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IFP
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newsletter

Zurich, June 2008

EDITORIAL

Dear colleagues,

It makes a year by now that you receive this Newsletter electronically. Looking at the reactions we may say that this change was quite well accepted. Needless to say that it eases our shipping enormously. Thank you for your support in this!

As our president reports in his section of the newsletter, the IFP is progressing quite well both on the level of memberships as well as in preparing the next world congress in 2010 in Lucerne.
In the middle of this edition we bring again some interesting papers. This time the centre of gravity lies on two works of one of our board members, Mrs. Mechthild Neises from Hannover, Germany. She is gynaecologist, psychotherapist and specialised in psychosomatics.
In the first paper she writes about the Chronic Pelvic Syndrome and shows how high the impact of psychological stress is on this difficult and widely spread suffering.
Another paper deals with a review of a book edited by Neises and Schmid-Ott on gender differences in medicine, its cultural gender identity and its relationship to psychotherapy. It gives a clear insight into the impact of gender differences into various aspects of life.

Eventually a last paper deals with the development of psychotherapy in Thailand. Prof. Pichet Udomratn, the President of the Psychiatric Association of Thailand (PAT) describes with great understanding the history and forms of psychotherapy in his country and combines the foreign influences with autochthon knowledge.

I remain like always with my best greetings

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President's Message

Dear friends and colleagues

The IFP is growing! I am delighted to report that over the last months, the number of IFP membership societies as well as individual members has increased substantially:

The **Australia and New Zealand Association of Psychotherapy (ANZAP)** has been an IFP member for many years if not decades. Since that time, our Council member and ANZAP past president Professor Russell Meares has always remained connected to the activities of the IFP. As some of you may remember, he gave a memorable keynote lecture at the last IFP World Congress in Kuala Lumpur in 2006. A couple of years ago, for reasons unrelated to the IFP, ANZAP discontinued their IFP membership. During the World Congress 2006 in KL, I spoke to Russell Meares who introduced me to the current ANZAP President, Cath Mc Grath. As a result of these talks, and more email communication, the ANZAP has now decided to renew their IFP membership: Welcome back!

The **Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde (DGPPN)** is Germany's strongest society for psychiatry and psychotherapy. Their annual meeting which is regularly held in November in Berlin is the largest German speaking conference on mental health, attracting several thousand delegates every year. Prof. Dr. med. Wolfgang Gaebel is the current DGPPN President. We are proud to have the DGPPN among our large membership societies!

The **European Federation of Centers of Positive Psychotherapy (EFCPP)** has 110 individual members, however, they are also an international umbrella organization. The EFCPP was formally established in 1997. The EFCPP has evolved from the International Center of Positive Psychotherapy (ICPP), which is the international umbrella organization of Positive Psychotherapy. EFCPP president Prof. Peseschkian is an internationally recognized psychotherapy expert whom many of you have probably met some time in the past.

A very warm welcome as well to the **Suchtbehandlung Frankental**, Zurich, Switzerland, the **South African Society of Psychiatrists (SASOP)**, and the **Integrative Psychotherapy Program of the Magid Institute**, established by the Hebrew University in Jerusalem, Israel. I am looking forward to a fruitful collaboration!

The **Secretarial Office in Zürich** is running smoothly under the watchful guidance of Cornelia Erpenbeck. She is responsible for all administrative matters concerning the IFP and may be contacted at her office should there be any queries. To further optimize the visibility of the IFP, I would like to encourage all our members to introduce a link to the IFP website (http://www.ifp.name) on your respective homepages. We would be happy to do so vice-versa: please feel free to approach Cornelia Erpenbeck in case you need a hand!

Presidential Election: According to the bylaws, a new President will have to be elected in 2010. By this time, I will have served as President for two full four-year terms, and will thus not be allowed to stand for election for a third term. Ideally, my successor should be elected in 2008 already, so that the President-elect can serve on the Board for two years prior to assuming office, to grant enough time to learn the ins and outs of the organization and the various duties involved. If you have any suggestions as to who should be approached to stand for election, or if you feel you yourself might consider running for president, please contact me directly (u.schnyder@ifp.name) as soon as possible!

Congresses: The 5th Conference of the Asia Pacific Association of Psychotherapists (APAP) was held by the Indonesian Psychiatric Association, Section on Psychotherapy, under the guidance of Prof. D. Bachtiar Lubis in Jakarta, Indonesia, April 5-7, 2008. The congress theme was „Listening to the heart of the East". For further information, please read Dr Sylvia Elvira Detri's congress report in this Newsletter!

The plannng of the **20th IFP World Congress of Psychotherapy** in Lucerne, Switzerland, 16.-19.6.2010 is now well under way. The congress will be organized by the Swiss Society for Psychiatry and Psychotherapy SGPP (http://www.psychiatrie.ch). The venue will be the „KKL Luzern", the Culture and Con-

vention Centre Lucerne (http://www.kkl-luzern.ch): This magnificent building was designed by French architect Jean Nouvel. Built between 1995 and 2000, the KKL ranks today as one of the most spectacular modern buildings in Switzerland. The KKL Luzern is centrally located in the town of Lucerne, directly on Lake Lucerne and right next to the railway station. The old town centre is only a few hundred yards from the KKL Luzern, as is Lucerne's distinctive landmark, the Chapel Bridge. - Regarding the scientific program of the World Congress, I am currently in the process of establishing a scientific program committee. A professional Conference Organizer (PCO) has been contracted, and a Congress website will be established soon, informing you on the progress of our planning.

IFP-sponsored master classes, workshops and seminars: The aim of these events is threefold, namely to help disseminate novel, evidence-based psychotherapeutic approaches, to raise the international profile and recognition of the IFP, and to recruit individual IFP members, thus generating income for the IFP. A workshop on Brief Eclectic Psychotherapy for PTSD with Prof. Berthold Gersons (Amsterdam) was successfully held April 17-18 2008 in Vienna, and a seminar on psycho-oncology will be organized by Board member Prof. Mechthild Neises in Hannover, Germany, September 19-20, 2008. Next year, a seminar on CBT for Eating Disorders with Prof. Chris Fairburn (Oxford) will be held in Zurich March 27-28, 2009. For further information, please visit our website at http://www.ifp.name.

Collaboration with other international societies: I was invited to serve on the International Advisory Committee for the 5th WCP World Congress of Psychotherapy, which is organized by the World Council for Psychotherapy in Beijing, October 12-15, 2008. I was also invited to deliver a keynote address at this conference, which will provide me with an opportunity to further liaise with our Chinese partners, and to strengthen our collaboration. Furthermore, IFP Council member Prof. David Orlinski, Chicago, invited me and WCP president Prof. Alfred Pritz to jointly organize a panel on the profession of psychotherapist at the 39th International meeting of the Society for Psychotherapy research SPR which will be held in Barcelona, Spain, June 18-21, 2008.

Finally, as always, all our members, meaning individual members of the IFP as well as individual members of associations who have membership status with the IFP, are offered the IFP's official journal, **"Psychotherapy and Psychosomatics"**, at a substantially reduced subscription rate. For details, please contact S. Karger directly at:
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Best regards

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Psychosomatic aspects of chronic pelvic pain in women

Mechthild Neises

Key Words

Chronic pelvic pain, psychosomatic, psychotherapy, bio-psychosocial disease model

Summary

Chronic lower abdominal pain has now become a recognized clinical syndrome in gynaecology since it is an affliction frequently presented by many female patients who complain of the severe discomfort experienced. Several definitions of these complex symptoms can be found in the literature; however, the symptoms are generally classified as somatoform pain. Menstruation discomfort, such as dysmenorrhoea and, in some cases, blood disorders, also pain associated with micturition urge, obstipation and other related symptoms including sexual and other genital disorders, e.g. pruritus, are some of the many cases suffered by a high percentage of women. The complexity of these afflictions requires an interdisciplinary approach. This not only involves extensive consultation and advice based on sound psychosomatic competence but also drug therapy and invasive procedures, such as diagnostic and operative laparoscopy and, in more severe cases, hysterectomy. In cases concerning the more chronic disorders additional multidisciplinary procedures such as balneotherapy, psychotherapy and physical therapeutic measures should be considered. This comprises relaxation therapy and instructive aid to relieve the pain. Psychosomatic preliminary care is of particular importance and is a lengthily process, however, essential to evoke the motivation and the need for psychotherapy on the part of the patient, i.e. introspective ability and frankness in order to diagnose the eventual psychogenesis of the pain. Chronic cases should be treated on an inpatient-psychic basis since the combination of physical therapeutic measures together with psychotherapeutic consultation will enable access to the more intimate experiences of the patients. A bio-psychosocial understanding of the symptoms is essential for the diagnostics and therapy of chronic pelvic pain in order to determine the psychic comorbidity and the social influential factors and thus, ensure the best possible individual therapy to be carried out.

1. Introduction

A consultation between the patient and the doctor is an optimal method of gaining a psychosomatic perspective. The somatic extent of the disorder is examined i.e. a diagnosis is made of the structural or functional impairment, the organs and the organic system; this represents the term "disease". The subjective perception and the effect of the patient's general well-being is discussed; this represents the term "illness". Finally, the status as an invalid is considered together with the benefits derived from being in this position; this represents the English term "sickness". These three aspects, namely, illness, feeling unwell and the status of being an invalid are in no way similar when taking into account the complaints and the course of diagnostics. In the case of chronic lower abdominal pain we are dealing with patients who seek a physician because of their physical symptoms, yet no specific organic causes can be found for their condition despite the alleged intensive and persistent symptoms. The complaints are often associated with a high degree of psychosocial adversities. More often than not, such patients are considered "difficult" and "problematic". This often provides the basis for various conflicts in the relationship between the doctor/patient and unfortunately, may result in discontinuation of therapy, change of physician and in some cases, exacerbation of symptoms (Kapfhammer 2001). To find a solution to these conflicts and problems is an important task for the physician. Studies in psychosomatic preliminary care help to provide the necessary competence required to deal with such cases and in the meantime, are obligatorily integrated in the faculty of gynaecology (Neises/Ploeger 2003).

2. Definition

Chronic pelvic pain is defined as pain in the lower abdominal region existing for longer than 6 months and with no known organic cause for the symptoms (DGPFG – guideline 2004). The American College of Obstetricians and Gynaecologists (ACOG) defines pelvic pain as a pain with no indication of tumourous growth and persisting over a period of 6 months. Corresponding to the ICD10-Code diagnoses are generally classified as somatoform disorder F 45.4, somatisation disorder F 45.0, undifferentiated somatoform disorder F 45.1 or undetermined somatoform disorder F 45.9.

Women with a somatoform disorder constitute the largest subgroup of patients with chronic pelvic pain, assessed at around 60 – 70 % (Siedentopf/Kentenich 2004). Localisation of pain is often inaccurate and over a period of time can present itself in different locations. It may frequently extend to the lumbal dorsal and urogenital regions, also to the hips, thighs and abdominal wall. Richter (1999) described chronic pelvic pain as a polysymptomatic affliction with a number of additional psychosomatic symptoms, such as sexual disturbances, gastric disorders, circulatory problems, headaches, dysmenorrhoea, chronic fluor, micturition impairment, obstipation, oligomenorrhoea and premenstrual symptoms. Many patients suffer psycho-social disturbances and relate stressful life experiences such as deprivation during childhood, sexual mishandling, physical assault and emotional neglect as a child, also sexual assault as an adult (Lampe et al. 2000). Women with chronic pelvic pain report a high comorbidity with psychic and psychosomatic disorders such as anxiety, depression, dissociation tendencies, posttraumatic stress symptoms and personality disorders (Siedentopf/Kentenich 2004, Beutel et al. 2005). This complex clinical picture presents a fairly accurate description of suffering experienced by the affected women and, on the part of the treating physicians, a certain doubt as to the appropriate diagnostics and therapy of such cases.

3. Epidemiology

There are few studies only in Germany referring to the epidemiology. In English speaking regions around 10 – 20% of all consultations have been recorded for inpatient gynaecological treatment of chronic pelvic pain (Scialli 1999; Reiter 1990). A study performed in the USA showed that 15% of women of reproductive age suffered chronic pelvic pain (Matthias et al. 1996). A British study reported 24% of all women questioned to suffer chronic pelvic pain – this was within a 3-month period (Zondervan et al. 2001). A German survey covering 1146 women with an average age of 49 years disclosed 12% of the women to suffer chronic pelvic pain. The data demonstrated that the symptoms were associated with age – pain as experienced by 15% of those women younger than 40 years, approximately 12% of the women between 41 – 60 years and approximately 8% of those women over the age of 60 years. In the investigation carried out by Matthias et al. (1996) involving 5263 women who were questioned via telephone 61% admitted that the cause of their symptoms was unclear. Postmenopausal women were not included in this inquiry. Any connection of chronic pelvic pain with multipararity and the number of pregnancies as well as the number of births could not be uniformly confirmed (Gürel 1997, Reiter, Gambone 1990). With a view to the social status of the questioned women, it appeared that those who were single, either widowed or separated, showed evidence of an increased risk of illness. This did not apply to those women who were unmarried. The outcome of the social status, that is, family status, education, income, gave no indication of uniform tendencies in the different studies carried out (Jamieson, Steege 1996).

4. Comprehension of Illness

Shorter (1994) intercepted the development of an illness by combining subjective knowledge of the illness with the leading medical opinions and in this way was able to determine the diagnostic potentialities. The number of various indications referring to the illness was recognized by Richter (1999) in connection with the difficulty in assessing the clinical picture and the desperate attempt of the patient and the physician to detect a somatic cause. According to Artner (1982) there are around 150 synonyms for chronic pelvic pain. In the middle of the 19th century an inflammation was reckoned to be the cause of this affliction. At the beginning of the 20th century associated illnesses in the form of constipation or circulatory problems connected with dysmenorrhoea and sexual disturbances were frequently observed and interpreted as spasmophilia genitalis. A relevant model by Taylor in the mid 20th century describes the "congestion fibrosis syndrome". He reckons the cause of chronic pelvic pain to be mainly due to a disturbance of the autonomous nervous system which in turn determines the circulation of the female pelvis besides the hormonal, inflammatory, mechanical and psychic factors. At this particular time, as with psychosomatic illnesses in general, the bio-psychosocial dimension was asserted in the observation of the causal symptoms. Prill reported in 1964 that around 33% of women with chronic pelvic pain required treatment for psychogenic illness. Molinski (1982) described the cause of the complaints to be latent depression. Here he was referring to those patients suffering pain without any known somatic-pathological findings. Richter described three main areas of conflict for the pelipathy syndrome (1999). One of the

areas lies in the partner relationship, in which the over-estimated desires of security collide with the sexual desires of the partner, thus leading to feelings of anxiety of being viewed as a sexual object only. The relationship towards offspring often acts as a substitute for the insufficiencies of the partner relationship. Richter sees the second area of conflict as situations of separation and deprivation. These situations often reveal a threatened or real loss of contact persons, e.g. due to separation, divorce or death. Furthermore, loss of social privileges such as certain areas of work or loss of job may result in conflict. These social privileges are frequently over-estimated. The third area of conflict as identified by Richter (1999) are situations entailing stress in the form of undefined limitations. These stress situations may be due to the environmental surroundings, e.g. partner, children, parents and profession where defined boundaries have not been laid down. Moore and Kennedy (2000) came up with a list of possible causes and contributing factors which give scope for extension (Table 1).

Table 1
Possible causes for chronic pelvic pain (Moore, Kennedy 2000 and Siedentopf: Kentenich 2004)

Gynaecological causes	**Causes related to other regions**
Endometriosis	Irritable bowel syn-
pelvic inflammatory	dromeobstipation
disease (PID)	interstitial cystitis
adhesions	urethral syndrom
pelvine varicosis	
Further causes	**Psychosocial causes**
Muscular pain	Psychogenic pain
Nerve compression	Stress-induced life
syndrome	experiences
Persistent pain neuro-	Physical and sexual
pathic pain	mishandling
modulation of nervous	
system	

Savidge and Slade emphasize the importance of an integral, bio-psychosocial model and integration of specialist knowledge regarding other specialized fields (1997). They stress the significance of the introduction of the subjective comprehension of the illness and the individual coping strategies, not only in knowledge of the clinical picture but also in the treatment of the patient. An inquiry per telephone made to 75 general practitioners in Great Britain (McGowan et al. 1999) revealed that the diagnostics and the treatment strategies were surprisingly similar concerning the cause of a somatic complaint. However, the psychosocial cause of the pain was clearly variable.

5. Diagnostic clarification
The basis of the diagnostics primarily includes an extensive discussion with the patients. The patients should be asked specifically to describe the type of pain they have, when the pain worsens and what helps alleviate the pain, the duration of the pain and whether or not the pain is related at all to the menstrual cycle. A standard method to quantify the pain should be introduced in order to assess the extent of the pain in future consultation follow-ups. Documentation of the progress of pain should be recorded in the form of a diary. It is essential to ask about any previous medical therapy undergone to help relieve the symptoms and whether side effects were noted. It is most important to record the reproductive case history since many of the symptoms are related to the menstrual cycle and giving birth. A screening to determine any indication of depression should be carried out, not only because depression is often a somatopsychic outcome of pain but because patients suffering pain are often subjected to suicidal attempts and substance abuse. Personality disturbances have a significant impact towards the benefits of a therapy. It is helpful for an experienced psychosomaticist or psychotherapist to be introduced to the patient. Particularly in cases of complex and persistent
symptoms of pain it is important to introduce a multidisciplinary procedures and rehabilitation programmes (Gunter 2003).

Concerning the case history, it is essential to enquire after possible dysmenorrhoea, the menstrual cycle, dyspareunia, bladder and gastrointestinal functions. Severe dysmenorrhoea, as opposed to a weak or

mild form of dysmenorrhoea, is one of the most evident indications of endometriosis. Dyspareunia can be associated with the following symptoms: endometriosis, pelvic dysfunction, vulvodynia, interstitial cystitis and irritable bowel syndrome. Indications of an interstitial cystitis include pain, micturition urge and frequency of micturition, also the necessity to micturate at night and frequent infections in the past with no evidence of germs in the bacterial culture. The frequency of irritable bowel syndrome in women with chronic pelvic pain is around 65 – 79%, therefore necessitating enquiry as to the gastrointestinal function (Gelbaya, El-Halwagy 2001). Data of the social case history is of particular importance in patients with chronic pain in order to gain an impression of their social environment and a screening with questions regarding possible domestic assault should be introduced. Victims of domestic physical assault are known to have a high risk of chronic pelvic pain with substance abuse, anxiety, depression and suicidal attempts. One must approach this complex area with great care since it is often happens that such patients refuse to cooperate with the medical therapy offered. It would also be of great significance to ask the patient if she has experienced sexual assault or mishandling since such victims often present with chronic pelvic pain. The literature gives no cause/effect in conjunction with this theme (Fry et al. 1997).

It is also necessary to introduce multidisciplinary aid as well as a data compilation of gynaecological diagnostics. This differentiated concept according to Bodden-Heidrich (2001) encompasses an orthopaedic examination, internal differential diagnostics together with urological and surgical differential diagnostics (Table 2). The integration of a laparoscopy is described by Richter 1998 as the gold standard of diagnostics. Around 40% of all laparoscopies are carried out to relieve chronic pelvic pain. A critical question is whether or not the desire to diagnose a somatic correlation is frequently induced by the patient and thus a reason for the physician to introduce invasive diagnostics and therapy. For instance, in the USA 80,000 hysterectomies are performed yearly to counteract chronic pelvic pain, whereby in a quarter of these cases pelvic pain persists even after surgery (Milburn et al. 1993). The importance of a laparoscopy is relevated as such since only the intraperitoneal changes are visible. Important causes for pain such as retroperitoneal lesion of nerves remain undetected with laparoscopy. It remains to say that laparoscopy offers false security in view of the actual cause of pain. Even evidence of pathological changes does not always ensure a true assessment of the reason for the pain. Determinant changes brought about by laparoscopy include endometriosis and adhesions. The advantage of this form of surgery is that diagnostics and therapy can be performed at the same time (Howard et al. 2000).

Table 2
Recommendations for a diagnostic procedure in the form of a multidisciplinary, differentiated programme (according to Bodden-Heidrich 2001)

Case history of symptoms
- Triggering situations: since when, situation of life at that time
- Description of pain as given by the patient: "is, as if, as"
- Effect of pain on:
  - the patient herself
  - relationship
  - sexual life
  - profession
  - free time/hobby

Psychosocial case history: graded biographical case history, general and gynaecological case history
- OP-report, do not read through or take note of physician's medical report
- case history of profession
- case history of medication administered
- symptoms from other disciplines

Gynaecological diagnostics
- gynaecological examination
- microbiological examination
  - vaginal smear test
  - exclusion of chlamydia/mycoplasma
- sonography

Orthopaedic examination, pay particular note to facet syndrome internal differential diagnostics
- exclusion of porphyria
- exclusion of lactose intolerance
- irritable bowel syndrome

Urological differential diagnostics: chronic cystitis, interstitial cystitis?
Surgical differential diagnostics: hernia? chronic appendicitis?
Psychosomatic diagnostics: somatopsychic successive illnesses, general psychodiagnostics
Psychiatric diagnostics: exclusion of psychiatric comorbidity

6. Possible therapy options

Therapy options can be of the non-invasive and invasive type. Non-invasive options include physical therapy, massage, and acupuncture, also alternative forms of nutrition and exercise programmes to counteract pain, such as certain forms of psychotherapy, behavioural and psychodynamic. Pharmacological substances are also of importance both as analgesia and as an adjuvant. Tricyclic antidepressants are sometimes administered as an adjuvant. Patients with chronic pain appear to respond more rapidly to this form of medication than when used for the purpose of relieving depression. A low dosage is often recommended (Guay 2001). Furthermore, anticonvulsive medication is administered as relief for pain together with antihistamines and muscle relaxants. Psychopharmaceutical measures should only be administered by those with specialized experience in pharmacology. Invasive therapy options include injections, for instance, in the region of trigger points or in the form of nerve blocks and also operative measures. With reference again to laparoscopy, 44% of patients treated for endometriosis presented with renewed symptoms one year after surgery. A high placebo effect of 23% was assumed by a number of authors (Sutton et al. 1997). Hysterectomy is the most frequently performed gynaecological operation in the USA with 600,000 cases yearly. Of these operations around 10% are performed because of chronic pelvic pain. The rate of success varies significantly between 60 and 90%. This indicates an extremely broad definition of chronic pelvic pain. Around 18 - 97% of women were reported to have had pre-operative pelvic pain. The outcome of a hysterectomy does not always result in relief of pain. This has been reported in several women with no indication of organic disorders and in those under the age of 30 years suffering depression and other psychological problems (Gunther 2003).

Chronic pelvic pain is a complex and puzzling syndrome brought about by the complex interaction of biological and psychosocial phenonema and thus resulting in psychosocial stress. It is important to understand that chronic pelvic pain is a symptom and not an illness and seldom reflects on a pathological process. Since many factors generally contribute towards the symptoms in each case it is essential to introduce integrated, multidisciplinary measures in the diagnosis and treatment of the symptoms. Recommended therapy is based primarily on extensive knowledge of the variety of symptoms as this will influence the therapy related to dysmenorrhoea or sexual disorders.

Nowadays it can be said that there is no differentiation between psychogenic and somatogenic pain in chronic pain syndromes as experience has shown that the psychic reaction and treatment represent a decisive factor in the multifactorial pain genesis. Independent of the original cause of the condition this factor influences the progress of the pain syndrome. It may be assumed that exacerbation of the process is conditioned by the sensibilisation of receptors and neurons, serving as a reminder of the pain (Beutel et al. 2005). In view of the frequent association with psychosocial stress, stressful experiences in life and sexual mishandling or assault in the case history, it is recommended that these factors be heeded when taking into account the case history data and also the introduction of the primary therapeutic measures, such as the psychosomatic basic care. Like with all chronic pain interdisciplinary treatment should be administered. This includes, besides gynaecological treatment, also physiotherapeutic measures and psychotherapeutic interventions. Relaxation procedures, guidelines to overcome pain and further behavioural-therapeutic methods, sexual-therapeutic therapies and psychodynamic procedures should also be included.

It must be said that denial of any psychic difficulties on the side of the patients with chronic pelvic pain will result in complications in the execution of the necessary therapeutic measures. A number of groups have been set up – to name in particular the group by Nijs (2002) and Richter (1998). Concepts for therapy have been developed which recommend a careful and gradual transition to encompass the organic to psychosomatic form of the illness taking

into account the adverse reaction of the patient. It has been proved that intensive clarification and consultation may help the patient to realize that the pain might not be of an organic nature, but of a psychosocial one. This concept resulted in successful treatment in 2 of 3 patients with relief or totally painfree condition. A condition which has exacerbated over a period of time might benefit from an inpatient psychosomatic treatment. This setup will provide a simultaneous approach to include physical therapy in conjunction with psychotherapeutic discussions and accompanied physiotherapy. Such a multiprofessional approach towards the patient will help bring about to light the in-depth experiences (Neises 2005).

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Mission Statement

1. The IFP is a worldwide umbrella organisation for psychotherapy. The Federation is open to professional societies, institutions and individual members.
2. The IFP aims to promote, endorse and maintain high professional and ethical standards of psychotherapy in practice, research, and training.
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The IFP realizes its aims by means of

- World congresses (every four years)
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Gender, cultural identity and psychotherapy

Introduction

Mechthild Neises, Gerhard Schmid-Ott

Considerable changes concerning the gender role have taken place over the past decades. Gender studies have been developed and established and numerous investigations have been undertaken to determine the origin and effect of gender roles in its diverse contexts. Despite all the investigations to date the true hierarchical differences between man and woman show evidence of only minimal changes. Ongoing persistence is evident in the most significant data of generic segregation entailing wage discrepancies, distribution of work or access to resources. At the same time, comprehensive deregulation has taken place regarding generic-oriented behavioural and appearance aspects. The provocative theory of Soilandt 2003 runs: "Gender role has led to a multitude of changes covering almost every aspect – with exception of the subordination of women to men". Relations do not necessarily exert an effect of power on regular lifestyle; however, gender relations contribute greatly to this problem and are a current topic of discussion in gender research (Butler 2001).

The principle question is namely, whether in relation to the gender disposition identity criticism and analysis focusing on the responsive behaviour or appearance are masked unconsciously by specific indoctrinations and images, referred to by psychoanalysis as unconscious aspiration. From this perspective, power does not offer any restrictions as such rather it represents our underlying desires and aspirations. This aspect is not necessarily affected by changes on the level of normality; on the contrary, it serves to raise minimally our conscious limitations. According to our conceptions extensive changes appear to have taken place without bringing about any influence on our unconscious implications and involvements. All borne identities and behavioural attributes may indeed vary without shedding light to our inner secret desires (Soilandt 2003).

Both men and women possess male as well as female attributes, asserted already before the 1st World War by Adler and Jung, approximating Platos Aristophanes and the term "androgynous". What exactly contributes to the indications of man and woman are socially defined. The female and male construction focuses on the concepts formed by the society, namely, their view on the so-called concept of what constitutes to male and female attributes. At the same time, there is a so-called standard determination of unwomanly and unmanly attributes. What is assumed as reality will, in turn, become indeed reality. These concepts serve to determine how each individual defines him/herself as a woman or a man despite all restrictions as to the true assessment of men and women. (Rohde-Dachser 1992, Cingsem 1995).

This book aims to introduce articles to the general public regarding the theme gender in the form of a series of lectures encompassing cultural identity, health and illnesses. All
topics have been presented by M. Neises and G. Schmid-Ott. These contributions depict an insight into health and illnesses with gender perspectives relating to psychosomatic medicine, psychotherapy and psychiatry, also migration experiences. These perspectives are imperative for the care and treatment of both male and female patients and have already been widely acknowledged by scientific research. We were able to successfully generate an interdisciplinary exchange of professional groups, including status representatives. Contributions referring to other scientific contexts based on the same theme were also included. A similar theme was also expressed by A. Rieder and B. Lohff who, with her book on "Gender medicine. Gender-specific aspects for clinical practice" (2004), came up with a significant and detailed contribution. Her book refers to gender medicine as a relatively novel scientific introduction – this is also the subject of her critical introduction – she attempts to expand on the previous research enquiries, diagnoses and therapy by means of a gender-oriented insight into health and illness, both from a biological and a psychological view. In her article, her book and her experiences she has amassed the differing clinical specialist fields, such as cardiology, rheumatology, intensive medicine and psychiatry, in a scientific-oriented as well as a practice-relevant account. A gender-specific research is presented depicting an improved and optimized prevention, diagnostics, early detection, therapy and rehabilitation.

Numerous gender differences are relevant for the planning of optimal gender care in middle age. Between the age of 30 and 65 years, the death rate of

men is twice as high as that of women, particularly regarding cardio-vascular illness, also accidents and suicide. Women, on the other hand, appear to suffer more from poor physical health and psychic disorders. This is evident due to the high consumption of medication. Almost 3/4 of all women aged between 45 and 65 years take medication on a daily basis. With men, the percentage is registered as around 1/2. With regards to alcohol – almost 1/3 of all middle-aged men consume high quantities of alcohol, thus presenting a risk to health. With women, only 1/2 as much women are reported to drink such large quantities of alcohol. Tobacco consumption is another health risk registered in both genders. Over the past 20 years a minimal reduction has been reported in the male population, on the other hand, an increase has been reported in the female population. The age of commencement of tobacco consumption is, on average, around 15 years for both genders. The causes for gender differences in health and illness are mainly due to the varying lifestyles and professional circumstances (Lademann, Kolip 2005).

The article compiled by M. Neises depicts the lifestyles of women by means of data material and attitudes relating to circumstances arising from relationships, social environment and in professional life. The data are based on a questionnaire established by the Federal Centre for Health. Besides, the concept of lifestyle is introduced both from a sociological as well as a psychological perspective in a general and individual context. A change in lifestyle takes place only in the case of a major or persistent experience, such as death of a partner, loss of job and also illness. The attempt to describe lifestyles in an accentuated form indeed raises more questions than answers.

The contribution of Jan Kruse refers to empirical studies which disclose that in the last 10 years men are stronger in favour of marriage and grounding a family. In his article he emphasizes the neglected male perspective concerning family planning and family life in general. It becomes evident that men are placed at a disadvantage when it comes to differing norms and biographically linked requirements in order to start a family.

Further contributions can be seen in the index.

We hope very much that many readers will find our articles of interest. Our aim is to impart practical treatment methods for physicians, respectively, dipl.-psychologists, also social workers in the field of somatic and psychosomatic medicine and psychotherapy, psychiatry and psychotherapy and finally, in other specialist fields of medicine. Helpful and informative advice for daily practice can be found in all the specialist areas of medicine. Furthermore, the articles are aimed to offer stimulation to all those active in the field of psychotherapy and those providing counselling, also for those laymen interested in such themes.

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PROF. DR. DR. MECHTHILD NEISES
DR. GERHARD SCHMID-OTT

The Assimilation of Current Western Psychotherapeutic Practice in Thailand

Pichet Udomratn

Psychiatry in Thailand has a long history (Udomratn P, 2007a). It has undergone continual improvement and development over the past century to suit the changing social, economic, and cultural climate and to keep up with technological advances (Udomratn P, 2006).

Mental health services were once concealed within general health services, religious ceremonies and other administrative activities. Thailand's first psychiatric hospital was established in 1889 in Tambon Pak Khlongsan on the western bank of the Chao Phraya River and named 'The Asylum'. It was under the jurisdiction of the Department of Nursing and the Ministry of Dharmakara (now the Ministry of Education). To begin with, patients were admitted here more for administrative than treatment reasons. In 1905, the Asylum's administration was transferred to the Sukhaphibal Medical Division, at the Ministry of City Administration. Dr Hugh Campbell - Highet, head of the Sukhaphibal Medical Division, became its director and introduced new and more humane treatment and care protocols (Siriwanarangsan P, 2001).

In 1925, the Asylum's administration changed hands again and came under the control of the Disease Detection and Treatment Division of the Ministry of the Interior. That year, a number of medical doctors graduated from medical school in Thailand and the authorities were prompted to issue new regulations barring certain positions of authority to foreigners. Luang Wichian Baedyakhom, then a doctor based at the Central Hospital, was appointed Thailand's first psychiatric hospital director. He was also the first Thai doctor to study psychiatry on a two-year scholarship to the USA. On his return, he changed the institution's name from 'Asylum' to 'Psychiatric Hospital' to help change public perceptions. He also launched the first technical and staff development programmes in Thailand, laying important groundwork for future psychiatric training. During Dr Luang Wichian Baedyakhom's tenure, a number of psychiatric hospitals were built in the Thai regions to broaden the extent of mental health care in Thailand. On the 50th anniversary of mental health provision in Thailand (1939), a Mental Health Division was formally established by Royal Decree as part of the Public Health Department of the Ministry of the Interior. This division was subdivided into three sections-central, psychotherapy and mental hygiene - and Luang Wichian Baedyakhom was its first director (Siriwanarangsan P, 2001). So, it can be assumed that Western psychotherapeutic practice was formally launched in Thailand in 1939.

An important turning point in the march to a new era can be marked in 1942 when Dr. Phon Sangsingkeo assumed the position of director of Somdet Chaopraya Hospital. The hospital commenced a period of remarkable reformation in many respects, becoming a modern psychiatric hospital. The services were improved and iron bars on cells were eliminated, replaced by moral treatment.

Words are inadequate to describe the tremendous contributions the late Professor Dr. Phon Sangsingkeo made to the development of psychiatry and mental health in Thailand. After Dr. Phon Sangsinkeo's period, psychiatry has been further developed along the same lines as in Western countries.

In 1942, The Ministry of Public Health was established when a Royal Decree proclaimed the reorganisation of the Department of Medical Services. The decree also authorised the transfer of all mental health matters from what was the Mental Health Division to the new Psychiatric Hospital Division - the latter supervised five psychiatric hospitals. Treatment was, by this stage, extensively available, but the psychiatric hospitals were beginning to experience problems in accommodating the increasing numbers of psychiatric patients. A Mental Hygiene Clinic was opened at Somdet Chaophraya Hospital to help alleviate the problem. Later still, this clinic was expanded to the four corners of Bangkok to provide outpatient mental health services. The Child Mental Health Centre on Rama VI Road in Bangkok became the central clinic office. Unfortunately, due to staff shortages, all but the Child Mental Health Centre were shut down in 1970. New therapeutic techniques from the West were also introduced between 1942 and 1960 - tranquilliser therapy, psychotherapy and behavior therapy, for example, all of which were applied through the group work of mental health teams comprising psychiatrists, clinical psychologists, psychiatric nurses and psychiatric social workers.

During 1961-1971, the Thai Government began to implement the first National Economic and Social Development Plan (1961-1966). The agenda included mental health in the form of the Psychiatric Hospital Project, one of 22 health development programmes. This project was geared towards expanding and improving various operations. In 1964, the first community mental health operation began to take concrete shape. Dr Sakondh Sobhano, then director of Suansaranromya Hospital, organised a mobile psychiatric unit to serve the people of the southern provinces. The service helped to extend mental health provision and facilitated medical check-ups and treatment closer to the onset of mental disorders. The treatment and rehabilitation of mental patients continued to develop. Novel services, such as the Day-Care Project at Somdet Chaophraya Hospital, the Milieu Therapy Programme and the building of a rehabilitation village based on the halfway house concept at Srithanya Hospital, were introduced. The aim was to help mental patients cope with everyday life, work and leisure time within the community but under professional supervision, protection and support, until they were fit to return home.

In the second National Economic and Social Development Plan (1967-1971), mental health was represented by a project to improve mental and neuropsychiatric hospitals and a project to set up psychiatric wards in general hospitals. During this period many Thai psychiatrists went to both the USA and Maudsley Hospital in London to learn Western psychotherapy. When they came back, they began to teach and write articles and books on psychotherapy such as Prof. Somporn Bussaratid (Bussaratid S, 1981) and Prof. Chamlong Disayavanish (Disayavanish C, 1979). In 1962, Prof. Jira Sritasuwan started to treat patients with group psychotherapy. Behavior therapy and cognitive therapy were introduced in Thailand in the 1980s and 1990s respectively. Prof. Isaac Marks from the UK was invited by the Psychiatric Association of Thailand (PAT) to organise a short course on behavior therapy for Thai psychiatrists in Bangkok in 1993. Recently, Satir's psychotherapy under the leadership of Prof. Nongpanga Limsuwan became more popular in our country perhaps due to the shorter time and fewer sessions required compared with a traditional psychoanalytically-oriented psychotherapy.

As the great majority of Thai people are Buddhists many Buddhists principles such as believing in "kamma" (law of cause and effect), the virtue of forgiveness, and the essence of life, are easily understood by Thais. Therefore, many leading Thai psychiatrists have emphasised the combination of Buddhist practice with psychotherapy or contribution of the Buddhist teaching to psychotherapy in helping Thai patients (Udomratn P, 2007b).

In Buddhism, there is a word called sunnata (or in Sanskrit, sunyata) which means the total absence of any object. When the mind is not grasping or clinging to anything whatsoever (as "I" or "mine"), it is in a state of emptiness (Udomratn P, 2008). The mind is then an empty or void mind of emptiness, in the sense of being void of content. All objects are there as usual and the taking processes are going on as usual, but they are not going the way of attachment and clinging with the idea of "I" and "mine". The mind is in a state of non – attachment, "non-self" and emptiness. According to Prof. Disayavanish, the concept of non-attachment and emptiness should be incorporated into the therapeutic process of the Western psychotherapy (Disayavanish C, 1979).

In recent years therapists from various clinical orientations in the West have been utilising the teaching of Buddha to help depressed patients challenge their depressive stance. This so called "mindfulness based procedures" is found in the form of mindfulness – based cognitive therapy (Ma S and Teasdale J, 2004) (Segal ZV et al., 2002) and mindfulness – based hypnotherapy (Lynn SJ et al., 2006). Buddha attributed human suffering to the tendency to cling to thoughts, feelings, and ingrained perceptions of reality and habitual ways of acting in the world. When mindful, one's attention is not entangled in the past or in the future, and one is not judging or rejecting what is occurring at the moment. One becomes the present and this kind of attention can generate energy, clean – headedness, and joy (Germer CK, 2005).

Depressed patients are encouraged to read books about different cultures and to begin to appreciate what they have. Patients are also provided with a culture – neutral explanation highlighting some of the general differences between Western and non-Western societies in terms of culture, beliefs, values, and models of mind. It is expected that such understanding will help the patients to re-examine their meaning of life and appreciate that success and failure are culturally determined (Alladin A, 2007).

Recently, Prof. Chamlong Disayavanish and Prof.

Primprao Disayavanish in Thailand have proposed integrating the relevant doctrines of the Buddha into various aspect of suicide prevention measures such as the Buddhist attitude toward suicide, providing monks with knowledge and understanding of suicide, practice of meditation, etc., (Disyavanish C and Disayavanish P, 2007).

In terms of meditation, the loving – kindness (metta) meditation, which is a form of concentration meditation is recommended. As suicide patients tend to act out suicidal fantasies because of a loss of love objects or a narcissistic injury, they may experience overwhelming affects like rage and guilt or identify with a suicide victim. Practicing loving – kindness meditation both to themselves and others will counteract the destructive effects of introjected aggressive impulses and will control anger or aggressive defilement (dosa) which is closely associated with suicide.

Another form of meditation, insight meditation, will also help to purify the mind of defilements and helps to create willpower, increase self confidence and self esteem. According to authors, Buddhist meditation not only promotes mental health but also is an effective means for the primary prevention of suicide.

In Thailand, there are two main psychiatric organisations: the Psychiatric Association of Thailand (PAT) and the Royal College of Psychiatrists of Thailand (RCPsychT). PAT organised a workshop on "Mind and Insight Development" applying Buddhist principles for self development for psychiatric trainees and young psychiatrists on the 4th and 5th February, 2006. The RCPsychT under the leadership of Prof. Nongpanga Limsuwan, President of the organisation, is now preparing and testing the curriculum on "Buddhist Psychotherapy" for training psychiatric residents. Hoping that when this curriculum is finalised, we will have good learning material for training on this subject (Udomratn P, 2008).

Conclusion

Western psychotherapy was perhaps formally launched in Thailand in 1939 after Dr. Luang Wichian Baedyakhom, the first Thai doctor to study psychiatry, came back from USA. Since then, various forms of psychological treatments such as behavior therapy, cognitive therapy, Satir's psychotherapy have been applied to Thai patients. As the great majority of Thai people are Buddhists, many leading Thai psychiatrists have advised combining Buddhist practices with psychotherapy. Recently, the curriculum on "Buddhist Psychotherapy" for training Thai psychiatric residents has been prepared and tested. Western psychotherapeutic practice combined with Eastern wisdom may be the best approach in our country.

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Congress Calendar

November 7 – 9, 2008, Zürich, Schweiz
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Gestalttherapie im Umgang mit dem älter Werden und alt Sein und (der Bewusstwerdung von) Sterblichkeit.
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März 13 – 15, 2009, Salzburg, Österreich
3-Länder-Tagung der Deutschen Gesellschaft für Psychosomatische Frauenheilkunde und Geburtshilfe, DGPFG,
zusammen mit der Österreichischen Gesellschaft für Psychosomatik in Gynäkologie und Geburtshilfe, ÖGPGG und
der Schweizerischen Arbeitsgemeinschaft für Psychosomatische Gynäkologie und Geburtshilfe, SAPGG

März 18 – 21, 2009, Mainz, Deutschland
60. Jahrestagung des Deutschen Kollegiums für Psychosomatische Medizin, DKPM und
17. Jahrestagung der Deutschen Gesellschaft für Psychosomatische Medizin und Ärztliche Psychotherapie, DGPM

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SEMINARS

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See detailed program (in German) in www.ifp.name

V. IFP Seminar
Januar 16. + 17, 2009, Zürich, Schweiz
<<Positive Psychotherapie als transkultureller und interdisziplinärer Ansatz:
Die 5 Stufen der Trauerarbeit unter Einbeziehung von Geschichten und Lebensweisheiten>>
Referenten:
Prof. Dr. Nossrat Peseschkian, Wiesbaden, Deutschland & Dr. Biland, Olten, Schweiz

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and

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