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Dynamic Psychiatry

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The Dynamic Psychiatry Concept of G. Ammon as the Theoretic Base for Interdisciplinary Approach in Modern Psychiatry

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The following text examines the need of introducing a holistic theory in mental health care, to integrate psychodynamic concepts and latest findings in neurosciences. Demands for such a model are outlined, such as consideration of group interaction and unconscious processes in a more and more globalized world, applicableness in multidisciplinary health care teams and the need for a patient centred approach in psychotherapy. With regard to these challenges, the human structure personality concept of G. Ammon is suggested and main components of the model are explained.

Keywords: dynamic psychiatry, psychotherapy, mental disorders, identity, multiprofessional setting, neurobiology

Modern science represents a field where every scientist is digging his own pit in a search and often can find required subjects while completely ignoring the neighbour. There are plenty of such pits holes for the time being, however somebody has to sit over the pits and observe the whole field.

Thor Heyerdahl

We are living in times of a tremendous development of new technologies, providing us with fascinating experimental results that feed our omnipotent wishes to know and to control everything. Nevertheless, looking more precisely we can see that sometimes the picture of progress is quite deceiving and we fool ourselves with our wishful thinking. Today, by the use of modern science, we can equally observe advancements as well as some regress tendencies concerning our understanding and treatment of illnesses, especially mental disorders.

Progress is determined by the use of more and more sophisticated techniques, providing us with various data also about brain functions that can be evaluated quantitatively. At the same time regress is taking place because often we don't know what to infer from the collected data; we as specialists fail to encompass the subject as a whole due to its multiple splitting and separation. As the well-known neuropsychologist Oliver Sachs wrote in 1992: „Due to the historical fatal irony the increase of our

knowledge and sophistication of diagnostic technique were accomplished at the expense of real loss of common understanding of the reasons and conditions of the illness". Now after more than 20 years we didn't improve much and he is still right. The adepts of the so-called evidence-based approach in medicine call for exact localization of mental functions in the human brain and since there is no definite structure encompassing the unconscious is found, they pretend it doesn't exist.

In 1990 collaboration between mind and brain researchers started, that gave us the opportunity to have a look at what is happening on the biological level during the process of psychotherapy with the help of functional neuroimaging. The number of studies supporting basic psychodynamic hypothesis related to processes, relationships and representations is constantly growing. Nevertheless as the leading researchers in this field Roffman J. L., Gerber A. J. in 2010 pointed out: „Given the distributed nature of brain processes and the complex interdigitation of the machinery that drives cognitive, emotional and social processes, it is difficult to imagine wholly discrete, unambiguous localization for any particular concept, whether it be unconscious mind, repression, transference or structural change."

The modern scientific tendencies have their practical implementations and have their impact to the existing splitting of the patient's image, like in modern abstractionists portraits we can adore the details and the sophistication of the artist but we can hardly recognize the subject. The loss of holistic approaches causes confusion in all participants of the health care system. We can observe distortions of intergroup mutual understanding, interrelationships and interactions. We accumulate more and more data that estrange us from each other at the same time; we don't have the time for reflecting what we got and to share our expertise with group peers. That is why the main humanitarian problem of the future will be maladaptation, determined by the retardation of adaptation processes in regard to globalization stress factors. The novelty, complexity and the number of daily events are the main challenges that we have to deal with, to prevent falling in the „information neurosis". The combination of inequality, unfairness, poverty and helplessness along with dependences and neglect by the authorities, intensified by mass media potentiates the growth of mistrust to all „parental figures", including therapists. This causes impotent estrangement of the population from the possible sources of mental health care as psychiatry, psychotherapy and clinical psychology. As

professionals we know, that estrangement is also a common feature of all kinds of psychopathology, its development is unavoidable effect of limitations typical for the dynamic of psychopathology, precluding anxiety. So it can only increase under unfavorable social conditions. As a result for example, about 15–20 % of the population in Russia need professional mental health care and only 5,0–5,5 % really receive it.

It exists along with other negative tendencies in clinical medicine, like pathological process chronification, prevalence of atypical signs of illness, growing of comorbidity (increasing rate of mental disorders) and therapy resistance, spreading of polypragmasia, and rise of early disability.

Considering the state of our discipline we would like to pay special attention to psychiatric mythology and the imperfection of the mental health care system, as the main obstacles for individual cooperation. We define it as a well determined system of myths considering psychiatry that is integrated in and consistent with other social myths. We need to create myths in order to cope with anxieties and uncertainties of the world. There are some important factors, defining psychiatric myths. First of all, the main material for myth creating is unreliable information.

No matter whether we deny or acknowledge the collective unconscious system of legends and beliefs, prejudices and distortions reproduced in gossip, jokes and works of art are an essential part of our existence, including our professional life. The other one, mythopoetic mentality, has some specific features, excluding the need in empirical verification and confrontation with reality. Namely its irrational and unreflected thinking. Because of the features mentioned above it never questions the results of its activity, such as well-known beliefs don´t need prove. The other issue is that the existence of social myths is a quite universal phenomenon. They have an important role in the development of behavioral patterns of individuals and social groups. Patients´ violation of ethic norms also has an impact in the mythologization process. The last but not the least factor is the repellent myths function.

Psychiatric mythology presents a system of inappropriate images, of the so-called „scarecrows" determining the borders of sanity. Mostly it's a set of rules how one should behave himself in order to escape the label of being mentally ill. It´s an essential part of the system of social norms and has two main functions. First of all as a psychological defense system, it decreases the individual´s anxiety to lose control over ones behavior and become an outsider. The second function is to stimulate scapegoat

dynamic, aiming to exclude mentally ill people from the society labelling them as an extremely dangerous, unbalanced, distressed type. This should be considered as a negative myth role. All aspects of mental health systems, namely patient representation, etiology and pathogenesis of mental disorders, diagnosis, illness itself, its course and prognosis as well as the organization of mental health care are included in myth creation. The way the mental health therapist is seen is also an important part of mythopoetic content and probably an even more popular subject of joke, anecdotes and prejudices than the patient himself. Therefore the psychiatrist from the first meeting on is challenged with the patient´s preexisting, partly unconscious expectations and ideas-of-a-psychiatrist, which might be connoted negatively, compared to his colleague surgeon for example.

The well-known consequences of psychiatric myths are stigmatization and self-stigmatization. The fear of stigma makes the patients avoid all the mental health institutions where they could get help. Those of them who belong to migrant population suffer from the double stigma burden and prefer to concentrate on the somatic symptoms of anxiety or depression and to seek help from the internists. The direct consequences of the stigmatization process are the increase of xenophobia and poor compliance. The situation can be improved only with the developing of strong partnership relationships between the group of mental health providers and the groups of consumers of mental health services.

During the last 50 years the society has changed tremendously bringing new challenges and new definitions also for mental health system. Globalization is a new trait of our time; it forces psychiatry to solve psycho-social and social challenges, addressing not just the individual but groups of healthy and sick people, to regulate their use of new opportunities, provided by new information technologies. Nowadays, we can hardly find a patient who wouldn't use the internet in order to get information about his suffering. Googling the key symptoms he would automatically, unconsciously identify himself with a group of other affected people having the same problems. Taking in consideration this phenomenon we have to acknowledge that individual therapy as we perceived it in the past doesn't exist anymore. If we want to succeed in our therapeutic endeavors we have to elaborate a treatment approach that has group thinking in its core that is able to deal with groups and explains how to use the resources of the groups for the improvement of mental illness. The dynamic psychiatry concept of G. Ammon, who always stated the importance of

the group for mental disease development and accordingly for treatment choices even in his early works in 1959, provides such an approach.
G. Ammon emphasizes, that health can be provided best in and through group experiences and also illness can be treated best in and through groups. G. Ammon and his disciples consider personality development, its strengths and deficits as the result of internalized different group experiences. The existing system of main principles of group dynamic should be taken as an example and applied in the daily work of mental health specialists, no matter what psychotherapeutic method they practice. It should also be included in the principles for multi-professional team work in big psychiatric hospitals with regularly group-dynamic supervision in order to overcome alienation and misunderstanding that often exist between the different team members, like psychiatrists, psychologists, nurses and managers. Dynamic Psychiatry today is an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes unconscious conflict, deficits and distortions of intrapsychic structures as well as internal object relations and group dynamics. It integrates these elements with contemporary findings from neurosciences. It's a holistic approach that is capable of including the achievements of different disciplines dealing with the problems of mental health, in an integrative multidimensional model, in which the data from one field can support and explain the statements from the other approach. The human ego-structure as the core of dynamic psychiatric theory presents ego-structure as a coherent structure organizing individual mental processes. It encompasses central ego-functions, located in the unconscious, which are among others aggression, ego-demarcation, anxiety, creativity, sexuality, narcissism, identity. Also it postulates primary functions, which are organic structures, describing the neurophysiological and biological functions of men as well as secondary ego-functions, found mainly in the conscious and predominantly determining behavior, capabilities and skills of a person. All the three areas are not strictly demarcated but permeable; there is a synergism of unconscious, conscious, mental and bodily activities, which must always be seen in a dynamic context. G. Ammon emphasizes that all ego-functions are group dependent, the group experiences of early childhood being of greatest significance. Nowadays the progress of neuroscience allows us to prove G. Ammon's prophetic thinking. Dennenberg (1981) established that radical environmental events and conditions can modify neural structures, so the conditions of the primary group can in-

fluence the neurophysiological and biological features of the person, defining his further reactivity and vulnerability to stress events. Malatesta and Izard 1984 also showed that neural structures and functions related to emotional behaviors are similarly affected by experiences with the environment.

The other advantage of G. Ammon's theory is his proposal of the gliding spectrum of mental disorders where the level of disorder depends on the maturity of ego-structure and its ability to self-regulation. It encompasses a wide spectrum from a mature, integrated and self-regulated ego with all the human-structure functions, supporting and complementing each other up, to disintegrated and regulation impending personality on the other hand. It enables the professionals to consider incompatible symptoms and behavioral traits as the varieties, which is sometimes not so obvious, of more general patterns and forms of behavior defined by deficit of personality structure. This approach on one hand allows specifying the treatment, according to the current needs of the patient, but also to be consequent during the whole course of the therapy and to understand the patient´s development during the psychotherapeutic process in terms of personality growth.

G. Ammon considers the resolution of the symbiosis-complex during the first three years of life as crucial for the further development of ego-structure. He emphasizes the importance of the relationship and contact between child and his surrounding group for the development of constructive ego-functions and first of all „healthy" anxiety. The attachment type and further symbiosis complex resolution are developing at the very early preverbal stage of life before the individual learns to use words to consolidate his experience. Therefore it is necessary to use non-verbal expressive psychotherapeutic methods to work through symbiotic problematic and to overcome personality development arrest.

With the help of multidisciplinary approach these ideas now can be supported with neuroscience data. Kandel E. R., Kupferman O. and Iverson S., in 2000, showed that the formation of long-term declarative memory, which is also described as associative implicit memory system, not readily accessible to consciousness, relies on the structures in the medial temporal lobe, prominently in hippocampus, with the involvement of amygdala and limbic system when significant affects are involved. We now know that we have different ways of memories storage depending on the involved type of knowledge. Here we have the complex of memories

where the connection between different pieces of information is not obvious for the individual and does not come automatically in one's mind, but it can be retrieved with therapeutic exploration. We can see here involvement of such structures as amygdala, hippocampus and limbic system, which are responsible for the emotion regulation. Apparently, the early primary group dynamic experience can influence the biological vulnerability to mental disorders in adult life. In 2010 Levy R. A., Ablon J. S. in their research showed that patterns of interpersonal relatedness and emotion regulation learned in the first few years of life, are encoded in a more procedural fashion and therefore are slower to change and less amenable to verbal interpretations. That means that we have to be realistic in our therapeutic expectations and acknowledge the limitations of the short-term psychotherapy. Patients suffering from severe ego disturbances need a long-term psychotherapy with the continuity between in- and out-patient cares. Treatment must always fit the needs of the patient. Here we can take as a standard the dynamic psychiatry therapeutic setting, elaborated by G. Ammon and his disciples, in which each individual patient receives a treatment program in correspondence with his particular ego-structure and is thus exposed to a number of different group situations. The treatment system aimed to the made up of the deficient development, which allows unstructured personality obtain a new structure. Therefore patient acquires new relationships and is not in need to cover the hole in his Ego with the help of the symptom. As a resource focused therapy, dynamic psychiatry is aiming on awareness, encouragement, strengthening and particularly the appreciation of the healthy identity parts of patients, as well as the discovery of creative potentials and unused possibilities form a central part of therapeutic work. From the biological point of view we can say that this system facilitate neuroplasticity and new neuronal network building. Summarizing all mentioned above we can say that theory of dynamic psychiatry of G. Ammon allows bridging the gap between the researchers of the brain and scientists of the mind, successfully responding to the one of main challenges of the 21th century.

Taking into consideration some of statistical issues, like p-value as the one and only criteria of the importance of empirical research brings about simplification of the study design and has pernicious effect on the improvement of treatment of mental illnesses.

Zusammenfassung

Interdisziplinäre Forschung gewinnt im Bereich der psychologischen Gesundheitsversorgung zunehmend an Bedeutung. Die rapide Entwicklung der Forschung und neue Messverfahren liefern eine Fülle von Informationen über strukturelle Veränderungen im Gehirn und Funktionsstörungen, die im Zuge psychischer Störungen auftreten. Ebenso bringt der Fortschritt in den Neurowissenschaften belastbare Daten über Veränderungen der Gehirnaktivität, die in der Psychotherapie stattfinden. Dies erlaubt es, zwei Forschungstraditionen, die des Geistes und die des Gehirns, zusammenzuführen und dadurch auf den Gebieten der Psychotherapie und Psychiatrie auf Augenhöhe mit anderen medizinischen Disziplinen zu gelangen. Allerdings gibt es noch immer nur wenige Theorien, die einen sorgfältig definierten, holistischen Ansatz vorschlagen, der sowohl psychosoziale, entwicklungspsychologische und biologische Faktoren in einem integrativen System zusammenführt und dazu auch theoriebasierte Behandlungsvorschläge macht.

Das humanstrukturelle Persönlichkeitsmodell von G. Ammon und seinen Kollegen stellt in wünschenswerter Weise einen multidisziplinären Ansatz dar, der eben jene Faktoren, biologische, soziale und psychologische, zur Erklärung psychischer Störungen miteinbezieht. Sowohl psychische wie neurophysiologische Strukturen werden als Resultat internalisierter Lebenserfahrungen sowie tatsächlicher gruppendynamischer Prozesse betrachtet; selbst synaptische Prozesse werden als durch Umwelteinflüsse, im speziellen durch Gruppenprozesse, gesteuert, angesehen. Nach diesem Konzept sind neurologische Befunde und psychodynamische Konzepte nicht länger gegensätzlich, sondern liefern wertvolle Dimensionen zur Beschreibung desselben Phänomens. G. Ammon sieht den gruppendynamischen Einfluss als den hauptsächlichen epigenetischen Faktor, der die Entwicklung zentraler menschlicher Funktionen sowie der Identität als Ganzes, in konstruktiver, defizitärer oder destruktiver Art bestimmt. Je gestörter die Gruppendynamik gewesen ist, desto defizitärer entwickelt sich die Persönlichkeitsstruktur und desto gravierender treten psychische Beeinträchtigungen auf. Konsequenterweise benötigt der Patient dann ein therapeutisches System, dass ihm Angebote macht, um die Auseinandersetzung mit existierenden Defiziten zu erleichtern. Trotz der Forderung von Vertretern des Gesundheitssystems nach kurzfristigen psychotherapeutischen Angeboten müssen wir uns realistische Ziele setzen und uns

vergegenwärtigen, dass es Zeit braucht, um eine defizitäre Entwicklung zu korrigieren. Dementsprechend zeigen neurobiologische Ergebnisse, dass Muster interpersonaler Beziehungen und Emotionsregulation, die in frühen Lebensjahren erlernt werden, eher prozedural verschaltet sind und daher schwerer zu erreichen und resistenter gegenüber Veränderung sind.

Die Hauptbestandteile des Konzepts der Dynamischen Psychiatrie, wie die Annahmen eines kontinuierlichen Spektrums psychischer Störungen, konstruktive, destruktive und defizitäre Dimensionen der wichtigen Humanpersönlichkeitsfunktionen und die Bedeutung primärer gruppendynamischer Prozesse für die individuelle Entwicklung hängen zum einen stark mit neurowissenschaftlichen Befunden zusammen, zum anderen ermöglichen sie es uns, die Nachteile der modernen Klassifikation psychischer Störungen zu umgehen und verschiedene klinische Bilder auch während der Behandlung zu erklären und nicht nur die Störung selbst.

G. Ammon hat ein theoretisches Konzept entworfen, das es den verschiedenen, im Therapieprozess involvierten Professionellen, wie Psychiatern, Psychotherapeuten, Hausärzten, Psychologen oder Sozialarbeitern ermöglichen soll, die pathologische Gruppendynamik des Patienten nachzustellen und auch zu reparieren, immer mit dem Ziel, die weitere Entwicklung der Identität des Patienten und seine Reintegration in die Gesellschaft voranzutreiben. Regelmäßige gruppendynamische Supervision muss dazugehören, um eine wirkliche multiprofessionelle Zusammenarbeit sicherzustellen und eine gemeinsame, multidisziplinäre Sprache zu entwickeln. Der Behandlungsprozess bezieht sich dementsprechend sowohl auf Therapiesettings, die den Patienten einschließen, sowie Therapiesettings ohne Patienten, integriert in einem zusammenhängenden Grundgerüst.

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Treatment of mental disorders. The importance of psychodynamic and psychosocial models in therapy. Reference to interventions in situations related to the economic crisis in Europe

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The main theme of the Congress „Multidisciplinary Approach to and treatment of mental disorders; myth or reality?“ evokes to us the central position of the so called myth theory in antipsychiatry with which it seems to be in mirror. This point of view is discussed and its supposed bases overcame. Effectively, mental illnesses have biological bases, well known today and the psychodynamic and psychosocial factors, scientifically studied, gave also important contributions for their understanding. Psychodynamic points of view, explaining mental illnesses, may be often linked to biological contributions allowing the development of neuropsychoanalysis. Finally the economical crisis in Europe, particularly in peripheric countries is described and analyzed. A scheme of intervention in the community is proposed. Two examples are given.

Keywords: Anti-psychiatry, biological bases of psychiatry, Dynamic psychiatry and neuropsychoanalysis, social and institutional psychiatry, economical crisis in Europe, therapeutic interventions in community

The treatment of mental disorders. A multidisciplinary approach

Myth or reality?

The main theme of our Congress „A Multidisciplinary Approach to and treatment of mental disorders: Myth or reality?” seems to be in a symmetrical position and reminds us of the so called „Myth theory” in anti-psychiatry, developed by SASZ and col., during the 1960s and 1970s, in which mental disorders weren´t considered real, as they were not recognised a pathophysiological basis, unlike what was observed in somatic illnesses.

Therefore, mental illnesses were considered to be mere artefacts, created by psychiatrists in order to explain certain atypical behaviours of individuals and their explanations through psychodynamic and psychosocial changes weren´t more than pseudoscientific concepts seeking to justify its

existence, although the lack of a biological basis, which was considered essential, was still, to him an indispensable factor.

Thus, according to SASZ and col., mental disorders did not have a scientific explanation, as a physiological basis was missing and the attempts to find psychosocial explanation did not, equally contain any scientific basis.

The biological basis of mental disorders

The developments occurred in psychiatry over the last decades, have shown, however, that both assumptions lack objectivity. The evolution of knowledge regarding CNS´s biology has completely changed this perspective, which is nowadays totally outdated.

Besides from the recognized importance of the cognitive functions of the CNS, whose location has been determined to be in the encephalon, there has been an increased knowledge of affective functions, whose study is fundamental and basic as to the mental disorders and centres on the limbic system, and has in its core the hippocampus, thalamus, amygdale and the basal ganglia (striatum, globuspallidus and the nucleus accumbens). Amongst others, the Portuguese researcher, António Damàsio, who´s been working in the USA for many years, has emphasized the predominance of the affective aspects in the determination of the mental disorder.

On the other hand, one should also refer to the great development verified in the importance of the neurotransmitters and neuromodulars in the functioning of the CNS and their action on the synapses, thus, forming its biochemical base. The various nerve fibres that are part of the CNS are organized into the dopaminergic, serotonergic, noradregeneric, glutamatergic, Gabaergic and acetylcolinergic systems, which form the biochemical base of their operation and explain the several mental disturbances.

In fact, we are nowadays aware of the fact that the mental disorders result from disturbances in the biochemical transmissions taking place in those systems and, particularly, in the limbic system, not to mention the changes that are observed in the genetic determination of the disorder associated with hereditary or in immunity processes.

Therefore, the idea supported by SASZ, that mental disorders don´t have a physiological basis and that, consequently would lack scientific explanation, is, today, completely overcome.

Psychodynamic and psychosocial theories

On the other hand, the perspective that the psychosocial explanation of the mental disorder lacked scientific basis and that was merely built by psychiatrists in order to explain a non-existent illness is far from reality.

As a matter of fact, these explanations were created by the need to find a link between the mental illness and certain psychological and social factors which seemed to relate to one another.

Thus, it is important to refer the genetic evolution of the individual regarding psychological aspects, leading to an individual function, marked by subjectivity.

This operation can be explained by conscious and, mostly, unconscious factors which find expression through topographical, economical and dynamical models that constitute the base of the psychoanalytical model.

This model initially used for the treatment of neurosis, has been progressively expanded to treat psychosis (Frieda Fromm-Reichmann, Rosen) and, later on by the Kleinian psychoanalysts, Kohut and others followers of self psychology disturbances of character and borderline states (Bergeret, Kernberg) and even in complex situations such as perversions (Etchegoyen).

Other authors, however, prefer to explain the psychological models, through means of philosophical concepts, focusing on the way the individuals explain their existence and/or their relationship with others and the community, on how they function individually (Jaspers, Husserl and von Gebsattel), or in their experience in participating in a particular interactive situation (Kierkegaard, Heidegger, Sartre), the latter finding expression in the psychotherapeutic concepts of Binswanger, V. Frankl and, more recently, Yalom.

Concepts associated with Moreno's theory of „spontaneity-creativity" establish another way of explaining psychotherapeutic models and have been successfully used in psychodrama and other body language psychotherapies.

Finally, the cognitive behavioural therapy seeks to explain mental disturbances through changes in behaviour that, in turn, are explained by the cognitive alterations determined by it.

Although these different models constitute the basis of conceptions and intrinsically different therapeutic approaches, they are not necessarily excluded, but present aspects of looking at the individuals which complete

each other and could even be integrated.

On the other hand, one cannot forget that the study of psychological phenomena, whose specificity, analysis and objectivity are well known – as is also the case in social phenomena – assents in its own scientific basis, although it can also be related to biological aspects. One must also not forget the contributions of Edelman, Damasio and Eric Kandel in this field, as well as those of Chaperot, Celacu and Pisoni amongst other contributions used in Neuroscience, such as in Neuropsychiatry and Neuro-psychoanalysis.

Regarding the social phenomena and its relationship with mental disorders, one must mention the importance of the interaction among society, groups and individuals that appear determinant in behaviours, as well as in psychopathological situations. Thus, the interactions within family and other groups appear in the origin of certain psychopathological disorders and their respective symptoms. The need to avoid these disorders, in turn, is connected to family therapy or multiple family therapy and group therapy which often play a decisive role in their treatment and prevention.

Furthermore, one should note the repercussion on individuals of the operation of the institutions that exist in society, as they are in contact with them, decisively influencing their personalities. Acquiring particular relevance in therapeutic interventions are treatment institutions, where, for instance, a total or partial hospitalization is necessary and one should analyse their impact on the treatment and operation of individuals and the way their skills are used in the modification of their personality.

Thus, arouse the so-called institutional psychotherapy institutions, which aim to acknowledge the positive aspects of the patient's personality, avoiding the negative impact that the institution can exert on him.

Lastly, the fact that the pathological process occurs in society raises the question of if the patient should be prepared to regain full capability to be included in it in order to return to a proper social integration, so it is often necessary to organize rehabilitation processes and social reintegration within society.

Thus, the final goals of any mental health team, which is responsible for coordinating the activities of mental health in a given area, should focus precisely on the society involved for the promotion of mental health and consequent prevention of mental disorders.

On the other hand, one must not forget that society and the social groups in which the patient are inserted, will shape the demonstration of these

disorders and condition the expression of the respective symptoms. This action of society on mental disorder and its manifestation is designated as „the Sociology of Mental Illnesses"

These aspects related to the sociology of mental illnesses will actually condition therapy itself (which incidentally is integrated and influenced by it) and the way its acts on the patient and its symptoms.

An ultimate goal is to emphasize the fact that the therapeutic action is carried out not by an individual psychiatrist, but by an entire group with therapeutic functions and composed by various specialties, such as psychologist, social worker, occupational therapist, not to mention the already referred psychiatrist, working jointly and in cooperation. Therefore, the therapeutic agent ceases to be an individual and becomes a whole therapy team, which coordinates the entire therapeutic process and/or preventive process. This team, thus, functions as an entity that plans and develops the whole therapeutic action, which aims to act on individuals but also on the community in which they are inserted seeking to the achievement of a joint action that implies a supportive and complementary modification on both.

Seeking an overview

To sum up, the therapeutic action looks for a modification of the individual together with society and in the groups where he/she is inserted, in the biological, psychological and social fields and the latter (society) has to be prepared to support and integrate this modification in all these perspectives.

Hence, to answer the initial question of this work, we will claim that the treatment and, in a more general and comprehensive manner, the prevention of mental disorders are not a myth as stated by SASZ, but rather a reality that the above aspects show, as well as the numerous sub-themes of our Congress' program.

If the development of the biological concepts allows the understanding of how mental disorders arise and develop and how their symptoms appear, including the psychological and social, the psychodynamic and psychosocial components are the ones to contribute the most to the understanding of the mental disorder and to the social integration of the mentally ill and to the appropriate organization of the psychiatric assistance, taking into account the inclusion of the individual in the community and in the

several pre-existing groups.

All these contributions are, as a matter of fact, crucial for the organization of mental order treatment and prevention and, ultimately, for the promotion of mental health.

II The economic crisis in Europe and in Portugal and its repercussions on individuals and the community. Intervention models

A. Economic crisis and its repercussions on the population

If one intends to extend and analyse a paradigm for multidisciplinary interventions in psychiatry and as a result of a social situation, with psychopathological impact on individuals who fall in society, one can refer the economic crisis that, as a result of a real estate bubble, struck first in the U.S. (2008) followed by Europe (2011), having marked repercussions in countries with more feeble economies and larger debts such as Spain, Italy, Greece, Portugal and Republic of Ireland.

This sovereign debt crisis was linked to the deficit spending and budgets of these countries. To remedy these situations, it was sought to lower costs and increase revenues, through means of the reduction of wages and pensions and the increasing of taxes, respectively. The aim was also to reduce disposable incomes, reduce consumption and force companies to develop export.

This reflected mainly on the lower and middle classes, whose income fell brutally, reaching in some cases situations close to extreme poverty, due to the large decrease of disposable income.

Moreover, this was accompanied by declining investments in health, education and social security which aggravated the situation. Consequently, a general attitude of protest and revolt, along with a general feeling of helplessness and depression developed amongst the population.

Well identified individual psychopathological conditions emerged, being those, mainly depressions. In some cases, endogenous depressions were aggravated by this situation, emerging therefore more serious conditions, of which the endogenous component was worsened by the development of psychogenic components. Reactive depressions also emerged.

Other conditions which very often emerge were the development of depressions in individuals with character disorders, various forms of anxiety and, particularly, panic attacks and psychotic outbreaks.

The main issue that was presented to us was to see how the mental health services could respond to such a serious crisis and, in part triggered by the government itself.

B. Proposed actions of the Mental Health services

To remedy this crisis, the mental health services developed the following actions:

1. Various mental health teams began working in this area and drew the attention of their service coordinators to the seriousness of the psychopathological conditions that were occurring amongst the population and for the need to remedy them, by reducing or easing up some (whenever possible) and, above all, by developing and supporting the most at risk and needy individuals and populations.
2. The development of lines of social and economic support to individuals with serious issues in this (economic) field.
3. Organise therapy of different psychopathological conditions that arise in the community as far as possible, due to this situation, free of charge as much as possible (since they were triggered by economic issues) with all resources available in the community (biological, psychological and social), if possible, all together.
4. Intervening in the community through support groups, seeking to raise awareness to the existing problems (which, in this case, is not difficult, since there is a whole political and social situation working towards in this direction) and helping them to make preventive healthcare (primary prevention), which, in this case, can be done by mobilizing them against the actions taken.
5. In cases of severe depression or psychotic outbreaks, processes of rehabilitation might be needed, aiming at the reintegration and social inclusion of patients in the community, once duly prepared, so that they can keep on playing a useful and appropriate role.

C. Two Examples

To finalize, I´ll be referring to two examples of intervention in this situation:

1. Francisco, aged 46, unemployed, unable to find a job for three years, due to the crisis. Beforehand, he was employed at an insurance compa-

ny, where he earned a relatively good salary. However, he had to spend all his savings and his situation began to be very difficult. Having been unemployed for over two years, he stopped receiving unemployment benefit.

He has developed, over the last six months, a very serious depression with sadness and inhibition of activity, showing now true difficulties in looking for a job. The fact that he has so far never found one, serves as justification to prove that his efforts are useless. He was given a free medical support by the National Health Service, where psychopharmacological and psychotherapeutic support was administered.

At last, he managed to find a job according to his qualifications, although with a much lower salary than his previous job. He managed to feel reinserted into the community, while his depression decreased remarkably.

2. A group of retired workers, after the last pension cuts feel (and they have indeed) that they have reached the limit of their economic capacities, with serious impacts on their standard of living, which was already relatively low. They feel deeply ill-treated and angry about the situation and claim to have been „robbed".

   This issue is common to all. A free group therapy was organized on a psychodynamic base to support them. They can discuss their problems, the causes of their depressions, their feelings of aggression and their feeling rejected by society. After a year, they feel included and supported by the therapist and by the group and their symptoms of depression remarkably decreased and they feel less rejected by the community and more included.

Summary

The main theme of this Congress „The Mulidisciplinary Appproach to and treatment of mental disorders: myth or reality?" is analysed as being in a symmetrical position with the so called myth theory in anti-psychiatry, developed by SASZ and his followers in the 60s and 70s of the last century.

For these authors, mental disorders weren't real, because they had not biological basis and the psychodynamic and psychosocial conceptions conceived to explain them were not scientific.

Today, we have no doubt that all mental illnesses have a biological basis

and are explained through changes in the anatomy, biology and biochemistry of the CNS, researches in this field are referred.

On the other hand, the bases to explain psychodynamic and psychosocial approaches were developed. The use of the first of these models was extended to the treatment of psychoses, borderline and narcissistic states and even perversions. Other psychotherapeutic models, as phenomenological, existential, psychodramatic and behaviour cognitive approaches are also referred.

The importance of social phenomena, their interaction with mental disturbs and the interference of groups, families and institutions, that function in the society lead to the development of group, family, multifamily and institutional therapies and to the study of the sociology of mental illnesses, their prevention rehabilitation and, consequently, mental health promotion are also referred and analysed.

Finally, the economical crisis in Europe and, particularly, in Portugal and its repercussions on mental health are described.

A program to remedy this situation is proposed in order to analyse the mental health situation determined by the crisis and to organize the prevention and even the therapy of psychopathological situations, developing lines of social and economical support and intervening in the community through support groups and treatment and even rehabilitation processes in some more serious disturbs.

Two examples of interventions are given, one centered in an individual with a depression, after having lost his employment and the other in a group of retired workers, with similar and severe cuts in their pensions.

Zusammenfassung

Ausgehend vom Thema des Kongresses „Multidisziplinärer Ansatz und Behandlung von psychischen Störungen: Mythos oder Realität?" reflektiert der Autor über den heutigen Stand der Auffassung von psychischen Störungen. Er nimmt das Thema zum Anlass, an die sogenannte „Mythos-Theorie" der Antipsychiatriebewegung zu erinnern, die von SASZ und seinen Anhängern in den 60er- und 70er-Jahren des letzten Jahrhunderts entwickelt wurde. Diese Autoren vertraten den Standpunkt, dass psychische Erkrankungen an sich ein Mythos seien, weil für ihre Erklärung keine biologische Basis bestehe. Die psychodynamischen und psychosozialen Modelle zur Erklärung psychischer Erkrankungen lehnten sie

als „unwissenschaftlich" ab.

Heute besteht kein Zweifel mehr daran, dass sämtliche psychische Erkrankungen ein biologisches Korrelat haben, was zahlreiche Belege von Veränderungen im zentralen Nervensystem bei solchen Erkrankungen bestätigt haben.

Auch die psychodynamischen und psychosozialen Ansätze zum Verständnis der psychischen Störungen haben sich weiterentwickelt und liefern Modelle zur Erklärung und Behandlung von Psychosen, Borderline-Störungen, narzisstischen Störungen und anderen Erkrankungen. Darüber hinaus haben sich auch phänomenologische, existentialistische, am Psychodrama orientierte und kognitiv-behaviorale Ansätze als fruchtbar erwiesen.

Die Bedeutung sozialer Faktoren und ihre Interaktion mit psychischen Störungen und somit die Bedeutung von Familien, Gruppen und Institutionen für die Therapie sind ebenso deutlich herausgearbeitet worden wie der Einfluss soziologischer Faktoren auf die Entstehung, Prävention und Behandlung psychischer Erkrankungen.

Gerade im Hinblick auf diese soziologischen Bedingungen befasst sich der Autor mit den Auswirkungen der ökonomischen Krise in Europa, insbesondere in Portugal, auf die psychische Gesundheit der Menschen. Seiner Meinung nach müssen in den betroffenen Ländern staatliche Programme entwickelt werden, um auf die Auswirkungen der Krise auf die Psyche der Menschen adäquat zu reagieren und Erkrankungen zu vermeiden bzw. zu behandeln.

(Stephanie Zodl, München)

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The Myth of Facebook. Relationship between Psychology, Addiction and Technology

Are We Addicted to Facebook, or Are We Just Addicted to Ourselves?

Ezio Benelli (Florence, Italy)

The article deals the issue of new dependencies: in particular those from Internet and social networks. Having distinguished between „dependent" (dependence from substances) and „addicted" (psychological dependence), the article refers to some neuroscience researches that confirm the empirical data. Then, it is stated how psychodrama, as it is practiced at the Pole Psychodynamics of Prato in Italy, can be an effective and powerful tool also for the treatment of new dependencies and reasons of it are explained. At last, after providing a brief history about the birth of psychodrama and its inventor, J. L. Moreno, the article describes building blocks, basic steps and different ways of interaction of psychodramatic practice.

Keywords: addiction, internet, social networks, Fromm, neuroscientific nesearches, theatre, psychodrama

In English language the notion of dependence appears in two different words. In the first, „dependent", the subject is physiologically dependent, as is the case for substances such as alcohol, drugs, tobacco; in the second, „addicted", the dependence is psychological. Addicted comes from Latin words addictio, addicere, which mean „to enslave because of a debt". But what debt the new addicted people have to pay? Or rather, which condition of inferiority leads them to be addicted?

The debts, of course, have always influenced the human being to live in a condition of inferiority with respect to the debtor, which can be, in turn, represented by a person, an object, an ideal of behavior etc.

According to Erich Fromm, the real problem of modern society is the lack of autonomy: human being depends pathologically on an entity considered superior, which conditions it to be a slave; human being is a lacking being; it is unable to accept the condition of absence and to share it with others. So human being searches desperately something that can compensate its own emptiness.

Fromm died in the 80s, when the new dependencies began to be visible only in the U.S.A., but in recent years the phenomenon has spread rapidly in all countries, affecting quickly every social class, from young to

old, from rich to poor people. In his opera Escape from Freedom, Fromm showed how to escape from themselves and from others, feeling completely isolated and lonely, leads to mental disintegration. The question of „non-being", the feeling of not having an identity, then, flows and resolves in the evasion, in the escape from reality.

We can think about the isolation of addicted people to internet, to social networks, we can think about the solitary purchases of the compulsive buyers, about the gambler who binds his eyes only on the outcome of his game. This is what it looks, but if we explore the „depending on who and what" the reality changes.

The new addictions lead people to be dependent on experiences and on situations that may somehow change mood and feelings; those same experiences and situations are constantly created and fostered by our society, because they are subjected to the economic laws of gain. The new addictions, however, unlike addictions to substances, have, paradoxically, one characteristic: they respond illusorily to the deep need to be part of, to be considered by.

When the addicted person accepts to be cured, it accepts also to recognize the impossibility of being what Lacan called „being the desire of the other", it accepts the anguish of its infantile and subordinate condition, it experiences the dark, with no false certainties, the dark of who does not receive the necessary approval to feel „needed".

The analytic psychodrama, usually applied at the Psychodynamic Pole in Prato, near Florence, in Italy, and also applied by us during the summer 2013 at the Hotel Byron in Forte dei Marmi, Lucca (Italy), has been tested by us also in the psychological dependencies, offering an innovative approach to new addictions.

But what is psychodrama? And why psychodrama for treatment of addiction to Internet?

The word „psychodrama", formed from the ancient greek word psyche, that is soul, and drama, coming from the verb drao, draomai, which is to act on the scene, then, means „the action of the psyche", or if you want „the theatre of the psyche".

It can be said that if Freud's psychoanalysis was defined „care through the word", Psychodrama can be defined as „care through the action", the theatrical action. And with this I have already given a broad definition of psychodrama: it is essentially a method of treatment, a therapeutic technique, a system to cure ailments and psychological and emotional dis-

comforts. But psychodrama can have not only therapeutic values, but also educational, training, social and so on.

To stay in our field, psychodrama is therefore a method of treatment which uses primarily theatre to achieve its goals and which consists in the direct staging, so to speak, in the „live" representation of mental conflicts and problems of patient, in order to let it take knowledge of them as much as possible and release it from its adverse effects.

In psychodrama you do not speak about the patient's problems, but those problems are acting, the interiority of patient is represented on the scene, giving real and material space, time, body, speech and sound to what would otherwise remain confined and locked inside the psyche of patient.

In short: with psychodrama we try to give the maximum of objectivity to subjectivity. The patient pulls out from itself its experiences and, with the help of the therapist and of the group, puts them on the stage and so makes them objects, that is, something outside itself, puts them at a distance from itself, beginning the work of awareness which is the beginning of a liberation.

Another important feature: psychodrama is a therapeutic group technique. And it is already very significant, in my opinion, that to fight the lonely, isolated, solipsistic, dispersed, fragmented and deconstructed Ego of those persons who are addicted to the internet, could be useful a therapeutic technique which is one of the most „social" that exists, psychodrama, in fact. Social as it was and still is sometimes Theatre. Social because psychodrama is possible only if there is a group, a community of people who witnesses, who contains and is the content of the psychodramatic scene.

At this point we need a clarification: theatre we see in psychodrama is not what we see in most of the cases on the stages of current theatres. It is a sort of improvisation theatre, or if you want, it is the theatre of spontaneity, a theatre which is created and invented „then and there", on the spot. In psychodrama, there are no written scripts to memorize and to play, but everything happens from moment to moment, everything can change from one moment to another: in psychodrama we work on what emerges moment by moment.

As it is known, psychodrama, in its earliest form, was developed by Jacob Levi Moreno, physician, psychiatrist, sociologist, philosopher, lover of mathematics etc., an extraordinary figure who has put in relation,

through his concrete research, different ideas and disciplines. Romanian by birth, but coming from a family of Jewish origin, Moreno formed himself in his youth in Vienna in the early twentieth century, a multi-ethnic and multi-lingual reality, a very vibrant and alive cultural and artistic ambit, that you can tell, is the basis of our contemporary culture. Moreno met Freud, Adler and Schnitzler. He studied Bergson, Rousseau, Pestalozzi, Nietzsche, Kierkegaard and Marx. And in those years he invented „The Theatre of Spontaneity" and „The Living Newspaper", forms of improvisation theatre, in which the same audience was invited to participate as character to the performance.

One of the merits of Moreno was also to collect and to make a synthesis of a number of elements coming from the theatrical tradition, to build his greatest invention. If you look, in fact, the history of theatre, there are many elements that have favored the emergence of psychodrama. I mention very briefly below some:

a) the concept of catharsis, that is the effect which, according to the ancient Greeks and to Aristotle, had to have the play on the audience. Catharsis means purification, that is to say, in essence, the liberation from passions and from negative emotions;
b) the so-called Theatre in Theatre (also called Metatheatre), that is the dramaturgic artifice which is stated in theatre of the Renaissance Age and which consists in giving life on the stage to a play inside another play. Thus, in this way, the characters of a comedy or of a tragedy are to be found in their turn viewers in another and different representation, and therefore are to be identified more or less with the representation they attend, a bit as it happens, in fact, to the group in psychodrama. A kind of theatre, the Theatre in Theatre, which has had much luck over the centuries: think of Shakespeare's Hamlet up to Six Characters in Search of Author by Pirandello;
c) the same Commedia dell'Arte, with her being a kind of improvisation theatre, built on a structure of fixed roles (the Masks), can be considered an illustrious precedent of psychodrama;
d) and the same Stanislavskij system for acting (why not?) with its appeal to psychological insight, to the revival of emotions, to the authenticity of actor's art, can be considered an element which has fostered the birth of psychodrama.

In the mid-twenties Moreno emigrates to the United States and there he sets up his great insight: he makes it become a therapeutic technique, a school, a theoretical apparatus, a method of social research, a method of training and education.

In the course of the twentieth century the psychodrama technique has met other theoretical and practical guidelines and approaches, giving rise to many different ways to practice and to use the Morenian invention. Particularly fruitful was the encounter with psychoanalysis, and especially with the neo-Freudian psychoanalysis that derives from Erich Fromm. But at this point a question has remained in the back-ground: why psychodrama? There are many good reasons. Not to go on too long, I would simply indicate three good reasons:

1) Because psychodrama is an experiential method, which is based on experience, on action. In psychodrama insight, learning, therapeutic progress can happen only if dynamics, conflicts and problems of patient are represented and acted on the scene. And it is well-known that learning and awareness through „doing" are more durable and stable than simply through „telling".
2) Because psychodrama is a therapeutic technique that comes closest to the so-called real life. Psychodrama is extraordinarily close and similar to situations, to relationships, to dynamics of patient in its everyday life. And then more easily and directly can affect on them.
3) Psychodrama is „mirror of life" not only for individual patient that presents its emotional dynamics, but also for the whole participant group, which may identify partly or entirely with dynamics of individual patient. The group can share experiences, memories, stories, emotions that have to do with what was experienced by individual patient. Or rather: the group resonates emotionally with the individual and the individual, in turn, with the group.

But back to the story of what we did in the summer of 2013 at the Hotel Byron in Forte dei Marmi. The participants were subjected to an entrance test, composed by the following questions: „Do you find yourself on Facebook for longer and more often than you expected? Have you given up or reduced your involvement in social, occupational or in recreational activities because of Facebook? Have you neglected your family? Have you made a conscious effort, but without success, to reduce the use of Facebook?"

Through the test, we wanted to investigate this new dependency, rather than those who use substances such as alcohol, heroin or cocaine. This has created many problems on the effectiveness of diagnostic criteria usually used for people who are dependent on substances: these criteria, in fact, are difficult to adapt to the dependence on social media networks.

It was interesting to see the transformation of the „affect facial expression" of participants, when they explained how the option „I like" on the post published could make them irritated and anxious, if the post did not get the desired success, or, on the contrary, how they are satisfied if the post obtained many consensus. We noted in subjects who were part in the study group an increase of anxiety at the thought of not being able to implement the „web feed".

We noted, however, pleasure and gratification in the participants at the thought of talking about themselves, or when they published their photos and when they communicated their thoughts. Our empirical investigation has confirmed by some studies done by researchers who have used neuroscientific methods.

Diana Tamir and Jason Mitchell at Harvard, for example, have undergone an experiment in neuroscience some habitual users of Facebook. In a programmed page they have brought them three options: (1) talk about their opinions and attitudes, (2) judge the attitude of another person, (3) answer frivolous questions. During the experiment, they measured the brain activity of participants. Every choice has been associated with a monetary payoff. This has allowed scientists to test whether individuals were basically willing to give money to talk about themselves.

On average, participants lost an average of 17 % of the potential gains to talk about themselves! Why would anyone give up some money to do this? This is not unlike the behavior of those people who renounce their work and family responsibilities, because of addiction to drugs and of gambling. During the self-disclosure, these participants have activated the nucleus accumbens. The nucleus accumbens is integrated in the ways of the limbic system and receives afferents from the prefrontal cortex and from the dopaminergic neurons in the ventral tegmental area (mediobasal region of the midbrain). It plays an important role in the reinforcement circuits, linked to the substances abuse, which causes an increase in the concentration of dopamine in the outer part of the nucleus accumbens. This area is also involved in the effect and in taste perception.

In a second study done by Dar Meshi and colleagues at Freie Universität

Berlin, it was measured the brain activity of volunteers while they received a lot of positive feedback. The research, similar to the Harvard study, also found that in some individuals the nucleus accumbens has become more active when they received rewarding feedback. The researchers also made the participants fill out a questionnaire which determined a score of „Facebook intensity": this score included the number of Facebook friends and the amount of time per day spent on Facebook (the maximum score was > 3 hours per day). When the time spent on FB was correlated with an enjoyable and rewarding activity, the nucleus accumbens was more intensely active. This suggests that the two variables, time spent on FB and rewarding activity, make nucleus accumbens more intensely active.

All this from the point of view of neuroscience. But if we continue the theme of „depending on who and what", we discover something more.

None of the addicted people of substances believes that, by satisfying its needs, it will be more integrated into society; the „new addicted person", on the contrary, when it exceeds to buy, to work, to communicate on the web etc., although with a sense of unease and guilt for its behavior, it hopes that others can recognize precisely in its being like others are, although this can be done through solitary activities and hidden compulsions. It hopes to be seen differently from the way it sees it, it hopes eventually to be considered for what it wants to be and not for what it really is.

The answer may come from the computer, from the items purchased and admired by the social context, or from the false certainty of winning and being admired. The difference between the old and the new dependencies, therefore, is expressed through two poles: the individual and the social. The intake of substances should cause the personal well-being, and it is better if no one sees; the new addictions, however, obey the realization of that dream that takes us from birth, the aforementioned Lacanian „to be the desire of the other".

In the psychodramatic game the vision becomes the fundamental element: the speaking subject, that is, the participant who expresses itself, looks and is looked at in a dimension of truth and recognition. The new addicted, so eager to social validation, realizes its „non-self", that is, of not being able to get something for someone, through destructive and alienating behaviors. The group becomes the context in which it is possible to analyze interpersonal relationships and their implications, the dynamics and their reactions.

In France, Kaes and Anzieu, recovering some of the concepts expressed

by K. Lewin and developing the theories expressed previously by other scholars who had used them as pedagogical support, made a careful and analytical work and continued the opera of change of group psychotherapy. They focused on deeper interior attitudes, on the unconscious instances. What has been described above allows to better understand the function that psychodrama has on the participants. Psychodrama in itself contains two functions: a social and educational function and an analytical function.

The reasons that promote this duplicity are highlighted in the spatial location and in the action that takes place in the setting of psychodrama. The technique used in psychodrama is that of Moreno, therefore the action or the game take on a significant value within the analytic session. The „direct" game, that is immediate and guided by the therapist, highlights the individual impulses of the „here and now", referring to a context and to a situation already lived in the „there and then". Psychodrama becomes, then, the game of the unveiling, where each participant is recognized as a subject no longer hidden, and the group, as a separate other entity, continually reveals the deception of everyone. Also in psychodrama takes place the bringing into play of an event or of a concrete situation which the subject highlights during the session.

To understand how and what happens in psychodrama, we should recall components, structure and basic modes of psychodramatic technique. First of all, in psychodrama there are four key characters:

– *Director or psychodramatist or simply therapist:* that is the one who leads the psychodramatic game, the one that allows the materials and the emotional experiences of the group members to come out, the one who takes care of staging of those emotional contents and of concrete situations related to them.

– *Patient or protagonist:* the person who at any given time is at the center of the psychodramatic scene, the person who narrates and describes conflicts and emotional problems, and whose is represented a situation, an event or a memory, which is the concrete representation of emotional contents.

– *Auxiliary ego:* they can also be more than one, and they are those members of the psycodramatic group called to embody the key characters in the protagonist scene: they can impersonate, time to time, parents,

wives, husbands, lovers, children, colleagues and employers, fictional characters etc.

− *Group:* The rest of the group that assists the psychodrama. It has the functions of testimony, acceptance and support the emotions of the protagonist; it can identify more or less with the scene of the protagonist and at the end it can share its experiences with those of the protagonist.

Psychodrama is organized and takes place in three different steps:

− *Warm up*: at first Protagonist tells and freely describes its emotional experience, then, with the help of therapist and of group, identifies an issue, particularly important for it, and also a concrete situation related to the topic, which then will be subject of the Scene.

− *Scene or Action:* it is the representation of the concrete situation previously chosen. It is played by Protagonist in the role of itself and by various auxiliaries Ego that embody the other key characters of the scene.

− *Discussion or Debate or psychoanalytic Return:* it is the phase in which it is interpreted what came out earlier, it is the phase in which the Group expresses how and how much was involved in the scene of the protagonist, through the narration of thoughts, emotions, memories, dreams, events related more or less to the protagonist scene.

And finally, in the course of psychodrama can be used the following three different modes of action or interaction:

− *The Double*: it is the mode that allows any member of the group, also an Auxiliary Ego, to give voice and body to emotions and feelings which the protagonist feels and imagines but can not express. Therefore it has a function of clarification and support.

− *The Mirror:* it is the mode for which, in the case the protagonist finds difficult to represent himself, an Auxiliary Ego can „mimic" the same protagonist. So protagonist can see himself reflected as in a mirror, as others see it.

− *The Role Reversal*: it can be applied when the protagonist is deeply involved in a dual relationship. Then the protagonist takes on the role, the function and the place of the Other, he „puts in Other's shoes", descending into a new reality and discovering emotions, feelings and points of view of the subject with which it is in conflict and in relationship.

It is almost needless to say that the whole thing takes place in a climate of intense emotion.

Summary

The article, first, distinguishes between the concepts and terms of English language „dependent" and „addicted": in the first case it is an addiction to substances such as alcohol, drugs or tobacco; in the second, addiction is psychological and the subject depends on behaviors, practices and situations, it is the case of the dependence on new technologies and on Internet. Erich Fromm, in his book Escape from freedom, he highlighted how the human beings become slaves to addictions because they can not accept the emptiness, that feeling of „not being", which lead them to give up the freedom and to isolate more and more from society. Fromm had somehow foreseen practices and effects of new dependencies, those from excessive exposure to Internet and to social networks.

And then in the article it is stated that Psychodrama analytical, as is practiced at the Polo Psychodynamic of Prato in Italy, may represent an innovative approach in the treatment of addictions from new technologies. For its being a cure through the action, the dramatic action (and not just through words), for being a group therapy and for being very close to the patient's daily life, psychodrama, more than others care systems, can achieve stable and lasting outcomes. Subsequently, the article recounts the experience, made in person by the writer in the summer 2013 at the Hotel Byron in Forte dei Marmi (Lucca) in Italy, that is the use of psychodrama in the treatment of psychological dependency. Empirical data and conclusions of this experience are similar to those which have come neuroscientific studies on new dependencies. And in the article are cited two of these studies: that one of Diana Tamir and Jason Mitchell of Harvard University and that one of Dar Meshi at Freie Universtät Berlin.

Then the discourse moves on to analyzing from a historical point of view the birth of psychodrama: its being rooted in some phenomena of the history of theatre and the human and cultural formation of its inventor, Jakob Levi Moreno, an eclectic and complex figure, which has been able to put together and summarized ideas, suggestions, contributions coming from different fields. Then briefly it is mentioned some reworkings of psychodrama practice occurred in the twentieth century and it is underlined that psychodrama has assumed over time not only a therapeutic value, but also educational and social. Finally, it is described basic components of psychodramatic practice: the four key characters (therapist, patient or protagonist, auxiliary-ego, group), the three different steps in which is subdivi-

ded the dynamics (warm-up, scene or action, return) and main modalities of interaction (the double, the mirror and the role reversal).

(Translated by Prof. Alberto Di Matteo)

Zusammenfassung

Zu Beginn wird in dem vorliegenden Artikel unterschieden zwischen den Konzeptionen der englischen Begriffe „dependent" und „addicted": Im ersten Fall handelt es sich um Abhängigkeit von Substanzen wie Alkohol, Drogen oder Tabak; im zweiten ist die Sucht psychisch und das Subjekt ist abhängig von Verhaltensweisen, Praktiken und Situationen – dies ist bei der Abhängigkeit von neuen Technologien und dem Internet der Fall. Erich Fromm hat in seinem Buch *Die Furcht vor der Freiheit* herausgestellt, wie menschliche Individuen zu Sklaven von Süchten werden, weil sie die Leere, das Gefühl des „Nicht-Seins" nicht akzeptieren können, welches sie dazu gebracht hat, die Freiheit aufzugeben und sich mehr und mehr von der Gesellschaft zu isolieren. Fromm hat sowohl die Praktiken als auch die Effekte der Neuen Abhängigkeiten von exzessiver Internetnutzung und von sozialen Netzwerken vorhergesehen.

Im Weiteren wird festgestellt, dass analytisches Psychodrama, wie es in dem psychodynamisch orientierten Institut in Prato (Italien) praktiziert wird, einen innovativen Ansatz in der Behandlung von Abhängigkeiten von neuen Technologien bilden kann. Es handelt sich hierbei um ein Verfahren, das mit dynamischer, aktiver darstellerischer Umsetzung arbeitet (und nicht nur mit Worten). Psychodrama findet im Gruppensetting statt und zeichnet sich durch eine große Nähe zum alltäglichen Leben der PatientInnen aus. Deshalb kann es, mehr als andere Verfahren, stabile und dauerhafte Resultate erzielen. Anschließend geht der Autor auf eine eigene Erfahrung ein, die er im Sommer 2013 im Hotel Byron in Forte dei Marmi (Lucca) in Italien gemacht hatte, als er Psychodrama im Fall einer psychologischen Suchtproblematik angewandt hat. Die empirischen Daten dieses Erlebnisses und die Schlussfolgerungen daraus sind nach seiner Meinung vergleichbar mit denen von neurowissenschaftlichen Studien über Neue Abhängigkeiten. Es werden zwei dieser Studien zitiert: eine von Diana Tamir und Jason Mitchell von der Harvard Universität und eine von Dar Meshi an der Freien Universität Berlin.

Der Autor macht anschließend einen historischen Diskurs über das Psychodrama mit seiner Verwurzelung in der Geschichte des Theaters und

der persönlichen und kulturellen Entwicklung seines Begründers, Jakob Levy Moreno. Moreno war eine vielseitige Persönlichkeit; er schaffte es, Ideen, Anregungen und Beiträge aus unterschiedlichen Feldern zusammenzufassen und miteinander zu verbinden. Danach werden kurz einige Veränderungen in der Praxis des Psychodramas während des 20. Jahrhunderts genannt. Es wird betont, dass das Psychodrama im Laufe der Zeit nicht nur therapeutischen, sondern auch einen erzieherischen und sozialen Wert angenommen hat. Abschließend werden die vier grundlegenden Komponenten des Psychodramas beschrieben: TherapeutIn, PatientIn/ ProtagonistIn, Hilfs-Ich und die Gruppe, des Weiteren die drei verschiedenen Schritte (Erwärmungsphase, Aktionsphase, Integrationsphase), in die die psychodramatische Arbeitseinheit unterteilt ist, und die Haupttechniken der Interaktion (das Doppeln, die Spiegelung und der Rollentausch).

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Narcissism in contemporary society: Implications and interpretations of Art psychology

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The purpose of this paper is to highlight the dynamics of regression, and especially the narcissistic dynamics, that underlie the production of the work in contemporary art, focusing on the dynamics of development of the "loss of the figurative". The work is built around the premises for a possible revision of the psychology of art in order to "imaginal thinking" and the mythical and archetypal perspective, to get to the manifestation of these aspects in the work of some famous authors, especially starting from work of Picasso and Duchamp, arriving to Cy Twombly, Andy Warhol, Lucio Fontana. This contribution gives an idea for reflection, to postpone to a later study, on how aggression and emotion traceable in contemporary post-modern art (kinetic, performance, the body art), can be originated from a form of a narcissistic wound – on that "shroud that we persist in calling canvas" – inflicted by the domain of the mediatic metaphor, which tends to renunciation of the "discrete object" (increasingly dematerialized), in favour of a "body-subject" always most used by the artist in his task of desecrating and subverting the conventions and expressive pre-existing codes.

Keywords: Bacon, Fontana, Imaginal, Narcissism, Psychology of Art, Twombly, Warhol

But we are curious about the result, just as we are curious about the way a book turns out. We do not want to know anything about the anxiety, the distress, the paradox. We carry on an aesthetic flirtation with the result.

Søren Kierkegaard, Fear and Trembling, 1843

I. The architrave and the leaf

Psychoanalysis and the whole modern psychology, not to forget philosophy, sociology and anthropology contribution, make available theories and works entirely devoted to the widest and accurate survey on foundational mitologema celebrated by Ovidio in his *Metamorphoses*. Narcissus is the beautiful son of river god Census and Lyrope, nymph of the ocean, who asked the soothsayer Tiresias on his son's destiny and had a cryptic answer: Narcissus would have lived as long as he wouldn't have known himself. Narcissus grew up beautiful, caring for nobody but himself. Thanks to his charm he broke the heart of many girls. Echo the Nymph

happened to be one of them, and fell for him after meeting him in the forest in which Narcissus used to hunt; just like the others, though, she was rejected. Because of such disillusion, Echo wore out of love to the point of turning into a shadow, having just the voice. The Gods decided to punish Narcissus and charged Nemesis, goddess of destruction and jus-tice, to scourge him for his indifference towards Echo‘s love. Nemesis led the boy to the sides of a clear spring which mirrored Narcissus image to his eyes ...

It‘s not relevant, to the end of this contribution, to enumerate the many portrayals of this myth in the classic and modern painting. Caravaggio, with his *Narcissus* (1597–1599) and Dali with *Narcissus metamorphosis* (1937) are the extreme poles in this continuum of duplicated figures, which nemesis in the history of narcissism is expressed in the endless series of self-portraits and selfies we are falling, either being the greatest painters or the most common smartphone users.

However the deception of Narcissus against Echo lies in this misunderstanding. First, he perpetrates the theft of the ideal of love as transfert, even before the rapture of the sense on behalf of image. Self-portrait and selfies are echoes of a sound played only by figures. They are but technical retreats of the elaboration of an aesthetic object, which can be established by one‘s own face like having the features of any other object which the artist or the sketcher feel to be unfinished inside themselves and which they portray in the never pacified attempt of reducing the gap between idea and perception. The echo is the process in which to run out the variance between the original sound and the one who‘s written down and stamped. By a psychodynamic point of view, a great misunderstanding happened between the narcissistic problem and the need to shape the idea of ourselves and of what we love. Also, the myth is charged by the matter of the theft of representation at the expense of depiction. Narcissus steals to Echo the only chance to turn the object into objectual relationship. And it‘s this kind of violent usurpation that turns Narcissus into a clearly mercurial myth: it‘s not a coincidence that Robert Graves in *The Greek Myths* (1955) claims that one of the names of Narcissus was Antheus, appellation of Dionysus, and that the flowers associated to its mythological figure were the narcissus, the hyacinth and the bluebottle: an identity with many faces, devoted to meditation and contemplation, but capable to change with sudden outburst of passion.

Narcissus‘s depiction in a painting or a sculpture, in a stage play or a comedy are expressions, whether brilliant or not, of imagery or narration

in their illustrative function. The narcissistic accent which must be considered as an inner movement, a dynamic that informs the creative process and the concept of an artwork: in other words, narcissism is mostly a starting condition imprinted on the work, an intrinsic motivation or even better the myth that lives inside the author and the work, the archetype riding a shore of art, appropriating it, apart from the artist will. Gilles Deleuze writes:

> [First], photography has taken over the illustrative and documentary role, so that modern painting no longer needs to fulfil this function, which still burdened earlier painters. Second, painting used to be conditioned by certain "religious possibilities" that still gave a pictorial meaning to figuration, whereas modern painting is an atheistic game. Yet it is by no means certain that these two ideas, taken from Malraux, are adequate. […] In past painting, in turn seems poorly defined by the hypothesis of a figurative function that was simply sanctified by faith. […] Thus we cannot say that it was religious sentiment that sustained figuration in the painting of the past; on the contrary, it made possible liberation of Figures, the emergence of Figures freed from all figuration. Nor can we say that the renunciation of figuration was easier for modern painting as a game. On the contrary, modern painting is invaded and besieged by photographs and clichés that are already lodged on the canvas before the painter even begins to work. It is dangerous not simply because it is figurative, but because it claims to reign over vision, and thus to reign over painting. Having renounced the religious sentiment, but besieged by the photograph, modern painting finds itself in a situation which, despite appearances, makes it much more difficult to break with the figuration that would seem to be its miserable reserved domain. Abstract painting attests to this difficulty: the extraordinary work of abstract painting was necessary in order to tear modern art away from figuration. But is there not another path, more direct and more sensible? (Deleuze 1981, p. 6)

Narcissus only owns his image as a way of knowledge. He picks the pomegranate infected from a painful desire not for love, but for a gnosis of life and death: of the extreme self-sacrifice. To look himself from the outside, like a stranger to himself, or to live in the limitation of love that is knowing the other like a condition of self-knowledge through the other? He makes amends of the possibility to portray with religious adherence to the Truth, to God, the World and Man to stay in the game of cross reference of the illusory self-representing which is, in the end, his only vision: his multiple horizon, multiplying at each blink of the eye.

And his pain lays in having to confront with this horizon trying to scratch it and peek on the inside like to a scenery of anatomic forces in the desperate try to return to the canvas the mystery that stays inside reality (Fran-

cis Bacon); to placate reality's quiet uselessness gave back from objects debased by routine and celebrated in their immortality (Andy Warhol), to hurt the projective field like a canvas tight and closed (Lucio Fontana), to fight against that figure that's semblance and emblem of itself shaking and blurring its outline like a scholar without a teacher (Cy Twombly), but never touching the dress of the gods and of some experiential truth, overstepping the logic of perception and of sensation, in a tiring game of forces that asks over an "untitled".

We focus our approach towards the reality of art: we must consider that each painting comes both from the previous art and the previous extra-pictorial reality, besides the influences and environmental, sociocultural, historical and personal conditions of the authors. It's the historiographic approach learned from Mario Praz with a thematic that "steps over any gap of aesthetic quality" undertaking the "junction responsibility" (Orlando 2009, p. XII. In: Praz, 1930). Vision must be heretic to be fertile. Our aesthetic judgement is apart from any positivistic analysis because it runs through intuition, through any history since it assumes art's universality as dimension – not just as a casual experience lent from a lucky building of chaotic perceptions: an axiomatic foundation of human Psyche.

When an artistic process can be defined inhabited by a narcissistic connotation? We can say, using a literary excerpt, that narcissism "isn't due to flesh, but to a sad initiation", as Isabella Inghirami says in *Forse che si, forse che no* (D'Annunzio 1910) about the theory on the painful incestuous delight. Let's try to go beyond the psychopathological dichotomy that opposes the love for self to love for others, and consequently narcissistic and objectual relations.

In Kohut's vision the artist reveals a narcissistic experience of the world in which there is a narcissistic past, some kind of "inclusion" of the world in his Self, which is in last instance the Self-object. The objectual love then fully combines to bring a positive development of the artist personality, in which the empathy role is crucial for the aesthetic development. He claims that "Self objects are objects which we experience as part of our self; the expected control over them is, therefore, closer to the concept of control which a grownup expects to have over his own body and mind than to the concept of control which he expects to have over others." (1978)

II. "Signo ergo sum"

Andy Warhol's Memento Mori

It is common to think that the perception of the human face changes mostly due to two reasons: its aging as time flows by; and because of the mimic "path" of expressions, emotions, of paralinguistic elements of communication. Of course, a face can change because of a trauma, too, or as it moves through childhood and teenage years, experiencing significant anthropometric variations which can affect the look of its owner even in the matter of identity. Andy Warhol (Pittsburgh, 1928 – New York, 1987) goes down in the history of iconography by engaging a new level of portraying the face: changing happens on a level of topologic-chromatic organization, turning on connections between areas of the face which aren't usually "perceived together". Warhol marks the debut of the greatest contemporary American art even through his most famous portraits, and with them he makes the big change happen (starting from the 60s) acting on the linguistic genome of Pop Art itself. Even though he ratifies, in his paintings, a brand new way of reading the human face, through a radical change in those neural paths that "build" an identity starting from the face, it is also true that throughout this complex mechanism of cognitive, perceptive and emotional re-construction, he devotes those faces, those human beings that he portrayed to immortality, shifting from a mundane to a hyperuranium dimension with a titanic psychological leap, which has something to teach us upon the correlation between death and the transience of the human life. Antonio Spadaro says:

> The death of Warhol's father, occurred when he was very young, left a deep mark on him. But let's also contemplate that he saved himself from a murder attempt by the radical feminist fanatic Valérie Solanas. Lots of signs of death or decay followed him through his brief life. […] Warhol exorcizes the fear of loss and of fading out, making parading death around its mediatic replication. There's something elusive and "slippery" in Warhol opera. Yes. Warhol fooled us: it was a camouflage all the time. (Spadaro 2007)

Andy Warhol approaches portrayal art with mercurial guile, through a strong work of avoidance of pictorial rules: in fact he's not universally considered an artist in the most classical meaning, but more a sociocultural, mediatic phenomenon. Truth is that "artist" is an ambiguous term and often used to define all those people whose contribution spreads out from those boundaries which were acceptable up until a certain moment in

time. Nevertheless, his works are a core of contemporary art's dynamics and overall in Art History. Says Walter Benjamin in a famous passage of *Theses on the Philosophy of History*:

> A Klee painting named *Angelus Novus* shows an angel looking as though he is about to move away from something he is fixedly contemplating. His eyes are staring, his mouth is open, his wings are spread. This is how one pictures the angel of history. His face is turned toward the past. Where we perceive a chain of events, he sees one single catastrophe which keeps piling wreckage upon wreckage and hurls it in front of his feet. The angel would like to stay, awaken the dead, and make whole what has been smashed. But a storm is blowing from Paradise; it has got caught in his wings with such violence that the angel can no longer close them. The storm irresistibly propels him into the future to which his back is turned, while the pile of debris before him grows skyward. This storm is what we call progress. (Benjamin 1940; ed. 2007, p. 257-258)

In Art History, Andy Warhol's portraits are a sequence of physiognomic declinations of the *Angelus Novus* reincarnated in the prophetic characters… When Marilyn Monroe died, in August 1962, Warhol tribute the actress with a series of works starting from a photography of the now legendary face of the actress which worldwide papers diffused all over the world. Starting from 1972 he commits himself to portraits: stars from fashion and jet set world (Giorgio Armani, Carolina di Monaco …), politicians (Mao Tze-Tung ...), actors (Liz Taylor ...), singers (Mick Jagger ...), artists (Keith Haring, Basquiat ...) and himself, with a long series of self-portraits. Those faces are appearances, countenances, they look, but they "are not", we may say ... but they *mean*! They mean to show an effort to represent the past of their lives in a historiographic perspective which commercializes the identity. Warhol's point of view has no moral ideal. He's cunning, ineffable, caring towards commitment needs, like an extraordinary *couturier*. The identities expressed in his portraits are „passed", life has „passed by", barely touching that body chosen as a simulacrum and became object for the trade of rights of servitude for those bright colours applied on wide areas.

A patchwork can result in warm blankets, but it's hard it becomes something entirely new, because it's made from cluttered pieces here and there, from raw materials wasted, consumed, waste. It becomes new if it's able to generate something new from its single components, but not only because it's something more than the sum of its parts. I mean to talk about the vision that sprinkles from the mosaic of elements that don't suggest the whole, if observed singularly, because that unity is something new that

wouldn‘t have happened without that peculiar way of joining the parts and which does not depend from the single elements, but from the compositive equation in the mind of the artist. The tints which Warhol uses are now well known in the world of fashion, the faces belong to lives worn out by fame, life, success. How could he reach to create such a radical new portrait of the face, for instance, of Marilyn, without debasing its elegance and without taking advantage of further elements? Through the vendor of illusion, beneath the emerging image and the underlying truth (afferent to the collective memory of that face) spawns a hiatus which inner sense is hardly placed. If the appearance rests untouched (the face), if the name stays unvaried (like Marilyn‘s), then why do we immediately gain the idea of something completely different, tossing through the future as an icon worth a museum? In other words, why does a simple photograph of Marilyn face is suddenly as worthy as a Cretan finely decorated vase which loses its function as a tool to become the stage onto which a tale is told? Also, what story does Marilyn portrait is telling us? Is it about her or about what she didn’t manage to be? Is it talking about things of her face that we never noticed? Her fertile beauty has been twisted on behalf of being consumed through the use of the painting for the spectators needs.

Just like the spectator of his private fantasies would have acted, but nevertheless in plain sight, right in the face, cutting away the Shadow, the “secret” element. The privacy of the transfert – kind of an iconological autonomy every single one of us nurtures in our own psychological domain – is exchanged with the social-graphic value of Marilyn‘s image, which turns itself into a serial object, like a trade ware, as a Campbell Soup may be.

Not by chance, starting from the 60s, Warhol seeks for new inspiration, far from luxury wares and turns its eyes on American mass consumers goods sold in Bronx and Brooklyn superstores. The flattening phenomenon out coming from the removal of the volumetric depth – as well as the elimination of shadows, literally speaking, but also of the archetypal Shadow – cuts out several centuries under the dominion of Brunelleschi‘s perspective rules and therefore activates the mental association for which everything serial goes with the absence of future, meaning, personality, ... like a deployed soldier, a social device useful for the community. All of this simply using flat colour coats. Sure! But that‘s not the painting of an unskilled scholar, but the chromatic implosions coming from a brilliant creative mind of fashion and communication, in this case an “artist of the times”, the restless host of his *Factory*, a focal point in New York‘s cul-

tural scene. Many artists gathered in this atelier and it‘s right there where the band *The Velvet Underground* was born. With Roy Lichtenstein, Claes Oldenburg, Robert Rauschenberg and Jasper Johns, Warhol unwillingly starts the much-discussed American Pop Art.

Philippe Daverio (2012) claims: “In the beginning of the 60s, Pop Art conquered Europe and nowadays we cannot overlook this art movement when inspecting art of our times, including artistic experiment of our youngest Italian generations.“ In fact, the world of art engages, starting with Pop Art – and not only because of it, but answering to an inner, unresolved tension – a regressive dynamic which leads to the dissolution of matter in the artwork. While Picasso is acting in the same way in Europe „hurting” the figure, and bringing to an almost decisive end the millenary moment of the supremacy of the form, Warhol does not harm, but we could say he ab-uses, using the image like a form, establishing a nomination, a labelling: our face is the primary instance connecting to our name, but even his *Brillo Box* identifies a whole world, a category, and Warhol distorts not the meaning, but the representability of this instance. Spadaro, again:

> If we consider Warhol‘s paintings keeping in mind oriental iconography, we can verify that they have a lot of aspects in common. The golden background of icons is translated into the abstract colour background, vivid and bright, of Warhol‘s portraits. The stillness of oriental display is given by the “freeze frame” look that we experiment when looking at his work, whether portraying people or objects. The de-contextualisation is at its peak compared to visual and historical context. What‘s also evident is the lack of emotional involvement. Contrasts are neat. Confronting Warhol‘s painting and icons can seem daring, but flows quite naturally when done in front of the artworks. Warhol‘s paintings are real “pop icons”, as said before. His portraits exhibit pop “saints”. By these figures, anyhow, it‘s worth noticing that in his production is always present the theme of death and the frailty of life. […] It was impossible for Warhol to escape a sort of constant memento mori. (Spadaro, 2007)

Decontextualize means to eradicate, if identity is involved. An aggressive component, which goes together badly with the theme of spirituality in which it‘s supposed to be sublimed, canalized. The affection outcomes as coerced, perverted, self-destructive.

Warhol‘s greatness mainly stands in having been able to transform the basic aesthetic conflict in a passionate juxtaposition between fame and originality on the one hand, and between reproducibility and seriality from the other.

Still, art critics and formalist theories don‘t seem to own the diagnostic tools sufficient to understand the change happened in contemporary art, to

understand and explain the novelty that it‘s facing, and to “read” artworks such as the *Brillo Box* or the *readymade* urinal of Marcel Duchamp. Overlooking all this with a diktat, stating that “it‘s not art” does not explain why, given two Brillo soap boxes, Warhol‘s one finds its spot in museums, while the “original” (yet “serial”) one stays on supermarket‘s shelvings. Tiziana Andina, in the review of *The Abuse of Beauty* by Arthur Danto, claims that

> “In this perspective, the elusiveness of Pop Art is, basically, a problem eminently philosophical, indeed on closer inspection, the metaphysical” [Danto says]. […] In a nutshell Danto would like to offer an essentialist theory. In that means that if we disregard the starting point, which may seem the most historically determined imaginable, Danto aims to provide a universal definition of art, which is not a definition that is forced to change historically, following the changes of its objects. For this, the definition that Danto has in mind must be sufficiently broad and flexible to include the Brillo boxes and can justify the inclusion or exclusion of beauty by contemporary art. (Andina 2007, p. 118)

To which necessity, not as much of the artist, but the man, does this phenomenon respond? Who is the man who no longer needs the classical form, but who feels close to his taste the destructive form, the dissonant image, the evanescent installation, who deprives himself from teachers (and thererefore from scholars) to leave the scenes to aesthetic artisans? This, because Pop Art wouldn‘t have had such a great relevance if it hadn‘t eradicated painting from history. And if it hadn‘t launched the transformation of art‘s Dna which development faces today an intricate crossing-over: a point of non-return, a loss of tradition and knowledge which, along with the new generations, will be impossible to recover. But our eyes must be trained to disenchant, because everything is turning, and nothing we can observe is free from a principal unconscious of its own individuation.

The narcissistic drift at the basis of dissociative dynamics, which tends to split the object from the subject, offers several possible interpretive returns, not only for Andy Warhol, but for a large portion of contemporary art. Let‘s start from the “aesthetic conflict” by Donald Meltzer:

> No event of adult life is so calculated to arouse our awe of the beauty and our wonder at the intricate workings of what we call Nature (since we hesitate nowadays to cite first causes) as the events of procreation. No flower or bird of gorgeous plumage imposes upon us the mystery of the aesthetic experience like the sight of a young mother with her baby and the breast. We enter such a nursery as we would a cathedral or the great forests of the Pacific coast, noise-

lessly, bareheaded. Winnicott's stirring little radio talks of many years ago on the Ordinary Devoted Mother and her Baby could just as well have spoken of the "ordinary beautiful devoted mother and her ordinary beautiful baby". He was right to use that word "ordinary", with its overtones of regularity and custom, rather than the statistical "average". The aesthetic experience of the mother with her baby is ordinary, regular, customary, for it has millennia behind it, since man first saw the world 'as' beautiful. And we know this goes back at least to the last glaciation. (1988, p. 16)

It's about understanding the aesthetic impact that the "sight" of the mother-art has upon the psychology of the sons-artists. This mother appears to be absent, deaf, blind, taciturn, absorbed in her need to generate and spread herself, while the man wears the burden of teaching, learning, improving, igniting, praying, serving, transferring knowledge, setting cities on fire, building cities, crossing oceans, being ready to sail again. She doesn't own, this "Great-Mother-Art", a lengthwise vision on the destiny of the man-apprentice, as striving as she is to extend, to ramify, to embellish every church, to ornate houses, to become history, war, society, organization, business venture. The folding of the man himself, his loneliness, reflected on his symbolic capacity. Meg Harris Williams (2007) says:

> Using an age-old (Platonic) metaphor often reiterated by the poets, Bion says the knowledge derived by means of LHK constitutes "food for the mind". This food takes the form of symbols, which incorporate knowledge within the personality. Here psychoanalytic theory comes into line with Romantic poetics, as when Coleridge said that "an idea cannot be conveyed except by a symbol" (Coleridge 1816).

Andy Warhol is the man who fully expresses the contemporarily of the artist deprived from the aesthetic conflict: he moves towards an apparently chaotic direction. The beauty of the Great-Mother-Art is alienating, metamorphic, her breast is elusive and maybe too far apart: old Europe with its cathedrals is inaccessible, overwhelming with beauty in its dungeons and catacombs, shut to prevent from the war menace. "Western" society becomes the present mother, allowing the only possible symbolization through the destruction of the beauty denied. The reciprocity of transfert between art and the object of art constellates as the only form of identity, marking the self-referenced and narcissistic destiny of the art that will follow through the years, in America as well as in Europe. Warhol seems to use the emotional negative potential of equipment to annihilate the impact of beauty on his fragile and odd polymorphic structure. His credit is to

have turned into "accessible", as a substitute object, the elusive. Marilyn, elusive. Dish soap and canned soup, shoes and armchairs, remains of memories of a mother-elsewhere.

The gesture in flood of Cy Twombly

Cy Twombly's art is a scream over America. A call of blood and heavens crowded with flowers which shatter in a crimped rumble of infected butterflies. His picture is a gush that breaks the banks of harmony, it's a blow stamping flights for destinations never to be reached, non-possible. Twombly's painting (Virginia 1928 – Italy 2011), express the failure of modernist utopias. Illegible, incoherent, unlikely. Nevertheless it's real, and utterly beautiful. It's important to understand how has it been possible to forge this violent, irreversible union, like an aeroplane plunging at vertiginous speed which tail on fire, and as it spins down like a shooting star. Paintings of such an extraordinary chromatic epiphany, of exploding light. Which signs, colours and shapes are the instrument of land surveying in a deserted planet, warding off its imminent deflagration.

The whole opus of Cy Twombly (painter, engraver, drawer, sculptor) is deep night bursting into dawn, it's the "forgotten language" of Erich Fromm on a screeching blackboard, it's crumbling slate into unlikely shapes, it's the blossoming of burning light scribbles moving fast like a skilled swimmer whose arms babbling into the abyss without loosing – although lost – their wise elegance in the unconscious turmoil.

The "painting" planned by Cy Twombly is a tangible form of non-painting, it's a frantic decision to run towards the language's crisis and sink into this spasm like on the threshold of the neoplasia which quickly eroded the perceptive universe in which decay we play as actors, bound to the monocular vision of reality marginalization or to the merging, regressive confusion of social networks. It's a painting of voices crowding a crossroad, where the contemporary artist is forced to stay, endlessly organizing over and over again images, metaphors and representations in the room of his conscience, while distressed by his own existential paradox, compelled to be at the same time son and god, creature and creator.

Cy Twombly appears to join, to face the stress of the devastating unilateral mythology of the contemporary world, to an "anti-creative" tradition, like his atelier were a renowned academy which highest chair has always been vacant. His originality is so potent that he must hide from himself in order to understand something of his own virtuous and undisciplined

art of the gesture. The technique that has him as a master (the blurring the outlines of his drawings), is the expression of an attack strategy to the sides of orthodoxy, it‘s a way of saying that the infant is more independent than the Gods and more confident, more violent, more demonic. Moreover, the desire for union is to be moved in a forward flight to the abode of perfection, toward which the puer moves with incessant falls and unfulfilled desire.

The forecast of the future (on what would have been a drawing by Cy Twombly if he had given us the beautiful forms of his immense talent in painting at the expense of his choice of authentic man who decides to become scenery of the myth of the light of the post-industrial), is already beginning to constellate in the controversial environment of the womb of Expressionism, where his first works are born, not in order to a chance, but to become a mythical perspective of the drama of their lives torn apart in which sign and design, outline and shadow, are cleaved yet paired in a tiling in which the dancers seem to stay lonely.

For Twombly the mythical perspective meant strength and feature, meaning and beauty. The painter loved to make his drawings “vehicles for literary contents”, and he fought against contours to make free the figures. Twombly‘s work, if ever ordered on parallel levels, would show a morphology similar to a geologic intra-psychic layering in which alchemical markers have been imprinted. The beginnings, in the early 50s, are defined by Kline and Paul Klee influences, and consist in gestural-expressionist paint strokes, in an original and smooth interlacing of lines, words, numbers and portions (“fractions”) of objects. He‘s deeply attracted to Italy, where he finally moves in 1960, when he sets up the first exhibition at Leo Castelli‘s Gallery.

The 60s are the *Blackboard Paintings* years, big sized works in which he performed calligraphy as in *graffiti* on solid grey, white or brown backgrounds (a technique halfway between painting and engraving) in which writing gets disrobed from its communicative function and transferred in the semantic field of the gesture, until it fully constellates action painting, rich of excerpts like in *Leda and the Swan* (1962) or in the famous battle of Lepanto. In this span of time, which is extremely productive, he starts his first abstract sculptures, which are always, though varied in shapes, covered in white painting. Twombly will use (and will promote through his entire life the use of poor matters) material borrowed from blacksmiths, carpenters, metalworkers, to give distinction to simple shapes put

together, recalling the art of master craftsmen in forging the tools of their trade; a homage to objects, which get free from their condition of useful tools (like letters and written words) to ascend to emblems of their utility: the object, humbled by its specific destination becomes subject of a silent and perennial beauty, like in a process of mummification, in which plaster, varnish, wood, cardboard, metal, paper, fabric, thread, pencils become elements of hand labour and that, covered in white, opaque varnish, undergo their last, immortal treatment.

Halfway through the 70s, Twombly creates "multi-layer" artworks, downright creatures representing the full accomplishment of its unconventional portfolio, built putting together a collage of paper sheets and other pictorial media.

The "hollows" are the necessary cement to the unravelling of a resplendent creativity, making free drawing from linguistic base systems. The sign becomes "lemma" and it's often retracted in a philological mould: like if a brilliant child had the sudden ability to communicate through a language in which word and image met in a volcanic mouth made out of wonders and delicacies, coming to light with extreme care, sometimes with geographic references like in the series of painting of Bolsena (the volcanic lake nearby Viterbo). In these works, the graphic components melt together with increasing technical strength in a whirling dissolution of complete unpredictability, but are sometimes defined by a phantasmagorical sharpness, like some alphabet only a few elected can decipher, like in *Apollodoro*, until reaching, in the 90s, the aesthetic peak of elegant floral specimen that somehow join him, in a sort of reunion with the starting, to the Fauves who characterized his beginnings half a century before, in the American years, during his scholarship with Robert Rauschenberg and Jasper Johns.

A brilliant sample is the Four Seasons, gigantic panels which appear to dwell between the stage space and the architectural one, in a dance where colours linking themselves in splashes forever challenging to move downward, pinned against the canvas through invisible strings, like hands struggling to muffle the scream of a goddess of archaic beauty, master of cave art.

The inner plates are filled with violent tension, with intrusive conflict characterized by a cryptic language, that reminds to the constant conflict between violence and silence, sexuality and play, light and background, in a relationship emotionally involving the spectator: a spectator that is

jumping into the painting and soaking his eyes in that mass of colour.

The flowers are, in some works, explosions that belong to the latter part of the pictorial journey of Twombly. He has never been included from American critics in the Pop Art movement; his stubborn style unicity was his greatest luck: his paintings are evaluated millions and desired by most gallerists.

Being his project "non-methodical", we can only retrace it backward and intercept some of it coordinates, with an inner vision which appears to be the only possible one. And getting back to that alchemical process, stigmatized in the geology of its artworks, it's not hard to trace an alternation of layers of white, red, black. The dynamic quality of Twombly 's work intersects with the static one, guardian of the message, therefore it's a majestic work separating gold from mud, and adds up an air of mystery and enlightenment, for that unusual proficiency of the teacher to make both the black and the red rich and aware one another, close tight on the line between abstract and symbolism, held together by the invisible chain of the expression of colour in full light, which seems to be able to say anything while in fact it procrastinates everything to elsewhere in an infinite mirror of representations.

The label of "expressionism" is, in fact, always relative because it does nothing but saying over and over again that under the expression there's a will to show, to say, to express. The message "expressed" by Twombly is still basically undeciphered. An idea, a desire, to go back to the dream of the heroes and to the amphorae of a time gone by.

The force and domain of form in Francis Bacon

Francis Bacon (Dublin, 1909 – Madrid, 1992) in a perfect mutuality of narcissistic close examination keeps a stand-alone position compared to his contemporaries, though addressing to the figural range. He operates with the aid of diversified sources (poetry, drama, works of other authors, photography). Critic evidences the intercourse between Francis Bacon poetic, with nihilism, existentialism, and with surrealism, due to Bacon's resonance with George Bataille and André Breton's thoughts.

Anyway any attempt to get close to Francis Bacon implies and encloses the involvement of parts of our Self. His artworks get in with a tremendous strength that springs from his full and hyper-narcissistic cohesion with his own way of feeling, seeing and perceiving the world. Just like the death of a son touches the deepest chord of a mother (and Echo, missed

the opportunity to be mother-lover, consuming herself in Narcissus loss, aware of being unable to mediate for him the meeting with the world), so the pain of his faces, his bodies and landscapes resonate in the most inner room of who moves close to them. The need to expose the loss of primary objects in Bacon's art is an alchemy of shame and refusal, the apotheosis of reality raped to avoid its imminent crash; deformation as last instance of deflagration of the reflection in the pond, to make the only possible reification of it, the ideal exponent of a negative Self, of the opposite sign to grandiosity, non-censorable from the Superego, because it comes from inner, solely conditioned by instinctive impetus basic to psychic structures: an outer manifestation of the mechanism of the flesh, a satisfaction in which

> [Exhibitionism, in a broad sense, can be regarded as a principal narcissistic dimension of all drives]. The object is important only in so far as it is invited to participate in the child's narcissistic pleasure and thus to confirm it. (Kohut 1966)

Developed through an extraordinary creative intelligence, somehow able to represent Narcissus drowning into himself, like a sort of narcissistic bond to the inside of the body as a Self-appendage. This radical research is reported by Bacon himself, as he claims (1991, p. 35): "I want to distort things beyond appearance, but at the same time I want deformity to record appearance". Gilles Deleuze (1981, pp. 40-42):

> In art, and in painting as in music, it is not a matter of reproducing or inventing forms, but of capturing forces. For this reason no art is figurative. Paul Klee's famous formula – „Not to render the visible, but to render visible" – means nothing else. The task of painting is defined as the attempt to render visible forces that are not themselves visible.[…] Bacon's Figures seem to be one of the most marvellous responses in the history of painting to the question, How can one make invisible forces visible? This is the primary function of the Figures.[…] It is as if invisible forces were striking the head from many different angles. The wiped and swept parts of the face here take on a new meaning, because they mark the zone where the force is in the process of striking. This is why the problems Bacon faces are indeed those of deformation, and not transformation. These are two very different categories. The transformation of form can be abstract or dynamic. But deformation is always bodily, and it is static, it happens at one place; it subordinates movement to force, but it also subordinates the abstract to the Figure. (Deleuze 1981, pp. 40-42)

For Deleuze, Bacon acts as a detector of the force and the movement of the force. He identifies three major groups of invisible forces in Bacon: the forces of isolation, the deformation forces, the forces of dissi-

pation. Naturally enumerates many others, such as the coupling strength, the strength of the changeable weather and the strength of eternal time ...

The mythical perspective is predominant and the dynamic de-idealizing applied to the figures only reinforces the narcissistic mirror that moves archaic forces, seeking a residual empathy, through a process similar to that in the analysis of transference Kohut calls "transmuting internalizations", to mitigate and modify the grandiose Self of the patient (Migone 1993).

You could call this narcissism aesthetic as a phase of conquest of iconological and iconographic, which defines "a special field of poetry, a situation in which art could take the road of emancipation from means of expression inherited, which in the past had served the tasks of illustration, interpretation, ideological documentation" (Teige 1973, In: Pacini, p. 12).

Jean-François Lyotard, in his critical analysis of the "subject" of postmodernity, dedicated to the relationship between art and figure a seminal essay, *Discourse, figure* (1971). A true landmark, among all the works, portraits: we offer to our eyes slopes as living, opening reflection on creativity and divergent delirious narcissism dialectical. Xenia Nibrandt says:

> The human figure is the subject that "devours the soul" of Bacon, pushing him to persist on portraits, whether of friends, of lovers, of himself. Though all of his paintings may be called, on his own statement, portraits and even self-portraits – in them the intimate relationship of the artist with the world in which he operates, on a erceptive and reactive level – the concern of this consideration is the same deformity these self-portraits must undergo. (Nibrandt 2008, pp. 72-89)

We can now catch the clothing of Narcissus as he's about to sink in his own reflection (in all the meanings) and let us go to some observation before leaving him to his fate. The instances of disintegration are so evident to interdict the thought, leaving it behind. Emotions tangle up trying to hold onto the ultimate life. The need to represent it replaces by the need to find an adequate language to a minimum understanding that does not leave the eye stiffened and excluded, the only witness to a lost story of loneliness, love and broken mirrors, sorrow for having to exist on the edge of a pond, unheard of screams that are dispersed in the echoes of the ruins and rubble, on a journey to meet the man stranger to himself, permanently deprived of the Other. This language should be formulated, and is perhaps the dream language, or closely resembles. Nibrandt (2008):

> The objectiveness constitution should be perceived as a "hiding-showing", because it generates a presence-absence, on the model of the "Fort-Da" relati-

onship studied by Freud. The language manages to establish the Sensitive as a substantial object because it makes it present (designs) and it subtracts it to its immediate meaning (signifies) at the same time. But, because of its fundamental reference features, is able not only to set what it displays-states, but also what it hides-denies: existence includes and hides a non-existence, to the invisible side of the perceivable world corresponds a non-world – the unconscious of delightful impulses which have been removed-denied. (Nibrandt 2008, pp. 72-89)

Walking into the unconscious, Hades opens up to infinite digressions. One of the problems is that in dreams, the languages are only apparently deconstructed and chaotic … Let‘s just say that the Narcissus who decides to take the path of self-knowledge it does not remain an immediate destruction and painless: embarks on a path that is actually the cross and resurrection, a wave whose constant perceptual passes through the body and the human face.

Narciso the Anarca, which touches wandering gaze switched on from the Self stranger, which it can not offer a fate accomplished deprived of the sense of time, it only remains to fall in the unfinished dream and in the underworld, before accepting a cure for his narcissistic wound.

Let‘s just say that Narcissus, choosing to head the way of self-knowledge, is not left with a painless, immediate destruction: he actually starts a path of agony and resurrection, a perceptive wave which constant flows through the human body and face. Anarchic Narcissus, cursed to wander with the eyes set on fire by a stranger Self to which he can‘t offer an accomplished destiny, deprived by the sense of time, is left with the unfinished fall into the dream and the underworld, before accepting a cure for his narcissistic wound.

The wound on empty of Lucio Fontana

A dream is useful to see the invisible and to hide invisible. A wound is certainly an elective place to access the imaginary world, and to the heart of that “aesthetic of evil” to use BATAILLE‘s words, which looks like the backside of a gentle embroidery, that dual sensation of truth that constellates each time the surcharge of Ego finds itself groping in that swamp that was the pond and mirror of Narcissus. Now, what‘s this wound in a linguistic order like the one of FONTANA‘s extraordinary “cuts”? It‘s deeper, image and word. And this change of perspective opens up like a fault, there‘s no time left to see things like before the underworld horizon opened up. An horizon that‘s *telos* and *nostos*. Because it‘s discovery, journey and

memory, it‘s passage and inner vision. This is the log of the *Doppelgänger* in the theme of dream. And it‘s metaphor as well. Pure, spaced metaphor, proto-verbal orders and disorders of primeval ideas, *embodied cognitions* of the perceptive shell of senses. It‘s not forbidden to step the paths of reduction in a map of digressions to understand Fontana‘s wounded vacuum. The wound is declination, is complex sign, is morpheme that defines a linguistic act compared to what happens, the way it happens.

Reducing Lucio Fontana‘s (Rosario, 1899 – Comabbio, 1968) creative production to “holes” and “cuts”, it‘s a blatant stereotype. Still, we can‘t ignore that these are symbols with which critics and public identify Fontana. One reason might be the psychological relevance of the “cut”, an actual blow inflicted with violence on that naked image that‘s a mute canvas, without an echo. An act of extreme freedom, that hurts and allows to see, climbing over, reaching a new space, in which formal and imaginative tension undergo the backlash of the journey, of the painful experience: a space that‘s a new annexation in favour of conscience, a new question.

A cut is prone to infinite interpretations. The problem could be flipped. What is to cut a canvas, if not “telling” something impossible to say in any other way? There, it lays the logos of any picture, the syntax of an otherwise impossible grammar operation. The focus of the consideration must be, in our opinion, the request for passing every kind, form, matter and traditional procedure in the name of a new art, in time and space, one with absolutistic meanings concerning matter, sound, motion, colour, wished from Fontana through his *Manifiesto Blanco* (Buenos Aires, 1946) and summarized in the need of integration into a “psycho-physical unity” in artistic manifestations, and in the *Technical Manifesto of Spatialism* of 1947, written by Fontana alone. The solipsism of these statements, their rage of grand denial towards all the codes previously used by artists appears to be the last voice of the urge of crossing the road and wiping out the mirroring function, pointing to the impossibility to enter some identification in the previous masters: the irreversible *Twilight of Gods* foresaw by Nietzsche (1888) at the end of 1800. If, according to Nietzsche , “Everything which is deep needs a mask“ (1886), what‘s the implicit beyond the canvas, which identity occurred in the space craved with such fierce, biting eagerness? Maybe a nauseating vacuum, vertiginous ... “sartrian”. And it‘s the mask, the canvas, the “wounded thing” which acquires identity in place of the desired space: the longing one controls the object appropriating it, integrating it in a place indivisible from the Ego,

just like it happens in the classic narcissistic, psychodynamic formulation.

What kind of alienation can fill the artist, therefore the man, acting such a sharp dissolution of shapes in favour a twist that marks the whole life of contemporary Art, conditioning it to its aesthetic fate? To video art, performance, installation, the rarefaction of matter?

The gestural anger expressed in Fontana is not different from a lifetime anger trying to outbreak the magma of a solely narcissistic condition. It‘s a tentative that pursues the way of aesthetic in a heroic dynamic, which we can “re-read” turning over the canvas, examining it inside out, whence Bacon observes the bodies of his portrayed men.

That gap “beyond the line” is the land of an aesthetic promise where the artist arrives at, feeling strongly responsible for the due he‘s committed to: denying the masters to reach a fully renewed vitality, in an utopic desire of uniqueness and unity. The passion he works with is only equal to the control he needs to exercise not to be tangled in his own nature, as material like the earth-mother he needs to deface, and as the raw canvas on which he operated the first ancestral signs of his art. The blade is sharp, the edge is cruel, the glance is piercing and petrified, saturated.

III. Conclusions: Of Passion and Shadow

Some big artists of modern art used an “important” symbolic-representative system, even resorting to myth, trying to “understand” the dynamics of anger, explaining them, submitting them to philosophical, psychological, religious questions.

In contemporary art, the artist seem to give up his function of “mediator” between unconscious instances and objective reality, sometimes looking deprived of the necessary strength to manage the tension sprung by being “media” and “creator” in the same time, giving up the religious dimension and the philosophical position that would hit him way beyond his possibilities. The 90s nihilism worsen his condition of impotence, often expressed through shifting the artistic action concerning a system of “paths” afferent to conceptual, informal and linguistic scope, into a moving “instinct”, an “acting out“. The language of contemporary art tends to express anger and violence applying a wound to representation: with Picasso (Les Demoiselles d‘Avignon, 1907) falls the domain of form and begins the big transformation of depiction, that move to metaphor‘s dominion.

Romano Biancoli‘s (exegete of Erich Fromm) interpersonal psychology says us that “control passion never fades, because the safety it chases

vanishes in the moment it‘s snatched. Demanding to grab life makes you entitled of just one life pattern. […] The strength and delight of control stand in the turnover between clasping and loosening the grip. The passion of control intensifies until death shows up, and then stops.“ (1986)

The strong narcissistic connotation of contemporary art makes more unlikely those identification processes at the base of vision and re-vision in creative dimension. Artwork makes way for performance and digital and multimedia art. The massive loss of the “tangible” share in this complex and over-communicative “world” needs an answer from the Man.

Ego, conscience, need a visual, relational, motion and linguistic field that bring back to a primal and primeval condition the real expression of depictive world. Contemporary society exploded the repressed memory of the body through a peculiar form of psychodrama starred by the body surface and the world of sexual relations as only available sceneries for the comeback of depiction. The outlining constellation of Shadow opens up to horizons that require amplifications of analysis of the transcendent function in the psychology of the artist, and in the inner dynamics of contemporary art. Social and individual Narcissism, matters of extreme vastness that arouse “fear and trembling”.

Zusammenfassung

Das Ziel dieses Vortrags ist es, die Dynamik der Regression, insbesondere die narzisstische Dynamik, hervorzuheben, die der Werkerstellung in der zeitgenössischen Kunst zugrunde liegt. Der Schwerpunkt liegt auf der Entwicklungsdynamik des „Verlusts des Metaphorischen“. Die Arbeit ist aufgebaut um die Prämissen für eine mögliche Revision der Psychologie der Kunst herum, um hinsichtlich des „bildhaften Denkens“ und der mythischen und archetypischen Perspektive zu der Manifestation dieser Aspekte im Werk einiger berühmter Autoren zu kommen. Dabei beginne ich speziell mit dem Werk von Picasso und Duchamp und ende mit Cy Twombly, Andy Warhol und Lucio Fontana. Dieser Beitrag zeigt, wie Aggression und Emotion, die man in der zeitgenössischen postmodernen Kunst (z. B. in der Kinetik, Performance und Körperkunst) erleben kann, aus einer narzisstischen Wunde heraus geschaffen werden können – auf jenem „Leichentuch, das wir weiterhin Leinwand nennen wollen“. Diese Wunde wurde geschlagen in dem Bereich des vermittelnden Ausdrucks, der zum Verzicht auf das „diskrete Objekt“ (zunehmend dematerialisiert)

neigt und es durch ein „Körper-Subjekt“ ersetzt, das besonders gern vom Künstler benutzt wird, wenn er die Konventionen und ausdrücklich schon existierenden Codes entweihen und untergraben möchte.

Einige große Künstler der Moderne benutzten ein symbolisch-repräsentatives System, wobei sie sogar zum Mythos Zuflucht nahmen, in dem Versuch, die Dynamik der Aggression zu verstehen, zu erklären und in philosophische, psychologische und religiöse Kategorien einzuordnen. In der zeitgenössischen Kunst scheint der Künstler seine Funktion als Vermittler zwischen unbewussten Instanzen und der objektiven Realität aufzugeben. Dabei wirkt er z. T. des Ernstes beraubt, der notwendig wäre, um die Spannung zu bewältigen, die dadurch entstanden ist, dass er einerseits Vermittler, andererseits Schöpfer ist, der die religiöse Dimension und die philosophische Position aufgibt, die ihm einen Weg freiräumen würde über seine bisherigen Möglichkeiten hinaus. Der Nihilismus der 1990er-Jahre verschlechterte seinen Zustand der Machtlosigkeit hin zu einer Triebhaftigkeit und einem Ausagieren, was sich oft darin zeigt, dass sich die künstlerische Aktion auf einen anderen Bereich verlegt und ein System von konzeptionellen, formlosen und linguistischen Zugängen benutzt.

(Übersetzung: Erwin Leßner, München)

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From myth to the reality of the neurological substrate: the path to psycho-neurologic psychotherapy

Enrico Zaccagnini (Florence, Italy)

Accepting the essential mind-brain unity does not reduce reality. A scientific approach to the brain entails studying its physiology and using it as a building block for the treatment of mental disorders, refraining from any arbitrary interpretation and making an effort to integrate the various discipline studying man's brain and mental disorders. A multidisciplinary approach to mental disorders and their treatment is not a myth. Experiments supported by neuroimaging brain monitoring are proving that our brain can repair psychological injuries as well as our body is geared to respond to injuries from the environment. This is the starting point of The Adaptive Information Processing Model (AIP). Most recent findings supporting the AIP model will be provided.

Keywords: EMDR, AIP, Default Brain Network, Episodic Memory Constructive

Theory

Leonardo considered man at the center of nature and cosmos. Though this idea of man is obsolete from an astronomical standpoint, it still governs human fundamental issues, where man is still a question mark in the center of the cosmic mystery. He used to study both the artistic aspects of man, nature and the cosmos in order to grasp their beauty, and the scientific ones to understand their proportions and relations. Thanks to his realistic perspective, Leonardo could see his artistic masterpieces and great scientific intuitions reflected in the nature of things. He was able to see the beauty and meanings of reality without availing of metaphysical artifacts. In the same vein, exploring the human brain starting from our brain-mind unity, without recurring to metaphysical hypotheses, is consistent with the reality of man, nature and the cosmos.

The mind is not in a place outside the brain. It is not contiguous, close, near, adjacent, adjoining or conterminous to the brain. Just like laughter is not something separable from the person who laughs but expresses his or her happiness, the mind expresses the way the brain operates. Science can no longer afford to fall back in the mind/spirit Cartesian dualism: the mind/body separation costs too much delay in the scientific study of man,

its brain, its personality and, last but not least, its mental disorders. Yet, many people are very vocal in their affirmation of an essential mind-brain unity though few in the psychotherapy realm work consistently with this scientific evidence.

Accepting the essential mind-brain unity is not a reduction of reality to something cheaper or more trivial. Reality – in its different orders of magnitude, cosmic, terrestrial and human – is complex: Science may grasp it by successive approximations, but cannot reduce it. Reality needs only to be investigated removing all what is not empirically, experimentally and statistically demonstrated; psychology was not exempt from these risks, as it shifts the issue and object of its research outside reality, sometimes creating unrealities and distress in clients. This is the time, on the contrary, to get rid of impurities on one side, and make an effort to integrate the disciplines studying – some of them directly, some less so – the human brain and mental disorders in a rigorously scientific way, on the other.

Until the 19th century, science was identified with philosophy: Science was philosophy. During the 19th century and throughout the 20th century, several sciences sprouted and separated from philosophy. Sciences, according to their statutes, deal rationally and concretely with portions of reality, which are the object of their investigation.

The brain is constituted of cells and chemical elements; can brain studies do without biology and chemistry? The brain substrate can become ill; can brain studies do without medicine and neurology? The brain can become ill in its mental expressions; can brain studies do without psychiatry, psychology and psychotherapy?

As we can see, a multi-disciplinary approach to mental disorders and treatment is no myth. It is a reality-mandated requirement. Research and therapy must adapt to reality without trying to interpret it with arbitrary theories and ideas.

Over the centuries, science progressed a lot, and so have the aforementioned disciplines, but the current approach of the different psychotherapies to mental disorders shows that the road to achieve scientific and really effective treatments is still long. The current mental disorders treatment mode shows a multitude of different epistemic approaches: psychiatric, psychoanalytic, psychodynamic, psychotherapeutic and neurologic. The difficulty of constructing a single treatment episteme still persists.

This presentation aims at being a contribution to the construction of an integrated approach, able to take advantage of the findings of the many

disciplines studying the mind-brain, starting from the assumption that every discipline has seen the same human being with the same brain from a different angle. It is preposterous for science to present users with a different theory of the mind and psychotherapy approach for each facet, discipline, and standpoint.

The time has come for a unified assessment of the data provided by the different disciplines. The time for integration has come. We must have the courage of discarding what was proved arbitrary, even though it entailed fame and power, and seriously and scientifically deal with the brain, starting from the research on its physiology, and build the treatment of mental disorders thereon.

What is, then, the right approach to mental disorders? A correct approach to mental disorders must protect the client's brain balance and homeostasis, honoring its physiology. Our body is geared to respond to injuries; why should our brain not be also geared to repair psychical injuries and protect us from the wounds of the environment? Is the brain the only organ unable to respond to the traumas impairing its specific functions? Can it only be healed through the passive intake of psychoactive drugs or through arbitrary psychotherapeutic theories, recommendations and interpretations?

These are the questions that the Adaptive Information Processing (AIP) Approach has been trying to resolve, presenting an operating model where the brain's responses to the environmental challenges, are all adaptive in their modes. Actually, in general, when an event bothers us, we can, through our normal brain functions, resolve it over time by resting it out, sleeping it out, dreaming it out, talking it out, thinking it out, and so on.

But, in some specific conditions, when the event impact potential is high, cognitive, emotional and somatic information related to the experience of such an event may remain frozen in unconnected neural networks and nodes, maintaining the beliefs, emotions and body sensations experienced at the time of the event, together with their symptoms and distress.

What do we then mean when we talk about a brain geared to adaptively process information? Over the last few years, psycho-neurology, corroborated by psychological experiments supported by neuroimaging brain monitoring, is paving the way and providing authoritative confirmations of the AIP.

I will now briefly present two of the most recent findings, which I believe support my thesis: the Default Brain Network and the validity of the Epi-

sodic Memory Constructive Theory. Very briefly, according to the findings of the Default Brain Network, some brain areas, instead of being inactive or less active, showed an increased activity level during apparently idle (default) states, compared with task-performance states. The brain in idle state rests from the stress of the response to the environmental stimuli, but, rather than shifting to passive dormancy, it is intensely and continuously aroused and such arousal can be undoubtedly traced to internal mental life processes, which is an important fact in a psychotherapy perspective.

These findings may indicate that the brain could envisage two information processing possibilities. One associated with the extraction of the information focusing on the data originating from the sensory pathways. The second option is related to the neural data extraction activity from the brain itself. Experiments on subjects under real-time neuroimaging monitoring, to check the activation of the brain areas corresponding with the Default Brain Network, showed that the brain, released from the focused attention to the sensory pathways, focuses through the physiological activation of the Default Brain Network, on the exploration of the data stored in it, to process them and prepare response strategies to future challenges. Also very briefly, the validation of the Episodic Memory Constructive Theory confirms and reinforces the hypothesis of the brain processing and self-repairing ability.

According to the episodic memory constructive theory there are no brain loci where the images of the events experienced are stored. Memory is not a photo album or a collection of videos truthfully reproducing the actual episodes experienced by a person. On the contrary, the brain breaks down the event into several components, located in different anatomic areas, and associated to existing data according to functional, semantic and adaptive criteria. During recovery, the recoding does not reconstruct the original event, it rather combines the important elements of a recent event with those of relatable and related past experiences. Both, high-negative and high-positive-affect events, remain in memory to preserve and indicate important data, adaptively useable for future strategies. The huge volume of insignificant events is rapidly removed from memory. The negative-affect events keep what caused the suffering and the negative consequences the person could not avoid which shall obviously be processed. The positive-affect events keep what created the associated well-being. They show the personality resources that allowed positive emotional experiences. The brain keeps them for installation and future reuse. In summary,

the default brain network is a search engine, continuously monitoring the information stored. On the other hand the episodic memory theory clarifies that the data originating from important events are semantically stored and assembled, ready for processing by the brain systems, in particular by the default network. The brain is not a storeroom, passively collecting the information stored during a lifetime.

The body has repair resources for all its systems, including the brain, when it is affected by a mental disorder. When the body is affected by an illness it cannot overcome with its own resources, medicine must intervene and recommend remedies favoring recovery, while respecting the physiology. Polio was eliminated with a vaccine. Vaccines use the body immune resources. People recover from flue when the antibodies defeat the viral pathology. Likewise, a proper psychotherapy must take advantage of the brain „immune resources", i.e., the traumatic events processing skills highlighted by the aforementioned neurological findings. The time available here does not allow me to go into the technical details of such a psychotherapy structure. Suffice it to highlight that the brain does not need to be burdened with external solutions alien to it. When it is blocked by a distress, it just needs some guidance to process the life events causing such distress, healing them with the natural resources already available to it.

In this perspective the multi-disciplinary approach in brain studies cannot be ignored. Each discipline, starting from its standpoint and from the observations of the object on which it focuses, must provide data in a clear, transparent and converging way, so that treatment of mental disorders may be adapted, and so that effective interventions can be recommended. Effective interventions are based on the knowledge of the substrate reality, in simpler terms, on the knowledge of how the brain is actually constituted and works.

I was trained as a Jungian psychoanalyst but, nowadays, I must admit that it is difficult for me to identify with anything, in the field of mental disorders, which identifies itself as being different from something else. I hope the huge psychodynamic knowledge-base can be combined with the latest scientific findings. For about ten years our Florence Psychotherapy Institute – called Istituto di Psicotraumatologia e Psicodinamica di Firenze (IPPF) – of which I am one of the founders, tried to pursue this path with encouraging results. The introduction of the Eye Movement Desensitization and Reprocessing Therapy (EMDR), which is the clinical and operational application of the AIP, combined with some elements originated

from Body Centered Therapies, together with the precious psychodynamic background on the relationship, as well as with a suitably revisited dream interpretation technique, decreased treatment time and reduced dropouts. Doing psychotherapy with and for the brain physiological processes positively motivates clients, restoring them their dignity as active participants in their healing process.

Conclusions

The brain does not need to be burdened with external solutions alien to it. When it is blocked by a distress, it just needs some guidance to process the life events causing such distress, healing them with the natural resources already available to it. The latest neurobiological findings provide proof of the possibility to build new scientifically psychotherapy models according to the Adaptive Information Processing Model.

Summary

The current mental disorders treatment mode shows a multitude of different epistemic approaches. This presentation aims at being a contribution to the construction of an integrated approach, able to take advantage of the findings of the many disciplines studying the mind-brain, starting from the assumption that every discipline has seen the same human being with the same brain from a different angle.

It is preposterous for science to present users with a different theory of the mind and psychotherapy approach for each facet, discipline, and standpoint.

The time has come for a unified assessment of the data provided by the different disciplines. The time for integration has come.

We must have the courage of discarding what was proved arbitrary, even though it entailed fame and power, and seriously and scientifically deal with the brain, starting from the research on its physiology, and build the treatment of mental disorders thereon.

What is, then, the right approach to mental disorders?

A correct approach to mental disorders must protect the client's brain balance and homeostasis, honoring its physiology.

The presentation attempts to show how the Adaptive Information Processing (AIP) Approach has been trying to resolve the problem, presenting an operating model where the brain's responses to the environmental chal-

lenges, are all adaptive in their modes.

Over the last few years, psycho-neurology, corroborated by psychological experiments supported by neuroimaging brain monitoring, is paving the way and providing authoritative confirmations of the AIP.

In a very briefly way the presentation introduces two of the most recent findings which I believe support AIP approach thesis: the Default Brain System and the validity of the Episodic Memory Constructive Theory.

The multi-disciplinary approach in brain studies cannot be ignored. Each discipline, starting from its standpoint and from the observations of the object on which it focuses, must provide data in a clear, transparent and converging way, so that treatment of mental disorders may be adapted, and so that effective interventions can be recommended. Effective interventions are based on the knowledge of the substrate reality, in simpler terms, on the knowledge of how the brain is actually constituted and works.

Doing psychotherapy with and for the brain physiological processes positively motivates clients, restoring them their dignity as active participants in their healing process.

Zusammenfassung

Die aktuellen Behandlungsmodelle für psychische Erkrankungen zeigen eine Vielfalt verschiedener erkenntnistheoretischer Ansätze. Die vorliegende Arbeit will einen Beitrag für einen integrierten Ansatz leisten und dabei die Erkenntnisse der verschiedenen Disziplinen, die die Hirnforschung miteinbeziehen, berücksichtigen. Die Autoren gehen davon aus, dass jede Fachrichtung den Menschen mit seiner Geistigkeit nur von verschiedenen Blickpunkten aus betrachtet. Es erscheint sinnlos, Behandlern immer wieder verschiedene Theorieansätze von Geistigkeit und verschiedene Therapiemethoden für jede Disziplin und jeden Standpunkt anzubieten. Es ist an der Zeit für eine vereinte Auswertung der Daten der verschiedenen Disziplinen. Die Zeit ist nach Ansicht der Autoren reif für einen integrativen Ansatz.

Hierfür wird es notwendig werden, mutig bekannte Ergebnisse, die nicht bewiesen sind, zu verwerfen. Und wir sollten uns ernsthaft mit der Hirnforschung beschäftigen und diese in die Behandlung von psychischen Störungen integrieren.

Was ist der richtige Behandlungsansatz für psychische Störungen? Nach

Ansicht der Autoren muss dieser das Gleichgewicht des Gehirns und die Homöostase des Patienten mit Einbeziehung seiner Körperlichkeit beachten.

Die Autoren dieses Artikels zeigen, wie mit der Methode des „Adaptive Information Processing" (AIP) versucht wurde, das Problem zu lösen, und sie präsentieren ein Anwendungsmodell, bei dem die Antworten des Gehirns auf die Herausforderungen der Umwelt in ihren verschiedenen Anpassungsweisen integriert werden.

Im Laufe der letzten Jahre ebnete sich die Psychoneurologie den Weg – untermauert von psychologischen Experimenten, die mittels bildgebender Verfahren und Gehirnabbildungen durchgeführt wurden – und bestätigte glaubwürdig die Annahmen des AIP.

Kurz zusammengefasst präsentiert dieser Artikel zwei der neuesten Erkenntnisse, die der Autor zur Stützung der These für eine Behandlung mit AIP heranzieht: das „Default Brain Network" und die Theorie des Episodischen Gedächtnisses.

Nach Verständnis der Autoren darf die multidisziplinäre Methode bei Gehirnstudien nicht ignoriert werden. Jede Disziplin, die von ihrem Standpunkt und von den Beobachtungen des Gegenstandes ausgeht, den sie im Fokus hat, muss ihre Daten in einer klaren, transparenten und konvergierenden Weise zur Verfügung stellen. Dann ist es möglich, dass die Behandlung von psychischen Erkrankungen angepasst und wirksames Eingreifen empfohlen werden kann.

Wirksames Eingreifen basiert auf den Kenntnissen der „Substratwirklichkeit", d. h. auf der Kenntnis dessen, wie das Gehirn aufgebaut ist und funktioniert. Das Durchführen von Psychotherapie im Zusammenhang mit den physiologischen Gehirnprozessen motiviert die Klienten und stellt ihre Würde als aktive Gestalter ihres Heilungsprozesses wieder her.

(Zusammenfassung von Annegret Dorendorf, überarbeitet von
Prof. Dr. Maria Ammon)

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Psychiatric morbidity and adverse childhood experiences in patients with endometriosis

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Endometriosis is a chronic gynecological disorder which can affect women at reproductive age and is associated with chronic pelvic pain. In a cross-sectional study in a university hospital we assessed differences in the health status and psychiatric morbidity between women with endometriosis and a healthy control group. Women with endometriosis reported to attend psychotherapy significantly more often than the healthy control group. They also reported more traumatic experiences during childhood, and displayed more depressive symptoms and a higher level of anxiety. Further research is necessary to assess the longterm relations between negative life experiences during childhood and psychological well-being among endometriosis patients, as well as possible beneficial effects of psychotherapy in the treatment of endometriosis patients.

Keywords: Endometriosis, Pain, Psychopathology, Childhood Trauma, Psychotherapy

Introduction

Endometriosis is a nonmalignant gynecological disorder where endometrial-like tissue is located outside the uterus, primarily in the pelvis. It affects women at reproductive age and is often associated with infertility (Giudice 2010). Endometriosis is accompanied by symptoms such as abnormal bleeding, intermenstrual pain, pain during sexual intercourse, dysmenorrhea, and sometimes bowel motion pain (Rose 2005). However, some women may have no symptoms at all, and in those suffering from chronic pelvic pain often little correlation between the severity of pain and severity of endometriosis is found (Leeners & Imthurn 2007). The prevalence of endometriosis is estimated at 10 to 15 % in Germany and at least 40 % of patients with endometriosis require therapy (Ebert 2010). Endometriosis is mostly found in structures such as the ovaries and the fallopian tubes (endometriosis genitalis externa). Deep infiltrating endometriosis (endometriosis extragenitalis) affects rectovaginal regions, urinary bladder, and the ureters. The third form, adenomyosis (endometriosis genitalis interna) appears within the myometrium (the thick muscular layer of the uterus) (Ebert 2010). Several risk factors for en-

dometriosis have been discussed: a family history of endometriosis, a short menstrual cycle with longer menstrual flow, pre-menstrual spotting, and also constitutional factors such as a low body mass index and voluntary delaying of child bearing (Rose 2005). Diagnosing endometriosis includes physical examination and imaging techniques such as ultrasound and magnetic resonance imaging. The standard way of diagnosing and staging endometriosis is laparoscopic assessment with taking of tissue samples which simultaneously serves as surgical therapy (Rose, 2005).

Endometriosis is staged by a scoring system of the „American Society for Reproductive Medicine" (rASRM) (Canis et al. 1995). The stages are based on the type, location, appearance, depth of invasion of the lesions, and the extent of the disorder. They range from stage I, indicating minimal, to stage IV, indicating severe disease. However, the rASRM classification does not include extragenital endometriosis and adenomyosis.

Medical treatment includes hormonal therapy that is aimed at reducing symptoms, mainly pain by minimizing inflammation, suppressing ovarian hormone production and reducing or eliminating menses. Pain relief mostly lasts for six to twelve months (Giudice 2010). The surgical treatment may involve the complete removal of the reproductive organs. Conservative therapy consists of the resection of implants and associated adhesions to retain the normal anatomy and function of the affected organs (Arason & Luciano 1995). Moreover, as 30-50 % of women with endometriosis are infertile, fertility treatment also plays an important role (Franklin & Grunert 1995). During pregnancy endometriosis becomes inactive but the symptoms usually recur afterwards.

Psychosomatic aspects of endometriosis

The negative impact of endometriosis affects many different areas of life, including bodily condition and psychosocial impairments that are usually mediated by the presence of chronic pelvic pain. Living with endometriosis can directly lead to considerable psychological strain (e.g. experiencing pain regularly) or in a distal manner (posing a threat to a woman's goals such as starting a family or maintaining a satisfying sexual relationship).

Chronic pelvic pain (CPP) is defined as nonmenstrual pain in the pelvic region lasting for more than six months, severe enough to cause disability or to require medical care, and occurring in locations such as the

pelvis, anterior abdominal wall or below the umbilicus, and lower back or buttocks (Bloski & Pierson 2008). About 66 % of endometriosis patients suffer from chronic pain but neither can the pathology of pain be fully explained by endometriotic lesions, nor does the severity necessarily correlate with the stage of disease (Low, Edelmann, & Sutton 1993). Some women are diagnosed with endometriosis by coincidence and in other cases the severity of pain may vary over time (Denny 2004). Thus, somatoform pain disorder is discussed as possible comorbidity (Rohde & Dorn 2007). It was suggested that fresh atypical lesions may cause functional pain such as dysmenorrhea and older typical lesions may cause an organic type of pain such as dyspareunia or chronic pelvic pain. Moreover, deep infiltrating endometriosis (which can exist at stage I or II according to rASRM and indicate minimal endometriosis) is associated with severe pain (Porpora et al. 1999). This has been explained by the implants infiltrating nerves of the pelvic space; thus this kind of pain can indicate the location of endometriosis whereas cycle-related pain is independent of the macroscopic type of the lesions (Fauconnier & Chapron 2005). However, some women with endometriosis report no pain at all and in some cases no visible pathology can be revealed despited laparoscopy, performed due to chronic pain. Studies that included follow-up after surgery indicated that in patients with endometriosis who undergo reoperation because of chronic pelvic pain there is not necessarily evidence of recurrent endometriosis (Warren, Morozov, & Howard 2011). Chronic pelvic pain is one of the most discomforting aspects of endometriosis which affects different areas of life such as sexuality, career and psychological well-being (Leeners & Imthurn 2007). Unrelieved pain is one of the risk factors for depression and anxiety disorders in chronic diseases (Clarke & Currie 2009). As in other fields of clinical psychology the diathesis stress model compensates the deficits of purely somatic models, integrating psychological aspects such as individual preexisting vulnerabilities which may be cognitive (maladaptive cognitive evaluation, expectations), affective or behavioral (social withdrawal) and environmental factors that may contribute to the maintenance of pain. On the contrary, protective factors such as social support, may moderate pain intensity (Jacob 1995). The relation between pain and psychological well-being remains correlational. Moreover, there is a problem of 'criterion contamination' when measuring both of them due to overlapping symptomatology, as depression also contains somatic symptoms, even in patients without chronic pain (Dersh, Polatin,

& Gatchel 2002). Suggestions have been made that chronic pain should predict future depression, but even studies aiming at verifying causal effects conclude that pain leads to distress mostly by other co-morbid features such as fatigue, somatic symptoms or health-related anxiety than pain itself (McBeth, Macfarlane, & Silman 2002). Women with endometriosis may be particularly sensitive to pain, which may result in depressive symptoms, fear and stress which on the other hand reinforces pain perception. Some authors found that women with endometriosis reported greatest interference with daily activities because of pain and greatest distress (Mathias, Kuppermann, Liberman, Lipschutz & Steege 1996). Other authors found no differences referring to quality of life between women with endometriosis suffering from chronic pelvic pain and women with chronic pelvic pain of other origins (Souza et al. 2011). In a case-control study, Barnack & Chrisler (2007) compared 41 women with endometriosis suffering from chronic pelvic pain to 32 women with chronic migraine headaches. Their results showed that women with endometriosis experienced lower general health, social, physical and emotional functioning, more pain and more role limitations due to emotional problems. Women with endometriosis particularly felt that their pain was not accepted by society and that even healthcare providers attributed their pain to imagery or exaggeration or an attempt to receive more attention or pain medication. Peveler, Edwards, Daddow, & Thomas (1996) also found that women with endometriosis experienced more severe pain and greater social dysfunction due to pain than women with unexplained chronic pelvic pain.

According to a great body of research, women who suffer from chronic pelvic pain often reveal a history of mental disorders and dysfunctional family relations (Thomas, Moss-Morris & Faquhar 2006). In a review, Latthe, Mignini, Gray, Hills, & Khan (2006) identified adverse childhood experiences, notably sexual abuse as a signicifcant factor predisposing women to chronic pelvic pain. Meltzer-Brody et al. (2007) found that trauma history among women with pelvic pain was associated with worse daily functioning, more medical symptoms, more lifetime surgeries and more dysfunction due to pain. Leserman, Zolnoun, Meltzer-Brody, Lamvu, & Steege (2006) contended that especially women with diffuse pelvic pain (compared to women with cyclic pain) reported more lifetime trauma and more health impairment. As-Sanie, Clevenger, Geisser, & Williams (2014) found that history of abuse in childhood was not related to pain intensity, but abuse in adolescence or adulthood was related

with pain-related disability. Lampe et al. (2003) found that physical abuse was related to the occurrence of chronic pain in general, while childhood sex-ual abuse was specifically related to chronic pelvic pain. Moreover, the relationship revealed to be complex and based on interactions with other variables, such as depression and stressful life events. The investigation of the relations between abuse and pain is often impaired by very small study samples. Moreover, the findings are mostly based on self-reported abuse which might defer from abuse which is court-documented (Raphael, Chandler & Ciccone 2004).

In line with previous research, the aim of the present study was to assess the prevalence of chronic pelvic pain in a sample of women suffering from endometriosis. Psychological well-being was compared between women with endometriosis and a healthy control group. Physical and emotional abuse during childhood and associations with present psychological well-being were assessed retrospectively.

Methods

The present study included 156 women; 96 women with histologically confirmed endometriosis, recruited at the women's hospital of the Charité Universitätsmedizin Berlin during outpatient gynecological consultation and 60 women from general population. The patients filled in questionnaires on psychosocial factors such as depression, anxiety, and adverse childhood experiences. Moreover, the general health status, socio-demographic data, including age, marital status and employment status were investigated. The study was approved by the ethics committee of the Charité University Hospital of Berlin.

Data included in the scope of this work were collected between November 2011 and December 2013. The patients were informed about the purpose of the study and received a declaration of consent and a questionnaire which was to be completed at home and sent back in a preaddressed and prestamped envelope. The consent to participate could be withdrawn from at any time without naming the reason. The data were coded in strictly pseudonymous form. A reminder was sent within one month to participants who had declared to participate but did not complete the questionnaire.

A total of 190 women with endometriosis received questionnaires. The response rate was 52 %. One participant had to be excluded because she

could not be identified due to the lack of a declaration of consent. Another person was excluded because of severe health problems other than endometriosis. One participant sent back blank sheets and was not included in the analyses. No pregnant women were recruited. The criteria of inclusion were age ranging from 18 to 55 years and the diagnosis of histologically confirmed endometriosis. The response rate among the healthy control group was 33 %.

The basic questionnaire included general information about the patient, age, marital status, education level, physical activity, and nutrition. Other health-related questions concerned menstruation, pregnancy, medical history including co-morbidities, psychiatric disorders, and psychotherapeutic treatment. All information was based on personal anamnesis.

Pain was assessed by German modified versions of the Brief Pain Inventory (BPI), originally developed by Cleeland (1991). The BPI is an instrument which assesses the prevalence and severity of pain. The questionnaire is brief and self-administered, easily understood but assesses the most important aspects of pain. It is not limited to a specific illness or a specific type of pain. The items, included for endometriosis patients were ratings of average pain in the last four weeks. The severity was assessed on a scale ranging from 0 (no pain) to 10 (pain as bad as one can imagine). The BPI is a reliable and valid instrument to assess pain (Radbruch et al. 1999). The internal consistency was assessed in 151 outpatients for pain severity (Cronbach alpha = .88) and interference with daily activities (Cronbach alpha = .92) in a German sample. Test-retest reliabilities (before and after treatment for pain) amounted to .976 for pain severity and .974 for pain interference. Criterion validity was measured correlating factors of the BPI with subdomains of health related quality of life measure by the Short Form-36, resulting in correlations (Pearson r), ranging from .17 to .59 for pain severity and .32 to .60 for interference.

Depression was measured by the short form of the 'Gesundheitsfragebogen für Patienten' by Löwe, Spitzer, Zipfel & Herzog (2002), the German version of the Prime MD Brief Patient Health Questionnaire (PHQ) by Spitzer, Williams, Kroenke, & Hornyak (1999). The questionnaire was developed to diagnose the most typical mental disorders according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (APA 2000) and is especially used by primary care clinicians. The short form of the questionnaire for depression measures typical symptoms such as anhedonia, changes in the appetite and restlessness on a four-point Li-

kert scale. The total score ranges from 1 to 27 and corresponds to different grades of severity, ranging from "none" to "severe depression". The validation of the PHQ was performed in clinical outpatients and cardiac patients comparing the results with a clinical structured interviews indicating good validity of the instrument in diagnosing mental disorders.

Anxiety was measured by the General Anxiety Disorder Scale (Spitzer, Kroenke, Williams, & Löwe 2006). Similarly to the Patient Health Questionnaire the questionnaire assesses anxiety according to the DSM-IV (APA 2000). The scale contains seven items representing typical symptoms for general anxiety referring to the last two weeks such as 'feeling nervous, anxious or on edge', 'worring too much about things', 'being so restless that it is hard to sit still' and 'feeling afraid as if something awful might happen'. The total score reflects gradual severity of anxiety, ranging from minimal anxiety to severe anxiety. Scores higher than 10 are indicative of general anxiety disorder. Employing this cutoff yields the optimized sensitivity of .89 and specificity of .82 (compared to structured psychiatric interviews according to DSM-IV). The scale displays good reliability and construct and criterion validity.

Adverse childhood experiences were assessed by the German version (Gast, Rodewald, Benecke, & Driessen 2011) of the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink 1998). It is a self-report questionnaire which assesses retrospectively abuse and neglect during childhood. It consists of scales and subscales assessing emotional, physical and sexual abuse, as well as physical and emotional neglect. The German version also contains a scale investigating experience of inconsistency in the upbringing. The items are answered on a five-point Likert scale indicating the frequency of negative or positive experiences (items were reversed). A total score indicates the severity of negative experiences. The reliability ranged from fair to good and the answers were stable over a period of three to four months. The CTQ-score reached high correlations with expert ratings.

Statistical analyses were perfomed using the SPSS version 21 (SPSS, Chicago, Illinois). The significance was set at $\alpha = .05$. For all relevant variables the mean and standard deviation were calculated in the case of continuous variables and absolute and relative frequencies for categorical data. The quantitative data were checked for normal distribution. The sample was divided in two subgroups with and without pain. Comparisons between different groups were calculated employing the Student t-test.

Homogeneity of variance was calculated by Levene's test. Categorical data were compared by the Chi2-Test. Correlations were computed by Pearson correlation coefficient when the assumption of normal distribution was met. Otherwise the Spearman correlation coefficient was applied.

Results

Patients with endometriosis included in this study were 36 years old on average (SD = 7.25) with a range between 22 and 54 years. The mean age of the women in the control group was 31 years (SD 9.13) with a minimum of 19 and a maximum of 53. The women with endometriosis were significantly older ($T = 3.65$, $p < .001$). 63 (66 %) women with endometriosis reported to live in a relationship with little difference to the control group. 62 women (64.6 %) had completed the Abitur (the German university entrance qualification examination) and 40 (49.2 %) also had university degree. There was no significant difference to the control group.

Among comorbidities or symptoms not directly related to endometriosis and often experienced the most frequently named complaints among endometriosis patients were fatigue (52.1 %), neck pain (58.3 %), back pain (35.3 %), sleep disorders (32.3 %), mood swings (33.7 %), indigestion (32.3 %), migraines (26.3 %), depression (22.9 %), irritability (22.9 %), and chest pain (20 %).

51 (53.1 %) women stated to have been treated with psychotherapy, in 34 cases (65.4 %) for other reasons than endometriosis. Out of these 36 women (67.9 %) attended more than 20 sessions. 39 % of the study sample received psychiatric diagnoses, the most frequent were depression (14 %) and anxiety disorder (15 %). Women in the control group reported fewer physical complaints, mostly neck pain. Only 16 (26.7 %) women in the control group reported to attend psychotherapy ($X2 = 10.55$, $p = .001$). Psychotherapy was not related to age within the whole sample ($r = - .11$, $p = .157$) or within each group.

The two groups were compared in terms of differences in depressive symptoms, anxiety, and adverse childhood experiences. The results are presented in Table 1.

Table 1: Means (SD in Parentheses) of the Inventories CTQ, PHQ, and GAD-7, with T-Tests for a Comparison between Women with and without Endometriosis

Inventories	**Total sample**	**Endometriosis Patients**	**Healthy Control Group**	
Scale	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**t-Value**
CTQ				
Emotional Abuse	8.68 (4.12)	9.45 (4.47)	7.48 (3.20)	3.17 (P = .002)
Physical Abuse	5.86 (2.25)	6.05 (2.48)	5.54 (1.79)	1.47 (P = .143)
Sexual Abuse	5.94 (2.62)	6.40 (3.21)	5.23 (0.85)	3.31 (P = .001)
Emotional Neglect	9.96 (3.45)	10.96 (4.74)	8.47 (3.18)	3.85 (P < .001)
Physical Neglect	6.49 (2.31)	7.05 (2.64)	5.62 (1.24)	4.55 (P < .001)
Inconsistency	5.65 (2.87)	6.18 (3.13)	4.82 (2.19)	3.19 (P = .002)
Total Score	36.77 (11.35)	39.74 (12.61)	32.41 (7.33)	4.43 (P = .001)
PHQ	15.80 (5.34)	16.94 (5.67)	14.05 (4.27)	3.48 (P = .001)
GAD-7	12.32 (4.62)	13.24 (4.97)	10.91 (3.63)	3.25 (P = .001)

Women with endometriosis obtained significantly higher scores in the CTQ total score ($T = 4.43$, $p < .001$) and almost all subscales, except for Physical Abuse ($T = 1.47$, $p = .143$). The CTQ total score correlated significantly with depression ($r = .38$, $p < .001$), anxiety ($r = .45$, $p < .001$), and attending psychotherapy ($r = .41$, $p < .001$). Interestingly psychotherapeutic treatment correlated positively with secondary illnesses listed in table 2, such as migraine ($r = 0.24$, $p = .003$), sleep disorders ($r = 0.39$, $p < 0.001$), chest pain ($r = 0.32$, $p < 0.001$), neck pain ($r = 0.32$, $p < .001$), back pain ($r = .24$, $p = .003$), fatigue ($r = 0.35$, $p < .001$), mood swings ($r = 0.42$, $p < 0.0001$), and irritability ($r = 0.41$, $p < .001$).

Women with endometriosis also obtained higher scores for current depression ($T = 3.48$, $p = .001$) and anxiety ($T = 3.25$, $p = .001$).

Sociodemographic data did not correlate with any of the psychometric variables except for the positive relation between depression and being single ($r = .23$, $p = .006$) and between attending psychotherapy and being single ($r = .24$, $p = .003$).

Among the group of endometriosis patients, 64 women (67 %) reported to suffer from chronic pain. 41 women (42.7 %) had been suffering from pain for more than five years. Among these patients 95.2 % indicated pain located in the lower abdomen, 68.9 % also suffered from back pain and

53.6 % from headache. 28 women (45.2 %) suffered from cycle-related pain. The presence of pain was not related to age (r = - .02, p = .827). 46 women (47.9 %) suffered from pain at least several times per week, 10 women (15.6 %) experienced pain permanently. The duration of pain per day also varied across the sample. The severity of pain was rated on a 10-point scale. The mean pain level of all women suffering from chronic pain was 5.2 (SD = 2.14).

Discussion

The present study investigated differences in psychological well-being between women suffering from endometriosis and a healthy population. Endometriosis is not a life threatening disease however it can affect women's quality of life in many ways (Gao et al. 2006). The psychological repercussions of endometriosis vary among the affected women depending on the severity of disease, the frequency and rapidity of its occurrence (Weinstein 1988). Longterm goals can be disrupted when endometriosis is associated with infertility.

Endometriosis patients displayed relatively higher rates of comorbidities not directly related to endometriosis that had a negative impact on their physical and mental health status. They also reported negative childhood experiences, more depressive mood and more anxiety, compared to a healthy control group. The most striking results were found in the assessment of psychiatric morbidity in women with endometriosis. 53.1% of the women had undergone psychotherapy and psychotherapeutic treatment was also associated with comorbidities such as migraines, sleep disorders, chest pain, stomachache and fatigue. This highlights the relevance of psychotherapeutic treatment as a predictor for psychological well-being and psychosomatic symptoms. However the patients did not indicate if the treatment had taken place in the past or was still present and if they were undergoing pharmacotherapy. This might have influenced the results of the depression and anxiety scores. No suggestions had been made about positive effects of psychotherapy over time. There might have been a positive effect on psychological well-being indicating the positive effect of the treatment itself. On the contrary the negative correlations indicate that psychotherapeutic treatment might represent higher levels of psychiatric morbidity among women with endometriosis. In a study by Low et al. (1993) women with endometriosis obtained higher levels in neuroticism

and psychiatric morbidity compared to normative data for general medical and surgical patients. Other studies also suggest higher prevalence rates of abuse history and psychiatric morbidity in women suffering from chronic pelvic pain (Collett, Cordle, Stewart, & Jagger, 1998; Walker et al. 1988). However most of these findings rely on subjective reports and are cross-sectional. This finding could encourage further research analyzing in more depth the characteristics of women who attend psychotherapy. Other (cognitive) variables such as suppression of emotions in psychotherapeutic patients (Thomas et al. 2004) might be associated with maladaptive coping with pain leading to a greater impact of pain upon psychological well-being should be investigated in women with endometriosis. Somatizing patients are characterized by having difficulties identifying and expressing emotions (Egan & Kenny 2011). This should be the focus of psychotherapy in order to replace somatic symptoms by the experience and coping with negative emotions.

In a longitudinal study setting the correlation between psychopathology and psychotherapy might change its direction over time due to the beneficial effects of therapy/support. Moreover, the background of psychotherapeutic treatment as a risk factor for psychological impairment should be analyzed in more detail in order to assess the associations with endometriosis and chronic pelvic pain. Especially, the self-reported childhood experiences might be subject to a perception bias. Complementary qualitative expert assessment on the biographic backround might be useful in order to validate the proposed relationships between the variables. Some authors found that among patients with chronic pelvic pain endometriosis was not a specific condition related to worse mental and physical health status (Leserman et al. 2006). A comparison of endometriosis patients to patients with other forms of chronic pain might shed more light on the specifity of the disorder.

The results of the study confirm the importance of psychosomatic aspects of endometriosis and call for an interdisciplinary approach, including experts from different areas when treating the disorder. Psychological support for women with endometriosis should focus on the most disrupting interferences of the illness in order to help women with endometriosis to manage their disease and still live fulfilled lives. Future research should investigate more deeply possible underlying cognitive and behavioral mechanisms that reduce women's health-related quality of life.

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Psychiatrische Morbidität und negative Kindheitserfahrungen bei Patientinnen mit Endometriose (Zusammenfassung)

Einleitung

Endometriose ist eine gutartige gynäkologische Erkrankung, bei der Gewebe, welches der Gebärmutterschleimhaut ähnelt, außerhalb der Gebärmutter angesiedelt ist. Es betrifft Frauen im reproduktionsfähigen Alter und ist oft mit Unfruchtbarkeit verbunden (Giudice 2010). Endometriose wird häufig von Symptomen wie abnormen Blutungen, Regelschmerzen, Schmerzen während des Geschlechtsverkehrs, Mittelschmerzen und teilweise Schmerzen im Darmbereich begleitet (Rose 2005). Die Prävalenz wird in Deutschland auf ca. 10–15 % geschätzt und mindestens 40 % der Betroffenen benötigen eine Behandlung (Ebert 2010). Die Endometriosis genitalis externa bezeichnet das Auftreten von Endometrioseherden auf dem Bauchfell, den Eierstöcken und den Eileitern. Bei der Endometriosis extragenitalis kommen Endometrioseherde außerhalb des kleinen Beckens vor, z. B. am Darm, an der Blase oder in weiter entfernten Organen, wie in seltenen Fällen am Zwerchfell oder im Nabel. Die Endometriosis genitalis interna bezeichnet das Auftreten der Endometrioseherde in der Gebärmuttermuskulatur (Ebert 2010). Die Ursache der Erkrankung bleibt ungeklärt. Als Risikofaktoren werden u. a. eine familiäre Veranlagung, die absolute Anzahl an Menstruationstagen, prämenstruelle Vorblutungen, weniger Kinder, spätere Schwangerschaften und ein niedriger Body Mass Index genannt (Rose 2005). Die Diagnostik umfasst manuelle Untersuchung, Ultraschall und manchmal eine Kernspinuntersuchung (MRT). Die Laparoskopie stellt die sicherste Methode dar, um den Verdacht auf Endometriose zu bestätigen und dient gleichzeitig als operative Therapie (Rose 2005).

Psychosomatische Aspekte der Endometriose

Die Endometriose kann als chronische, nicht heilbare Erkrankung das Leben einer Frau in verschiedenen Bereichen beeinträchtigen. Die Einschränkungen können unmittelbarer Natur sein, wie z. B. das Leben mit

wiederkehrenden Schmerzen oder indirekt durch die Beeinträchtigung von Lebensplänen, wie der Familienplanung oder Einschränkungen in der Partnerschaft/Sexualität.

Eines der Kernsymptome der Endometriose ist chronischer Unterbauchschmerz, welcher als andauernder, schwerer und quälender Schmerz der Frau mit einer Dauer von mindestens sechs Monaten definiert wird und zu einer Einschränkung der Lebensqualität führen kann (Bloski & Pierson 2008). Es gibt keine eindeutige Definition und auch keine Klassifikation in ICD-10 oder DSM-IV. Ca. 66 % der Endometriosepatientinnen leiden unter chronischem Unterbauchschmerz, aber weder können die Ursachen der Schmerzentstehung durch Endometrioseläsionen allein erklärt werden, noch hängt die Intensität und Häufigkeit der Schmerzen zwangsläufig mit dem Krankheitsstadium zusammen (Low, Edelmann & Sutton 1993). Bei der Schmerzverarbeitung spielen kognitive Prozesse eine nicht zu vernachlässigende Rolle (Leeners & Imthum 2007). Bei einigen Frauen stellt die Endometriose einen Zufallsbefund dar und verläuft ohne Symptome und in anderen Fällen variieren die Schmerzintensität und -häufigkeit über die Zeit hinweg (Denny 2004), so dass zusätzlich eine somatoforme Schmerzstörung vorliegen kann (Rohde & Dorn 2007). Nicht zu lindernder Schmerz ist ein Risikofaktor für Angststörungen und Depression (Clarke & Currie 2009). Affektive und behaviorale Faktoren (z. B. sozialer Rückzug, übertriebene Schonhaltung) können zu einer Verstärkung und Aufrechterhaltung der Schmerzen führen. Darüber hinaus kann auch eine Hypersensibilität bei Frauen mit Endometriose zu depressiven und Angstsymptomen sowie einer Schmerzverstärkung führen. Als weitere psychosoziale Risikofaktoren für die Entstehung chronischer Unterbauchschmerzen werden traumatische Erfahrungen in der Kindheit, insbesondere sexueller Missbrauch diskutiert (Latthe, Mignini, Gray, Hills, & Khan 2006; Leserman, Zolnoun, Meltzer-Brody, Lamvu, & Steege 2006; Meltzer-Brody et al. 2007). Diese These bleibt jedoch umstritten und Untersuchungen hierzu basieren in der Regel auf kleinen Personenstichproben und Querschnittsdesigns.

Auf Basis der beschriebenen Untersuchungen war das Ziel der vorliegenden Studie die Untersuchung der Prävalenz chronischer Unterbauchschmerzen in einer Berliner Patientenstichprobe. Darüber hinaus sollte das psychische Wohlbefinden zwischen Endometriosepatientinnen und einer gesunden Kontrollgruppe verglichen werden. Es wurden auch Zu-

sammenhänge zwischen körperlichem bzw. emotionalem Missbrauch und dem aktuellen psychischen Wohlbefinden untersucht.

Methoden

Die vorliegende Studie schloss 156 Frauen mit ein, darunter 96 Frauen mit histologisch gesicherter Endometriose, welche in der Endometriosesprechstunde der Poliklinik der Charité rekrutiert wurden und 60 Frauen aus der Allgemeinbevölkerung. Die Patientinnen und Kontrollprobandinnen füllten Fragebögen aus mit Fragen zur allgemeinen Gesundheit, Depressivität, Ängstlichkeit und negativen Erfahrungen in der Kindheit, sowie soziodemographischen Angaben. Endometriosepatientinnen beantworteten zusätzlich Fragen zur Endometriose, der bisherigen Behandlung und zu Schmerzen. Die Studie wurde von der Ethikkommision der Charité Universitätsmedizin Berlin anerkannt. Die Daten wurden zwischen November 2011 und Dezember 2013 erhoben. Die Probandinnen wurden über die Ziele der Studie informiert und gaben eine Einwilligungserklärung zu der Teilnahme und Veröffentlichung der Daten ab, die jederzeit zurückgezogen werden konnte. Die Antwortrate lag bei 52 % unter den Patientinnen und 33 % bei den Kontrollprobandinnen.

Schmerzen wurden anhand einer deutschen, modifizierten Version des Brief Pain Inventory (BPI, Cleeland, 1991) erhoben. Die Schmerzintensität wurde auf einer Skala von 0 bis 10 angegeben. Depressivität wurde durch die Kurzversion des Gesundheitsfragebogens für Patienten (PHQ-K, Löwe, Spitzer, Zipfel & Herzog 2002) gemessen. Ängstlichkeit wurde durch die deutsche Version der General Anxiety Disorder Scale (GAD-7, Spitzer, Kroenke, Williams & Löwe 2006) erfasst. Negative Kindheitserlebnisse wurden durch die deutsche Version (Gast, Rodewald, Benecke & Driessen 2011) des Childhood Trauma Questionnaire (CTQ, Bernstein & Fink 1998) gemessen.

Ergebnisse

51 (53.1 %) Patientinnen gaben an, psychotherapeutisch behandelt worden zu sein, in 34 (65.4 %) Fällen waren die Gründe der Behandlung andere als die Endometriose. Bei der Kontrollgruppe waren es signifikant weniger 16 (27 %) Frauen ($X2 = 10.55$, $p = .001$). Die Frauen in der Kontrollgruppe waren zwar signifikant jünger ($T = 3.65$, $p < .001$), jedoch hing Psychotherapie nicht mit dem Alter zusammen, weder in der Gesamtstichprobe noch jeweils in den zwei Substichproben.

Frauen mit Endometriose wiesen einen signifikant höheren Gesamtwert im Childhood Trauma Questionnaire auf ($T = 4.43$, $p < .001$), ebenso bei fast allen Subskalen, mit Ausnahme der Subskala „Körperliche Misshandlung“. Der Gesamtwert des CTQ (Gesamtstichprobe) korrelierte signifikant positiv mit Depressivität ($r = .38$, $p < .001$), Ängstlichkeit ($r = .45$, $p < .001$) und psychotherapeutischer Behandlung ($r = .41$, $p < .001$). Psychotherapeutische Behandlung korrelierte signifikant mit verschiedenen Symptomen wie Migräne ($r = 0.24$, $p = .003$), Schlafstörungen ($r = 0.39$, $p < 0.001$), Brustschmerzen ($r = 0.32$, $p < 0.001$), Nackenschmerzen ($r = 0.32$, $p < .001$), Rückenschmerzen ($r = .24$, $p = .003$), Erschöpfung ($r = 0.35$, $p < .001$), Stimmungsschwankungen ($r = 0.42$, $p < 0.0001$) und Reizbarkeit ($r = 0.41$, $p < .001$).

Im Vergleich zur Kontrollgruppe wiesen Patientinnen signifikant höhere Werte für Depressivität ($T = 3.48$, $p = .001$) und Ängstlichkeit ($T = 3.25$, $p = .001$) auf.

Innerhalb der Patientenstichprobe berichteten 64 (67 %) Frauen, unter chronischen Schmerzen zu leiden, bei 95.2 % am Unterbauch, bei 68.9 % auch am Rücken und 53.6 % gaben Kopfschmerzen an. Bei 28 (45.2%) Frauen waren die Schmerzen zyklusabhängig. Das Vorhandensein von Schmerzen hing nicht mit dem Alter zusammen. Bei 46 (47.9 %) Frauen traten die Schmerzen mehrmals in der Woche auf, 10 (15.6 %) Frauen gaben permanente Schmerzen an. Die Häufigkeit der Schmerzen fiel unterschiedlich aus. Die Schmerzintensität lag bei dem Wert 5.2 ($SD = 2.14$) auf einer Skala von 0 bis 10.

Diskussion

In der vorliegenden Studie wurden Unterschiede im psychischen Wohlbefinden zwischen Frauen mit Endometriose und Frauen aus der Allgemeinbevölkerung untersucht. Obwohl Endometriose keine lebensbedrohliche Erkrankung darstellt, kann sie das Leben einer Frau in vielen Bereichen negativ beeinflussen (Gao et al. 2006). Endometriosepatientinnen wiesen relativ mehr gesundheitliche Beschwerden auf, welche nicht in direktem Zusammenhang mit Endometriose stehen. Sie berichteten auch öfters über negative Erlebnisse in der Kindheit und wiesen höhere Werte für Depressivität und Ängstlichkeit auf. Psychotherapie erwies sich somit als ein Indikator für psychiatrische Morbidität und (psycho-)somatische Beschwerden. Alternativ hätte Psychotherapie ein Faktor der Linderung sein können, wären die Korrelationen negativ gewesen. Zum Nachteil

dieser Untersuchung wurde der Zeitraum der Behandlung nicht angegeben und es fehlten Daten zu psychopharmakologischer Behandlung. In einer längsschnittlichen Untersuchung hätten unter Umständen positive Auswirkungen der Psychotherapie auf das Wohlbefinden verzeichnet werden können. Auch wenn nur ein Teil der Patientinnen klinisch relevante Depressivitätswerte aufwies, waren diese stets signifikant höher als bei der Kontrollgruppe. Gleiche Ergebnisse wurden beim Vergleich negativer/traumatischer Erfahrungen in der Kindheit festgestellt. Für eine profunde Untersuchung dieser Zusammenhänge sollten künftig weitere Variablen erhoben werden. Bestimmte kognitive Prozesse, wie z. B. die Unterdrückung von Emotionen, können Somatisierungsstörungen begünstigen (Thomas et al. 2004) und die Untersuchung dieser Variablen könnte somit mehr Aufschluss über Unterschiede bei der Krankheitsverarbeitung geben. Die Angaben zu Erfahrungen in der Kindheit können mit der Zeit Wahrnehmungsverzerrungen unterliegen; deshalb sollte deren Anamnese um eine qualitative Datenerhebung durch Experten ergänzt werden, auch um spezifische Angaben zu den Biographien der Patientinnen zu erhalten.

Die Ergebnisse der vorliegenden Studie bestätigen die Relevanz psychosomatischer Aspekte bei Endometriose und somit auch die Notwendigkeit eines interdisziplinären Ansatzes mit Vertretern verschiedener Forschungsfelder bei der Behandlung der Erkrankung. In Zukunft wären Untersuchungen zu spezifischen kognitiven und behavioralen Mechanismen bei der Krankheitsverarbeitung erforderlich, um Faktoren zu identifizieren, welche zu einer besseren Lebensqualität und zu einem gesteigerten Wohlbefinden bei Frauen mit Endometriose beitragen können.

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The use of psychometric tools in the assessment of changes in the process of therapy

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The process of psychotherapy can be analyzed from three perspectives: 1) psychotherapy progress monitoring, 2) outcome assessment measurement, 3) psychic processes occurring during psychotherapy analysis. There are various psychological measurers used in the assessment of the process of change in therapy. The paper discusses methodological problems and difficulties in reasoning that arise during the analysis of data provided with the use of these tools. The goals of their application, referring to the three dimensions of psychotherapy process evaluation, overlap which can both facilitate as well as blur the conclusions drawn from the research results. Apart from various benefits, doubts and questions concerning both the methodology and practical application of psychometric tools will be outlined.

Keywords: psychometric tools, psychotherapy, treatment effectiveness

The effectiveness of psychotherapy

Most psychotherapists believe that their efforts produce a significant effect for the patients. Clinical studies examining the benefits of psychotherapy have demonstrated ambiguous results. Some research seem to suggest that psychotherapy, even carried out by highly trained professional, is ineffective or even causing deterioration (5 % -15 % of deteriorations, up to 50 % without any change) (Asay et al. 2002). Other results are significantly more encouraging, indicating substantial improvement, leading to full recovery in 20 % to the surprising 95 % of the treated patients. The diversity of results relates to, inter alia, the assumed methodology and the adopted definition of psychotherapy effectiveness (Orlinsky et al. 2003).

The controversy starts when we take into consideration the assumption of some clinicians and researchers claiming that all of these studies are misleading as the long-term influence of psychotherapy is simply too subtle to be measured by means of the currently applied techniques in outcome studies. Here is the point where the questions about how and what do we measure to assess the effectiveness of psychotherapy arise. Is it the relation between the patient and the therapist, assumed by some researchers as the essential feature of successful therapy (Brown 1999). Shall

we consider the setting, type of psychotherapy, the patients' diagnoses, previous experience with treatment, the patient and therapists expectations, symptoms deterioration or rather the real change in the patient's life and functioning? Finally, should we focus on the outcome of psychotherapy results or rather on the process itself? To make the issue more complicated and multifaceted, we arrive at another set of questions concerning the tools used in the measurement. There are various approaches to the assessment of psychotherapy results, and even more difficulties, doubts and obstacles arising from them.

Three perspectives of psychotherapy process analyzes

The process of psychotherapy can be analyzed from three perspectives: 1) psychotherapy progress monitoring, 2) outcome assessment measurement, 3) psychic processes occurring during psychotherapy analysis.

Progress monitoring includes the overall analysis of the directions, goals, course etc. of therapy, connected also with the expectations concerning the therapy. Starting with expectations, researchers have identified two broad classes: expectations about the process of therapy and expectations about the outcome of therapy (Lambert et al. 2005). Expectations about the process of therapy refer to patients' beliefs about what will happen during therapy, including the behaviors of the therapist and the patient, the procedures that will occur or the length of treatment. Outcome expectations, sometimes referred to as prognostic expectations, are related with the patients' hope for improvement and the helpfulness of therapy. Often patients come to therapy with distinct goals: the alleviation of symptoms of one sort or another, and then go on to contemplate other changes in the way they live (Neuma 2013). Are we able to measure them adequately?

Outcome assessment measures are said to be ultimately intended to guide clinicians in tailoring treatment and to identify efficient treatment approaches (Smith et al. 1999). Practice-based evidence requires that practitioners adopt an individualized plan for each patient, acknowledging the patient's goals for treatment, ideas about how change occurs, and a view of an effective therapeutic relationship (Lambert et al. 2005). However, many current psychometric tools lack essential components such as brevity, ease of administration, and content simplicity, all of which are vital if such measures are to be used on a session-by-session basis to enhance patient care. Miller and Duncan have distinguished and defined

outcome measurers as tools that should identify both immediate outcomes of psychotherapeutic session or sessions, as well as long-term results in the patient's life (Miller & Duncan et al. 2004).

Process measurers, in turn, are to be focused on what is happening in the patients' emotions, feelings, attitudes, beliefs, etc. during the process of psychotherapy, taking into account the subtle individual patient's experiencing. They are intended to be used regularly (e.g. at every session) during the course of treatment. Their main function is to provide practitioners with the patient's „vital-signs" of psychological functioning allowing practitioners to easily and quickly assess progress in treatment (Miller & Duncan et al. 2003).

Psychometric tools selection

Following the above assumptions, Duncan and Miller developed two psychometric tools: the *Session Rating Scale 3.0* (SRS) and the *Outcome Rating Scale* (ORS) (Campbell 2011), both being four-items brief scales with confirmed reliability and validity, employed in a number of clinical settings with positive effect (versions also for children and young children). Providing feedback to therapists regarding the patients' experience of the alliance and progress in treatment via the *SRS* and *ORS* (called together the *Partners for Change Outcome Management System – PCOMS)*, on the basis of the Heart and Soul of Change Project by Duncan et al. has been designed to improve the retention of participants in treatment and to assist them in reaching reliable and clinically significant improvement, mostly in cognitive and behavioral, but also psychodynamic therapy.

The two aforementioned tools obviously are not the first and only fruits of psychometric efforts to produce suitable psychotherapy outcome and process measurers. In 1996 Howard et al. demonstrated how measures of client progress could be used to *„determine the appropriateness of the current treatment ... the need for further treatment ... [and] prompt a clinical consultation for patients who [were] not progressing at expected rates"* (p. 1063). *The Working Alliance Inventory (WAI)* (Horvath et al. 1989), which directly translates Bordin's description of the alliance; the *Session Evaluation Questionnaire* (Stiles & Snow 1984), which assesses the depth and smoothness of the session; and the Empathy Scale (Burns et al. 1992), which specifically addresses the relationship, are only a few examples of psychometric tools developed in the mid- twenties (Duncan,

Miller & Sparks 2003). *Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM)* (Barkham et al. 1998), *Treatment Outcome Package (TOP)* (Kraus et al. 2005), *Polaris - Mental Health*, formerly known as the *Treatment Evaluation and Management System* (Grissom et al. 2002), *Behaviour and Symptom Identification Scale – 24 (BASIS-24)* (Eisen 2004) or *Behavioural Health Measure – 20 (BHM-20)* (Kopta et al. 2002), formerly *Behavioural Health Questionnaire-20*, reflect the clinicians and researchers range of efforts in this regard.

The *Outcome Questionnaire-45 (OQ-45)* is a 45-item self-report scale designed to assess three domains of functioning on a sessional basis. These include symptoms of psychological disturbance, interpersonal problems, and social role functioning (Overington et al. 2012). The *Outcome Questionnaire-45 (OQ-45*) and previously listed *Working Alliance Inventory (WAI)*, apart for the above mentioned *Session Rating Scale 3.0 (SRS)* and *Outcome Rating Scale (ORS)*, seem to be the most popular and valid current outcome assessment measures. However, they lack the essential component of utility. The length and complexity of the questionnaires make them impracticable for everyday use due to the fact that they were largely developed for research purposes (Duncan & Miller et al. 2003).

The same and even more can be said about personality inventories, represented by the two competing for the title of a gold standard measurers: *Minnesota Multiphasic Personality Inventory (MMPI-2)* and the *Revised NEO Personality Inventory (NEO-P-R)* (Siuta 2006). These are useful psychometric tools, applied also in our everyday practice, to observe long term changes that occur in the structure of personality in the process of psychotherapy, but administrated only at the beginning and at the end of psychotherapy provide results concerning the two boundary points (the beginning and the end of therapy), leaving what happens between upon suppositions. Similarly, the *Neurotic Personality Questionnaire (KON-2006)*, developed by Aleksandrowicz et al. (2006), supplies us with essential for the diagnostic and psychotherapy outcome results analysis information, provided by means of the 23 scales and the XKON indicator, but does not resolve the questions about the unique quality of patients experiencing. More frequent use of the tools would confront us not only with the problem of time and economy, but also with the issue of habituation.

Bearing this in mind, we keep on searching some compromise in the adequate measurement of psychotherapy effectiveness from the perspective of both: the final outcomes and the process itself. One of such solu-

tions can be the symptom checklists application. The most widely used is the implemented in Krakow Department of Psychotherapy *Symptom Checklist KO "0"* (Aleksandrowicz et al. 1994). Filled in by the patients once a week, it allows assessment of the type and severity of 135 symptoms experienced by patient during 7 days preceding the examination, on a scale: "0" – a symptom was not present, "a" – symptom was present, but it was only slightly uncomfortable, "b" – ... average uncomfortable, "c" – ... highly uncomfortable. Worth mentioning is also the most widely used in the international setting *Symptom Checklist-90-R (SCL-90-R)*. The symptoms-oriented approach is again a valuable complementation of the psychotherapy effectiveness psychometric measurement, but alone does not satisfy the psychotherapy process analyzer in his doubts, mentioned above.

One more deserving consideration scientific attempt to render the changes in the process of psychotherapy is focusing and toughly analyzing one selected aspect of the patients experiencing or functioning, depending on the patient's main diagnosis (like depressiveness measured by the *Beck Depression Inventory (BDI)* or the *Hamilton Depression Rating Scale (HAM-D)*; anxiety explored with the *Generalized Anxiety Disorder Severity Scale (GADSS), Hamilton Anxiety Rating Scale (HAM-A)* or the *State-Trait Anxiety Inventory (STAI)* or post-traumatic stress disorder assessed with the use of *PTSD Symptom Scale (PSS)* (Wampold 2001).

Benefits and limitations of such attitude again concern the process of diagnosis, monitoring the process of an immediate change in the patient's experiencing as well as the long term psychotherapy outcomes, scientific usefulness and practical implementation.

Evidence in practice

It is undoubtful that various psychometric measurers can be useful in identifying patients who are not progressing or who potentially may not benefit from a given type of psychotherapy, in increasing cost effectiveness, evaluating the quality of services as well as in a broader application, including assessment of the three main domains: psychological symptoms (anxiety, depression, sleep, etc.), well-being (life satisfaction, etc.), functioning (school/work, sexual, etc.). Progress monitoring measures should allow practitioners to introduce evidence into routine practice – and in many aspects they do – to some extent.

There is a fine line in the application of the tools presented – the goals

of their use referring to the three mentioned at the beginning dimensions of psychotherapy process evaluation, overlap, which can both facilitate as well as blur the conclusions drawn from the research results. Apart from the mentioned benefits, many doubts and questions concerning both the methodology and practical application remain not fully answered. Catamnestic studies are example of a research field not sufficiently explored yet in the analysis of psychotherapy effectiveness. Also, the medical measurers open a space for further scientific interest.

Zusammenfassung

Der Prozess der Psychotherapie kann von drei Perspektiven aus analysiert werden: 1) der Analyse des Psychotherapieverlaufs, 2) der Outcome-Messung und 3) der Analyse psychischer Prozesse, die während der Therapie auftreten. Die Verlaufsanalyse umfasst insgesamt die Analyse der Richtung, der Zielsetzung und des Ablaufs der Therapie. Der Messung der Ergebnisse kommt die besondere Bedeutung zu, insgesamt effiziente Behandlungsansätze zu identifizieren. Prozessanalysen hingegen sollten darauf fokussieren zu erfassen, was sich im Einzelfall während der Therapie bei den Gefühlen, Einstellungen und Überzeugungen des Patienten verändert, wobei die subtilen subjektiven und individuellen Erfahrungen des Patienten im Mittelpunkt stehen.

Standard sollte sein, dass die Behandler für jeden Patienten einen individuellen Therapieplan erstellen, der die Therapieziele des Patienten und seine Vorstellungen darüber, in welchen Bereichen Veränderungen auftreten sollen, einbeziehen und ein Bild über eine gelungene therapeutische Beziehung beinhalten. Vielen der gängigen psychometrischen Verfahren mangelt es jedoch an essenziellen Eigenschaften wie Kürze, Einfachheit der Anwendung und Verständlichkeit der Inhalte – alles Komponenten, die unverzichtbar sind, will man solche Instrumente in der Prozessanalyse Sitzung für Sitzung anwenden. Die Nützlichkeit eines solchen Instruments sollte dabei abhängen vom Ziel der Untersuchung und der Forschung, den Möglichkeiten der Datenverarbeitung und anderen Faktoren.

Es wurden verschiedene psychometrische Verfahren entwickelt, die helfen sollen, die Teilnahme der Beteiligten an der Behandlung zu fördern und sie dabei zu unterstützen, eine reliable und klinisch bedeutsame Verbesserung zu erreichen. Am weitesten verbreitet sind, unter anderem, die *Session Rating Scale 3.0 (SRS)* und die *Outcome Rating Scale (ORS),*

die meist in der kognitiv-behavioralen, aber auch in der psychodynamischen Therapie angewendet werden, sowie die *Working Alliance Inventory (WAI)*, der *Session Evaluating Questionnaire* und die *Empathy Scale.* Andere Verfahren beziehen sich mehr auf die Verbesserung der Therapie-Effizienz insgesamt wie die *Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM)*, *Treatment Outcome Package (TOP), die Polaris-Mental Health, Behaviour and Symptom Identification Scale (24 –BASIS -24)* oder die *Behavioural Health Measure (20-BHM-20)*. Die Länge und Komplexität der Fragebögen macht sie jedoch für die tägliche Praxis häufig unbrauchbar, da sie meistens für die Anwendung in der Forschung entwickelt wurden.

Das trifft genauso und fast noch mehr für Persönlichkeitsfragebögen zu. Hier sind etwa zu nennen der *Minnesota Multiphasic Personality Inventory (MMPI-2)* und der *Revised NEO Personality Inventory (NEO-P-R)*. Der *Neurotic Personality Questionnaire (KON-2006)* von Aleksandrowicz et al. liefert uns für Diagnostik und Psychotherapie wichtige Outcome-Ergebnisse und Informationen.

Einen Kompromiss bei der Suche nach angemessenen Messmethoden in der Psychotherapie könnte die Anwendung von Symptom-Checklisten sein. In Polen weit verbreitet ist die *Symptom Checklist KO „0“* des Krakauer Instituts für Psychotherapie. Zu erwähnen ist außerdem die international bekannte *Symptom Checklist – 90-R (SCL-90 R)*. Zu beachten ist auch der wissenschaftliche Ansatz, Veränderungen des Patienten während bzw. nach der Therapie in Hinblick auf seine Hauptbeschwerden bzw. seine Hauptdiagnose zu betrachten mit Inventaren wie dem *Beck Depression Inventory (BDI)* oder der *Hamilton Depression Rating Scale (HAMD)*, der *Generalized Anxiety Disorder Scale (GADSS),* der *Hamilton Anxiety Rating Scale (HAMA)*, dem *Strait-Trait Anxiety Inventory (STAI)* oder mit der *PTSD Symptom Scale (PSS)*.

Eine gute Entscheidungsrichtlinie bei der Anwendung der Testverfahren und Messinstrumente bilden die eingangs erwähnten drei Forschungsziele, welche sowohl den Nutzen als auch die Begrenzungen der Methoden für den Wert der Forschungsergebnisse bestimmen. Abgesehen von den unzweifelhaften Vorteilen der Instrumente bleiben viele Zweifel und Fragen offen, sowohl was die Methodologie als auch die praktische Anwendung betrifft.

(Dipl.-Psych. Gisela Finke)

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The use of medical tools in the assessment of changes in the process of therapy

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The search for biomarkers of psychiatric disorders and psychotherapy effectiveness has significantly intensified in recent years. The application of biomarkers is expected to improve qualification, diagnostics and treatment process. Considerable number of available publications delivers interesting results, however clinical applicability of the findings remains limited due to methodological limitations of the research. The scope of search for valid biomarkers useful in psychotherapeutically oriented clinical practice includes neurobiological phenomena (measured using various neuroimaging techniques), endocrinological changes (e.g. the hypothalamic-pituitary-adrenal axis: cortisol, catecholamines), modulation of gene expression through psychotherapy (epigenetic factors) and cellular/tissue effects (e.g. changes in proportion and distribution of lymphocytes). In further research innovative and proper methodology needs to be applied in order to deliver applicable results.

Keywords: biomarkers, psychotherapy, treatment effectiveness

In recent years the scientific and research attention directed to biomarkers has increased in most medical specialties. In the field of psychiatry and psychotherapy hopes associated with biomarkers include: objectification of diagnosis, improvement of treatment process and outcome evaluation, increase in accuracy of prognosis of post-treatment functioning. Moreover, researchers suggest the importance of biomarkers as predictors of susceptibility to psychotherapy and psychotherapeutic techniques hypothesizing that certain biomarkers (e. g. C-reactive protein, catecholamines) could to some extent predict psychotherapy effectiveness for individual patients (Riess et al. 2012, O'Connor et al. 2013, Pace et al. 2013)

Biomarkers are characteristics which are objectively measured and evaluated as indicators of the intrinsic cause of illnesses, the clinical course, and its modification by treatment (Frank et al. 2003). An intensively growing number of publications reveals genuine research interest in means of objectification of psychotherapy assessment through biomarkers. Critical review of the published research leads however to the conclusion that currently the use of biomarkers does not provide clinically significant data either for diagnosis of patients seeking psychothe-

rapy or for the evaluation of the process of treatment. There are several reasons for such limitation of applicability of research data in clinical setting where psychotherapy is being applied (Barsaglini et al. 2014). The paper discusses some of these reasons and presents a critical overview of research on selected neurobiological, endocrinological, epigenetic and cellular biomarkers hypothetically useful in psychotherapy.

Neurobiological markers

Studies conducted in recent years have proven beyond doubt that the function of the brain is influenced by the process of psychotherapy and that this influence can to some extent be analyzed using neuroimaging techniques. Analysis of available data from current research on the process of psychotherapy conducted with the use of functional magnetic resonance imaging and positron emission tomography reveals the complexity of the researched phenomena and sometimes severe methodological difficulties and shortcomings of the published research. Nevertheless interesting findings of numerous research suggest similarities of changes in the brain function obtained with the use of psychotherapy and pharmacotherapy. In a study conducted on patients suffering from obsessive-compulsive disorder both pharmacological treatment with fluoxetine and psychotherapy have been associated with similar reduction of metabolic activity in the caudate nucleus (Baxter et al. 1992). In another study patients diagnosed with phobic disorder were treated with cognitive-behavioral psychotherapy or citalopram. In both groups significant reduction of activity in limbic and paralymbic regions of the brain has been observed (Furmark et al. 2002). It remains unclear however what these findings say about the nature of the process of psychotherapy – whether and eventually to what extent the observed changes are specifically associated with the psychotherapeutic process. Regardless of the growing number of research this question remains unanswered mainly due to the diversity of the applied research protocols. Recently published metaanalysis of existing longitudinal studies on changes in the function of the brain associated with psychotherapy and examined with the use of neuroimaging in patients suffering from depression and anxiety disorders reveled some interesting findings (Fu et al. 2013). Out of 50 loci of decreased activation and 29 foci of increased activation postulated as significant when comparing pre- and post-treatment-measurements in individual studies only two clusters of

decreased activation and one cluster of increased activation were detected as significant in meta-analysis. The clusters of increased activation were situated in fronto-parietal attentional system (one in the left superior and medial frontal gyri, and one in the right inferior parietal lobule). The cluster of decreased activation was located in the inferior and middle temporal lobe. According to the dual-process-model of affective disorders and their therapy, a change in prefrontal functioning would be expected when comparing patients before and after therapy. However, no involvement of the dorsolateral prefrontal cortex was demonstrated. Several other critically conducted metaanalyses of neuroimaging research on the process of psychotherapy did not provide a convincing candidate for reliable neurobiological biomarkers (Cheung et al. 2013, Fu et al. 2013, Messina et al. 2013). An interesting attempt to use neuroimaging to monitor psychotherapeutic process has been described by Anna Buchheim et al. in a case report of individual psychoanalytic psychotherapy of a female dysthymic patient with narcissistic traits (Buchheim et al. 2013). In that paper it has been demonstrated that brain activity analyzed with fMRI emerging in response to certain relational stimuli (attachment-relevant scenes from the Adult Attachment Projective Picture System, AAP) differs significantly depending of the relational quality (evaluated with the Psychotherapy Process Q-Set, PQS) of the therapeutic session performed before the scan. The mode of relational functioning visible in the therapy session preceding fMRI scan was significantly associated with modulation of the signal elicited by personalized attachment-related scenes in the posterior cingulate/precuneal region. Although the findings can barely be seen as a neurobiological proof of psychotherapy effectiveness, this research provides a model of utilization of neuroimaging techniques to analyze important aspects of phenomena (enacted self-distancing defensive strategies) emerging in the process of psychotherapy. Moreover, the complexity of the research protocol shows clearly the difficulties in designing methodologically and logically valid study on the process of psychotherapy that utilizes neuroimaging techniques.

Endocrinological markers

Among many hypothetical hormonal biomarkers researched in recent years most attention was directed at the hypothalamic-pituitary-adrenal axis. Considerable number of publications has been published examining

both the baseline level of cortisol in stress-related disorders and the magnitude of cortisol release after pharmacological and nonpharmacological challenges (de Quervain et al. 2011, Hsiao et al. 2012, Plag et al. 2013).

The published research has been conducted on various disorders treated with psychotherapy including panic disorder, GAD, social anxiety disorder, phobic anxiety, PTSA and OCD. Surprisingly recently published review does not provide convincing evidence for a clinically significant involvement of the HPA axis in anxiety disorders and psychotherapy of anxiety disorders (Plag et al. 2013). The following methodological shortcomings of research included in the reviews limit considerably the generalization of results: differences in composition of research groups, comorbidity, differences of stress level associated with lifestyle or objectively difficult life events, small research groups, major differences in treatment procedures (including treatment length and intensity).

Catecholamines were considered in recently published research as suitable candidates for biomarker of susceptibility to psychotherapeutic treatment (Oei et al. 2010, O'Connor et al. 2013). Unfortunately the interpretation of some promising research results is limited by the fact that the pre-treatment plasma concentration level of catecholamines is higher in patients with greater intensity of various symptoms (e. g. anxiety symptoms). Therefore it remains unclear whether high levels of catecholamines can be regarded as a biomarker of lower susceptibility to psychotherapy or only as an indicator of pre-treatment severity of selected symptoms. Moreover the findings are difficult to replicate and vary significantly across studies depending on various factors (e. g. target study groups, research methodology, type of treatment) (Oei et al. 2010).

Epigenetic markers

Research conducted in the last decade brought into attention the role of epigenetic factors in the development of the brain. The comparison of methylation status of various genes (among others genes of regulatory proteins associated with the development of the central nervous system) in offspring of caring mothers compered to offspring of mistreating or avoidant mothers shoved significant differences. In general, analysis of samples collected from offspring of caring mothers revealed significantly lower methylation of genes coding several proteins that play an important role in neuron migration and forming (Feinstein et al. 2010, Yehuda et

al. 2013). These findings firstly limited to rodents where later researched also in humans. Based on the research results a new question emerged whether psychotherapy can alter gene methylation. In a study conducted on 115 subjects with borderline personality disorder downregulation of brain-derived neurotrophic factor (BDNF) has been examined (Perroud et al. 2012). BDP subjects had significantly higher methylation status at BDNF I and IV exons in comparison to healthy subjects in the control group. Moreover methylation status corresponded with the intensity of childhood trauma measured using the Childhood Trauma Questionnaire. Patients included in this study underwent intensive dialectical behavior therapy (I-DBT; 4 weeks of treatment). Examination of the methylation status at BDNF I and IV exons after treatment revealed an increase of methylation status in the group of nonresponders, whereas in the group of responders (patients who have gained significant improvement in the severity of symptoms associated with hopelessness and depression) a decrease of methylation status was observed. Moreover, subjects with the best response to treatment achieved the level of BDNF methylation comparable to the one measured in control subjects. In light of the results of this study and other studies it is safe to assume that exploring methylation of various genes (e. g. NR3C1, HTR2A, MAOA, MAOB and COMT) in humans suffering from psychiatric disorders may in the future deliver biomarkers helpful not only in diagnosis but also in monitoring treatment effectiveness and the process of psychotherapy.

Cellular markers

The search for biomarkers has extended beyond brain activity changes, hormone level monitoring and even epigenetic factors. Results of a recently published study (Morath et al. 2014) conducted in a group of patients suffering from post-traumatic stress disorder treated with trauma-focused therapy support the hypothesis that patients who gain improvement in the course of treatment benefit further on a biological level: the unfavorable reduction of suppressor T cells (FoxP3+ regulatory T lymphocytes) observed in PTSD patients is being reversed making the patients less prompt to the development of autoimmunological diseases (Morath et al. 2014). This effect has been observed in an analysis of data obtained from samples collected in a one-year follow-up and was limited to suppressor T cells. The applied treatment consisted

of 12 sessions (90 minutes long) of narrative exposure therapy. No favorable changes in the proportion of memory T lymphocytes to naïve T lymphocytes have been observed. Although the methodology of the research imposes severe limitations on the generalizability of results (e. g. no control group at 1 year follow-up) it delivers interesting perspective on the scope of biological changes attainable through psychotherapy.

Conclusions

The search for reliable biomarkers of psychotherapy effectiveness (and psychotherapy process) has intensified in recent years. The need to objectively evaluate psychotherapeutic treatment drives researchers to reach beyond the currently available knowledge. Very interesting and intriguing research results are being published almost every week. The complexity and diversity of the therapeutic processes and psychiatric disorders treated with psychotherapy pose a serious challenge for designing methodologically valid research on biomarkers in psychotherapy. Moreover, technical difficulties and disturbances within therapeutic session associated with sample and data collection as well as the impact of conducted research on psychotherapeutic relationship and alliance are examples of factors which may influence greatly the results. Currently available research, although encouraging to conduct future explorations, does not provide sufficient evidence to use biomarkers in everyday clinical setting as a reliable tool helpful in diagnosis, treatment monitoring and evaluation of effectiveness of psychotherapy. Methodological correctness remains crucial for future research to enhance obtaining reliable results useful in clinical setting.

Zusammenfassung

Die Suche nach Biomarkern von psychiatrischen Erkrankungen und von psychotherapeutischen Effekten hat sich in den letzten Jahren signifikant intensiviert. Man erwartet, dass die erforschten Biomarker eine nützliche Objektivierung von Diagnosen, Verbesserungen im Behandlungsverlauf und der Ergebnisevaluation sind und zudem eine validere Prognose liefern, um die Befindlichkeit der Patienten nach der Behandlung vorherzusagen. Mehr noch vermutet man, dass Biomarker als Prädiktoren der Ansprechbarkeit auf eine psychotherapeutische Behandlung dienen können. Eine kritische Durchsicht der veröffentlichten Forschung zeigt jedoch, dass – obwohl durchaus von wissenschaftlichen Interesse – die gegen-

wärtig verfügbaren Forschungsergebnisse nicht auf ein klinisches Setting übertragbar sind. Diese Begrenzung der Anwendbarkeit ist eine Folge verschiedener methodologischer Mängel der veröffentlichten Studien.

Die Suche nach Biomarkern mit neuro-bildgebenden Verfahren hat eine überzeugende Evidenz erbracht, dass Psychotherapie Hirnfunktionen signifikant ändern kann. Es bleibt aber trotz einer wachsenden Anzahl von Veröffentlichungen unklar, welche spezifischen Veränderungen mit dem therapeutischen Prozess verknüpft sind und welcher Aspekt der Psychotherapie genau dafür steht. Eine kritische Betrachtung der Ergebnisse führt zu dem Schluss, dass die Hypothese, dass Psychotherapie bei verschiedenen psychiatrischen Erkrankungen in ähnlicher Weise zu Veränderungen des Gehirns führe wie die Pharmakotherapie, zu simpel ist. Jüngste Studien belegen die Notwendigkeit, eine innovative Methodologie zu entwickeln, um wirklich Ergebnisse zu liefern, die helfen, den psychotherapeutischen Prozess und die Pathogenese psychiatrischer Erkrankungen zu verstehen.

Endokrinologische Biomarker wurden in den letzten Jahren extensiv untersucht. Da bei der Pathogenese bestimmter Angststörungen eine Beteiligung der Hypothalamus-Hypophyse-Adrenalin-Achse postuliert wird, wird die Suche nach mit dieser Achse assoziierten Biomarkern forciert. Überraschenderweise zeigt sich aber, dass die einfache Messung der Baseline-Hormonlevel (z. B. Cortisol, Katecholamin) nicht zu reproduzierbaren und klinisch nützlichen Ergebnissen führt. Darüber hinaus korrelieren die beobachteten Veränderungen der Höhe der Hormonausschüttung nach pharmakologischen und nicht pharmakologischen Interventionen nicht mit der mit Standardmethoden erhobenen Behandlungseffizienz.

Die Entdeckung, dass die Beziehung zwischen Mutter und Kleinkind die Expression verschiedener Gene (einschließlich neurotroper Faktoren) durch epigenetische Mechanismen modulieren kann, erbrachte eine wissenschaftliche Erklärung einiger Aspekte des Freud'schen Determinismus-Paradigma. Hieraus hat sich die Frage abgeleitet, ob sich solche Veränderungen auch durch Psychotherapie evozieren ließen. Das letzte Jahrzehnt hat hierzu Daten geliefert, die tatsächlich darauf hinweisen, dass Psychotherapie die genetische Expression durch Epigenese verändern kann. Die methodologischen Mängel der Studien mindern zwar die Durchschlagkraft dieser ersten Entdeckungen, gleichwohl wurde die Suche nach epigenetischen Markern verschiedener psychiatrischer Störungen und Psychotherapieeffekten ein vielversprechendes Forschungsfeld.

Eine andere interessante Beobachtung bezieht sich auf die Analyse ausgesuchter zellulärer Biomarker. Im Verlauf einer Psychotherapie konnten deutliche Veränderungen in der Verteilung und Größe verschiedener Lymphozyten-Typen beobachtet werden. Diese Veränderungen verringern die Anfälligkeit gegenüber Autoimmunerkrankungen. Die Erforschung von Biomarkern der psychiatrischen Erkrankungen und der Psychotherapieeffizienz sowie das Therapieprozessmonitoring liefern neue und bereichernde Perspektiven für ein größeres und tieferes Verständnis der Pathogenese von Erkrankungen und der Natur des psychotherapeutischen Prozesses. Obwohl die klinische Anwendbarkeit der vorliegenden veröffentlichten Daten noch sehr begrenzt bleibt, werden zukünftige methodologische Weiterentwicklungen und methodisch sauber durchgeführte Studien klinisch wertvolle Ergebnisse liefern.

(Dipl.-Psych. Gisela Finke)

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Patients and Artists: Revisiting the Boundaries between Art and Psychiatry

Carlos Zubaran (Blacktown, Australia)

The artistry of the mentally ill is now recognized as a genuine form of artistic manifestation. The use of art in mental health care followed changes championed by philosophers, physician and humanists during the 19th century in Europe. Subsequently, avant-gardist artistic movements assimilated the creative process of the insane. The benefits of artistry and handiwork for restoring one's physical and mental capacities was later recognized and art therapy was utilized in the assistance to war victims. The use of art for therapeutic purposes has gradually gained the endorsement of the medical community worldwide. The oeuvre of Arthur Bispo do Rosário, who spent most of his life in a asylum in Rio de Janeiro, has gained international acclaim as outstandingly creative art.

Keywords: Art, Art Therapy, Psychiatry, Mental Health, Mentally Ill, Creativity

Art and Psychiatry: A Brief Historical Account

There is an increasing appreciation of the genuine aesthetic value of artworks produced artists affected by mental disorders. This genre of creative manifestation, usually referred to as *Art Brut*, has been endorsed by various museums dedicated to the creative works of the mentally ill worldwide. Apart from the artistic merit of the creative works themselves, there is a growing recognition of the restorative potential of industriousness and craftsmanship in health care.

The use of art in mental health care has come a long way. Historically, the Moral Treatment, which was in vogue during most of the 19th century in Western Europe, was probably the most influential movement to propagate ideals of change in treatment of the mentally ill. As a result, gradually, less punitive measures started to be dispensed in the asylums. These changes represented ideological tendencies heralded during the Enlightenment, with emphasis on reason and progress through the scientific method. The pioneering interventions of Philippe Pinel favoured non-medical initiatives in the care of the insane (Conti 2008). He referred to the „habitual execution [of] the natural law of bodily labour" as „contributive and essential to human happiness". While significant changes took place

in the nosocomial environment in France, as depicted by Robert-Fleury in the painting entitled *Pinel a la Salpêtrière* (1876), across the English Channel, a reformation of the treatment dispensed to the mentally ill was spearheaded by leaders of the Quaker community. New facilities were created under humanistic doctrines, including the York Retreat, founded by William Tucke in 1796 and, in the next century, the Crichton and the Montrose hospitals in Scotland. It was at the latter institution that Adam Christie had an atelier dedicated to his stone carving skills, probably the first consigned to a mentally ill patient.

It did not take much for avant-garde artists to discern the original and inventive nature of artworks produced by the mentally ill. The russian futurists established a formal connection between art and the sciences of the mind. Nikolai Kulbin, who graduated at the Military Academy of Medicine in St. Petersburg, founded the Triangle Art and Psychology Group (1907–1910). He also wrote about artistic creativity in the *Almanac*, the manifesto publication of *Der Blaue Reiter*, an artistic group based in Munich (1911–1914), now considered a fundamental step in the development of Expressionist movement. In the *Almanac*, the art of the insane was considered an authentic example of artistic creativity. The emphasis on irrationality and intuition was explored further in Dadaism and Surrealism, artistic movements which radically transformed the cultural scene in the early 20th century.

Following the World Wars, sanatoria beds were mostly occupied by cases of tuberculosis and disabling lesions (Hogan 2001). The British artist Adrian Hill, who coined the term *Art Therapy* in 1942, was one of these recovering men. He promoted the benefits of drawing and painting for restoring one's physical and mental capacities. Art therapy as a modality of care was also utilized by occupational therapists, who played a pivotal role in the assistance to war victims in need of rehabilitation.

The most fundamental medical contribution in this field was made by Hans Prinzhorn. His pioneering work (1922) on the frontiers between psychiatry and art, conducted while he was at the University of Heidelberg, is considered the first formal analytical work on the creative process of the mentally ill. Exceptional advances occurred in this field when several brilliant minds came together at Netherne Hospital in Surrey during the late 1940's. Edward Abramson implemented inaugural art therapy programs; Francis Reitman developed clinical research on this theme; and Eric Cunningham Dax espoused the use of art within mainstream psychia-

tric treatment. Important collections of raw art have been put together and named after these pioneers: the Adamson Collection has been conserved by a trust in England; whereas the Dax Centre houses its namesake collection in Melbourne. Nise Da Silveira was instrumental in the dissemination of these ideas in the developing world. She organized painting classes at the National Psychiatric Centre in Rio de Janeiro and later established the Museum of Images of the Unconscious, a fundamental psychiatric and cultural advance in Latin America.

Although activities involving artistry and handiwork, among other skills, have been considered a useful agency to improve mental health for more than a century, only recently have these modalities been tested againt the methods of evidence-based medicine. In an RCT conducted by Richardson et al. (2007), art therapy produced a beneficial effect on negative symptoms of schizophrenia. Yet, in a more recent trial with a larger sample, aptly named Matisse, art therapy did not improve mental health or global level of functioning (Crawford et al. 2010). The potential benefits of art therapy may be applicable to additional disorders and medical specialties. Beneficial effects of art therapy have been confirmed in trials for individuals with Alzheimer's disease (Hattori et al. 2011), children with asthma (Beebe, Gelfand and Bender 2010), and women with breast cancer (Boehm et al. 2014), although sample sizes were not substantial in these studies. Arts therapies are recognized in the British national treatment guidelines (NICE) among other psychological and psychosocial interventions for schizophrenia.

While additional evidence is needed in order to determine whether arts-based interventions represent a cost-effective and valid tool to mitigate the suffering of our patients, its role in helping to allay stigma and prejudice does not require further exegesis. The arts can be used as a vehicle to portray human subjectivity and social circumstance, contributing thereby to societal change and collective well-being. In a therapeutic context, art invites reflection on the interface between artist and illness. It allows the afflicted and feeble to declare one's fulfillment, comfort and dignity. It calls on the viewer for sympathy and discernment, so that we come to distinguish together the true colours of our existence.

Arthur Bispo do Rosário: From The Asylum to Stardom

Arthur Bispo Do Rosario was born in Japaratuba, Sergipe, on the Brazilian Northeast Region, to where he would never return (Hidalgo 2001). A descended from African slaves, he was born on the 14th May 1909, or according to other sources, on the 16th of March 1911. He died of heart attack in Rio de Janeiro on the 5th of July of 1989.

Bispo – as he is known, which means „bishop" in Portuguese – joined the navy in 1925 and later dabbled as an amateur boxer. In 1933 he moved to Rio de Janeiro where he had a series of menial jobs. Between 1933 and 1937, he worked in the Light Electricity Company. Bispo then met a lawyer in the context of a legal action associated with a work-related accident. Bispo later obtained support and shelter from the lawyer's family.

In December 1938, Bispo left the flat where he was living and wandered the streets of Rio. He embarked on his own „pilgrimage" informing local clergymen that he had come to „judge the dead and the alive". He was subsequently arrested, and taken by police to a psychiatric hospital as an indigent. Diagnosed with schizophrenia, Bispo was subsequently transferred to the Colônia Juliano Moreira, a public asylum in the outskirts of Rio de Janeiro, where he would remain for the next 50 years. There he began to develop his artistic skills. He used to work intuitively with virtually all materials that were available in his immediate environment. He used to say he was in a „divine mission" for the Judgement Day. His creativity would soon gain notoriety in the asylum.

Bispo created more than 800 artworks, including cloaks, banners, assemblages, sculptures and installations. Bispo was an autodidact. He never regarded himself as an artist. He used to work in reclusiveness, usually oblivious to what happened in the „outside world".

Bispo utilized objects found at the asylum, including brooms, furniture, mugs, spoons, galoshes, flip-flops, sheets, blankets, deodorant and detergent containers, and cardboard among other items. Bispo used to draw, write, embroider, nail, overlay, and unravel (uniforms) to reuse threads. Themes from Bispo's past, when he was a sailor and a boxer, were notorious in his artworks.

He used material collected from remains; discarded objects or goods given by others were also used in his works. Word was a central element, often expressed in fragmented constructions to convey subjective meanings. He embroidered texts on clothing, asylum uniforms, and bed sheets. In

some of his works, he listed the names of those he considered destined to go to heaven, mostly women.

Recognition arrived months after Bispo's death in 1989 when his works were shown at a major exhibition in Rio de Janeiro. International acclaim came in 1995, when Bispo's works were shown at the 46th Venice biennial. His works were also shown in the „Brazil Body & Soul" exhibition at the Guggenheim in 2002. Exhibitions in Paris (2003) and various other art centers worldwide followed. In 2011, his works were shown in Valencia, Brussels, and at the Lyon biennial. Exhibitions in the Sao Paulo biennial, Lisbon and London followed in 2012.

The fact that Bispo's oeuvre has achieved acclaim while shown alongside prestigious artists, in three biennials and in solo exhibitions, has projected his work into the leading esthetic expression. It has been stated that presenting Bispo as a lunatic represents an unnecessary glamorization of his artistic creativity.

Conclusion

Ideological tendencies heralded during the Enlightenment have spawned more humane forms of treatment for the mentally ill. The creative process of the mentally was recognized and assimilated by avant-gardist artistic movements early in the 20th century. The artworks of individuals affected by mental illness started to be progressively recognized by art critics and cognoscenti as genuine and meritorious artistic manifestations. The oeuvre of Arthur Bispo Do Rosario, who spent most of his life in a asylum in Rio de Janeiro, has gained international acclaim as groundbreaking and outstandingly creative art. The artistic expression of the mentally ill has finally been recognized as a creative process of legitimate aesthetic value and appeal. The therapeutic potential of art therapy has also been acknowledged in the medical community.

Patienten und Künstler: ein Blick auf die Grenzbereiche zwischen Kunst und Psychiatrie

Kunst und Psychiatrie: ein kurzer historischer Abriss

Der Wert der Werke, die von Künstlern mit psychischen Erkrankungen geschaffen wurden, erfährt eine zunehmende Anerkennung. Verschiedene Museen weltweit haben die Bedeutung dieses Genres – bezeichnet als *„Art Brut"* – unterstrichen, indem sie den Arbeiten von psychisch Kran-

ken große Ausstellungen gewidmet haben. Die Bedeutung der Kunst in der Behandlung von psychisch Kranken hat eine lange Geschichte. Die moralische Behandlung, die in Westeuropa über weite Strecken des 19. Jahrhunderts bestimmend war, war wahrscheinlich das einflussreichste Behandlungskonzept, das andere Ideale als rein medizinsche in der Behandlung von psychischen Erkrankungen vertrat. Wegbereitender Vorläufer war hier Philippe Pinel, der bereits im 16. Jahrhundert stark auf nichtmedizinische Interventionen bei der Behandlung von seelischen Störungen setzte (Conti 2008).

Unter dem Einfluss einer humanistischen Sichtweise wurden neue Einrichtungen wie der „York Retreat" von William Tucke im Jahr 1796 gegründet, im darauffolgenden Jahrhundert in Schottland das Cichton und das Montose Hospital. In letzterer Einrichtung hatte Adam Christie ein Atelier für seine Steinmetzarbeiten, vermutlich das erste, das einem psychischen kranken Patienten überlassen wurde.

Den Künstlern der Avantgarde fiel es nicht schwer, die Originalität und innovative Natur von Kunstwerken, die von psychisch Kranken gemacht wurden, wahrzunehmen. Die russischen Futuristen etablierten einen offiziellen Zusammenhang zwischen der Kunst und der Wissenschaft von der Psyche. Nikolai Kulbin gründete die „Triangle Art and Psychology Group" (1907–1910). Er schrieb diesbezüglich über die Kreativität im Almanach des Blauen Reiters, der Münchener Künstlergruppe um Kandinsky (1911–1914).

Die Betonung von Irrationalität und Intuition findet sich auch im Dadaismus und Surrealismus, künstlerische Bewegungen, die die kulturelle Szene im frühen 20. Jahrhundert radikal veränderten. Die Bezeichnung „Art Brut" für nicht akademische, naive Kunst von Laien und Behinderten geht auf den französischen Künstler Jean Dubuffet zurück.

Der größte medizinische Beitrag auf diesem Gebiet kommt von Hans Prinzhorn. Seine bahnbrechende Arbeit (1922) über die Grenzbereiche individueller künstlerischer Expressivität und die Merkmale der Psychose entstand zu seiner Zeit an der Universität Heidelberg. Es ist eines der ersten Werke über den Zusammenhang von kreativen Prozessen und Geisteskrankheit.

Nach den beiden Weltkriegen waren die Betten in den Sanatorien meist durch Tuberkolosekranke und Verwundete besetzt (Hogan 2001). Der britsche Künstler Adrian Hill, der 1942 den Begriff „Kunsttherapie" prägte, war einer dieser Rekonvalszenten. Er beschrieb den Nutzen von Zeich-

nen und Malen für die Wiederherstellung der physischen und psychischen Funktionen. Außergewöhnliche Fortschritte auf diesem Feld entstanden, als einige brillante Köpfe im Netherne Hospital in Surrey in den späten 40er-Jahren zusammenkamen.

Wichtige Sammlungen „roher Kunst" wurden zusammengetragen und nach den Pionieren dieses Feldes benannt: Die Edward Abramson Sammlung wird von einem englischen Trust unterhalten, während das Eric Cunningham Dax Center die gleichnamige Sammlung in Melbourne beherbergt. Nise da Silveira war maßgeblich beteiligt bei der Verbreitung dieser Ideen in den Entwicklungsländern. Sie gründete das „Museum of Images of the Unconscious" in Rio de Janeiro, ein fundamentaler Vorstoß der Psychiatrie in das kulturelle Feld in Lateinamerika.

Jüngst wurde die Wirksamkeit der Kunsttherapie durch Methoden der evidenzbasierten Medizin getestet. In einem RCT, durchgeführt von Richardson et al. (2007), zeigte Kunsttherapie einen signifikanten Effekt auf die negative Symptomatik von Schizophrenie. In einer neueren Versuchsreihe mit einer größeren Stichprobe unter dem Namen Matisse erbrachte Kunsttherapie jedoch keine nachweisbare Verbesserung von psychischer Gesundheit oder dem allgemeinen Funktionsniveau der Patienten (Crawford et al. 2010).

Signifikante Effekte durch Kunsttherapie zeigten sich bei Untersuchungen an Alzheimerpatienten (Hattori et al. 2011), an Kindern mit Asthma (Beebe, Gelfand und Bender 2010), an Frauen mit Brustkrebs (Boehm et al. 2014), auch wenn die Stichprobengröße dieser Untersuchungen nicht repräsentativ war. Kunsttherapien wurden in den britischen nationalen Behandlungsleitlinien (NICE) unter anderen psychologischen und psychosozialen Interventionen bei Schizophrenie anerkannt.

Arthur Bispo Do Rosario: Aus der Anstalt zum Ruhm

Arthur Bispo Do Rosario wurde am 14. Mai 1909 in Japaratuba, Sergipe, im Nordosten von Brasilien geboren (Hidalgo 2001) und starb am 5. Juli 1989 in Rio de Janeiro. Er war ein Nachfahre afrikanischer Sklaven.

1933 ging er nach Rio de Janeiro, wo er sich mit verschiedenen Hilfsarbeiterjobs durchschlug. Nach einer scheinbar psychotischen Episode wurde bei Bispo eine Schizophrenie diagnostiziert. Anschließend wurde er ins Colonia Juliano Moreira Krankenhaus eingewiesen, eine öffentliche Irrenanstalt in den Außenbezirken Rio de Janeiros, wo er die nächsten 50

Jahre verbrachte. Dort begann er seine künstlerischen Fähigkeiten zu entwickeln. Schnell wurde er aufgrund seiner Kreativität zu einer Berühmtheit in der Anstalt.

Bispo schuf mehr als 800 Werke: Stickereien, Kostüme, Banner, Assemblagen, Skulpturen und Installationen. Dazu verwendete er alltägliche Materialien wie Anstaltskleidung, Bettpfosten, Decken, Deodorantspraydosen, Flip-Flops. Bispo zeichnete, schrieb, stickte, bastelte usw.

Aufmerksamkeit erfuhr sein Werk wenige Monate nach Bispos Tod 1989 durch eine große Ausstellung in Rio de Janeiro. Internationale Berühmtheit erlangte er 1995, als sein Werk auf der 46. Bienniale in Venedig gezeigt wurde. 2002 wurden Bispos Arbeiten im Guggenheim Museum im Rahmen der Ausstellung „Brazil Body & Soul" ausgestellt. 2003 folgten Austellungen in Paris und anderen Kunstmetropolen weltweit, 2011 in Valencia, Brüssel und der Bienniale in Lyon, 2012 auf der Bienniale in Sao Paulo, Lissabon und London.

Bispos Werk fand Würdigung insbesondere dadurch, dass seine Arbeiten neben denen namhafter Künstler auf drei Biennalen und in Einzelausstellungen gezeigt wurden und hoben sein Werk damit auf das führende Niveau ästhetischen Ausdrucks.

Fazit

Neue ideologische Sichtweisen während der Aufklärung waren wegbereitend für humanere Behandlungsmethoden von psychischen Störungen. Der kreative Prozess im Rahmen von Geisteskrankheiten wurde zu Beginn des 20. Jahrhunderts von avantgardistischen Künstlern erkannt, die sich davon inspirieren ließen. In der Folge wurden die Werke von Menschen mit psychischer Erkrankung zunehmend als ernsthafte Kunstwerke wahrgenommen.

Das Werk von Arthur Bispo Do Rosario, der den größten Teil seines Lebens in einer Anstalt in Rio de Janeiro verbrachte, fand international Anerkennung als bahnbrechende und herausragend kreative Kunst. Die künstlerischen Arbeiten von psychisch Kranken wurden letztlich in ihrem kreativen Wert und Ausdruck erkannt. Daneben wurde in der Medizin das therapeutische Potenzial der Kunsttherapie anerkannt.

(Dt. Zusammenfassung von Dipl.-Psych. Stefanie Zodl)

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Close collaboration between the Psychiatric clinic and the Social services in the Municipality of Södertälje – The Södertälje Model

Helena Forslund (Schweden)

In Södertälje the Psychiatry and the Social services collaborate closely in five joint outpatient rehabilitation units to meet the needs of long term severely mental ill persons. Together they provides medical treatment and housing, daily support and different kinds of employment. Care plans are made jointly together with the individual. Most individuals live in their own apartments. Evaluation shows that patients quickly get coordinated efforts and are offered a wide range of interventions.

Keywords: Collaboration, psychiatry, municipality, outpatient rehabilitation units

Preface

The Mental Health Reform was taken by the Swedish parliament in 1994 after a major investigation "Psykiatriutredningen". The investigation showed that people with psychiatric disabilities had the worst living conditions of all disability groups. The situation was partly due to that large mental hospitals were closed in the 1980s without offering support in outpatient care. The investigation also noticed that people with psychiatric disabilities seldom sought care or support themselves and that their knowledge of their civil rights were lacking. Another problem for people with mental illness was that different organizations were responsible for various services. This was causing difficulties for the target group. People with severe illness were discharged from inpatient care without support in everyday life and the result was that they soon were back in inpatient care again.

The Swedish Mental Health Reform

In January 1995 the Mental Health Reform was implemented in Sweden. The mental health reform targeted people with chronic and severe mental illness – mainly psychotic and similar disorders – involving permanent disabilities. The aim of the reform was to improve their conditions and create opportunities for them to get involved in the community

life just like other citizens. The intention was also that the Public Employment Service and the Social Insurance Agency would have a more prominent role in, for example, vocational rehabilitation.

A clearer division of responsibilities between municipalities (social services) and County Councils were established. The municipalities were responsible for housing, employment and overall planning. The County Councils (psychiatry) retained responsibility for psychiatric treatment. But the reform also made clear that close cooperation between the different agencies, and a holistic approach, was required to focus on the needs of people with permanent disabilities. To gain this goal a good collaboration between each Municipality and each County Council was needed.

Unfortunately the outcome of the Psychiatric reform essentially became an economic reform with a division of responsibilities between the municipality and county council. The Public Employment Service and the Social Insurance Agency did not get the central role that was intended.

Two project managers – but no project

When the Mental Health Reform was carried out Södertälje psychiatric sector (county council) and the municipality of Södertälje (social services) – the largest of the three Municipalities in the catchment area which also included Nykvarn and Salem – started a close collaboration to fulfill the aim of the reform.

Södertälje municipality has 90000 inhabitants, Salem has about 15000 inhabitants and in Nykvarn live just over 9000 people.

The joint activity was built up as a project, but mainly with existing resources. To start activities for persons with long-term needs for support and treatment by using project funds was not considered an option. An expansion of the outpatient care was a prerequisite for close collaboration between the municipality social services and the psychiatric clinic. Changing focus from inpatient care to outpatient care required a total reorganization of the psychiatric clinic. It was made by reducing the number of inpatient beds, which funded the expanded outpatient care.

In the midst of the 90s there were 86 inpatient beds in the Psychiatric clinic. Since 2008 the number of beds in inpatient care is only 26.

The Södertälje model – this is how we started

Two project managers – one from each authority responsible – had

a common mission. They were responsible for keeping the goals alive and that the collaboration model was implemented.

Representatives from the Psychiatric clinic and the Municipality social services formed a number of working groups. They studied the goals of the Mental Health Reform and worked out a common vision of what quality of life should be. They also formulated the overall aim for the implementation of the reform.

Important starting points for these discussions were:
- the individuals participation/empowerment
- the needs of the individual at the center
- the idea of collaboration and joint planning

The basis of our collaboration model

The basis of our collaboration model was that it should be only one way in to both support and treatment for long term mentally ill. It also meant that support and treatment had to be located at the same place.

If we managed with this, people would much easier get the help they needed and no one would have to fall through the cracks any longer. We also agreed on common objectives and missions.

Our common vision

Good living conditions

Södertälje creates a good living environment for all its residents and provides people with mental disabilities good living conditions through:

Treatment

The psychiatric treatment offered is well developed and conducted on the basis of best available scientific knowledge.

God housing conditions

A well-developed housing support and housing with differentiated and flexible support provides people with mental disabilities a good opportunity to have their special needs met.

Support with well-developed collaboration

A well-developed collaboration with other health care providers and service organizations such as the Elderly care, the Social Insurance Agency and Public Employment Service, means that no one with mental disabili-

ties should risk being without support.

The individual is – based on his/hers own ability – actively involved in the rehabilitation/the treatment.

Employment and social relationships

The individual chooses employment by will, needs and ability. The support is individually designed with a focus on work, study and leisure. Rich potential for employment/job training, work and meaningful leisure activities allows people with disabilities experience a high degree of quality of life.

Patient influence

A well-functioning interaction with the lively Representative organization and the active patient audit leading to many good initiatives in in development and democracy issues related to the target audience related to the target audience.

Early Intervention

An active focus on early intervention to prevents sickness and relapse.

Increased knowledge

Together with the user organizations we contribute to a good understanding of mental disability among the residents of Södertälje.

Our common goals

The discussions about the vision and the concept of quality of life leads us to a number of general common goals that are still valid:

We want to develop the quality of life and thereby reduc ill-health of the individual by

- opportunities for social relationships and community
- access to employment
- a need for tailored and flexible support in housing
- psychiatric treatment that is flexible and accessible
- to work together with the individual in planning and evaluating the support he/she receives

By offering a well-functioning and available outpatient support our common goal is to reduce the need for

- special housing

- placements on individual nursing homes
- psychiatric inpatient care

The Södertälje model today

Today we can say that we have come a long way towards realizing our vision. The target group has been extended to – except those with long-term disabilities – also include persons with other serious mental illness/health problems and needs of efforts from both authorities responsible. The goal of the Södertälje model is to offer as much as possible of the support in the form of outpatient treatment.

We have a special unit – the Psychiatric Abuse Team – that works with people who (in addition to their mental illness) also have abuse/dependency problems and complex needs.

A partnership model that has torn walls

With the shared main responsibility as a starting point we have built a model of cooperation without new walls and boundaries between the principals.

In our model, the individual should be central – not be sent between the authorities responsible – and the need for continuity and long-term contacts are to be met. It has also been important to build a team that does not shut out people with serious mental disabilities referring to some homemade rule.

Other bearing thoughts of our model has been to create a business

- which is not subjected to temporary project funding
- without „gap of rehabilitation“ (none of the authorities take its responsibility for the rehabilitation)
- which, together with the network, as far as possible are able to support people in their homes and avoid admissions in inpatient care.

In order to realize our basic ideas we have – the municipality and the county council – chosen to work in outpatient joint rehabilitation units. Each unit offers social activities, psychiatric treatment and housing support. The individual knows that the unit offers both social support and medical treatment and don’t have to bother which principal h/she should contact depending on his/her needs. Through the shared main responsibility there are “open channels” both to the psychiatry inpatient care and to the municipal social services.

Five rehabilitation units

Our collaboration started with three community rehabilitation units for people with severe psychiatric disease, mental disability and needs of long-term treatment. Now there is also a Psychiatric Abuse Team and a Psychiatric Rehabilitation Unit for people with severe psychiatric illness and need of both medical treatment and social support. The units provide care to the approximately 900 people in the target group living in the catchment area.

Each unit consists of personnel from the municipality and the county council on an integrated base. The unit is led jointly by two managers, one from each authority.

The three first established units are primarily geared to people with psychotic illnesses. The Psychiatric rehabilitation unit caters to people with other psychiatric conditions. The Psychiatric Abuse Team now has a common manager, employed by both the municipality and the county council.

Rehabilitation is a joint responsibility of the municipality and County Council. The individual will have two coordinators/Case Manager (CM), one from the municipality and one from the County Council, which has responsibility for coordinating support and treatment.

Our jointly offer include the medical investigation, diagnosis, medication, family work, and furthermore patient and family education (about the illness), assessment of activity and functional ability, psychological assessment, counseling, planning, investigation of the social needs, housing, employment, job training and assistance in studies. Each unit has an open meeting place with a small café. The meeting place also offers different forms of structured activities, such as cooking, gardening and walks.

The staff of each unit consists of doctors, nurses, psychiatric technicians, occupational therapists, psychologists, social workers, housing support/rehabilitation assistants, receptionist/medical secretary and cleaning staff.

In one of the units (Österäng) the County Council staff is also collaborating with the social service in the municipality of Salem. The county council staff of Grengården is working together with the social service in the municipality of Nykvarn.

Both the municipality and the psychiatric clinic finance their own activities and hire its own staff. The costs of the premises are shared.

Joint planning

When a patient is referred to a rehabilitation unit is treated by an intake team. The team consists of the two heads, the psychiatrist and the social

worker/counsellor. After the social and medical investigations a decision is made on intake or not. The psychiatrist and the social worker make a joint plan for support and treatment. Two Case Managers (CM) are appointed on a planning conference. The CMs and the patient have their first meeting. The first CAN-evaluation (Camberwell Assessment of Needs) is made always with the client throughout the process. A network meeting with people close to the patient – family members as well as professionals, and of course the patient him/herself – is planned.

A rehabilitation plan is made by the case managers and the patient. The plan describes how the medical treatment and the support will be designed.

The activities included in the plan should be monitored, evaluated and revised regularly (at least once a year). The two CMs are responsible for this. They gather the network (resource group), that is, those who are responsible for different activities. A new plan is made based on the results of the evaluation.

Case manager (CM)

The case manager´s main duties, besides being "the spider in the planning network", is motivational work and supportive discussions on issues that are important to the patient. If necessary the CM also is a problem solver. The CMs are also responsible for initiating a crisis plan.

Two heads in one unit

Two managers of an operative unit is impossible – that was the general view when the model was presented. Our experience is that there are both success factors and difficulties in joint leadership.

Success factors are:

- A manager from each authority responsible provides a mandate from both organizations
- Two heads give the ability to use each other's strengths
- As a manager you always have a backup which means less working alone
- Being two heads provide training in networking and problem solving
- Two managers is less vulnerable and gives better continuity

The difficulties with two heads in common leadership are that it requires trade-offs and compromises. As one of two heads at the same unit you are always "odd" in your own organization. It could be a challenge to find managers with the collaboration skills required.

PWC evaluation 2012

On behalf of the social director in Södertälje PWC (Pricewaterhouse-Coopers i Sverige AB) in 2012 evaluated the Södertälje model. The study showed that the model had good cost efficiency with few patients in municipality sheltered housing and few beds in psychiatric inpatient care. The Psychiatric clinic had a lower percentage of inpatient occasions in psychiatric care compared with the two other clinics in the study. PWC also showed that the municipality offers more services at a lower cost per service compared with the other two municipalities in the study.

CAN evaluation

The individual‘s needs are the starting point when a rehabilitation plan is made. To obtain a complete picture of the needs the so called CAN-scale is used to make estimation. The scale shows both the individual‘s and staff‘s perceptions of the need for aid. Family members may also participate in the estimates. Estimation of the scale results – along with the individual‘s desire for support – is the starting point for future activity planned.

CAN data have been collected yearly since 1996/1997 for all patients with severe mental illness in Södertälje catchment area. CAN forms are filled in yearly by the patient and his/her personal contacts from both the psychiatric clinic and from social welfare, together. The data have been used to make an individual plan for rehabilitation. The rehabilitation plan has been revised yearly.

Changes in needs have been analysed over time in research projects. A group of 90 patients (of 218) that have completed the CAN form in both 1996/1997 and 2006 have been followed.

Patient data:

- 36 women and 54 men
- Average age 2006: women 48 years, men 49 years.
- Median age 2006: 49 years for both sexes
- Diagnosis mostly schizophrenia, sometimes schizoaffective psychosis, rarely bipolar disorder.

Reason for exclusion:

- Identification not given by patient
- Assessment only by staff
- Patient has left the area

A comparison of results shows that unmet needs decreased during the period in 18 of 22 fields (especially close relations, emotional disturbances, serious psychiatric symptoms, social contacts).

Domains with decreased serious needs ("2")

Domain	1997/98	2004	2006
Intimate relationships	18	4	5
Psychological distress	15	9	5
Company	14	6	4
Psychotic Symptoms	14	8	5
Physical Health	12	10	9
Money	9	4	5
Benefits	7	4	1
Information about health	7	7	5
Food	7	2	2
Transport	6	3	3
Sexual expression	6	1	3
Daytime Activities	6	2	3
Basic education	5	0	0
Childcare	4	1	1
Accommodation	4	1	1
Telephone	3	0	2
Safety to self	2	1	0
Safety to others	1	0	0

There was a very slight increase in four fields (personal care, housekeeping, drugs and alcohol).

Domains with increased serious needs ("2")

Domain	1997/98	2006
Looking after the home	1	2
Drugs	1	2
Alcohol	0	1
Self Care	0	2

Staff often rated needs higher than patients especially regarding occupation, psychotic symptoms and nutrition. The fact that staff estimated the

prevalence of psychotic symptoms higher than the patients could suggest that the symptoms still occur, but that patients no longer experience them so hard.

These results have motivated development of activities in fields with high needs and have been important in the dialogue with purchasers and politicians and other decision makers. Our conclusion is that CAN is a useful tool for tailoring work with individual patients but also for development of organization and for quality assurance.

Summary

The Mental Health Reform in Sweden was carried out in 1994. The aim of the reform was to improve the conditions for people with long term mental disabilities and create opportunities for them to get involved in the community life just like other citizens.

As a result of the mental health reform Södertälje Psychiatric sector (county council) and the Municipality of Södertälje (90 000 inhabitants) in 1995 started a close collaboration to fulfill the aim of the reform. We know that long term, severely mentally ill persons need close cooperation between those responsible for treatment, lodging and occupation. For this reason, the Psychiatric clinic and the Social services formed an integrated model of cooperation without walls and boundaries. The individual‘s need for continuity and long-term contacts are central to the model. In five joint outpatient rehabilitation units a professional team gives treatment and care to about 700 individuals. The units consists of personnel from the municipality and the county council on an integrated base. Each unit is led jointly by two managers, one from each authority.

The County Council provides medical treatment and the Municipality is responsible for housing, support to cope with daily life and different kinds of employment. The care plans are made jointly together with the individual. The flexible and “seamless care” enables most of the individuals to live in their own apartments. For about 40 individuals with severe illness the municipality offers special accommodations with staff present both day and night. Almost everybody takes part in different activities and/or get special support to find a job in the open labor market or to study. In an evaluation in 2012 the integrated cooperation between the Municipality social services and the Psychiatric clinic in Södertälje were compared with the organization of two other municipalities in Swe-

den. The results showed that our approach is effective and saves time. Patients quickly get coordinated efforts and are offered a wide range of interventions. The comparison shows that Södertälje can deliver a high quality within "the social psychiatry" at lower or comparable costs.

Zusammenfassung

Die Psychiatriereform in Schweden wurde im Jahre 1994 umgesetzt. Das Ziel der Reform war es, die Verhältnisse für Menschen mit langwierigen psychischen Behinderungen zu verbessern und Möglichkeiten für sie zu entwickeln, am Leben der Gemeinschaft ebenso teilzuhaben wie andere Bürger.

Als ein Ergebnis der Psychiatriereform begannen die Psychiatrie des Landkreises Södertälje sowie der Stadtgemeinde (90.000 Einwohner) im Jahr 1995 eine enge Zusammenarbeit, um das Ziel der Reform zu erreichen. Wir wissen, dass langfristig schwer psychisch kranke Menschen eine enge Zusammenarbeit brauchen zwischen denen, die verantwortlich sind für ihre Behandlung, ihr Wohnen und ihre Tagesstruktur. Deshalb entwickelten die psychiatrische Klinik und die sozialen Dienste ein integriertes Modell der Zusammenarbeit ohne Mauern und Grenzen. Das Bedürfnis des Einzelnen nach Kontinuität und langfristigen Kontakten ist maßgeblich für das Modell. In fünf miteinander vernetzten ambulanten Wiedereingliederungs-Stützpunkten behandelt und versorgt ein professionelles Team über 700 Menschen. Die Stützpunkte werden von Mitarbeitern der städtischen und ländlichen Versorgungsdienste auf einer integrierten Grundlage getragen. Jeder Stützpunkt wird gemeinschaftlich von zwei Leitern, einer aus jeder Behörde, geführt.

Der Landkreis trägt für die medizinische Behandlung Sorge und die Stadt ist verantwortlich für Unterbringung, Unterstützung bei der Lebensführung und verschiedene Beschäftigungsangebote. Die Betreuung wird von beiden Diensten gemeinsam mit dem Patienten geplant. Die flexible und „nahtlose Betreuung" erlaubt den meisten Patienten, in ihren eigenen Wohnungen zu leben. Für etwa 40 schwer Kranke bietet die Gemeinde spezielle Unterkünfte an, in denen Tag und Nacht Betreuungspersonal anwesend ist. Fast jeder Betroffene nimmt an unterschiedlichen Angeboten teil und/oder bekommt Unterstützung bei der Stellensuche auf dem offenen Arbeitsmarkt oder beim Studium. In einer Auswertung wurde 2012 die integrierte Zusammenarbeit zwischen den

städtischen Sozialdiensten und der psychiatrischen Klinik in Södertälje verglichen mit der Organisation zweier anderer Stadtgemeinden in Schweden. Die Ergebnisse zeigten, dass unsere Herangehensweise wirkungsvoll ist und Zeit spart. Die Patienten erhalten zeitnah koordinierte Leistungen und Angebote einer breiten Palette von Hilfen. Der Vergleich zeigt, dass Södertälje eine hohe Qualität innerhalb der „sozialen Psychiatrie“ liefern kann – zu niedrigeren oder vergleichbaren Kosten.

(dt. Zusammenfassung von Erwin Leßner)

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Clinical and social aspects of systemic Art Therapy in the context of contemporary psychiatry

Alexander Kopytin (St. Petersburg)

Clinical systemic art therapy (CSAT) is presented as such form of art therapy, which integrates clinical and social dimensions in rehabilitation and psychotherapy. The development and implementation of clinical systemic art therapy is considered taking into account the history of art therapy and the improvements in the mental health care system based on the biopsychosocial paradigm, which enables complimenting biological, psychological, and social aspects of psychiatric treatment. Findings of the study of therapeutic and rehabilitation effects of clinical systemic art therapy have been presented. Findings indicate that CSAT used in a form of a brief interventions provides various positive effects on symptomatic status, personal adaptation, self-perception, cognitive abilities, creativity and quality of life of patients treated at the psychotherapy departments and psychiatric day hospital. Though certain positive effects were also observed in control groups, these effects were less evident than in experimental groups. Certain measurements used in the study helped to reveal more significant, profound effects of CSAT on a complex of indicators that can be more sensitive to the specific nature of the art therapy intervention.

Keywords: art therapy, systemic, clinical, social, rehabilitation, psychiatry

Introduction

Recent developments with regard to psychosocial rehabilitation and psychotherapy in mental health settings involve the increased use of arts as a factor of more effective psychiatric treatment and social inclusion of patients. Art therapy is nowdays more often regarded to be a legal and even necessary ingredient of mental health service. Though the use of artistic activity of psychiatric patients as one of supportive factors go back to the beginning of the 20th century and become more visible after the World War II in the European and North American contex, its present state is strongly influenced by the transition to the biopsychosocial platform for mental health services. It is a demand to complement biological, medical treatment of psychiatric disorders with various forms of psychological and psychosocial support, in order to provide not only the successful reduction of symptoms, but to enable changes in personal positions of patients, their perception of themselves and the world and, thus, secure more generalised

and prolonged effects of treatment including better social functioning and adaptivity.

It becomes more obvious that the strength-based model of contemporaty mental health services is highly congruent to the core art therapy's principles and methods. It cannot be ignored however that art therapy is still often regarded by mental health professionals as a very 'marginalised' phenomenon, a kind of the 'secondary therapy' with vague and controversial theoretical foundations and lack of scientific evidence. Though advances of medical art therapy become more observable throughout the last two decades (Chapman, Morabito, Ladakakos et al. 2001; Hagen 2007; Killick 1996; Malchiodi 1999a, 1999b; McClelland 1992; Malchiodi 1999a, 1999b; Ridenour 1998; Rusted, Sheppard and Waller 2006) it is still underestimated as reliable treatment modality, because „there is a conspicuous absence of research oriented […] studies in support of art therapy in medical and nursing journals" (Hagen 2007, p. 145). Thus more efforts should be invested, in order to provide art therapists' more effective liasion with medical professionals and patients themselves.

Clinical and social dimensions of contemporary art therapy

Contemporary art therapy embraces the wide scope of different forms and approaches related to different clinical and social-demographic groups. As one of the components of psychosocial rehabilitation and psychotherapy in the mental health milieu it is characterised by cultural richness and based on esthetic expression and human relationships as the powerful key factors of resilience and positive changes in the personality. Historically, art therapy is also linked to medicine, psychotherapy and psychology that can potentially provide an appropriate scientific foundation to understand the role of the brain, neuropsychological and psychological processes involved in the esthetic expression.

Art therapy was a term first used in such countries as United Kingdom and USA in 1940-s during the post-World War II rehabilitation movement. At first, it was initiated and supported by the several professional groups, such as artists/art educators (Adamson 1984; Dewey 1934; Hill 1945; Lydiatt 1971; Kramer 1958; Petrie 1946), psychoanalists (Champernowne 1963; Dalley 1993; Kris 1952; McNeilly 1987; Milner1950; Naumburg 1947, 1966; Waller 1993) and psychiatrists. Two strands of art therapy developed: one as a sensitive form of art teaching

applied in clinical settings and other as an aspect of psychotherapy through art. The role of psychiatrists, who believed in the protective/therapeutic role of artistic activities in patients, supported initiatives of artists in their strives to establish esthetic platforms in mental health institutions, or studied and collected artworks of patients should be emphasised too. Walter Morgenthaler (Switzerland), Hans Prinzhorn (Germany), Leo Navratil (Austria), Vittorino Andreoli (Italy), Robert Volmat, Jean Delay, Claude Wiart (France), Istvan Hardi (Hungary), Irene Jakab, Harry Wilmer, Nolan Lewis (USA) are just few of them.

Though psychiatrists contributed to the development of art therapy medical/clinical discourse is untipycal for 'transatlantic' art therapy models with their prevailing psychodynamic and artistic-pedagogic stance. Only in the last two decades as a result of art therapists' increased institutionalisation their dialogue and cooperation with medical professionals have being strengthened. It is noteworthy that continental European, in particular, Russian clinitians are often active in the further explorations of art therapy potential within psychiatric and wider medical context (Beregulina 2012; Burno 2002; Ionov 2004; Kopytin 2010, 2011, 2012; Kopytin & Lebedev 2013; Koszokhina & Kopytin 2012).

Clinical (Chapman, Morabito, Ladakakos et al. 2001; Hagen 2000; Killick 1996; Malchiodi 1999a, 1999b; McClelland 1992; Ridenour 1998; Rusted, Sheppard and Waller 2006) and social (Hogan 1997, 2001; Levine & Levine 2011) dimensions of art therapy become more evident in the last years as its multifaceted functions in treatment and rehabilitation of mental and physical maladies have been further studied. Art therapy becomes more sensitive towards particular pathologies with their clinical targets and social-cultural/discursive environments with their significant and even crucial roles in the manifestation of psychosocial problems.

Contemporary clinical/medical art therapy is concerned in the use of art in medical and psychiatric settings in order to improve therapeutic, preventive and rehabilitation interventions based on the biopsychosocial paradigm of mental and physical disorders. Clinical/medical art therapy is characterised with the following main qualities:

- It is primarely applied with therapeutic, preventive and rehabilitation purposes.
- It involves creative, mostly artistic-expressive activity of patients as the major or minor/secondary factor of treatment and rehabilitation.
- It is concerned not only with universal curative functions and ap-

proaches related to artistic expressive activity of patients, but with more specific interventions aimed at particular disorders with their symptoms and biopsychosocial patogenic configurations.
- It strives to standardise therapeutic interventions related to particular pathologies in order to make effects more controled and predictable.
- It emphasises therapeutic efficacy of interventions and requires evidence-based studies to be done to to confirm that.
- It is mostly performed by specially trained medical/paramedical professionals knowledgable and skilled enough to do clinical work either they are clinical art therapists (as in the USA, or UK), or mental health professionals, such as psychotherapists or clinical psychologists with further art therapy training (as in Russian Federation or some other continental European countries).
- It is centralised and controlled mostly by the medical authorities, though certain control on the part of public organisations and citizens is also implied.
- It is payed mostly through medical insurance system, though some non-governmental/non-federal funds can be involved too.

As far as social dimension of contemporary art therapy is concerned, certain avenues of work supplementing clinical/medical ones should be further mentioned:
- It strives to reduce and prevent psychosocial problems of patients related to their position in the society and considered to be a result of mental and physical disorders. One of its functions is to prevent and fight psychiatric stigma and social exclusion based on mental or physical limitations of a patient. Thus inclusive orientation of many art therapy projects dealing with various clinical populations is typical.
- Clients‘ social efficacy and quality of life are a result of their creative stance in the world are given more attention.
- Social issues in contemporary art therapy are more effectively resolved, provided no only patients and medical staff, but public organisations, patients’ families and society in general are involved.

Social dimension of art therapy is currently being more actively developed in certain relation to advances in visual anthropology, social sciences and cultural studies paying more attention to the role of social/cultural construction issues including people’s identities, their understanding of health and pathology, discursive factors and medial en-

vironment. Social dimension of contemporary art therapy is also strongly related to power struggle and institutional gegemony, multicultural issues, politics, ethical and legal considerations and unequality, needs of different minority groups and their empowerment.

Clinical Systemic Art Therapy: A brief characteristic

Clinical Systemic Art Therapy (CSAT) (Kopytin 2010, 2011, 2012) integrates both clinical and social dimensions in contemporary psychotherapy and psychosocial rehabilitation. It has certain significant differences from prevailing models of contemporary art therapy and serves as a complex form of the therapeutic intervention that embraces artistic expression, therapeutic and group relations and person-oriented exploration of patients' artworks not only in the clinical, but the wider social-cultural context too. Its called "systemic", because it provides multidimensional perception of mental health issues as they are dynamically reflected and resolved through artistic-expressive activities of patients in their complex relations with the inner and outer worlds.

CSAT takes into account different biopsychosocial patogenic and protective factors of mental disorders involved in creative processes, both clinical and social dimensions of patients' existence, their many conections with other people, each other, mental health professionals and institutions and society in general. It provides careful consideration of social, cultural, institutional and other external impacts on the art therapy process.

The core of CSAT is psychological (psychodynamic) theory of personality, which is understood as a system of relationships and implies the following constituent parts:

- psychological concept of identity as a dynamic system developed in order to regulate self-perception,
- theory of creative activity as a means to regulate and stabilise identity, provide resilience and adaptation (on intrapersonal, interpersonal and societal levels),
- the concept of projective-symbolic communication as a form of discursive/formative activity and a means of reflecting and transforming the environment and relationships,
- the concept of psychological defenses and coping skills,
- the concept of inner and outer factors of personal creative activity (needs, motivations, meanings, attitudes etc.).

According to such psychological (psychodynamic) theory, personality is understood as a dynamic system of relationships established and regulated through a complex of human functions including creative function as the central one. This particular function is performed not only in the wide spectrum of routine everyday situations, but in extraordinary situations as well including different pathologies. It is based on the increased cortical activity involving coordinated and synergetic both left and right brain structures and excited imaginary perceptions in their strong connection to the 'emotional center of the brain', the limbic system, in order to provide better neuroplasticity, learning processes and restructuring of information.

Another crucial methodological part of CSAT is the theory of mental disorders based on the biopsychosocial platform and embracing such theoretical ingredients as:

- medical phenomenology (patopsychology as far as psychiatry in concerned), that is careful analysis of clinical manifestations (symptoms) and their configurations (syndromes),
- nosology, that is identifying mental disorder according to one of the international classification systems,
- theory of patogenesis linked to the study of patogenic, protective factors and triggers of mentals illness including the impact of biological/ neurobiological, neuropsychological, intrapsychic (psychodynamic), environmental, social-cultural, familial and other factors in the development of mentals disorders,
- multiaxial/functional diagnosis including inner and outer protective factors and resilience, in particular, patients' attitude towards illness and treatment and their ability and wish to cope with malady and its consequences.
- developmental theory embracing normal, patological and compensatory pathways etc.

According to CSAT, as a result of integrating both psychological (psychodynamic) understanding of personality and that of mental disorder with its particular psychosocial disfunctions art therapy intervention must be developed. On the theoretical and practical levels it implies the following:

- theoretising both general and specific factors of therapeutic changes according to transtheoretical approach,
- defining goals and targets of art therapy intervention related to par-

ticular mental illness with its clinical manifestations and patogenic factors, personality, motivational and functional level of patients,
- conceptualising the art therapy process and its processual-technological specifics including forms and stages of art therapy, combination of general and specific factors and activities, particular psychotherapeutic techniques and styles of therapeutic interaction,
- concept of therapeutic and group relationships and the therapeutic environment.

The main differences of CSAT from other models of contemporary art therapy are as follows:
- transtheoretical approach has been used in order to define the general factors and processes of therapeutic changes,
- focusing on individual and group targets related to the stages of treatment, levels and stages of therapeutic changes, group dynamics and symptoms throughout the art therapy process is provided,
- a complex of therapeutic interventions depending on the clinical nature of disorders and functional levels of patients has been developed.
- Art psychotherapist must have appropriate clinical and psychotherapy training.

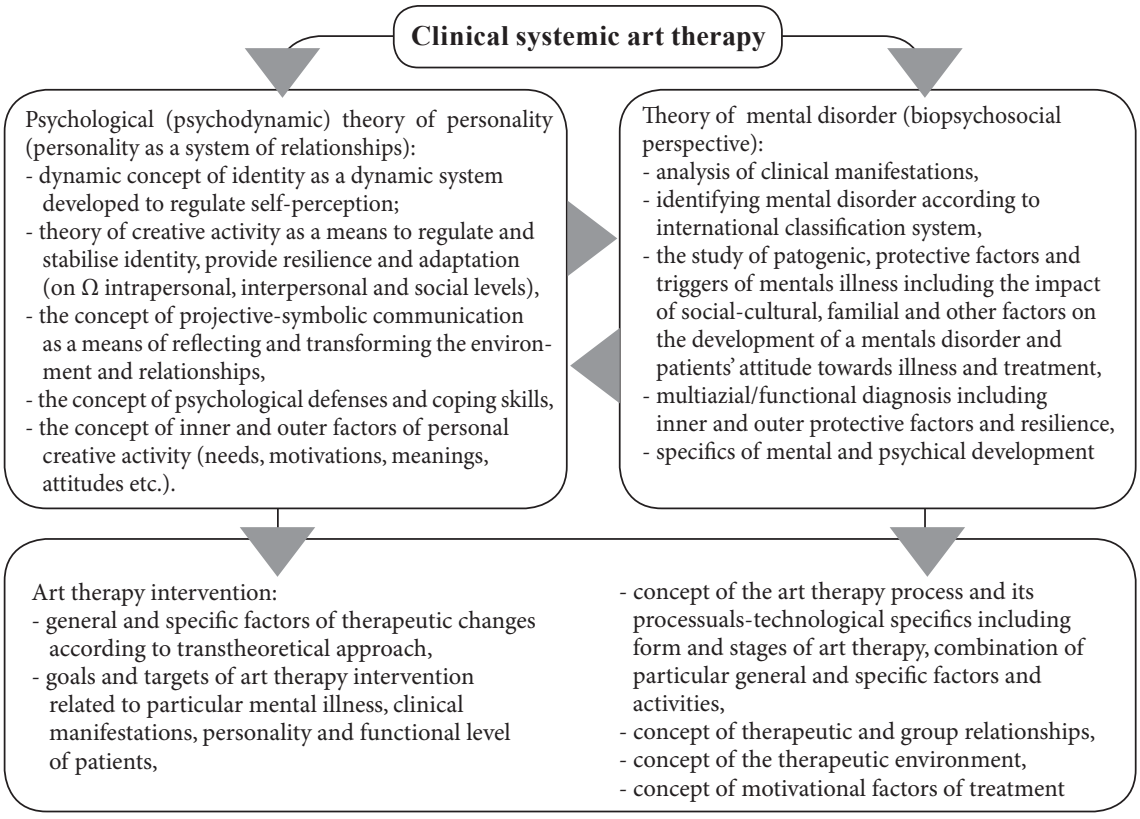

Figure 1. Main theoretical components of CSAT

The study of therapeutic and rehabilitation effects of CSAT

Patients and measures

The goal of the study was the assessment of general therapeutic efficacy of CSAT applied in the form of brief group intervention with patients with various mental disorders: (1) those, who are treated at the specialized psychotherapy departments and suffered with mostly neurotic, stress-related and somatoform disorders; affective disorders, organic disorders or behavioral or personality disorders (2) those, who suffered with more severe than neurotic, stress-related disorders including those with psychotic disorders, such as schizophrenia.

Patients of different sex and age comprised the experimental and control groups (Table 1). A total of 300 patients were enrolled in the study: 170 patients received the art therapy CSAT intervention and comprised the three experimental groups, while 130 patients didn't participate in art therapy and comprised the three control groups. Patients from both experimental and control groups received biological therapy (antidepressants, tranquilisers etc.) and physiotherapy. Patients from the control groups also get physiotherapy and occupational therapy instead of CSAT. Patients' age varied from 25 to 57 years.

Most patients from non-psychotic groups suffered from neurotic, stress-related and somatoform disorders, affective disorders, organic disorders, or personality and behavioral disorders (Table 2). However those suffering from non-psychotic organic disorders prevailed in the experimental and control groups comprised of the patients treated at the psychotherapy department, hospital for war veterans, while those with neurotic, stress-related and somatoform disorders prevailed at the groups comprised of the patients treated at the sychotherapy department, St. Petersburg Scientific-Research Psychoneurological Bekhterev Institute.

Schizophrenia, schizotypal and delusional disorders, affective and organic disorders prevailed in the experimental and control groups comprised of the patients treated at the psychiatric day hospital, district psychoneurological dispensery (St. Petersburg) (Table 2).

Table 1: **Participant Demographics**

Psychotherapy department, hospital for war veterans		
	Experimental Group (N=62)	Control Group (N=50)
Age:		
20-29	15 (24 %)	13 (26 %)
30-39	29 (47 %)	23 (46 %)
40-49	10 (16 %)	9 (18 %)
50 and more	8 (13 %)	5 (10 %)
Sex :		
male	51 (82 %)	41 (82 %)
female	11 (18 %)	9 (18 %)

Psychotherapy department, St. Petersburg Scientific-Research Psychoneurological Bekhterev Institute		
	Experimental Group (N=55)	Control Group (N=35)
Age:		
20-29	21 (38 %)	10 (29 %)
30-39	24 (44 %)	15 (42 %)
40-49	10 (18 %)	10 (29 %)
50 and more	0 (0 %)	0 (0 %)
Sex :		
male	10 (18 %)	5 (14 %)
female	45 (82 %)	30 (86 %)

Psychiatric day hospital		
	Experimental Group (N=53)	Control Group (N=45)
Age:		
20-29	8 (15 %)	11 (24 %)
30-39	12 (23 %)	11 (24 %)
40-49	25 (47 %)	18 (40 %)
50 and more	8 (15 %)	5 (12 %)
Sex :		
male	31 (60 %)	31 (68 %)
female	22 (40 %)	14 (32 %)

Table 2: Participant Diagnoses According to ICD-10*
Diagnoses and ICD-10 codes

Psychotherapy department, hospital for war veterans		
	Experimental Group (N=62)	Control Group (N=50)
Neurotic, stress-related and somato-form disorders (F43.22, F45.3, F48.0, F43.23)	17 (24 %)	14(28 %)
Affective disorders (depression) (F32.0, F32.10, F32.11, F33.01)	10 (16 %)	7 (14 %)
Organic mental disorders (F06.6 F06.4, F06.3, F06.2, F07.0)	35 (60 %)	29 (58 %)

Psychotherapy department, St. Petersburg Scientific-Research Psychoneurological Bekhterev Institute		
	Experimental Group (N=55)	Control Group (N=35)
Neurotic, stress-related and somatoform disorders (F41.2, F45.0, F48.0, F45.3, F45.2)	34 (62 %)	11 (44 %)
Affective disorders (F32.0, F32.10, F32.11, F33.01)	0 (18 %)	6 (24 %)
Personality and behavioral disorders (F60.4, F60.7, F60.1, F60.3, F60.6)	8 (15%)	4 (16 %)
Organic mental disorders (F06.3 F06.4, F06.6, F07.0)	3 (5 %)	4 (16 %)

Psychiatric day hospital

	Experimental Group (N=53)	Control Group (N=45)
Schizophrenia, schizotypal and delusional disorders (F20.0, F20.3, F20.6, F20.9, F20.2, F21, F23.3, F25.1, F25.2)	18 (34 %)	18 (40 %)
Neurotic, stress-related and somatoform disorders (F41.2, F45.0, F48.0, F45.3, F45.2)	5 (9 %)	5 (11 %)
Affective disorders (depression) (F31.4, F32.0, F32.1, F32.2, F32.10, F32.11, F32.3, F33, F34.0)	11 (20 %)	7 (15 %)
Organic mental disorders F06.6 F06.4, F06.3, F07.0)	9 (17 %)	5 (11 %)
Personality and behavioral disorders (F60.0, F60.2, F60.3, F60.4, F60.6, F60.7)	8 (15 %)	10 (23 %)
Mental and behavioral disorders as a result of intake of psychoactive substances (F10, F11)	2 (5 %)	0 (0 %)

Reference: * International Statistical Classification of Diseases and Related Health Problems (ICD-10), World Health Organisation, 1992

The instruments used provided assessment of symptomatic improvement in patients' condition, changes in their self-perception, relationships, cognitive and personality functioning and their quality of life. Quality of group interaction and patients' artistic expression were also taken into account.

The following assessments to pretest and posttest the study participants treated at the psychotherapy departments were used:

- Symptomatic Checklists (Derogatis et al. 1974)
- Questionnaire of Depressive Conditions (Bespalko2004)
- General Condition-Activity-Mood Test (Doskin et al. 1973)
- Silver Drawing Test (Silver 2002)
- Integrative Anxiety Test (Bizyuk et al. 2005)
- Elexitimic Scale (Eresko et al. 1994)
- The Questionnaire of Quality of Life, developed by the World Health Organization (Burkovskij, Kotsubinskij, Levchenko, Lomachenkov, 1998; Whog, 1998)

The following assessments to pretest and posttest the study participants treated at the day psychiatric hospital were used:

- General Condition-Activity-Mood Checklist (Doskin et al. 1973)
- Standardised Clinical Personality Questionnaire (MMPI) (Gilyas-Heva et al. 1984)
- Personality and Situational Anxiety Spielberger-Khanin Scales (Khanin 1976)
- Questionnaire of Creative Activities (Kopytin 2010)

All these tests were used twice, first time in the beginning of treatment at the psychotherapy department of day psychiatric hospital and second time in a month period, not long before patients' discharge from the department or the hospital. To compare statistical difference between pre- and posttest results in two groups T-test measure was used.

Art Therapy Intervention

Participants in the experimental groups took part in CSAT group sessions three times per week in after-lunch sessions that lasted two and a half hours. Group sessions usually consisted of 5–8 patients. The course of art therapy lasted one month and included 12–14 sessions that were facilitated by a trained art-psychotherapist. Each session was structured with warm-up activities, a main art-based activity with discussion, and closure. Basic art materials were available, such as crayons and pastels, colored

pencils, gouache and acrylic paints, and white paper of different sizes.

Group art therapy involved various art-based activities that corresponded with appropriate stages of treatment and group dynamics aimed at different therapeutic clinical, intrapersonal, interpersona and group targets. Art therapy rogram included the three main phases, such as the beginning phase, the intermediate phase, the working phase and the concluding phase with appropriate goal-oriended activities and therapeutic procedures. However activities and therapeutic procedures varied depending on particular pathologies, personal specifics of participants and group dynamics. For example, participants created individual and group squiggle drawings that encouraged warming-up, creative stimulation, and the safe release of emotions, and also presented their current emotional state through drawing. A complex of drawing tasks and themes were introduced to allow clients to develop interpersonal skills and mindfulness; to express and understand their own self-perception; to perceive their attitude to others and position in a group, their disease and resources; and to gain perspective on their past and present life situations. Directives included „realistic and metaphoric self-portraits", „my life line", „positive and negative feelings", „my resources in the past and present", „challenging life situations and how I overcome them", „personal coat of arms", „my life achievements and goals", and „presents I give myself and others". Issues that arose from group dynamics also were worked through using art-based activities and discussion.

Results

Psychotherapy departments

The pre-treatment measures found no significant overall difference ($p > .05$) in patients' scores between those who received CSAT and those who did not receive it at the start of treatment. Pretest results in most tests (SCL-90, Integrative anxiety test, Questionnaire of Depressive Conditions) in all the experimental and control non-psychotic groups were considerably higher of the normal levels that was indicative to the severe clinical abnormality in both groups in the beginning of treatment. For instance, the use of SCL-90 demonstrates very high levels of anxiety, somatisation, psychoticism and hostility. According to the Questionnaire of Depressive Conditions pretest results of 35 patients in experimental group and 21 patients in the control group treated at the hospital for war

veterans reached depressive level, while according to the Integrative anxiety test pretest results in both groups are indicative to the high levels of situational and personality anxiety. Alexitimic level according to Toronto scale was also high.

Comparison of pretest and posttest results in both groups treated at the hospital for war veterans indicates on the positive dynamics in all measures. However positive changes in the experimental group were more considerable and observed in more scales than in the control one. Significant differences between the groups in mean scores for several measurements appeared in a month period according to T-test measure (Table 3).

As for SCL-90 Symptom Checklists, there was a statistically significant difference in the post- (M = .47, m = .07) to post- (M = .67, m = .10) scores in the Depression Scale ($t = -1.62$, $p < .05$) and in the post- (M = .45, m = .07) to post-test (M = .73, m = .13) scores in the Hostility Scale ($t = -1.91$, $p < .05$) between groups. Statistical significance was in favor of the experimental (art therapy) condition, while difference between groups in other scales was insignificant at the end of treatment (Table 3).

Comparison of post-test scores in the experimental and control groups for the Questionnaire of Depressive Conditions indicated a lower level on the Depression/Nondepression Scale in the experimental group as compared to the control group, and no significant difference in Endogenous/Neurotic Depression Scale between groups. There was a statistically significant difference in the experimental group's post-test scores (M = 66.18, m = 2.69) as compared to the control group's post-test scores (M = 73.69, m = 3.05) in the Depression/Nondepression Scale, $t = -2.11$, $p < .05$ and no significant difference in Endogenous/ Neurotic Depression Scale between groups, $t = .59$, $p > .05$ (Table 3).

Comparison of mean pre-test- and post-test scores in the experimental group for the Integrative Anxiety Test indicated a significant decrease in General Indices and most Scales of Personality and Conditional Anxiety ($p < .05$), whereas a decrease in scores was less evident in control group. There was a statistically significant difference in the post- (M = 4.44, m = .38) to post-test (M = 6.56, m = .36) scores in the General Index of Personality Anxiety Scale ($t = -3.16$, $p < .005$) and in the post- (M = 3.58, m = .35) to post-test (M = 5.28, m = .46) scores in the General Index of Situational Anxiety Scale, $t = -2.39$, $p < .05$, between groups in favor of experimental group at the end of treatment (Table 3).

For the General Condition-Activity-Mood Test scores there was a statis-

tically significant difference in the post- (M = 5.39, m = .11) to post-test (M = 5.01, m = .14) scores in the General Condition Scale, t = 2.55, p < .05, in the post- (M = 5.22, m = .12) to post-test (M = 4.54, m = .17) scores in the Activity Scale, t = 4.08, p < .001, and in the post- (M = 5.48, m = .12) to post-test (M = 4.77, m = .18) scores in the Mood Scale, t = 3.47, p < .001, between groups in favor of the experimental one (Table 3).

Comparison of mean post- to post-test scores in the experimental and control group for the Draw-A-Story and the Silver Drawing Test indicated a more significant increase on the Emotional Content and Self-Image scales and on three cognitive scales in the experimental group as compared to the control one. There was a statistically significant difference in the post- (M = 3.42, m = .13) to post-test (M = 3.05, m = .19) scores in the Emotional Content Scale, t = 1.91, p < .05, in the post- (M = 3.56, m = .09) to post-test (M = 3.23, m = .16) scores in the Self-Image Scale, t = 2.08, p < .05, and in the post- (M = 13.82, m = .16) to post-test (M = 12.68, m = .31), t = 4.46, p < .001, total scores in cognitive scales, between groups in favor of the experimental one (Table 3). The increased scores in cognitive scales are indicative of such improvements as the ability to select, combine ideas, and represent a story. These and other abilities are basic for effective cognitive functioning and creativity.

Table 3: Comparison of posttest results in experimental and control groups (psychotherapy department, hospital for war veterans).

Tests and scales	Experimental group M ± m	Control group M ± m
SCL-90:		
Somatisation	.56 ± .07	.62 ± .08
Obsessivity-compulsivity	.63 ± .08	.79 ± .10
Interpersonal sensitivity	.55 ± .07	.70 ± 0.11
Depression	.47 ± .07	.67 ± .10*
Anxiety	.44 ± .07	.61 ± .10
Hostility	.45 ± .07	.73 ± .13*
Phobic anxiety	.28 ± .07	.34 ± .08
Paranoid ideation	.51 ± .07	.61 ± .11
Psychotism	.26 ± .06	.40 ± .08
Additional scales	.58 ± .10	.66 ± .09
GSI	.48 ± .06	.62 ± .09
PSI	31.26 ± 3.13	38.41 ± 4.44
PDSI	1.29 ± .04	1.32 ± .05

Questionnaire of Depressive Conditions:		
Depression No-Depression Scale	66.18 ± 2.59	73.69 ± 3.05**
Endogenous-Neurotic Depression Scale	47.12 ± 1.46	45.22 ± 2.03
Integrative Anxiety Test (personality anxiety):		
General index	4.44 ± 0,38	6.56 ± 0,36**
Emotional discomfort	4.88 ± 0,32	6.38 ± 0,37**
Asthenic component	4.96 ± 0,35	6.59 ± 0,36**
Phobic component	3.54 ± 0,37	5.31 ± 0,37**
Perception of perspectives	5.00 ± 0,36	6.34 ± 0,36**
Social phobic reactions	4.00 ± 0,42	4.31 ± 0,44*
Integrative Anxiety Test (situational anxiety):		
General index	3.58 ± .35	5.28 ± .46**
Emotional discomfort	3.50 ± .30	4.91 ± .44**
Asthenic component	4.10 ± .34	5.34 ± .43**
Phobic component	3.04 ± .34	4.34 ± .46**
Perception of perspectives	4.82 ± .38	5.88 ± .41
Social phobic reactions	4.16 ± .36	5.16 ± .41
Toronto alexitimic scale	63.32 ± 2.35	70 .53 ± 2.53*
Activity-Mood Test:		
General Condition	5.39 ± .11	5.01 ± .14
Activity	5.22 ± .12	4.54 ± .17*
Mood	5.48 ± .12	4.77 ± .18*
Silver Drawing Test:		
Emotional content scale	3.42 ± .13	3.05 ± .19*
Self-image scale	3.56 ± .09	3.23 ± .16*
Ability to select	4.49 ± .07	4.05 ± .14*
Ability to combine	4.69 ± .08	4.45 ± .13
Ability to represent	4.62 ± .07	4.14 ± .16*
Total in cognitive scales	13.82 ± .16	12 .68 ± .31*

Reference: *difference is significant (P< .05) **difference is significant (P< .001)

As for the Questionnaire of Quality of Life the improvement in quality of life was significantly more evident in the experimental group than in the control group. While significant increase in the control group was only in the Sleep and Rest subsphere (F3), the experimental group demonstrated significant increase of results in the majority of subspheres (F1, F2, F3, F4, F5, F8, F9, F10, F19, F21) and spheres: in the physical sphere (I), in the level of independence (III), in the perception of environment (IV) and in the spiritual sphere (VI) as well as in the Total Score Reflecting Health and Quality of Life and the General Index of quality of life and health (G).

Comparison of post-test scores in experimental and control groups for the World Health Organization Quality of Life Questionnaire indicated that participants in the art therapy group had a significantly higher General Quality of Life and Health Index ($M = 14.3$, $m = .51$) as compared to participants in the control group ($M = 11.86$, $m = 1.07$), $t = 3.24$, $p < .05$. Also mean post-test scores were significantly higher ($M = 88.98$, $m = 1.93$) in the experimental group as compared to the control group ($M = 78.95$, $m = 4.48$), $t = 4.12$, $p < .05$, as well as in the sub-spheres of Life Activity/Energy/Fatigue (F2; I Physical Sphere) ($M = 14.43$, $m = 0.46$ and $M = 12.14$, $m = .92$, accordingly), $t = 2.04$, $p < .05$, Cognition/Memory/Concentration (F5; II Psychological Sphere) ($M = 14.77$, $m = .39$ and $M = 12.5$, $m = .95$, accordingly), $t = 2.94$, $p < .05$, Mobility (F9; III Level of Independence) ($M = 17.1$, $m = .59$ and $M = 14.12$, $m = 1.11$, accordingly), $t = 3.21$, $p < .05$, Physical Safety and Protection (F16) ($M = 15.5$, $m = .54$ and $M = 12.43$, $m = .73$, accordingly), $t = 3.39$, $p < .05$, Medical and Social Aid (F19; V Environment) ($M = 14.5$, $m = .50$ and $M = 12.36$, $m = .73$, accordingly), $t = 2.75$, $p < .05$, and Spirituality/Religion/Personal Values (F24; VI Spiritual Sphere) ($M = 16.03$, $m = .48$ and $M = 13.0$, $m = .90$, accordingly), $t = 4.12$, $p < .05$.

As a result of comparison of post-test scores in experimental and control groups most significant differences were revealed in such spheres as spiritual, physical and level of independence, while least significant difference was found in the sphere of social relationships among all main six spheres. As for the most considerable difference with regard to post-test scores in the spiritual sphere it can be indicative for the considerable improvement in patients' satisfaction with spiritual aspects of their existence that include their system of beliefs and values giving meaning and perspective in their life. It is also indicative for the increase in patients' creative stance in the world. (Burkovskij, Kotsubinskij,

Levchenko, & Lomachenkov 1998; Whog, 1998).

Similar dymanics was observed as a result of comparison of pretest and posttest results in both groups treated at the psychotherapy department, St. Petersburg Scienticic-Research Psychoneurological Bekhterev Institute. Though positive dynamics in many measures was present at the end of treatment both in experimental and control groups, positive changes in the experimental group were more considerable and observed in more scales than in the control one. Significant differences between the groups in mean scores for several measurements appeared in a month period according to T-test measure (Table 4). Differences between groups were either least, or absent only in Questionnaire of Depressive Conditions and situational anxiety indices according to Integrative Anxiety Test.

Comparison of post-test scores in experimental and control groups for Self-Actualisation-Test indicated that participants in the experimental group had a significantly higher Self-Actualisation-Test indices on several scales as compared to those in the control group. The following scales appeared to be most sensitive to patients' involvement in CSAT: Self-Respect, Synergy, Acceptance of Aggression, and Creativity ($t = 4.12$, $p < .001$).

Table 4: Comparison of posttest results in experimental and control groups (psychotherapy department, St. Petersburg Scientific-Research Psychoneurological Bekhterev Institute)

Tests and scales	Experimental group M ± m	Control group M ± m
SCL-90:		
Somatisation	.89 ± .11	.93 ± .12
Obsessivity-compulsivity	.89 ± .15	.97 ± .15
Interpersonal sensitivity	1.08 ± .13	1 .29 ± .14*
Depression	1.15 ± .12	1 .24 ± .11
Anxiety	1.09 ± .12	1 .32 ± .13*
Hostility	.58 ± .09	.72 ± .13*
Phobic anxiety	.78 ± .12	1 .29 ± .11*
Paranoid ideation	.65 ± .11	.72 ± .12
Psychotism	.57 ± .08	.56 ± .13
Additional scales	.96 ± .12	.91 ± .11
GSI	.89 ± .09	.88 ± .13
PSI	43.18 ± 3.43	41.46 ± 2.15
PDSI	1.69 ± .07	1.71 ± .16

Questionnaire of Depressive Conditions:		
Depression No-Depression Scale	70.43 ± 2.39	68.46 ± 1.12
Endogenous-Neurotic Depression Scale	48.95 ± 1.69	49.65 ± 1.75
Integrative Anxiety Test (personality anxiety):		
General index	7.70 ± .23	4.40 ± .37
Emotional discomfort	7.70 ± .22	4.12 ± .35
Asthenic component	7.30 ± .22	4.75 ± .45
Phobic component	6.73 ± .32	3.90 ± .43
Perception of perspectives	7.57 ± .21	5.13 ± .44
Social phobic reactions	5.50 ± .45	3.25 ± .45
Integrative Anxiety Test (situational anxiety):		
General index	7.81 ± .13	5.24 ± .21**
Emotional discomfort	8.21 ± .19**	4.65 ± .17**
Asthenic component	7.31 ± .16	5.29 ± .17**
Phobic component	6.89 ± .21	4.36 ± .18**
Perception of perspectives	7.61 ± .21	5.48 ± .18*
Social phobic reactions	5.72 ± .33	3.67 ± .24
Toronto alexitimic scale	67.70 ± 1.73	63.35 ± 2.13**
Self-Actualisation Test:		
Orientation in time	46,90 ± 1,11	45,89 ± 0,81
Support	51,08 ± 1,89	50,17 ± 1,36
Value system	43,08 ± 1,78	40,83 ± 1,34
Flexibility of behavior	50,65 ± 1,74	48,02 ± 1,44
Sensitivity	51,48 ± 1,56	50,63 ± 1,24
Spontaneity	52,65 ± 1,58	53,48 ± 1,24
Self-Respect	49,75 ± 1,52	53,37 ± 1,32**
Self-Acceptance	51,45 ± 1,89	49,46 ± 1,24
Velieves about nature of human beings	50,63 ± 1,82	48,63 ± 1,29
Synergy	57,80 ± 2,08	53,8 ± 1,44**
Acceptance of aggression	49,15 ± 1,54	46,78 ± 1,52*
Contactivity	53,53 ± 1.55	51,54 ± 1,45
Cognitive needs	49,08 ± 1,57	47,71 ± 1,43
Creativity	50,15 ± 1,53	46,21 ± 1,54**

Silver Drawing Test:		
Emotional content scale	4.03 ± .13	3.56 ± .25*
Self-image scale	4.23 ± .12	3.76 ± .15*
Ability to select	3.78 ± .15	3.15 ± .13**
Ability to combine	3.93 ± .18	2.99 ± .18**
Ability to represent	3.30 ± .11	2.71 ± .15**
Total in cognitive scales	11.06 ± .28	8.89 ± .35**

Reference: *difference is significant (P< .05) **difference is significant (P< .001)

Psychiatric day hospital

The pre-treatment measures found no significant overall difference ($p > .05$) in patients' scores between those who received CSAT and those who did not receive it. Pretest results in most scale according to the Standardised Clinical Personality Questionnaire (MMPI) and the General Condition-Activity-Mood Checklist indicated on severe clinical manifestations and personal disadaptation. MMPI profiles in both groups at the beginning of treatment indicate that neurotic and psychotic symptoms are abundant and personality and situational anxiety is considerably higher of the normal levels.

Comparison of pretest and posttest results in both groups shown the positive dynamics in most measures. Though positive changes in many measures took place in both experimental and control groups such changes were more considerable in experimental one. Significant differences between the groups in mean scores for the MMPI scales in favor of experimental group appeared in a month period according to T-test measure: Depression ($t = 3.54$, $p < .001$), Psychopathy ($t = 4.14$, $p < .001$), Paranoya ($t = 3.12$, $p < .05$), Psychasteny ($t = 3.26$, $p < .05$), Schizophrenia ($t = 3.42$, $p < .05$), and Social Introversy ($t = 4.48$, $p < .001$). Personality anxiety level according to Spielberger-Khanin Test more considerably decreased in experimental group as compared to control one ($t = 3.64$, $p < .001$).

As for the Questionnaire of Creative Activities, the comparison of mean posttest scores in the groups shows that significant difference appeared in both impressive and expressive creative activity scales ($t = 4.24$ and 4.62 accordingly, and $p < .001$). Indices of creative activity considerably increased in experimental group and have not changed in control group in a month period.

The comparison of mean posttest scores in experimental and control groups for the General Condition-Activity-Mood Checklist haven't shawn any statistically significant differences between groups in a month period ($p < .05$).

Conclusion

Recent developments with regard to psychosocial rehabilitation and psychotherapy in mental health settings involve the increased use of arts as a factor of more effective psychiatric treatment and social inclusion of patients. Art therapy is nowdays more often regarded to be a necessary ingredient of mental health service. However while advances of medical and social art therapy become more observable research oriented studies in support of art therapy interventions related to different mental pathologies and stages of treatment and rehabilitation with more attention given to clinical and social dynamics and issues become vital. As biological and other medical treatments are improved patients' social efficacy and quality of life as a result of their creative stance in the world are given more attention.

Clinical Systemic Art Therapy (CSAT) (Kopytin 2010, 2011, 2012) has been developed, in order to integrate both clinical and social dimensions and make contemporary psychotherapy and psychosocial rehabilitation in psychiatry more effective. It embraces both person-oriented dimension of therapy and the complex of pathogenetic biopsychosocial factors as a foundation for the art therapy intervention.

Based on CSAT theoretical model group art therapy programs that involved various art-based activities aimed at different therapeutic clinical, intapersonal, interpersonal and group targets have been developed and implemented. In order to study their therapeutic efficacy a complex of clinical and person-oriented measurements have been selected.

Results of the study indicate that Clinical Systemic Art Therapy used in a form of a brief interventions provides various positive effects on symptomatic status, personal adaptation, self-perception, cognitive abilities, creativity and quality of life of patients treated at the psychotherapy departments and psychiatric day hospital. Though certain positive effects were also observed in control groups, these effects were less evident than in experimental groups. Certain measurements used in the study helped to reveal more significant, profound effects of CSAT on a complex of indicators that can be more sensitive to the specific nature of the art therapy

intervention. One of examples could be the significant increase in Emotional Content and Self-Image scores as well as cognitive scores in Silver Drawing Test observed in experimental groups treated at the psychotherapy departments and consisted of patients with neurotic, stress-related, affective and organic disorders and personality and behavioral disorders after one month of art therapy. Dramatic positive dynamics of indices according to SDT in experimental groups appears to be one of its specific effects, which was absent in control group. These effects support publications indicating on an important role of image-formation and artistic activity in cognition and creative solutions of various cognitive tasks and their ability to improve self-esteem (Calvin 1996, Horowitz 1983, Solso 1994).

Significant increase in impressive and expressive creative activities of patients treated at the psychiatric day hospital in a month period as a result of their involvement in CSAT appears to be another specific effect absent in control group. Important finding of the study is the complex improvement in patients' quality of life especially with regard to such it's main spheres as spiritual and physical spheres and level of independence.

One of limitations of the study was that no test-retest analysis and no inter-rater measure has been done. More expended follow-up study is also needed to demonstrate more generalized effects on patients' clinical manifestations and personal adaptation as a result of their possible grounding in creative activities after art therapy intervention.

Summary

Recent developments with regard to psychosocial rehabilitation and psychotherapy in mental health settings involve the increased use of arts as a factor of more effective psychiatric treatment and social inclusion of patients. Art therapy is nowadays more often regarded to be a legal and even necessary ingredient of mental health service. It helps to complement biological, medical treatment of psychiatric disorders with various forms of psychological and psychosocial support, in order to provide not only the successful reduction of symptoms, but to enable changes in personal positions of patients, their perception of themselves and the world and, thus, secure more generalized and prolonged effects of treatment including better social functioning and adaptation. It cannot be ignored however that art therapy is still often regarded by mental health professionals as a

'marginalized' phenomenon, a kind of the 'secondary therapy' with vague and controversial theoretical foundations and lack of scientific evidence.

Clinical systemic art therapy (CSAT) has been developed as such form of art therapy, which integrates clinical and social dimensions in rehabilitation and psychotherapy. The development and implementation of CSAT is related to the improvements in the mental health care system based on the biopsychosocial paradigm, which enables complimenting biological, psychological, and social aspects of psychiatric treatment. It is called "systemic", because it provides multidimensional perception of mental health issues as they are dynamically reflected and resolved through artistic-expressive activities of patients in their complex relations with the inner and outer worlds.

CSAT takes into account different biopsychosocial pathogenic and protective factors of mental disorders involved in creative processes, both clinical and social dimensions of patients' existence, their many connections with other people, each other, mental health professionals and institutions and society in general. The core of CSAT is psychological (psychodynamic) theory of personality, which is understood as a system of relationships and implies the following constituent parts: psychological concept of identity as a dynamic system developed in order to regulate self-perception; theory of creative activity as a means to regulate and stabilize identity, provide resilience and adaptation (on intrapersonal, interpersonal and societal levels), the concept of projective-symbolic communication as a form of discursive/formative activity and a means of reflecting and transforming the environment and relationships, the concept of psychological defenses and coping skills, the concept of inner and outer factors of personal creative activity (needs, motivations, meanings, attitudes etc.).

Another crucial methodological part of CSAT is the theory of mental disorders based on the biopsychosocial platform and embracing such theoretical ingredients as: medical phenomenology (abnormal psychology as far as psychiatry in concerned), that is careful analysis of clinical manifestations (symptoms) and their configurations (syndromes), nosology, that is identifying mental disorder according to one of the international classification systems, theory of pathogenesis linked to the study of pathogenic, protective factors and triggers of mental illness including the impact of biological/neurobiological, neuropsychological, intra-psychic (psychodynamic), environmental, social-cultural, familial and other factors in the development of mental disorders, functional diagnosis inclu-

ding inner and outer protective factors and resilience, in particular, patients' attitude towards illness and treatment and their ability and wish to cope with malady and its consequences, developmental theory embracing normal, pathological and compensatory pathways etc. According to CSAT, as a result of integrating both psychological (psychodynamic) understanding of personality and that of mental disorder with its particular psychosocial dysfunctions art therapy intervention has been developed.

The research had been conducted, in order to assess therapeutic effects of CSAT applied in the form of brief group intervention with patients with various mental disorders: (1) those, who are treated at the specialized psychotherapy departments and suffered with mostly neurotic, stress-related and somatoform disorders; affective disorders, organic disorders or behavioral or personality disorders and (2) those, who suffered with more severe than neurotic, stress-related disorders including those with psychotic disorders, such as schizophrenia.

Patients of different sex and age comprised the experimental and control groups. A total of 300 patients were enrolled in the study: 170 patients received the art therapy CSAT intervention and comprised the three experimental groups, while 130 patients didn't participate in art therapy and comprised the three control groups. Patients from both experimental and control groups received biological therapy (antidepressants, tranquillizers etc.) and physiotherapy. Patients from the control groups also get physiotherapy and occupational therapy instead of CSAT. Patients' age varied from 25 to 57 years.

Most patients from non-psychotic groups suffered from neurotic, stress-related and somatoform disorders, affective disorders, organic disorders, or personality and behavioral disorders (Table 2). However those suffering from non-psychotic organic disorders prevailed in the experimental and control groups comprised of the patients treated at the psychotherapy department, hospital for war veterans, while those with neurotic, stress-related and somatoform disorders prevailed at the groups comprised of the patients treated at the psychotherapy department, St. Petersburg Scientific-Research Psychoneurological Bekhterev Institute.

Schizophrenia, schizotypal and delusional disorders, affective and organic disorders prevailed in the experimental and control groups comprised of the patients treated at the psychiatric day hospital, district psychoneorological dispensery (St. Petersburg).

The following assessments to pretest and posttest the study participants treated at the psychotherapy departments were used: Symptomatic Checklists (Derogatis, et al., 1974); Questionnaire of Depressive Conditions (Bespalko 2004); General Condition-Activity-Mood Test (Doskin et al. 1973), Silver Drawing Test (Silver 2002), Integrative Anxiety Test (Bizyuk et al. 2005), Elexitimic Scale (Eresko et al. 1994), The Questionnaire of Quality of Life, developed by the World Health Organization (Burkovskij, Kotsubinskij, Levchenko, Lomachenkov 1998; Whog, 1998).

The following assessments to pretest and posttest the study participants treated at the day psychiatric hospital were used: General Condition-Activity-Mood Checklist (Doskin et al., 1973), Standardised Clinical Personality Questionnaire (MMPI) (Gilyasheva et al. 1984), Personality and Situational Anxiety Spielberger-Khanin Scales (Khanin 1976), Questionnaire of Creative Activities (Kopytin 2010).

All these tests were used twice, first time in the beginning of treatment at the psychotherapy department of day psychiatric hospital and second time in a month period, not long before patients' discharge from the department or the hospital. To compare statistical difference between pre- and posttest results in two groups T-test measure was used.

Results of the study indicate that Clinical Systemic Art Therapy used in a form of brief interventions provides various positive effects on symptomatic status, personal adaptation, self-perception, cognitive abilities, creativity and quality of life of patients treated at the psychotherapy departments and psychiatric day hospital. Though certain positive effects were also observed in control groups, these effects were less evident than in experimental groups. Certain measurements used in the study helped to reveal more significant, profound effects of CSAT on a complex of indicators that can be more sensitive to the specific nature of the art therapy intervention. One of examples could be the significant increase in Emotional Content and Self-Image scores as well as cognitive scores in Silver Drawing Test observed in experimental groups treated at the psychotherapy departments and consisted of patients with neurotic, stress-related, affective and organic disorders and personality and behavioral disorders after one month of art therapy. Dramatic positive dynamics of indices according to SDT in experimental groups appears to be one of its specific effects, which was absent in control group. These effects support publications indicating on an important role of image-

formation and artistic activity in cognition and creative solutions of various cognitive tasks and their ability to improve self-esteem.

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On the Issue of Multidisciplinary Approach to Disease and Treatment Experiences of a Borderline and Neurosis Clinical Department

O. Lomounoff (Moskau)

The article reports the examination of biopsychosocial factors involved in developing and maintaining psychic asthenia as well as the effects of providing a multifactorial concept of treatment. Based on case histories of 149 patients, potential risk factors, such as work environment, housing condition and alcohol consumption are explored. Modern methods of treatment were applied, including psychotherapy, physiotherapeutic methods, natural factors, newer psychotropic medicaments and, during the last 2 years, non-standard dynamic psychiatric methods. The work was conducted in contact with the leading neurosis clinics, using the best practices of the medical institutions of St. Petersburg [Clinic of W. Bechterev Institute, Clinic of Myliteri S. Kirov Akademi, Neurosis Clinic I. Pavlov]. Benefits of a holistic approach in therapy as well as ways for early prophylaxis of mental asthenia are discussed.

Key words: asthenic syndrome, borderline disease, mental disorder, treatment, prevention

The author tries to study the influence of biosociopsychological factors, and first of all of unfavourable micro-and macro-social environment of the patients, as the source leading to nervous and psychic asthenia and preparing the ground for appearance of disease state.

Involved were the case histories of 149 patients. In the course of their examination and treatment modern methods were applied, including psychotherapy, physiotherapeutic methods, natural factors, newer psychotropic medicaments and, during the last two years, non-standard dynamic psychiatric methods. The study was conducted in contact with the leading neurosis clinics, using the best practices of the medical institutions of St. Petersburg.

What does mental disorder mean?

A mental disorder, also called a mental illness or psychiatric disorder, is a mental or behavioural abnormality, that causes either suffering or an impaired ability to function in ordinary life (disability) and differs from the healthy developmental or social norm. Mental disorders are defined in general by a maladaptive combination of how a person feels, acts, thinks or perceives.

What does psychotherapy in the Dynamic Psychiatric concept stand for?

It is important highlighting the influence of the Dynamic Psychiatric Psychotherapy, as an important method of Therapy (M. Ammon 2000), with its main characteristics:

- Group dynamics, identity, personality structure and unconscious are in constant reciprocal exchange.
- Human development is to think as a life-long process.
- Dynamic psychiatric psychotherapy is an identity and contact therapy.
- Identity refers to the individual engaging in questions like: "Who am I, what do I want, what meaningful activity can I pursue in my life?"

Identity as a challenge for society implies:

- to create meaningful areas of contact and work, which facilitate participation and which values can be adopted
- the gap between rich and poor can be closed
- the loneliness and emptiness of people can be avoided
- caring about nature and resources

In the last half of the last century we are in the state of constant revolutionary transformation of our society's life, due to scientific and technological developments; the time is called "atomic", "aminazine", "digital" and "new genetic engineering" period. We observe interferences in cellular-level processes in human organisms, allowing to understand disease states more deeply and to provide necessary therapeutic intervention. And this process continues. We have just begun the next successive period of nanotechnology development allowing us to discover totally new possibilities in all areas of life and health care.

In recent years, with increasing emotional overpressure, prevention of asthenic conditions of psychogenic origin and treatment of conditions involving neuropsychic exhaustion (NPE), neuroses and borderline states have become important. Borderline diseases are more widespread in society than they are reflected in statistical records, and only 20 % of those patients have consultations with medical specialists and receive treatment. To a great extent, medical specialists are helped by ICD 10 Chapter 5 classification.

When referred to consultations and hospital treatment, these patients were diagnosed with very different disorders up to suspected mental illness. Indeed, identifying the case without examinations was often quiet

challenging. These patients came to us for consultation after they had repeatedly visited internal medicine specialists and neurologists. Actually all of them deliberately avoided going to a psychiatrist and did it unwillingly even when referred to. As a result, when they did get to the right doctor in a polyclinic or a hospital they had more pronounced symptoms and signs of neuropsychiatric and somatic disorders.

We performed examinations and treatment of patients in the room of the diagnostic and treatment center (DTC) within the hospital department of clinical psychoneurology and followed them after their discharge. The primary diagnosis these patients had was an asthenic condition as a consequence of different kinds of overpressure as well as the impact of psychogenic factors. Hence, we dealt mostly with "psychogenic" asthenias. This group is different from other borderline patients because of the dominance of the asthenic symptom complex. Among the patients admitted into our clinic are also those who have suffered in the past from combatant's syndrome, having alcohol and tobacco addictions, in case they are not dealt within a detoxication unit.

In total, we examined and treated 149 patients (mostly engineering personnel, students and post-graduates) in the middle age of 35 to 50 years, patients older or younger accounting for only 10 % of the group. All of them were first treated on an outpatient basis and at a hospital (at clinical departments for the treatment of neuroses) and subsequently were followed up in the DTC facilities. In most cases, the patients were followed up for 2 to 3 years till full recovery. However, 16 % of the patients had to be followed up for 4 to 5 and more years and were at a risk group. According to specific features of patients' conditions, especially, at early stages, the following clinical types could be distinguished: neurasthenic (28 %), asthenic with vegetative vascular lability (14 %), astheno depressive (up to 17 %), affective lability group (7 %), with paranoiac traits (3 %) and anxiety and suspiciousness and hypochondrial traits (4-6 % each). There were also patients with mixed type disorders. Many patients complained of different somatic disorders which seemed to precede their neuroses such as cardiac neurosis, gastrointestinal dysfunction, latent depression and others, which eventually led them to consult a doctor, and usually disappeared following a course of treatment of their neurotic condition. The patients also reported that there was a direct relationship between exacerbations of the somatic disorders and deterioration of their nervous status. We can understand these patients as being psychosomatic. Most common

for them are specific working conditions (12 %), overwork, including extra work at night to get additional income (19 %). Nowadays, a new concept, off-hour work, appeared. This term is more often applicable to those people who are working in shifts or for twenty-four hours. These people frequently use their days off for extra work to receive additional income. Other patients suffer from severe illness of the family members or family and other domestic troubles (11 %). An even higher number of patients included themselves in the latter group because of poor living conditions (those who have to rent a dwelling, live in shared apartments or company-owned dwellings, often with a minimum of conveniences). A selective investigation performed in labour collectives revealed while only 11 % of staff members have flats and permanent places of residence for their families, more than half of them live in company-owned dwellings, usually of small size, or together with their families. Often they are confined to a room in a shared apartment. About 20 % of them have to rent dwellings, often located in the country, 40 to 80 km away from their place of work. Other causative factors include premorbid personal characteristics (up to 5 %), afflictions such as stammering, pronounced vegetative lability from childhood, etc. (2 %) and single marital status (4 %). We would like to make a special emphasis on ever increasing figures of disorders due to exogenic intoxication (13 %). As patients usually do not regard alcohol abuse as being a disorder, the pathogenic role of this factor remains uncovered until behavioural disorders or signs of secondary somatic disorders such as compromised liver function are evident.

A conceptual change is taking place regarding alcohol intoxication being a state of disease. The clinical entity of chronic alcoholic intoxication was mentioned in reports until the mid-1990s. According to our studies, which were performed on the initiative of Dr. G.P. Kolupaev, Chief Psychiatrist of the Main hospital, 6 % of the people on follow-up in labour collectives suffer from this form. This figure is tightly linked to prevalence of the disease in the country adult population. From medical standpoint, even regular consumption of alcohol (vodka, beer, gin and tonic and other alcoholic beverages) in low doses should be regarded as alcohol abuse if such consumption leads to addiction. Addiction is the key symptom of chronic alcoholism. People prone to alcohol abuse usually show an explosive behaviour, they are becoming rapidly exhausted and incapable to vigorous and productive activity. They show changes in emotional and conative spheres close to those seen in severe endogenic mental illnes-

ses, which can lead to patient‘s invalidation. Patients with neurotic conditions often present signs and somatic disorders typical for those suffering from alcoholism. However, they usually deny their pernicious habits. The frequency of these ambiguous cases (i.e. cases diagnosed as functional nervous disorder with alcohol intoxication as the key pathogenic factor) is higher than the 8 % mentioned above. There are generally recognized data confirmed by non-formal investigations, suggesting that 1,4 % (2 Mio.) of the country population´s males are suffering from alcohol abuse.

The medical record of patient T. born in 1965 might serve as an illustrative example in this respect. According to annual epicrisis, the patient was diagnosed with a neurotic condition with affective disturbances in 2003, a neurotic condition complicated with alcoholisation in 2004 and 2005, and alcohol abuse and chronic intoxication. Unlike to previous explanations obtained for this patient´s condition (suffering from an asthenic condition), we found that individual orientation and motivation to work are now markedly affected by moral and psychological factors such as dissatisfaction, job image wane, tightness of money, and, not infrequently, by poor psychological environment in the labour collective and society as well as the community, especially in areas with various kinds of conflicts. In our opinion, these factors play an important role in promoting development and progression of neurotic conditions.

It is important to emphasize the role of a psychological investigation and the use of appropriate techniques for the assessment of the patient’s clinical condition. This investigation is useful for revealing peculiarities of the patient’s condition, his/her personality features as well as for choosing the right treatment and objectifying treatment results.

Examples of conclusions made on results of psychological investigations:

Patient Z. born in 1965. High-level functional capabilities of psychic adaptation are revealed. Personal accentuations according to relevant scales: emotivity, anxiety, fixedness, sensitive-type attitude to disease. Primary diagnosis: emotionally labile personality.

Patient L. born in 1956. Cognitive changes and pronounced tendency to rapid exhaustion, decreased short-term memory capacity and fragmentary perception. Mentality is characterized by decreased capacity for generalization and increased specification of intellectual activity. Long-term effects of the closed-head injury are the key to the patient’s diagnosis.

Investigations performed after the treatment using individual symptoms severity scales like Mmpi, Catell and others usually give more

information about improvements of the symptoms. In the clinic, patients with pronounced asthenia were usually presented with an overall decrease of psychic functions, rapid exhaustion and emotional lability. No marked changes in EEGs were observed, except for patients with a depressive status. Some of them showed desynchronisation and diffuse contraction of the amplitude of the alpha rhythm. Investigations revealed no changes in protein fractions and blood electrolytes, which are usually observed in asthenias of infectious and posttraumatic genesis.

When examining patients with neurotic conditions, it should be kept in mind that the patient's condition often depends on many factors and, first of all, on situational factors, as well as on the patient inclination and attitudes. To choose the right method of individual therapy in each particular case, we analysed the etiopathogenesis of the disease, apart from collecting data on clinical presentation, including factors related to the patient's micro- and macroenvironment, his/her financial and social status and moral and psychological factors, which we considered playing a leading role in the building of a positive motivation to work, an active living position, resistance and immunity to impacts of negative psychogenic factors.

In our study, treatment was aimed, first of all, at reducing the maintaining factors, resolving the pathogenic situation and, if possible, elimination of the factors fostering it. Nearly in half of the cases, the situation required an active intervention for resolution and protection of the patient's interests. With this in view, family members, health service and the management were involved. This is quite an important part of the work of a psychiatrist and to a great extent facilitates preventive tasks. In our study, a combined and multimodal treatment approach was applied which included the use of various methods of psychotherapy, including the one developed by G. Ammon, systemic vitamins (in the presence of exogenous toxic hazardous factors, we prescribed high doses of vitamin B complex), physiotherapy, acupuncture, individual regimens of anxiolytic and neuroleptic drugs (in the past year and as maintaining therapy with continuous administration of neuroleptic drugs in minimal doses, including new-generation drugs, such as Rispolept, Olanzapin and other drugs and antidepressant medications such as Paxil among others).

After their discharge, minor tranquilizers were prescribed in small doses to maintain therapy even if the treatment yielded relatively good results. All patients remained on follow-up or were included in the group of risk. Most of the patients were on hospital treatment at the clini-

cal department for the treatment of neuroses. The average duration of hospital stay for the patient contingent under consideration is 21 days. In some cases of concomitant somatic disorders, psychological traumatic experience and other conditions, the hospital stay may be prolonged up to 35-40 days. Two patients of those on follow-up were registered as temporally disabled given their psychoneurologic profile due to protracted diseased conditions. One patient had to retire from employment due to persistent exacerbations of the neurosis and affective lability. The other patient was allowed working on load-limiting conditions.

Previously, a questionnaire was developed to interview students. Using this questionnaire enables managers of educational establishments and health professionals to get additional information useful in terms of psychoprophylaxis. In particular, it allows revealing early asthenic manifestations as well as tendencies to use psychotropic substances in students.

Finally, it should be noted that asthenic conditions, e.g. NPE, represent a large group of disorders which require a close attention of managerial staff and health services at all levels. Prevention of asthenias, successive treatment of the disease at early stages and follow-up of the patients are important ways to prevent of neuropsychic and neurogenic somatic disorders. In our opinion, disregarding appropriate measures for prevention and treatment can lead to asthenic conditions and NPE will develop to serious neurotic conditions.

From our experience obtained in this study the previous follow-up of patients with borderline conditions and in the course of questioning healthy students, we conclude that for prevention and treatment of nervous exhaustion, it is essential to follow existing recommendations to improve living conditions, maintaining order, creating an atmosphere of psychological comfort in labour collectives, sustaining discipline, regarding the biorhythms and creating conditions for relaxation through physical exercises and sports, in general promoting of healthy life-style in the broad sense of the word.

Healthy lifestyle with correction according to age

1. To create in one‘s environment the atmosphere of psychological comfort. In case that´s not possible, creating a virtual model is advised.
2. Regular meals at specified times – lunch, breakfast, dinner; besides, symbolic meals at 11 am, 5 pm and 10 pm (fruit, vegetables or kefir)
3. For the purpose of relief: Physical exercise, for example in form of walking – up to 10 km per day

4. Half an hour before going to bed – massage of the collar zone (cosmetic massage, like it is usually done for the face)
5. Daily practice such as autogenous training for at least 10 minutes, also before going to bed
6. To get up and to go to bed always at the same time as well as doing one‘s morning exercises (better in an hour after breakfast), water procedures.
7. To try to know everything that is happening in respective profession, life and culture
8. To dress oneself fashionably
9. To have hobbies for the good of one‘s soul – indoor and outdoor, i.e. several hobbies (in the area of talent, interests, likings).
10. To cultivate harmonious relations in the family, including in matters of sexuality.
11. Once in a month (if the tolerance is good and if there are no contraindications relating to internal organs) to visit the Finnish bath – but not to be overexposed to heat and not to use the pool with low temperature of water, to end the procedure by general massage.
12. To take according to the doctor‘s recommendation:
    - Vitamins according to the season
    - According to the condition and in the event of emotional load – sedatives in the form of valerian, small tranquilizers; for 1 or 2 days in succession at most, before going to bed Valocordin or Corvalolum 25 drops per one intake
    - Vascular protectors and antisclerotics, nootropics once or twice in a year
    - Diet poor in proteins, fats and carbohydrates

Zusammenfassung

Entsprechend des Hauptthemas “Multidisziplinäre Ansätze in der Behandlung psychischer Störungen”, untersuchten wir biopsychosoziale Faktoren, im Besonderen Mikro- und Makroebenen ungünstiger sozialer Umweltbedingungen der Patienten, um die Ursache für nervöse und psychische Erschöpfung festzustellen.

Wir untersuchten Fallstudien von 149 Patienten. Im Zuge der Untersuchung und Behandlung benutzen wir moderne Methoden, die unüblich für bisherige psychodynamisches Methoden waren, einschließlich Psy-

chotherapie, Physiotherapie, natürliche Faktoren und neuere psychotrope Medikamente. Die Behandlung fand in Zusammenarbeit der führenden Neurosekliniken in St. Petersburg statt. Die Effektivität und Vorteile der Behandlung wurde mit objektiven Methoden erfasst und die Patienten waren nach ihrer Entlassung für zwei bis drei Jahre unter Supervision.

Die Patienten waren zum Großteil zwischen 35 und 50 Jahre alt, zumeist Ingenieure, Studenten, bzw. Akademiker und sie wurden zwei bis drei Jahre lang bis zur vollständigen Heilung begleitet. 16 % der Patienten benötigten eine Nachsorge über vier bis fünf Jahre. Die vorherrschenden Störungsbilder umfassten u. a. Nervenschwäche (28 %), Erschöpfungssyndrom mit vegetativer, vaskulärer Schwäche (14 %), Körperschwäche mit Depression (17 %), emotionale Instabilität (7 %), paranoide Charakterzüge (3 %) sowie Angststörungen, Verfolgungswahn und hypochondrisches Wesen (6 %).

Es wurde ein direkter Zusammenhang zwischen der Stärke der somatischen Symptome, die mit dem Erschöpfungssyndrom einhergehen und der Veränderung des nervösen Status aufgedeckt, was die psychosomatische Natur des Syndroms unterstreicht. Faktoren, die das Syndrom begünstigen bzw. herbeiführen sind die Arbeitsbedingungen, Überstunden oder zusätzliche Nachtschichten, um ein höheres Einkommen zu erreichen. Darüber hinaus führen maladaptive Familiensysteme oder die Versorgung stark erkrankter Familienmitglieder zu Erschöpfung; auch die Unterbringung spielt eine wichtige Rolle, entweder weil die jeweiligen Wohnungen weit vom Arbeitsplatz entfernt sind oder sich Zimmer mit mehreren Kollegen geteilt wird. Zuletzt stellen die Autoren der Studie heraus, dass Alkoholkonsum ebenfalls das Erschöpfungssyndrom hervorruft.

Die Therapie zielte in erster Linie darauf ab, die das Syndrom aufrechterhaltenden Faktoren zu behandeln, um die Belastung der Patienten abzumildern und eine Heilung zu ermöglichen. Zur Behandlung kamen psychotherapeutische Verfahren nach M. Ammon, systemische Vitamine (bspw. Vitamin B-Komplex), Physiotherapie, Akkupunktur und individuell verschriebene Anxiolytika oder Neuroleptika (bspw. Risolept, Olanzapin). Nach der Entlassung aus der Klinik wurden weiterhin Beruhigungsmittel verabreicht. Die durchschnittliche Aufenthaltszeit in der jeweiligen Klinik betrug 21 Tage. Das Therapieprogramm umfasste in dieser Zeit für die Patienten folgende Empfehlungen:

1. Den eigenen Lebensbereich und das Lebensumfeld im Sinne einer guten Psychohygiene zu gestalten
2. Mahlzeiten zu festen Zeiten; symbolische Mahlzeiten (Obst, Gemüse, Kefir) um 11.00 Uhr, 17.00 Uhr und 22.00 Uhr
3. Körperliche Aktivität, bspw. bis zu 10 km am Tag gehen
4. Eine halbe Stunde vor dem Zubettgehen: Massage des Nacken- und Schulterbereichs
5. Autogenes Training, auch vor dem Zubettgehen
6. Aufstehen und Zubettgehen immer zur gleichen Zeit
7. Sich bemühen, Interesse für Neues im jeweiligen Beruf, der Gesellschaft und der Kultur zu entwickeln
8. Sich modebewusst kleiden
9. Hobbys etablieren, die den eigenen Interessen und Stärken entsprechen
10. Harmonische Beziehungen in der Familie kultivieren
11. Sofern keine Kontraindikation vorliegt, wird empfohlen, einmal im Monat die Sauna zu besuchen
12. Entsprechend der Verschreibung durch den Doktor:

- Vitamine abhängig von der Jahreszeit
- Abhängig vom persönlichen Zustand und im Falle hoher emotionaler Anspannung: Sedativa in Form von Baldrian oder kleinen Beruhigungsmitteln; für ein bis maximal zwei aufeinanderfolgende Tage kann Valocordin oder Corvalolum vor dem Zubettgehen genommen werden; Dosis: 25 Tropfen pro Einnahme
- Protein-, fett- und kalorienarme Ernährung

Aus den Ergebnissen der Untersuchung schließen wir, dass es für die Prävention und Behandlung von nervösen Erschöpfungszuständen essenziell ist, die Lebensbedingungen zu verbessern und die o.g. Empfehlungen zu berücksichtigen.

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INDIGO-Studie – Internationale Studie zu den Folgen von Diskriminierung und Stigma psychisch erkrankter Menschen in ihrem Alltag

Petra Decker (München)

Fighting against Stigma and Discrimination supports earlier treatment of mental disorders, and therefore, supports a better ethiopathology, avoids social marginalisation, and try to ameliorate material poverty. In the INDIGO-Study (International Study of discrimination and Stigma Outcomes) participants were asked in a cross-sectional design by face-to-face-interviews between staff and people with the diagnosis of schizophrenia about their experience of stigmatisation and discrimination in their daily life at one point in time. A questionaire, the Discrimination and Stigma Scale (DISC), was developed and all included 732 people with a clinical diagnosis of schizophrenia in 28 countries participated. Here I will also mention some results from the Munich Center in Germany.

Keywords: Stigmatisation, Discrimination, Schizophrenia, Antistigma-Intervention

Der Mensch, auch der so genannte Geisteskranke, ist keine lebendige Maschine, deren Funktion mit Befriedigung von Essen und Trinken und kahler mechanischer Arbeit abgetan wäre; er hat Sinne, er hat Interessen, er hat ein Herz.“

Wilhelm Griesinger (1817–1868), deutscher Psychiater und Internist

Definition

Das erste wissenschaftliche Werk im Bereich der „Stigma“-Forschung wurde 1963 von Goffmann veröffentlicht: „Stigma: notes on the management of spoiled identity.“ Ein Stigma ist ein Zeichen, ein Mal oder eine Etikette, die eine bestimmte Person von anderen abgrenzt oder ihr negative Eigenschaften zuschreibt, wie z. B. das Etikett „psychisch krank“ oder „Psychiatriepatient“ (Link und Phelan 1999). Dieser Mensch wird auf ein negatives Stereotyp des oder der psychisch Kranken reduziert. Es findet eine Trennung zwischen Kranken und Gesunden statt, nach dem Muster „die und wir“: Die Kranken sind vollkommen anders als die Nichtkranken. Im weiteren Verlauf kommt es zu Marginalisierung, Ausgrenzung, Diskriminierung psychisch erkrankter Mitmenschen. Die

Folgen sind Statusverlust und sozialer Abstieg, die sich an einem kleinen sozialen Netzwerk, einem hohen Arbeitslosigkeitsrisiko, finanziellen Nöten und möglichem Wohnungsverlust zeigen (Ruesch 2005).

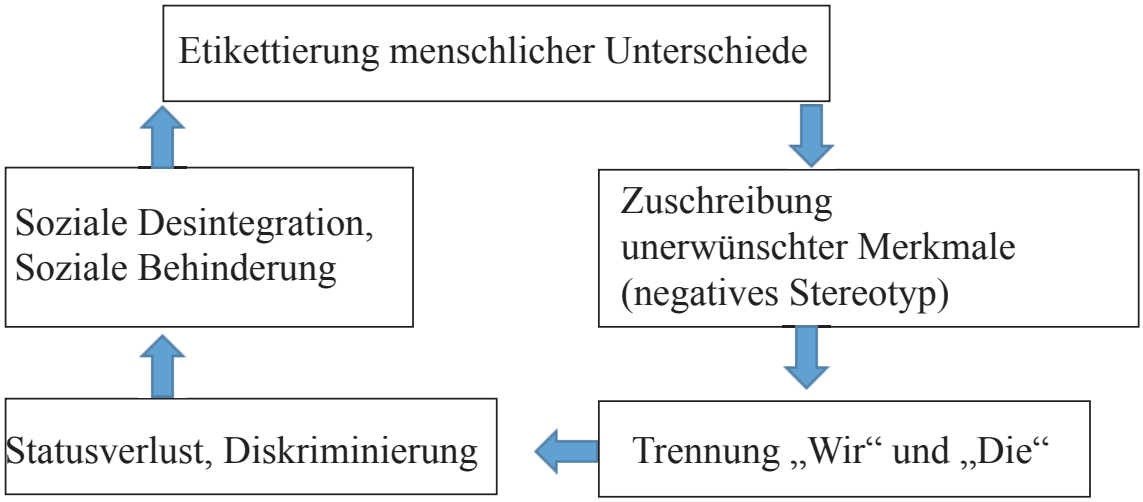


Abb. 1: Ursprung und Folgen von Stigmatisierung und Diskriminierung (angelehnt an Ruesch 2005, S. 197)

Das Stigma psychischer Erkrankungen

Häufig werden schizophren Erkrankte als unberechenbar und gefährlich angesehen. An Depressionen Erkrankte gelten vielen als willensschwach und disziplinlos, Suchtkranke oft als selbst und schuldhaft verantwortlich für ihre Erkrankung. Dies führt bei den Betroffenen zum Verlust des Selbstwertgefühls, dem Verbergen der Erkrankung, sozialem Rückzug, erschwertem Zugang zu Arbeits- und Wohnmöglichkeiten und verminderter Lebensqualität. Der Krankheitsverlauf wird beeinträchtigt auf Grund von verzögertem Hilfesuchverhalten und geringerer Therapiecompliance.

Ausbreitungstendenz des Stigmas

Von Stigma betroffen sind neben den psychisch Erkrankten auch:

- Angehörige (z. B. Partner, Eltern, Kinder und Geschwister)
- Personen, die beruflich eng mit psychisch Erkrankten zu tun haben (z. B. Ärzte, Pflegekräfte, Therapeuten)
- Behandlungsinstitutionen (z. B. Kliniken, Ambulanzen, Tagesstätten)
- Behandlungsmethoden (z. B. Psychopharmaka)

Maßnahmen gegen Stigmatisierung und Diskriminierung weltweit

Aufklärung: Verbesserung von Wissen, Einstellung und Verhalten in verschiedenen Zielgruppen (z. B. der Allgemeinbevölkerung bei Schülern, in relevanten Berufsgruppen).
Kontakte zwischen psychisch Erkrankten und nicht Erkrankten reduzieren Vorurteile und „normalisieren" psychische Erkrankungen.
Proteste gegen unkorrekte und diffamierende Darstellungen psychisch Erkrankter in den Medien.
Versorgung: Der Ausbau und die Optimierung der Behandlung und Versorgung psychisch Erkrankter als primäre Präventionsstrategie.

Wichtige Antistigma-Programme:

- Das Programm der „World Psychiatric Association" (WPA): „Fighting against Stigma and Discrimination because of Schizophrenia" – Open the Doors" (seit 1998).
- Das Programm der Weltgesundheitsorganisation (WHO): „mhGAP – mental health Global Action Programme – Stop Exclusion – Dare to Care" (seit 2001).
- Die Programme des „Royal College of Psychiatrists: Changing Minds/Every Family in the Land" (seit 1998) und „NIMH England: SHIFT-Initiative".

Wichtige Aktivitäten gegen Stigmatisierung und Diskriminierung in Deutschland: „Open the Doors"-Deutschland

Diese Aktivitäten umfassen Interventionen zum Abbau von Stigmatisierung und Diskriminierung, eine Verbesserung des Wissens über die Schizophrenie sowie eine Verringerung negativer Stereotype und sozialer Distanz, die von sieben lokalen Projektzentren deutschlandweit durchgeführt wurden:

„ASAM" (Anti-Stigma-Aktion München), „BASTA" (Bayerische Anti-Stigma-Aktion, München), „Open the Doors" Düsseldorf, „Irrsinnig Menschlich e. V." Leipzig, „Irre Menschlich Hamburg" und „Open the Doors" in Itzehoe und in Kiel.

Inhaltlich wurden folgende Interventionen durchgeführt (Gaebel et al. 2007):

- Zielgruppenorientierte Veranstaltungen (z. B. in Schulen, mit Polizeischülern, Pflegekräften oder Journalisten)
- Öffentliche Veranstaltungen (Kino, Theater, Ausstellungen, Lesungen)
- Verleihung eines Anti-Stigma-Sonderpreises sowie des Lilly Schizophrenia Award „Innovative Konzepte für neue Perspektiven" 2002 in Kooperation mit der Deutschen Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde (DGPPN) in Berlin
- Stigma-Alarm-Netzwerke (SANE): Interventionen gegen konkrete Diskriminierungsfälle

Die INDIGO-Studie, Stichprobe aus dem Münchner Zentrum (Psychiatrische Klinik der Ludwig-Maximilians-Universität) und die Stichprobe weltweit

Fragestellung:

Welche Erfahrungen machen Patienten aufgrund ihrer Diagnose einer psychischen Erkrankung und haben sie das Gefühl, aufgrund ihrer Diagnose anders als andere Menschen behandelt worden zu sein?

Vorgehen:

Durchführung standardisierter persönlicher Interviews von geschultem Personal – Mitgliedern des „Globalen Programms gegen Stigmatisierung und Diskriminierung aufgrund schizophrener Erkrankung" der WPA. An der Psychiatrischen Klinik der LMU wurden 26 Patienten interviewt, davon waren 22 Patienten stationär und 4 Patienten in deren Tagesklinik. Der Fragebogen „DISC-10" besteht aus 41 Items, unterteilt in 16 Unterskalen, jede betrifft einen anderen Bereich des Lebens, z. B. Arbeit oder Familie. 32 Items (13 Unterskalen) werden mit einer 7-stufigen Likert-Ratingskala von +3 „starker Vorteil" bis –3 „starker Nachteil" abgefragt. Die verbleibenden 9 Items (3 Unterskalen) werden mit einer Likert-Ratingskala von 0 „überhaupt nicht" bis 2 „sehr viel" befragt. Es wurden drei Subskalen errechnet: ein Gesamtscore für „positiv erlebte Diskriminierung", ein Gesamtscore für „negativ erlebte Diskriminierung" und ein Gesamtscore für „erwartete Diskriminierung aufgrund der Erkrankung Schizophrenie". Die quantitative Analyse wurde mit MS Excel, SPSS und/oder STATA berechnet. Für die qualitative Analyse wurden die Interviews von der eng-

lischen Sprache in die jeweilige lokale Sprache vor- und rückübersetzt (Thornicroft et al. 2006, 2009).

Patientenstichprobe, Zentrum München:
Alter: 20 – 59 Jahre (MW 34,8; SD 11,9)
Geschlecht: w 9 (34,6 %)
m 17(65,4 %)
Dauer seit Erstkontakt mit psychiatrischen Einrichtungen (Patienten, die einige Tage bis insges. 22 Jahre in psychiatrischen Einrichtungen waren):
0 – 22 Jahre (MW 8,2; SD 6,6)
Diagnose: ICD-10 Codes:
F 20.0: 21 PatientInnen
F 20.1: 5 PatientInnen
Alle Patienten kannten ihre Diagnose, 24 von 26 PatientInnen waren mit ihrer Diagnose einverstanden.

Tab 1: Erlebte Diskriminierung schizophren Erkrankter im öffentlichen Leben und in ihrem sozialen/privaten Leben, Stichprobe Zentrum München

Öffentliches Leben	**Nachteile in %**	**Kein Unterschied in %**	**Soziales/ Privates Leben**	**Nachteile in %**	**Kein Unterschied in %**	**Vorteile in %**
In ihrer Ausbildung	23 %	30,8 %	Eingehen und Aufrechterhalten von Freundschaften	20,9 %	50,0 %	–
Bei der Arbeitssuche	19,2 %	42,3 %	Beziehungen zu Ihren Nachbarn	15,4 %	65,4 %	–
Beim Erhalt eines Arbeitsplatzes	15,3 %	46,2 %	Intimen oder sexuellen Beziehungen	15,3 %	61,5 %	–
Bei der Eröffnung eines Bankkontos	7,6 %	50,0 %	Bei Verabredungen	19,2 %	61,5 %	–
Beim Abschluss einer Versicherung	7,7 %	42,3 %	Von Ihrer Familie	34,6 %	19,2 %	46,1 %
Nutzung öffentl. Verkehrsmittel	15,4 %	76,9 %	–	–	–	–

Patientenstichprobe weltweit:
Alter: 16 – 76 Jahre (MW 39,20; SD 11,32)
Geschlecht: w 279 (38 %)
m 453 (62 %)
Dauer seit Erstkontakt mit psychiatrischen Einrichtungen:
0-15 Jahre (MW 14,28; SD 9,63)
Diagnose: ICD-10 Codes:
F 20
83 % Patienten kannten ihre Diagnose, 59 % waren mit der Diagnose einverstanden, 14 % waren nicht mit der Diagnose einverstanden, 7 % waren ambivalent.

Tab. 2: Erlebte Diskriminierung schizophren Erkrankter im öffentlichen Leben und in ihrem sozialen/privaten Leben, Stichprobe weltweit (Daten aus der Interimreportanalyse des DISC-10, 2006)

Öffentliches Leben	**Nachteile in %**	**Kein Unterschied in %**	**Soziales/ Privates Leben**	**Nachteile in %**	**Kein Unterschied in %**	**Vorteile in %**
In ihrer Ausbildung	32,0 %	53,0 %	Eingehen und Aufrechterhalten von Freundschaften	49,0 %	44,0 %	–
Bei der Arbeitssuche	41,0 %	50,0 %	Beziehungen zu Ihren Nachbarn	33,0 %	60,0 %	–
Beim Erhalt eines Arbeitsplatzes	42,0 %	49,0 %	Intimen oder sexuellen Beziehungen	49,0 %	44,0 %	–
Bei der Eröffnung eines Bankkontos	–	90,0 %	Bei Verabredungen	33,0%	60,0 %	–
Beim Abschluss einer Versicherung	–	89,0 %	Von Ihrer Familie	44,0 %	32,0 %	24,0 %
Nutzung öffentl. Verkehrsmittel	–	82,0 %	–	–	–	–

Öffentliches Leben (Tab. 1 und Tab. 2):

1. Sind Sie aufgrund Ihrer Diagnose einer psychischen Erkrankung während „ihrer Ausbildung“ anders als andere Menschen behandelt worden?
   23 % der PatientInnen hatten Nachteile, 30,8 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 32 % der PatientInnen hatten Nachteile, 53 % empfanden keinen Unterschied.)
2. … bei der Arbeitssuche…
   19,2 % der PatientInnen hatten Nachteile, 42,3 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 41 % hatten Nachteile, 50 % empfanden keinen Unterschied.)
3. … beim Erhalt ihres Arbeitsplatzes…
   15,3 % der PatientInnen hatten Nachteile, 46,2 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 42 % der PatientInnen hatten Nachteile, 49 % empfanden keinen Unterschied.)
4. … beim Eröffnen eines Bankkontos…
   7,6 % der PatientInnen hatten Nachteile, 50 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 90 % empfanden keinen Unterschied.)
5. … beim Abschluss einer Versicherung…
   7,7 % der PatientInnen hatten Nachteile, 42,3 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 89 % empfanden keinen Unterschied.)
6. … bei der Nutzung öffentlicher Verkehrsmittel…
   15,4 % der PatientInnen hatten einen Nachteil, 76,9 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 82 % empfanden keinen Unterschied.)

Die Antworten des Zentrums München weisen darauf hin, dass weniger Patienten Nachteile in der Ausbildung, bei der Arbeitssuche und beim Erhalt ihres Arbeitsplatzes empfanden. Beim Abschluss einer Versicherung zeigte sich anhand der Antworten weltweit nahezu keine Diskriminierung, während nur nahezu die Hälfte der Patienten der Münchner Stichprobe keinen Unterschied feststellte. Bei der Nutzung öffentlicher Verkehrsmittel entsprechen sich die Antworten annähernd, beide Gruppen empfanden keinen Unterschied in der Behandlung ihnen gegenüber.

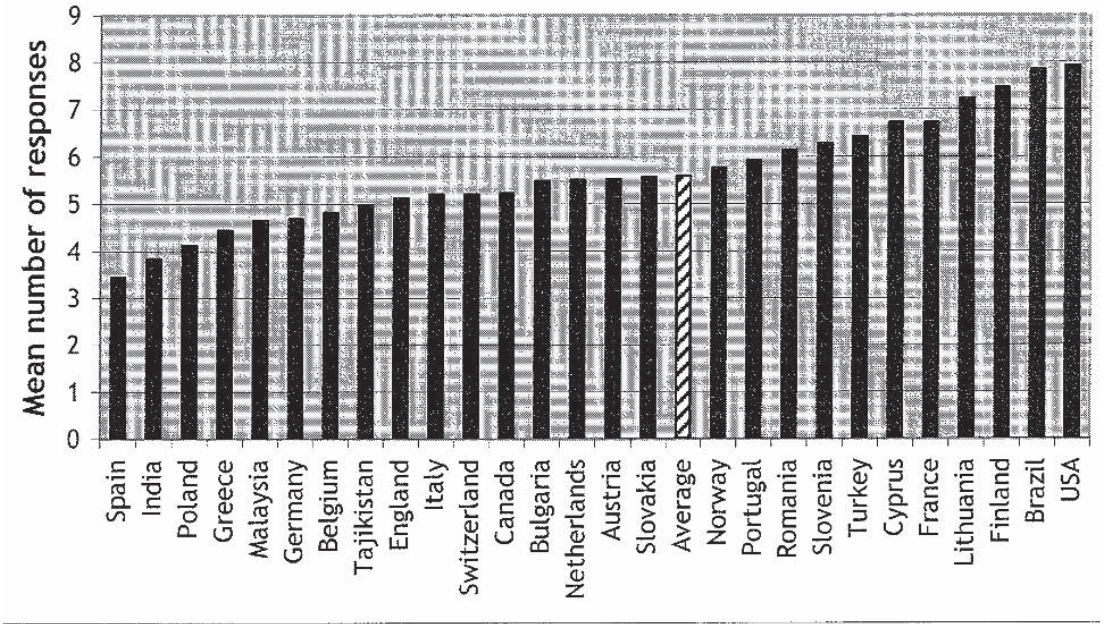
Soziales/Privates Leben (Tab. 1 und Tab. 2):

1. Sind Sie aufgrund Ihrer Diagnose einer psychischen Erkrankung beim „Eingehen oder Aufrechterhalten von Freundschaften“ anders als andere Menschen behandelt worden?
   20,9 % der PatientInnen hatten Nachteile, 50 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 49 % der PatientInnen hatten Nachteile, 44 % empfanden keinen Unterschied.)
2. …Beziehungen zu Ihren Nachbarn…
   15,4 % der PatientInnen hatten Nachteile, 65,4 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 33 % der PatientInnen hatten Nachteile, 60 % empfanden keinen Unterschied.)
3. …intimen oder sexuellen Beziehungen…
   15,3 % der PatientInnen hatten Nachteile, 61,5 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 49 % der PatientInnen hatten Nachteile, 44 % empfanden keinen Unterschied.)
4. …bei Verabredungen…
   19,2 % der PatientInnen hatten Nachteile, 61,5 % empfanden keinen Unterschied. (Im Vgl. die weltweite Stichprobe: 33 % der PatientInnen hatten Nachteile, 60 % empfanden keinen Unterschied.)
5. …von Ihrer Familie…
   34,6 % der PatientInnen hatten Nachteile, 19,2 % empfanden keinen Unterschied, aber 46,1 % hatten Vorteile (Im Vgl. die weltweite Stichprobe: 44 % hatten Nachteile, 32 % empfanden keinen Unterschied, 24 % hatten Vorteile.)

Die Münchner Gruppe empfand deutlich weniger Nachteile beim Eingehen und Aufrechterhalten von Freundschaften und in den Beziehungen zu ihren Nachbarn als die weltweite Gruppe. Ebenso verhält es sich in intimen oder sexuellen Beziehungen und bei Verabredungen. Man könnte interpretieren, dass die soziokulturellen Unterschiede einen entscheidenden Einfluss auf die Ergebnisse der Antworten in der Gesamtstichprobe haben. Interessant ist das Antwortverhalten beider Gruppen in Bezug auf die Familie in Bezug auf den sekundären Krankheitsgewinn. Ein doppelt so hoher Prozentsatz der Münchner Gruppe meinte in der Familie Vorteile zu haben, während in der Gruppe der Gesamtstichprobe nur 24 % Vorteile empfanden. Vergleicht man das öffentliche Leben und das soziale/private Leben, könnte man interpretieren, dass je näher man sich

kommt, desto höher die Ablehnung werden kann. Insgesamt gesehen ergeben sich relativ hohe und stabile Werte erlebter Diskriminierung anhand des Antwortverhaltens der Patienten über alle beteiligten Länder hinweg.

Tab. 3: Negativ erfahrene Diskriminierung aufgrund der Erkrankung Schizophrenie

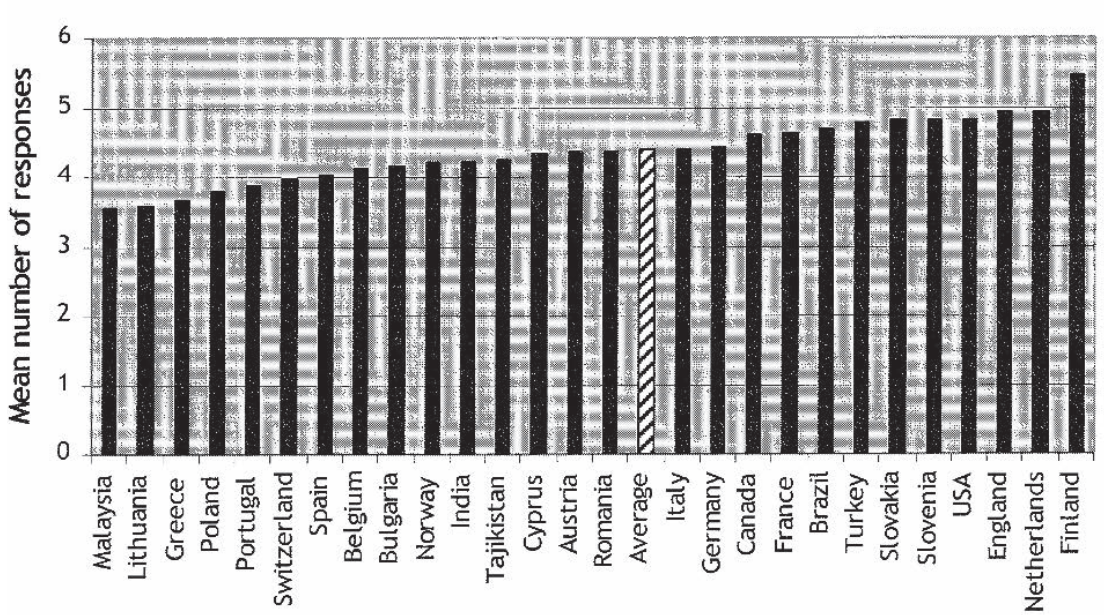


(Grafik aus: Global Pattern of Anticipated and Experienced Discrimination against People with Schizophrenia; Lancet. 2009 Jan 31; 373 (9661): 408-15. doi: 10.1016/S0140-6736(08)61817-6. Epub 2009 Jan 21.)

In Tab. 3 sind die negativ erfahrenen Diskriminierungen aufgrund der Erkrankung Schizophrenie anhand des Antwortverhaltens der Patienten im Durchschnitt aller beteiligten Länder dargestellt. Es wurden die Antwortkategorien von starker, mittlerer und leichter Diskriminierung zusammengefasst. In den USA, in Brasilien und in Finnland haben Patienten die meiste Diskriminierung erfahren, während sie am wenigsten in Spanien, in Indien und in Polen diskriminiert wurden. Im Mittel lag die Diskriminierung in den Ländern Norwegen, Portugal, Slowakei und Österreich.

Tab. 4 zeigt die erwartete Diskriminierung aufgrund der Erkrankung der Schizophrenie anhand des Antwortverhaltens der Patienten im Mittel aller beteiligten Länder. Die erwartete Diskriminierung war am höchsten in Finnland, den Niederlanden und in England. Am geringsten war die erwartete Diskriminierung in Malaysia, in Litauen und in Griechenland.

Tab. 4: Erwartete Diskriminierung aufgrund der Erkrankung Schizophrenie



(Grafik aus: Global Pattern of Anticipated and Experienced Discrimination against People with Schizophrenia; Lancet. 2009 Jan 31; 373(9661): 408-15. doi: 10.1016/S0140-6736(08)61817-6. Epub 2009 Jan 21.)

In Italien, Deutschland, Rumänien und Österreich lag die erwartete Diskriminierung im Mittel.

Als Fazit kann man anmerken, dass sich die erfahrene und die erwartete Diskriminierung anhand des Antwortverhaltens der Patienten mit der Erkrankung Schizophrenie mehr oder weniger stark ausgeprägt in allen beteiligten Ländern zeigte.

Summary and future perspectives

According to Günter Ammons 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, foreword of the Program from Prof. Maria Ammon, p. 5). Until now no satisfying investigations in this field of research exists. As I mentioned in the beginning, Stigma and discrimination leads to under-treatment, delayed treatment, extended treatment, thus to poor prediction and higher costs in our mental health care system. Our task as people, working in the health care system for human beings is, to care for them patient-centered

with the recent standard in science, research and technic. Essentially therefore is also the generous financial support from Governments and others.

Every day we should reflect our actions ethically and think about the consequences Diagnosis will have for the people and for their families in their environment, especially the Diagnosis F 20 (Ruesch 2005, S. 205). Meanwhile there existing nationwide and worldwide „Early Intervention Centers for Psychosis", open to everybody getting informed at an early stage and an early treatment (Häfner et al. 2012, Koutsouleris et al. 2012, Kommescher et al. 2014). Till this day Schizophrenia is stigmatized with the most discrimination but it is not the only illness, mentally or physically. In 2012 there was a recent survey with the questionnaire DISC-12 – Discrimination against people with Depression (Laslavia et al., 2012). In 2014 a recent 5-year-research-project will start worldwide, supported from the „National Institute of Mental Health" (NIMH). There are two research subjects: One will be in the area of AIDS-research – Stigmatisation and Discrimination against HIV-associated Stigma, field related high-risk-persons, discrimination against racial and ethnic groups. Another subject will be Stigmatisation, Depression and suicidal tendency. Especially low and middle income countries will be supported financially, because in these countries the mental health care system and supply is a misery.

All in all, I am very thankful that I have been working within these projects to try to get better conditions for mentally ill people. No matter in which position we are, at least these are projects from people for people – from heart to heart.

Anmerkung:

Die INDIGO-Studie wurde im Rahmen des „WPA Global Programme to Fight Stigma and discrimination because of Schizophrenia" durchgeführt, bestätigt durch das „Ethical Comitee of the Institute of Psychiatry, South London" und „Maudsley NHS Trust (reference 039/04)". Studienkoordinator: Professor G. Thornicroft, King's College London, E-Mail: g.thornicroft@iop.kcl.ac.uk in Zusammenarbeit mit: Professor N. Sartorius, Wissenschaftlicher Direktor, E-Mail: sartorius@normansartorius.com und Dr. D. Rose, Kings's College London.

Es besteht kein Interessenkonflikt. Aus Platzgründen können hier nicht alle Teilnehmer der „INDIGO“-Studie aufgeführt werden. Diese sind genannt in der Veröffentlichung von Prof. G. Thornicroft in „The Lancet“ von 2009.

Die „Open-the-Doors”-Projekte sind Teil des „German Research Networks on Schizophrenia“ (GRNS) (www.kompetenznetz-schizophrenie.de), unterstützt vom Bundesministerium für Bildung und Forschung (Grant Nr. 01 GI 9932).

Special cordial thanks to Prof. Shridhar Sharma and his global view of 50 years in Psychiatry in my workshop on the WADP, it was like the Holi festival in India – colourful, joyful and fruitful.

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The affective Dynamics in the work and thought of Alexander Sergeyevich Pushkin

Andrea Galgano (Prato-Florence, Italy)

Alexander Sergeyevich Pushkin (1799-1837) went through the harmony and its bound exclusion. The analysis of his affective dynamics allows to see his hidden liberty, his connection with the historical events and the destinies of his time. He feels the strength of the contradiction and the inexhausted dialogue with the vertex of the freedom, which passes through every aspect of his literary output. Even his family life felt this strong tension. The drama of his injury, the fatality and the end pervade his lyrics, where the lost youth and the yearning are perceived in the vitality of myth and reality that merge.

Alexander Sergeyevich Pushkin (1799-1837) is the poet of harmony and its forced deprivation, such as correspondence of cosmic forces and order of universal life. In the analysis of his affectivity flows his secret freedom, his integral attachment with the historical events and the destinies of his time[1].

The art of Pushkin feels the weight of the art's contradiction and its never-ending dialogue with the vertex of the freedom. It has gone through the literary and lively drama, as evidenced by the lyric, the tragedy, the prose and the history of criticism. Even his family life shows a wound and an icy breath.

In this regard, so Pietro Citati writes:

I don't know what modern poet has scattered around him the charm, that Aleksandr Puškin radiated in the last years of life. Perhaps only the young Goethe and Baudelaire. When he walked on the Nevskij Prospect, had a bit threadbare tuba, and a long coat clothed with fur and marked by time: to the coat was always missing a button. He was no longer the tumultuos rebel of the youth. He had accepted the reality, the society, the family: even the tsar; and the Petersburg's society, worldly, frivolous, perfidous liked his wicked and percipient worldly spirit. He loved the dried music of gossip, the short sound of the gag, the ephemeral elegance of the dancings. Just him, the freer spirit of Nineteenth Century, had become a courtier-poet, like Ariosto and Tasso: was counselor and confidant of the tsar; he liked this part and humiliated him. Many witnesses portray him in court, or in the aristocratic salons of St. Petersburg. He loved good conversation: played with words, interlocked the laces of exquisite frivolity, he became inflamed: let his casual thought take his natural step: distracted, indifferent to the systems, in love with pointe and image. He was very elegant, whimsical, unpredictable:

his grace was established on mobility, the unconcern and, mainly, a conscious arrhythmia. […] All of sudden he becomes sad. The joy revelead a melancholy more and more grim and shadowy, and the passions and furies that at the first sight seemed incomprehensible. So no-one of the listeners followed him anymore. No one understood as Puškin could reach, in fury, a kind of cool detachment: no-one grabbed his demonic lightness, which led him beyond the world of the bodies – and the Emptiness, when he advanced, the dizzy void which was the only sovereign, and that allowed him to become all the gazes, all the places, all the parts, and where in the end he threatened to lose [2].

The inevitable fate is accompanied by the fatality dramatically lived, that hasn't only the tragic meaning, but tries always to chase the harmony and the balance point. Myth and reality that merge and end up to look the same.

The reflection on his literary component is inseparable from his biography, in his dream and detachment, lived under the power of the poetry, authority and everyday life, such as rightly Giovanna SPENDEL argues: „The Pushkin's biography is momentous for the understanding of his work and, conversely, there isn't a significant moment of the latter that it can't result in the name of a place or person, in a date, in a situation" [3].

Between the date of his birth (26 May 1799) and the date of his death (29 January 1837) he lives his troubled life, his poetry that covers all the literary genres, as his novel in verses, in which „flows a dense and varied list of passions; flows a long gambling with the autocratic power, in which the social image of the 'great poet' ends with the impoverishment, self-degrading day by day; flows, finally, in the rhythm more and more fast and unforgiving, a growing and personal sorrow, a kind of self-punishing fury, whose marriage with the beautiful and young Natal'ja Goncharova and the duel with her suitor seem accidental conclusions" [4]

The writer that represent Russia and its „russianness" brings his soul to the language, the feature and the landscape of his classical literature that coexist in a everlasting elusiveness.

A vitality that describes its images of women, love and its raptures, the Eternal Feminine and the Beauty. At sixteen, in an epitaph he had written: „Here Pushkin is buried with the young Muse / With love, with laziness He spent his merry life, / He didn't good, but in the soul, / Thank God, he was a good man", like a belonging that asks the Eternal, a passage that grazed his soul of a young eagle.

His dynamic affective is restless. All women touched, loved, or even

grazed receive his devoted footprint and his amazed torment, as evidenced Marina Cvetaeva, referring to the poem *To the sea*:

My sea – the pushkinian free element – was the sea of last time, of the last sight. For what reason I, still small child, so many times I wrote in my hand: Goodbye, free element!" – or even no reason at all: I, all the things of my life, fell in love with them, and then I love with the farewell, and not the meetings, but the yanks, not the fusion, not for life, but for the death. And, in a sense quite different, my encounter with the sea turned out to be just a farewell, a double farewell: a farewell to the sea free element that was not there in front of me and that I, turning my back to the real sea, recreate – white on gray – digit by digit – and say goodbye to the real sea that was in front of me and that I, because of that first sea, I couldn't love. And I will say more: the ignorance of my childhood, which identified the element with the verses, reveals a vision: the „free element" express itself with the verses, and not with the sea, with the verses, that is with the one element that you never say goodbye. [5]

A desolate secret remains in his work. Pushkin has known the loneliness and the exilem, the drama of the freedom and country, relived in the correspondence with the elements (sea, ship, exotic landscape, freedom) that, in some ways, bring close him to Byron, maintaining a classical dynamics of idea and thought, as argued by D. P. Mirskij[6].

In his poems establishes an internal lament, a voluptuous passion and the complete inner room: „Lida, my faithful friend, / Why do through the mild sleep / I often, exhausted by love, / feel your light lament? / Why, in the happy love / When I see a scary dream, / The still look, afraid / is fixed to the darkness? / Why, when I savour / the rapid swoon of ecstasy, / I watch sometimes / Your secret tears?" *(At a young widow)*.

When instead he describes „the genius of pure beauty", Anna Petrovna Kern, the pushkinian's soul stands in a visual wonder that, soon, leave enough time for the solitude and the storm, as if the sudden affective manifestation should embrace the solitary space that doesn't leave respite to the distances:

I remember the enchanted moment: / in front of me you are appeared, / Like a fugitive vision, / Like the genius of pure beauty. / In the anguishes of a desperate sadness, / In the mess of a noisy vanity / For a long time a tender voice resounded in me, / And I dreamed the dear features. / The years have passed. The rebel impetus of the storms / Disperses the dreams of the past, / And I forgot your tender voice, / Your heavenly features. / In the solitude, in a darkness of prison / my days dragged along quiet / Without a god, without inspiration, / No tears, no life, without love (A K***).

Then the return of the beloved image, though fleeting, brings a new thrill, full of an intense phenomenology, as Eridano Bazzareli says:

> This poem is perhaps exceptional for its infinite harmony: the 'lyrical hero' reviews after some time one who is 'the genius of the pure beauty'. The word 'genius' was, of course, in the style of the age, a 'neo-classical' word (but with some different shades, romantic). But let us take, in the despite of the crudeness of the translation, the shine of the great Pushkin's tenderness, the story of his 'desperate' sadness, the story of the memory of the 'tender voice', the desperation and the desert followed by the enthusiasms of the love of a time. And behold the reappearance of the genius of the pure beauty, with her celestial features, that the lyrical hero, in the storms of life had forgotten, that he had forgotten in the solitude of a 'jail', when he was without a god, inspiration, tears, life, love, so here is that the reappearance of the beautiful woman, like a 'fugitive vision', awakens the poet's heart, breathing life back into him, tears and love. […] And this lyrics 'summarizes', if we say that, throughout the Pushkin's existence, the movement of his life.[7]

The exaltation of the everyday life passes through the philosophical thought, the breath and shadows, makes to live his characters and „[…] the nature seen as a landscape, in the flow of the seasons, and also as a symbol of the man and the inexorable passage of time. It can bring almost all of the reasons that emerge in many poems: the aspiration to the freedom, the journey as a movement or as a search for a destination and a shelter, a desire for peace and serenity, the fragility of the beauty, the ends of the love" [8]: „Spring, spring, time of love / How it weighs on me when you arrive, / which languid ferment / In my soul, in my blood … / How to the heart is stranger to me the enjoyment … / all that celebrates and shines / for me is anxiety and tedium".

The hopeless vitality of his landscape is a moving nature, irresistible life, an existence that chases the seasons and their ambiguity, their tarnish or flourish, for the example, the snowstorm: „The snowstorm destroys the men's intentions and, as if it play, divides the ones, drags the other, creates new destinations. But in the end, albeit with a changed appearance of the characters, recovers that idyll wich tend the tales of the cycle" [9].

The snowstorm represent the symbol of an external force that conquers the scene where the characters live their theater (think of the encounter between the noble Grinev and the fugitive peasant Pugachev in *The Captain's Daughter* or in the story *The snowstorm*), comes in the dreams, establishes a strong connection with the death, weaves the plot of the vicissitudes, and as Irina Kolewa writes:

… assumes a compositional function, because the Grinev's life and his girlfriend Masha will be later in the hands of the rebels led by Pugachev; on the other hand, acquires an intense and symbolic post, representing the popular revolution. An unnamed farmer tumult suddenly degenerates into a fierce bloody civil war, which, like a snowstorm, drags into its destructive vortex the human lives.

The excruciating struggle looses the atrocity in both protagonists: the farmers decimate the nobility, for their part, for saving their own power, they act ruthlessy against the rebels. The Pushkin's tragic thought on the impossibile reconciliation between the adverse parties impinges upon overall problem of the work – the realationship between the social struggle and the ethical human criterion.[10]

Therefore, it takes on a last and decisive meaning, not only as a crucial scene, but as completed work, as a gash of characters's daily life, described in the historicity of the tale and in the literature that becomes history. The storm, then

… always dominates the will and the men's intentions. Of course, in the Pushkin's story also feels the echo of the romantic theme of the fate, expressed, perhaps, in a greater extent by the Austrian writer and playwright Franz Grillparzer. However, the theme of the fate, even thug dramatic, in Pushkin never acquires a tragic meaning, since it expresses harmony and balance – the essential features of his poetic world.[11]

The harmony and the balance follow a clear line of expression, human and poetic inebriation that touches the erotic vertigo („Ol'ga, Cipride's pupil / Ol'ga, prodigy of beauty, / as you're used / To effort caresses and insults! / With the kiss of the pleasure / you unsettle us the heart, / And a temptress happiness/ you tell us the secret hour / […] In the name of joyful deabuchery, / in the name of the troubles of Priapus, / In the name of the tenderness, in the name of gold / in the name of your charm, / Ol'ga, priestess of the pleasure, / Listen to our cry in love"), the death, the extreme beauty, the prophecy of a fles, the anacreontic[12] of light eroticism *(The Gabrieliad)*.

The synthesis of the real and literary knowledge blend her feminine figure in a single movement of vision and reality, merged into a only song of love, in any possible plating, in every light or bright light, but always fleeting: „I have loved you: the love again, maybe, / Not turned off completely in my soul; / But I don't want it there yet restless; / In no way I want to grieve. / I loved you silently, without hope, / Weighed down by the shy-

ness now, now by jealousy; / I loved so sincerely, so tenderly / May God grant you to be so loved by another one“ or like a flash of fleeting dream and unattainable beauty („As the horses hung up me, / took my mind and my heart / your gaze and your wild beauty“), even cursed doubt: „I curse the wicked labors / of my crime youth / and the expectations of agreed meetings / In the gardens, in the silence of the nights. / I curse the love's whisper of words, the mysterious melody of the verses, / and the caresses of foiled maidens, / and their tears and the late remorse“.

His kaleidoscope returns a sequence of snapshots: the representation of the scene gives, on one side, the lived life and, on the other side, the contradictions and the fractures of life itself. It's the art of the Harmony that holds together the freedom of the poetry and the prophecy in a universe of impressions and existential frameworks which tend to the Unity.

In his mythical and epic experience there are choral elements, a signification in a combination of lights and shadows, as it happens in *The Queen of Spades*:

> In the fantastic literary Pushkin, like most of the writers of his time, always explains everything with realistic motivations. The German's final madness fits in the tradition of time which is considered as a kind of liberation from everyday life, a supreme state of freedom, and that is a constant element in the aesthetics of Romanticism: however, before he became mad, the Pushkin's hero stands out for a cold, thin and calculating intelligence.[13]

As the same German affirms, so „the game interests me greatly, but I'm not able to sacrifice the essential for the hope of buying the superflous“, and shortly after his author reveals: „He had strong passions and burning imagination; but the firmness saved him from the usual mistakes of the youth“.

The last chapter presents the light of the shadows. The reality finds its opposite and everything is mixed, as the Liza's despair and disappointment and the German's madness, in fact.

Spendel still comments:

> The appearance of the phantom assumes a fantastic and realistic motivation at the same time because the cards named by the deceased countess would later lead to the win. Right in the constant oscillation between the real and the fantastic element and in the veiled remarks about reality, all the Pushkin's irony hide itself.

However, it's through the concision and the sobriety of the phrase that Pushkin tries to build that „metaphysics language" that only knows how to make the richness of life.[14]

The Pushkin's ego lives the eternal struggle between the enchantment of the freedom and the opposing force of the power and subjugation, in that space forwards his gaze to the perspective view of the world, open to the Infinite, but always ready for a retreat and an acceptance: „And I will be dear to the people because / noble sentiments I awoke with my lyre, / and in cruel century I sang the freedom / and I grant grace for the fallen. / At the God's command remain mild, Muse, / without fear of offense or asking the crown, / indifferent accept the slander and the praise, / and with the fool don't contend".

The sacredness wraps his poetry, as a mystical beauty, and thrusts to Eternal Feminine, only cosmic principle trascendent[15]: „My wishes are realized. The Creator / has sent you to me, you, my Lady, / the purest image of the purer enchantment".

In *The Bronze Horseman*, his unpublished work in life and perfect metaphor of the power, there is the gigantic struggle between the employee Eugene and the emperor's power, symbolized by the equestrian statue of St. Petersburg, the bronze horseman.

The tsar moves the capital from Moscow to St. Petersburg, forcing to a human work thousands of men and even the inhabitants themselves having to deal, for the confluence of the city with the river Neva, each type of flooding.

The architectural magnificence of the city, given in the preface, is swept away by the story that presents its unexpected.

Gianfranco Lauretano comments:

In this struggle the person, for Pushkin, is crushed and destroyed. The neoclassical and romantic, byronic and shakespearian Pushkin, that poetically clings to the individual forces and the nature, has a tragic vision of the destiny of the person in front of the violent and gigantic will of the power. […] There is a specific point in the poem which begins the Evgenij's misfortune: when he begins to make plans, to settle his future and his girlfriend. Note that's the only point in which Puskin allows the protagonist and from there begins his tragedy. When do the person is defeat? When it looks like the power. When one pretends to cage the life and outline the time. And in doing states, such as the power, his self-sufficiency and self-reference. The faith of Evgenij in its forces and its capacities is

at once swept away by the flood and he dies. The power made him presumptuous and, intrinsically, alone in front of the unexpected. The relationship that develops between the bronze statue of Peter the Great and Evgenij now crazy is gothic and monstrous, is a non-relationship between the two solitudes, two self-references that the mystery of natural events destroys.

The power, according to Pushkin, finishes off making us to drive out our fate with our own lonely and loser strength.[16]

Pushkin crosses the Beauty's domain, encroaching on the territory of the Muses. In this exaltation and supreme manifestation of the World Soul, vibrates all his personal tension, as a mythopoeic vocation.

The dear image of Natalia Goncharova, wife and companion, is his tumult of broken ecstasies. Remains the beauty that outlives death and the ecstasy.

His poetic imagos chases the prophetic and biblical dream *(The prophet)* and the Beauty until the ends, the freedom of an endless tension and the belonging to the homeland.

The light becomes wonder, flame, burning pain, broken consciousness.

The introspection, the memory, the infinite reflection of the vanity of the life plumb his meditation, such as regret and mystery of a sweet sudden sadness: „Through the rolling mists / the moon shines, / On the sad glades / It pours sadly the light. / On the winter road, boring / Runs the bold trojka, / The bell from the monotonous sound / Echoes grueling" or Elegy, which combines the classical chastity of the regrets of days gone to the desire to live, to love, to achieve.

The Pushkin's landscape counts its hours, establishes a holy and ineffable natural relationship, steals the versatile russian soul and its cities (central Russia, St. Petersburg, but also the Caucasus, Crimea and Georgia) and paints the smell of its mysterious singing.[17]

The pushkinian restlessness *(toska)* comes from a greek ideal, develops its spleen *(chandra)* in a view of loss and regret but without annihilation.

The wonder gets out the way to a fire within, as if the anxiety, the singing, the shadowy soul must stick out and try a sweet space, which remains clouded and lost, and the same harmony, the same measure which define the existence remain between shade and pictorial delicacy.

Then a new route, most painful, leave its omen. „In the song of the postilion / there is something familiar: / now the glee that glows, / now the pain in the heart…/ Boredom, sadness … but Tomorrow, Nina, / tomorrow I'll be with you, / I will not stop more than look at you, / near the fireplace

I'll forget everything", so all the time is consumed in the fog: „Then the hour hand / will end on his lap, / and turned away the importunates / the midnight will unite us. / Sad and joyful, Nina, is the way / the postilion was asleep, / the bell is a dirge, / the face of the moon becomes fogged".

As well as the heroic virtues of women (*The prisoner of the Caucasus)* reaches the acme of an extreme elevation without savings, until the price of the life. Indeed, it's in the ultimate gesture that the existence becomes clear and decided.

The Pushkin's heroic drama is a drama of freedom „between the libertarian (in fact quite moderate) and the Russian nobleman of ancient family, proud of the successes of the homeland and the dynasty, is perhaps the secret of the Pushkin's life, the key of many his attitudes, often very contradictory."[18]

The *Eugene Onegin*, a novel in verses that keeps him occupied from 1824 until 1830-31, as well as being a sort of encyclopedia of Russian life, contains the vital experience of the poet, sums up his hopes and disappointments, carries out his diary:

„Eugene is a free character, independent also from Pushkin, with whom he shared a number of attitudes, idiosyncrasies, vices, ideals. Puskin e Onegin are children of the same age, the same civilization, the same social and cultural group, the cultured nobility and its way of seeing themselves and other classes. […] The poem finds its more subtle expression in an admirable balance between the subjective force and its poetic objectification, its yield in words and syllables, none of which go around in circles."[19]

Venceslao Ivanov writes:

> The poet isn't confined to drawing features and to narrate the lives of individual characters against the backdrop of Russia painted on a large scale, with its still people and its upper class vaguely restless with its landscapes and customs, with its great and small world, with is hierarchical traditions and its lust for foreign west ideas and fashions, but he does something more, in other words tracks down (which is a task reserve for the novel and feasible only part of it) the development of the characters, their slow formation through the successive inner events and some crisis of the soul that they transfigured it.[20]

Tatiana e Onegin live their flow of the season, reflect the conflicts, the feelings and vitality of the characters. Eugene Onegin is a dandy who has lost his wealth, but finds themselves thanks to the inherited fortunes from

an uncle. Having to live for some time in the country, he knows the poet Lenskij, becomes his friend and he introduced him to the Larin's family. The Larin's eldest daughter, Tatiana falls in love with Onegin at first sight, who she will write a extreme and inflamed letter, but he initially refuses her.

Soon after, Lenskij insists because his friend assist at a dance for Tatiana's name day. Bored, Onegin decides to take revenge, seducing Olga, Lenskij's fiancee who is in the game. Feeling betrayed, the poet challenges him to a duel at dawn the next day. Onegin kills him and is forced to leave the city.

A few years later, he goes on the road and returns to Moscow, finds Tatiana, married to a prince and immersed in high society.

He realized the mistake before and its rejection: she prefers to remain faithful to her husband, but in the secret the wonderful flame of her love is alive.

The St. Petersburg's [21] and Moscow cultural world is represented in all its fluidity: Onegin is the extraordinary emblem that escapes to the understanding of his time, put himself into the anguish, his friend Lenskij escapes the mystique elegy of his fantasy, Tatiana marries a general who wants to remain faithful, in her Dostoevskij in his *Speech about Pushkin* makes it the traditional virtues of the Russian woman, faithful to her husband and the religion and to which the poet has a special tenderness, gives her a sweet aura of dream, keeping his wound not closed: „The Onegin's conclusion is the anxiety, the sadness and restlessness, which push him without peace, causing him a number of failures, in starting with what the story, the failure of his meeting with Tatiana" [22].

Onegin knows the fracture of the boredom and an invisible desire, as if the consciusness of a mature step is a farewell letter:

> Beautiful are you, Tauride's banks, when I see you from the ship in the light of the morning Aphrodite, as I past the first time here; and you appeared to me like the splendor of the weddings; under the blue and bright sky shone your mountains; the embroidery of the valleys, the trees, the villages lays before me. And there among the Tartars's huts… which flame awoke in me, of which enchanted melancholy tightened my burning heart! But forget the past, Muse!

Franco Cordelli writes:

„Essentially Eugene is a dandy, indie a real libertine. He can't love. He refuses. Tatjana is there, but he goes away. Then he prefers Olga, who judges less demanding. What can do Lenskij if not challenge to a duel that irresistable youth, that overwhelming nature that Onegin embodies? They are the Puskin's two souls. The Onegin's swagger soul can accept the challenge and that plagued by the idea of the Lenskij's honor, faithful to the supreme idea, can only fall on the ground (like seven years after he finished the poem will happen to Puskin, whom he suspected of being betrayed by his wife Natal'ja and conceited d'Anthes). When Evgenij will decide for Tatjana, will be too late. The verses of the poem perhaps most beautiful are in the last song: the XXVIII and XLI, the two Tatjana's metaporphoses – still loving Evgenij, but now married – she will refused him. There isn't alternative, Puskin tells us: the metaphor (the metamorphosis), indie, the Romanticism, excruciates; and the letter, the catching seriously, indie the Realism, kills." [23]

The Onegin's melancholy expands his feeling („suffering egoist" Belinskij called him[24]), it's ultimately the collapse of the youth after the Napoleonic exaltation.

The character here doesn't coincide with its author but it has similar traits, an objective identity, an incurable fever, the subtle magic of the hope that he would like to live.

The cheeky boredom is the disorder. He lives in the confusion of a disordered physiology, that represents the modernity of the man, his perennial and inexhaustible search for the meaning.

The Pushkin's poetry recreates the reality, belongs to the harmony of the mystery of the time, the secret freedom that allowes the geometry[25] of the poetic magma.

His vanished dream of freedom, the resignation of having to face the numerous enemies, by the Minister of Education Sergej Semjonovič Uvarov, up to court's society, jealous of his fame and greatness[26], the debts, the loan sharks, performer the fracture of the dream of forming a stable shelter: „For his general, the Puškin's ideology can be defined as a conservatism, but which joins a strong tension to free development of the culture, for an insured and political independence of the personality." [27]

Georges d'Anthès, who emigrated to France, claimed to be in love with Natalia, the poet's beloved wife:

A chilling series of cases that haven't no relationship to each other, yet they form a strict chain of small events, coincidences, feelings, vulgar habits, coarse jokes, small faults, furies, death desires.

This iron chain of details do we have to call them Chance or Fate? As for us, we are terrified by the fact that the events, without which no human hand has preparated them, show an intention so stubborn and dark, as if some truly superhuman figure in the shadow, in the unknown mechanisms of the history, has meticulously thought-out the Puskin's ruin. [28]

He seemed to fall in love with a extreme death, challenged to a duel d'Anthès and the mud of the informings and he died, in excruciating pain to defend his honor in the winter of 1837[29], as an immutable and eternal blanket („Oh no, the life wasn't tired myself, I love to live, I want to live, the soul hasn't become cold after the loss of the youth. Yet I lie ahead my pleasures for my curiosity, for the dear dreams of the imagination, for the feelings … for everything"), as resounds this lyric poem written on the eve of his death: „Forgetful of the forests and the freedom, / A prisoner sparrow over me / gets a bean and sprinkles the water, / and he comforts himself with a lively song", aware that he will not die at all, his letter on the water will surrender to the immortal future and „the soul in my singing / will outlive the ashes surviving the breakup / and I will have glory until the moonlight / Even a single poet remains".

Summary

Alexander Sergeyevich Pushkin (1799-1837) is the poet of harmony and its forced deprivation, such as correspondence of cosmic forces and order of universal life. In the analysis of his affectivity flows his secret freedom, his integral attachment with the historical events and the destinies of his time.

The art of Pushkin feels the weight of the art's contradiction and its never-ending dialogue with the vertex of the freedom. It has gone through the literary and lively drama, as evidenced by the lyric, the tragedy, the prose and the history of criticism.

Even his family life shows a wound and an icy breath. The inevitable fate is accompanied by the fatality dramatically lived, that hasn't only the tragic meaning, but tries always to chase the harmony and the balance point. Myth and reality that merge and end up to look the same. The reflection on his literary component is inseparable from his biography, in his

dream and detachment, lived under the power of the poetry, authority and everyday life. The writer that represent Russia and its „russianness" brings his soul to the language, the feature and the landscape of his classical literature that coexist in a everlasting elusiveness. A vitality that describes its images of women, love and its raptures, the Eternal Feminine and the Beauty. His dynamic affective is restless. All women touched, loved, or even grazed receive his devoted footprint and his amazed torment. A desolate secret remains in his work. Pushkin has known the loneliness and the exilem, the drama of the freedom and country, relived in the correspondence with the elements (sea, ship, exotic landscape, freedom) that, in some ways, bring close him to Byron, maintaining a classical dynamics of idea and thought. In his poems establishes an internal lament, a voluptuous passion and the complete inner room. The hopeless vitality of his landscape is a moving nature, irresistible life, an existence that chases the seasons and their ambiguity, their tarnish or flourish, for the example, the snowstorm that represents the symbol of an external force that conquers the scene where the characters live their theater.

The harmony and the balance follow a clear line of expression, human and poetic inebriation that touches the erotic vertigo, the death, the extreme beauty, the prophecy of carnality and the anacreontic of light eroticism.

The synthesis of the real and literary knowledge blend her feminine figure in a single movement of vision and reality, merged into a only song of love, in any possible plating, in every light or bright light, but always fleeting. His kaleidoscope returns a sequence of snapshots: the representation of the scene gives, on one side, the lived life and, on the other side, the contradictions and the fractures of life itself.

It's the art of the Harmony that holds together the freedom of the poetry and the prophecy in a universe of impressions and existential frameworks which tend to the Unity. The Pushkin's ego lives the eternal struggle between the enchantment of the freedom and the opposing force of the power and subjugation, in that space forwards his gaze to the perspective view of the world, open to the Infinite, but always ready for a retreat and an acceptance. Pushkin crosses the Beauty's domain, encroaching on the territory of the Muses. In this exaltation and supreme manifestation of the World Soul, vibrates all his personal tension, as a mythopoeic vocation. Therefore, in this analysis, the Pushkin's poetry recreates the reality, belongs to the harmony of the mystery of the time, the secret freedom that allowes the geometry of the poetic magma.

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ses mumbled full of pathos? Fate has pronounced its sentence! / Was it not you who spitefully / rebuffed his free, courageous gift / And for your own amusement fanned / The nearly dying flame? / Well now, enjoy yourselves … he couldn't / endure the final torture: / quenched is the marvelous light of genius, / withered is the triumphal wreath." (Lermontov M. J. (ed. 2006): Liriche e poemi. Milan: Adelphi)

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Multidimensional psychiatry: rationality, evidence and gut feelings. Some considerations.

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Multidimensional psychiatry needs openness and discussions for sustainable credibility and development. Follow-up and evaluation is most important as the rationale for choice of treatment is most often limited. The psychiatrist as a person is a crucial point.

Keywords: psychiatry, psychiatrists, rationality, evidence, values, stigma

Background

The challenge and charm of psychiatry is to work with models from several dimensions simultaneously – with one´s own person as a tool. Mental processes take place in families, in societies, in belief systems and in the anatomy/physiology of the brains of patients and of psychiatrists/therapists. Genes are involved. Hardcore is now often considered to be something visible in the brain. However, complaints of patients have other dimensions which, of course, should be most important.

Contacts with other countries have showed me different ways of thinking and different value systems. In Sweden, as in many other western countries, the Age of Enlightenment with rationality in focus set a powerful agenda. This was not the case in Russia, nor in the Far East, nor in Africa where other ways of thinking exist. These differences can give contradictory opinions which need discussions but can also provide more dimensions to be used in psychiatry. I shall quote some philosophers, however, not analyze their thinking much further – rather ask some questions.

It is with some hesitation I publish these lines. I know that there is a body of philosophical knowledge that I am not familiar with.

Some dimensions of psychiatric work

- Rationality
- Scientific paradigm, relevant diagnoses, effective methods
- Person centered psychiatry
- Society friendly psychiatry
- Stigma reducing psychiatry

- Spiritual dimension
- Economic dimension – who pays for what?
- Psychiatrists: their knowledge, prejudices, ambitions …

Rationality

"Rationality is the quality or state of being reasonable, based on facts or reason. Rationality implies the conformity of one's beliefs with one's reasons to believe, or of one's actions with one's reasons for action. A rational decision is one that is not just reasoned, but is also optimal for achieving a goal or solving a problem." (Wikipedia, 24. June 2015) This definition relates rationality to the pursue of a specific goal and evaluates the used methods in terms of their usefulness for goal achievement. If a decision or behavior is judged to be rational or irrational is depending on common shared key assumptions: if one accepts a model of benefitting oneself to be optimal, then rationality is equated with behavior that is self-interested; whereas if one accepts a model in which benefiting the group is optimal, then purely selfish behavior is deemed irrational.

Is there a difference in the place for rationality in psychiatry compared to other branches of medicine?

- Yes, and for the good because there is place in psychiatry for accepting individual values and wishes, points of view and explanations that lack proofs.

- Yes, and for the bad because the knowledge concerning diagnosis and treatment is less robust against criticism, and more open to influence "from outside".

Is there a difference in the place for rationality in psychiatry compared to religion, art, politics?

- Yes. Psychiatry has greater ambitions to offer care that has an important rational base and offer results with a measurable probability.

Epistemological considerations

William Shakespeare: "There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy".

David Hume: Our experience of "causation" is often psychological expectations and coincidences – not a real causal relationship.

Albert Einstein and Karl Popper: You can never prove a scientific hypothesis – only falsify it.

Lev Sjestov: “We live surrounded by an immense amount of mysteries”, “Science can never give us truth.”

Nikolaj Berdjajev: “There are two thruths: truth as knowledge, and truth as reality itself = man´s communion with spirit.” “A personality is like nothing else in the world.” “The meaning in any dialogue is unique to the sender and recipient based upon their personal understanding of the world as influenced by the socio-cultural background”.

Ethical considerations, human rights?

Can ethical/moral, doctrinal/ideological (religious, political), social, and aesthetic values be stronger than rational arguments? Can a religious/political organization advice/decide against rational arguments? Are there human rights for psychiatric patients in a society? What do they include?

Different philosophers have different points of views:

Immanuel Kant: Man is a goal in him-/herself. Your acts must be able to withstand elevation to general law.

Fjodor Dostojevskij: Rationality is not within traditional (Russian) values, sometimes contradictory. The rights of an individual in relation to society are not given – there is also a responsability. This responsibility can sometimes be large – “radical responsibility”; ”we are all responsible to all and for all and I most of all”. This reminds me of the concept of original sin, which I perceive as a depressive thinking. It might have a meaning nevertheless. However, I don´t see its implications in daily life. Opposite is the United Nations Universal Declaration of Human Rights, article 1: “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood”. Implication of this article also has met substantial difficulties.

Scientific methods, evidence based psychiatry

What does *scientific* mean? Strict scientific methods are based on empirical and measurable evidence subject to specific principles of reasoning for investigating phenomena, acquiring new knowledge, or correcting and integrating previous knowledge. Science has its base in rationality.

What do*es evidence* mean? Usually that an individual case – on more or less probable grounds – can be subsumed under universal laws and general hypotheses. Statistics can never give a proof of causal association – only a probability.

Diagnosis in psychiatry

A diagnosis is important as it is useful for choice of treatment. Also, a diagnosis gives a feeling of clarity and relief to those concerned, even when an ICD or DSM diagnosis only describes a part of a patient 's situation. Names are important.

Bases in psychiatry are patients' narrations, psychiatrists' narrations' of these narrations and of clinical observations, not laboratory findings. Nevertheless, there are understandable, meaningful psychiatric syndromes with a reasonable degree of rationale, at least in the core. But there are considerable overlaps, unclear borderline to ”normality”, and changes over time.

The operational DSM system shall be free from speculations about subconscious things and constructs of defined diseases, clear in the core but like a comet evasive in the end. But in reality diagnoses imply thoughts about genesis and prognosis in most persons concerned.

What should be the role of psychiatrists' experiences and “gut feelings”? Earlier, some psychiatrists proclaimed to “smell schizophrenia”. Probably the diagnosis was right sometimes – but hardly evidence based and hardly reliable enough for choice of therapy or support from social service. Genetic studies and clinical observations indicate overlapping and transition between existing psychiatric disorders. National Institute of Mental Health, NIHM, in USA makes a retake skipping both DSM and ICD for Research Domain Criteria, RDoC. Quite a new diagnostic system might appear.

But, actually, do PET scans, fMRIs etc. give us a more true image of a person and her/his pains than the narration? The suffering of the person must be in focus. But brain scans can help with explanations about processes in the patient and hopefully indicate suitable treatment.

Effective, evidence based methods?

”Evidence based medicine, EBM” is king now, but, again: statistics can never give a proof of causal association – only a probability of outcome of an action. “Number needed to treat, NNT” offers a measurement of the impact of a medicine or therapy by estimating the number of patients that need to be treated in order to have an impact on one person.

NNT = 4 for a drug is usually considered as very good. It gives a probability of good outcome of 25 % in relation to placebo treatment or natural

course. This is, however, far from a certain effect of treatment! 75 % of patients given the drug will perhaps only have some side effects.

NNT = 20 (which might be the case when treating hypertension) gives a probability of 5 %. This means that it is an overwhelming probability that the individual patient will not benefit from the treatment. On a group level, however, it might be a clear benefit with the treatment in question.

Placebo treatment is obviously very "evidence based" – how to use in an ethically acceptable way?

Consequencies of lack of rationality in psychiatry?

Most people have opinions about psychiatric disturbances, their consequences and how they should be treated. These opinions might be more or less rational. Professionals sometimes get trapped by their own culture and less responsive to motivated criticism. Psychiatrists are also human beings and not always rational which makes an open dialog with many stakeholders is necessary. Psychiatry will, however, not have much to offer without development of rational, scientific methods, effective with a reasonable probability.

Power does not need arguments for actions. Vulnerable persons, as those with long term mental illnesses, must have a platform where rational, ethical arguments are listened to for getting a decent living. There must be for these arguments and they must be.

Efficiency of a society is dependent on common health. Mental illness stands for much illness in societies and needs prevention and treatment. This is not evident for each person who usually considers her/himself as mentally OK but in a democratic society it generally becomes clear that we must work for this, together.

Consequencies of too much rationality in psychiatry?

Rationality without a decent moral might point toward evil goals directions – cf. Nazi experiences. A psychiatrist might have good, rational arguments for actions that are contrary to a patient's will. Such actions might be needed for saving lives, but need very strong arguments, in accordance with applicable laws, and preferably predicting patient´s later approval.

Person centered psychiatry

What is evidence based treatment in individual cases?

Each patient is considered unique – in which ways? What are the implications in individual cases? This should be described, not only ”felt in the guts” in the psychiatrist.

There is mostly a limited, but valuable, scientific base for choice of treatment in individual cases. Patients' personal experiences, preferences, economical, ethical, spiritual, cultural considerations must have a large place – person-centered psychiatry.

Follow-up and evaluation are most important as the rationale for choice of treatment in most cases is rather limited.

Society friendly psychiatry

Good psychiatric care contributes to a good society that supports its inhabitants when needed. It cannot be repressive.

Stigma reducing psychiatry

I consider the management of stigma of mental disorders as a most important issue for society – not only for psychiatry. The concept of exclusion is obviously very human, probably with some survival values earlier but nowadays very destructive. By providing value based, scientific, effective and appreciated care psychiatry should contribute to inclusion of psychiatric disorders in society, as well as persons who are affected – more or less temporarily. Furthermore, long-term care in asyls are not cost-effective.

Spiritual dimension

Spirituality is another mental sphere, important for humans. Borderline to psychiatry is mostly clear but not always. There are spiritual thoughts with definite depressive, paranoid or manic characters. It will be interesting to follow if differences in brain physiology can be seen.

Economic Dimension

Every kind of psychiatric care costs money. Psychiatrists cannot abdicate from taking responsibility for how the limited resources of every society should be used for best effect on mental health in the population. This might include more than we are educated for – maternal health, poverty alleviation, life style, family medicine – but also how we use our time for

patients – reimbursement systems are important. But this should not mean that psychiatrists use much of their time for billing.

Psychiatrists – their knowledge, prejudices, ambitions …

With limitation in the scientific base for diagnosis and for choice of treatment the psychiatrist as a person is even more important than other physicians. Her/his scientific and professional education is important. It is more difficult to make a decision when the information is more vague than when it is rather clear as e. g. an x-ray of a fractured hip. Doctors' judgements are important – not her/his feelings. Intuition might be useful in a process but cannot be the only base for decisions.

The psychiatrist's most important tool is her/his own person. Therefore a thorough self-knowledge is necessary for using the tool in the best ways and for avoiding pitfalls of all kinds. This can be achieved in many ways – the most used is psychotherapy.

The ideological/political/religious association of a psychiatrist as well as usual prejudices can obviously interfere with relations to patients.

Sometimes it is wise to let a colleague take over. The psychiatrist's own values and wishes should come after the patient's.

A psychiatrist does not exist in a social vacuum. Diagnosis is often a matter of assessment. Pressure from non-psychiatric forces might influence and be difficult to resist. Financial matters are important and psychiatrists cannot avoid them. The integrity of a psychiatrist might be more important but also more difficult to maintain than for physicians in general.

Summary

The challenge and charm of psychiatry is to work with models from several dimensions simultaneously – with one´s person as a tool.

Dimension rationality is powerful, stressed by philosophers and scientists in the Enlightenment tradition. Others point to other values. Scientific paradigm, relevant diagnoses, effective methods are in focus of development. But how evidence based is EBM?

Dimension person centered psychiatry demands a wide range in care provided. What sort of evidence can be used? Follow-up and evaluation is most important in all cases. Dimension society friendly psychiatry is important for societies. Good psychiatry cannot be repressive.

Dimension stigma and exclusion of psychiatric patients might be under-

standable as reactions but are most destructive, prevents rehabilitation and costs money. Spiritual dimension – another mental sphere, borderline not always clear. Economic dimension: psychiatrists have a responsibility to use resources in a cost-effective way. No others can do it better.

Dimension psychiatrists: these persons are the most important tools in psychiatric care. Their knowledge, prejudices, ambitions, "sobornost", integrity etc. are of course varying and should be clear for them and for patients.

Multidimensional psychiatry needs openness and discussions for sustainable credibility and development. Follow-up and evaluation is most important as the rationale for choice of treatment is most often limited. The psychiatrist as a person is a crucial point.

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Berichtigung

Der Bericht über den 17. World congress of the World Association for Dynamic Psychiatry WADP 2014 in St. Petersburg (Nachrichten/News) stammt nicht, wie angegeben, von G. A. Sofronov, sondern von Dr. Petra Decker, Dynamisch-Psychiatrische Klinik Menterschwaige, München.

Buchbesprechungen

Christiane Eichenberg, Stefan Kühne
Einführung Onlineberatung und -therapie.
Grundlagen, Interventionen und Effekte der Internetnutzung

Ernst Reinhardt Verlag, München 2014, 238 Seiten

Die Autoren stellen mit dieser kompakten Einführung für Forschung und Praxis die drei Felder klinisch-psychologischer Intervention im Internetsetting (Information, Beratung, Therapie) mit deren Chancen und Grenzen unter Einbezug neuester wissenschaftlicher Untersuchungen vor.

Dieses Grundlagenwerk gliedert sich in vier Kapitel. Die Einführung in Kapitel I systematisiert das Themenfeld und untersucht die Bedeutungen der digitalen Medien für Beratung und Therapie und geht auf das Qualitätsmanagement in der Onlineberatung ein. In Kapitel II werden die drei zentralsten klinisch-psychologischen Online-Interventionen „Information", „Beratung" und „Therapie" dargestellt. Es setzt sich mit den Vor- und Nachteilen der Online-Information und Selbsthilfe im digitalen Zeitalter auseinander. Zum Thema „Patienten googeln Ärzte, Ärzte googeln Patienten" werden interessante Ergebnisse einer Befragung erwähnt. Einer der Standards in der Online-Beratung basiert auf dem „Vier-Folienmodell" von Knatz und Dodier (Hilfe aus dem Netz. Theorie und Praxis der Beratung per E-Mail. Stuttgart: Klett-Cotta, 2003), welches den klientenzentrierten Ansatz von Carl Rogers einbezieht. Bei der Onlinetherapie wird auch speziell auf die Situation in Deutschland eingegangen. Es wird der Einsatz virtueller Realitäten (VR) in Bezug auf verschiedene Störungsbilder wie Phobien oder Posttraumatischer Belastungsstörung beleuchtet als auch die Nutzung von E-Mail und Handy-Kontakten zwischen Arzt und Patient. Im Kapitel III werden Fragen zu exzessiven, dysfunktionalen, selbstschädigenden und devianten Nutzungsweisen digitaler Medien behandelt. Es beginnt mit der Nosologie der Internetsucht und diesbezüglicher diagnostischer Einordnungen und Neuerungen im DSM-V und ICD-11 und geht auf spezifische Formen wie Cybersexsucht oder Cyberchondrie ein. Beleuchtet werden weiter Suizidforen, Foren zu selbstverletzendem Verhalten (SVV) und Pro-Ana-Foren (Pro Anorexia nervosa). Zu devianten Nutzungsweisen wie Cyberstalking und Cybermobbing wird der eindrucksvolle Fernsehfilm „Homevideo" vorgestellt, der mehrere hochkarätige Preise gewann. Die Mobbingsituation stellt für Betroffene

eine sehr große Belastung dar. Die Autoren zeigen auf, dass wir heute aufgrund der digitalen Medien solchen Situationen mehr denn je ausgesetzt sind und dass die Folgen entsprechend vielfältig und schwerwiegend sein können. Weiterhin gehen die Autoren auf die sexuelle Internetnutzung ein, z. B. sexuelle oder verbale Belästigung Erwachsener oder Minderjähriger. Jugendliche nutzen das Handy und Internet für „Sexting", den Austausch sexueller Nachrichten oder Bilder, welche in den sozialen Netzwerken geteilt werden können und sie zum Opfer von Mobbing machen können. Weiterhin gibt es das sog. „Grooming", in dem es um sexualisierte Kommunikation zwischen Erwachsenem und Kind mit dem Ziel eines realen Treffens geht. Abschließend besprechen die Autoren in diesem Zusammenhang die Aus- und Weiterbildung und beziehen ethisch-rechtliche Aspekte mit ein.

Dieses Lehrbuch zeigt praxisnahe Methoden und Fragen zu jedem Kapitel auf und ermöglicht E-Mental-Health-Interessierten, Ausbildungskandidaten sowie psychosozialen und psychotherapeutischen Berufsgruppen in der Fort- und Weiterbildung einen breitgefächerten Überblick über dieses Thema.

Petra Decker (München)

Ernst Kern
Personzentrierte Körperpsychotherapie

Ernst Reinhardt Verlag, München 2014, 186 Seiten

Psychotherapie und Beratung lassen sich durch körperorientierte Vorgehensweisen enorm bereichern. Personzentrierte Körperpsychotherapie basiert insbesondere auf den Werten der Empathie, bedingungsfreier Anerkennung und Präsenz des Gegenübers. Wichtig in der therapeutischen Arbeit sind dabei Achtsamkeit und Körperwahrnehmung.

Das Buch gliedert sich in acht Kapitel. Zu Beginn steht eine ausführliche Darstellung und Diskussion der Wurzeln einer personzentrierten Körperpsychotherapie in der Phänomenologie und Humanistischen Psychologie. Die starke Verankerung in der Phänomenologie fundiert die besondere Betonung der Körperwahrnehmung und der Öffnung des Körperbezugs im praktischen Vorgehen. Es zeigt die Stärke der personzentrierten Therapie in ihrer Betonung von therapeutischer Haltung, in ihrem (dem Ansatz inhärenten) Wertbezug und in ihren eher sanften (und gerade

deswegen sehr mächtigen), an die Selbstheilungskräfte der Klienten glaubenden Interventionen.

Als weitere zentrale Perspektiven dieses Buches wurden die Emotionszentrierung und der Bezug auf Entwicklungskonzepte vorgestellt, die im personzentrierten Spektrum über die prozessorientierten und experientiellen Ansätze vertreten sind. In den Praxiskapiteln (Kap. 3–7), die auch unabhängig voneinander gelesen werden können, steht zu Beginn die praktische körperorientierte Umsetzung der personzentrierten Grundhaltung, gefolgt von einer kurzen Darstellung des Focusing an der Schnittstelle zwischen Sprechen und Körper. Davon ausgehend wurden Focusing-orientierte Vorgehensweisen verbunden mit deutlicher akzentuierter Körperpsychotherapie. Als praxisnahe „Eingänge" in den Körper werden Körperwahrnehmung und innere Achtsamkeit, Atmung, Körperhaltung, Bewegung und Körperkontakt vorgeschlagen. Als besonderes Merkmal der personzentrierten Körperpsychotherapie liegt der Schwerpunkt auf einer achtsamen, verstehenden und nichtbewertenden Wahrnehmung des eigenen Erlebens.

Entwicklungskonzepte speziell von Daniel Stern dienen als orientierende Modelle, Therapieverläufe aus körperorientierter Sicht zu verstehen und zu organisieren. Eng damit verknüpft ist die starke Emotionsfokussierung der Therapie, die auch neurobiologisch begründet wurde (Embodiment) und sich wie ein roter Faden durch die ganze Darstellung zieht. Abschließend folgt eine kurze Zusammenstellung von Ideen für körperorientierte Zugänge bei einzelnen psychischen Störungen.

Personzentrierte Körperpsychotherapie ist kein eigenständiges Verfahren. Die in diesem Buch vorgeschlagene Sichtweise kann Psychotherapeuten und Beratern helfen, den Körper selbstverständlicher in die Therapie oder Beratung miteinzubeziehen.

Als Praktiker ist es dem Autor wichtig, immer wieder auf Gemeinsamkeiten der von ihm beschriebenen Konzepte und Vorgehensweisen mit neuen Verfahren der Verhaltenstherapie und Tiefenpsychologie hinzuweisen. Der Autor erläutert die theoretischen Grundlagen der Körperpsychotherapie. Er stellte viele Praxisideen vor, wie man vom Sprechen zur Körperarbeit gelangt. Die zahlreichen Fallbeispiele, Arbeitsblätter und anschaulichen Anleitungen erweitern das Interventionsspektrum und helfen bei der Umsetzung der Körperpsychotherapie des Therapeuten im Praxisalltag.

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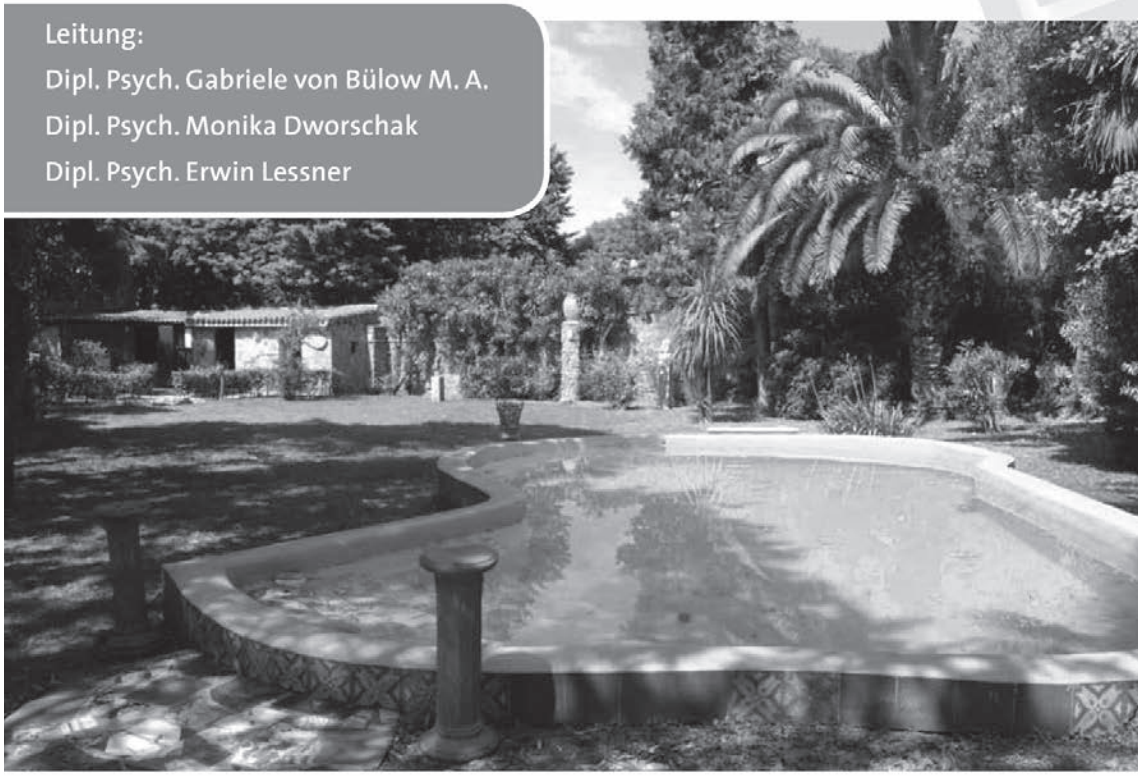

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„Analytisch Strukturelle Tanztherapie (AST) als Identitäts- und Gruppenpsychotherapie. Erweiterung, Differenzierung und Transformation."
Referentin Prof. Dr. Ilse Burbiel
16.00 bis 19.00 Uhr | Teilnahmegebühr 60,00 Euro | Bei der Psychotherapeutenkammer mit 4 FE zertifiziert | Um Anmeldung wird gebeten, da die Teilnehmeranzahl begrenzt ist.

VORTRAG, Freitag, den 05.02.2016

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20.00 bis 22.00 Uhr | Eintritt: 7,00 Euro (ermäßigt 5,00 Euro) | Bei der Psychotherapeutenkammer mit 3 FE zertifiziert | Keine Anmeldung erforderlich.

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In verschiedenen Gruppen mit unterschiedlichen Schwerpunkten haben Sie die Möglichkeit, sich selbst mit Ihren bewussten und unbewussten Persönlichkeitsaspekten in einer Gruppe zu erleben. Es finden täglich 2 doppelstündige Selbsterfahrungsgruppen statt sowie eine Analytisch Strukturelle Tanzsitzung jeweils am Nachmittag. Die Mitglieder können sich im Spiegel der Gruppe selbst erfahren und gruppendynamische Prozesse erleben und verstehen. Die gewonnenen Erkenntnisse erschließen neue Möglichkeiten der zwischenmenschlichen Kommunikation und ermöglichen den Teilnehmern ein Kreativierung und Erweiterung ihrer Persönlichkeit.

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