

An interdisciplinary team approach of Günter Ammon's dynamic psychiatry: theory and practice at Mengerschwaige Hospital

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Summary

The integrative model of person-centred clinical care in dynamic psychiatry comprises interdisciplinary features and approaches. The central integrative aspect is the holistic view of a person as a unique human being, influenced by the dynamics of the surrounding groups. We present the theoretical conception of human development and the therapeutic conceptions and intervention methods of dynamic psychiatry as a person-centred clinical care concept. This concept is introduced at the Mengerschwaige psychiatric hospital in Munich. The Mengerschwaige hospital bases its multidimensional psychiatric-psychotherapeutic work on the analytic group dynamics and thus follows systemic psychiatry principles means that staff as well as patients are daily challenged with interdisciplinary demands. Based on theoretical considerations about the necessary preconditions of such an interdisciplinary team approach in person-centred clinical care, its implementation will be discussed in this paper. This approach is realised through group-dynamic and self-reflective processes within various groups of the clinical system, for instance, in the team's regular group dynamic sessions. A case study is presented to show what essential significance this self-reflective work has in successful person-centred treatment of seriously mentally disordered patients.

psychiatric care / dynamic psychiatry / integrative model

INTRODUCTION

According to the free encyclopaedia Wikipedia (2014) "interdisciplinarity" [2] is defined as "the use of approaches, ways of thinking, or at least methods of different disciplines". In contrast

"One of the key elements of person centred psychiatry and medicine is the cultivation of relationships at all levels. These include relationships between the clinician, the patient and the family, as well as collaboration among the various health professionals involved. The latter refers to the *team approach*."

Juan Mezzich [1]

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to "multi-disciplinarity" [3], which represents "the weakest form of cooperation with regard to content in subject-transcending work" (Wikipedia, 2013), "interdisciplinarity" is regarded as methodological, terminological or conceptual exchange and integration between the disciplines, developing a uniform conceptual frame and working on common strategies for solving problems. The goal is a frame of work that al-

lows for interactive and reciprocal activities as opposed to working side by side.

For the interdisciplinarity and its integration eclecticism is a possible component to integrate clinical methods of different sources, but it is also the weakest form of cooperation between the various disciplines. Lazarus [4-6] differentiates between technical and theoretical eclecticism, whereupon the theoretical eclecticism refers to various systems that are not supposed to match epistemologically and ontologically, technical eclecticism on the other hand conditions various possibilities from different approaches without allocating these to theories. Integration, however, has a stronger theoretical significance: to create something new, to define a superordinate level, a kind of meta-theoretical framework. Meanwhile efforts are undertaken within the various treatment approaches to bring together and integrate the different approaches.

In this paper interdisciplinarity and its integration is described from a person-centred psychodynamic-psychiatric perspective. Person-centred psychodynamic clinical care offers a manifold concept of psychological interrelations; these psychic subject constitution theories and methods are based on life praxis and are always open, merge and, like the language, are translatable and transformable [7]. The turn to language, the "linguistic turn" in the philosophy of science "should enable different therapy directions to translate themselves mutually by preserving their definiteness and singularity"¹ (Hardt, p. 24, transl.: Ilse Burbiel) [8]. Hardt demands that if one wants to integrate the manifold subject constitutions one should not base that on a mere academic survey but put complete subject constitutions within ways of life with fundamental experiences and related life problems. This turn of discussion in psychotherapy to life praxis signifies a praxeological turning point. Thus the "linguistic turn" in treatment becomes the "neo-pragmatic turn" [9]. This linguistic turn to praxis means that through the psychic subject constitutions the day-to-day praxis is transformed. If we view psychotherapy as a way of life it means also respecting dif-

ferent ways of life and to search for like-minded people sharing this way of thinking. Similarly, it allows having communications beyond different discipline borders.

According to Küchenhoff, the prerequisites for an effective integration process are the ability to cooperate, curiosity, knowledge of and respect for the perspectives of other participants, competence, not claiming methodological omnipotence, and refraining from participating in "religious wars" within the profession [10]. The meta-theory Küchenhoff calls for should relate the different methods to each other and bring them into a structural interrelation. In addition, it should reveal what effect is performed by which elements on the whole structure. A common language has to be found, a language that is creative, innovative and emotional.

Petzold et al. [11] talk about an "integrative paradigm" [11] in treatment understood as "human-therapy". This would consist of three guiding principles: (1) the theory orientated on psychology, social, bio- and neuroscience, (2) praxis based on clinical experience, and (3) self-awareness. Through these guiding principles a biopsychosocial-ecological model should be built that facilitates a school-overlapping concept development leading to a systematic integration of multi-theoretical and multi-praxeological approaches.

Despite the postulation for overlapping theories as revealed in literature, due to a multitude of theory and methods approaches there is no substantial philosophy of science able to integrate the non-rational areas as the unconscious, mythos and religion, the philosophical, culture-scientific, political-social-scientific and natural-scientific perspectives as well as the multiple psychic processes and structures.

Günter Ammon's dynamic psychiatry: a holistic approach in clinical care

Ammon proposes [12] that the criterion for interdisciplinarity and its method integration should be the human being, together with an understanding of illnesses and constructive, creative development opportunities. This should be integrated into a personality model. He also said already in 1982 that interdisciplinarity

¹ Orig.: "(...) macht es möglich, die Einheit der verschiedenen psychotherapeutischen Dialekte im Übersetzen zu fordern. Das heißt aber zugleich, ihre jeweilige Begrenztheit und Eigenart zu respektieren."

should integrate psychiatry, psychology, medicine, pedagogy, philosophy, linguistics, study of religions, sociology, political science, jurisprudence and neurological findings. That is to say, a team's training should encompass their whole personality within the frame of diversified education [12].

Thus Ammon recommends a holistic approach in clinical care that integrates the findings of different branches of science but also aspects of diverse schools. All this is put under a central principle, the holistically formulated image of man. A model for interdisciplinarity and integration should be measured by its benefits for the person, i.e. to understand them better and to develop better healing methods [13].

The theoretical model should never be systemised or inflexible according to Ammon. It should be an open system with the possibility of change and constant integration processes [13]. To integrate different disciplines, clinical care needs to have a theoretical concept as a basis to rely on. The central theoretical concepts of the interdisciplinary methods-integrative approach of dynamic psychiatry are the concept of social energy, the personality-structure model and the identity concept.

The development of individual identity is seen as a process of "internalizing" the consciously and unconsciously evolving group dynamic in the various external groups a person is born into and in which they live and work. Psychodynamics becomes an internalized "experienced group dynamic" when the external "interpersonal" is transformed into the intrapsychical personality structure. Here the "transmitter" between the inside and the outside is taken to be a basic energy, a "social energy".

Social energy, identity and group

Social energy is the psychic energy originating through the group, that is, through inter-human contacts and relationships within and between the members of a group. Social energy means "contact, debate, security, reliability, love (...) demand for identity, (...) request and encouragement for action, occupation and duty" [14]. Social energy is vital to the development of a human being, especially in its very early life. Social

energy determines the intrapsychical processes of exchange between the individual's inside and outside and thus leads to the structural formation, expansion and a change of identity. From this perspective, the structure of identity can be considered a "manifested social energy" [13]. On this Ammon says: "The integrative function of social energy creates an inner unity between psychic energy and psychic structure; it creates both unity and dissimilarity between the individual and his environment, respectively the individual and the group" [15]. In this process interpersonal events in the here and now converge with life experiences.

Identity can be developed in a more constructive, destructive or deficient way depending on the relevant group dynamic conditions of life, especially in the pre-oedipal time of childhood development. As a consequence of predominantly constructive group dynamic and social-energetic experiences we can observe, structurally speaking, a differentiated, integrated and well-regulated identity system with mainly constructively developed identity functions, i.e. constructive aggression, anxiety, demarcation, narcissism, sexuality, and so on. As a structural result of a predominantly destructive and deficient group dynamic experiences, we can observe deficiency within the central, unconscious core of identity, connected with destructively and deficiently developed identity functions as well as blocked processes of demarcation, differentiation, regulation and integration of personality.

From a structural perspective, for the recovery of identity a reactivation of the healthy identity structures, an integration of dissociated identity structures, a transformation of arrested, destructive and deficient parts into constructive identity structures, and the development of human potential in a framework of a constructive, group dynamic, social-energetic, verbal and non-verbal field of relationships is required. This is because the structure gets "energized" by interpersonal encounters in the group and facilitates further dynamic processes of regulating intersubjective communication. Every member of the group, with their own specific identity, contributes to the social-energetic quality of the group, its atmosphere, group dynamics and group identity.

The group thus stands for the "interconnectedness" of its members. In the process of forming

such connections the group shapes a particular formation of its members. In *Therapeutic Group Analysis*, Foulkes (1964) [16] calls this formation "network" and by taking into account the unconscious process it is called a "group matrix". By paying attention to unconscious processes of energetic exchange within and between groups this formation is called by Ammon a "group-dynamic/social-energetic field".

Thus the social-energetic understanding of groups in dynamic psychiatry is based on its insight that human beings, with their different dimensions and distinct individuality regarding physicality and spirituality, are always interwoven with others, with groups and society. Human development evolves through debate and the interplay of group dynamic and inter-individual processes.

Ammon explains: "Identity and group belong to each other because only through the experience of one's own personality, mirrored through other people as well as through recognition, respect and awareness regarding other persons within the group, ego- and identity development can take place" [13, p. 10].

The personality structure model

A further essential integrative concept is "identity" which is based on the "personality structure model" formulated in 1976 [17]. The model is a holistic concept of personality where the biological, psychological and behavioural and spiritual aspects of man are integrated. In Ammon's understanding, the personality structure model is seen as an abstraction of energetic, dynamic, structural and genetic processes. Man's personality structure is considered a net of primary, secondary and central functions. The primary personality functions include all biological and neurophysiological aspects, such as the central neural system, the endocrine system and the sensory organs system. The secondary personality functions are the functional carriers of personality; they determine the behavioural area of man and are mainly concentrated in the consciousness. The core of personality is formed by the central personality functions, rooted in the unconscious, such as aggression, creativity, sexuality, narcissism, anxiety, ego demarcation and

others. The personality function of identity is of special importance. It has the task of dynamisation integrating and bringing into relation all personality functions, and as a whole, it constitutes the personality of man.

In this sense, identity is the integrative central power of personality. It can be regarded both as having an integrative function and as a total structure. Identity should be the central integrating moment in person-centred care, both in the meta-theoretical conception and in the praxeology of treatment. Identity means the actual totality of the personality and at the same time it is in constant development.

The personality structure theory includes process-oriented thinking with ever-present possibilities of multidimensional functional and process-oriented changes, i.e. diagnosis and course of illness can always change [18].

The integration of new group experiences within the core of personality is of central importance, where the group is the power that integrates through its social-energetic group-dynamic fields.

The holistic multidimensional image of man, where body, mind and soul constitute a unity, ranks superordinate as an integrative theoretical concept in person-centred care. Such a view, also endorsed by the BPS (biopsychosocial) model, will free a person from being reduced to a "carrier of disease", and hence their individuality and dignity will be restored to them.

Interdisciplinarity at the Mengerschwaige dynamic-psychiatric hospital

Multidisciplinary fields tend to evolve into highly complex structures, dynamics and processes. An example is the dynamic-psychiatric Mengerschwaige Hospital in Munich. The hospital was founded on the basis of person-centred integrative treatment concept, as a multi-professional, multi-modal and multi-dimensional treatment space shaped by group dynamics and social energy. It was conceived of as a "space for development", a space in which a multitude of unconscious and conscious group dynamics develop in simultaneous and coexisting processes that interconnect into the dynamics of the "large group".

In order to facilitate a retrieving identity therapy, this therapeutic space has to be structured both constructively and differentially as well as integrated as a whole system with its multifaceted verbal and more non-verbal single and group psychotherapies, such as the milieu therapy, the analytic dance therapy, theatre, music, painting, art, sport, body and horse-riding therapies, special interest groups and especially the large group comprising all patients and the multidisciplinary team. For person-centred care this means involvement of the whole team into the treatment process as parts of the social-energetic field, including nurses, psychotherapeutically trained psychiatrists, doctors and psychologists, social workers, milieu therapists, therapists for the expressive therapies, as well as the administration and kitchen personnel. Interdisciplinary team approach for person-centred clinical care implies that all people and professions involved in the interdisciplinary healing process cooperate in the various designated groups on the basis of a commonly shared holistic image of man, and, derived from it, a model of personality and a common understanding of health, illness, healing and development.

Since the goal of dynamic-psychiatric treatment is to open up patients by emotionally corrective and new group dynamic experiences so that they will regain their health, it is important that the total hospital, as well as its different teams and patients groups are structured and dynamized as spaces for constructive social-energetic exchange processes as much as possible. It is therefore the daily task of the group leader and of the team to reflect and regulate both conscious and unconscious group dynamics that develop within and between the groups, including the dynamics of the "plenary group".

Scapegoat dynamics have to be neutralised, deadlocked role arrangements resolved and changed into role variability, split-off subgroups integrated, the work on boundaries intensified to make those more flexible. Furthermore, shared solidarity has to be learned and mutual responsibility taken. In terms of methodological equipment, it is advisable to resort to the fundamental principles of analytic group dynamics and their methodological execution [18].

In addition, it is the task of hospital leadership to maintain and foster the supportiveness and

capacity for mentalization of their staff. Below we will explain why.

The role of mentalization

Since Fonagy [19] conceptualized mentalization as the capacity that enables one "to think of mental states as explanation of behaviour in oneself and in others", mentalization can be seen as the basis for any psychotherapy. Sperry expanded on the concept of mentalization by adding the "intersubjective" component and describing the capacity for mentalization as a variable entity dependent on the surrounding relational context. Mentalization "is constantly shaped by relational contexts. The accessibility and maximization of a person's capacity to mentalize is influenced by the dynamic interplay between that person's capacity and the capacities of the other members of the person's relational world" [20]. Consequently, therapists have to mentalize themselves in order to maintain and promote mentalizing in their patients. "For hospitals, but also for any organization, the promotion and maintenance of mentalizing in their staff is a crucial prerequisite for successful collaboration in the treatment team"² [21] (Schultz-Venrath, 2013, p. 21, transl.: I.B.). This happens essentially through self-reflection and reflection on others in the inter-professional cooperation as well as in all supervisory work of the hospital. The goal is to reflect on the conscious, and most importantly on the unconscious processes in communication on various levels so that these will not "evolve into a disturbing subterranean dynamic in the process"³ [22] (Gfäller, 2010, p. 41, transl.: I.B.).

Praxeological consequences

Praxeological consequences of the principles for an integrated interdisciplinary team ap-

² Orig.: "Für Kliniken, aber auch für Organisationen aller Art sind die Förderung und das Aufrechterhalten des Mentalisierens bei Mitarbeiterinnen und Mitarbeitern eine wichtige Voraussetzung für eine funktionale Zusammenarbeit innerhalb des Behandlungsteams."

³ Orig.: „Werden diese Ebenen nicht genügend in der Reflexion der Kommunikation

proach considered above are realized through several procedures.

Weekly interdisciplinary team meetings for each patient. That means different team members meet and bring together different treatment methods which are applied for each patient. It is always the objective to integrate the various therapeutic strategies in order to enable the patient to integrate their various experiences and to resolve splitting processes. Every patient thus receives an individual space for bringing together the different personality and treatment aspects such as achievements and difficulties. The developments within the different therapeutic approaches will be pointed out, the individual therapeutic plan together with the therapeutic aims of the patient and the diagnosis will be charged, the biological and physical aspects will be considered, and splitting processes, transference and countertransference will be discussed. Group-dynamic and contact aspects, interests, life concepts and social realities, cultural and religious needs, family dynamics, work situation and coping with reality demands also have to be discussed and brought together. All these aspects have to be considered for further treatment consequences and development and also the aspects of life after separation from the hospital. Individual integration conferences, especially at the end of treatment. Everyday network meetings of the team, where the daily processes are brought together. The plenary group (once a week) with all patients and most of the team.

The uni-professional single- and group supervisions.

The inter-professional supervision group (the team's control group, meeting twice a week) in which all co-workers involved in the treatment of a particular patient or patient group try to get a picture of the status and process of the patient's development in the light of the dynamic-psychiatric model of personality and treatment. The team is working with transference, countertransference and resistance processes and thus creates an internal contact with the patient in his absence. In this kind of "dynamics of mirroring [the patient]" evolves and, unconsciously, relational dynamics occur in the control group that

contribute to the psycho- and group dynamic understanding of the patient while the team is reflecting on him. Corrections in the treatment or other treatment consequences are often the result. In the relational spaces between the patient and the co-worker there are not only the patient's mental space and his dynamics but also elements of the co-worker's self and his dynamics that are brought to the table, and these may be either conducive to or interfering in the interpersonal dynamic and work on the relationship with the patient. Reflection on the patient has to be supplemented therefore by team members' "self-reflection".

These self-reflective processes in team supervisions are supposed to help staff become aware of the destructive and deficient elements in themselves and to verbalise and reflect on them. One's own negative feelings (among them, sorrow, rage, anxiety) as well as one's own destructive or deficient qualities, lacking abilities social incompetence, problems in setting boundaries, projections onto the patient, fixations in the countertransference and projective identifications, traumatic experiences "triggered" from one's own life but also personal and inter-professional conflicts (e.g. rivalries, jealousy and envy within the team) all need to be made conscious. Because the team is willing to identify those elements as their "own", it is accepting the "responsibility" for their own dynamics. This acceptance helps the patient or patient groups because they do not have to bear or act out the parts of the team or its dynamic. The intersubjective distance and the boundaries between patients and the team are thus re-established with the aim of improving the staff's capacity for making contact, for mentalization and containment, as the following example of an interdisciplinary team supervision shows.

An example of team supervision

At the beginning of August the hospital team was meeting for team supervision under the leadership of one of the authors. Over the past few months the team had to say goodbye to a few very experienced, older colleagues whose places were filled with new staff. The head physician of the hospital and several co-workers were on holiday and the leading milieu therapist

was in the process of leaving. In the meeting, there was a leaden heaviness that spread across the room – silence. The consultant psychiatrist was the last member to enter the room and was beckoned by the team to take his seat to the right of the team supervisor. Playfully the supervisor took up this “enactment” and talked about the fantasy of a “marriage” between the consultant and her. But why did she say that? From the fantasies of the staff she gathered (a) the wish for a strong, central leadership of the hospital, and (b) the vote of confidence on the consultant whether he could steer the (hospital) ship well enough with the chief physician being away. In a slightly changed fashion from Bion [23], the supervisor was interpreting the “wish for pair building” [23] as the team’s demand for a strong parental couple out of fear that otherwise the team might fail. After this interpretation, the tension in the room relaxed. The group could then turn to the imminent leaving of their well-liked colleague, the milieu therapist. Feelings of sadness, separation anger, threats to one’s identity and fears of failure were being voiced, but also feelings of powerlessness and resignation in the face of the fact that, despite all these feelings, the colleague would indeed leave.

The supervisor was working in an anti-regressive manner, and made the following interpretations: powerlessness and resignation were the prevailing feelings, which was a sign that the team were acting in an infantile group-dynamic state that prevented them from perceiving their competence; the supervisor began working with the team’s resources, their multitude of experiences. The team were reacting positively to this anti-regressive boundary and were beginning to open up. It was to be expected that now also the new members could complain that they were not being supported by the older ones and hence they felt abandoned. On the one hand, the team were reacting to this complaint in self-defence; on the other hand, they were offering support. In the process of the meeting, the conflict was resolved and the co-workers who voiced complaints could be integrated.

This group session demonstrates how anxiety and massive emotional stress fuels regressive processes in a team. Such regressive tendencies reduce the “intra-psychical space” of the hospital team and their capacity for containment.

When parts of the self are embedded in the relational context of a team group, self-reflection can push these parts back within the boundaries of one’s own identity; thus, they can be isolated from the intersubjective context of a symbiotic relationship with patients: “Moving from an enactment to a mentalizing process requires that [the group] ... self-organizes and develops interactional patterns that facilitate and support mutual reflection on their relational process” [20]. Everybody is in the same boat. The development of a self-reflective community in team supervisions represents the actual inter-professional “work on communication”, lifting professional barriers and boundaries.

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

Therapeutic efficacy depends on the social energy that a therapeutic team is able to provide. In clinical treatment of patients with personality disorders various therapists build a social-energetic net around the patient. Therefore the team has to have its own group dynamic supervision once a week for establishing contact and exchange.

CONCLUSIONS

The goal of person-centred psychiatric treatment should always be an identity and humanising therapy, which means making a person able to have contact with themselves and others again. It also means strengthening their creative and integrative powers and getting into work with the destructive and deficient parts of their personality, especially with destructive aggression, destructive anxiety and destructive narcissism.

Of special importance for the integrative personality development is the separation process at the end of the treatment, where patients

have to be enabled and supported to integrate into their own identity the developments experienced and positive, constructive personality aspects as well as interpersonal contacts.

As we have seen, person-centred psychiatric care based on Ammon's dynamic psychiatry is an integrative treatment paradigm for mentally disordered patients that leads to an identity and contact therapy. It means a multidimensional bio-psychosocial-ecological model with a multidimensional metatheoretical and praxeological integrative treatment concept. A real interdisciplinary approach is always open for development and further integrative possibilities which will be necessary for the treatment of our patients in this fast changing world.

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