation’.
- Although the once learned treatment concept seems to play a minor role in a psychotherapist’s daily practice, these results do not support the view that the training of psychotherapists in a specific treatment concept is no longer justified or that psychotherapy would be an eclectic something of helpful communication skills everybody with an interpersonal sensitivity could practice.
- A successful psychotherapist seems to be a person who works on the basis of a once learned treatment concept with its inherent theoretical assumptions and its technical interventions and integrates continuously technical modifications of interpersonally helpful communication skills which fit his/her personality and add to his/her authenticity as a

competent person and a skillful psychotherapist.

- Thus, psychotherapy is not the simple or pure usage of applying a technique from a once learned treatment approach or concept in a way that each given situation would have its one best answer or action from the therapist (sic: manualization does also not apply in psychotherapy; s. TSCHUSCHKE, FREYBERGER 2014), but rather a sophisticated use of once learned techniques at the right moment, or the non-usage of theoretically prescribed interventions in favor of a better handling of the patients or clients actual situation.

As this research and recent meta-analysis show, treatment adherence seems not to play an important or direct role with regard to treatment outcome. Thus, the debate centered around differently effective types of psychotherapy is obsolete (WAMPOLD 2001; BUDD, HUGHES 2009). It may be that the degree of treatment fidelity plays an indirect role via nonspecific factors such as the professional experience of the therapists, the severity of patients' psychological problems, or the quality of the therapeutic alliance.

The concept of 'therapeutic competence' is currently discussed in the field of research as a very promising one (BALDWIN, IMEL 2013). As we have shown in another paper of the PAP-S (BERGLAR, CRAMERI, VON WYL et al. 2014), there are differently effective psychotherapists. And again, the amount of treatment adherence did not play a crucial role with regard to treatment outcome. The question is still not answered: What constitutes an effective psychotherapist and what a less effective one? There are some characteristics of psychotherapists that hold true across different patient personalities and seem to go far beyond a technically perfect requirement of a once learned theory or treatment concept (BARBER, GALLOP, CRITS-CHRISTOPH ET AL. 2006; HOGUE, HENDERSON, DAUBER ET AL. 2008; WEBB ET AL. 2010; BERGLAR ET AL. 2014).

Zusammenfassung

In dem Beitrag werden Bedeutung und Rolle der 'Behandlungstreue' (treatment adherence) im Lichte neuerer Metaanalysen und Forschungsergebnisse aus einer großen Schweizer Studie diskutiert. Ergebnisse der PAP-S-Studie in der Schweiz bestätigen den Stand der Forschungslage und der daraus gezogenen Schlussfolgerungen: Am Beispiel von 81 Behandlungsfällen von acht verschiedenen psychotherapeutischen Basiskon-

zepten spielte die Behandlungstreue (konzeptkonforme Interventionen = spezifischer Wirkfaktor) keine Rolle im Hinblick auf das Therapieergebnis, sie blieb bei allen acht Konzepten weit unter dem Erwartbaren, im Gegensatz zu den nichtspezifischen Interventionstechniken, die zwischen 50 % und 80 % eingesetzt wurden. Dagegen waren sogenannte nichtspezifische Wirkfaktoren, wie die Qualität des therapeutischen Arbeitsbündnisses, das Ausmaß der psychischen Eingangsbelastung der Patienten oder das Ausmaß der professionellen Erfahrung der Therapeuten ausschlaggebend.

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The intertwined world of parents and infants: implications for adult and child psychiatrists

Miri Keren, Sam Tyano (Tel Aviv)

Transition to parenthood is a major event in the young adult's life. For those individuals who are psychologically vulnerable, it often becomes an overwhelming challenge. One of the main components of parenting that may be negatively influenced by parental psychopathology, is the parent's capacity for mentalization of the emotional meanings of the infant's behaviours. Parental distorted perceptions of their infant reflect themselves in verbal and non-verbal parenting behaviours that, in turn, may lead to dangerous processes of projective identification in the infant. In this paper we review and illustrate with short vignettes how parental psychopathology, regardless of the specific diagnosis, impinges on the child's socio-emotional development. Hence, one must treat the parent as well as the parent-infant relationship.

Keywords: parental preoccupation, parental psychopathology, clinical infant

Transition to parenthood as a major stressful life-event in the young adult's life

Relating to the first months of the entry into parenthood, WINNICOTT (1956) has introduced the concept of „maternal preoccupation”, defining the phenomena as „almost an illness” that a mother must experience and recover from, in order to create the environment that can meet the physical and emotional needs of the infant. This is about a special state of heightened sensitivity, like a dissociative state, that heightens the mother's ability to anticipate the infant's needs and to learn its unique signals. LECKMAN et al (2004) have shown that this unique obsessive-like psychological state takes place in fathers as well, though less intensively than in mothers. Emotionally vulnerable mothers may have difficulty to tolerate such a level of intense preoccupation, and may react with either too much preoccupation or too little. Both situations are detrimental to the infant and the mother as well: too much preoccupation does not leave space for other family members' needs nor leaves room for other caretakers, such as the father. Too little maternal preoccupation, as seen in postpartum depression, psychosis, severe narcissistic personality disorders, when the mother's needs come first, may lead to deprivation and even to maltreatment. Pregnancy and the year after giving birth are therefore a time where a woman is most

at risk of increased mental symptomatology by either triggering a latent vulnerability or exacerbating an existing psychopathology (MUNK-OLSEN et al. 2006; 2009). Among these, are antenatal major and minor depressive disorders (MELVILLE et al. 2010), especially common when risk factors are present, including domestic violence, chronic medical conditions, single parenthood, teenagers pregnancies, and poverty. Approximately 1-6 % of women experience postpartum post-traumatic stress disorder (PTSD) following childbirth. Most often, this illness is caused by a real or perceived trauma during delivery or postpartum. Past traumatic events, such as sexual abuse, have been related to the development of postpartum PTSD shortly after delivery (REYNOLDS 1997). The presence of post traumatic symptoms, such as dissociation, numbing, and re-experiencing, has a negative impact on the mother's capacity to enter the maternal preoccupation state. Women with obsessive personality disorder often find the transition to parenthood as an overwhelming challenge. The three clinical vignettes below illustrate these processes.

The capacity for Mentalization and Reflective Functioning as bridging concepts between adult and infant psychiatry

Mentalization is defined as the process of interpreting oneself's and the others' behaviours in terms of mental (emotional) states. Reflective functioning is the construct, or the operationalization of mentalization (FONAGY, GERGERLY et al. 2002). More recently, GERGELY & UNOKA have conceptualized mentalization as „*an innate social-cognitive evolutionary adaptation implemented by a specialized and pre-wired mindreading mechanism that seems active and functional at least as early as 12 months of age in humans*” (2008, p. 59). Mentalization is crucially needed for adaptive interpersonal functioning (what is named „social intelligence”) in a highly sophisticated social world. Mentalization and reflective functioning involve cognitive components, including the acquisition of a Theory of Mind (LESLIE et al. 2004), as well as affective components, such as empathy, that develop from the earliest affect regulating attachment relationships between infant and caregiver. Hence, dysfunctional and traumatic early attachment relationships due to neglect, abuse, dissociative, highly intrusive, grossly unpredictable patterns of parental responses, have long term detrimental and disruptive effects on the one's later capacity to use his/her innate competence for mentalization, and to adequately

deal with the challenges embedded in intimate and affiliative relationships (BATEMAN et al. 2000, 2003, 2007). Contingently, a strong link has been found between severe childhood adverse attachment and early traumatic experiences with the development of personality disorders, especially borderline personality disorders (LYONS RUTH et al. 2005; SROUFE et al. 2005). As FONAGY and BATEMAN wrote: „*Individuals with BPD are ‚normal‘ mentalizers except in the context of attachment relationships.*” (2008, p.141) „*Individuals with BPD tend to misread minds, both their own and those of others, when emotionally aroused.*“ (2008, p. 143). When these individuals become parents, one of the main mediating factors in the trans-generational transmission of personality disorders is the impairment in the adult’s capacity for mentalization and reflective functioning (FONAGY & TARGET 1997). MACFIE et al. (2009) showed among 30 children aged 4-7 whose mothers have BPD, as compared with 30 normative dyads, significantly different representations of caregiver-child relationship and of the self, as reflected in story-stem completion task. The offsprings of borderline personality mothers told stories with more parent-child role reversal, more fear of abandonment, and more negative mother-child and father-child relationship expectations, more shameful representations of the self, poorer emotion regulation with confused boundaries between fantasy and reality and less narrative coherence. Maternal identity disturbance and self-harm were the most potent predictors of these maladaptive self and caregiver-child relationship representations among the children of BPD mothers. The quality of the family environment has a major role in the development of mentalization: the frequency of perspective taking in caregiver-child verbal interactions (DE ROSNAY & HUGUES 2006; LOHMANN et al. 2005), the amount of role play in the family, and the degree of family verbalization of conflicting emotions (CUTTING & DUNN 1999), have been found as correlates of mentalization capacity in parents as well as in the child. Maltreatment, parental neglect, alcoholism, affective instability, as often found in maltreating families, disrupt the child’s opportunity to engage in pretend play, which in turn impinges on the emergence of mentalization: „*It is less the fact of maltreatment than a family environment that discourages coherent discourse concerning mental states that is likely to predispose the child to BPD*” (FONAGY & BATEMAN 2008, p. 145) and too poor future mentalization skills.

The impact of adult psychopathology on parenting behaviours and infant's development

RUTTER (1966, 1975) has studied the long term impact of parental psychopathology on offspring's in the widely known Isle of Wright longitudinal study, and pointed out some major findings, such as a significant but not very close link between parent's psychiatric or physical illness and child's psychopathology and that parental personality disorder and family conflict, in addition to the mental disease, are the most significant predicting factors of child's psychopathology. Similarly, in a study of high-risk infants aged 4 to 36 months, children of chronic psychiatric disordered mothers had significantly less coping behaviors than controls, but there was no specific effect of the maternal diagnosis. Hence, *parental psychopathology, regardless of the specific diagnosis, impinges on the child's socio-emotional development through the impact of associated presence of impaired parenting behaviors* (RUTTER & QUINTON 1984). Not the diagnosis but the parent's behaviors that interfere early and directly with the child's developmental tasks and needs such as regulation of behaviors and affects, basic sense of security, balanced autonomy and dependency, and the development of a positive view of self and others. Repeated parent's hospitalization is especially difficult for offspring's between 6 months and 5 years. DICKSTEIN (1998) emphasized the role of family functioning, as she found it to be the most powerful mediator of parental mental illness impact on child. In addition, *it is the number of risk factors in the infant, the parent, and their environment, that is more predictive of offspring's psychopathology, rather than the nature of the risk factors* (SAMEROFF 1993).

Some parenting behaviors such as hostility are detrimental for all ages, but sadness is especially problematic for young children (FIELD et al. 1997). Postpartum depression impacts on the infant's development through genetic transmission, as well as through the impact of the conditions correlated with mother's depression, such as disturbed family life, marital conflict, past maternal interpersonal experiences, and through its impact on the quality of the early mother-infant relationship (touch, gaze, affect). Mothers with depressed mood touch their infants more negatively and talk to them in a way that is less well adjusted to their infant's developmental needs (HERRERA et al. 2004). Indeed, three different patterns of depressed mothers' interactions with their infant, with decreasing order

of impact on the infant have been identified (COHN et al. 1986): *Disengaged and apathetic, engaged, but angry and intrusive, and engaged and positive*. Compared to normal infants, infants of depressed mothers were more drowsy, more passive, more distressed and fussy, look at mothers less, and engage in self-centered activity, and most bothering is the finding that these infants' reactions to their depressed mothers generalize to non-depressed strangers, and elicit depressed-like behavior in non-depressed adults (FIELD, MURRAY & TREVARTHEN 1985).

The nature of the child is a significant determinant of how much parent psychopathology is transmitted. RADKE-YARROW's 15 year longitudinal study (1985) has shown that there is no universal outcome of children early exposed to maternal depression, each case is the result of the interplay between vulnerability and resilience factors in child and parents, and overall growing up as a child of a depressed parent is costly: many have serious and multiple diagnoses, not only depression. Older girls of depressed mothers have more disruptive and acting out behaviors than boys (opposite trend for children of healthy mothers). Difficult temperament children of depressed mothers are more at risk for later problems than those of healthy mothers. The long term impact of maternal depression on offspring's is rather worrying: 65 % of infants with depressed mothers had insecure attachment classifications one year of age, and the quality of the mother-child interaction and the child's behavioral problems did not improve in parallel to the remission of depression (RUTTER 1994). Cognitive and developmental deficits (MURRAY 1988, 1992), negative self-image (JAENICKE 1987), conduct disorder associated with concurrent maternal depression, and affective disturbances, have all been observed among children who grow up with depressed mothers. Obviously, these children's difficulties make them more difficult to handle, which in turns, impact negatively on the mother's self-esteem. To summarize the dynamic interplay between maternal depression and parenting the infant, it is the consistency and pervasiveness of messages across interrelated contexts of the family relationship, the maternal specific behaviors related to her depression, and the characteristics of her interaction with the child, that increase the child's vulnerability. *It is this negative vicious cycle we aim at preventing, by joint adult and child psychiatrist's assessment and treatment of both mother's depression and impaired mother-infant relationship. It is not enough to treat the mother's depressive symptomatology. We must also address, as early as possible, the maladaptive mother-infant interactive patterns, the*

*specific mother's „depressive” attitudes conveyed to child, the **other parent's** functioning, and the proximal support system.*

The challenging task of parenting, that involves the provision of a safe environment for the infant, attendance to physical needs, appropriate age-related stimulation, and the establishment of an attuned and secure relationship, can be very much affected by a new-onset postnatal psychosis, as well as by long-standing illness, such as schizophrenia, bipolar illness, and substance abuse. The way these severe mental disorders impact parenting, is the extent to which the parent's symptoms determine her parenting behavior. For instance, a psychotic mother who perceives her baby as a dangerous, ill-intentioned creature, may become dangerous to him/her, or may withdraw from caregiving tasks. Furthermore, some mothers with a psychotic disorder are so preoccupied with psychotic thoughts that they behave in a disorganized way and are unable to take care of the baby in a safe manner. In these situations, the main therapeutic challenge is to ensure the baby's physical and emotional safety, and in parallel, to try to keep some continuity of contact between the mother and the baby, so that if and when she feels better and comes back home, both she and the infant will not be strangers one to the other.

Surprisingly, little attention has been given to the impact of parental OCD on the quality of parenting. In our clinical experience, we have come to know that the entry into parenthood, often exacerbates an already existing OCD, and parenting make it worse, up to the point of evoking aggressive feelings towards the baby who is perceived as preventing the mother to perform her rituals. UGUZ et al. (2007) have reported an incidence of 4 % among 302 women who developed post-partum OCD (PPOCD) at six weeks. The most common obsessions were contamination (75 %), aggressive (33.3 %) and symmetry/exactness (33/3 %). The most common compulsions were cleaning/washing (66.75 %) and checking (58/3 %). Interestingly, the PPOCD women had significantly more frequent aggressive obsessions and less severe obsessive-compulsive symptoms than the OCD patients without postpartum onset. The predictors of PPOCD were avoidant and obsessive personality disorders. A more recent study (ZAMBALDI et al. 2009) of 400 postpartum women reported an incidence of 2.3 % PPOCD, and 9 % of OCD in general. Similarly to the first study, aggressive and contamination were the most common obsessions, together with a cleaning/washing and checking compulsions. 38,9 % had also comorbid depression. Previous psychiatry history, somatic disease, or com-

plications at delivery were risk factors for developing PPOCD. In spite of this very significant clinical data, the literature about the psycho-social development of these mothers with postpartum OCD is practically inexistent. In our clinical experience at a community infant mental health unit, we have had in the last five years some 15 cases of infants born to mothers with OCD. None of them have developed childhood OCD, at least in their first four years of life, but all of them have oppositional behavioural traits, mixed with anxious features.

As we have mentioned above in the paragraph about mentalization, Borderline Personality Disorder (BPD) represents a severe distortion in attachment representations, mentalization, self and emotion regulation. HOBSON et al. (2009) have compared the mother-infant interaction characteristics of 13 borderline mothers with 15 depressed mothers and 31 healthy mothers. Disrupted affective communication and prevalence of exhibition of fear/disorientation in response to their infant's attachment bids, a pattern strongly associated with infant disorganised attachment, which in turn, predicts significant behavioural and interpersonal problems at kindergarten age and later on (SROUFE 2005). Maternal disrupted communication is predictive of the infant growing into a young adult with dissociative defence mechanisms, and disrupted affective communication with her/his own child (DUTRA et al. 2009). A most recent prospective, controlled study (CONTOY et al. 2011) showed the impact of combined personality disorder and depression on the infant's cognitive and emotional development at 18 months of age: dysregulated behaviour, impaired cognitive scores and high levels of internalizing behaviour, were the main negative outcomes.

In terms of early detection of these dyads at risk, it is extremely important to note that the strong impingement of BPD on parenting, is manifested already when the infant is two month old, as CRANDELL et al have shown (2003). Indeed, mothers with BPD were more intrusively insensitive to their infants during the Still Face procedure (TRONICK et al. 1978), who, in turn, showed increased looking away and dazed looks.

Zusammenfassung

Die Autoren gehen in ihrem Beitrag besonders auf die psychische Eltern-Kind-Verbindung ein. Sie sehen den Übergang zur Elternschaft als ein zentrales einschneidendes Ereignis im Leben eines jungen Menschen.

Für Menschen, die eine psychische Vulnerabilität zeigen, kann dies oft zu einer nicht bewältigbaren Herausforderung werden. Eine der Hauptkomponenten, die beeinträchtigt werden bei Vorliegen einer psychischen Erkrankung der Eltern, ist die Mentalisierung der emotionalen Mitteilungen des Kindes. Die auf diese Weise gestörte Wahrnehmung des Kindes, die sich verbal und nonverbal im Verhalten der Eltern zeigt, kann zu problematischen Prozessen von projektiver Identifikation beim Kinde führen. Die Autoren stellen in ihrer Arbeit an Hand von Fallvignetten dar, wie sich die psychische Erkrankung der Eltern, unabhängig von einer spezifischen Diagnose, im sozio-emotionalen Verhalten des Kindes niederschlägt. Dies bedeutet, dass sowohl die Eltern als auch die Eltern-Kind-Beziehung behandelt werden müssen.

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Psychological Aspects of Psychosocial Dynamic Rehabilitation: General Strategy, Different Tactics

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This paper contains a range of topics regarding the psychological aspects of psychosocial rehabilitation. Starting from Günter Ammon's ideas (understanding of health and illness as a gliding spectrum, the multidimensionality of man, and a multidimensional diagnostic and treatment concept), modern trends in psychosocial rehabilitation, its strategy and tactics are presented. The psychological theories that support psychosocial dynamic rehabilitation as well as the concept of protective and preventive psychosocial rehabilitation are described. Ways in which the wider trends already noted within psychology can operate are discussed in relation to psychosocial rehabilitation: disease\medical model and health\strengths perspective, recovery in the mental health context, psychology-enhanced conceptualization of recovery and multidisciplinary.

Keywords: psychosocial rehabilitation, mental patient, recovery, dynamic approach, Günter Ammon, health\strengths perspective

Introduction

It is the purpose of this paper to highlight a range of topics regarding the psychological aspects of psychosocial rehabilitation. We will begin by referring to the issues raised by Günter AMMON with his concept of the Berlin School of Dynamic Psychiatry (AMMON 1979, 1982) and then move on to other topics regarding the modern trends in psychosocial rehabilitation, its strategy and tactics – as we proceed.

G. AMMON has been changing the theoretical landscape of psychiatry. He has made a real and enduring contribution to the different areas that he has become involved in. His theory represents an open system which allows further developments. A differentiated survey on Ammon's theory and practice of Dynamic Psychiatry was presented by Maria Ammon in 1996 (AMMON 1996), and it is a base of our further considerations.

The modern trends in psychosocial rehabilitation, its strategy and tactics are quite congruent with G. AMMON's ideas. Of central importance are the following principles: understanding of health and illness as a gliding spectrum, as a continuum of mental health and 'mental illness', the concept of social energy, the multidimensionality of man, and a multidimensional diagnostic and treatment concept.

Psychosocial rehabilitation: from disease\medical model to health\strengths perspective

For the last half century psychosocial rehabilitation has been largely consumed with very definite topics – and it has done fairly well with it. We now know a fair amount about how to use the psychiatric rehabilitation strategies and rehabilitative tactics and interventions – to minimize residual social and occupational handicaps and maximize community adjustment, to reduce disability, to maximize a patient's ability to function, to enhance social supports, to train a patient in specific areas of deficits, to use the „environmental” interventions, which help a patient to protect against the vulnerabilities and help him to diminish relapses etc. Nevertheless, in general, the field of psychosocial rehabilitation has focused heavily on pathology, while not overcoming the barriers of „mental patient subculture”, and overlooking other aspects such as growth and healthy adaptation.

The „mental patient subculture” has its advantages and disadvantages. The danger is that one can take on the mental patient role as an identity and, indeed, despite not living in an asylum, after a number of months in the subculture it can have an asylum-like institutionalizing effect – as if invisible walls are keeping one there. In some sense, relieving the states that make a patient's life miserable has relegated building the states that make a patient's life worth living to a distant back seat! Participating with other ex-patients in day hospitals, day centers or outside social events – is useful as a mean of widening one's life radius again. But within the disease\medical model it is really not a move out of the subculture back into real communal everyday life.

The recent transformation of the study of psychosocial rehabilitation, with attention being given to the positive outcomes of psychosocial functioning along with the positive outcomes of illness experience etc., is in part a reflection of, and in part an influence on, the wider trends already noted within psychology. From being a discipline with a primarily pathological focus, psychology can expand its attention to embrace the pinnacles of human attainment. It is contrasted the prevalent disease\medical model of clinical psychology with the health\strengths perspective of positive psychology (LINLEY, JOSEPH 2004). Under the disease\medical model we have become „pathologisers” and „victimologists”, forgetting about normal lives, and failing to develop positive interventions.

The considerable body of research from the last years challenges conventional ideas about „mental illness” and „psychosocial rehabilitation” (CHOU et al. 2012, FISZDON, REDDY 2012). In accordance with the conventional ideas the patients were seen increasingly as consumers of „psychosocial rehabilitation” services and hence their views, reactions and experiences should be seen legitimately as part of the corpus of knowledge in the broad field of psychopathology. Current trends mentioned above inspire a revaluation and reformulation of the scope of the discipline, with attention being called to the investigation and promotion of a science of human strength and optimal functioning (SELIGMAN, CSIKSZENTMIHALYI 2000).

This movement towards a positive psychology is reflected in psychosocial rehabilitation strategy which is based on a set of principles designed to foster the independence and development of people with mental disabilities. To name but a few, the basic principles governing the psychosocial rehabilitation are: early intervention, environmental approach, changing the environment, work-centered process, psychosocial rather than medical supremacy, equipping patients with skills, differential needs and care etc.

Protective and preventive psychosocial rehabilitation for psychiatric patients

Whereas it was once thought that rehabilitation in psychiatry is associated with a more complete reestablishing of patients’ position in the society, protective and preventive psychosocial rehabilitation (GUROVICH 2007, 2014) has refocused the field on the other factors that also have an impact on functional outcomes, namely environmental and social factors and socio-psychological characteristics of specific age groups of patients. According to the concept, the psychosocial rehabilitation is an essential component of care on every stage that follows treatment, throughout the whole course of disease, so the rehabilitation process may not lag behind and certain possibilities may not be missed. The psychosocial interventions are aimed at both preserving social capacities of the patient and prevention of social losses in future.

According to the concept, we distinguish the most problematic patients groups, and address each patient’s strengths, weaknesses as well as functional needs. Individualizing a program increases the likelihood that a patient will be sufficiently but not overly challenged. In both theoretical principles and corresponding practical applications, the concept’s

approach places a premium on enhancing the patient's social capacities, and prevention of social losses. The flexibility in session planning insures that the rehabilitation program can meet the patient's needs, which may change over time. It is constantly evaluated and modified to assure that the program reflects the demonstrated motivational needs of the patient, as they are manifest in their daily progress toward their recovery goals.

The rehabilitation programme based on the protective and preventive psychosocial rehabilitation pursues two goals. At the environmental level it should provide meaningful opportunities for social integration. At the individual level it should focus on the activities subjectively associated with optimal experiences in order to exploit the behavioral flexibility and resource potential (strengths) of mental patients, promoting their development and their active contribution to the society.

Multidisciplinarity

According to G. AMMON, each attempt to integrate different methods has to be made in the service of the patient, with the aim to better understand him in order to be able to help him in a better way. G. Ammon had very early on not only demanded an interdisciplinary collaboration of psychiatry and psychoanalysis but also the collaboration of other scientific disciplines such as psychology, pedagogy, philosophy, neurophysiology and neuropsychology, sociology, anthropology, ethics and especially analytic group dynamics (AMMON 1979, 1982).

These early ideas of G. AMMON towards a multidisciplinarity are reflected in the recent developments within psychosocial rehabilitation, which needs a broad theoretical base incorporating theories, models and frameworks from a number of different areas. No one model is sufficient to address all the problems faced by person with mental disorder. We need models of cognition, recovery, behavior, learning (including 'errorless learning'), compensations and emotion to deal with mental illness.

The holistic and multidimensional understanding of man inevitably results in a multidimensional concept of treatment. Psychosocial treatments, in conjunction with pharmacotherapy, are increasingly utilized in treating cognitive impairments in schizophrenia, especially for patients with severe and persistent mental illness and accompanying cognitive deficits. There has recently been an emphasis on the role of the cognitive neurosciences in informing theories of cognitive rehabilitation – and, conse-

quently, some approaches had been emphasized at the expense of others. But it seems to be obvious that the cognitive neurosciences alone cannot provide a broad enough framework to cope with the complexity and sheer scale of the concerns that mental patients are faced with (CHOI, FISZDON, BELL 2013). We argued that highly successful rehabilitation programmes can be developed to help the mental patients, and their families on the basis of an integrative approach. A much broader theoretical framework is more appropriate, which can include models of cognition, emotion, behavior, learning and recovery, along with empathy and clinical skills – which is in line with the above mentioned G. AMMON's writings.

What follows are the psychological theories that have already supported a psychosocial rehabilitation: neuropsychology, educational psychology, self-determination theory, rehabilitation psychology (MEDALIA, CHOI 2010).

The neuropsychological and educational psychology principles are to be used within the context of the rehabilitation programs that offer patients training in the educational, vocational, social and independent living skills necessary for recovery and reintegration into society. Behavior and learning theories provide us with an understanding of the process of learning. For example, shaping, errorless learning and generalization are commonly used to facilitate the process. Shaping refers to the gradual changes in behavior in response to incremental, corrective reinforcement. Errorless learning includes the careful titration of difficulty level so that the patient does not have to resort to „trial-and-error” learning. Generalization refers to the transfer of a learned skill or behavior to other situations besides the one where the training occurred (KERN et al. 2003; MEDALIA, CHOI 2010).

Educational psychology has made significant contributions to understanding of the conditions under which optimal learning can take place and some of the best strategies for effective instruction. Whereas it was once thought that learning is directly correlated with intellectual (cognitive) ability, educational psychology has refocused the field on the other factors that also have an impact on learning, namely – motivation to learn (MEDALIA, CHOI 2010). Research with students (as well as with mental patients) has shown that they learn the most and retain knowledge the longest when they are motivated for the pleasure of learning. One way to promote motivation is to use tasks that are contextualized, personalized and allow for patient's control. Contextualization means that rather than presenting material in the abstract, information is instead put in a context

whereby the practical utility and link to everyday life activities are obvious to the patient (in his or her real-life settings at home, at school and at work). Personalization refers to the tailoring of a learning activity to coincide with topics of high interest value for the patient. Learner control can be gained by offering a patient the opportunity to choose from among a forced-choice menu of activities (MEDALIA, CHOI 2010).

Self-determination theory is an approach to personality and motivation that examines how the interplay of social-contextual conditions and innate psychological needs fosters well-being and optimal functioning, and it is another concept which is crucial to us (RYAN, DECI 2000).

Rehabilitation psychology is a separate specialty area of practice that appreciates the interaction of personal and environmental variables in the recovery process (SOHLBERG, MATEER 2001; FRANK, ELLIOTT 2000).

Recovery

By addressing recovery as a dynamic process, as opposed to just targeting some issues, rehabilitation psychology considers the interrelationship between and among factors related to the patient's recovery and the environment in which recovery takes place.

The movement towards a positive psychology (mentioned above) is also reflected in recent development of interest in the „recovery” (ANTHONY 1993; KUKLA, SALYERS, LYSAKER 2013). Recovery in the mental health context refers to the process of changing one's attitudes, values, feelings, goals, and skills in order to live a satisfying life within the limitations caused by illness (ANTHONY 1993).

The adoption of „person” orientated rather than „symptom” orientated recovery model is beneficial. The patient perspective on recovery from psychosis, patients' experiences may be enlightening for mental health professionals. Increasing attention has been given in recent years to allowing patients to report their experiences and to have voice in the manner in which the quality of their lives is improved (PARK, SUNG 2013). Psycho-social rehabilitation, its strategy and tactics, are working to empower sufferers rather than have them regarded as „victims” or organic entities on the receiving end of the ministrations of „experts”. In line with the above, the considerable body of research covered a range of similar points: the understandability of many „psychotic” experiences in terms of normal psychological processes, the importance of treating people as „experts”

on their own experiences etc.

A mental health service system based on the recovery concept incorporates the services of a community support system organized around the rehabilitation model's description of the impact of mental illness. Each service is examined in terms of amelioration of impairment, dysfunction, disability, and disadvantage. A recovery-based mental health system assumes that recovery can occur even though symptoms recur, and that recovery is not a linear process.

According to G. AMMON (AMMON 1979, 1982) the main treatment goal is to help the patient to make life worth living and it is corresponded with the key strategy of psychorehabilitation. The patients' conditions are often highly heritable and unchanging, so we argued that our focus should not always be on trying to cure patients of their conditions. Instead, we should help them to live rewarding and fulfilling lives even with mental illness. So, patients are working toward getting better and re-entering society at the degree that individual circumstances permit. In this sense, it is also essential to focus psychosocial rehabilitation tactics on strengthening the individual resources rather than on improving of social expectations. The tactics might be quite different and based on the principles of paternalism or either of partnership, are provided in strictly constructive or in spontaneous manner, by therapist's teaching and training the social skills or just being with the patients in their ordinary protected social environment. Different types of recovery programmes are used to provide tactically an appropriate psychosocial care for the patients, while a key purpose as a general strategy of rehabilitation is to promote recover which means a better self-functioning and return to life.

Multidimensionality of man

As noted before, the „mental patient subculture” has its advantages and disadvantages and it is close to understanding of the wholeness and uniqueness of a man including the patients' „psychotic potential” (AMMON 1979, 1982). The negative valence of patients' psychotic experiences is only one side of the story – increasingly, positive outcomes are being recognized following suffering and illness. Some findings and clinical observations suggest that mental impairments rather than preventing development, can help patients discover new opportunities for optimal experience and can foster personal growth. As the dramatic nature of mental illness

becomes increasingly recognized, so in parallel the list of circumstances grows in which positive adaptations have been identified, suggesting that positive adaptation to illness experience is one route through which a positive life may be achieved. The patients reported positive changes in their outlook on life. They described reordering their priorities and so on. Like combat veterans (one of the most consistently studied „trauma” populations) mental patients revealed greater psychosocial resiliency in later life. It is these patients that became peer leaders within the group format psychosocial rehabilitation programmes. They become a heartening, real-life symbols of hope to beginners who may be struggling to figure out how they will productively manage their illness and become the kind of persons they want to be.

The patients had to face dramatic changes, often being deprived of activities previously associated with optimal experiences. Some patients recognized optimal experience in their present life. Some of them associated it with work, discovering new activities or adapting previous ones to their changed mental and physical conditions. Some of them learned or acquired new skills through rehabilitation practice – which is vital for reintegration into active life.

However, we cannot simply generalize from what we know about the treatment of mental disorder to the facilitation of the growth. The facilitation of the growth as well as the use of positive valence of patients’ psychotic experiences are not easy amenable to treatment approaches taken from manual. In the meantime, subtle infusion in rehabilitation procedures may be the most effective and acceptable way to integrate these constructs into a progressive rehabilitation framework, particularly in pathology-focused settings.

Strengths psychology

Dynamic Psychiatry is counting on patient’s existing healthy possibilities. A special consideration should be paid to patient’s creative potentials and abilities (strengths), his interests, his experiences in life and his group relations. G. AMMON also speaks of so-called „health-diagnostics” (AMMON 1979, 1982), that is, the psychological-biological examination shall especially examine the healthy parts of a human being.

Again, patient’s human strengths, positive emotions, wisdom, creativity, optimism, personal growth (to name but a few) were traditionally distinct

research domains – far from central to psychological endeavors, if not viewed through the lens of psychopathology.

What are patient's strengths (patient's own trait-like strengths)? Mental patients often do not fully appreciate their strengths, and may not even know what they are. It is also reflected in the research, where patient's strengths have been the subject of very little systematic empirical investigation. However, with the advent of current trends, this is now changing. So, what has been missing until now is an integrative framework of strengths that allows patient's strengths to be studied and understood in relation with each other, rather than in isolation.

An interdisciplinary collaboration of psychiatry and other scientific disciplines such as strengths psychology may be useful in this respect. Following a recovery approach in mental health services by focusing on the development of personal strength has the potential to reduce depression in patients with psychosis and improving their life (SIBITZ et al. 2011).

Strengths psychology offers much to the understanding of constructive human nature as well as to putting patient's strengths into practice (LINLEY, JOSEPH 2004). Specific strengths-based therapies, building self-esteem and developing new skills with mental patients, using one's strengths to guard against relapses – all these areas could benefit from strengths psychology.

Paradigm enrichment

The own experience of having spent much of a career working with this patient group (SEMENOVA 2014) gives us the general feeling that the flavor of the positive perspective on psychosocial rehabilitation issues should be conveyed. We argue for paradigm enrichment (not for a paradigm shift) by asserting that positive, psychology-enhanced conceptualization of recovery could be used to provide effective psychosocial dynamic rehabilitation.

Most importantly, psychologists are now beginning to provide a common vocabulary for researchers and practitioners interested in the good life of happiness, health, well-being and fulfillment (LINLEY & JOSEPH, 2004). Basing the ideas of Martin SELIGMAN (SELIGMAN 2003), it is possible to lay out a terminology upon which a scientifically viable rehabilitation might rest. In doing so, we distinguish three domains of desirable lives for mental patient: the pleasant life, the good life, and the meaningful life.

The pleasant life in this context might be determined as a life that suc-

cessfully pursues the positive emotions about the present, past and future. What we refer to as the good life is the following. The gratifications are the other class of positive emotions about the present, but unlike the pleasures, they are not feelings, but activities patients like doing. It cannot be obtained (or permanently increased) without developing the strengths and virtues (just what the patient acquire due to rehabilitation interventions). And the gratifications are the routes to what we conceive the good life to be.

A meaningful life adds one more component to the good life – it is the use of patient's strengths and virtues in the service of something much larger than he or she is. Mental-disablement can be conceptualized as an interaction between individual and environmental features comprising not only impairment of psychological structures or functions, activity limitations – but participation restrictions (consequences of impairment that limit or prevent the fulfillment of expected social roles). The clinical benefits of paid work activity in schizophrenia are well known as a mean of overcoming the participation restrictions. The vocational rehabilitation can favorably affect the functional outcomes (SAPERSTEIN, FISZDON, BELL 2011). „Work and meaning” – this is a title of well-known paper of LYSAKER (1995) on work rehabilitation. Jobs and learning are occasions for enjoyment, intrinsic reward and skill development, as well as opportunities for participation in the productive life.

Conclusion

It has been our purpose in writing this brief paper to highlight the psychological aspects of psychosocial dynamic rehabilitation which are significant for both the strategy and the tactics. We argue against a prevalent disease\medical model of psychosocial rehabilitation. The recent transformation of the study of psychosocial rehabilitation, with attention being given to the positive outcomes, is in part a reflection of, and in part an influence on, the wider trends already noted within psychology, namely, the health\strengths perspective of positive psychology. The modern trends in psychosocial rehabilitation, its strategy and tactics – are also congruent with G. AMMON's ideas: understanding of health and illness as a gliding spectrum, as a continuum of mental health and „mental illness”, the multidimensionality of man, and a multidimensional diagnostic and treatment concept. Inspired by these trends, and on the basis of the research evidence, the mental health professionals are increasingly able to explicate

the processes and outcomes of these transformations. Rather than a paradigm shift it is our belief that it is a paradigm enrichment that transcends the clinician-patient divide and at a process level to produce a „person” rather than „symptom” oriented approach will produce rehabilitative efforts that should command greater confidence with people we treat.

Summary

Traditional psychosocial rehabilitation procedures and strategies focus on the identification of negative, maladaptive psychological states of the patient. Moreover, they generally focus on a single area of the patient’s life, rather than attend to the unity and diversity of multiple environments and contexts within which patients function. The recent transformation of the study of psychosocial rehabilitation, with attention being given to the positive outcomes of psychosocial functioning along with the positive outcomes of illness experience etc., is in part a reflection of, and in part an influence on, the wider trends already noted within psychology. From being a discipline with a primarily pathological focus, psychology can expand its attention to embrace the pinnacles of human attainment. It is contrasted the prevalent disease\medical model of clinical psychology with the health\strengths perspective of positive psychology. Psychologists are now beginning to provide a common vocabulary for researchers and practitioners interested in a better life of happiness, health, well-being and fulfillment for the patients. Psychological aspects are mainly focused on the interaction of personal and environmental variables in the recovery process. And it does not depend on whether the rehabilitation tactics are based on the principles of paternalism or partnership, are provided in strictly constructive or in spontaneous manner, by therapist’s teaching and training the social skills or just being with the patients in their ordinary protected social environment. Different types of recovery programmes are used to provide tactically an appropriate psychosocial care for the patients, while a key purpose as a general strategy of rehabilitation is to promote a better self-functioning and return to life. By addressing recovery as a process, as opposed to just targeting some issues, rehabilitation psychology considers the interrelationship between and among factors related to the patient’s recovery and the relevant social environment.

These modern trends in psychosocial rehabilitation, its strategy and tactics, are congruent with early G. AMMON’s ideas: understanding of

health and illness as a gliding spectrum, as a continuum of mental health and „mental illness”, the multidimensionality of man, and a multidimensional diagnostic and treatment concept. Dynamic Psychiatry considering a person as holistic system is counting on patient’s existing healthy possibilities, his or her creative potentials and abilities (strengths). So-called „health-diagnostics” in terms of G. AMMON, refers mainly on the psychological-biological examination with the focus on the healthy parts of a human being. Some findings and clinical observations suggest that mental impairments rather than preventing development, can help patients discover new opportunities for optimal experience and can foster a personal growth.

Application of the G. AMMON’s ideas and the strength-based positive psychology principles in psychosocial clinical work with mental patients will contribute to a better treatment efficacy, and will provide a more balanced approach to understanding the levels of adjustment, development, and post-disease growth of the patient. In line with the above is recent development of interest in the „recovery” in the mental health context which refers to the process of changing one’s attitudes, values, feelings, goals, and skills in order to live a satisfying life within the limitations caused by illness. Recognizing both strengths and challenges experienced by patients, we advocate moving beyond the „mental patient subculture” with its advantages and disadvantages, the mental patient role as an identity, as well as dichotomous thinking that emphasizes either strengths or deficits – to a more holistic approach that incorporates the wealth of traditional knowledge in this field.

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Certain Aspects of Leadership and Employees' Psychological Development in Work Organizations

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The aim of this paper is to describe certain characteristics of the leadership context to employees' psychological development, and highlight some aspects of it from a Dynamic Psychiatric perspective. Following Günter Ammon's theory individuals through their lives are involved in a process of mutual social energetic exchange within their groups. Leadership – under constructive interpersonal dynamics – acts as a source of social energy being vital for the group members' on-going identity development. Transformational Leadership, an influential theory of the past decades aims to treat employees as 'full-human beings' (NORTHHOUSE), for which idea a support and enrichment by insights from and deeper considerations involved in Dynamic Psychiatric concepts can be suggested.

Keywords: Transformational Leadership, Employee Development, Identity, Dynamic Psychiatry, Social Responsibility

„... it is 'immoral not to develop others or not to allow them to develop to their fullest potential ...' F. Yanmarino

Introduction

The aim of this paper is to describe certain characteristics of the leadership context to employees' psychological development, and to try to highlight some Leadership Employee Development principles from a Dynamic Psychiatric perspective. As shown below some of the modern Leadership Theories introduce deep personal changes of the employees as functional and/or desirable within the Leaders-Followers relationship. For a better understanding of these changes there is a need for further explanations and references to underlying concepts of personal growth and development. As a Leadership instructor my interest in teaching and theory has led me towards a search for theoretical linkages beyond the basic Transformational Leadership paradigm. Because of the depth of personal changes envisioned and deemed desirable in the mentioned Leadership context, relevant concepts of psychological development, i. a. the Dynamic Psychiatric approach to „Identity” as a „dynamic process evolving on the border of space and time” (G. AMMON 1986) can be key in offering

theoretical foundations.

In this paper first I would like to introduce the areas and scope of personal change targeted by Transformational Leadership as a representative Leadership Theory, and, as such, one of the cornerstones of managerial thinking of the last decades. In the second part I would like to deal with certain issues of the relation of work/leadership and psychological development from a Dynamic Psychiatric perspective. In the third part an illustration of certain employee development practices will follow through a brief case example.

Areas and scope of personal change targeted by Transformational Leadership as a representative Leadership Theory of the past decades

Transformational Leadership is often defined in contrast to Transactional leadership. In NORTHOUSE's interpretation: „Transactional leadership focuses on the exchanges that occur between leaders and followers”, whereas „Transformational leadership refers to the process whereby an individual engages with others and creates a connection that raises the level of motivation and morality in both the leader and the follower” (NORTHOUSE 2001, p. 132).

As the author notes Transformational Leadership (TL) encompasses multiple theoretical and pragmatic approaches with various scopes of analysis (op. cit., p. 131). In an attempt to synthesize the definitions of several authors the following can be stated: TL refers to the use of a *broad range of* (i. a. non-traditional) *means of influence* in the leadership process with an aim to *develop followers* in order to *bring about necessary changes in organizations*. As regards the various *means of influence* they include i. a. the leaders' own development, the clarification of common values, a commitment to shared goals and mutually agreed performance criteria, the use of special emotional-symbolic-charismatic effects by the leader and practices of empowering employees. Within this process of influence the *development of followers* (raising their level of aspiration and commitment) is targeted whereas the ultimate goal can be seen as bringing about necessary changes in the organization (FEHER 2009).

Though Transformational Leadership is often defined as a counterpart of Transactional Leadership we should not forget about the fact that TL does not constitute itself as a replacement but rather as an addition to

Transactional Leadership. As AVOLIO and BASS suggest: „Transformational leadership does not replace transactional leadership. [...] Transactional leadership [...] provides a broad basis for effective leadership, but a greater amount of effort, effectiveness, innovation, risk taking, and satisfaction can be achieved by transactional leadership if it is augmented by transformational leadership.” (AVOLIO, BASS 2002, p. 6)

As regards the various means of influence applied by the Transformational Leader it is also important to note that Transformational Leadership can be practiced through a wide variety of 'Leadership Styles'.

AVOLIO and BASS state the following: „Transformational Leadership can be directive or participative, democratic or authoritarian, elitist or leveling”. (op. cit.) While the authors argue: „There are many good reasons for encouraging shared decision making, empowering followers, and self-managing” they also emphasize the fact: „Nonetheless, many circumstances call for a leader to be authoritative, decisive, and directive.” (op. cit.)

No matter how important the latter behaviors can be under specific circumstances, it is also an error to misunderstand Transformational Leadership as „elitist and antidemocratic” (op. cit.), and so it is to identify the theory solely with special patterns of „Heroic”, or „Autocratic” leadership styles.

After introducing some generic aspects of Transformational Leadership let us focus our attention to certain more specific parts of the topic of employee development within the theory.

In an attempt to identify the areas/scope of the various forms of targeted personal changes of employees involved in the process of developmental leadership I have found the following main, broad categories:

- a consciousness about goals and a high level of aspirations,
- a balance between common and self-interests (FEHER 2009).

The category „consciousness about goals and a high level of aspirations” includes i. a. a consciousness of values, hopes, dreams and beliefs (KOUZES, POSNER 1995; ANDERSON 1992), an activating of higher-order needs, and a raising to higher levels of morality and motivation (BASS 1985), a feeling that the activity (achievement) is important (BASS 1985), an enhancing the development of the leaders and that of the organization (TICHY, DEVANNA 1986), and an experiencing of common social responsibility (TICHY, DEVANNA 1986).

Example of the targeted effects and means of Employee Development

Author	Leader's targeted effect on individuals	Specific means of employee development
B. M. Bass	Raising the awareness of the importance of the aimed corporate result Overcoming self-interest Activating higher-order needs „Raising to higher levels“	Individualized consideration: • support • encouragement • coaching Intellectual stimulation: • enhancing sensitivity to problems • fostering new approaches Inspirational Motivation

Source: B. M. Bass, 1985, chart edited by the author

The category „balance between common and self-interests” entails i. a. an evolution of common set of values, and attitudes, accepting group-identity and philosophy of the organization (BENNIS, NANUS 1985, 1996), an identification with the mission, following common purposes (YUKL 1998), a meeting of the expectations expressed in the symbolic actions of the leader (YUKL 1998), a consciousness of own interests (KOUZES, POSNER 1995), nonetheless, an overcoming of self-interests (BASS 1985), making sacrifices (YUKL 1998), putting generosity in the limelight (TICHY, DEVANNA 1986), and a determination (KOUZES, POSNER 1995), a higher level of motivation than expected (BASS 1985), and also a balance between morality and love of money (TICHY, DEVANNA 1986).

Besides the two above mentioned categories also other/related targeted behavioral characteristics occur in the literature. To these belong i. a. an elimination of defensive reactions (TICHY, DEVANNA 1986), putting rationality and tolerance in the limelight (TICHY, DEVANNA 1986), undertaking responsibility, initiative, taking risks (KOUZES, POSNER 1995), successorisation, sharing an atmosphere of celebration (YUKL 1998).

Generally speaking, and specifically, in the light of the types and scopes of targeted behavioral changes, the theory is often challenged for potentially hiding manipulative tendencies. In response to these criticisms AVOLIO and BASS distinguish between transformational and pseudotransformational leaders, emphasizing that in contrast to transformational lea-

ders „pseudotransformational leaders are self-oriented, self-aggrandizing, exploitative, and narcissistic. Power-oriented pseudotransformational leaders openly preach distorted utilitarian and crooked moral principles” (AVOLIO, BASS 2002, pp. 8-9).

Pseudotransformational leadership can be one cause for TL’s serving hidden organizational/institutional agendas, and offering a masque on exploitative tendencies. Other factors of hiding manipulative tendencies can be of less psychological but more organizational and economic-sociological nature. The psychological and economic-sociological threats of the misuse of Transformational Leadership are a reality, constitute a real danger. From a certain aspect TL is „leverage”, a „toolkit”, and for its socially functional use responsibility and control are needed. We should be ready to cope with the danger of potential misuse. Nonetheless it is rightly a more effective, more functional – in specific terms: authentic (WALUMBWA, WERNING 2013, p. 395) – use of TL which can theoretically be one of the effective ways to eliminate or prevent from a misuse of its principles.

Another criticism in the light of the types and character of targeted behavioral changes is about „TL as a moralist/utopist trap” denying the generic principle of reciprocity in human relations.

In response to this criticism it can be stated that reciprocity is identifiable within the logic of TL, but with the above mentioned new content of exchange „currencies”. While the rule of the traditional exchange is „Work Efforts for Money, etc.”, the new exchange formula is about: „More Commitment for Development”, „Better Performance for a better Quality of Working Life etc”. This new exchange formula could paradoxically be called the „Transformed Transaction” (FEHER 2010).

After dealing with the challenges to the theory, in summary we can state that the employee development principles of Transformational Leadership introduce and outline deep and enduring personal changes as desirable on the part of the followers. Further questions and explanations of these changes are offered by some leadership concepts (examples to these include: SHAMIR, ARTHUR 1993; LORD, BROWN 2001; LÜHRMANN 2006), but regarding the depth and continuity of these changes generic psychological theories of adult personal growth and development can be key in offering necessary interpretations. As regards potentially relevant theoretical linkages in this paper I would like to highlight certain Dynamic Psychiatric interpretations of work environment and leadership in their relation to the psychological development of employees.

Work and psychological development from a Dynamic Psychiatric perspective

Because of the essential nature of personal changes hitherto envisioned I find it reasonable to turn our attention to Identity as a focal phenomenon within the concept of Dynamic Psychiatry.

In this concept identity and development are, by their very nature, inseparable, whereas „Identität, [...] als offenes System [...] nach sozial-energetischem Austausch zwischen innen und außen strebt und sich dabei ständig weiterentwickelt.“ (BURBIEL 2008, p. 16) (In English: Identity as an open system strives for a social-energetic exchange between the internal and external, and is being constantly further developed through that exchange. Translated by J. F.)

Günter AMMON wrote: „Identität ist das Bleibende in einer Persönlichkeit, und sie ist gleichzeitig nichts Bleibendes. Identität ist ein Prozess, ein fortwährendes Suchen, eine fortwährende Entwicklung. (G. AMMON 1999, in: BURBIEL 2008, p. 8) (In English: Identity is the enduring/constant element in the personality and, simultaneously, is something what is ever changing. Identity is a process, a constant search, a continuous development. Translated by J. F.)

The Dynamic Psychiatric concept of Identity and Identity Development attributes a centralistic role to groups. „AMMON [...] understands the structural development of personality – which as a whole he terms as ‘identity’ – as embedded in the structures of the surrounding group of an individual. [...] man is born into groups, develops his identity in groups, and receives psychic energy for his development from the group [...]” (M. AMMON 2009, p. 32)

Regarding the leadership/work organizational context to employees' psychological development we have to consider that the notion of identity in Günter AMMON's concepts is immanently related to work. AMMON suggests that „[...] work and activity are regarded as essential to man and characteristic of his general psychological structure” (G. AMMON 1993, p. 136, with a special reference to RUBINSTEIN and LEONTJEV and other authors). Further he states that „Work is [...] the center or focal point of the social-energetic exchange processes.” (op. cit. p. 138) Group, working process, and the individual group members have the function to mediate the social-energetic exchange in [...] synergistic interrelatedness.” (op. cit. p. 146). As far as the leader is concerned „[...] the central person en-

sures that creativity, work and learning are possible in the group” (op. cit. p. 146).

The importance of work for the group and individual is well reflected by the following suggestion: „A group without a work project cannot be a group, just as a person without a meaningful task cannot develop personality and identity.” (op. cit. p. 138).

G. AMMON offers us even a special approach of defining identity in connection to work: „Identity is the sum of the identification processes during life history, of the identification processes initiated by working projects.” (op. cit. p. 145)

In the light of these Dynamic Psychiatric principles workplace is conceived as objectively a key scene and factor of adult identity development. Consequently the role of work activity, projects, and organizations goes far beyond merely ‘influencing’ this development: work is a generator/an original source of the formulation of identity and a key constituent of it in adulthood. There are many factors explaining why and how work with its group, leadership, and organizational environment offers a specific context, and, in a deeper sense, an essential source and scene for psychological development.

The organizational environment as a whole represents a unique combination of development factors for employees. It surrounds the individual with a physical-cognitive-emotional milieu including task and material milieu, communication and information networks, training and other programs plus non-work social contacts in the major part of the active lifetime. An abundance of formal-informal relationships, i. a. organizational relations between leaders and followers within and beyond the formal hierarchical structure exists normally and/or is made potentially available in this milieu.

To the nature of this complex social energetic force-field belong also some further special characteristics. The conditions for psychological development in the workplace normally include:

- relatively well-defined goals, success-criteria, and requirements
- a relatively high measurability of performance: often a high transparency and a visibility of the contributions, an availability of metrics of success, performance management indicators.
- following from the above an availability of relatively rich, and quantifiable, objective feedback information on performance and behaviors.

- an availability of financial rewards of key importance to individual survival, self-esteem, etc., and tied normally to good performance.

Within this special force-field of social energetic exchange the leader's developmental impact on followers is evolving in interplay of some inseparable, interrelated behavioral components:

- the leader's personal approach to his/her followers within the dynamic force-field of the group
- the leader's relation to and role within the group
- the mutual activity of the leader and followers in shaping the task milieu.

The formerly introduced Leadership Theories outline deep psychological changes of employees as functional in a specific Transformational Leadership framework. In NORTHOUSE's interpretation Transformational Leadership „helps move employees toward their fullest potentials” (NORTHOUSE 2001).

The Dynamic Psychiatric principles about the dynamic nature of identity, the importance of work in identity development, the role of group and leadership in the social energetic exchange offer additional insight and deeper considerations for understanding the leaders' developmental impact on followers. The Dynamic Psychiatric interpretation goes further beyond the cited leadership principle (op. cit.) by presenting work, group and the leader as key constituents/creating actors of the „full potential” of employees.

Based on Transformational Leadership development concepts and lessons from Dynamic Psychiatry a broader interpretative framework to Employee Development can be outlined in comparison to a more traditional Leadership approach.

The traditional, narrower approach I suggest to call „Instrumental Approach”. The aim of the leader here is to produce better performance. In this framework the leader's perception of his/her role is „to help move employees toward their fullest potentials” (op. cit.). Methodologically this approach could be called „educational”. The tools for developing employees include individual, job-related and group interventions, like training, competency feedback, job-redesign, group facilitation and social skills development etc.

Approaches to Follower's Development at Work Organizations

	Instrumental Approach	Human Process Oriented Approach
Priorities	Better performance	Shared value (including better performance) gained from development
The Leader's perception of ED Role	To help ,move employees toward their fullest potentials'	To be by nature a psychological constituent/creating factor of this ,full potential'
Methodological Approach	Educational	Interpersonal Behaviour
Tools for Development	Individual, job-related and group interventions	Deeper, integrated individual, group and job environment (work-milieu) interventions

The broader interpretative framework can be called „Human Process Oriented Approach”. The aim of the leader here is to create shared value gained from development. The potential shared value is broader than better performance i. e. includes additional economic, psychological and social gains deriving from the development on the part of the employee, the development of the leader and the group as well. In this framework the leader's perception of his/her own role is to be by nature a psychological constituent/creating factor of the „full potential” of follower employees and groups. Methodologically this approach could be called „interpersonal behavioral”. The tools for developing employees include individual, job-related and group level interventions, like under the „Instrumental Approach”, but the main difference lies in the level of depth and integration of these solutions, e. g. life coaching, work milieu development, individual and group interventions under a deeper Organizational Development perspective.

In relation to the above framework I would like to raise the issue of the responsibility of the leaders toward the development of their followers. In the formerly shown broader interpretation of Employee Development we find that the leader's interpersonal/social/ethical responsibility for the

followers' development and creating shared values can be interpreted as to be broader, too. (It should be noted that the term „responsibility” is intended to be used in an interpretative, not in a normative way in this context.) In spite of the fact that the leader typically is an incumbent of a formal organizational role in organizations pursuing professional/business goals still we can talk about his/her responsibility reaching out behind specific professional/business concerns.

One approach to defining the leader's broader responsibility can be to use the Corporate Social Responsibility (CSR) paradigm as an analogy. CSR is „the comprehensive approach organizations take to meet or exceed the expectations of stakeholders beyond such measures as revenue, profit and legal obligations. It covers commonly investment, human rights and employee relations, environmental practices and ethical conduct.” (CABLE 2005, p. 11, in: MULLINS 2007, p. 542) Insofar organizations are responsible under this paradigm for broader social issues similarly an extended interpersonal/social/ethical responsibility of the leaders in relation to the development of the followers can be conceived. The link between Leadership Employee Development concepts and Corporate Social Responsibility theory can be the leader's – objectively – special, thus highly irreplaceable role in promoting the learning and personal growth of his/her followers in their groups (FEHER 2009).

A Case of Developmental Leadership

The following short case is about Lóránt, a retired company director, a highly successful manager of a 25 year period. The main location of his activities was in Hungary, the companies led by him were typically under international or foreign ownership. I met and have been in acquaintance with Lóránt in my capacity as HR professional service provider. His managerial successes were strongly related to his commitment to self-development and developing others. His case is not intended to be a direct illustration of some of the specific theoretical concepts mentioned in this paper rather to serve as a generic example of certain possible developmental behaviors of a leader.

Lóránt's leadership style, according to my observations, consisted of highly variable elements. Assertiveness, clear and high expectations, a consequent monitoring of results, reward and reprimand were not missing, but intellectual challenge, inspirational motivation, and individual consideration toward emplo-

yees were present to a perceivably higher than average extent. He knew how to empower employees: it happened through delegating, and leading them towards experiencing interdependence between them and their peers, their superiors and their subordinates.

Throughout his managerial career Lóránt always expressed his deep own, personal commitment to development both regarding his own learning and growth and those of his followers. He had pursued an academic occupation before his managerial career. His excellence in self-education was shown by his being up-to-date in international management and business literature. He kept on looking for and carefully selected special and high-value management courses and seminars personally to attend. Besides he showed a strong reliance on consultants in HR and related areas whereas one important aspect of hiring the consultants was to gain feedback on his own decisions and behaviors from them. It could be hypothetically suggested that his wish for feedback could signalize the presence of a considerable measure of constructive anxiety in his personality.

One important aspect of his activity in developing others was to educate people, with a focus on his followers. He set up a rich portfolio of in-company training programs, including professional and behavioral program types. He was thinking on „training is an investment”. The company training sessions conducted at some of his organizations gained wide publicity and fame via professional journals of Hungary.

Many training sessions ran with his involvement in person: as a course opener and closing ceremony host, course committee chair, examination and course project evaluation faculty or as one of the instructors. His instruction activity was well-known in the relevant businesses, industries and among the participants of the related publicity segments. His dynamic, highly professional and well-received lecturing certainly showed signs of constructive aggression and constructive narcissism. Hypothetically it could be raised that his personal involvement in teaching could be an effective way of elaboration of some of his destructive aggression and destructive narcissistic tendencies.

He was also an instructor during meetings, besides, often held guest lectures on request, and was actively developing others also in professional circles, fulfilling an important position in a managerial association.

The broad range of training and education offered and executed at his companies was normally accompanied by special educational support, markedly team programs. The instruction process was followed by and embedded into Organization Development projects, including group-work and large group meetings. The course participants were parts of problem solving teams. Simultaneously with the instructions the teams received team building education and solved professional tasks to be presented at the program closing meeting. A mentoring program was also part of the talent development.

Lóránt's another way of developing others was his showing up his own values regarding own career development and career decisions. Some of his followers knew about several of his deeply value-based decisions highly impacting his own career. One of these was to withstand a push of his newly appointed mother company boss who tried to superimpose an arbitrary managerial style on his

subordinates thus ruining the co-operative culture so far developed within the organization. Another example was to resist an attempt to be party-politically influenced by a traditional power syndicate. As it finally turned out his ethical behavior had weakened his own power base to a point that at this time his appointment was not renewed for a new CEO assignment period. These examples can be interpreted as implications of his strong identity development, expressed i. a. in behaviors offering possible illustrations of constructive ego-demarcation, and constructive aggression.

Fostering others' career development was always his passion. The managerial trainings at his companies were always accompanied by personal development and career planning program parts. He was managing others' careers in a creative way. Many of Lóránt's followers took inventive, sometimes radical, positive steps in order to change their career in a positive way following his advice or listening to his inspirations.

Zusammenfassung

Das Ziel dieses Vortrags ist es, bestimmte Charakteristika von Führungskraft zu beschreiben, die sich auf die psychologische Entwicklung der Mitarbeiter auswirken, und zu versuchen, einige Prinzipien der Mitarbeiterentwicklung durch Vorgesetzte aus einer dynamisch-psychiatrischen Perspektive hervorzuheben. Mein Interesse an Lehre und Forschung der Personalführung veranlassten mich, jenseits des grundlegenden Mitarbeiter-Entwicklungs-Paradigmas der Transformationalen Führung (TL) nach weiterreichenden theoretischen Grundlagen zu suchen. Wegen der Tiefe der Persönlichkeitsveränderungen, die im Zusammenhang mit der TL in Betracht gezogen und für wünschenswert gehalten werden, können einschlägige Konzepte psychischer Entwicklung, wie etwa die dynamisch-psychiatrische Auffassung von „Identität“ als ein „dynamischer Prozess an der Grenze von Raum und Zeit“ (G. AMMON 1986), ein Schlüssel sein, der theoretische Fundierungen ermöglicht.

Transformationale Führung wird oft in ihrem Kontrast zur Transaktionalen Führung definiert. NORTHOUSE schreibt: „Transaktionale Führung konzentriert sich auf den Austausch zwischen Führern und Geführten, [während] Transformationale Führung sich auf den Prozess bezieht, in dessen Verlauf sich ein Individuum mit anderen befasst und eine Verbindung entstehen lässt, die die Motivation bei beiden, dem Führer und dem Geführten, hebt.“ (NORTHOUSE 2001, S. 132) Der Autor macht darauf aufmerksam, dass TL unterschiedliche theoretische und pragmatische Ansätze mit unterschiedlicher Reichweite umfasst (ebenda S. 131). In einem

Versuch, die Definitionen verschiedener Autoren zusammenzufassen, kann Folgendes festgestellt werden: TL bezieht sich auf den Gebrauch eines weiten Bereichs von Bedeutungen von Einfluss im Mitarbeiterführungsprozess, mit der Absicht, Mitarbeiter zu fördern, um notwendige Veränderungen in Organisationen zu bewirken (FEHER 2009).

Obwohl Transformationale Führung dann niemals transaktionale Führung ist, müssen wir festhalten, dass TL sich selbst nicht als einen Ersatz, sondern eher als eine Ergänzung für die ursprüngliche Theorie konstituiert. AVOLIO und BASS schreiben: „Transformationale Führung ersetzt nicht Transaktionale Führung. [...] Transaktionale Führung gibt eine breite Grundlage für effektive Führung her, aber ein besserer Erfolg, Effektivität, Innovation, Risikobereitschaft und Zufriedenheit können mit Transaktionaler Führung erreicht werden, wenn sie durch Transformationale Führung erweitert wird.“ (AVOLIO, BASS 2002, S. 6) Hinsichtlich der verschiedenen Bedeutungen von Einfluss, die von einem transformationalen Führer angewendet werden, muss man auch feststellen, dass Transformationale Leitung mit einer großen Variationsbreite von Führungsstilen verwirklicht werden kann.

In einem Versuch, die verschiedenen Formen von Persönlichkeitsveränderungen bei Beschäftigten zu unterscheiden, die an dem Prozess von entwicklungsbezogener Führung beteiligt sind, habe ich die folgenden wichtigsten allgemeinen Kategorien gefunden:

- ein Bewusstsein der beabsichtigten Ziele und ein gesteigerter Ehrgeiz
- ein Gleichgewicht zwischen gemeinsamen und Eigeninteressen (FEHER 2009).

Die Kategorie „Bewusstsein der Ziele und gesteigerter Ehrgeiz“ beinhaltet unter anderem ein Bewusstsein von Werten, Hoffnungen, Träumen und Überzeugungen (KOUZES, POSNER 1995; ANDERSON 1992), eine Aktivierung höherrangiger Bedürfnisse, eine Entwicklung zu höheren Graden von Moral und Motivation (BASS 1985), ein Empfinden, dass die Aktivität bzw. deren Erfolg wichtig ist (BASS 1985), eine verbesserte Entwicklung der Leiter und der Organisation (TICHY, DEVANNA 1986) und die Erfahrung gemeinsamer sozialer Verantwortlichkeit (TICHY, DEVANNA 1986). Die Kategorie „Gleichgewicht zwischen gemeinsamen und Eigeninteressen“ beinhaltet die Entwicklung eines gemeinsamen Wertekanons und gemeinsamer Einstellungen, die Akzeptanz der Gruppenidentität und Philosophie der Organisation (BENNIS, NANUS 1985, 1996), Identifikation mit dem gemeinsamen Anliegen, Verfolgen gemeinsamer Zwecke (YUKL

1998), ein Eingehen auf die Erwartungen, die in den symbolischen Aktionen des Leiters zum Ausdruck kommen (YUKL 1998), Bewusstheit über eigene Interessen (KOUZES, POSNER 1995), aber auch eine Überwindung egoistischer Interessen (BASS 1985), Opferbereitschaft (YUKL 1998), das bewusste Herausstellen von Großzügigkeit (TICHY, DEVANNA 1986) und eine Begrenzung (KOUZES, POSNER 1995), bessere Motivation als erwartet (BASS 1985) und ebenso ein Gleichgewicht zwischen Moral und finanziellem Eigeninteresse (TICHY, DEVANNA 1986).

Allgemein gesprochen, und auch speziell, im Lichte dieser angestrebten Verhaltensänderungen, wird die Theorie oft bemüht, um nach Möglichkeit manipulative Tendenzen zu verbergen. Pseudo-transformationale Führung (AVOLIO, BASS) kann ein Grund dafür sein, dass ein transformationaler Leiter versteckten Zwecken der Organisation bzw. Institution dient und eine Maskierung von Ausbeutungstendenzen bietet. Andere Faktoren des Verbergens manipulativer Tendenzen können von weniger psychologischer als vielmehr organisatorischer und ökonomisch-soziologischer Art sein. Die Gefahren psychologischen und ökonomisch-soziologischen Missbrauchs der Transformationalen Führung sind eine Realität, eine Gefahr, mit der wir uns zu befassen haben. Wir können nicht außer Acht lassen, dass von einem bestimmten Blickwinkel aus TL ein Hebel ist, ein Werkzeugsortiment; und dass für ihren gesellschaftlich zweckmäßigen Gebrauch Verantwortlichkeit und Kontrolle erforderlich sind. Dazu ist zu sagen, dass es tatsächlich ein effektiverer, funktionellerer, ein „authentischer“ (WALUMBWA, WERNING 2013) Gebrauch von TL ist, der theoretisch ein wirksamer Weg sein kann, vor einem Missbrauch ihrer Prinzipien zu schützen. Ein anderer Kritikpunkt im Licht dieser angezielten Verhaltensänderungen betrifft „TL als eine Falle für Moralisten und Utopisten“, die das grundlegende Prinzip der Wechselseitigkeit in menschlichen Beziehungen leugnen. Als Antwort auf diese Kritik kann konstatiert werden, dass Wechselseitigkeit innerhalb der Logik von TL identifizierbar ist, aber auf der Grundlage neuer Tausch-„Währungen“. Diese neue Tauschformel könnte die „Transformierte Transaktion“ genannt werden (FEHER 2010).

Wegen der wesentlichen Natur der Persönlichkeitsveränderungen, die durch TL anvisiert werden, finde ich es vernünftig, unsere Aufmerksamkeit der „Identität“ zuzuwenden, einem Kernphänomen innerhalb des Konzepts der Dynamischen Psychiatrie. In diesem Konzept sind Identität und Entwicklung von Natur aus untrennbar miteinander verbunden, da „Identität, [...] als offenes System [...] nach sozialenergetischem Austausch

zwischen innen und außen strebt und sich dabei ständig weiterentwickelt” (BURBIEL 2008, S. 16). Günter AMMON schrieb: „Identität ist das Bleibende in einer Persönlichkeit und sie ist gleichzeitig nichts Bleibendes. Identität ist ein Prozess, ein fortwährendes Suchen, eine fortwährende Entwicklung.” (G. AMMON 1999, in: BURBIEL 2008, S. 8)

Das dynamisch-psychiatrische Konzept von Identität und Identitätsentwicklung schreibt Gruppen eine zentrale Rolle zu. „Ammon [...] versteht die strukturelle Entwicklung der Persönlichkeit – die er als ganze als 'Identität' bezeichnet – als eingebettet in die Strukturen der umgebenden Gruppe eines Individuums. [...] Der Mensch ist hineingeboren in Gruppen, entwickelt seine Identität in Gruppen und bekommt psychische Energie für seine Entwicklung von der Gruppe [...]” (M. AMMON 2009, S. 32)

Hinsichtlich des organisatorischen Kontexts von Führung und Arbeit bezüglich der psychischen Entwicklung der Beschäftigten müssen wir berücksichtigen, dass die Idee von Identität in den Konzepten Günter AMMONS schon von vornherein auf Arbeit bezogen ist. AMMON gibt an, dass „[...] Arbeit und Aktivität als lebensnotwendig für den Menschen angesehen werden und als charakteristisch für seine allgemeine psychische Struktur” (G. AMMON 1993, S. 136, mit einem speziellen Hinweis auf RUBINSTEIN und LEONTJEW und andere Autoren). Weiter stellt er fest: „Arbeit ist [...] das Zentrum oder der Brennpunkt sozialenergetischer Austauschprozesse.” (ebenda, S. 138) Gruppe, Arbeitsprozess und die individuellen Gruppenmitglieder haben die Funktion, den sozialenergetischen Austausch in [...] synergetischem Aufeinander-Bezogensein zu vermitteln.” (ebenda, S. 146) Was den Leiter betrifft: „[...] die zentrale Person stellt sicher, dass Kreativität, Arbeit und Lernen in der Gruppe möglich sind.” (ebenda, S. 146)

Die Wichtigkeit von Arbeit für die Gruppe und den Einzelnen ist gut vermittelt durch den folgenden Satz: „Eine Gruppe ohne ein Arbeitsprojekt kann keine Gruppe sein, so wie eine Person ohne eine bedeutsame Aufgabe nicht Persönlichkeit und Identität entwickeln kann” (ebenda, S. 138). G. AMMON bietet uns sogar einen speziellen Ansatz an, mit dem Identität in Abhängigkeit von Arbeit definiert wird: „Identität ist die Summe der Identifikationsprozesse im Verlauf der Lebensgeschichte, der Identifikationsprozesse, die durch Arbeitsprojekte veranlasst worden sind” (ebenda, S. 145).

Im Lichte dieser dynamisch-psychiatrischen Grundsätze muss man Arbeitsplätze als wirkliche Schlüsselszenen und Wirkfaktoren der Identität

tätsentwicklung des erwachsenen Menschen denken. Folglich reicht die Wirkung der Arbeitsaktivität, -projekte und -planungen weit über eine bloße Beeinflussung dieser Entwicklung hinaus (ein Grundsatz der TL): Arbeit ist ein Erzeuger, eine Quelle der Formulierung von Identität und ein entscheidender Bestandteil der Identität des Erwachsenen.

Zur Natur dieses komplexen sozialenergetischen Kraftfeldes gehören spezielle Charakteristika. Die Bedingungen für psychische Entwicklung am Arbeitsplatz umfassen normalerweise:

- relativ gut definierte Ziele, Erfolgskriterien und Anforderungen
- eine relativ gute Messbarkeit der erbrachten Leistung: besonders eine hohe Transparenz und Sichtbarkeit der Beiträge sowie Verfügbarkeit von Erfolgskriterien
- daraus folgend eine Verfügbarkeit relativ umfassender, quantifizierbarer und objektiver Rückmeldung an die Mitarbeiter bezüglich ihrer Leistung und ihres Verhaltens
- Verfügbarkeit finanzieller Belohnungen, die unter anderem für das individuelle Überleben und die Selbsteinschätzung von großer Wichtigkeit und im Normalfall mit guter Leistung verknüpft sind.

Auf der Grundlage von Entwicklungskonzepten der Transformationalen Führung und Erkenntnissen der Dynamischen Psychiatrie kann, im Vergleich zu einem herkömmlicheren Verständnis, ein breiterer interpretativer Rahmen für die Entwicklung der Beschäftigten bereitgestellt werden. Ich schlage vor, das herkömmliche, enger gefasste Verständnis als „instrumentellen Ansatz“ zu bezeichnen. Das Ziel des Leiters hierbei ist, bessere Leistung zu erreichen. In diesem Rahmen sieht der Leiter seine Aufgabe darin, „den Beschäftigten zu helfen, ihr Potential voll auszuschöpfen“ (ebenda). Methodisch könnte man diesen Ansatz „erzieherisch“ nennen. Die Mittel zur Entwicklung der Beschäftigten schließen auf den Einzelnen bezogene, auf Aufgaben bezogene und Gruppen-Interventionen ein, wie Training, Rückmeldung über Fähigkeiten, Arbeitsplatzänderungen, Arbeitserleichterungen, Schulung der Sozialkompetenz und andere.

Der breitere interpretative Rahmen kann als „Ansatz, der sich an der menschlichen Entwicklung orientiert“ bezeichnet werden. Das Ziel des Leiters hierbei ist es, einen gemeinsamen Wert zu schaffen, der sich aus der menschlichen Entwicklung ergibt. Der mögliche gemeinsame Wert ist weiter gefasst als bessere Leistung, d. h., er schließt weitere wirtschaftliche, psychologische und soziale Vorteile mit ein, die sich aus der

Entwicklung des Beschäftigten, des Vorgesetzten und auch der Gruppe ergeben. In diesem Rahmen bedeutet das Selbstverständnis des Leiters, „dass er ein von Natur aus psychologischer Bestandteil und Auslöser des 'vollen Potentials' der Mitarbeiter und Gruppen" ist. Methodisch könnte diese Herangehensweise „auf zwischenmenschliches Verhalten bezogen" genannt werden. Die Mittel zur Personalentwicklung schließen auf den Einzelnen bezogene, Aufgaben-bezogene und Gruppen-Interventionen ein wie beim „instrumentellen Ansatz". Der Hauptunterschied liegt aber im Tiefegrad und der Integriertheit dieser Lösungen, z. B. Coaching der Lebensführung, Entwicklung der Arbeitsumgebung, Individual- und Gruppeninterventionen unter einer weiterreichenden organisatorischen Entwicklungsperspektive.

Schließlich würde ich gerne noch die Verantwortlichkeit der Führungskräfte gegenüber der persönlichen Entwicklung ihrer Mitarbeiter in Bezug auf den oben dargestellten Rahmen ansprechen. In der zuvor aufgezeigten breiteren Interpretation von Personalentwicklung sehen wir, dass die zwischenmenschliche, soziale und ethische Verantwortung der Führungskraft für die Entwicklung und Aneignung eines gemeinsamen Wertekanons der Mitarbeiter ebenfalls als umfassender angesehen werden kann. (Es sollte beachtet werden, dass der Begriff „Verantwortung" in diesem Zusammenhang in einem interpretativen und nicht in einem normativen Sinn gebraucht werden sollte.) Eine Möglichkeit, die umfassendere Verantwortung der Führungskraft zu definieren, kann sein, das Paradigma der Gemeinsamen Sozialen Verantwortung (Corporate Social Responsibility; CSR) als eine Analogie dafür herzunehmen. Die Verbindung zwischen Konzepten der Mitarbeiterentwicklung durch Vorgesetzte und der Theorie der Gemeinsamen Sozialen Verantwortung kann die wirklich einzigartige und so in hohem Maße unersetzliche Rolle des Leiters bei der Förderung des Lernens und persönlichen Wachstums seiner Mitarbeiter in ihren Teams sein (FEHER 2009).

(Übersetzung von Erwin Leßner, München)

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The Image of Home as a Personal Resource for Adolescents with Mental Disorders

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The article addresses the issue of personal resources in adolescents with mental disorders. It claims that addressing the objective of their psychological rehabilitation necessitates the use of the concept of psychological resilience. The theory and practice of resilience is based primarily on studying a person's resources rather than his or her deficiencies. Study of personal resources of adolescents with mental disorders presents certain challenges. The author makes a case for the application of an innovative diagnostic tool – the „Home of My Dreams” creative art therapy technique and a five-line poem, the cinquain. The study results demonstrate that for all of the adolescent subjects the image of home is resource-related. The author concludes that application of these techniques may be useful for identifying psychological resources in adolescents with mental disabilities.

Keywords: psychological rehabilitation, psychological resilience, personal resources, adolescents with mental disorders, projective techniques, cinquain

Addressing issues of psychological rehabilitation is closely related to the concept of psychological resilience. The theory and practice of resilience is based on study of a person's positive traits and resources rather than deficiencies or pathologies. M. UNGAR, head of an international project that studied resilience in adolescents (see www.resilienceproject.org), defines resilience as an individual's ability to manage his or her own health resources and use the family, society and culture for this purpose in a socially acceptable way.

This ability is not inborn but is developed in individuals throughout the lifespan [10]. Whether a child possesses supportive psychological resources becomes critical in an adverse real-life situation.

A mental illness is a very severe burden for a person at any age. For an adolescent who has embarked on a complex, obstacle-filled path to adulthood, this burden is exponentially heavier. Deteriorated relationships with the parents and close social circle, hospitalization, drug therapy – all of these uproot the teenager from the very soil that is supposed to be his supportive foundation and robs him of the ability to tap into the familiar supportive environment for coping resources.

A counselor's help has a lot to do with identifying or creating internal psychological resources in his patients. A question arises as to how to deliver this help in case of a mental illness. In order to test the diagnostic tools and assess mentally ill adolescents' willingness to be involved in creative activity, we undertook a pilot study as part of O. ZELIKINA's college coursework completed under our guidance.

The study involved two groups of test subjects. The first group was comprised of adolescents with a variety of mental disorders who were undergoing treatment at a children's inpatient intensive mental care unit. The mental disorders diagnosed in this group included worried depression, depression with a psychopathy-like disorder, chronic brain disorder, psychopathy-like syndrome, schizophrenia, and epilepsy. The second group was comprised of adolescents of the same age without mental disorders being raised in a family and attending regular school. A total of 14 persons participated in the study.

Proceeding from the premise that various concepts of resilience emphasize active involvement as a powerful enabler, we asked the adolescents to complete a creative assignment [9]. The assignment involved creating a scaled model of a home using a provided paper cutout and some other materials (aluminum foil, yarn, construction clay, etc.) on the basis of the *Home of My Dreams*, an art therapy technique developed by M. G. DREZNINA [2].

The image of home as a content for the teenagers' creative assignment was chosen on the basis of its apparent relevance to resources and anticipated value to the test subjects. The concept of „home” in a person's mind may connote many meanings and is always emotionally colored [3, 6, 7]. We assumed that the polysemanticism of this image (i.e., „home” meaning protection, the heart of a family, a micromodel of the universe, and a projection of one's intimate personal space) would allow each subject to seek out his or her own connotation of „home” and express it in his or her craft item. Our assumption proved to be correct: when we asked the teenagers to dream up their future home, all of them without exception showed interest in discussing the topic.

Further, we asked the study participants to write a cinquain. This five-line poem is used in pedagogical settings as a tool for clarifying the content of various concepts [4]. Writing a cinquain is a form of free creativity. This creativity requires a person to be able to identify the most essential elements of the content, analyze them, draw conclusions, and review the

results on the basis of an analysis. Our study is the first to propose the use of a cinquain as a psychological diagnostic tool. The results obtained using these tools appear to be interesting.

Writing a cinquain using the key word „home/house”, the teenagers used the following vocabulary:

- Beautiful, nice, sweet, cozy, comfortable, warm, kind, my father's, my, new, big, brick, nine-story.
- It keeps you warm, protects, people live in it, it contains people, it makes one feel warm, people eat and drink in it.
- A warm feeling, home means a lot to me, without a home, people would have died long ago.
- Place of residence, „home sweet home”, homesickness („I want to go home!”), it feels good, warm, positive, I can get by without my own [home].

We identified several significant themes in the adolescents' comments made during their work on their home models.

1. Who is in charge at home:

- I am the boss at home and I call the shots on everything.
- My brother will be in charge of running the household but the house will belong to me.
- I am the homeowner, I live with my family without my parents, and there are three persons living in the house: me, my wife and our child.
- I live there alone, I am the owner. All rooms belong to be.
- I am the homeowner, there are four residents: me, my wife and two children.
- I am the homeowner, I live alone, there is barely enough space for myself there.
- A country/suburban house. My wife lives in the city and sometimes comes to visit.
- The homeowner is my girlfriend. I make decisions on property matters.

2. I love my home:

- Home means love, joy, happiness, a retreat. It is a „planet of happiness”. It must be a fun place and have light-colored wallpaper.
- I love my home.
- My home is welcoming. It is not boring.
- Most families are not very close, their homes do not appear welcoming – my family will be close and my home will be welcoming.

- What are you thinking about when you look at your home? – About freedom.
- I like it.

3. My home is my fortress:

- The door has six locks, bolts, three latches, two security systems.
- There is no door. That is, there is a door, but no evildoer can get in or get out. We can get out or get back in, but others can't get in – think about it. And this is our surveillance camera. It is hidden.
- The house is secured with a lock, the fence is high, and there is a security alarm and entry phone system. The fence is impenetrable.
- The house is protected by a security alarm system.
- The door has a lock.

4. Who else lives in the house?

- All of my family live in the house, but I am in charge – this is how I dream it. There are no pets – they are too messy.
- A lot of people will live in my house – my family, my girlfriend, my friends, two Caucasian Shepherd dogs, a Rottweiler, a male and a female cat, two parakeets, and a turtle.
- As a pet, I will have a Dachshund, a she.
- I will have two Yorkshire Terriers – they are so sweet.
- A wolfhound and a cat live in the house.
- I have a big dog.
- I do not have any pets so I don't have to worry about taking care of them.

5. Visitors:

- Only my close people and friends come to visit.
- Visitors will be my parents and neighbors.
- My guests will be my friends, parents and close acquaintances.
- Anybody can come visit.
- The guests are my friends, sometimes my parents.
- The visitors are: my mom, grandma, maybe friends.
- No one comes to visit me. I will go visit others.

Discussion of Results

At the beginning of the study, we made the following assumptions:

1. A desirable image of home reflects significant traits and psychological issues of an adolescent.

2. A token embodiment of a desirable image of home should help identify and understand an individual's values and needs.
3. An image of home is a psychological resource we can rely on when working with adolescents.

These assumptions proved to be correct.

Application of the *Home of My Dreams* technique helped to gain, in a non-intrusive and indirect manner, a number of holistic insights about the adolescents' personality traits, needs and values, reveal their perception of themselves and the immediate community, and identify their visions of the future.

A lexical semantic analysis of the cinquains and the comments made by the subjects while making a model home give grounds to conclude that for virtually all of the adolescents the image of home is resource-related – i. e., it is warm, protective and beautiful. It is important to note that one of the needs revealed most vividly was the need to be a „master” of the house. In our opinion, this speaks to the presence of a critical psychological resource – a desire to have a subject position. The need to be a „master” or „boss” is linked to frustration experienced by all adolescents and particularly by adolescents with a mental illness [8, 5, 11]. Work on psychological adjustment of such adolescents should include designing accessible activities that would allow them to take up a subject position.

Also, we will stress that a majority of the adolescents revealed warm feelings toward their parents – they wish to see them as guests or even live with them together in the same house. The adolescents' willingness to keep in touch with their families represents an essential psychological resource, which we should rely on in our rehabilitation efforts.

M. DEWULF, in his article on psychological rehabilitation of persons with mental disabilities [1], points out that a person typically spends more time on activities that he or she enjoys. These efforts result in useful outcomes and various positive reinforcements. It is noteworthy that the teenagers participating in the study, despite their objectively severe condition, spent from 40 minutes to two hours on building their model home. This outcome indirectly suggests that the creative activity to make a symbolic representation of their dream home captivated them and gave them positive emotions, and therefore was therapeutic.

A comparative analysis of the results obtained for the two adolescent groups shows that the issues of interpersonal communications and social adaptation in „benchmark adolescents” do not differ significantly from the

results of the patients of the mental care unit. For both groups, this issue is central, which is consistent with the expectations for adolescence and suggests that development of teenagers with mental disorders generally follows universal age-specific trends.

An obvious difference was revealed in the fact that the healthy teenagers actively explored the space representing the area around the house. They spent a significant amount of time and attached greater significance to it compared with their peers from the main group, who virtually ignored the space around their „house“.

The study results confirmed the usefulness of an art therapy technique based on creating a visual representation of a home as a tool for indirect identification of psychological resources in adolescents with mental disabilities. In addition, it was demonstrated that it was possible in principle to use the cinquain technique for the same purpose.

The psychological resources identified by the study constitute factors of psychological resilience and can serve as benchmarks for further rehabilitation work.

Zusammenfassung

Die Lösung der Fragen zur psychologischen Rehabilitation ist eng verbunden mit dem Problem der psychischen Stabilität. Die psychische Stabilität versteht sich als Fähigkeit des Menschen, seine eigenen Ressourcen und die Ressourcen der Familie, der Gesellschaft und der Kultur zu nutzen (M. UNGAR). Die psychischen Ressourcen des Kindes besitzen eine enorme Bedeutung in schwierigen Lebenssituationen, zum Beispiel bei Krankheit. Um die persönlichen Ressourcen von Jugendlichen mit psychischen Erkrankungen zu erforschen, wurde eine Untersuchung durchgeführt, an der zwei Versuchsgruppen teilnahmen. Die erste Gruppe bestand aus Jugendlichen mit verschiedenen psychischen Störungen, die sich zur Behandlung in der Akutstation der psychiatrischen Kinderklinik befanden. Die psychischen Störungen waren: Angstdepressionssyndrom, Depression mit psychopathologieähnlichen Störungen, psychoorganisches Syndrom, psychopathologieähnliches Syndrom, Schizophrenie, Epilepsie. Die zweite Gruppe bestand aus Jugendlichen gleichen Alters ohne psychische Erkrankungen, die in ihrer Familie erzogen wurden und eine normale Schule besuchten.

Den Jugendlichen wurde eine schöpferische Aufgabe vorgeschlagen:

die Herstellung eines Hausmodells aus vorbereitetem Papier unter Verwendung zusätzlicher Materialien (Folie, Schnur, Plastilin usw.). Ebenfalls wurde das Verfassen eines „cinquain“ als Instrument der psychologischen Diagnostik eingeführt. Dieser Fünfzeiler wird in der Pädagogik verwendet mit dem Ziel, einen Begriffsinhalt zu präzisieren.

Die Analyse der Lexik und Semantik der von den Versuchspersonen erstellten Fünfzeiler und der Kommentare während der Herstellung des Hausmodells zeigt, dass praktisch bei allen Jugendlichen das Bild vom Haus als Ressource erscheint – warm, schützend und schön. Es ist wichtig anzumerken, dass es eines der am deutlichsten auftretenden Bedürfnisse war, „Herr“ des Hauses zu sein. Unserer Meinung nach zeugt das vom Vorhandensein der wichtigsten psychologischen Ressource, dem Streben, eine subjektive Position einzunehmen. Außerdem muss man betonen, dass die meisten Jugendlichen herzliche Gefühle zu ihren Eltern zeigten, sie möchten sie als Gäste sehen oder sogar mit ihnen in einem Haus wohnen. Erstaunlicherweise verbrachten die jugendlichen Untersuchungsteilnehmer, trotz ihrer schweren Erkrankungen, mit der Herstellung des Hausmodells 40 Minuten bis zwei Stunden. Dieses Resultat zeigte indirekt, dass die schöpferische Arbeit beim Erschaffen einer symbolischen Repräsentation des Hauses ihrer Träume die Jugendlichen begeisterte, ihnen positive Gefühle vermittelte und damit therapeutisch war.

Eine Vergleichsanalyse der Ergebnisse aus den zwei Gruppen Jugendlicher zeigte, dass die Probleme der zwischenmenschlichen Kommunikation und der sozialen Adaption „normaler Jugendlicher“ sich nicht in Vielem von denen der Patienten aus der Psychiatrie unterscheiden. Auch die Entwicklung von psychisch kranken Jugendlichen verläuft in den Bahnen allgemeiner Gesetzmäßigkeiten des Alters. Ein deutlicher Unterschied zeigte sich darin, dass die gesunden Jugendlichen aktiv den Raum einnahmen, der das Grundstück neben dem Haus symbolisierte. Sie widmeten diesem eine beträchtliche Zeit und maßen ihm mehr Bedeutung bei als die psychisch kranken Altersgenossen, die praktisch nicht den ihr Haus umgebenden Raum gestalteten.

Die Resultate bestätigten die Zweckdienlichkeit unserer Methode: die bildhafte symbolische Repräsentation eines Hauses als diagnostisches Instrument einer indirekten Manifestierung der psychologischen Ressourcen von Jugendlichen mit psychischen Erkrankungen. Auch die Verwendung des „cinquain“ eignet sich in diesem Sinne für die psychologische Diagnostik.

Die ermittelten psychologischen Ressourcen dienen als Faktor der psy-

chologischen Stabilität und als Stützpunkte für die weitere Rehabilitationsarbeit. In der Arbeit über die psychologische Rehabilitation von Jugendlichen mit psychischen Erkrankungen ist es notwendig, zugängliche Tätigkeitsformen zu entwickeln, die ihnen die Möglichkeit geben, eine subjektive Position einzunehmen. Als wichtigste psychologische Ressource, auf die man sich in der Rehabilitationsarbeit stützen sollte, dient die Bereitschaft der Jugendlichen, mit ihrem familiären Umfeld in Kontakt zu treten.

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Schizoid and Borderline Personalities: Can two walk together except they are agreed?

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We propose a theoretical framework for an understanding of schizoid and borderline personalities. This framework is grounded in an attachment approach. We hypothesize that both diagnostic entities, albeit phenomenologically different, emanate from a common developmental source, which is a disruption in attachment, and the different ways those people manage it. Both personalities under discussion use split as a leading mechanism that aims at coping with frustrations that come from insufficient, inadequate attachment in critical phases of early childhood. While the schizoid personality internalizes his or her needs and materializes a phantasmized fulfillment of them, the borderline personality externalizes his or her drama, and is characterized by a seemingly endless efforts to materialize his or her needs in the external world.

Keywords: schizoid, borderline, attachment, psychodynamics, diagnosis

In this article we would like to introduce the notion that schizoid and borderline personality disorders emanate from a common underlying structure. While this idea does have some precursors in professional literature, it apparently diverges from daily common sense, as well as from formal psychiatric formulations.

Daily perception of schizoid people views them as introverted, lonely, and emotionally suppressed, in addition to their other associated traits and characteristics, like indifference to praise or criticism, lack of interest or ability for social and intimate relationships, and so on. Borderline people, on the other hand, are perceived as extroverted, emotionally stormy, with variety of superficial relations, as well as having diffused identity, impulsivity, acting out, self destructiveness, and a lot of aggression. The DSM5, representing the up-to-date psychiatric nomenclature (American Psychiatric Association, 2014) counts schizoid personality in the Cluster A (the ‘weirdos’) personalities, together with paranoid and schizotypal personalities, while borderline personality is grouped together with the antisocial, histrionic, and narcissistic personalities in the Cluster B, the ‘emotional’ personalities. Continuing for a while with the DSM definitions, it describes the essential feature of the schizoid personality as a

pervasive pattern of detachment from social relationships and a restricted expression of emotions in interpersonal settings. The DSM goes on to portray the schizoids as lacking desire for intimacy, seemingly indifferent to opportunities to develop close relationships, and not deriving much satisfaction from belonging to social groups. As concerning the borderlines, the DSM describes their essential feature as a pervasive pattern of instability in most domains of life, including interpersonal relationships, self-image, and affects. Worth mentioning, the DSM marks as the first criterion for diagnosis of borderlines ‘frantic efforts to avoid real or imagined abandonment’.

The Psychodynamic approach to psychiatric diagnoses (PDM, 2006) relates to borderline as a ‘megastructure’, a personality organization which transects all personality pathologies. Borderline, according to the PDM, is characterized as having difficulties in relations, in capacity for emotional intimacy, problems with work, mood swings and anxiety, and destructive behaviour toward self or others. Schizoid people gain the diagnosis of personality disorder, in which they are described as „highly sensitive and reactive to interpersonal stimulation, to which they tend to respond with defensive withdrawal ... they easily feel in danger of being engulfed, enmeshed, controlled, intruded upon, and traumatized, dangers that they associate with becoming involved with other people“.

So far it seems we are having two personalities who lie in the extremities of the personalities scale. And indeed, some authors, e. g. Theodore MILLON (MILLON 1984, 2004), had related to them as such, claiming they have no overlap among them.

However, some other authors thought differently. But let us first make a very quick survey of the history of the birth of these two concepts. The term schizoid is thought to be offered by Eugen BLEULER (BLEULER 1908), the famous inventor of the term schizophrenia – and the similarity of the two terms is not incidental, since BLEULER had seen them as points on a continuum, resemble in their predisposition to inner, surreptitious life, and occasionally glitch to distorted modes of thinking. The relation of schizoid personality to schizophrenia is not unequivocally clear to date, however in our opinion schizoid personality is not commonly a prodromal to an onset of schizophrenia, but is rather a distinct personality type stands for its own, and characterizes the person from his or her early adulthood, as the DSM formulates.

Borderline personality had entered the psychiatric dictionary later, in

1938 (STERN 1938) as a desperate trial – as we see it – to term hard-to-treat patients. In a vicissitude of fate, frustrated therapists had described a class of patients characterized by their intolerance to frustration ... Since the commencement of this term as a nosological entity, there had been accumulated an incredibly vast amount of literature about this term – a phenomenon that indicates, in our opinion, the uncertainty of the professional community when relates to this term. Put it shortly and straightforwardly, we are having grave difficulty to comprehend what borderline personality really is.

And not that we did not try. Reviewing the history of the concept of borderline is much beyond what we are able to do in this lecture (see for example chap. 4.2 in NEZNANOV and WIED, 2008), so we will very briefly summarize some of the leading theories about borderline:

One approach sees the borderline as a distinct psychiatric entity, which putatively has biological origins. This approach fits best the formal psychiatric position, as articulated in the DSM (see for example HERPERTZ et al 2007, HUGHES et al 2012).

A psycho-analytic structural approach, best described by O. F. KERNBERG, sees the borderline as a personality organization, characterized by so-called primitive defenses, and consolidated around a failing in proper internalization of object relations (see, among many other references, KERNBERG 1970). A variation of the psychoanalytical approach is G. AMMON's Humanstructorological theory which conceptualizes the borderline syndrome as a disturbance in the development of identity, combined with deficiencies in narcissism, aggression, ego regulation (which is manifested in difficulty in frustration tolerance, a well-known phenomenon of borderline patients), and also deficits in efficiency, thinking, and sexuality (AMMON 1998). While idiosyncrasies in sexuality may be considered as a frequent characteristic of borderlines, thought distortions are not; with this addition, AMMON's view makes the borderline a bit closer to the schizoid and schizotypal personalities.

Another approach views borderline as an affective disorder – a chronic pattern of mood instability (see for example AKISKAL 2004).

Still another approach sees the borderline as the sequel of a complex and prolonged trauma in crucial developmental phases in childhood (HERMAN 1992).

The self-psychology school of thought tends to view the borderline in terms of developmental emotional deprivation, rather than a continuous

struggle with a conflict around aggression, as may be inferred from a Kleinian point of view (ADLER 1981).

A related, inter-subjective approach views the borderline not per se but as contextual, mostly a manifestation of frustration emanates from lack of empathy in meaningful relations (BRANDCHAFT & STOLOROW 1984).

A neuro-developmental approach views borderline as a disturbance (most likely innate) in the capacity for emotional self-regulation (SCHORE 1994, HUGHES et al. 2012)

Finally, we may mention an attachment related approach (one which is close to our approach, as we will portray below) which perceives borderline as a disturbance in early attachment. This disturbance is thought to create maladaptive bonding patterns which accompany the patient for most of his or her life, and is expressed in the habitual ways the patient handles his or her adaptation to his or her human surrounding (FONAGY 2000).

One may easily see that those approaches do not necessarily contradict or exclude each other, and there may be some overlap or complementarity among them. Allan SCHORE's 'socioemotional' theory, for example, is a 'neuro-psychoanalytic' theory, and combines a hypothesized brain innate hypersensitivity to a failure in caregiver's approval. GOLDSTEIN (1996) tries to combine the structural to the self-psychology approaches, showing that borderline can be viewed as both suffering from a developmental deprivation as well as from essential conflicts.

Relying on those theories some models of treatment have been developed. Treatment, albeit important, is not in the focus of our present lecture, although the relation between a theoretical understanding of a phenomenon and its treatment is more or less self-evident. KERNBERG's structural, object relation theory of borderline, had yielded to a Transference Focused Therapy (TFP) (YEOMANS et al. 2002). G. AMMON's Dynamic Psychiatry approach led to a variety of therapeutic tools (see discussion in chap. 7 in NEZNANOW and WIED 2008). An abstraction that puts the difficulty in mentalization as the core problem of the borderline, derived from attachment theory, had yielded to the development of Mentalization Based Treatment (MBT, BATEMAN and FONAGY 2006). Dialectical-Behavioral Treatment (DBT, LINEHAN 1993), although developed from non psychodynamic thinking, seems to rely on socioemotional view, where a hypothesized biological congenital sensitivity is presumed to gain not enough validation from caregiver environment. Jeffrey YOUNG'S Schema-Focus-Therapy (YOUNG

et al. 2006) is another therapeutic approach which had been derived from the cognitive school of thought; however it hypothesizes that borderline pathology originates from so-called 'toxic childhood experiences', a term relates mainly to attachment failures.

Back to the schizoid. In spite of its seniority it did not gain a list of abbreviated therapeutic models. One cannot avoid being impressed that schizoids are not as sexy as the borderlines – well, indeed, schizoid people with their flattened affect and emotional detachment are less touching when compared to the emotional, charming, and stormy borderline. However along the years some momentous literature had been accumulated. The main insight we may gain from this literature is that the problem of schizoids is not that they do not need interpersonal relations. On the contrary – they do gravely need! Their tragedy is that they are afraid of such relations. They are often highly vulnerable, which may lead to the hypothesis that a traumatic hurt is an essential part of the aetiology of the schizoids (KOHUT 1971, L'ABBOTT 2005). But we will come to aetiology soon.

The core of being schizoid is the superiority of the inner world over the external one (KHAN 1960). It should be emphasized, though, that this superiority of the inner world is not identical to reality misjudgment. In fact, we believe that schizoids only rarely loose their reality testing. On the contrary, schizoids typically develop an external mantling showing an almost complete normality, as Helen DEUTSCH (1942) wrote, which might bring to mind her concept of 'as if personality' or WINNICOTT's 'false self' (WINNICOTT 1965). Schizoids invest much in an adaptation to their surrounding, an adaptation they need – one may say – in order to 'take them (other people) off their back' and to enable them (the schizoids) to preserve their inner world intact.

When hypothesizing the developmental origin of the aetiology of the schizoid personality one may find a surprising resemblance to that allocated to the borderline. Most authors in the field, amongst are Wilhelm REICH (1933), Silvano ARIETI (1955), Melanie KLEIN (1975), W. R. D. FAIRBAIRN (1952) and his disciple Harry GUNTRIP (1969), Masud KHAN (1960) and Salman AKHTAR (1987) – to mention only a few – agree (with minor variations in formulation) that schizoidity is likely to origin from emotionally unsatisfying relationship with the parents, mainly the mother, in crucial, early phases in the toddler development. The child-to-be schizoid soon learns to split from his or her unbearable external world, and to build an inner world of fantasies. As Thomas OGDEN (1989) formulated it, „the schi-

zoid patient mostly withdraws from object relations with external whole objects toward an inner world consists of conscious and unconscious relations with internal objects“. Since this inner world is almost always more satisfying than the external one, it regains stability over maturation.

Now, when we group together the little we have gathered so far, we may propose the common underlying mechanism – or dynamism, as H. S. SULLIVAN might have called it – which unites the borderline and the schizoid. *This is a disruption in attachment*. This notion could be traced in some existing literature. KERNBERG (1970) perceived the schizoid as the underdeveloped level of the borderline personality organization. Both GRINKER (1968) and PLAKUM (1985) thought the two diagnoses are essentially in proximity. KERNBERG (2004) suggested that both the schizoid and the borderline represent the ‘pure’ personality disorders, organized around a single fixation from the separation phase of development, and both use splitting as the main mechanism of defense.

Our theory goes as follows: The little child lives in a parental environment which is not good enough for his or her emotional needs. This environment is insensitive, invalidating, not empathic and not containing (or holding, depending on the theoretician you favour). As a consequence, the child splits his or her inner life from the external, unbearable reality. Splitting means that the actual ties take place only with parts of the object, not with its whole. By objects here we mean all constituents of the individual’s world one is to perceive, introject, and relate: significant others, self, abstractions, ideas, interests, joys and sorrows. The child soon learns to relate to them only partially, preserving within him or herself some intact, phantasized version of them. The relations which take place in the real world, though, are only parts, fractions, or shadows of the real objects. The relations thereby created represent a maladaptive style of attachment, which means that the ways the individual developed for the task of connecting to objects in the world are not as efficient as should have been providing harm to the primary attachment would not have taken place.

Now we will add one more theoretical constituent to our thinking. Beside the well-known attachment styles – anxious, avoidant, ambivalent or disorganized – which may determine the ways of relating a person would execute when grows up we would like to bring up here Sydney BLATT’s concept (see, among many BLATT’s publications, BLATT 2008) about two personality configurations, which he called ‘anaclitic’ and ‘introjective’. The first is centered around interpersonal (or object) relations, the second

is centered around issues of self-definition. When relating to the schizoid and the borderline we hypothesize that they oscillate on the axis that lies between these two configurations. That means that each individual can be situated on a certain point on the anaclitic – introjective axis, or the person itself may oscillate, in times, depending on inner rhythm or external circumstances, on that scale. People may be diagnosed in formal psychiatric or psychodynamic terminology as schizoids or borderlines, but in essence the core of their personality dynamics may be formulated differently: It may be rooted in striving for relations, leaving behind the consolidation of their identity, or the other way around, namely, it may neglect the development of the inter-personal skills for the sake of a more firm and reassured self. Alternatively, the individual may defend against difficulties in interpersonal relations by sticking to a rigid or stiff identity consolidation, or another individual (or probably the same one in different circumstances or other phase in life) defends against a sense of loose psychological skeleton by investing in hasty relations. The richness of variations seems to be obvious.

Worth mentioning here that the psychodynamic diagnostics system (PDM, 2006) perceives the schizoid as laying „firmly” at the introjective pole, namely, engaged with self-definition rather than with relations.

We argue here that the nature of the personality configuration one develops largely depends on the nature of the environment one has in one's early childhood, the one which contributes to the ways the child copes with the developmental obstacles the child encounters. The nature of interpersonal environment the child possesses, interacting with the child's constitutional attributes, influences the attachment patterns the child develops. A child may be cathected to his or her self-definition, to the molding of his or her identity, on the account of developing adaptive interpersonal relations. On the other way around, such a child may invest in interpersonal relations, striving to acquire affiliation, recognition, appraisal and so forth, at the expense of developing a solid self-identity. And when tackling the task of fulfilling his or her object relation needs – namely, creating meaningfully satisfying interpersonal relations – one's patterns may be situated on the continuum which moves from a withdrawn and avoided to superficial and chaotic nature of relations. The individual may internalize one's needs or may externalize them. The one we call schizoid puts *inward* his or her drama of life, the one we call borderline puts his or her drama of life *outside*, in the interface between oneself and one's surrounding. The schi-

zoid creates a hypothetically rich, complex, vivid and emotional matrix of figures, all *within* his or her soul, invisible to outer observers, hereby protected against invasion, intrusion, or hurt. The one we call borderline copes with similar task – creating a satisfying interpersonal environment. Since he or she does not know how to make it, his or her interactions are often chaotic, impulsive, hastily constructed and deconstructed. He or she experiences a lot of rapidly alternating expectations and yearnings, disappointments and disavowals. He or she is often frustrated, and acts out his or her frustrations, in ways which we perceive as aggressive and call them ‘acting out’. He or she fights over gaining success in relations, very often in vain, and reacts to failures with rage. Inside him or herself he or she is afraid of being abandoned, being rejected, being alone. *And here he meets the schizoid!* The schizoid is *already* alone. He defends him or herself from this distasteful vicissitudes by withdrawing from the very external interactions the borderline fights over. The schizoid does not fear abandonment – he ‘runs forward’ toward it. While the borderline fights over achieving some fulfillment of human object drives, the schizoid achieves them in his or her phantasy life. While the borderline is frustrated for real failures, the schizoid restrains from them.

We can now offer some comprehension of clinically observed phenomena. The schizoid suffices him or herself, while the borderline, lacking this aptitude of self-sufficiency, experiences emptiness. When tackles frustrations in meeting real world the schizoid withdraws or dissociates, while the borderline becomes depressed or destructive. We claim that all those behaviours, while differ phenomenologically, emanate from one common source – the desperate efforts to create and retain satisfying meaningful relationships; to fulfill the need of object relations.

The Concept of Personality

The DSM (American Psychiatric Association, 2014) relates to personality disorders as „enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.” The emphasis on endurance and constancy is not to be missed. However, it was not always like that: the notion of personality disorders is not as self-evident as one might assume. FREUD had not dealt with personality typology, since his

conceptualizations were concerned with mental dynamics – the ego deals with the reality requirements, the id demands, and the superego dictates. The concept of personality (or character, as it was named from the outset), has emerged as an attempt to propose a psychodynamic typology of stable patterns of human behaviours. However, attributing a particular personality to an individual implicitly puts aside one's context, one's environment. We propose that the concept of personality and personality disorder should be more dynamic, interactive, and contextual. Personality by its nature is not necessarily firm and consistent, but also fluid and changeable. We meet the personality on the background of certain relations (often inside the therapeutic relations), and it might be different when met within other relations (JORDAN 2004). STONE (1993) thought that the term personality related to the aggregate of modes in which we relate to our human environment. Accordingly, accomplishments and failures are to be perceived as outcomes of relations, not necessarily of inner stable constructs. Those relations may consequently be experienced as benevolent, containing, constructive, and alternatively as not empathic, not containing, neglectful or abusive. Such relations may nurture the personality or pathologies it. According to BLATT (2008) the two axes in which the personality operate and is typified along life – the anaclytic and the introjective – are mutually and reciprocally interacting, defending and compensating for each other, thereby creating variable contingencies. L'ABOTE (2005) claimed that personality and psychopathology should not be conceived as intra-personal process but rather as inter-personal, carried out especially in intimate milieu. L'ABOTE proposed, therefore, to change the common term of 'personality development' to the term 'personality socialization'. The subject of this approach is not merely the mind nor the behaviour, but rather the relations. BRANDCHAFT and STOLOROW (1984), mentioned above, even suggest that borderline may be an iatrogenic diagnosis, generated within therapeutic relations which are not empathic enough to suite the patient's susceptible needs. Borderlines, therefore, is not an independent pathology but an inter-subjective phenomenon.

Diagnoses are often ways of labeling phenomena rather than understanding them. Present day nosology tends to rely mainly on observable patterns of behaviours. It does not take into account, at least not to a sufficient degree, in our opinion, the underlying mechanisms that create those behaviours. Also, it does not always consider the interpersonal and situational context in which those behaviours take place. Our explanation as set down

above tries to explain observable behaviours, traits and habitual patterns, in terms of attachment patterns which hypothetically derived from relevant developmental environments.

Due to limitation of our scope we have not got through other factors we sense to be relevant, such as the ways borderlines and schizoids respond to psychological and psychiatric treatment, and the transference-countertransference matrix. Probably worth mentioning that not all schizoid people are the same, as well as not all borderlines. Patients in real world do not really distribute according to diagnostic systems. We propose that when one takes a close and profound look at the phenomena under investigation one reveals that these personalities – namely, the schizoid and the borderline – are not divided to ‘eccentric’ versus ‘emotional’; what is really there – we suggest – is their divergent ways of coping with the intricacies they meet in their shared need for engagement with human touch.

Zusammenfassung

Der phänomenologische Ansatz betrachtet die schizoide und die Borderlinepersönlichkeit als dezidiert unterschiedlich, aufgrund ihrer Züge und Verhaltensweisen sogar als Gegensatzpaar. Mit unserer Arbeit wollen wir demgegenüber eine andere Sichtweise auf diese beiden Persönlichkeitstypen anbieten.

Unserer Fragestellung liegen verschiedene theoretische Überlegungen zugrunde. Zum Ersten die psychoanalytischen Objektbeziehungstheorien, insbesondere der Ansatz von O. F. KERNBERG. Er stellt die Art und Weise, wie Menschen ihre Beziehungen gestalten, in den Fokus und beschreibt darüber, wie sich Persönlichkeiten und bestimmte Pathologien einordnen lassen. Zum Zweiten beziehen wir uns auf die Überlegungen von W. R. D. FAIRBAIRNS zum zentralen Abwehrmechanismus der Spaltung, mit dem beide Persönlichkeitstypen die Herausforderungen der Beziehungsgestaltung zu meistern versuchen. Zum Dritten legen wir die Sichtweise der Bindungstheorien zugrunde. Demnach bilden die primären Beziehungserfahrungen mit den versorgenden Bezugspersonen die „Prototypen“, nach deren Muster ein Leben lang die zwischenmenschlichen Beziehungen gestaltet werden. Viertens beziehen wir uns auf die Persönlichkeitstheorie von S. BLATT. Er beschreibt Persönlichkeiten anhand zweier Hauptmerkmale, der anaklitischen und der introjektiven Dimension. Die anaklitische bezieht sich auf die Beziehungen, die introjektive auf die Selbstdefinition des Menschen.

Unter dem Blickwinkel dieser theoretischen Ansätze haben wir unsere klinischen Erfahrungen betrachtet und sie unserem Verständnis der Dynamiken unserer Patienten zugrunde gelegt. Aufgrund detaillierter Fallbeschreibungen konnten wir damit die Komplexität der Diagnostik und des Verständnisses von schizoiden und Borderlinepatienten gut darstellen (GIL, VILINKY, IOFAN, BAREL, unveröffentlicht). Es zeigte sich, dass Menschen mit offensichtlichen Borderlinestörungen auch schizoide Merkmale und Züge haben können, sowie umgekehrt schizoide Persönlichkeiten durchaus Züge und Verhaltensweisen zeigen können, die man eigentlich der Borderlinestörung zuordnet.

Letztlich erwies sich, dass die herkömmliche phänomenologische Unterscheidung zwischen beiden Störungsbildern nicht optimal ist. Die typologische Unterscheidung der beiden Störungsbilder, wie sie sich in den Diagnosesystemen, z. B. dem DSM findet, beruht auf beobachtbarem Verhalten, gibt aber damit nicht unbedingt Aufschluss über die grundlegende Essenz der Diagnose und zieht auch nicht unbedingt sinnvolle Trennungslinien zwischen beiden Störungsbildern.

Wir gehen demgegenüber davon aus, dass beide Persönlichkeitstypen (und wahrscheinlich auch andere Persönlichkeitsstörungen, die wir jedoch nicht untersucht haben) verschiedene Manifestationen dessen sind, wie Menschen mit einem strukturellen Defizit – vermutlich entstanden in der Interaktion mit den primären Bezugspersonen in der frühen Kindheit – versuchen, zwischenmenschliche Beziehungen zu gestalten und zu bewältigen. Auf welche Weise und in welchem Ausmaß frühe Bindungserfahrungen schädigen können, ist verschieden und wir gehen davon aus, dass dies jeweils andere Wege bedingt, wie das Kind und später der Erwachsene seine interpersonellen Bedürfnisse im Hinblick auf Andere zu gestalten versucht. Menschen versuchen dieses existenzielle Problem auf verschiedene Arten zu lösen.

Für die Bedürfnisse nach bedeutsamen Beziehungen sehen wir dabei zwei Hauptwege: Man kann diese Bedürfnisse, ihre Erfüllung und ihre Frustration eher internalisieren oder aber externalisieren. Wir haben versucht zu zeigen, wie mit dieser Betrachtungsweise die klinischen Bilder der schizoiden und der Borderlinepersönlichkeit erklärt werden können.

Man sollte deswegen die anderen Aspekte dieser Persönlichkeitstypen nicht vernachlässigen, ein umfassenderes Diagnosesystem von Borderline- und schizoider Persönlichkeit steht noch aus. Trotz des bedeutsamen Unterschieds in der Beziehungsgestaltung sollte man diese Persönlich-

keiten nicht ausschließlich anhand dieses Kriteriums beschreiben. Gleich bedeutsam sind möglicherweise angeborene Qualitäten, Temperament, Ich-Stärke und -Schwäche, emotionale Regulationsfähigkeit und Impulskontrolle.

So gibt es z. B. Forschungsansätze, die sich darum bemühen, biologisch ätiologische Faktoren für die Borderlinepersönlichkeit zu finden, bezüglich der Störung in den kognitiven Bereichen der Aufmerksamkeit, unmittelbarem und verzögerten Erinnern, ausgehend von der Überlegung, dass die bei Borderlinestörungen beobachtbaren neuropsychologischen Beeinträchtigungen mit Dysfunktionen im Frontal- und Temporallappen (SERES et al. 2009) oder auch anderen neuro-kognitiven Funktionen in Verbindung gebracht werden können (RUOCCO 2005, MILLER 2007).

Persönlichkeitsstörungen im Allgemeinen und Borderlinestörungen im Besonderen sind sehr komplexe Phänomene, die nicht anhand der Ausprägung eines einzigen Faktors beschrieben werden können.

Während einige Autoren Zweifel bezüglich der Borderlinediagnose haben (BRANDCHAFT & Stolorow 1984), schlagen andere vor, sie im Kontext interpersonaler und beziehungstheoretischer Ansätze zu beleuchten (JORDAN 2004). Wir hoffen, dass wir einen Beitrag zu einer solchen neuen Sichtweise dieser Persönlichkeiten und ihrer Entstehungsgrundlage geleistet haben.

(Deutsche Zusammenfassung von Stefanie Zödl)

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Some methodological problems of the reliable assessment of the changes in the therapy

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Methodology of the research on psychotherapy effectiveness does not take into consideration the inhomogeneity of the treated groups and forms of treatment. Psychotherapy applied to treat illnesses is not differentiated from helping mostly healthy people in their problems. Conclusions concerning psychotherapy effectiveness based on the methodology of meta-analyses are far from reality. Also different efforts of monitoring psychotherapy process do not provide convincing knowledge how psychotherapy works. Research of the changes occurring during the psychotherapy sessions are difficult due to the fact that the state of mind provoked by therapist interventions and consecutive behavior are mostly short-term phenomena. Perhaps the changes of symptoms during the session could be the best way to access the individuals' modifications of the state of mind provoked by psychotherapy settings.

Keywords: methodology, inadequacy, psychotherapy, effectiveness, changes, monitoring

The evaluation of the effectiveness of psychotherapy – of the changes evoked by it, which correct distortions of psychic processes and functioning – appears to be surprisingly difficult. Both the evaluation of the effectiveness of each particular modality as well as comparison of their usefulness do not provide unambiguous results. Some studies bring about optimistic statements on substantial effectiveness of various – almost all – varieties of psychotherapy (BOGELS 2014, COOPER 2008, HUHNS 2014, LEICHSENRING 2005). Another indicate that each of them is useful in some area of psychopathology – „what to whom“ (ROTH 1996). However, many of the research show doubtful curative impact of the therapy itself, underlying mainly the role of the formation of therapeutic relationship (TSCHUSCHKE 2014). The latest concept deflates psychotherapy to activation of nonspecific therapeutic factors – support, reassurance, mobilization and so on – which leads to relative growth of a well-being, but not necessarily to real cure.

The results of the studies on the effects of the same kind of therapy in similar groups of patients are often contradictory. This is extremely con-

fusing for researchers as well as for practitioners. Neither the thesis of the equal value of all the modalities, nor that of their particular usefulness in various disorders, is generally recognized by psychotherapist and insurance companies. Practically, only the conviction of greater effectiveness of combination of psychotherapy and pharmacotherapy is commonly accepted by therapists.

The divergence of the results seems to be a consequence of the limitations of such research methodology, which assumes the formation of groups of patients with the same diagnosis and the assessment of the impact of homogenous treatment based on statistical procedures. Such methodology derived from the *evidence-based medicine* is also not fully adequate. It would be justified only if the groups formed on the basis of diagnostic categories were truly homogeneous in terms of the etiopathogenesis of disorders.

First of all, in case of mental disorders the task of creating such groups seems impossible to be fulfilled. Contemporarily, despite of frequent modifications, the system of their classification is not sufficiently adequate to the clinical reality, and, as a consequence, the groups of patients constructed up to the category of the diagnosed disorder are not truly homogenous. It seems that the methodology justified in case of many types of somatic disorders cannot be applied in mental disorders. This distorts the results of studies on the effectiveness of both pharmacotherapy and psychotherapy.

Secondly, in contrast to pharmacotherapy, in which homogenous effect of a given substance can be assumed, the therapeutic influence of psychotherapy, even though relating to clearly defined theoretical assumptions and highly structured manuals, is not always the same. In every therapeutic center and by each therapist they are slightly differently understood and implemented. Moreover, they are modified due to the individual specifics of the patient and his/her disorder. Another, not less important factors, making the psychotherapies only seemingly similar, are connected with the person of therapist. He/she acts in the process of therapy depending on his/her personality traits, mainly cognitive patterns, as well as emotional attitudes, on his/her experiences which affect the formation of a therapeutic relationship, current fatigue and so on (COOPER 2008, TSCHUSCHKE 2014).

So, in the assessment of psychotherapy effectiveness we must face the task similar to equation with two unknowns. Neither groups of patients with an identical diagnosis based on the type of symptoms are actually homogeneous in terms of the type of disorder, nor any type of psychotherapy

is every time implemented in the same way, even if strict rigors of actions arising from the theory are assumed.

Moreover, psychotherapy is applied in various areas with different goals. Treatment of disorders being of mainly psychogenetic etiopathology is only one of them – and the only one in which the rules of EBM can be adequately applied. Helping people with various psychological needs – in this suffering from different inconveniences connected with the illness or with conditions of their treatment – requires different approach, resulting from the aims' differences. Nowadays perhaps the most frequent is the perspective of applying „psychotherapy” for helping healthy persons, who search the stimulation of their personal growth, better communication with others, success in their interpersonal and professional life and other aims. Psychotherapeutic methods are used here as educational, counseling or coaching tools. It is evidently inadequate to try to assess the effectiveness of psychotherapy in general – or of just one of the psychotherapeutic modalities – without considering such different aims. This causes additional chaos in ideas about psychotherapy and its effects. So, the crucial step for appropriate methodology of the research in this field is to differentiate psychotherapy as the way of treatment from different forms of helping people.

Studies of psychotherapy effectiveness based on measurements taken before and after the treatment (immediate or follow-up) generally are looking for statistically significant changes in the analyzed parameters (typically – the reduction of the number and severity of symptoms). Such changes – despite different effect sizes – occur only in some part of the studied population. Usually, a statistically significant difference between the percentage of groups who manifest such changes, and the percentage found in the control groups (generally 20-40 %!) is considered as an evidence of treatment efficacy.

Such consideration is, as a matter of fact, unjustified. Statistical significance of the some difference is only a guideline of reason for further research and it is not, *per se*, the scientifically proved answer for the question concerning psychotherapy effectiveness.

Considering the fact that the studied populations are usually limited to several dozen, convictions concerning the effectiveness of therapy most often refer to the meta-analyzes, the subject of which are publications reporting the results of studies conducted in accordance with the applicable standards. Apparently, it creates the chance for more reliable conclusions

based on larger groups of patients. This procedure, however, has a very limited value, mainly due to the differences in the practical application of the DSM or ICD classifications and of the diagnostic methods, as well as in ways of implementing theoretical assumptions of psychotherapy.

Moreover, the limitations of the meta-analyses conclusions are deepened by the necessity for the artificial unification of the categories of the degree of change applied in particular studies. The need to unify the variety of results categories leads to faulty conclusions, such as in the famous work of Eysenck (Eysenck 1952). So, the use of meta-analyses, in fact, reduces the reliability of the conclusions instead of increasing them. Another shortcoming of meta-analyses is the fact that their subjects are publications and not directly obtained material allowing to draw conclusions. This is why the results of meta-analyses should not be treated as a really reliable source of knowledge.

There are more such doubtful concepts in the methodology of the process of drawing conclusions. One of them is considering the results of two „independent“ and methodologically correct studies as a criterion of scientific confirmation of the therapy effectiveness. Only two publications presenting similar results are definitely too little. Moreover, it is hard to believe that some studies of effectiveness could be really independent from the even unconscious presumptions and opinions of the researchers (as well as of their milieu) concerning the investigated theory or modality, and other factors like wishful thinking of researchers.

That is why we can only harbour optimistic conviction that „generally psychotherapy works“ and support it with various, sometimes questionable argumentation used for supporting the psychotherapies and therapists survival in the social system and the market.

But the question „Does and how psychotherapy work?“ is still open in spite of numerous and various attempts aiming at finding the answer. In the past decades, perhaps the strongest expectations were connected with the studies monitoring the course of treatment. They are looking for the answer to the question whether the interventions used by the psychotherapists lead to measurable changes in the patients/clients experiencing and, if yes, what circumstances determine the scope and direction of these changes. The essence of such research is monitoring the patient's reaction being the response to psychotherapy setting and to the therapist behaviour during the session.

Here also a severe methodological problems arise, making the results of

those researches very doubtful. Monitoring of the changes in patient's experiencing *in situ*, during a therapy session, is very difficult. In the everyday practice, it is usually limited to tracking changes in mood and behaviour, based on the patients' introspection and/or the therapists' feelings and observations. Information obtained in this way, due to its subjective nature, has a very limited value and making decisions about the next steps in the therapy on the basis of it often leads to errors.

Evidently, examining the direct reaction to the therapeutic interventions would be the best information of the therapy process. But mental state, which is a reaction to the stimulus generated during the therapy session usually lasts for a short period of time – rather several seconds than minutes. Generally it remains intrapsychic phenomenon, mostly unrealized, sometimes unconscious, which can only be speculated on the basis of external manifestations. Rarely it is clearly expressed in observable, verbal and non-verbal behaviours of the patient. What is more, opportunities to observe the manifestations of these experiences are limited by the difficulties in focusing the attention, therapist's emotions, cognitive schemes imposed by the psychotherapy theories, etc. This also evokes many other methodological obstacles. First of all, defining what should primarily be the subject of observation is not so easy to consider. Secondly, the therapist being involved in interactions with patients does not have the necessary free hand and distance, moreover he/she is limited by the scope of his theoretical presumptions.

The most common solutions seem to be observation of interaction in the session (direct or – more frequently – indirect), using registration of important events by independent professionals. Such information received from observers could be useful as well for research purposes as for amelioration of the particular therapy. However, this is difficult and also methodologically doubtful. The comments of the persons observing the session (e. g. of the psychotherapy group) are frequently disturbed by the tension resulting from the requirement of neutrality and passiveness, by the competition with therapist and other factors. Moreover, their observations are inevitably distorted by the selection of the observed phenomena, conditioned by the theoretical background of the observer. Therapists are prisoners of cognitive schemes imposed by the psychotherapy theories, which inevitably limit the field of observation and dooms to make mistakes. On the other hand, being experienced in certain form of therapy seems to be useful in knowing what we should pay attention to – for instance, an

observer who is not a psychoanalyst rather will not see the signs of transference.

The most valuable information on the presence of important changes in psychic processes under the influence of the psychotherapy seems to be the occurrence or sudden withdrawal of disturbances of functioning (symptoms) during the session. The appearance or disappearance of tension, anxiety, intrusive thoughts or somatic dysfunction are usually reported by patients or can be observed by the therapist. It provides indirect information about the content of mind, which express themselves by these symptoms – emotions, memories, the experienced conflict, etc. Detecting these episodes is of great importance for the understanding of the current mental state of the patient and, consequently, the assessment of the direction of changes.

In spite of all limitations, it seems that the only way to really monitor the course of psychotherapy is a direct observation of verbal and non-verbal behaviour of the patient during the session. The patients' response to psychotherapist's interventions, especially mentioned above the immediate changes of symptoms informing on the current state of disturbances in the psyche, could be the way to access the (beneficial or not) changes in individuals' state of the mind provoked by psychotherapy settings. It is difficult, however, to objectify these observations. One of the possibilities seems to be using e.g. the symptom or personality questionnaires, but they should not be used during the session, due to the inevitable break of interaction.

In spite of this, the common practice of monitoring the course of therapy is based on the use these tools *ex post* after the session or even once a few days. This is treated as a way to answer the questions about the progress of the therapy. It must be, however, taken into account that monitoring of changes occurring in the course of therapy should be based on the same tools as in the course of the diagnostic process, which is extremely time consuming. In addition, too frequent use of them, e.g. every few days, poses a threat of „learning“ and/or automatic repetition of answers on questionnaire items. Last but not least, the feedback resulting from such procedures cannot be used by the therapist during the session, which makes its usefulness for the practice limited.

An additional difficulty in the reliable monitoring of therapeutic process by using such methods is a lack of tools that record the areas important in terms of the type of disorder. What is more, it is difficult to have certainty

which of the numerous aspects and areas of experiencing are actually related to the essence of these disorders. Different areas seem to be important in case of neurotic disorders and different seem to be important in case of affective disorders, substance abuse, etc. The answer to this doubts is a task of psychopathology rather than psychotherapy.

Nowadays new opportunities of measuring the impact of psychotherapy on the state of patients mind seem to be: measuring functional changes observed in neuroimaging (ABBASS 2014), the analysis of hormonal changes and so on (DAMSA 2014, LE 2014). Obviously, this creates new methodological and technical problems. For instance, it is difficult to imagine the use of neuroimaging as a method of monitoring the patient's response during psychotherapy. So, we are rather pessimist for the future evolution of the reliable way of the research aiming at explanation of the psychotherapy influence on the person.

Thus, at the moment it seems possible only to describe the difficulties and shortcomings of the research methodology, designed to prove the effectiveness of psychotherapy. Being aware of the complexity of this task can both facilitate the use of available methods and avoidance of unjustified conclusions resulting from the limitations of the methodology.

Zusammenfassung

Die Untersuchungsmethodik bezüglich der Wirksamkeit von Psychotherapie berücksichtigt nicht die Inhomogenität der behandelten Gruppen und Formen der Behandlung. Es wird nicht unterschieden zwischen psychotherapeutischer Behandlung von Krankheiten und Hilfe bei der Lösung der Probleme weitestgehend gesunder Menschen. Rückschlüsse bezüglich der Psychotherapiewirksamkeit, die sich auf die Methodik von Meta-Analysen stützen, sind realitätsfern. Ebenso führen verschiedene Bemühungen, den Psychotherapieprozess zu kontrollieren, nicht zu überzeugenden Erkenntnissen darüber, wie Psychotherapie funktioniert. Die Erforschung der Veränderungen, die während der Psychotherapiesitzungen auftreten, ist schwierig, da es sich bei der Stimmung, die der Therapeut durch seine Intervention provoziert, und das darauf folgende Verhalten größtenteils um kurzfristige Phänomene handelt. Vielleicht könnten die Entwicklungen der Symptome während der Sitzung der beste Weg sein, um auf die Änderung der Gemütslage der Einzelnen zuzugreifen, die durch die psychotherapeutischen Szenarien hervorgerufen wird.

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Faith and Healing: An Another Approach to Healing

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Attempt is made to understand 'what is faith' and the 'relationship between faith and healing' by looking primarily into the Indian traditional thought. Faith is considered 'intuitive trust' whose context has often been spiritualism. It is contended that faith is where physics and metaphysics meet and interlink and only 'unshakable faith' works. Bahkti yoga is touched upon as an illustrative case for explicating the highest form of faith and how it works. The process of faith healing is addressed by highlighting the 'internal' and 'external sources' that are likely to facilitate the healing process. Accordingly, at one instance, the self's healing energy is 'liberated' initiating the healing process by the efforts of the health seeker. At the second instance, an outer source (the 'healer') acting as the medium of the sacred, initiates the healing process. The role of the 'subconscious mind' is briefly touched upon for suggesting that fortified 'faith in one self' makes it possible for the subconscious mind to work on what is desired and sought.

Keywords: Faith, Faith and healing, Bhakti Yoga, Spiritual healing, Auto-suggestion, Chi

*Faith is knowledge within the heart, beyond the reach of proof.
Faith is an oasis in the heart which will never be reached by the
caravan of thinking. (Khalil Gibran)*

Coming from a country where people are likely to have invincible 'faith' in some deity, or divine power, religious rituals, faith healers and even 'mantras' and prayers, the author proposes to address to a basic question namely 'what is faith?' Further the interest extends to the question, 'if faith heals how does it facilitate the healing process?' Drugs, medicine doctors, surgeons or medical science in general are very important for health and healing concerns but for a poor country where the presence of professionals is far less than the desirable numbers, it may be argued that the role of faith and faith healers needs to be critically evaluated and examined as a viable multiple approach for healing negative affective states, and addressing to the health and healing issues in general. However, the ultimate aim is to understand whether faith has a role in the therapeutic process, and whether having faith in divine powers create favourable conditions for initiating the self healing processes conducive for beating negativity that might be blocking the healing process on the one hand, and strengthening the health reinstating psychological functions on the other.

A Personal Note on the Chosen Topic

Innumerable people all around the world are believers in some power and have faith which has worked for them as an alternative method for healing the mind, body and the psyche.

At the same time the problem of a social scientist might not be the topic as much but the prerogative of the scientific world which wants evidence to show that faith heals and if it does how? It is understood that the tradition of scientific enquiry demands an apt methodology which can deal with, and empirically verify a phenomenon. However, the premise of faith and faith healing is unfathomable and enigmatic according to these standards and therefore, when a social scientist talks about 'faith' and the process behind 'faith healing' the subject becomes extremely challenging. What is personally most disturbing thing for the author herself is the question: 'Does she believe that faith can heal and does she has faith in faith?' With this dilemma she has decided to 'let her self go' and look at the chosen topic primarily with the mood of awe and fascination of a curious student but 'not let go' the sincerity in her effort for learning, sharing and 'enjoying' the process of this exercise as it develops.

The Plan for Dealing with the Subject

- Attempt would be made to understand 'what is faith' by searching for its meaning and connotations primarily in the Indian traditional and philosophical texts and as explained by some Indian thinkers, and experts of the subject.
- Bahkti yoga will be touched upon as an example of the highest form of faith.
- Effort would also be made to figure out 'whether faith has potentials for healing and pacifying the believer's body and psyche'?
- Attempt would be made to understand the process of faith healing and examine the internal and external sources that facilitate the healing process of the faith holder.
- Finally, it would be of interest to bring forth the likely connection between faith and healing and very briefly touch upon the phenomenon of autosuggestion.

1. What is Faith?

Beginning with an interesting news item seems to be a good way of initiating the discussion on the topic. An item published in a very popular Patna Daily had the news title: ISRO (Indian Space Research Organization) Chief seeks divine help. The news read as follows: „Some 1000 scientists have been checking every parameter at the spaceport from where PSLV-C25 will lift at 2.38 pm on Tuesday carrying the Mars orbiter and rocket science sought to co-opt spiritualism. Carrying on with the tradition followed by his predecessor G. MADHAVAN NAIR, ISRO CHIEF K. RADHAKRISHNAN offered puja at the Tirupati Venkateshwar temple, 100 km from launch pad, with miniature replicas of the rocket and the Mars orbiter spacecraft.” (Times of India, Patna, November, 5, 2013, p.1)

Apparently people's faith (i. e., confidence or trust) could be as common place as in a person or a thing, or it could be in some, unseen authority/energy/deity, invisible scared Divinity, God or cosmic power. On the other hand, one could have faith in some strong political view point or in the doctrines or teachings of a religion. In religion, faith often involves accepting claims about the character of a sacred deity, nature, or the universe.

Faith and Belief

Trust however is a common element in both 'faith' and 'belief'. Nevertheless, 'faith' is envisioned as more of experiential 'intuitive trust' in Nature or Divinity which is different than 'ideological trust' in a religious dogma or a secular idea. Mark TWAIN presents an articulate idea of 'belief' as he observes that, in religion and politics people's beliefs and convictions are in almost every case gotten at second-hand, and without examination, from authorities who have not examined the questions themselves but have taken them at second-hand from other non-examiners. On the other hand, faith appears to be „a knowledge within the heart, beyond the reach of proof” (Kahlil GIBRAN). It has been mentioned that trust is a common element in both 'belief' and 'faith' but it's meaning shall depend on the intention of the person using the word, and the context of such use.

It may be said that faith transcends or goes beyond reason and belief and is 'open to the unknown'. On the other hand, 'belief', creates an assumption of 'knowing' and follows ideas from the past which may or may not support a faith. The crux of the matter appears to be that 'faith' is intuitive trust or confidence especially in the miraculous unknown and for some

perhaps also in life. Furthermore, the context of 'faith' has often been spiritualism. A lucid definition of faith comes from the Hebrews verse (11.1) which says, 'Faith is the assurance of things hoped for, the conviction of things not seen'. The Book of Mormon prophet Alma compared faith to a seed (32:21). It is said that if a seed is planted and nourished and if it, is a good seed it will grow and eventually bear fruit (ALMA 32:28-43). It seems that faith is more than a theoretical belief in the inherent powers of the object of one's faith. Apparently, to have faith is to trust and to have confidence and not loose hope. Faith also includes the willingness to act and therefore it is a principle of action and power. While one may argue that faith is opposed to reason, proponents of faith contend that the proper domain of faith concerns questions which cannot be settled by evidence.

Faith in the Indian Traditional Thought

Under the Indian traditional thinking the question of faith and what faith does to heal the mind and the body, can be understood by bringing in the 'Soul' in the picture. Soul has been addressed as the Higher Self or 'Psychic' by Sri AUROBINDO and the Mother, one of the finest spiritual saints of India. It is generally understood that 'Soul' is an element of the Divine which exists in the material being without ever leaving the Divine, and goes back to it without ceasing to manifest. In sum, in the 'Soul' the individual and the Divine are eternally one; therefore, to identify with one's 'Soul' is to unite with the Divine (The Mother, in: *The Psychic Being*, 1989).

According to the Mother says that „faith is the movement of the soul whose knowledge is spontaneous and direct and even if the whole world denies and brings forth a thousand proofs to the contrary, still it knows by inner knowledge, a direct perception that can stand against everything, a perception by identity” (p. 43). Accordingly, faith in its very nature is, „unshakable” otherwise it is not faith at all. In that sense faith has to be integral and immovable and with half-belief the matter is spoilt. Therefore, the state of complete faith or „faith consciousness” has no scope for any argument.

Mother categorically says that the true inner soul's faith is always sincere, but if there is insincerity in the exterior being and the goal of the seeker is personal power and not spiritual life, then he/she is misled (the same argument works for linking faith with healing). In other words, when

the faith holder doubts and is insincere towards what he/she is looking for (i. e., spiritual life in one case and healing in the other), he/she is not benefitted or helped. It may be understood that faith may get diluted in the low movements and it is then that one is mislead and feels betrayed. The Mother wants to emphasize that the fault lies not in the faith but the faith holder who doesn't remain in the same relentless state of „faith consciousness” and therefore feels being let down.

Deepak CHOPRA now world acclaimed USA based Indian origin spiritual guru who was trained as a medical doctor, thinks that in our drugs-and-surgery society, we don't take enough advantage of non-material approaches. According to his own view 'faith is a small part of the enormous field of consciousness' and faith is to be in tune and aware of the great consciousness. CHOPRA who is also well versed in different religious and philosophical traditions refers to Jesus who defined faith as the key to miracles and to the kingdom of God. It is noteworthy that this implies that faith creates transformation and allows a person to transcend physical boundaries and step into the unknown therefore, faith is where physics and metaphysics meet and interlink and cannot be treated as a „new age nonsense”.

CHOPRA argues that at the minimum faith induces subjective well-being with about as much reliability as pharmaceuticals, minus damaging side effects. However, for the present purpose the highly connotation loaded expression of 'faith' is being examined as a means for coming in contact with the Self's Divine powers which may be utilized for healing the mind and the body and attaining overall wellbeing. Apparently, people who have faith in some God/deity, cosmic power or sacred energy, function through a special cognitive mode and are often able to experience subjective wellbeing.

Bhakti Yoga the Highest form of Faith

FADIMAN and FRAGER (1994) note that it is easier for most people to love God personified in human form than to love abstract spirit or consciousness. „The practice of devotional Yoga is closer to the traditional religion than any other form of Yoga” (p. 519). Followers of Bhakti yoga use deep devotion to focus the mind and transform the personality. The bhakta or devotee is a spiritual seeker whose emotional life undergoes a gradual transformation as he/she begins to reside more and more in a state of pure

and unconditional love of, and for the Divine (VARMA, under publication). At the manifest level a bhakta engages him/herself in chanting, performing devotional activities (puja) and doing certain ritualistic practices. The manifest part however is in complete consonance with the bhakta's thoughts, feelings and behavior and is an expression of love and yearning for the chosen deity or the ista.

It is most striking that a true bhakta fully places down his/her total existence to the ista in the gesture of complete surrender as he/she chooses the cover and security of the ista over any other form of security. It is this unprecedented total trust and unshakable faith in the ista that makes a bhakta fully convinced of being cared, protected, not let down, and healed when there is a need. Moreover, with the gesture of surrender the bhakta has already made the shift to go beyond his/her worldly self and personality as his/her move is not a superficial act but a step taken after the realization that there is singularity hidden behind the mask of the deity's personality and therefore, is very vital for discovering one's true Self in the deity. The bhakta may choose to pray and worship and through such practices strive to connect her/himself with the Universal/source of power which is represented in the form of some deity. In fact, each deity in Indian philosophy, represents the Universal Consciousness, and the unchanging reality that is veiled by the world. Therefore, the practice of worship has a serious meaning and like any other spiritual practice it becomes the means for liberating or awakening the mind pacifying and overall healing powers of the inner self. This is more or less also the process of faith healing where the Self feels totally convinced that it would be able to heal itself by connecting to its prime source of power or the larger field of Cosmic Consciousness.

Another interpretation would be that the Bhakti Yoga cultivates a spiritual orientation in the devotee who accepts his/her present situation 'as it is' or 'as given' without experiencing self pity, anger, complaint or grievance. This is an exceptional mental state as there is no mood for resisting the present situation nor feelings of anguish and giving up. The bhakta seems to be living in the spirit of total acceptance of his/her situation because this acceptance comes as a natural consequence of his/her strong conviction that what happens has a reason to be, and cannot be wrong in the larger context. Such profound balance of mind is possible when the Self is connected to its source of strength and power or with the one in whom it has its faith. From a psychological point of view this orientation

speaks of a mental state which is in full command of itself and therefore is able to experience the highest level of wellbeing.

It may be highlighted that Bhakti Yoga is not about 'giving up effort and waiting lamely for things to happen as one has surrendered to one's ista'. In its true sense Bhakti Yoga is a very positive concept which is not about favouring passivity but is about living the wisdom that one is only the 'means' for 'things that happen' and thus 'uncertainty' (i.e., what may come) is no reason for fear. A bhakta's mental status exemplifies a high state of subjective well being (a) as there is no fear or apprehension for eventualities and (b) the bhakta's total faith in the ista has set the stage for a trusting relationship to work well. One will not fail to see an ideal therapeutic situation in this scenario recommended for a desirable relationship between the bhakta and the ista or the therapist and the client.

Interestingly, one finds some semblance between the bhakta and the 'believer' in the Lord in the explication of relationship between faith and healing. The Old Testament asserts that a person has to believe and submit completely to the divine powers in order to be cured from the illness. It is explained that when a person invests in faith in the Lord they are also investing faith in themselves on a subconscious level. Therefore, the self's healing process is based on the assurance that an undisclosed divinity is present and this boosts the confidence level of the faith holder. In sum, the objective of faith is not to get well first and then believe that God has heard prayer. But it is a steadfast confidence that God is at work and that he will do what he has promised.

An attempt to put together 'what is faith' leads to the following:

1. The very nature of faith is that it is 'unshakable' other wise it is not faith. In other words, faith is 'relentless trust' of the faith holder in whom he/she trusts without any chance, doubt or question. The faith holder's confidence is absolute and there is no apprehension that something else might happen other than what is expected.
2. Faith and belief can be distinguished. Unlike 'belief' which is mental, (i.e., rational or intellectual) 'faith' is transcendental because it is the 'movement of the soul' whose knowledge is direct and unprompted and based on inner comprehension. It may be said that faith is „a direct perception, a perception by identity that can stand against everything" (The Psychic Being, 1898, p. 43). Faith follows 'intuition'

and the 'way', it follows the 'self' and the 'heart' and is open to the 'Unknown'.

3. The faith holder places his/her total existence under the safe guards of an intuitively chosen entirely different 'field of consciousness' which helps him/her transcends the physical boundaries and step into the unknown. The transformation is thus known as the 'elevation of the spiritual planet' of the faith holder. With faith comes the extraordinary sense of being 'connected' with the source of all power, the Cosmic Consciousness and freedom from all kinds of insecurity, fear and apprehension.
4. Having progressed towards the spiritual planet, faith becomes the miraculous power of the faith holder. However, only the state of integrated faith consciousness can make miracles happen. For miracles to happen the soul's knowledge (insights, perception, experiences) has to be brought to the mental (reasoning), vital and physical planes together. Perhaps this is the kind of faith that saints, sages and spiritual healers, even some Chaplains hold when they are said to be creating miracles in healing.

The Indian Scenario for Faith Healing

Talking of India and faith healing, the foremost fact is that Indian people have relentless faith not only in their countless Gods and deities but also in the people supposedly having the 'powers to heal' the mind, body and the spirit. In this country faith healing is often an alternative to psychiatric treatment (RAGURAM et al. 2002) and the centers for healing are scattered all over India that include, temple of a Hindu deity or a Dargah, (i. e., a shrine built over the grave of a Sufi Muslim saint), majars, and places where local deities are placed and worshiped. It is to be seen to be believed that these places have not lost their relevance even today and people from all backgrounds, caste, creed, community and educational levels throng them continuously. It may be mentioned that Hinduism welcomes worshiping deities from all the spiritual paths and it is common for Hindus to appeal to Muslim rituals within the Dargah in addition to their own traditional temples primarily in time of illness. KAKAR (1982) remarks that in India, the brotherhood of sickness may be far more inclusive than the brotherhood of health.

DE LOOZE (2011) observes that temples and Dargahs sometimes colla-

borate with mental health institutions, but delineating where mental health diagnoses overlap with their descriptions in the temples and Dargahs presents a challenge. In contrast to the medical psychiatric diagnoses, mental health diagnoses in places of faith healing include, spirit possession, black magic, or evil spells and the faith healers include Shamans, gurus, tantrics, ojhas and priest, etc. Often the faith healers have mastered the art of dealing with a variety of social and personal problems (KAKAR 1982). How the faith healers are able to help the sufferer shall be revisited when we are trying to understand the process of faith healing.

2. Whether Faith has Potentials for Healing

While asking the question ‘whether faith has the potential to heal’ one is likely to think of the sources that possibly facilitate and help in commencing the faith healing process and therefore, would like to address them. It may be said that faith healing utilizes two kinds of resources for making the healing process work. At one instance the self’s healing energy is made to liberate and the health seeker herself becomes the instrument for initiating the healing process. In the second instance the ‘healer acts as the medium of a Divinity or the sacred’ for reinstating the wellbeing of the health seeker.

For example, prayer has been an integral part of the mind pacifying spiritual practices not only in India but in all religions and cultures and also a means for getting in touch with one’s own inner source of power. It has been said that „Prayer is the cry of the soul” and the act of praying has the power to bring transformation” (Sri Sri RAVISHANKAR 2014). Those who practice prayer have pointed out that it happens at the subtle level of feelings and feelings transcend words, and religion.

Yoga and meditation are some other practices, having similar goals. Meditation and Yoga are complementary and often inseparable practices as they work at various fronts for reaching a common goal. Accordingly, Yoga is the practice for bringing together the force and vitality of the mind, body and soul in perfect union, therefore, striving to reach the state where self’s energies converge, and become the source for a person’s total well being. Yoga works on fronts like regulating the rhythm of the breath (cosmic current, or prana) and adopting conducive body postures (which helps the prana to flow in the desired manner). At the same time, meditation, most importantly focuses on the thought process, observing the

thoughts come and go by without resisting them. The practice continues till the disturbing clatter of the innumerable thoughts and their tributaries fade out naturally, losing their existence and vitality and finally leaving the mind peaceful and quite. In this sense meditation works on the ‘inner self’, training it for transcending the outer distractions and becoming quiet and focused to its positive core. There are numerous examples of spiritually realized Indian yogis and saints who have gone through the mind pacifying process of meditation and ultimately experiencing holistic wellbeing.

Dwelling further at a subtle level, one may bring forth the concept of ‘Chi’ for understanding the self’s healing energy and its liberation. The word Chi has many translations, such as energy, air, breath, wind, vital breath, vital essence, cosmic current prana and so forth. Chi is the most basic and general principle of Taoist thought and its status in the Chinese philosophy is developed in the popular works of LAO TZU (604-511 BCE) and CHUANG TZU (399-295 BCE) though its origin goes back much further. Although difficult to define, Chi can be envisioned as the ‘activating energy of the universe’ (an obvious reminder of the presence of the Divine element or the fraction of the Cosmic Consciousness in all human beings). Chi’ is considered the source of all movement in the universe, including the pattern of our thoughts and emotions that occur because of ‘Chi’. ‘Chi’ is source of our life force and the animating (conscious) factor in all living beings and that is why when the human body loses its breath of life (i.e., the original energy or life force) the body decomposes.

‘Chi’ condenses and disperses in alternating cycles of negative and positive (yin and yang) energy, materializing in different ways, forms, and shapes. It is so that all states of existence (including sickness) especially those of physical matter, are therefore, temporary manifestations of ‘Chi’. In the practice of Tao, self healing involves the mind/eye/heart power to take more Chi and transform it to heal ourselves. This doesn’t mean using the mind or imagination alone. The body and the mind is trained to use our own ‘Chi’, nature’s Chi, and Earth’s forces to provide healing energy. These energies can be drawn in and circulated through the Microcosmic Orbit, they can also be drawn in through other anatomical structures like bone marrow (CHIA 2008, p. 29).

To recapitulate, in the first case, the element of the Divine energy present in the physical being is liberated for healing the troubled. The self’s liberating energy is extraordinary because it represents the ‘larger Cosmic

force', 'Chi' or the 'Divine fire' in the physical being whose release elevates the status of the self. Here the word 'Cosmic' shouldn't be taken as a decorative expression but as the uncharted powers of the worldly being who is nothing but 'pure Consciousness' in its most fundamental form, a constituent element of the 'Cosmic Consciousness' present in the human body. Once liberated this energy pacifies the mind, comforts the body and makes it possible for the self to experience wellbeing. The practices for liberating the self's own Divine fire could be meditation, Yoga, prayer and worshiping deities depending upon which practice suits and convinces the practitioner.

Healing Process Set by the Faith Healers / Centers of Healing

The other type of healing process is set off by the faith healer who uses some traditional healing method and acts as the medium who evokes the 'powers of the sacred' to work in favour of the help seeker (DALAL 2007). It is noteworthy that often the faith healers or the 'center of healing' (i.e., temple, majar or, shrine, etc.) has an impressive history and had acquired the status of a scared place with powers to heal. It will be useful to examine the 'healer as Diviner' for understanding the healing process set off by the faith healer.

DALAL (2007) presents an excellent account of the folk healing tradition in India as an alternative approach to healing and informs how 'faith' facilitates healing especially where the healer uses scared therapies. DALAL quotes KAKAR (1982) who explains the role of the sacred in the healing practices. Accordingly „the whole weight of community's religion, myths and history enters sacred therapy as the therapist proceeds to mobilize strong psychic energies inside and out side the patient ...”(p. 5) It is added that often this history has its origin in some myth or chance miracles which is supposed to be a consistent phenomenon and is respectfully seeped into the local folk stories. Similarly, it is not uncommon to find that there are rituals associated with the folklores that are followed with zeal. Apparently, the sacredness of the healing practices is reinforced by the stories and legends associated with the healer or the healing centre and the 'authority and aura' of a healer is carefully cultivated through the stories of miraculous healing. Moreover, the priests, swamis, fakir and tantrics maintain the sacredness of the centers so that these become attractive enough to draw people from all walks of life and religious communities.

KAKAR (1982) an authority on the subject visited a number of shrines and healers, and observed what transpires in the healing session. His observations suggest that often the suffering person doesn't understand the rituals in which the healer engages but the ambience (i.e., the surrounding influence or atmosphere) created by the healing sessions transfers him/her to an altered state. Kakar also underlines that the most important thing is the trust and confidence or 'faith' that a healer is capable of implanting in the mind of its clientele. It has to be taken note of that in most of the folk practices the „healers are the mediators between the physical and the metaphysical” (DALAL 2007, p. 5) and apparently, it is the client's belief in the healer and not his or her conceptual system or technique, which is detrimental in the healing process (KAKAR, referred by DALAL 2007).

Often the healer may evoke the sacred in the form of the Hindu Gods like Lord Shiva and Hanuman, or in the forms of spirit of ancestors and demons. It is pointed out that the different healing practices use different forms of the sacred but “for most of them the physical and metaphysical worlds overlap. Deities, demons and spirits are as much part of this physical worlds as they are of the metaphysical” and the effort is directed towards „preserving harmony between the two worlds” (DALAL 2007, p. 3).

The crux of the matter is that it is the unquestionable faith in the powers of the healer, the sacred evoked through him/her, which lays at the core of the positive outcomes. The description finds a parallel in the patient who has full faith in submitting herself in the hands of a competent/renowned surgeon whose medical success stories are known widely. This also finds semblance to some degree by the trust shown by the passengers in the driver/pilot of a bus, train or a plane. Another example (already mentioned) comes from a true devotee (bhakta) who totally surrenders to the one in whom she has the faith.

Known for their healing powers, India is full of sacred centers and pilgrimages that are thronged by millions of faith holders from time immemorial. Some of these are said to be reverberating with the positive vibrations of genuine spiritual seekers and liberated souls who had visited them or had made them their hub of faith. Many find such nucleuses of supernatural powers having soul pacifying environment and the destination for rejuvenating ruffled minds and ailing bodies. Often it is difficult to explain what happens there and how, and perhaps it is at such instances that 'faith' gets a fair chance as an explanation.

Prerequisite for the Therapist for Setting the Healing Process

A moment of reflection on healing in the traditional Indian context reveals that when individuals in distress approach their guru, the healing begins with the love and unconditional acceptance of the person seeking help by the guru. VARMA (Under publication) points out that one cannot become a 'guru' or for that matter a therapist without having undergone an arduous and serious 'self work' (sadhana). He observes that „the most essential pre-requisite on the part of the therapist/spiritual guide for healing to take place, is a posture of and groundedness in unconditional love”. Therefore, sadhana or work on the self is extremely important for a healer, guru or a therapist. Varma refers to Carl ROGERS (1961) of the Western world who emphasizes the absolute necessity of the attitude of „unconditional positive regard” on the part of the therapist towards the client for the therapy to have an impact.

Chaplain Bruce D. FELDSTEIN, M.D. founder and Director of The Jewish Chaplaincy and an Adjunct Clinical Professor at Stanford University School of Medicine, had worked in emergency medicine for 19 years, but was led to a deeper sense of his life's work as a Chaplain after an injury. After a series of experiences he chose to treat people by providing spiritual care and shifted his focus from 'curing' or 'fixing' to bringing comfort and healing, by bringing all of himself to the bedside: body, intellect, heart, soul, and as well as his training and life experience.

When trying to heal a serious patient FELDSTEIN (2011) repeated his intention in the following words: „May I meet you in your world as it is for you and accompany you from there. Whatever time I have with you, may I be fully present. May I serve you with all of my life experience as well as my expertise. May I listen fully with generous heart, without judgment, and without having to fix what cannot be fixed. May my presence allow you to connect with your source of comfort, strength, and guidance as it is for you. May I be well used” (p. 158).

Apparently healing is in recognizing that there is a part of each one of us that is pure and good, along with a human longing for meaningful connection. Suffering is alleviated when we create the conditions for connection with each other and what we hold sacred. Rachel Naomi REMEN, M.D. at Stanford, who developed courses for students on 'Spirituality and Meaning in Medicine' and 'Healer's Art' observes, „we can offer healing with our humanity that we can't fix with our science”. Apparently it is impor-

tant that healing facilitates the process of moving from brokenness toward wholeness and acceptance. At this juncture one is strongly reminded of Dr. Günter AMMON, M.D. (1918-1995), founder of Dynamic Psychiatry in Germany, whose premise for holistic healing recommended having faith in the therapeutic value of the 'social energy' inherent in the close social group of a patient.

3. The Connection between Faith and Healing

The connection between faith and healing has been explained by bringing in the role of the subconscious mind in the healing process. Accordingly, the individual has to think about what he/she wants at the start, and then let it go and let the subconscious mind take over the manifestation process. The real healing power resides within the patient him/herself, and any method that serves to arouse that inherent power will tend to cure. It may be said that a method that is capable of arousing total faith consciousness in the person concerned is the best method for that particular patient.

This seems to be an appropriate juncture to very briefly bring in the idea of autosuggestion. It is understandable that suggestions operate powerfully when administered in the waking stage or when used by experts in the hypnotic sleep. However, a third form of suggestion also seems to operate in which the idea presented to the mind takes its origin not from 'without' (as in the case of hypnotic suggestion or in the suggestion given in the waking state) but, from 'within' and is therefore produced by the activity of one's own brain. This process has been given the name of autosuggestion. Therefore autosuggestion may be defined as a self imposed narrowing of the field of consciousness to an idea. Here the given thought is held in the mental focus to the exclusion of all other thought meaning thereby that the 'hint is offered by the self to the self'. Cures have been brought about through autosuggestion and perhaps one can argue that the healing system may be originating 'from above', or it may be 'from beneath'.

Techniques have been developed for using autosuggestion in a systematic manner for the healing purpose. For example, according to a very early method utilized by Emile COUE (1857-1926) the client was asked to practice autosuggestion by repeating certain magic words such as: „Every day, in every respect, I am getting better and better”. It is essential that the healing words are recited mechanically without passion, without will, with gentleness, but with absolute confidence for a set number of times

with the help of knots on a string like a rosary. It is contended that while the words are articulated they get registered by the unconscious. In this method the emphasis is not on will but on the imagination and in this sense 'imagination' is viewed as a great motive force. Moreover, having confidence in the self is very important because faith with fortified firmness makes it possible to do what is desired.

It hereby appears that what one thinks about is what one gets, but it isn't just the person's conscious thinking but his/her unconscious thinking too, which influences what one receives. It is matter of experience that in temporary forgetfulness we stop consciously thinking about something desired, but the subconscious mind still continues to think about it. A point of caution is, that from here it is very difficult to determine the exact therapeutic value of any remedy including faith healing, unless the element of suggestion is carefully weighed and considered in its application.

The Essence of Faith Healing Process: Restoration of the Connection between the Mind and the Soul

Faith healing is not only found in Asian traditions or Christianity but also in other spiritual discourses all around the world. Restoring the connection between the mind and the soul so that the mind can immerse in the light of the Soul (Higher Self) seems to be more or less the essence of faith healing. As such, faith healing distinguishes itself from medical approaches in curing mental illness. VARMA (under publication) makes an important point when he says that in the West, doctors may try to reestablish the ego as an integrated whole, but faith healing redirects the mind away from the ego. Accordingly in the Indian traditional world view the more important goal is the 'movement from the Ego to the Self', or a shift in the direction 'from the Ego to the Soul' (or Higher Self) which is in fact, a common goal in the context of spiritual healing.

It is argued that the real line of demarcation in the healing professions and among different healers is not simply between traditional and modern or between Western and Asian, or between healers belonging to different cultures. According to KAKAR (1982) the demarcation cutting across cultures and historical eras, seems to be between those whose ideological orientation is more toward the biomedical paradigm of illness (i. e., who strictly insist on empiricism and rational therapeutics having a self-image close to that of a technician), and others whose paradigm of illness is me-

taphysical, psychological, or social, who accord a greater recognition to a rationality in their therapeutics and who see themselves (and are seen by others) as nearer to the priest (KAKAR 1982). Mention has been made to FELDSTEIN who was „glad to overcome his reluctance and followed the call to step more deeply into the sacred dimension of healing”. According to him, „as we each respond to this call, we help to evolve health care into something more complete, something that encompasses bio-psychosocial-spiritual care” (FELDSTEIN 2011, p. 155).

Whether Faith Holds Much Ground

There are countless people and belief systems that assert that faith doesn't hold much ground for healing. They have very strong points and empirical evidences to say so. However, presently the objective was to examine an alternative approach for addressing to the health and wellbeing of individuals without being judgmental towards the others healing traditions in general and the bio-medical traditions in particular. The purpose at the moment is to bring forth the proposition of many believers who think that faith may be integrated into a more holistic approach to mental health care. Such an approach would include cultural and anthropological perspectives on the internal logic of faith healing (RAGURAM et al. 2002; SHANKAR, SARAVANAN, and JACOB 2006).

Nevertheless, it would be fair to point out that acknowledging the efficacy of faith healing (RAGURAM et al. 2002) frequently cite fears that this might „leave unwary patients with an unjustifiably favorable impression that healing temples can cure their diseases” (KALANTRI 2002). Faith healing is generally understood as any non-medically based cure where the means could be supernatural. In general, this form of self healing relies on a supernatural power or power of the sacred and therefore, is often called divine healing. Though faith healing is used and is popular all over the world in one form or the other, meditation is the only exception where scientific research does indicate positive impact of meditation on health. The process of healing through the divine however, is often looked at with scepticism.

The author wants to submit that going through the material on faith and faith healing has given her some understanding about what is faith. She can also see the point that only ‘unshakable faith’ works and that is why it doesn't work indiscriminately for everyone. Moreover, as an Indian, she

trusts the wisdom of her philosophical heritage and is tolerant to the idea that faith is a fraction of the enormous field of Consciousness (spark of the Divine) in mortal beings and can heal when there is total trust in the true form of one's inner Self. Process wise faith healing occurs when the insights, perception and experiences of the inner Self are brought to the reasoning or mental, vital and physical planes together creating integrated faith Consciousness.

Perhaps we are trying to say that the move made by the 'Self or Soul' towards its real and fundamental form with total trust and unwavering faith in its powers, paves the way for its transformation and wellbeing because this seems to be the process for the releases of the self's healing energy which can pacify the mind, body and the soul. As a psychologist she would like to say that individual's do have unexplored and unutilized tremendous powers in them and having a strong faith in one's inner powers along with an attitude of acceptance of 'what is', is the ground for healing to begin. Moreover, keeping in view the fact that the mortal beings are part of the powerful Nature and Divinity creates the necessary positive state to register the message that healing will happen and one can heal herself. Having said this, she would certainly like to examine and understand the idea of 'integrated faith consciousness' more thoroughly which is said to be a guarantee to one's overall well being.

Summary

The author subscribes to the argument that the real line of demarcation in the healing professions and among different healers cutting across cultures and historical eras, seems to be between those whose ideological orientation favours the biomedical paradigm and non-material approaches to illness and others, who subscribe to metaphysical, psychological, or social paradigm of illness and alternative approaches to healing. Coming from a country where people have invincible 'faith' in innumerable deities, divine power, religious rituals, faith healers and even 'mantras' and prayers, the author proposes to address to the basic question namely, 'what is faith' and 'if faith heals how does it facilitate the healing process?'

Conceptually, trust is a common element 'in faith' and 'belief'. However, 'faith' is envisioned as more of 'experiential intuitive trust' or confidence in Nature, Divinity or 'miraculous unknown' unlike 'ideological trust' in a religious doctrine or a secular idea where beliefs and convictions

are mainly acquired at second-hand from other non-examiners (Mark TWAIN). Belief, creates an assumption of 'knowing' while faith appears to be „a knowledge within the heart, beyond the reach of proof" (Kahlil GIBRAN). Therefore, notably, faith in its very nature is 'unshakable', 'transcends reason and belief' and is 'open to the unknown'.

Secondly, the Indian world view, brings in the notion of 'Soul' for explicating the relationship between faith and healing because the context of 'faith' has often been spiritualism. Soul is known as the 'Higher Self' or 'Psychic' (Pondicherry ASHRAM 1989) and the 'element of the Divine.' It exists in the material beings without ever leaving the Divine. It goes back to the Divine without ceasing to manifest. In other words, the individual and the Divine are eternally one in the Soul. According to an Indian saint, The Mother (1989) „faith is the movement of the soul whose knowledge is spontaneous and direct [...] a perception by identity" (p. 43). It is argued that the knowledge of the soul is 'complete' and assures total 'faith consciousness' with no scope for doubt in whom it has its faith.

It is cautioned that when the faith holder doubts and shows insincerity in his/her efforts (for example, aspiring for a spiritual life in one case and healing in the other), she is not benefitted. Deepak CHOPRA, the famous USA based Indian origin doctor and a spiritual guru thinks that faith is a fraction of the enormous field of Consciousness in us and having 'faith is to be in tune with and aware of the field of Consciousness. He tells beautifully that faith is where physics and metaphysics meet and interlink and cannot be treated as a 'new age nonsense'. CHOPRA argues that minimum faith induces subjective well-being with about as much reliability as pharmaceuticals, minus damaging side effects. Apparently, people who have faith in some God/deity, cosmic power or sacred energy, function through a special cognitive mode and often experience subjective wellbeing.

The phenomenon of Bahkti yoga (devotional yoga) in the India philosophical tradition is a fine case for illustrating the highest form of faith, explaining the nature of faith, the act of surrender in faith, and the process of faith healing. Accordingly, A bhakta (devotee) is a spiritual seeker whose emotional life undergoes a gradual transformation as he/she uses profound devotion to focus the mind and transform his/her personality, and moves towards a state of pure and unconditional love of, and love for the Divine (VARMA, under Publication). At the manifest level a bhakta's practices like chanting, performing devotional activities (puja) and ritualistic acts are in complete consonance with his/her thoughts, feelings and

behavior and becomes an expression of love and yearning for the chosen deity or ista. In Bhakti yoga like any other spiritual practice, worshipping becomes the means for liberating or awakening the mind pacifying and overall healing powers of the inner Self.

Most strikingly, a true bhakta lays down his/her total existence under the cover of the ista (the chosen deity) in the gesture of complete surrender, choosing the ista's protection over any other form of security. The unprecedented total trust and unshakable faith in the ista makes the bhakta fully convinced of being cared, protected, not let down, and healed. The gesture of surrender is not a superficial act. It is a step taken after the realization that there is singularity hidden behind the mask of the deity's personality which is vital for discovering one's true Self in the deity. A bhakta's mental status exemplifies a high state of subjective well being because there is no fear or apprehension for eventualities and the total faith in the ista has set the stage for a trusting relationship to work well. One may see a therapeutic situation in this scenario recommended for a desirable relationship between the bhakta and the ista or the therapist and the client.

The Old Testament too, asserts, that a person has to believe and submit completely to the divine powers in order to be cured from illness. It is explained that when people invest in faith in the Lord they are also investing faith in themselves on a subconscious level. Therefore, the self's healing process is based on the assurance that an undisclosed divinity is present boosting the confidence level of the faith holder. In sum, the objective of faith is not to get well first and then believe that God has heard prayer. But it is a steadfast confidence that God is at work and will do what he has promised.

The Indian scenario of faith healing is quite interesting. India a country of relentless faith holders, countless Gods and deities and people supposedly having the 'powers to heal', faith healing is often envisaged as an alternative to psychiatric treatment (RAGURAM et al. 2002). The centers for faith healing are scattered all over India that include, temple of a Hindu deity or a Dargah (i. e., a shrine built over the grave of a Sufi Muslim saint), majars, and places where local deities are placed and worshiped. Indians visit all the centers of faith healing irrespective of their caste, creed, religion and ethnicity. In contrast to the Shamans, gurus, medical psychiatric diagnoses, mental health diagnoses in places of faith healing include spirit possession, black magic, and the faith healers include tantrics ojhas and priest, etc.

In the context of faith and healing, the obvious question is always the same: ‘whether faith has the potential to heal?’ And, to answer this question one would like to mull over the ‘sources’ that facilitate the process of faith healing. Referring to what we know from the Indian front, faith healing seems to utilize two kinds of sources that can be revoked and utilized for commencing the healing process. At one instance, the self’s healing energy is ‘made to liberate’ and the health seeker becomes instrumental for initiating the healing process. At the second instance, the ‘healer becomes the source or the medium of a Divinity or the sacred’ and reinstates wellbeing in the health seeker.

The means for liberating the self’s healing energy are prayer, Yoga and meditation. Prayer has been an integral part of the mind pacifying spiritual practice in all religions and cultures and a means for getting in touch with one’s inner source of power. According to Sri Sri RAVISHANKAR (2014) „Prayer is the cry of the soul” and prayer works at the subtle level of feelings for bringing transformation and wellbeing in the person. Meditation and Yoga are complementary and often inseparable practices. Yoga is the practice of bringing together the force and vitality of the mind, body and soul in perfect union, so that the Self’s energies converge and become the source of a person’s total well being. In other words Yoga works on fronts like regulating the rhythm of the breath (cosmic current, or prana) and adopting conducive body postures (which helps the prana to flow in the desired manner). At the same time, meditation, focuses on the thought process, observing the thoughts come and go by, without resisting them until the disturbing clatter of the innumerable thoughts and their tributaries fade out, finally leaving the mind peaceful, quiet and focused on its positive core.

Similarly, the concept of ‘Chi’ is helpful in understanding the Self’s healing energy and how it is liberated. Known as the ‘activating energy of the universe’, Chi has many translations: Energy, air, breath, wind, vital breath, vital essence, cosmic current prana, etc. Chi is the most basic and general principle of Taoist thought in Chinese philosophy LAO TZU, 604-511 BCE and CHUANG TZU, 399-295 BCE). Chi is considered the source of all movement in the universe, including the pattern of our thoughts and emotions. It condenses and disperses in alternating cycles of negative and positive (yin and yang) energy, materializing in different ways, forms, and shapes. It is so that all states of existence (including sickness) especially those of physical matter, are therefore, temporary manifestations of ‘Chi’.

In the practice of Tao, self healing involves the mind/eye/heart power to take more Chi and transform it to heal ourselves. The body and the mind is trained to use our own Chi, the nature's Chi, and the Earth's forces to provide the healing energy (CHIA 2008).

To recapitulate what is being said is as follows: The self's liberating energy is extraordinary because it represents the 'larger Cosmic force' or the 'Divine fire' in the physical being whose release elevates the status of the self. Here the word 'Cosmic' shouldn't be taken as a decorative expression but envisioned as the uncharted powers of the worldly being who is nothing but 'pure Consciousness' in its most fundamental form residing in the human body. Once liberated, this energy pacifies the mind, comforts the body and instates the feeling of wellbeing. The practices for liberating the self's own Divine energy could be meditation, using Chi, Yoga, prayer and worshiping deities depending upon which practice suits and convinces the practitioner.

It has been mentioned that another instance for faith healing is where the healing process is set by the faith healers and centers of healing or from an 'outside source.' Here the faith healer uses some traditional healing method and acts as the medium who evokes the 'powers of the sacred' to work in favour of the help seeker (DALAL 2007). Often the 'faith healer' or the 'healing center' (i. e., temple, majar or shrine, etc.) has an impressive history and had acquired the status of a sacred place.

According to KAKAR (1982) „The whole weight of community's religion, myths and history enters sacred therapy as the therapist proceeds to mobilize strong psychic energies inside and outside the patient ... (p. 5).” It is explained that the sacredness of the healing practices is reinforced by the stories and legends associated with the healer or the healing centre, and the 'authority and aura of a healer' (i. e., the priests, swamis, fakir and tantrics) is carefully cultivated through the stories of miraculous healing for drawing people. Often the history of the healer and the healing centre has its origin in some myth or chance miracles supposed to be a consistent phenomenon and is respectfully seeped into the local folk stories. Often there are rituals associated with the folklores that are followed with zeal.

This is an appropriate place to recall the prerequisites for the therapist who too is an 'outer source' who sets the healing process in the patient. A moment of reflection on the healing process from the Indian traditional context reveals that the most essential pre-requisite on the part of the therapist, guru or the spiritual guide is to have a posture of, and groundedness

in unconditional love and acceptance for the distressed individual. This is a condition, which the healer or the guru can achieve after an arduous 'self work' or sadhana (VARMA, under publication). Varma refers to Carl ROGERS (1961) who too emphasizes absolute necessity of the attitude of 'unconditional positive regard' on the part of the therapist towards the client for the impact of therapy.

The experiences of Chaplain Bruce D. FELDSTEIN, M. D., is an illustrative case in this context from the West. Feldstein decided to treat people by providing spiritual care and shifted his focus from 'curing' or 'fixing' to bringing comfort and healing by bringing his whole existence and technical experiences at the bed side of the patient. He made the decision to provide spiritual care after having worked in emergency medicine for 19 years.

Additionally, one is reminded of Dr. Günter AMMON, M.D. (1918- 1995), the founder of Dynamic Psychiatry in Germany, whose premise for holistic healing recommends having faith in the therapeutic value of the 'social energy' which is generated when a group's members closely connect with each other at a deep affective level assuring social-emotional support to each other.

Having said the above, it seems important also to touch up the connection between faith and healing from the tradition of psychology which brings in the 'role of the subconscious mind' for explaining the relationship between faith (confidence in one's self) and healing. It is well known that suggestions operate powerfully when administered in the waking stage or in the hypnotic sleep induced by an expert. A third form of suggestion operates too. In this case, the idea presented to the mind takes its origin not from 'without' but from 'within' and is therefore produced by the activity of one's own brain or subconscious mind. This process is called autosuggestion which has cured and helped people. We may argue that the healing system may be either originating from above, or may be from beneath.

The point made here is that the connection between faith and healing can be explicated by bringing in the role of the 'subconscious mind'. The idea isn't just the person's conscious thinking but his/her unconscious thinking too, which influences what one receives. In fact, fortified firmness makes it possible for the subconscious mind to work on what is desired and sought.

Faith healing is found in Asian traditions, Christianity and other spiritual

discourses all around the world. What has been said so far, suggests that restoration of the connection between the mind and the soul (so that the mind can immerse in the light of the Soul, or the Cosmic element present in the human body) seems to be the essence behind the relationship between faith and healing. As such, faith healing distinguishes itself from medical approaches in curing mental illness.

An inevitable question in discussion on faith and healing is: 'Whether faith holds much ground?' There are more stories and instance which are against than in support of the question. However, presently the effort was to bring forth the proposition of many believers who think that 'faith' may be integrated into a more holistic approach to mental health care and include cultural and anthropological perspectives on the internal logic of faith healing. Lastly, the author submits what she could learn from her present exercise:

- First she learnt that 'Faith' is intuitive trust especially in the miraculous unknown and the context of faith has often been spiritualism. Further, only 'unshakable faith' work.
- As an Indian, she trusts the wisdom of her philosophical heritage and is tolerant to the idea that faith is a fraction of the enormous field of Consciousness in us.
- She got exposed to the idea that mortal beings have an element of the Nature and Divinity in them and a move made with total trust and unwavering faith to wards 'one's true and fundamental form' initiates the self healing energy.
- As a psychologist she could see the logic behind the role of the subconscious in healing and that faith with fortified firmness can help reach the desired goal.
- She would agree that the therapists full presence for the patient and being able to connect with the patient's source of comfort and strength, makes sense for healing.
- She would still like to thoroughly revisit the idea of 'integrated faith consciousness' which is said to be a guarantee to one's overall well being.

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A model of group Psychotherapy of Integration somatic-psychic, even in subjects with severe psychiatric diagnosis. The BerTosa method

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The BerTosa method arises from a multi-dimensional approach to the patient with emotional disorder. It evolves between the psychological sciences and those of human movement. Its goal is to get and maintain the patient's somatopsychic integration in order to obtain a whole Self. The method consists in a group psychological activity, where the psychic and physical movements co-evolve. The working method refers to a interpersonal and tonic/emotional approach. The approach is focused on the human system and its functions, the development of self-consciousness. Our starting point is the idea that a work on the body isn't automatically a psychological work. It becomes so only if develops a cognition and integration of the different functional levels in the structure of Self.

Keywords: interpersonal and tonic-emotional approach, implicit unconscious, whole Self, tonic function, perception, emotion.

The BerTosa method, working on the quality of body proper perception, is experimenting on the possibility of intervention in therapy for psychiatric diseases, even severe, for growth a whole and Authentic Self.

The BerTosa method is the outcome of a multidisciplinary study between psychological sciences and those of the human movement. Its goal is to get and maintain the patient's somatopsychic integration in order to obtain a whole Self. The method consists in a group psychological activity making the bodily motion and emotional movement co-evolve. The working method refers to a interpersonal and tonic/emotional approach (MOLÉ 2003).

This therapeutic experience, focused on patients having some kind of psychic disease, even severe, is conducted by two psychologists and psychotherapists, one of whom having competences in dance therapy and a motor sciences doctor.

We propose an integrated and circular model of intervention, changing into a working model in the psychotherapy group. We will highlight the concept path for forming the method called BerTosa method.

We think of a model as a „representation, providing a set of [theoretical] points used to reproduce some feats of the subject or object we are interested in” (GATTICO and MANTOVANI 1998). It is a representation describing the evolution of the observed phenomenon. The [theoretical] points come from a multidimensional and multidisciplinary integrated working model proposing a constant integration of the various levels of the model.

The model is circular since an explicit feedback activity is a fundamental part of the organization. Our reference model provides, on one hand, an indivisible coexistence of body and mind, so that we can define man as *Synolum* (TOSARELLI and MARTELLI 2011) of this two substances and, on the other hand, a feedback and feedforward (FORD and LEARNER 1992) activity. This structure of communication is found useful to register ourselves our own presence. The method works through giving bodily inputs by gymnastic movements. Through a research for perceptive feedbacks, we try to make a change through registration of the differences between the tonic and kinetic levels before and after the treatment. The discovery of the self through feedforward places the subject in space and time. The feedback registration happens mainly in supine or prone position, those of feedforward though happen mostly in movement, in upright posture or by overshadowing one specific sensory reference (such as sight). By overshadowing the visual perceptual channel we increase the other senses and enlarge and underline a different source for collecting inputs.

This way we have the subject concentrating more about himself. Moreover, we hypothesize that the block of visual perception drives the attention on the internal environment and activates an increased perception of the internal organs, muscles and skeleton.

This element is important since the BerTosa method, while taking care of the Man System (MERAUVIGLIA 2005, 2012), visits and activates again the functions of that system

The approach focused on the structure is justified by the thought that the body as a unique whole has not to be considered as an instrument or a condition for life, but it is life itself. A good dialogue between the structure and its functions creates a *body proper* (FONTANILLE 1999) in solidarity with its own life experiences.

The expression *body proper* is not related to the materiality of the body, but rather to be considered as an instance of self-representation in the phenomenological sense. Jacques FONTANILLE (1999) said that a *corps proper* can be properly defined as a sensing body. We accept this definition of *sensing body*.

Our working model, then, is organized through the exploration of three structural levels: skin, muscles and skeleton (LESAGE 2008). Equally important for the method is the concept of circulation between levels of organization in the structure, identified in the somatic, psychic and energetic spheres.

Our method has in mind that a work on the body isn't automatically a psychological work. It becomes so only with specific conditions, mainly by developing a self-cognition and integration of the different functional levels in the structure. As Didier ANZIEU (1990) says, the skin is the first structural element of the Man System, since it functions as a border with the external world (ANZIEU 1993). A. LAPIERRE (2001) adds that we are not just made of a Skin Ego (ANZIEU 1985), but we also have a *Flesh Ego*, made of subcutaneous tissues and musculature. „The feelings do not only affect the skin but also, and perhaps more importantly, through the skin, subcutaneous tissues and muscles in particular have their own sensitivity: it is not only a piece of skin that touches and another piece that is touched, but it is also a muscle that transmits to another muscle that some pressure will be transmitted to the tendons and musculature near. This brings into play a whole bunch of feelings that cannot be reduced to the epidermis.” (LAPIERRE 2001, p. 85) Hence the Man System is recognized in its volume: a body consists of muscles in relations with each other „a report flesh to flesh, where musculature is at the same time sending and receiving.” (LAPIERRE 2001, p. 85)

In our working model, in order to give consistence and shape to this volume we take bodily, perceptive registrations and even emotions from the three functional levels. If there is a structure, a volume, a case, then emotions can be truly recognized and expressed. Feeling the body proper's volume becomes feeling the volume of our inwardness: finding an internal consistency.

One of the most useful structure's functions is the *tonic function* (WALLON 1942) which shapes the dialogue between the baby and the mother as Henry WALLON (1942) explains. In his writings, he describes how this function stays under all possible forms of communication. „The tonic function, in its fluctuations, always reflects the harmony or not harmony in relating with the other [...] it is firmly linked to the evolutionary history of the subject.” (GHILLANI 1984, p. 1-3) „The contraction acts as a defence [...] it is an ineffective defence, since, for a man in tension, the threaten is not external anymore, but it is internal.” (LEMAIRE 1964, p. 15)

„The tonic state can influence the psychic activity and mental alertness of the subject through cross-linked and subcortical structures; it is possible to say that there is no emotion that can't be expressed on somatic and tonic level as well.“ (LANG 2010, p. 416, ROBERT-OUVRAY 1993). Several types of tonic regulation coexist in the body and they do not only relate to posture or muscular patterns: there is an emotional tone as well. Every change in the emotional state involves a change in the tonic and postural shape and vice versa.

The tonic state influences the structure of the basic motor patterns and, by doing so, it also influences the kinetic activity's development. The basic motor patterns are organized by the natural and fundamental shapes of human movement. They are called basic since they already come up in the very first moment of the individual's development, they express his motor and cognitive heritage and they work as a foundation for the affective one. The ontological development describes the phylogenetic development of the human being, rooting the child in his primitivist moment. The motor patterns allow the individual to relate so as interpersonally and intrapsychic, in space and time. Between the motor patterns we have: to walk, to run, to jump, to grab, to push and to pull, to roll, to slither. The motor pattern's enrichment is continuous and lasts all through one's life. The psychic disease usually reduces them to a state of latency and their rediscovery generates new bodily and emotional tones and renovates the kinetic abilities and those of exploring reality.

In 2004 Gerald EDELMAN explained how the body becomes a neutral reference space and the center of life's scene. He said so: „The first conscious discrimination necessarily relates to the perceptual categorization related to the body itself. These are mediated by signals from brainstem structures and the different value systems that form the map of the state of the body. The signals from this system of self-refer to the report of the body with the internal and external environment. These signals include components proprioceptive, kinesthetic or somatosensory, and self-employed. These components which indicate, respectively, the position of the body, the action of the muscles and joints and the regulation of the internal environment, affecting almost every aspect of our being. Necessarily the first conscious discrimination relates to the perception categorization related to the body itself.“ (EDELMAN 2004, p. 60)

MULDER and colleagues (2004) says that such basic motor patterns are nothing more than procedural memory's schemes. Pre-verbal and pre-

symbolic memories linked to precocious experiences „stored in sensory and iconic images rather than in verbal representations” (PERSON and KLAR 1994, p. 135) and create the Implicit Unconscious as described by Mauro MANCIA (2004). In his theory he explains how men show an implicit memory, impossible to put into words and bearing no remembrance defined as Implicit Unconscious. His hypothesis is that there is *a non-removed unconscious nucleus of the Self* (MANCIA 2004) which constantly influences our psychic lives.

The body, *Perceptual Substance of the Living Being* (FREUD 1915), reflects the events through images, noises and smells in the procedural memory rather than through words on the explicit one. Marco SANTELLO (1998), researcher in artificial intelligence, will describe the organization of these sensory redundancies through motor, sensory and sensomotor synergies as a place of structuring the implicit unconscious. Such organization influences both the body structure and the psyche of the subject. Sandor FERENCZI already spoke of bodily memory (FERENCZI 1928c) „which keeps vibrating in some part of the body“ (FERENCZI 1938h) „only sensations and subsequent body reactions. The remembrance is stuck in the body and only there it is possible to wake it. Everything becomes sensation without object.“ (FERENCZI 1938h)

The precocious trauma, ascribed to the implicit moment, is impossible to keep in mind. It negatively interacts with the organization of the basic motor patterns which happen to be compromised by precocious and traumatic emotional experiences. This generates serious contractures limiting the subject's potential articular freedom. Impressed in the body and stored in the implicit memory, the precocious trauma does not respond to an associative and interpretative process: in order to be taken care of it needs the analogic language of the body, the image, the metaphor and the symbol.

Daniela DE ROBERTIS, an Italian psychologist explains, „that the interpretation, centered on the removed content brought to conscience, is not the focus of the change anymore”. The author says that „the change does not involve the conscient insight, but the area of the procedural conscience being implicit unconscious and not verbal by nature.” (DE ROBERTIS 2009, p. 132).

Giacomo RIZZOLATI, an Italian neuroscientist, says that „the perception is sunk in the dynamic of action [...] it is a pragmatic, pre-conceptual and pre-linguistic comprehension” (RIZZOLATI 2006, p. 3-4).

What appears to be relevant, in our approach, is the development of

an embodied self-consciousness generated by an embodied intelligence. Such intelligence is nurtured by bodily movement. This viewpoint finds confirmation in the studies of Esther THELEN (THELEN, SMITH 2002; THELEN 2013). These studies connect the embodiment of cognition to simple bodily movements. The therapeutic action we purpose is not based on the recovery of remembrance, but on the creation of a cognition and of the self and of the environment, through the restructuring of basic motor patterns (CASOLO 2002). This, together with a renewed self and environment perception, helps creating a body proper: self-consciousness in its body.

If precocious experiences are anchored to traumatic situations, the one-self won't develop on integration lines, but around unavoidable rifts in both procedural and affective memory. This changes the tonic function. We think that such change negatively effects on the non-removed unconscious nucleus of the Self, generating cracks in the development of an integer and authentic Self. We think we are able to activate a new process of self-integration through embodiment (MONTESSORI 1950), finding inside of the implicit some unknowable bases, which are, though, replayable. Maria MONTESSORI, Italian pedagogue, was the first to introduce the concept of embodiment, taken from the Christian theology, to explain the process of personal development in the child. She also introduced the concept of an implicit original dimension. This can be considered a precursor of the concept of implicit unconscious. Montessori's theory, in the 50s described embodiment as an evolution and psychic-educative movement transforming the subject's original project in acts (MONTESSORI 1949). In the 90s with Francisco VARELA and Humberto MATURANA (1973), neurophenomenologic sciences (CERUTI and DAMIANO 2009) start talking about the process of embodiment cognition. An Italian dance therapist, Alba NACCARI (2006), adds that the embodied subject dwells in his life in a personal and fluid way.

If MONTESSORI sustained that the sensory-motor allows embodiment up to the third year of age (MONTESSORI 1949), NACCARI (2006) reflects on the role of movement in helping the process of becoming ourselves, embodying in the unicity of our own personality. This process, she says, isn't only present in the developmental age, but can be activated all through one's life.

We define this possibility the generative path (GREIMAS ALGIRAS 1966) of an authentic embodied Self. Precocious traumas often generate *broken men* (MONTESSORI 1949) who will be forbidden a process of embodiment

in their implicit. We say that a broken man has a *Cracked Self*. This broken men, having a *vague and scattered psyche* (MONTESSORI 1950), will also have disharmonic and non-fluid body movement. The defense systems will mostly be escape or muscle contractures, these contractures appear to be barricaded areas of the subject where an energy implosion develops. It is also possible to have a splitting of body and perceptions.

These defenses leave a real imprint in the body and an implicit imprint in relations and generate *Closed Areas*, unknown and sealed: this way it will not be possible to get a real somatic-psychic integration. The subject will present disturbed degrees of articular freedom and muscular rigidity. On the psychic level this concept can be represented as an oscillation between internal deconstruction and an uncertain psychic territory, made of bridges and holes of significance that has no defined limit.

The broken man has a body which is a non-place where subjectivity struggles to emerge. In this body, experience paths hardly create a whole Self. The body, then, is a liminal space (VAN GENNEP 1909) of transition between States and Transformation (GREIMAS ALGIRAS 1966), which can be defined what is happening, it only becomes a possession, an object detached from the subject.

The *Cracked Self* would already come up in the newborn. The baby, in feeling annoying incitements, shows to be able to get away from them with a muscular action of escape. This happens because the implicit memory is mediated by many systems, included the one of fear composed of the amygdala and the areas linked to it. These areas organize emotional answers of precocious defense and tend to leave an indelible imprint. „The learned trigger opens the dam of emotional arousal and turns on the bodily answers related to fear and defense through the amygdala system”, as sustained by Joseph LEDOUX (1996, p. 262).

Consequently, an approach based on Talking care, is enhanced by a working body. The psychotherapy becomes more radical and more capable of taking care of the precocious relational trauma (STERN 2004) if it considers the primitive muscular defenses. These defenses determine sort of a primitive contracture, micro deviations in the muscular chains and in the development of basic motor patterns.

This perimeter of reflections allowed us to organize a method that takes care of the muscles, movement and action as efferent. The method, then, opens ample space to sensory afferent, perceptions, emotions and representations.

On the bases of what have been said by now, the BerTosa method starts from body movement and helps the sensory integration. The sensory integration is an innate neurobiological process and it regards the integration and interpretation of sensory stimulation from the brain. It is the movement to be always in the bases of change (RESNICK 1995). We work on the sensory, proprioceptive, kinesthetic and visceral axis. We elaborate the perceptions coming from the somatopsychic territory to get to a development of emotions.

Our approach puts on balance the structural, functional and psychodynamic element (ARIANO 2000). Our goal is to get a warm, lively and loud body: a body made of skin, muscles, bones and emotions. Only in the dead body, cold, dumb and motionless all the elements overlap.

We are, symbolically, in the pre-verbal phase of life when movement is the first vehicle of both communication and affective regulation. The path goes from movement, to sensation to perception ending with the development of emotions through the body proper experience.

In building this model of intervention's setting we found three main needs: the need for movement, the psychic need for perceptions and, lastly, the psychodynamic need for care. Every group session goes through the ontogenetic development of the human being from its birth to the conquest of upright position, setting roots in the human phylogeny.

The BerTosa setting is a long holding moment in which the operators and the group get into sort of a ghost of a common skin (ANZIEU 1985) to then get out with their own individuality. In this group experience we hold as very important the concept of holding as expressed by Donald WINNICOTT (1965).

The setting is made of a first work centered on self-perception through perceptive listening of one's support on feet and one's contact with their skin. Then the group lays down and makes stretching and muscle strengthening exercises. This central phase of the work goes with a perception of the subject physical state, shared with the group through descriptions that are first real then symbolic.

Once reached the bliss point in a distressing and welcoming holding the patients fall asleep to then wake up to sound of the singing therapist's voice. The singing is a vibrational singing and works as a psychic skin to the sleep, having also a function of integration with the self, as described by SULLIVAN's theory (1962).

By waking the group up we stimulate the progressive transition to an

upright position with a movement that integrates all of the body's parts, even the rhythm and the singing of the voice. The last part of the activity is dedicated to dance therapy, to exercises of interpersonal relation and to the sharing of emerged dynamic experiences.

The method's transformation process oscillates between regressive and more evolved phases of individuation and separation (MAHLER and PINE 1975).

This set of proposals: self-massaging, gymnastic movement following basic motor patterns, vibrational (GRUNGO 2013) and phonemic singing (DE FONZO 2010), driving of perceptions, brief integrator sleep (SULLIVAN 1953) and danced movement, becomes the vehicle of the transformation process.

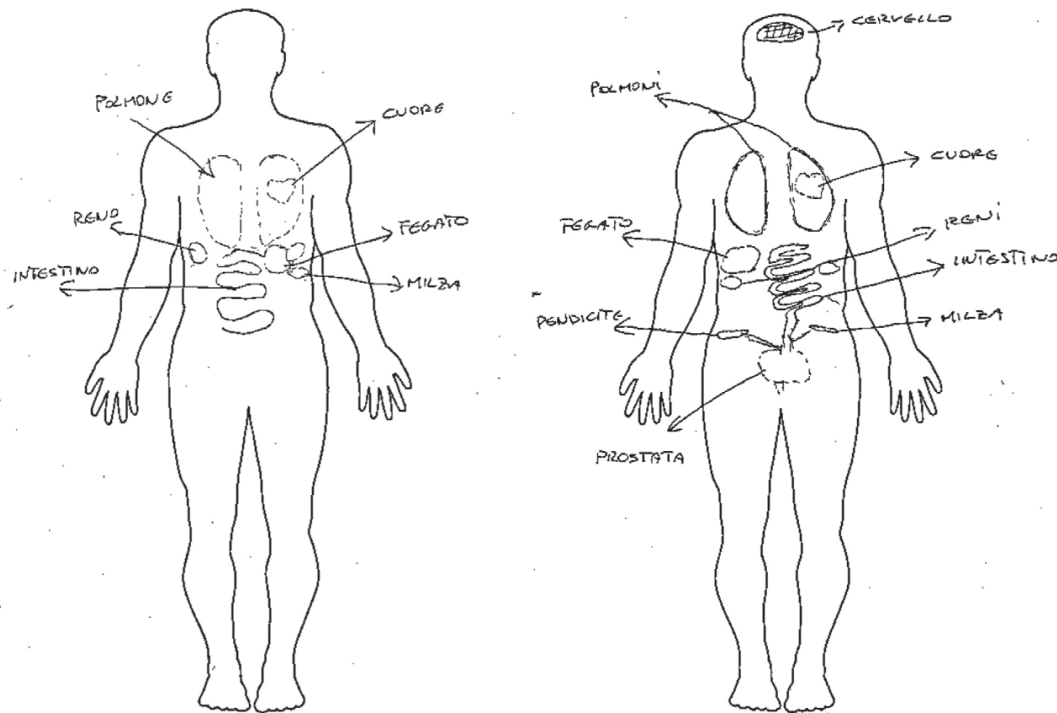
The assessment of the results is made through a brief test we call „test of Human body“. The test consists in the drawing of the human figure as shown in the following pictures. The patient fills out the test in the first meeting of the group (pictures 1.1, 2.1, 3.1). He will repeat the test after at least 10 sessions (1.2, 2.2, 3.2). The patient draws the internal organs of the human body, as well as remember them. Then their appointment.

The outline test allows us to observe some of the changes in the patients frequenting the group.

Change in internal organs collocation

Patient A (pictures 1.1 and 1.2) relocated the liver and the intestines. The patient C (pictures 2.1 and 2.2) replaced the genital organs, specifying them and separating them from the anus. In addition he defines the intestines position and separates the trachea from the esophagus. In patient C's pictures (3.1 and 3.2), the patient relocated the liver and the stomach appeared. In addition he freed the lungs from the chest cage. On the language plan patients B and C were able, during the activity, to go from generic and not precise perceptions to the ability of punctually expressing themselves and even symbolize their perceptions. It appears that there is a relation between graphic changes and the patient's increased ability of speech. We can think of every organ as a syntagma of an overall speech. As explained by generative-transformational grammar (CHOMSKY 2006; GRAFFI 2008) a change in the syntagmatic tree generates different speeches. The changes in the patient's use of grammar are so important that they make his speaking communicative. As the structure expands so do the symbolic abilities and their expression. The body is, as described by

Gerald EDELMAN (2004): „A neutral reference point based on the body, a scene centered on the body the concrete aspect of the self, which opens the experience of rootedness safe” (p. 60), „and it is wonderful to feel you are on earth with your body. Everything is so simple in one’s existence”. So spoke a patient who is affected by obsessions and has a psychotic personality organization.



Pictures 1.1 and 1.2

Patient A has participated in a group of 10 sessions (10 weeks).

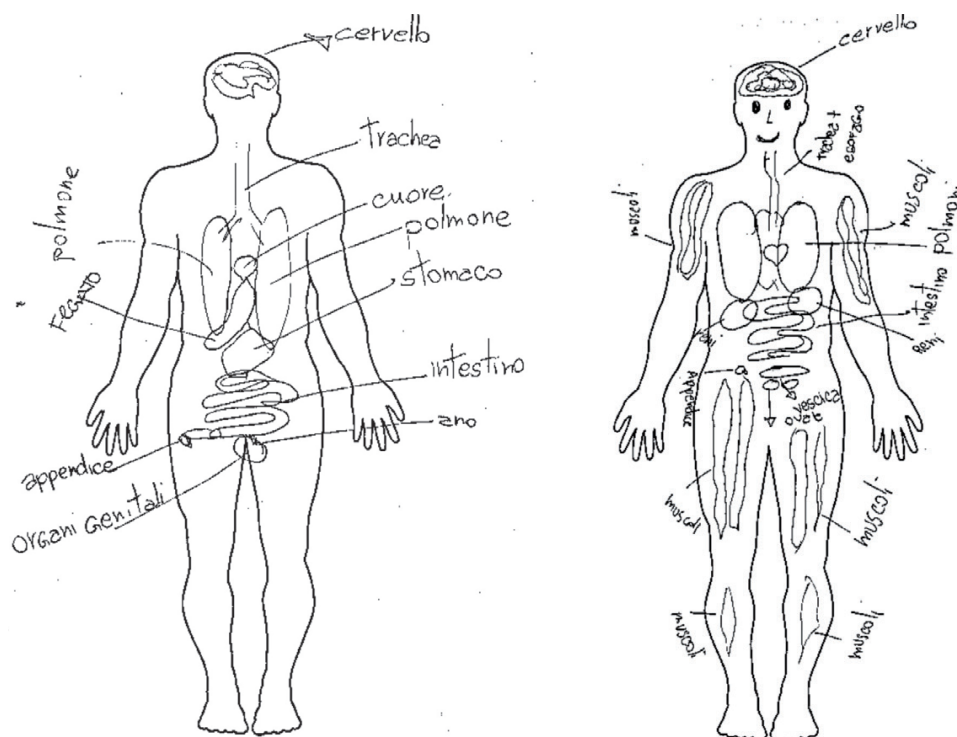
„I see myself lying as the streets of San Francisco. All straight and aligned.

I feel a little crooked too. I feel the right side more swollen, raised off the ground.

They are fully supported on the left side. I see myself as a lawn that goes up and down.“

An increased capability to remember and recognize internal organs

In all our examples the number of depicted organs is increased. We observed as this is related to a renewed attention on the self, the integration of previous knowledge and hidden thoughts made visible. The integration happens in a fluid way, it is a blossom of perceptions, sensations and emotions. There is an increased capability to define the single organ’s identity and that of the renewed connections between them. In all of the three examples we find a better tone in the second description than the one in the first, the volume of the single organs is better and better is the linking between them.



Pictures 2.1 and 2.2

Patient B has participated in a group of 10 sessions (10 weeks).

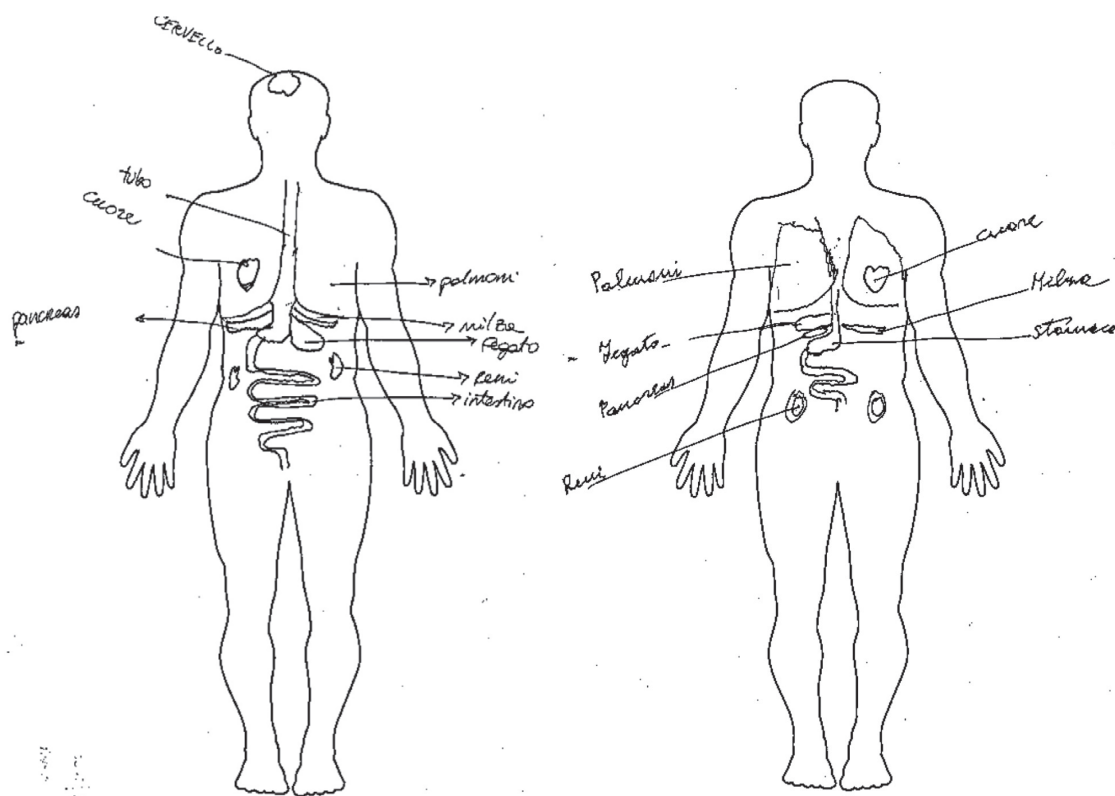
„I see the chain of Mont Blanc. It gives me strength and majesty, but also peace of mind.

There are the foothills of the snow, I look at the glacier that is melting and the streams that descend slowly. I do not know if the glacier will melt completely, a little, is dissolved. And I do not know where the water goes. The lawn at the bottom of the mountains, it needs the water.“

The difference between inside and outside

People realize that they put in the final analysis external organs such as a face, masculine genitals, bosoms and belly.

To support of our experience we report a research appeared on „Le Scienze“ on March 11th 2014. A group of researchers from Karolinska Institut and Umeå University of Sweden, explain how episodic memory deeply depends on the quality of bodily perception. We read: „Without a perception of your own body, you do not activate the hippocampus, the brain region in which you structure your new memories. There is a strong correlation between bodily experience and memory: the brain creates our experience of the body in space collecting the information coming from all senses. The hippocampus then connects all the information which are found in the cerebral cortex in an unified memory, intended for long-term storage. We have to feel inside our bodies in order to develop an episodic



Pictures 3.1 and 3.2

Patient C has participated in a group of 18 sessions (18 weeks).

„The liver is fine, it is in its position. I feel a headache, but the body is loose and well.

I see my body strong and sturdy walking.

My right side is stretched, however my left side is like a hedgehog.“

memory” (BERGOUIGNAN, NYBERG, EHRSSON 2014), function which appears fragmentary in psychiatric disturbs and the absence of which is registered in dissociative phenomena.

The BerTosa method, summarizing, working on the quality of *sensing body* perception, experiments an intervention in therapy for psychiatric diseases, with the aim to develop and Authentic Self. It is not gymnastic activities, but it is a holistic psychological approach that recognizes the person in its entirety. It is not to be considered a multi-disciplinary method: the focus is on the customer and not on scientific disciplines. Instead, the BerTosa method is multi-dimensional and multifactorial approach centered of the whole person.

We report some of the comments expressed during the course, from our patients. Comments are both on the identification of the structure of the body and its functions that on the perception of self.

„I feel my body knotted, knots I didn't know I had. I'd need to look at my body from the outside. Like a bed sheet which has just been washed; the right arm is detached and it's going away“; „My body is splitted in two parts, in half, the right and the left part. The right part is in movement, in ferment, the other one is like it didn't exist“; „Everything knotted. I found tension in my arms and legs I didn't know I had“ – a 60 years old man, hypochondriac, endogenous depression, obese patient.

„I see my body as a voltage pole. I see every wire passing through the pole and it's big“; „There's a black hole in my body, between my belly and my back. Outside it's cold and snowy and my body is cold“; „I see a hole, a cave in my belly“; „I don't know where that is. There's a hole in my belly. My liver's hungry.“ – a 35 years old women, anorexic and bulimic patient, post-partum depression.

Ein Modell zur gruppenpsychotherapeutischen Integration von Körper und Psyche auch bei psychiatrisch schwer erkrankten Patienten – das BerTosa Verfahren (Zusammenfassung)

Die BerTosa Methode ist das Ergebnis der wissenschaftlichen Zusammenarbeit von Lorenza Tosarelli, einer Psychoanalytikerin und Psychologin, und Carlotta Berti, einer Wissenschaftlerin auf dem Gebiet des Sports und der angewandten Leibesertüchtigung. Sie wendet sich an Menschen mit psychischen Störungen. Ihr Ziel ist die somatopsychische Integration des Patienten zur „Heilung des Selbst“ im Sinne der Theorie KOHUTS. Die Methode beinhaltet eine Reihe von Aktivitäten im Rahmen eines gruppenpsychotherapeutischen Settings, die auf die Mobilisierung des Zusammenwirkens von körperlicher und emotionaler Bewegung abzielen. Die Arbeitsweise folgt einem interpersonellen und emotional bestärkenden Ansatz (MOLE 2003).

Die BerTosa Methode basiert auf einem integrierten und zirkulären Interventionsmodell (GATTICO und MONTOVANI 1998). Die Autoren betrachten den Menschen als Synolon (TOSARELLI und MARTELLI 2011), als Körper-und-Geist-Ganzheit, ausgestattet mit der Fähigkeit zur Rück- und Vorwärtskoppelung dieser Bereiche (FORD und LERNER 1992).

Die Methode wirkt mittels der Suche nach körperlich wahrnehmbaren Rückkoppelungen, die einen Wechsel zwischen den tonischen (im Sinne einer Grundspannung), kinetischen und später emotionalen Ebenen in

Gang setzen. Sie berücksichtigt die Struktur des „Men system“ (MARAVIGLIA 2005, 2012) und seiner Funktionen, um den wahren Körper („proper body“, FONTANILLE 2006) zu generieren, in Übereinstimmung mit den eigenen Lebenserfahrungen. Der Ausdruck „proper body“ bezieht sich nicht auf die Stofflichkeit des Körpers, sondern muss eher als eine Instanz der Selbstrepräsentanz im phänomenologischen Sinne betrachtet werden. Jacques FONTANILLE (1999) bemerkte, dass ein „corps propre“ eigentlich als ein fühlender Körper definiert werden kann. Die Autoren übernehmen im Weiteren die Definition eines „sensing body“.

Das Arbeitsmodell leitet sich vom Vorgang der Erforschung ab. Auf der Suche nach einer inneren Konsistenz verschafft uns umfängliches Erspüren des fühlenden Körpers (sensing body) einen ganzheitlichen Zugang zu unserer Innerlichkeit.

Er beginnt mit der Funktion der Grundspannung („tonic function“), wie sie von Henry WALLON (1942) beschrieben wurde, welche „fest verbunden ist mit der Entwicklungsgeschichte des Subjekts.“ (GHILLANI 1984, S. 2) „Die Kontraktion dient (auch) als Abwehr.“ (LEMAIRE 1964, S. 15)

Der Muskeltonus kann die psychische Aktivität und geistige Wachsamkeit des Subjekts mittels vernetzter und subkortikaler Strukturen beeinflussen“ (LANG 2010, S. 416; ein ähnliches Konzept wurde bereits 1993 von ROBERT-OUVRAY vertreten). Der Tonus beeinflusst die Struktur der motorischen Grundmuster („basic motor patterns“, vgl. BAUR 1983). Die psychische Erkrankung führt zu ihrer Herabsetzung, sie bleiben aber latent vorhanden, und eine Wiederentdeckung erzeugt neue körperliche und emotionale Spannungen.

2004 erklärt Gerald EDELMAN, wie der Körper zum neutralen Bezugsrahmen als auch zum Zentrum des Schauplatzes des Lebens wird. MULDER et al. (2004) schreibt, dass derartige motorische Grundmuster nichts anderes sind als die Vorlagen für die Arbeitsweise des Gedächtnisses. Jene sind eher „gespeichert in sensorischen und ikonischen Bildern als verbal repräsentiert“ (PERSON und KLAR 1994) und bilden das „implizite Unbewusste“, wie es Mauro MANCIA (2004) beschrieben hat. Dieser Autor nimmt an, dass ein „non-removed“ unbewusster Kern des Selbst ununterbrochen Einfluss auf unser Seelenleben nimmt.

Der Körper, die „Wahrnehmungssubstanz des Lebewesens“ (FREUD 1915) sammelt und reflektiert sensorische Redundanzen. Marco SANTELLO (1998) wird später die Organisation dieser sensorischen Weitschweifigkeiten mittels motorischer, sensorischer und sensomotorischer Synergien

als Ort der Strukturierung des impliziten Unbewussten beschreiben. 1920 sprach Sandor FERENCZI bereits von einem „Körpergedächtnis“ (FERENCZI 1928c), das „lediglich“ aus „Empfindungen und nachfolgenden Körperreaktionen“ besteht (FERENCZI 1938h). Die Erinnerung steckt im Körper und nur da kann sie geweckt werden. „Alles wird [erstmal] Empfindung ohne Objekt“ (FERENCZI 1938h).

Die frühe Verletzung (precocious trauma) wirkt sich negativ auf den Aufbau grundlegender Bewegungsmuster aus. Es erzeugt ernsthafte primitive Einschränkungen der Beweglichkeit (Kontrakturen). Das frühe Trauma steht im Gegensatz zu einem assoziativen und interpretativen Prozess, wie Daniela DE ROBERTIS (2009) erläutert. Was bedeutsam erscheint, ist die Entwicklung eines leiblich verankerten Selbstbewusstseins (THELEN und SMITH 1966, THELEN 2013), hervorgebracht durch eine körperbezogene Intelligenz, welche sich durch Bewegung entwickelt.

Die therapeutische Aktion, so wie sie von den Autoren beabsichtigt ist, ist nicht auf die Wiederbelebung der Erinnerung gerichtet, sondern auf die Hervorbringung sowohl einer Selbsterkenntnis als auch einer Erkenntnis ihres Umfeldes durch die Restrukturierung der Basic Motor Patterns (CASOLO 2002). Sollten frühe Erfahrungen fest verankert sein mit traumatischen Situationen, wird die Linie der Integration verfehlt, und das geschieht rund um unvermeidliche Kluften sowohl im prozessualen als auch im affektiven Erinnerungsvermögen. Die Autoren meinen, dass eine derartige Veränderung den nichtbewegten (non-removed) unbewussten Kern des Selbsts erheblich beeinträchtigt, wobei Risse und Brüche bei der Entwicklung eines ganzen und authentischen Selbst entstehen. Die Autoren denken auch, dass sie fähig sind, einen neuen Prozess der Selbstintegration mittels Verkörperung zu aktivieren (MONTESSORI 1950; VARELA und MATURANA 1973; NACARRI 2006; CERUTI und DAMIANO 2009), um damit im Innersten einige unerkannte Basen zu finden, die entgegen aller Erwartungen wieder anspielbar sind.

Die Autoren definieren diese Möglichkeit als den fruchtbaren Weg („generative path“) zu einem authentischen, körperlich verankerten Selbst.

Frühe Traumata bringen „gebrochene Menschen“ (MONTESSORI 1949) hervor, die an dem Prozess der Verkörperung, der dem Einschluss von Gefühlen dient, die dann verfügbar sind, gehindert wurden. Die Autoren sagen, dass ein gebrochener Mensch ein zerissenes Selbst hat. Diese gebrochenen Menschen mit einer „verschwommenen und zerstreuten Seele“ (MONTESSORI 1950) haben ebenfalls disharmonische und nicht fließende

Körperbewegungen. Zur Abwehr dienen meistens Flucht oder Muskelkontraktion. Diese Muskelkontraktionen gleichen verbarrikadierten Zonen des Subjekts, in denen sich eine Energieimplosion entwickelt. Eine Spaltung von Körper und Wahrnehmungen ist in diesen Fällen auch möglich.

Diese Abwehrformen generieren „closed areas“, unbekannte und versiegelte Areale: auf diese Weise bleibt eine reale somatische und psychische Integration unerreichbar. Das Subjekt zeigt verstörte Grade artikulärer Beweglichkeit und muskulärer Steifheit. Auf der psychischen Ebene nimmt diese Verfassung die Form einer Pendelbewegung ein zwischen innerer Dekonstruktion und einem unsicheren psychischen Gebiet ohne ein definiertes Ende, in welchen auf der Sinnsuche Leerstellen überbrückt werden sollen. In diesem Körper führen die Erfahrungen kaum zu der Schaffung eines ganzen Selbst. Dieser Körper ist dann eine Schwelle („liminal space“, VAN GENNEP 1909) am Übergang zwischen Zustand und Wandlung (GREIMAS ALGIRAS 1966), ein Vorgang, der definiert werden kann als ein Ereignis. Der Körper wird lediglich besessen als ein Objekt, losgelöst vom Subjekt.

Das zerrissene Selbst kommt bereits bei der Geburt auf. Das Baby, das verdrießliche Aufregungen verspürt, zeigt bereits, dass es ihnen entkommen kann durch eine muskuläre Anspannung. Dies geschieht, weil das implizite Gedächtnis vermittelt wird durch eine Vielzahl von Systemen, einschließlich desjenigen der Furcht, welche sich aus der Wirkungsweise der Amygdala und den mit ihr verbundenen Arealen ergibt (LEDOUX 1996).

Der Ansatz, der die Heilung auf das Gespräch gründet, wird verbessert durch die Arbeit mit dem Körper. Die Psychotherapie wird im besten Sinne radikaler und dadurch eher befähigt, Sorge zu tragen für das frühe Beziehungstrauma (STERN 2004).

Auf der Basis des bisher Ausgeführten soll klar werden, dass die Bertosa Methode notwendigerweise mit der Bewegung des Körpers beginnt und nur dadurch zu einer verbesserten Integration verhelfen kann: Es ist grundsätzlich die Bewegung, die eine Veränderung herbeiführt (RESNICK 1995).

Der hier vertretene Ansatz betont vor allem das Gleichgewicht seines strukturellen, funktionalen und psychodynamischen Anteils (ARIANO 2000).

Das Setting ist charakterisiert durch einen langen Moment des Haltens, in dem sich die Veranstalter und die Gruppe in einer Art fast gemeinsamer

Haut („common skin“, ANZIEU 1985) wiederfinden, um dann doch ihre eigene Individualität wiederzuerlangen (MAHLER und PINE 1975). Diese Gruppenerfahrung leitet ihre Bedeutsamkeit von Winicotts Konzept des Haltens (1965) ab.

Hat das Setting seinen Höhepunkt erst mal erreicht in einem entspannenden und angenehmen Gehalten-Werden, fallen die Patienten in einen Schlaf, aus dem sie der Klang der Stimme des singenden Therapeuten (DEFONZO 2010) erwachen lässt. Das Singen ist ein vibrierendes Singen (GRUNGO 2013) und wirkt wie eine psychische Haut, die den Schlaf umgibt, hat aber auch eine integrierende Funktion für das Selbst, wie es SULLIVANS Theorie (1953, 1962) beschreibt. Zum Abschluss berichten die Autoren zur Unterstützung der Stichhaltigkeit ihrer Theorie und zum Beweis der Übertragbarkeit ihrer Erfahrung von einer Forschungsarbeit, die in „Le Science“ am 11. März 2014 erschien. Eine Gruppe von Forschern des Karolinska Instituts und der Umea Universität in Schweden erklären hier, wie sehr das episodische Gedächtnis von der Qualität der körperlichen Wahrnehmung abhängt.

Die BerTosa Methode und die damit einhergehende Arbeit der qualitativen Verbesserung der gefühlsmäßigen Körperwahrnehmung wird experimentell eingesetzt in der Therapie von – auch schweren – psychiatrischen Erkrankungen. Diese Methode zielt ab auf das Wachstum eines ganzheitlichen und authentischen Selbst der Patienten – im Sinne einer nachholenden Entwicklung, die bei defizitären Ich-Strukturen angezeigt ist.

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Nachrichten / News

XXX. International Symposium
of the German Academy for Psychoanalysis (DAP) e. V.
17th World congress of the World Association
for Dynamic Psychiatry WADP inc., Berne
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Moskovskye Vorota, Russia



Multidisciplinary Approach to and Treatment of Mental Disorders: Myth or Reality?

Multidisciplinary approaches have recently become one of the most discussed topics among mental health scientists. This is quite understandable because of the financial difficulties that we are experiencing to various extents all over the world, and these have a major impact on health care systems, including mental health care services. The discrepancy between the costs of any new generation of medicines and their efficacy is constantly growing. We can observe the regular appearance of new and quite diverse approaches in the list of health care services. It is indeed difficult to define how valuable these are if we don't compare them with the already existing ones, especially when these new approaches belong to different fields and specialties in mental health care. At the same time, national ministries of health care, insurance companies, patients themselves and their relatives make increasing demands on the quality of the provided mental health care services.

All of this creates a great challenge to integrate therapeutic programs, linking the most effective approaches from different fields of mental

health care system. Their efficacy should be proved by the means of evidence-based medicine. It is quite obvious that the development of such programs can only be successful as a result of constructive discussions among the representatives of all disciplines of the mental health system – psychiatrists, professionals of the in- and out-patient and ambulance care units, psychotherapists, clinical psychologists, social workers and nurses.

In the literature one can already find the call for joining this new movement in mental health care. The reports on its successful application in real settings are also increasing. Nevertheless they are far away from becoming the standard of practical mental health service, especially in settings of managed care. The complexity in establishing a mutual understanding and a common language among participants of multi-professional teams is evident. This causes doubts about the reality of the determined goals and leads to the question whether a multidisciplinary approach is an emerging true reality or just a myth.

Nikolaj G. Neznanov

President of the World Association for Dynamic Psychiatry (WADP)



The congress took place in close collaboration with the internationally renowned Psycho-neurological Bekhterev Institute.

The claim for a holistic view of the individual is increasingly argued in psychiatry and psychotherapy, for instance with the demand that the exclusively biological and psychosomatic model of illness should be expanded in the direction of a bio-psychosocial understanding of the human being. This implicitly requires an interdisciplinary collaboration with researching efforts to provide an insight into the conditions of human develop-

ment, both in health and illness, and their implementation into practice. Such efforts, however, are linked to a number of theoretical and practical problems. One challenge is, for instance, to combine the development of integrative research models and treatment approaches with the insight of the diverse human sciences and the results of the various schools in a way, that these efforts can be effectively applied to stimulate the well-being of the person in development requiring treatment including their surrounding groups and society.

For our patients, exposed to the incessant demand of identity development through the changing social structures and the progressing globalization (this topic was extensively discussed at our 16th World congress), we need a new kind of thinking and new ways leading to a holistic understanding. Therefore it is important to integrate the different scientific branches and disciplines has become a necessity for the technique of treatment.

However, Günter Ammon added his comment: „Each attempt to integrate different methods has to be made in the service of the patient, with the aim to better understand him in order to be able to help him in a better way” (Ammon 1982).

With his concept of the Berlin School of Dynamic Psychiatry, Günter Ammon very early not only demanded an interdisciplinary collaboration of psychiatry and psychoanalysis but also the collaboration of other scientific disciplines such as psychology, pedagogy, philosophy, neurophysiology and neuropsychology, sociology, anthropology, ethics and especially analytic group dynamics.

Since he considered the eclecticism especially within the psychiatric, psychotherapeutic and psychosomatic treatment as a great problem for the treatment of personality disorders in particular, he always intended – on the background of his multi-dimensional-integrative research and treatment approach – to integrate the newest results from the interdisciplinary research into the treatment of people.

In the course of realising this demand for „integration”, numerous misunderstandings, resistance and deficits are occurring in practice within the group-dynamic network of interdisciplinary efforts, challenging us to come together in order to search for new ways of communication and networking. There to facilitate a discourse transcending the diverse cultures, societies and scientific disciplines was the aim of this congress.

Maria Ammon

President of the German Academy for Psychoanalysis (DAP) e. V.

Myths and Reality – Art therapy studios Exhibition supported the congress with their marvellous work

The paradigm of the present-day psychiatry represents a bio-psychosocial approach, which combines the development of various forms of psychosocial therapy and rehabilitations, overcoming stigma? Reintegration of patients into the community and improving their quality of life alongside with the latest biomedical research. In this sense, art therapy has been traditionally one of the most popular practices: the elements of art activities were introduced in psychiatric clinics as early as in the nineteenth century, and in the twentieth the term of art therapy denoted already a whole trend within the socio-therapeutic movement. Art work enables patients to express their feelings in visual form, to actualize their creative potential, to cope with anxiety and stress, and to improve communication skills. The attitude of psychiatrists material while others after J. Dubuffett adhered to the idea that pieces of Art Brut should be evaluated solely for their artistic value. This has been still the matter of debate between representatives of two different approaches – the „artistic” and the „psychiatric”.

Up to the present time, art therapy activities have been most often organized in the form of an open studio, which implies the principle of de-



mocratic environment for the users and no prescriptive methods, imposed, with such therapeutic benefits as sedative, activating and cathartic effects.

For example, paintings from the Saint-Petersburg Regional Department of the All-Russia Public Organisation „New Opportunities”, from the Art Studio „Zazerkalie” Orenburg, from the Skvortsov-Stepanov 3rd city

mental hospital St. Petersburg, from the P.P.I Kaschenko 1st city mental hospital art studio St. Petersburg, from the Art Studio at Psychoneurological Outpatient Clinic in St. Petersburg, from the Foundation for Support of Social and cultural Initiatives „InART” in St. Petersburg, and from the Psychiatric clinic Mengerschwaige, art therapy studio, Munich, Germany.

Keylectures

The opening session began with the interesting topics „The Dynamic Psychiatry Concept of G. Ammon as the Theoretic Base for Interdisciplinary Approach in Modern Psychiatry” by Nikolaj Neznanov & Anna Vasilieva (St. Petersburg) who gave an overview about G. Ammons „Human Structure Personality Model” in the context of a multidisciplinary approach with the integration of social, psychological and biological issues in the understanding of mental disease.

Furthermore he explained G. Ammons view about group dynamic influence as it is the main epigenetic factor defining the development of central



human functions and the identity as a whole in constructive, destructive or deficient way. This speech was followed by the theme „Dynamic Psychiatry, an „Integrative Theoretical and Practical Psychodynamic Treatment Concept“ from Maria Ammon (Berlin/Munich). The author lined out the important history of Dynamic Psychiatry starting from the 19th century to the present integrative concept of G. Ammon. The therapeutic conception and intervention methods of Dynamic Psychiatry as an integrative treatment concept was demonstrated as verbal and non-verbal approaches.

Levent Kuey (Istanbul) talked about the „Subthreshold States in Psychopathology: Myth or Reality?“. His presentation mainly discussed the phenomenon of threshold and subthreshold states in the context of psychopathology, clinical practice and classification systems, including also the forensic and administrative grounds. He pointed out the mindfulness and responsibility we have in our daily work and the consequences the clients and their families will have, living with the diagnoses.

The Key Lecturer Petr Viktorovich Morozov (Moscow) showed us a range from „Psychopathology to Biological Correlates“ by using the wellknown Kandinsky-Clerambault Syndrom, described by Russian psychiatrist V. K. Kandinsky in 1885 and the French psychiatrist G. G. de Clerambault in the first half of the 20th century. This term has been used in psychiatric literature and clinical practice of East European countries for more than 80 years. It describes a set of interrelated symptoms like pseudohallucinations, delusions of persecution and influence, feelings of being captured and openness. It is typified by alienation, loss of one's own mental processes and a feeling of being constantly influenced by external forces f. e. Analysis of history of creation of both authors' mentioned works, similarities and differences in views of Kandinsky and Clerambault were given in the presented work. Estela Welldon (London) talked interesting about „Wagner, Freud and the End of Myth“. Freud once asserted that his intention was to re-interpret myths and stories as products of the inner world, and thus „transform metaphysics into metapsychology“, but had Wagner got there before him? By taking the mythic dimension and bringing it into the human realm, Wagner anticipated Freud in his depiction of unconscious processes of the mind, while Freud's science of the unconscious' gives unprecedented insights into Wagners' monumental achievements. E. Welldon concentrated on the psychodynamic development of Brunhilde in the Ring as a means of demonstrating Wagner's enormous capacity to understand the substantial complexity and power of femininity and the related capacities of change.

Gerald Hüther (Göttingen) in his charismatic and humorous speech manner gave us an overview about the „Lifelong Plasticity of the Human Brain and its Implications for the Prevention and Treatment of Mental Disorders“. The recognition and general acceptance of the human Brain's ability to reorganize its neuronal connectivity throughout lifetime is the most important breakthrough in 21st century neuroscience. It became the most provocative challenge for all conceptualizations of mental disorders,

made under the earlier association of a more or less unchangeable neuronal connectivity. This lifelong experience-dependent plasticity of the human brain was described and, derived from this evidence, some predictions were contributed. The validity of these predictions was illustrated and was exemplified in case of stress and anxiety related, attentional, obsessive-compulsive and addictive disorders. Last but not least Ilse Burbiel (Munich) talked encouraged about the “Multidisciplinarity from the View of Dynamic Psychiatry – What does it Imply? Some Theoretical Reflections and Practical Consequences.” She reflected this question – against her background of thirty years of experience as an in-patient practicing psychological psychotherapist – on the example of the Dynamic-Psychiatric Hospital Mengerschwaike. By means of a case study it was discussed what essential significance the self-reflective work in this clinic has for a successful psychiatric-psychotherapeutic treatment of seriously mentally ill patients. Margit Schmolke together with Nathaly Hoffmann talked about the „Mirror Processes in the Protected Space of Psychoanalytic Supervision”. Supervision is a useful instrument in psychodynamic psychotherapy as well as in a multi-disciplinary teamwork. The specific interest of the authors was the phenomenon of what happens within the trainee-supervisor-relationship in particular the mirror processes. The authors aim is, to find out in what way trainees can be sensibilized for these mirror processes in a cognitive and emotional manner.

Further important Key Lecturers like Michel Botbol talked about „Milieu Therapy with Borderline Adolescents: A Psychotherapy through the environment?” After a brief reminder of the borderline psychopathological characteristics from a psychoanalytical point of view a vignette was shown how milieu therapy allows the therapeutic team become the patient’s „widened psychic space” when the staff members by lend their thoughts and their imaginary abilities to make up for the patient’s disability to bear or elaborate its conflicts in its own inner space. Volker Tschuschke got deeper into the question „How specific is Psychotherapy – complex relationships between specific and common therapeutic factors”. His paper referred to data from a major Swisswide psychotherapy research project. The naturalistic study includes 10 different psychotherapy concepts from psychodynamic, humanistic, and integrative orientations, involving 88 psychotherapists and 350 patients from outpatient therapeutic settings. Path analyses and complex statistical analyses reveal process-outcome-related patterns which are stable across different therapeutic con-

cepts. Treatment integrity of therapeutic interventions do not play a significant role in regards to treatment outcome. The role of treatment integrity (adherence) of therapeutic interventions in psychotherapy was discussed in the light of these results and involved arguments from the perspective of the „Dodo Bird Verdict”. Hans-Otto Thomashoff (Vienna) came up with the topic „Brain and Society”. By understanding the constantly interactive constructive process which leads to the creation of our brain structure the roots of cultural phenomena become evident. This process starts long before birth and the traces of these earliest stages of subjective world creation can be recognized in different areas. Not only many cultural phenomena can be elucidated by integrating our knowledge of the interactivity of the brainstructures build-up, but also the creation of political systems can be understood as a result of psychological needs deriving from the brain’s functioning. E. g. like any form of behavior also trauma tends to be passed on from one generation to the next.

Seminars/Symposia

Furthermore Symposia about Teamwork and collaboration sections, psychoanalysis in Psychiatry, Dynamic Rehabilitation, and the phenomena of transference and countertransference in the psychotherapeutic process – features of the dynamics of the relationship between patient and therapist took place. These symposia were also specially for a junior programme with topics like „Aesthetic Experience and Psychoanalysis: Treatment as Art”. Treatment is an aesthetically organized realm of experience. The hypothesis for this is that art and the psyche are structured according to an aesthetic logic with an emphasis on development and the production of an emotional experience. Besides the comparison between art and therapy as well as the aesthetic aspects in the patient-therapist relationship, the question of the therapist’s (mother’s) desire for the patient, in the sense of Laplanche’s seduction, was problematized by Angelika Rapaport (Munich). „New considerations on Personality Structure Deficit and Development Stagnation” from Astrid Thome (Munich) were discussed, to mobilize or initiate new possibilities for psychic development. What does it mean? The communication discuss this question by proposing a psycho-physiological understanding of the stagnation of personality development, which refers to former research results of the dynamic-psychiatric hospital. Furthermore „Creative Steps out of Trauma, an illustrated Case Study of the Art

Therapy at the Hospital Mengerschwaike" from Georg Kress (Munich) could be attended. The author outlined how art therapy is especially suitable for early childhood disorders of the ego. Through visual expression and the „social energy" (G. Ammon) of the group the patient will be able to analyse and overcome his traumata via identity-development.

Special satellite symposia were offered about different mental disorders like Schizophrenia, cross-cutting issues of therapy of neurological patients, child psychiatry, addiction medicine, biological psychiatry, and interdisciplinary research and diagnostics in psychiatry. Furthermore Psychopharmacology and pharmacotherapy through time and standards and psychiatric aspects of neurology and neurosurgery.

More Symposia gave examples about traditions and highlights of multidisciplinary rehabilitation approaches to the mental health care from the Russian experience like P. O. Bombov et al. „Medical and psychosocial rehabilitation department – modern form of management patients with mental disorders in ambulatory caresystem and State-of-Art capabilities of rehabilitation of patients with mental disorders" like the topic from Gertraud Reitz (Munich), who talked ambitiously about „The Development of Body-Ego-Identity in the Framework of Outpatient Dance Therapy." Body-Ego-Identity has its roots in the very center of person, in the unconscious. Disorders in this field are therefore always disorders of identity and can only be dealt with under this aspect. Apart from the work with dreams this is possible especially in the human-structural dance therapy, as G. Ammon has developed it. In the dance there is a permanent interaction of the conscious and the unconscious, the individual and the group, female and male as well as healthy and unhealthy aspects of a person; the aim of therapy is the integration of the different dimensions into the identity of the person concerned.

Also important Symposia about the growing themes Religiosity, Faith and Spirituality were included, like the topic „Faith and Healing" from Verma, Jyoti (Patna). Coming from a country where people are likely to have invincible „faith" in some deity, (i. e., divine power), supreme influence, and even „mantras", prayers, religious rituals, and faith healers, the author proposed to address to a basic question namely, „what is faith?" Further the interest extended to the question, „if faith heals how does it facilitate the healing process?" At this instance „faith" needs to be examined as one of the multiple approaches for healing negative affective states and predominance of „negativity" in one's thoughts, action and feelings. The

ultimate aim is to understand whether „faith” seems to have a role in the therapeutic process and in activating the resources (inner power) of the „self”. Moreover an overall theme „The Development of Peace Capacity: Myth or Reality” by Ingeborg Urspruch (Munich) could be attended. To achieve and to maintain peace it assumes the inner peace capacity. The author performs thoughts about the meaning of inner peace capacity from the view of psychoanalysis. She looks at inner peace capacity as a prevention from interpersonal traumatic dynamics and therefore as well as a prevention for the severe traumatic results caused by the never ending wars between the people of the world and the resulting destruction of our world as living space. Gabriele von Bülow (Berlin) gave a deeper sight on „Spirituality as a Resource in Psychotherapy”. There are many empirical studies which come to the conclusion that spirituality has a mainly positive effect on the course of an illness in general and on the development of psychic health in particular. Here the question arises on the relationship between trust in people and trust in a comprehensive, transcendent dimension, capable of giving meaning to life. The last ground of being can become transparent in human relations where someone feels accepted and mirrored as a unique person, experiencing narcissistic gratification as well as challenges.

Workshops

In the afternoon every day the workshops took place with additional topics like „Space for Development through Dance and theatre” from Reitz Gertraud (Munich), Kiem Petra (Berlin) and Urspruch Ingeborg (Munich) or about the „INDIGO-Study-Group – Discrimination of Mentally Ill People in their daily Life” from Petra Decker (Munich). Discrimination, as we all know, can lead to under-treatment, material poverty, and to social marginalization. The International Study of Discrimination and Stigma Outcomes (INDIGO) included a cross-sectional survey conducted by face-to-face interviews between research staff and 732 participants with a clinical diagnosis of schizophrenia in 28 countries, using the Discrimination and Stigma Scale (DISC). Rates of experienced discrimination are relatively high and consistent across countries. Unexpectedly, in two of the most common and important domains (work and personal relationship) the anticipation of discrimination occurs more often without than with the prior experience of such actual discrimination. Further Alfonso Cesar

and Olarte Silvia (New York, Mendoza) worked on „Preventing Boundary Violations in Psychodynamic Psychiatry with an interactive workshop”. The two psychoanalysts, working for two decades collaborative in clinical practice, reviewed ethical guidelines in psychodynamic psychiatry, and brought the complex practice of combining pharmacologic and psychotherapeutic treatment together. Martindale Brian (Newcastle) had a workshop on „Family Work in Psychosis” and Horst Meinhardt (Bad Schoenborn) aroused our curiosity with his workshop about „The Psychoanalyst – a Magician?”

Enriched was this excellent international and warmly welcomed congress by a marvelous and unforgettable cultural program, a special visit of Peterhof at the evening with welcome dinner, classical music and ballet, the visits of Catherine’s Palace and Hermitage.

Conclusion/Summary

Unfortunately as it was a congress also important for international scientific exchange, a lot of important sessions and workshops were only in Russian without translation in English or power point in English like the sectional session on sexology and addictive shopping, but the congress language was English. For the next upcoming congress in Florence in 2017 this should be ameliorated, f. e. simultaneously translation in English as mentioned before, and some interesting sessions and workshop didn’t take place like new approaches in Music therapy like „Rewiring the Brain with Music”. All in all, the XVII World Congress of the World Association for Dynamic Psychiatry and the All-Russian Scientific Practical Conference „Multidisciplinary Approach in Understanding and Treatment of Mental Disorders: Myth or Reality?” was a great pleasure and success for attendants, lecturers and organizers.

The term „psychiatry” appeared over 200 years ago. Since then, psychiatry has formed into a most complicated field of knowledge based on the advancements and developments in fundamental biology and medicine as well as on humanist principles, which are particularly significant for the diagnosis and treatment of mental patients. An immense contribution to the development of psychiatry was made by the Russian scientist Vladimir Mikhailovich Bekhterev, who created the concept of a biopsychosocial understanding of the nature of mental disorders and predetermined the vector of the development of scientific research activities at the insti-

tute founded by him. A holistic understanding of the etiopathogenesis and therapy of mental disorders has become the logical development of this scientific school. The scientific presentation of the forum participants was of great interest to the audience. The keynote of the majority of lectures was a multidisciplinary approach corroborated by an extensive arsenal of innovative methods. This will allow us to broaden our horizons in the study of the fundamental issues of psychiatry. Undoubtedly, quite a few traditional concepts need to be reconsidered today. This applies equally to a more profound understanding of the nature of mental disorders and to the methods for their treatment. Only innovations in tandem with fundamental research will enable further development of psychiatry. The Congress and the Conference implied a creative interaction between noted scientists and novice researchers united by a common desire to make mental health care as effective as possible. The conclusions and recommendations of the forum should contribute to the preservation of the best traditions and, at the same time, encourage further progress in modern psychiatry.

G. A. Sofronov

Member of the Presidium of the Russian Academy of Sciences
Academician

Schlussfolgerung/Zusammenfassung

Leider waren viele Vorträge und Workshops nur in Russisch, ohne Übersetzung und Powerpoint-Präsentation in Englisch, wie z. B. eine ganze Sektion zur Sexualwissenschaft und zum suchterzeugenden Einkaufen. Dies erfolgte, obwohl die Kongresssprache Englisch war und es doch für einen internationalen Kongress wünschenswert wäre, sich mit KollegInnen aus aller Welt in dieser Sprache austauschen zu können. Es wäre sehr schön, wenn dies für den nächsten Kongress in Florenz in 2017 berücksichtigt werden könnte. Einige Vorträge fanden erst gar nicht statt, obwohl sie angekündigt waren, wie z. B. der Vortrag zu neuen Ansätzen in der Musiktherapie „Rewiring the Brain with Music“. Es wäre hilfreich, wenn es vor Ort Handouts geben würde, in denen das vermerkt ist. Abgesehen von dieser organisatorischen Problematik war die Teilnahme an dem 17. Weltkongress des Weltverbandes der Dynamischen Psychiatrie und der Russischen wissenschaftlichen Konferenz „Multidisciplinary Approach in Understanding and Treatment of Mental Disorders: Myth or Reality?“ ein großes Vergnügen und ein großer Erfolg für die Teilnehmer, für die Vortragenden und für die Veranstalter.

Der Begriff „Psychiatrie“ entstand vor über 200 Jahren. Seitdem entwickelte sich die Psychiatrie zu einem der kompliziertesten Wissensbereiche, basierend auf der Weiterentwicklung der Grundlagen der Biologie und Medizin, als auch auf humanistischen Prinzipien, welche maßgeblich für die Diagnostik und Behandlung von psychisch erkrankten Patienten sind. Einen immensen Beitrag zur Entwicklung in der Psychiatrie leistete der russische Wissenschaftler Vladimir Mikhailovich Bekhterev, der das Konzept des biopsychosozialen Verstehens der Natur von psychischen Erkrankungen und dem vorherbestimmtem Vektor der Entwicklung von wissenschaftlicher Forschungsaktivität in dem von ihm gegründeten Institut kreierte. Ein holistisches Verständnis der Krankheitsentwicklung und Therapie psychischer Erkrankungen war die logische Entwicklung, die aus dieser wissenschaftlichen Schule hervorging. Die wissenschaftliche Präsentation war von großem Interesse für das teilnehmende Auditorium. Der Hauptgedanke der Mehrheit der Vortragenden war ein multidisziplinärer Ansatz, bekräftigt durch ein umfangreiches Arsenal innovativer Methoden. Dies erlaubt uns, unseren Horizont im Bereich des Studiums der Grundlagenforschung der Psychiatrie zu erweitern. Unzweifelhaft sollten einige traditionelle Konzepte heutzutage überdacht werden. Dies führt zu einem grundlegenden Verständnis der Natur psychischer Erkrankungen und der Methoden ihrer Behandlung. Nur Innovationen im Tandem mit Grundlagenforschung werden uns eine Weiterentwicklung in der Psychiatrie ermöglichen. Der Kongress und die Konferenz implizierten eine kreative Interaktion zwischen renommierten Wissenschaftlern und jungen Forschern, vereint in dem gemeinsamen Wunsch, das Gesundheitssystem so effektiv wie möglich zu gestalten. Die Schlussfolgerung und Empfehlungen des Forums sollten zur Erhaltung der besten Traditionen beitragen und gleichzeitig zum Fortschritt moderner Psychiatrie ermutigen.

(Deutsche Übersetzung von Petra Decker, München)

XXXI International Symposium of the German Academy for Psychoanalysis (DAP) e.V.



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