02·08

IFP
international federation
for psychotherapy

newsletter

Zurich, December 2008

EDITORIAL

Dear colleagues,

The main function of the Newsletter is to build bridges between our members and to inform regularly about the ongoing in the IFP. I hope we accomplish this task to your satisfaction. To improve this part of life of our society you are always kindly invited to submit relevant information and papers for our members.

We are happy again to send you this Newsletter with interesting information about some of our members and their activities and offer you a few important papers.

As usual the president report informs you about the actual state of the IFP and the preparation of the next world congress 2010 in Lucerne.

We have the privilege to present our new Honorary Member Bachtiar Lubis from Indonesia.

The IFP Council has changed. We welcome the new Council Members Hans Kurt, Jürgen Margraf and Peter Schulthess from Switzerland; Sylvia Detri Elvira from Indonesia. They represent either societies which newly joined IFP or have been nominated ad personam (Jürgen Margraf). We also welcome Arend Veeninga from Holland in his function as new president of the Dutch Association for Psychotherapy (Nederlandse Vereniging voor Psychotherapie NVP). A short presentation of the Indonesian Psychiatric Association – Section of Psychotherapy winds up this section.

The papers of this journal correspond to the main topic: our new members. Thus the first paper comes from the new Honorary Member Bachtiar Lubis. He gave an impressing speech at our last World Congress in Kuala Lumpur in 2006 about Psychotherapy in Asia – Challenges and Future Direction. It honours us that we got permission to present you his experienced and well reflected vision and suggestions.

His former collaborator and actual president of the Section of Psychotherapy in the Indonesian Psychiatric Association, Sylvia Detri Elvira, submitted a description of a practical case and her paper "Psychotherapeutic Considerations in a Case of Culture Related Depression".

The tradition with IFP-workshops continues. This is the reason to give a short portrait of Nossrat Peseschkian who will give in Zürich the next workshop (January 16-17, 2009).

We close the Newsletter with useful information.

I remain like always with my best greetings and wishes for the season

Alfried Längle

ALFRIED LÄNGLE, M. D., PH. D.
Vice-President, IFP
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President's Message

Dear friends and colleagues

Professor D. Bachtiar Lubis, Jakarta, Indonesia, was appointed honorary member of IFP. The IFP Council took this decision based on Prof. Lubis' invaluable contributions over many years in developing, promoting, and supporting the field of psychotherapy, particularly in the Southeast Asian Region. When the Asian Pacific Association of Psychotherapists APAP, a chapter of IFP, was founded in Seoul, South Korea, during the IFP World Congress in 1994, D. Bachtiar Lubis volonteered to organize the first APAP conference which took place in Bali in 1996. The conference was a great success, and marked the beginning of a series of psychotherapy conferences, held under the auspices of IFP, and organized by APAP: Langkawi, Malaysia (2000); Singapore (2003); Taipei, Taiwan (2005). Just recently, D. Bachtiar Lubis was instrumental in organizing the 5th APAP conference in Jakarta, Indonesia, which he jointly chaired with his collaborator Dr. Sylvia Elvira Detri, and which took place in April 2008, under the congress theme „Listening to the heart of the East". Those of you who had the privilege to get to know Professor Lubis will certainly agree that he is an extremely knowledgeable scholar, a well respected authority, and last but certainly not least, a person of great integrity. We are proud to have D. Bachtiar Lubis on the list of our honorary members!

By the way, talking about the Asian Pacific Association of Psychotherapists APAP: The Philippine Psychiatric Association has agreed to host the **6th APAP conference in Manila, Philippines**, in 2010 or 2011 (exact date to be confirmed). Dr. Alma Jimenez and Dr. Maria Imelda Batar, President of the Philippine Psychiatric Association, will be jointly instrumental in organizing this conference.

The **Department für Psychosoziale Medizin und Psychotherapie (English: Department for Psychosocial Medicine and Psychotherapy)**, a department of the Donau-University Krems, Austria, has joined the IFP as a new membership society. The Donau-University Krems, is a rapidly growing university for further education exclusively. The Department for Psychosocial Medicine and Psychotherapy has currently over 500 students. They offer a range of curricula, the majority of which providing academic training in different psychotherapeutic approaches. Their overarching theme is the integration of psychotherapy. Welcome to the IFP, we are looking forward to a fruitful collaboration in the future!

We have also appointed two new Council members: **Dr. Hans Kurt, MD**, Solothurn, Switzerland, is currently president of the Swiss Society for Psychiatry and Psychotherapy SGPP who have taken on the responsibility for the organization of the 20th IFP World Congress of Psychotherapy in Lucerne, Switzerland. **Dr. Sylvia Elvira Detri, MD**, Jakarta, Indonesia, is president of the Indonesian Psychiatric Association Section on Psychotherapy IPA. As I mentioned above already, she was a co-organizer of the 5th APAP conference in Jakarta, Indonesia, which took place in April 2008.

The **Secretarial Office in Zurich** 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!

The plannng of the **20th IFP World Congress of Psychotherapy** in Lucerne, Switzerland, 16.-19.6.2010 is now well under way. We have chosen the congress theme **„Psychotherapy: Science and Culture"**. Our congress will be organized by the Swiss Society for Psychiatry and Psychotherapy SGPP (http://www.psychiatrie.ch), and co-sponsored by the World Psychiatrie Association WPA. The venue will be the „KKL Luzern", the Culture and Convention 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. - The scientific program committee will be chaired by myself. A professional Conference Organizer 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 Positive Psychotherapy is planned with Professor Nossrat Peseschkian (Germany) on Positive Psychotherapy in Zurich January 16-17, 2009 in Zurich. A seminar on CBT for Eating Disorders with Professor Chris Fairburn (UK) 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: The 5th WCP World Congress of Psychotherapy, organized by the World Council for Psychotherapy, was held in Beijing, October 12-15, 2008. The congress was organized by Prof. Quian Mingyi and Prof. Jie Zhong of the Department of Psychology, Beijing University. I delivered a keynote address, which provided me with an opportunity to further liaise with our Chinese partners, and to strengthen our collaboration.

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:

S. Karger AG
Journals distribution
PO Box
CH-4009 Basel (Switzerland)
Fax +41 61 306 12 34
E-Mail karger@karger.com

Best regards

Ulrich Schnyder

PROF. ULRICH SCHNYDER, MD
President IFP
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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.
3. The IFP fosters a worldwide intercultural, interdisciplinary dialogue and mutual learning among psychotherapists, psychotherapy researchers, psychotherapeutic orientations, traditions, and related sciences.
4. The IFP provides a platform for the development of theories, methods and treatment approaches, and promotes the integration of psychotherapeutic thinking in clinical and non-clinical fields.

The IFP realizes its aims by means of

- World congresses (every four years)
- Regional congresses
- Supporting and co-chairing the organization of scientific congresses of their members and/or national umbrella organisations (and under certain conditions supporting them also logistically and financially)
- Supporting scientific activities in research, practice, and training, particularly activities of intercultural relevance
- Information transfer by constantly updated homepage and newsletters

New Honorary Member

Bachtiar Lubis, Indonesia

Professor Dr.med. Didi Bachtiar Lubis, PhD, Indonesian (Tapanuli ethnic), is married and has two children and two grandsons.

Dr. Lubis graduated as a general physician from Faculty of Medicine at the University of Indonesia in 1958 and as a psychiatrist from the same school in 1963. A part of his training was undergone at the University of Victoria in British Columbia, Canada). He received his promotion as PhD in 1977. In 1984 he was elected as a professor of the Faculty of Medicine at the University of Indonesia.

Dr. Lubis is an associate member of the American Academy of Psychoanalysis and Dynamic Psychiatry, and serves as one of the Editors of the American Journal of Psychotherapy.

Dr. Lubis was elected for the Presidency of The Indonesian Psychiatric Association in the years 1984-1988, he figured also as the Director of Residency Training in the Department of Psychiatry at the Faculty of Medicine, University of Indonesia. He was a guest lecturer at the University of Kebangsaan, Malaysia. During his long journey in his academic carrier, he taught and practiced psychotherapy in the residency training program and also gave workshops in many Psychiatric Centers as well as in the neighbor countries.

New Council Members

Hans Kurt, CH

CURRICULUM VITAE

Born in 1948 in Solothurn, Switzerland

Study of medicine at the University of Fribourg, in Utrecht and at the University of Berne, Swiss State Examination 1978

Further qualification as a Specialist for Psychiatry and Psychotherapy FMH (Swiss Medical Association) at the psychiatric hospitals in Marsens (Canton Fribourg) and Solothurn, as well as at the Solothurn Höhenklinik Allerheiligenberg.

Head Physician for Social Psychiatry in the Psychiatric Centre at Biel Regional Hospital

Dissertation on cognitive improvement in older patients during their stay in a rehabilitation clinic (Solothurn Höhenklinik Allerheiligenberg)

Training in **Systemic Psychotherapy** (Dr. C. Gammer, Zurich/Paris). Additional training in supervision.

Current areas of work:

- General psychiatric treatment and care of young persons and adults in the context of a group practice (general practitioners, a psychiatrist and a psychologist)
- Health policy activities as President of the Swiss Society for Psychiatry and Psychotherapy SSPP and as a member of the Board of the Solothurn hospitals - "Solothurner Spitäler AG SOh".
- Psychiatric-psychotherapeutic supervisions (systemically-oriented)

Memberships

Swiss Society for Psychiatry and Psychotherapy SSPP
Swiss Association for Social Psychiatry SGSP
Swiss Association for System Therapy and Counselling SGS
European Psychiatric Association EPA

Peter Schulthess, CH

CURRICULUM VITAE

Date of Birth: 16-04-1950

Studies in Psychology, Pedagogics and Philosophy at the university of Zurich.
Psychotherapist EAGT (European Association for Gestaltpsychotherapy), ECP (Europeanwide certified psychotherapist), SPV (Swiss Association of Psychotherapists), SVG (Swiss Association for Gestalttherapy, Honorary member of PTPG (Polish Association for Gestalttherapy).

Teaching Gestalttherapy 25 years, mainly in Switzerland, Germany and Greece but also in other countries. Practising as psychotherapist and supervisor in private practice in Zurich.

President of the Swiss Charter for Psychotherapy and EAGT (European Association for Gestalttherapy).
Board member of EAP (European Association for Psychotherapy) and WCP (World Council for Psychotherapy).

Council member of DGPTW (German Association for Psychotherapy Science).

Author of several articles and chapters of books, Co-author and editor of 2 books, mainly on gestalttherapy and also the regulations of the profession of psychotherapists. Most published in Swiss and German Journals, but also internationally in other languages: English, French, Polish.

MAIN PUBLICATION:
BONGERS, D.; SCHULTHESS, P.; STRÜMPFEL, U.; LEUENBERGER, A. (2005): GESTALTTHERAPIE UND INTEGRATIVE THERAPIE. BERGISCH GLADBACH, EHP

SPECIAL RESEARCH INTEREST: COMPARATIVE EFFICACY STUDY IN NATURALISTIC PRACTICE ENVIRONMENT.

PETER SCHULTHESS, LIC PHIL I (= MSC)
Bergstrasse 92, CH-8712 Staefa, Switzerland
peter@pschulthess.ch; www.pschulthess.ch

Sylvia Detri Elvira, Indonesia

CURRICULUM VITAE

I. Personal Data

Name : Sylvia Detri Elvira
Date of birth : November 13, 1959
Nationality : Indonesia
Marital status : Married, 2 children

II. Educational Background

1985 : Medical Doctor, University of Indonesia
1992 : Psychiatrist, University of Indonesia
2005 : Consultant, Indonesian Psychiatric College

Elective & Postgraduate Training

1989 -1992: Psychoanalytically Oriented Psychotherapy course, Univ.of Indonesia - Prof.D.Bachtiar Lubis
1993 -1999: Dynamic Psychotherapy courses, Prof. D. Bachtiar Lubis
1993: Hypnotherapy course, Society of Hypnologia Education - Jakarta
1994: Rational Emotive Behavioral Therapy Course, C.Stager (Austin Hospital) in Jakarta
1995 & 1996: The First & Second Annual Jakarta International Epidemiology Courses for clinicians
1996: PANSS interrater training - Dept.of Psychiatry - Univ. of Indonesia:
1999: Advanced training course on Schizophrenia and Depression (Dept. of Psychiatry, University of Melbourne)
1999: PANSS & ESRS interrater training in Study ILP3002- Singapore
2005: Training on Evaluation for affective mode for medical and health students, Gajah Mada University
2007: Good Clinical Practice Training - Jakarta

III. Present & Past Appointments

Present Appointments:
1994-present: Lecturer in Psychiatry for undergraduate and postgraduate medical students, Faculty of Medicine, University of Indonesia
1994-present: Supervisor in Adult Outpatient Psychiatric Unit, Dr. Cipto Mangunkusumo National General Hospital.
1994-present: Research staff of the Dept. of Psychiatry - Faculty of Medicine - Univ. of Indonesia
2002-present: Chair, Student Consultant Team, Fac.

of Med, Univ. of Indonesia
2004-present: Secretary, Medical Committee, Dr. Cipto Mangunkusumo Hospital.

Past appointments:
1986-1988: Head, Public Health Centre, Ranomeeto, Kendari, South-East Celebes
1993-1994: Psychiatrist, Karawang District General Hospital, West Java
1994- 1998: Member, Student Consultant Team, Fac. of Med, Univ. of Indonesia
1998-2001: Secretary, Student Consultant Team, Fac. of Med, Univ. of Indonesia
1998-2001: Member, Student's Behavior & Welfare Team
2004 – 2006: Assistance Manager of Student's behavior and welfare

IV. Research

1991-1992: Correlation of Negative Symptoms and Neurological Soft signs in Chronic Schizophrenic Patients
1992-1996: Profile of MMPI of The first year students, Fac. of Med. Univ. of Indonesia (as a member of the Team)
1998: Validation Study of The Edinburgh Postnatal Depression Scale
1998: Identification of Relevant Factors in Pregnancy and Childbirth, A Qualitative Study in Cipto Mangunkusumo, Fatmawati and Persahabtan General Hospitals
1998: Positive EPDS on Postpartum Mothers and the Possible Risk Factors in Cipto Mangunkusumo, Fatmawati and Persahabtan General Hospitals.
1998-1999: Clinical Trial of Tianeptine
1999-2000: Cohort Study on Postpartum Depression
1999-2001: Double blind clinical trial of Iloperidone (phase 3) in Dr. Cipto Mangunkusumo National General Hospital, Jakarta
2005- : Hypnotherapy in patients with Vaginismus in Edelweis Clinic Dr. Cipto Mangunkusumo National General Hospital, Jakarta
2006-2007: Platinum Study (Multicentre Double blind clinical trial of quetiapine as anti anxiety (phase 3) in Dr.Cipto Mangunkusumo National General Hospital, Jakarta
2008- : Multicentre Double blind clinical trial of pregabalin as anti-anxiety (phase 3) in Dr.Cipto Mangunkusumo Ntiopnal General Hospital

V. Publications

A. RESEARCH AND OTHER PAPERS AT JOURNALS

1. COUNTERTRANSFERENCE IN DYNAMIC PSYCHOTHERAPY. JIWA, INDON. PSYCHIAT. QUART. XXIX: 4:1996
2. THE MEANING OF TRANSFERENCE. JIWA, INDON. PSYCHIAT. QUART. XXX: 1:1997
3. TRANSFERENCE AND COUNTERTRANSFERENCE. EDITORIAL. JIWA, INDON. PSYCHIAT. QUART. XXXI:2:1998
4. COUNTERTRANSFERENCE, THE DEVELOPMENT OF THE CONCEPT AND THE APPLICATION IN PSYCHOTHERAPY. JIWA, INDON. PSYCHIAT. QUART. XXXI:2:1998
5. VALIDATION STUDY OF THE EDINBURGH POSTNATAL DEPRESSION SCALE, JIWA, INDON. PSYCHIAT. QUART. XXXI:2:1998
6. PSYCHOSOCIAL ASPECTS OF PSORIASIS, INDONESIAN MEDICAL JOURNAL. VOL.48:10:1998.
7. IDENTIFICATION OF RELEVANT FACTORS IN PREGNANCY AND CHILDBIRTH, A QUALITATIVE STUDY IN CIPTO MANGUNKUSUMO, FATMAWATI AND PERSAHABTAN GENERAL HOSPITALS. JIWA, INDON. PSYCHIAT. QUART. XXXI:4:1998
8. POSITIVE EPDS ON POSTPARTUM MOTHERS AND THE POSSIBLE RISK FACTORS IN CIPTO MANGUNKUSUMO, FATMAWATI AND PERSAHABTAN GENERAL HOSPITALS. JIWA, INDON. PSYCHIAT. QUART. XXXII:1:1999
9. POSTPARTUM DEPRESSION. EDITORIAL. JIWA, INDON. PSYCHIAT. QUART. XXXIII:2:2000
10. PRELIMINARY REPORT ON POSTPARTUM DEPRESSION: A PART OF MULTI-ETHNIC AND MULTI-CENTRE COHORT STUDY (CENTRE: JAKARTA). JIWA, INDON. PSYCHIAT. QUART. XXXIII:2: 2000
11. FKUI'S CONSENSUS ON OPIATE, MEDICAL PROBLEM AND THE THERAPY. BALAI PENERBIT FACULTY OF MEDICINE - UNIV. OF INDONESIA. FIRST AND SECOND ED. JAKARTA 2000 & 2002
12. INCREASE OF HUSBAND'S SUPPORT IN DECREASING PREVALENCE OF POSTPARTUM DEPRESSION. J OF INDONESIAN OBSTETRIC AND GYNAECOLOGY: 2001
13. PSYCHOTHERAPY. EDITORIAL JIWA, INDON. PSYCHIAT. QUART. XXXV:2:2001
14. PROJECTIVE IDENTIFICATION AND IT'S SIGNIFICANCE IN PSYCHOTHERAPY JIWA, INDON. PSYCHIAT. QUART. XXXVII:2:2001
15. PENELITIAN PSIKOTERAPI PERLU DIKEMBANGKAN . EDITORIAL JIWA, INDON. PSYCHIAT. QUART. XXXVI:2:2003
16. DEPRESI PASCA PERSALINAN DAN DAMPAKNYA PADA ANAK, JIWA, INDON. PSYCHIAT. QUART. XXXVII:2:2004
17. PENANGANAN PSIKOLOGIK PADA OBESITAS. CERMIN DUNIA KEDOKTERAN VOL 147, 2005

18. ALIENATION FROM SELF – A CASE STUDY. ASEAN J OF PSYCHIATRY VOL 7 NO.1 JUNE 2006
19. PSYCHOLOGICAL ASPECTS OF FEMALE SEXUAL DYSFUNCTION, INDONESIAN MEDICAL JOURNAL. VOL.56:7:2006.

B. BOOKS

1. KUMPULAN MAKALAH PSIKOTERAPI BALAI PENERBIT FKUI, 2005
2. PENUNTUN WAWANCARA PSIKODINAMIK DAN PSIKOTERAPI. (AS A SECOND AUTHOR OF D BACHTIAR LUBIS) BALAI PENERBIT FKUI, 2005
3. DEPRESI PASCA PERSALINAN, BALAI PENERBIT FKUI, 2006
4. DISFUNGSI SEKSUAL PADA PEREMPUAN, BALAI PENERBIT FKUI, 2006
5. GANGGUAN PANIK, BALAI PENERBIT FKUI, 2008

VI. PROFESSIONAL ORGANIZATION MEMBERSHIP:

1. INDONESIAN MEDICAL ASSOCIATION (IDI - IKATAN DOKTER INDONESIA) – MEMBER (1986-)
2. INDONESIAN PSYCHIATRIC ASSOCIATION (PDSKJI- PERHIMPUNAN DOKTER SPESIALIS KEDOKTERAN JIWA INDONESIA) – MEMBER (1992-)
3. INDONESIAN PSYCHIATRIC ASSOCIATION, SECTION OF PSYCHOTHERAPY – CHAIRPERSON (2004-)
4. INDONESIAN COLLEGIUM OF PSYCHIATRY – MEMBER (2006 -)
5. INDONESIAN PSORIASIS STUDY GROUP (KELOMPOK STUDI PSORIASIS INDONESIA) – MEMBER (1999 -)
6. ASIA PACIFIC ASSOCIATION FOR PSYCHOTHERAPIST (APAP) – PRESIDENT (2008 -)
7. INTERNATIONAL FEDERATION FOR PSYCHOTHERAPY – INTERNATIONAL COUNCIL MEMBER (2008-)
8. THE AM ACADEMY OF PSYCHOANALYSIS AND DYNAMIC PSYCHIATRY - PSYCHIATRIC MEMBER (2007 -)

SYLVIA D. ELVIRA
Chairperson, Indonesian Psychiatric Association–Section on Psychotherapy
sylvia.d.elvira@gmail.com

Veeninga, Arend T, NL

Date of Birth: 11-11-1944

Qualifications

Member of the Dutch Association for Psychiatry
Member of the Dutch Association for Psychotherapy (Chairman)
Member the Dutch Association for Behaviour Therapy and Cognitive Therapy (Teacher / Supervisor; Member of the Educational Committee)
Member of the Dutch Association for Client Centred Therapy

Present jobs

- Jewish Psychiatric Hospital Sinai Centre Amstelveen, the Netherlands: Senior psychiatrist-psychotherapist. Member of the Department of Research and Education in treatment of Posttraumatic Stress Disorders.
- Principal trainer in Psychotherapy at the Universitas Padjadjaran, Facultas Psikologi, Bandung, Indonesia.

CURRICULUM VITAE

Arend Veeninga (64) obtained his M.D. at Utrecht University, the Netherlands; then specialized in tropical hygiene and worked for 3 years in a rural medical mission hospital in Kenya as a medical officer in charge. After that, he was trained as psychiatrist at the Academic Medical Centre of Utrecht University, the Netherlands. Subsequently he obtained a doctorate in psychology (Ph.D.) at the University of Amsterdam. For several years he worked as clinical psychiatrist in General Psychiatric Hospitals in the Netherlands, training resident doctors in psychiatry. A training in psychotherapy was completed with a specialisation in cognitive behaviour therapy (CBT). At present he is the chairman of the Dutch Association for Psychotherapy; teacher / supervisor and member of the Educational Committee of the Dutch Association for Behaviour Therapy and Cognitive Therapy and a Member of the Dutch Association for Client Centred Therapy.
Currently he works at the Sinai Centre, Jewish Psychiatric Hospital at Amstelveen, the Netherlands as senior psychiatrist-psychotherapist and a member of the Department of Research and Education in treatment of Posttraumatic Stress Disorders.

In 2007 a collaboration with the Universitas Padjadjaran, Facultas Psikologi, Bandung in Indonesia was started for a training programme in psychotherapy and at present he is the principal trainer.
He has published more than 50 articles in international and local (Dutch) scientific journals on different subjects, such as psychiatric and psychological aspects of menstrual disorders, vitamin-D deficiency in psychiatric inpatients, irrational combinations of psychotropics, education in psychotherapy, PTSD, EMDR, aggression, evaluation of psychotherapy and CBT.
His specific scientific interest and fields of research/work are PTSD, psychotherapy research, cultural sensitive aspects of psychotherapy.

INTERNATIONAL PUBLICATIONS

KRAAIMAAT FW, VEENINGA AT. LIFE STRESS AND HYSTERECTOMY-OOPHORECTOMY. MATURITAS, 1984, 319-325.

VEENINGA AT, WESTENBERG HGM, WEUSTEN JTN. FLUVOXAMINE IN THE TREATMENT OF MENSTRUALLY RELATED MOOD DISORDERS. PSYCHOPHARMACOLOGY, 1990, 102: 414 416.

VEENINGA AT. LIFE STRESS, SOMATIC AND PSYCHOLOGICAL COMPLAINTS AROUND THE MENOPAUSE. JOURNAL OF REPRODUCTIVE AND INFANT PSYCHOLOGY, 1991, 9: 132.

VEENINGA AT, WESTENBERG HGM. SEROTONERGIC FUNCTION AND LATE LUTEAL PHASE DYSPHORIC DISORDER. PSYCHOPHARMACOLOGY, 1992, 108: 153 158.

VEENINGA AT, KRAAIMAAT FW. LIFE STRESS AND THE CLIMACTERIC. JOURNAL OF REPRODUCTIVE AND INFANT PSYCHOLOGY, 1992, 10: 169 176.

VEENINGA A. PSYCHIATRIC AND PSYCHOLOGICAL ASPECTS OF THE PREMENSTRUAL SYNDROME AND THE CLIMACTERIC. THESIS, UNIVERSITEIT OF AMSTERDAM, 22 SEPTEMBER 1992.

VEENINGA AT, KRAAIMAAT FW. LIFE STRESS AND SYMPTOMS IN MENOPAUSE CLINIC PATIENTS AND NON-PATIENTS. JOURNAL OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY, 1989, 10: 269 277.

VEENINGA AT. A TREATMENT STRATEGY FOR PSYCHIATRIC PATIENTS IN A DAY HOSPITAL. SOCIAL AND CLINICAL PSYCHIATRY, THE JOURNAL OF THE RUSSIAN SOCIETY OF PSYCHIATRISTS, 1994, 4, 105-108.

VEENINGA AT, KRAAIMAAT FW. CAUSAL ATTRIBUTIONS IN PREMENSTRUAL SYNDROME. PSYCHOLOGY AND HEALTH, 1995, 10, 219-228.

VEENINGA AT, KRAAIMAAT FW. A MULTIFACTORIAL APPROACH OF COMPLAINTS DURING THE CLIMACTERIC. JOURNAL OF REPRODUCTIVE AND INFANT PSYCHOLOGY, 1995, 13, 69-77.

HAFKENSCHEID, ANTON J, MAASSEN, GERARD H. AND VEENINGA, AREND T. (2007). THE DIMENSIONS OF THE DUTCH SCL-90: MORE THAN ONE BUT HOW MANY? NETHERLANDS JOURNAL OF PSYCHOLOGY, 63, 29-35.

LOCAL (DUTCH)SCIENTIFIC PAPERS:

ABOUT 40 PUBLICATION ON DIFFERENT SUBJECTS SUCH AS: VITAMIN-D DEFICIENCY IN PSYCHIATRIC INPATIENTS, PTSD, AGGRESSION, EVALUATION OF PSYCHOTHERAPY, CBT.

Present specific scientific interest and fields of research/work

PTSD, psychotherapy research; cultural sensitive aspects of psychotherapy

VEENINGA, AREND T, MD, PHD
PSYCHIATRIST-PSYCHOTHERAPIST
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3431 GA Nieuwegein
The Netherlands
atveeninga@telfort.nl

Jürgen Margraf, CH

SHORT CURRICULUM VITAE

Personal and Education

Born June 29, 1956, in Korbach (Germany), married, two children. High school diploma ("Abitur"), German School of Brussels (1975). University studies in psychology, sociology and physio¬logy in Munich, Brussels, Kiel, and Tübingen. Diplom in psychology (German degree between masters and Ph.D. level) at the University of Tübingen (1983); Ph.D. in psychology, University of Tübingen/Stanford University (1986); Habilitation (scientific degree after the Ph.D.) in clinical psycho¬logy and psycho¬physio¬logy at the University of Marburg (1990).

Career

1983-1986: Research Scholar in Psychiatry and Behavioral Sciences at Stanford Uni¬ver¬sity, USA; 1986-1990: Assistant Professor of Psychology ("wissenschaftlicher Mitarbeiter" and "Hochschulassistent") at the Universities of Tübingen and Marburg; 1990-1992: Acting Professor of Clinical Psychology ("Lehrstuhlvertretung C4"), University of Münster; 1992-1993: Pro¬fessor of Clinical Psychology, Free Uni¬versity of Berlin; 1993-1999: Professor and head of the Department of Clinical Psychology and Psycho¬the¬ra¬py, Technical University of Dresden. In addition, director of the outpatient behavior therapy clinic (1993-1999), Vice-Dean ("Prodekan") of the Faculty of Mathematics and Natural Sciences (1995-1996), scientific director of the Christoph-Dornier-Foundation for Clinical Psychology (1993-1998) and vice-chair of the Public Health Research Network Saxony (since 1993). Since 1999: Professor of Clinical Psychology and Psychotherapy ("Ordinarius"), University of Basel. In addition, Head of the Institute of Psychology (2000-2002), director of the Department of Clinical Psychology of the Psychiatric University Hospital of Basel (1999-2002), Director of the Swiss National Centre of Competence in Research „sesam“ (Swiss Etiological Study of Adjustment and Mental Health, 2005-2009), Dean of the Faculty of Psychology (2007-2009).

Scientific Acitivities

Author of some 400 publications on mental health (especially anxiety and other emotional disorders), experimental psychopathology, psychotherapy research, cognitive behavior therapy, assessment and diagnosis of mental disorders, clinical psychophysiology, obesity, public health, primary prevention of mental disorders. Functions in various scientific societies including Past President of the European Association for Behavioural and Cognitive Therapies (EABCT) and Past President of the German National Scientific Council on Psychotherapy ("Wissenschaftlicher Beirat Psychotherapie der Bundesrepublik Deutschland").

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Indonesian Psychiatric Association - Section On Psychotherapy

Sylvia D. Elvira

Indonesian Psychiatric Association has several sections that established a few years ago. Psychotherapy as one of those sections – along with Substance abuse Section, Psychiatry Forensic Section and Psychophysiological section - were announced officially by the President of The Indonesian Psychiatric Association in the Biannual Scientific Meeting in Jakarta on 2003. The members of the Psychotherapy section are Indonesian psychiatrists who are interested in and would like to study more in depth about psychotherapy. .

The goals of this organization are to increase the value and role of psychotherapy in psychiatric practice, to improve the competence of psychiatrists in doing psychotherapy for the sake of patient's health and well being, to make Indonesian psychotherapy books, to develop psychotherapy researches, etc.

At the moment, we are collecting the varieties of many of psychotherapies used by psychiatrists in all Indonesian parts in order to find the characteristics of psychotherapy in our country. We are also supporting psychotherapy study groups in many cities which organized psychotherapy discussions and supervisions. We are now have a communications media called "Warta Psikoterapi" that is published quarterly.

In 2004, the Section held the First National Conference on Psychotherapy in Bali, which was participated by 349 persons. The participants were very enthusiastic to follow all of the programs including the workshops. The second National Conference was held on 16-17 November 2006 in Batam, a little island, east of Sumatra. The theme of the conference was "The Price of Mental Health, Maturity and Freedom", which was provided with a rich variety of lectures, panel discussions, symposia. Our guest lecturer Professor Sowntharaleela Ryan from Malaysia spoke about "Child Psychotherapy update".

In 2008 we were pointed as the host of the fifth congress of the APAP (Asia Pacific Association of Psychotherapists) with the theme of "Listening to the heart of the East" (note: the first congress of the APAP were also in Indonesia in 1996, and it was a very successful congress as well). This last congress was a successful and pleasant congress as well. The next APAP congress by the way will be in the Philippines.

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Psychotherapy in Asia
Challenges and Future Direction[1]

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Abstract

What will happen to psychotherapy in Asia depends on how psycho-therapists conceive and relate to their professional task. In Western countries, biological psychiatry, managed care, and the drug industry are among the forces that are removing the listening and talking functions from the therapeutic armamentarium. These forces will come to operate in many regions in Asia too. On the other hand, especially in a number of Asian regions, moralistic movements find followers among the general public, leaders and professionals alike which tend to deal with problems (health or morals) in an authoritarian way rather than by listening and understanding.

If psychotherapy remains to be regarded mostly as a therapeutic modality only, within the field of medicine, to remedy [mental] illness, then it may indeed eventually become obsolete or irrelevant, incapable to meet the above challenges. Fortunately, a cursory survey among therapists in this region tends to show that they conceive of the purpose of their work as not merely to cure illnesses, but has to do with the way patients think about themselves, their relations with others, their worth and the meaning of their lives. They might bring this kind of conception from along their respective cultures, most of which put a dominant value on the human and spiritual, over the biological and socio-biological. Most of these therapists do not feel cultural differences as obstacles in their work. They do not demand proof of effectiveness, measured by symptom reduction, to keep their faith in the meaningfulness of their work and their zeal to advance their skill in it. Apparently, seeing their patients regain self confidence, self reliance and self respect, using "techniques that listen and speak directly to the human heart", is for these therapists ample incentive to keep that faith. They see helping sick people in the larger context of elevating the dignity of humanity. Just a small number of such people (a larger number would be even better, of course), in the right teaching or decision-making positions in society, could foretell a good future for psychotherapy. In depends on the choices they make and the changes they activate, not only for healthier, happier and more productive living by more cost-effective means, but for better, worthier people and for making human life truly worth living.

What is happening to psychotherapy?

To assess the current status of psychotherapy – dynamic psychotherapy, to be more precise – with a special focus on Asia, to recognize the challenges and to discern its future course, this lies close to the heart of a psychotherapist – in particular one who works in Asia. This cannot be done – if at all – in a disinterested and objective manner. The devoted psychotherapist fervently hopes that the outcome of the assessment will show the increasing use, value and effectiveness of psychotherapy for mental health – for the goodness of humanity. And he dreads the possibility that it could show or predict it to be otherwise, that its use, value and effectiveness are on the decline. The latter would gravely undermine the spirit that drives him to study and practice good psychotherapy, the spirit derived from his conviction that he is engaged in a meaningful activity, towards important and highly worthy goals, which cannot be replaced or supplanted by another type of activity with equal (not to mention: better) results. Therefore, in a presentation like this, it is hard to suppress all bias; there will be a tendency in every dedicated psychotherapist to brighten the observations and interpretations to support an optimistic look at its future. As there will be – no doubt – a tendency in people who from the outset "do not believe in psychotherapy" to paint a gloomy future from their observations. And all this against the backdrop of experience in history that presaging the future is an uncertain undertaking, and one for which our methods have not considerably improved. It had, therefore, better not become a presentation in the manner of a story about "the rise and fall" (of psychotherapy).

The reports we read about how dynamic psychotherapy fares in the countries of the West do not much cheer us up, and rather put an added strain on whatever optimism we here, in Asia, in the East, may have been able to maintain. Observes Corradi (2006): Psychodynamic psychotherapy – psychological exploration and self-understanding for therapeutic gain – has little currency in contemporary American psychiatry. While Tasman (2000) in his presidential address to the APA points at biologic academic psychiatry, managed care, and the drug industry, as the confluent forces that are redefining contemporary

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American psychiatry, effectively removing its listening and talking functions from the therapeutic armamentarium; and in many academic centers, young psychiatrists are being trained in a biologic, split-treatment orientation that gives short shrift to psychotherapy. Plakun (2006) notices with some optimism, that dynamic psychiatry and psychotherapy, having had its heyday during the third quarter of last century, has lost ground to a biological and medical model of psychiatry over the last generation, but that the value of psychodynamic thinking and psychodynamic therapy is [still] being recognized and preserved. This is reflected by the [re-]introduction of psychotherapy training and set skill requirements in the psychiatric residency training programs, after such training had already been all but abandoned in some training institutions, and training staff (mostly psychoanalysts) had started leaving.

The sights and sounds of Kuala Lumpur

Now, venturing to say something about how it is with psychotherapy in Asia and where it is going, is an immense task, and – with the very limited knowledge and sources of information at my command – is most likely to yield dubious answers. For one thing, Asia is a very big place, with so many geographical areas each with their own history and culture. Yet, one ought to understand the urgency to formulate some ideas, to have some pointers; an urgency that is growing with the uneasiness and discontent, not only about the universal appropriateness, necessity and usefulness of psychotherapy, but its very meaningfulness, the very sense of it. In the case of its usefulness, for instance, does the Asian scene face the same contingencies (mentioned above) as the Western world? That is bad enough already for psychotherapy, if Asia doesn't present other challenges all characteristically its own. One cannot fail to notice that the topic of psychotherapy is conspicuously ignored in conferences on psychiatry and mental health in this region, unless the conference is specifically on psychotherapy.

Unable to grasp Asia, I shall sample the site of the present conference as a vantage point. "Truly Asia" is how the travel brochures – appropriately indeed – describe and promote Malaysia as a tourist destination. Southeast Asia, Malaysia in particular, with its amalgam (not just "mixture") of Asian (and European) cultures and participation in history, constituting a character and identity all its own, should be a place as good as any to frame and test an Asian perspective.

In Asia, except for a few centers in India, Korea and Japan, we cannot even say that psychotherapy (dynamic, that is – and let alone psychoanalytic) has had a real "heyday". It is the rare (if existing at all) academic medical or psychiatric training institution where competence in dynamic psychotherapy is one of the explicit educational goals. Except in the countries just named, professional organizations, societies, or academies of psychotherapy are few and small. Not that psychological healing is unknown; on the contrary, it is, actually, a significant aspect of most of the cultures of Asia and existing often in elaborate procedures with philosophies and theories behind them, very much believed in, and counting many practitioners – and clients, naturally. However, as a professional scientific discipline, psychotherapy has only begun to make inroads into the larger part of Asian society and its academic world. From this point of view, one could say that is has nowhere to go but up. But, so far it did start to create an image; and this image is worth looking into, to give us an inkling of what psychotherapy in Asia may be growing into. After all, there is no "psychotherapy" or a "future of psychotherapy" apart from psychotherapists and their patients, their growing or receding number, their increasing or waning faith in, and dedication to, the meaning of their work together. And that – I believe – can only be gauged partly by looking at the psychotherapy process, the validity of its supporting theories, and finding convincing proof of therapeutic effectiveness. Why people do this work with hope and enthusiasm, why they pursue this art and try to attain perfection in it, is ultimately not because of its usefulness, productiveness, profitability, or prestige – although those are immensely powerful motives the absence of which can certainly constitute significant disincentives. People have thrown themselves on tasks, devoting themselves to life missions, even at considerable sacrifice rather than reward, undaunted by absence of tangible proof of success, or even by ridicule and suppression. There is no denying that missions carried out in such spirit have, just the same, often faltered and been cast into oblivion, perhaps (a big "perhaps") because it served a cause that went against the grain of history or human evolution or against "the right course". And even the apparent success of a mission is not necessarily evidence that it is on the right course; it may

have been stimulated by motives such as the ones mentioned above, and by skillful and clever argument. But one thing seems to be quite certain. A mission to be accomplished by human beings will not succeed on account of its "rightness" alone, and because it is destined to take its course; that is very much the way of thought systems, ideologies, and religions – the way of what is held to be true, good, and just.

Psychotherapy will not flourish and spread just because it is a good thing, because proof is accumulating that it brings health, sanity, and the associated individual and societal benefits; formal proof of that has actually remained doubtful. It has to be sustained and powered by an emotional factor, very much like devotion and faith, on the part of the therapist and his patients, rooted in an inspiring "image of psychotherapy". And even given this factor, the growth could still be impeded by all sorts of social, economic and political developments as mentioned above, that can happen in Asia just as they happen in the West. And added to that, there is growing uneasiness about the appropriateness of medicine and psychiatry to deal with illness – especially mental illness. There are the findings, that the remission rate of major psychoses is something like 60 to 65% higher in developing "third world" countries as compared with advanced industrialized countries. There is also the impression, that there has been no significant reduction of the worldwide incidence rate of psychoses, being still the traditional estimate of 0.1 to 0.3% (not to mention neurotic and personality disorders in two-digit percentages) after many decades almost of development of science-based treatments – psychopharmacology being the most sophisticated and impressive among them. We are still kept fairly in the dark about mental illness and its treatment; what is the "truth" about the treatment of mental illness?

The matter of cultural boundaries

It has become customary to look at cultural differences and boundaries as significant obstacles to the applicability, appropriateness and effectiveness of psychotherapeutic methods and procedures developed in one cultural environment when applied to a patient population of another culture – obstacles also to the teaching and learning of these procedures. Can wellbeing, carried by way of psychotherapy, reach mankind "across cultures", eventually overcoming cultural "barriers" – that is the question imbedded in the theme of this conference. A sweeping division is often drawn between "West" and "East". The West, held to be the mainspring of what is called psychotherapy grounded in western medicine and science, philosophy and psychology, and the East as seen to differ in certain significant aspects from the scientific, philosophical and cultural foundations upon which psychotherapy, as we conceive it, is built. W.S. Tseng mentions, among others the emphasis on philosophical acceptance of problems as they are, contrasting with the western way of active resolution of problems; the intuitional approach, rather than the logical approach advocated in western therapy. He further points to psychological characteristics, such as the relatively blurred ego boundary in Asian culture, extending into surrounding people, unlike the clear, individual boundary emphasized in western culture, and a great many more of such contrasts.

Efforts are made to "overcome barriers", make linkages and adjustments, so that the reach of the truth and benefits of psychotherapy can be widened beyond the boundaries of western culture – as if it were all that convenient to determine such boundaries and to select and target the specific and prominent contrasting features between East and West to facilitate psychotherapy's progress into Asia. The expectations range from great hope that the barriers can and will be overcome, to despair that "western" psychotherapy is just unsuitable for "the East". If these efforts were looked at purely as a sort of marketing proposition – a promotion campaign how to sell psychotherapy in Asia – the prospects wouldn't look too bad, really. And, by the way, that is, indeed, what we are also doing. That would then not necessarily imply that it flows from the conviction that this psychotherapy constitutes progress in our capability to overcome mental illness (and all sorts of problems ascribed to it), that it is so many steps forward in our understanding, in our healing art and science – the right thing to do to be and to make better men and women. It may be vigorously pursued, for all that, as we may promote mountain climbing, nurturing household pets, or the study of ancient drama, which can all – at the very least – produce surcease of mental stress and enlighten and elevate the soul. All these kinds of things may, in any given case and at any given time, be substituted by another occupation that may have the same – or a better – effect on one's

experience of wholeness and one's enjoyment of life. All these kinds of things are pursued, promoted, and in vogue at one time, for certain reasons of a temporary and local nature, which made them prestigious, enjoyable and/or lucrative and satisfying a particular need or desire. Something like this – we hope – should not be the case with psychotherapy.

We hope that in psychotherapy we have hit upon the discovery of something of a fundamental nature about the human mind, indeed, about being human, a real advance in our knowledge to make correct choices, a real advance in our power to steer towards betterment. Something eminently worthy of our best efforts to learn and to practice it, of which "doing it well" is by itself already ample reward. Can this be shown to therapists and aspirant therapists in Asia? Or are they perhaps already favorably predisposed to it?

Psychodynamics, dynamic therapy may be called an invention made in the West. Practiced in various forms, comprising a continuum of approaches between extremes of analytic and supportive, its core is in the art of listening. It is rooted in psychoanalytic concepts or their derivatives, which add a novelty to this art: listening to and hearing not only the reasoning and conscious patient, but also his irrational and unconscious part, understanding it, and conversing with it. What we hear, listening in this way, and can make sense of (interpret) using certain techniques based on psychoanalytic principles, presents us usually with a mental content that is offensive to our moral taste, to cultural standards of decency. Not only Eastern, Asian, standards. Even when introduced in Europe, it was regarded as scandalous right away, what with its supposed expounding of the supremacy of sexual and aggressive instincts hidden in the unconscious, among other obnoxious and obscene human inclinations. This could only be seen as undermining and subverting culture and religion, was feared to threaten the moral order (eventually even the social order) and vigorously resisted and opposed. What salutary benefits and values could possibly accrue from such a procedure (except from stirring up immoral behavior while justifying and enjoying it)? That its scientific legitimacy is also held to be in question, does not help either. Thus, not only is this procedure in disagreement with a particular culture, its value system, its symbol system, its ethical codes, and its "discoursive structure"- it is an inquiry and a critique of culture as such, and it forces deep cultural and social changes. On the other hand, and by the same token, dynamic psychotherapy can thrive only where the social and cultural ambient is prepared for it, has a certain tolerance and permissiveness for change, that is, in a democracy.

Certain sociological theories have it that there is a Western invention, which had deep and far-reaching consequences for the development of social order. History records how three millennia ago the republic of Athens started to experiment with it, implement it, to be neglected and revived again, spreading to other places in the world, until it eventually became – for better or for worse for humanity – a charter for many organized communities and nations and the relations between them. This invention is broadly referred to as democracy. That concept is, indeed, quite often abused and adulterated; it has been, and still is, subject to different and divergent interpretations in various communities and changing with the times. But, by and large, it implies the idea of the equality of all men, human rights, individual freedom of belief and speech, and majority rule for the determination of truth and justice. Some of these ideas are new or alien to the culture of a certain region, some of them can be more easily assimilated. The establishment of democracy brings with it the creation of certain institutions, estates and professions, and makes others obsolete, irrelevant, or redundant. Being a doctor, a practitioner of scientific medicine, is one such profession in the former sense; and so is being a psychotherapist (whether he also happens to be a doctor, or not). It requires the prevalence of democratic thought, as mentioned above, which then also leads to an image of the individual human being as having a unique identity, at a particular stage of development and integration, subject to certain influences from its environment, yet in possession of his own inherent will and power to direct his actions and entitled to direct them to his own satisfaction. So, he can feel discontented, indisposed, sick, in a state of suffering, and ask someone to heal him – by working at certain mechanisms of body and mind at which the healer is an expert – so that his wellbeing is restored.

How do psychotherapists work in this region?

To determine the status of psychotherapy and make perhaps a cautious prediction about its future, we should have reports on how psychotherapy is actu-

ally carried out, and how it is appreciated. I venture to describe what I have observed – a glimpse, really, into the reality of psychotherapeutic practice. And it describes the doings of medical practitioners, psychologists, and others in the healing professions, who apply any sort of systematic psychological methods for the purpose of healing, which they themselves call and believe to be psychotherapy. They call it by that name, since the procedure and methods they use are linked to, or derived from, ("western") scientific psychological theories and techniques which these practitioners have studied. They use the various methods of behavior modification, including interpretation and management of transference, to the extent they feel confident and skilled in each of these methods. The degree of knowledge and skill varies greatly among them, from very superficial to moderately experienced. Since there are hitherto no standards for official certification, it depends largely on the practitioners' own confidence how they rate their expertise in psychotherapy. His own confidence, often bolstered by peers, that he knows enough about academic psychology and that his patients responds favorably to his treatment. And on the average they – fortunately – rather rarely overrate themselves.

There may be perhaps a few hundred whose regular service might qualify as psychotherapy in this region. Surely, probably only a handful among them would meet the specific and rigorous standards of an American or European institute of psycho-therapy, but – on the whole – they seem to be as successful with their patients and clients as the average certified psychotherapist in the western world. In fact, there are many among those who actually give good therapy but are hesitant or too modest to claim to be psychotherapists, thus mystifying and holding "psychotherapy" in exalted esteem. Indeed, there are also, as always, a few making that claim while they are clearly incompetent, and it would be nice, for obvious reasons, if we knew of a way to spot them (by fair and objective criteria) and sort them out. But for now, it is important for our region with such limited resources of competent psychotherapy, to recognize good therapy and workers who provide it, and encourage and upgrade them, regardless whether and to what extent it follows standard procedure or is grounded in certain theories.

The criterion for whether an intervention has been proper or helpful is not the extent to which it follows standard procedure, but rather the extent to which it enables the patient to speak more freely, to disclose more genuine or troubling feelings, to deepen the work. Thus says McWilliams in her textbook. Now – how come that our therapists (as mentioned above) have relatively little difficulty with "cultural barriers" in their work with patients in our multicultural society, but for the exceptional case where the patient and the therapist speak a different language. Their concern has been, probably from the start, how to get the patient to talk to him, an intuitive concern likely to arise before there is a desire to get data about the other person (the patient) in terms of more sophisticated theories of personality. The effort to win the patient's trust and to get the patient to open up to him – first of all – could be based on a "drive" to test his (the therapist's) capacity to lay a bond and "know" the other person. To "know", that is, in his own experiential terms, what the experiential terms of the other person are. It is probable that this inclination in the Asian or Eastern therapists is stronger than his desire to compile data and categorize his patient according to a scientific classification system. It can be said that the aspirant therapist's natural human capacity to achieve this is quite remarkable, but can be dampened or suppressed by anxiety and neuroticism. Cognitive knowledge such as acquired through scientific study or learned in various ways from the environment can highly increase and refine this capacity and enable declarative consciousness of what is being experienced (to tell it in words). Because – after all – dynamic psychotherapy deals with just such barriers, namely the very "cultural" barriers that exist between the components of the personality, and interpersonally. But an excessive bent on "interpretation", trying naively to emulate the example of dynamic and analytic psychotherapy in the admired West, can also blunt and adulterate that capacity. In the latter lies an important catch for the understanding how the Asian therapist relates to his work.

Cultural (including ethnic and religious) difference between patient and therapist can actually favor good rapport and stimulate positive transference, if the therapist can handle this adroitly. For instance, a patient can be surprised and intrigued when his therapist, being of a different faith or ethnicity, seems to know so much about the patient's religion and ethnic tradition. Sometimes, a patient even feels freer to talk to a therapist of a different faith, if he has dis-

creet difficulties with his own religion and his family traditions. A public atmosphere of interreligious and interethnic tolerance is, of course, a highly desirable precondition for this arrangement to work. Such an atmosphere used to prevail in this region up until a few decades ago, but seems to have taken an unfavorable turn lately. This does not make such situations insuperable for therapists, but surely demands more delicate and skillful handling. Still, most psychotherapists feel that cultural differences are less of a "barrier" to the establishment of a therapeutic relationship, compared with differences in social position and financial status (wealth).

The treatment of human suffering

Is psychotherapy a treatment method discovered by medical science? The answer is most probably: no. One of the creations of democracy and modern science is the so-called medical model of human suffering and misfortune. They are all, according to this model, illnesses that can be recognized, classified – and their origins traced – by systematically observing all the symptoms. By thus knowing what sort of illness the patient suffers from, rational treatment becomes possible; the patient should recover, and if he does not recover, we can explain what factors block or retard his recovery, or which aspects of the illness have not yet been sufficiently examined. In this way, there can be progress in the art and science of healing through improvement of techniques and drugs, by discovering new and better techniques and drugs, and observing whether they work faster, more efficiently and with more lasting results. The indicator of therapeutic success would be, of course, the removal or significant mitigation of the symptoms. If psychotherapy were another treatment for certain illnesses (say, neuroses) belonging to the medical therapeutic armamentarium, then its future – like any medical therapy – will depend on its provable effectiveness and efficiency and on whether it will at some time become replaceable by another therapeutic method. And the enthusiasm for applying this treatment method by professional healers, and patients, and health service funding alike, will depend on that too. Change can no longer remain localized in the world as it is today, and there is little reason to believe that whatever fate befalls psychotherapy in Europe or in America will eventually spread and descend upon this region too. The demand that treatment (including treatment for mental ill health) must be cost effective, evidence based and solution focused, to be entitled to financial and legal support and scientific status, combined with a powerful lobby of providers of industrial products (psychotropic pharmaceuticals) constitute a most serious challenge to psychotherapy. That wave of change, what with globalization on the march, is certain to hit our Asian shores – or has already done so – and work against our short-lived gains in the growth of psycho-therapeutic practice. This train of events is often linked with the advent of the "age of the brain" or the "biological era".

That is, if psychotherapy continues to be regarded as a medical treatment for certain illnesses, the purpose of which is to eradicate the symptoms of illness by removing the pathogenic agent, extirpating the seat of the disease, reinforcing specific defense mechanisms of the organism and/or compensating for certain incapacities or dysfunctions caused by the disease. Treatment works this way with the medical model of illness, with the class of people designated by medical science as "patients". But psychotherapy does not work in this way. How it works against illness cannot be explained by using a medical model, and its effectiveness can – therefore – not be verified and measured like other medical treatment procedures. Psychotherapy exists outside and apart from medical science and practice; it was once called "the fifth profession". It invents and designates its own population of "people in need of psycho-therapy", which does partly overlap with the population of the mental patients of medicine. It can be put to use for its curative and ameliorative effect on "mental patients", more or less like music, drama, or Zen meditation can help mental patients. We know that music has therapeutic effects; there is music therapy – and the better music, the better its therapeutic effect. Yet music and drama and Zen remain fields of art in their own right, far more than healing techniques. They are practiced and supported, and they live and flourish, independent from how useful and beneficial they can be to overcome ill health. Music is created by and for those whose lives are enriched, ennobled and transformed by it. Medicine does a highly noble job, discovering treatments and drugs that can cure illnesses; it must also stay in business by discovering or inventing illnesses that "fit" those treatments and drugs, people who have such illnesses and therefore "need" those treatments and drugs, who are called "patients".

With a large investment in the health industry serving the need to create healthy citizens (i.e. in good physical and mental condition to be productive and creative), this industry, which is understandably not above profit motives, dominates the scene in fashioning the "truth" about illness (including mental illness) and the "truth" about its proper treatment. Of course, it adduces scientific evidence, trial data, follow-ups, which will invariably be supportive of that "truth", whenever and as long as science is regarded as the sole judge and source of truth. Truth changes, says Foucault, and this change is a function of the changing distribution of political and economic power in a given era. The shift into the "biological era" marks such a change, after which there may hardly remain a place for psychotherapy as a rational treatment for mental – or whatever – disorders. And who will uphold, by then, that the organo-biological approach in the study of behavior and mind processes does not suffice to understand and to engineer them. If, for instance, special drugs can and do – to people's satisfaction – relieve mental depression, make unhappy people happy and productive, straighten out irrational disturbing behavior, clear up confused thinking, and create peace of mind, then, what indeed do we still need psychotherapy for. Psychotherapy simply becomes irrelevant. And it will become politically incorrect to deny that.

The "biological era" will not merely be a shift in emphasis or modification of scientific theories. It brings along a change in what is held to be true which used to include humanistic propositions, foreboding a decline of humanism in the appraisal and conduct of health service in particular (among human affairs in general).

The goals of psychotherapy – an "Asian" understanding

But is humanism really that important – not to say, essential – for the recognition and treatment of health problems? That depends entirely on one's idea about a "healthy" person, about the state of "well-being" that a therapist is supposed restore, maintain, or facilitate by his professional service. One may hold the notion, that a healthy person is free of functional impediments, well adapted, and productive – and that he would, by virtue of those conditions, naturally be happy, self-assured and social. A society of such persons would run smoothly, continually improving efficiency of problem control, each person for him as well as supporting and stimulating those around him. Illnesses are untoward events that impede functioning, adaptation and productivity, and cause mental disturbances, tension, strife and unhappiness. Of course, doctors, like anybody else, want to make people happier, promote physical, mental, social and even spiritual wellbeing, but their specific professional contribution to this mission lies in their fight against illness. Illness (physical unwellbeing) underlies all the other disturbances of wellbeing. And illness is "really" a matter of cells, genes, hormones and neurotransmitters. Not that psychotherapy produces any benefit for wellbeing, but it is of no special relevance to a medical health professional's task to apply it towards therapeutic goals. This leads – as its mildest consequence – to a split-treatment orientation in mental health.

The above notion, reflected in an anecdotal way, is a spin-off from western liberalism, which contains the belief in the progress of humanity driven by the advance of human reason. It makes assumptions regarding the unity of humanity, linear progressive evolution, the belief in the liberating role of science, the objectivity of science, which all held allure and made inroads into the East. Western ideas still have superiority, but eastern ways of thinking in large parts of Asian society may have remained preserved and could stem the fall-out in Asia from the "biological era". This can favor continued growth of psychotherapy in medicine and psychiatry. Among those ideas, "innately" experienced (they are not entirely or exclusively "Asian", of course) are the following. Most people (including doctors) believe, openly or secretly, that disease is not only caused by germs (organic, biological). It can be a punishment by divine powers, one's past can have something to do with it, it can be caused by sin, guilt and regret, evil spirits, bad thoughts in oneself or in others, and the like. Another idea is that a disease can be the source of pain, anxiety, depression, and a soul broken, but can also be the result or manifestation of such mental states.

What are our assumptions about how psychotherapy works, and what is supposed to be achieved as a "therapeutic result"? As mentioned above, it does not work in a way similar to other medical treatments of illness. What it "does", what it makes happen is what psychodynamic psychotherapists in short refer to as "integration". It helps along,

helps to progress, and removes hindrances to, the emotional growth processes in the human individual, so that he can fully and harmoniously develop and mature his human capabilities. A person, thus matured, should be optimally capable of exercising all his functions and integrate them, to withstand stress and pressures without having to "regress" and be susceptible to develop symptoms (part of which conventional medicine designates as "mental illness"). Psychotherapy for the mental patient does not primarily work at removal of the illness or the symptoms thereof, but at the person. If we must use the word "cure", then we should say that psychotherapy attempts to cure the person, or that a psychotherapist personally treats the patient as person. This seems to be more pronounced in the East, where the sufferer does not look for a healing method but for a healer, and has difficulty to respond to an objective, dispassionate therapeutic method no matter how sophisticated and advanced. Similarly for the healer in the East, who believes and capitalizes on his charisma and his understanding. Healer and patient still share the indigenous understanding that the "healthy" state of the human being consists of more than his ability to reason properly, to control his irrational passions and to work productively. It is about being a good person, it is about what a person is supposed to be, and able to do what he should be doing and what he there for. And if he is – or becomes – less than a good person, he may become ill, as just mentioned above. It is about a person who is in full possession of the human capability to experience and conduct life. It is about the person who is aware of himself and his purposes, of what he thinks and dreams of, muses about, imagines, contemplates, and transcends himself; the person who knows that he is happy or unhappy, who can love, joke and praise, play and pray. The person who is aware of a sense of worthiness and dignity, his will to affirm himself and live up to an image of a worthy human being. In short, it is about who and what he is – his being – in contrast to merely how well he behaves, acts and functions, and feels about that. This understanding is imbedded in, and supported by culture, before the advent of western scientific criteria concerning health and illness, the advent of medicine, scientific medicine.

Culture itself has a healing potential, or underlies the healing potential of any therapeutic procedure, scientific or traditional. It provides certitude, solace and guidance, moral rules, fortitude in the face of adversity, hope for betterment. It prescribes ways (rituals, but also quite realistic ways and means) to deal with illness and the fear of dying, and improve the quality of life. It does this mostly in the form of religion and procedures and manipulations based on religion-inspired beliefs. Their power as therapy, or at least as therapeutic aid, is hard to deny. They work in the humanistic aspect of the therapeutic process, and their effectiveness, in any given case, depends very much on the nature of the relation of the patient and healer to their respective cultures. They help to restore the subject's human wellbeing in a total sense including a person's sense of worthiness, and his life worth living. It must be said, that almost all psychotherapists in this region appeal to the religious sensibilities of their patients; there is a considerable reliance on advice and encouragement for patients to practice their respective religions.

For most therapists, also, the degree of their enthusiasm for their work is not directly related to issues of evidence and efficiency. They are not so much encouraged or discouraged by expectation of success or failure of their treatment. More often than not they come to the conviction that their treatments are – on the whole – beneficial. It is much more related to the "mystique" of the procedure, the awe of what they come to know about their patients and their relations to them through psychodynamic approaches over and above what they can discover by "conventional" methods. The interaction itself is experienced, by both patient and therapist, as meaningful, enlightening and wholesome.

Dynamic psychotherapy in an Asian culture

Rather than imposing barriers, practically all of the traditional cultures in this region imply humanistic images of man, human life and human destiny, which are much in line with those of psychotherapy. They can become barriers, when culture is denuded of its humanistic underpinnings. Whether that will happen or not, depends on the choices mankind makes; human destiny is determined by Man himself, and we cannot count on an obligatory course of evolution in this matter. Whether that will happen in Asia, depends very much on the psychotherapists of Asia. Since olden days, the poet was regarded as the great civilizer of humanity, and some of us today consider [psychoanalytic] therapy one of the last redoubts of humanism [in our barbaric era]; thus says Chessick.

Could we do without humanism? That would not at all be inconceivable. We know about societies without it – or with only a thin veneer of it – which have not only survived, but were stable, prospered and dominated (atrocities notwithstanding). And there is no primary reason why we might not opt for creating or reestablishing just that kind of social order. There would not be any mental patients, because there is no mind; there can be brain disorders, though, but for that we have pertinent remedies. And people would not even be aware that they missed out on anything. In fact, individuals in such a society, who insist on humanism, are considered a danger to the social order. This is a moral choice, for Asia to be made by this region's psychotherapists, if we can maintain our presence and our dedication to a humanistic destiny. In his work, the therapist should have adequate knowledge of, and maintain a sincere respect for the local culture and its values (which, fortunately, happens to be the case). He must impress his patients, first of all, with his superior skill in the art of listening, with unwavering sincerity and honesty. He must not succumb to the influences mentioned before, that – in the West – threaten to depreciate psychotherapy, when those influences press for entry into these regions, just because of his eagerness to catch up with the "progress of the West". And neither should he give in to another conspicuous phenomenon in these regions, namely extreme moralistic militancy, often in ideological or religious guise, which is constantly waiting in the wings to jump into a cultural vacuum. That represents an attempt to make up for existential doubts and injuries to identity and dignity, which are more likely to appear among the peoples of Asia feeling themselves to be less prosperous compared with peoples of the West. It provides assurance, certainly, but also creates intolerance, while it constrains freedom of thought. It would not seem to be conducive to continuing evolution of humanness. Giving in to them, while knowing the consequences, would mean that we – in the name of human progress – have settled for a condition of diminished human worth, for the sake of convenience. We should – in the face of them – rather be stimulated to improve techniques, do better psychotherapy. If culture must change (the culture of a society as well as the "intrapersonal culture" of the individual), let good and properly culture-adjusted psychotherapy be one of its guiding factors. The psycho-therapist of Asia has an outstanding opportunity to do that.

In an address at a recent conference on the Millennium Development Goals, the President of Indonesia said: "We are all gathered here to help advance the greatest project humanity has ever embarked on: the global pursuit of Millennium Development Goals (MDGs). This project is much more ambitious than the last great project of humanity, namely the march towards freedom, emancipation, equality and independence that spread throughout our planet at the last century including here in the Asia Pacific. That, of course, was a great struggle that drained our blood, toil, and tears. And it was, in my view, a struggle that defined the 20th century. It permanently changed the world's political landscape, and restored the dignity of Man. For I have every conviction that our great struggle to accomplish the targets of the millennium development goals by 2015 are well within our ability to reach them". If the affirmation of the dignity of Man is indeed adopted as the benchmark of success of this project, as the President assumed, we may rejoice that our future planners have chosen to keep the evolution of Man as a moral and spiritual (over and above biological) being, on the foreground. In such a plan, clearly, psychotherapy is indispensable and plays a decisive role, in the matter of mental health, but definitely exceeding it and extending into health and wellbeing in general, and the quality and worthiness of every individual as a human being.

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June 5 + 6, 2009, Krems, Germany
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Psychotherapeutic Considerations In a Case of Culture Related Depression[1]

Sylvia D. Elvira

Introduction

Treatment of depression often continues to be a struggle. It is important to develop treatments or combination of treatments that address the neurophysiological and psychological vulnerabilities that may predispose patients to persistent symptoms or recurrences of depression. According to Gabbard, psychodynamic psychotherapy should be considered as an approach to reducing this vulnerability. Hilsenroch et al (2003) found a significant reduction in depressive symptoms with psychodynamic treatment and a decrease in symptoms correlated with the use of psychodynamic treatment techniques.

According to the psychodynamic theories, it is considered that individual's biological and temperamental vulnerabilities, the quality of the person's earliest attachment relationships, and significant childhood experiences (frustration, shame, loss, helplessness, loneliness, or guilt) and feelings are seen as creating dynamic susceptibilities to a range of depressive syndromes later in life, including narcissistic vulnerability, conflicted anger, excessively high expectations of self and others, and maladaptive defense mechanism.

This paper attempts to look at psychodynamic psychotherapy as a comprehensive means of understanding and treating depression, which is related to the patient's personality and the culture. It is also discussed how to overcome it and to become more adaptable through-out patient's life. The case, Ms R, has narcissistic vulnerability that could be seen as fundamental to susceptibility to her depression, which related to her role in the family as a woman of Tapanuli or Batak ethnic. The paper also discusses the treatment strategy of Ms R which consists of evaluation of the depression and her capacities to engage in dynamic psychotherapy, forming the therapeutic alliance and frame of treatment.

Psychodynamic theories of depression

Theorists have developed a variety of models to explain why certain individuals develop depressive disorder and to aid in the development of a treatment plan for them. Almost all psychoanalysts describing their patients with depression have emphasized narcissistic vulnerability as triggering susceptibility to this syndrome. The basis of this vulnerability varies, from disappointments in early relationships to fragile self-esteem based on factors such as childhood experiences of helplessness or reactive fantasies of disempowerment or castration. A sense of narcissistic injury predisposes patients toward the experiences of shame and anger, which may become important aspects or triggers of later depressive episode.

Theorists also focus on conflicted anger as playing a key role in the dynamics of depression, although the origin of the anger and the form is takes may vary. In general, the anger is seen as triggered by narcissistic injury, loss, frustration, or a sense of helplessness.

Most theorists mentioned that aggression ultimately is directed toward the self, although the basis of this dynamic varies. The possibilities include hatred projected outward and then experienced as directed toward the self, and aggressive feelings and fantasies directed toward aspects of the self identified with an ambivalently experienced other. A severe superego attacks the self for various aggressive, competitive, and sexual feelings, lowering self-esteem.

Several authors have referred to attempts to modulate self-esteem and aggression via idealization and devaluation, leading to increased susceptibility to depression when idealized others prove to be disappointing. Other authors also emphasized an overly perfectionist ego ideal and superego in their depressed patients. Patients fail to live up to their narcissistic aspirations and moral expectations, leading to a loss of self-esteem.

Characteristic defenses, such as denial, projection, passive aggression and reaction formation, are described as a means of warding off painful depressive affects but often result in a further lowering of self-esteem.

According to literature, there are two broad models of depression: those involving aggression toward others that is ultimately directed toward the self, and

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those focusing on difficulties with self-esteem in patients whose expectations of themselves far exceed their capacity to live up to them. Some theorists refer to links between the two models. Rudden et al (2003) have attempted to integrate these factors into core dynamic formulation for depression. In this formulation, narcissistic vulnerability is seen as fundamental to the susceptibility to depression. This vulnerability results in sensitivity to disappointment and rejection and thus to easily triggered rage, which leads to feelings of guilt and worthlessness. The self-directed rage compounds the injury to an individual's self esteem, which then escalates the narcissistic vulnerability, and so on, in a vicious cycle. Defenses, including denial, projection, passive aggression, identification with aggressor, and reaction formation, are triggered in an attempt to diminish these painful feelings but result in an intensification of depression. Precipitants for depression in this integrative model can include either perceived or actual loss or rejection, the failure to live up to a perfectionist ego ideal, and superego punishment for sexual and aggressive fantasies.

Treatment approach

When evaluating a patient who presents with depression, the clinician assesses whether psychodynamic psychotherapy can or should be employed as a treatment. Indications for psychodynamic treatment include patient characteristics that felt to be conducive to this approach, such as motivation to understand the sources of symptoms, the ability to think psychologically, the capacity to have and think about meaningful and complex relationship with others, the capacity for control over impulses, the ability to understand metaphors, the capacity to acknowledge emotional states, and good reality testing.

In psychodynamic psychotherapy for depression, a therapist maintains a continued focus on understanding depressive symptoms. As the treatment progresses, the patient achieves greater insight into the ways in which the dynamics of depression have become embedded in self-perceptions and in relationships with others. Furthermore therapy comes to the vulnerability to depression, i.e. understanding the core dynamics for depression in the present and during the patient's development (narcissistic vulnerability based on experiences and perception of loss, rejection; her conflicted anger that often directed toward the self, guilt resulting from anger, compensatory idealization of self or others, and defenses employed in coping with painful affects).

During the middle and termination phases of the treatment, there is opportunity to explore the manifestations of the conflicts in multiple and varied circumstances, i.e. her perception of woman's role, the meaning of her existence and identity, the role of her son and herself in the culture, including also the relationship with the therapist. Gradually, the patient begins to recognize the contexts that tend to elicit depression, to understand what is happening internally during these times, and to feel more in control of the depressed feelings.

Case illustration

Ms R was an overweight, 52-year-old married housewife – a North Sumatran (Tapanuli or Batak ethnic) – who presented herself for treatment as suffering from depression since two years ago with a history of depression for 25 years. Her symptoms included very low energy and motivation, impaired concentration, increased appetite with weight gain, often felt pain around her left chest. She does not want to do anything that she previously liked to do (i.e. being active at church, shopping, reading, cooking, being active in cultural activities).

GENERAL IMPRESSION AT THE INITIAL INTERVIEW

When she entered the room, she looked at me with depressed face, she also presented with uneasiness and restlessness. When I greeted her, she smiled with a look of sorrowfulness. When I extended my hand, she shook it limply.

Ms R appeared as a woman who looked as her age. She was fat, wore a complete make-up, had black wavy hair, and was neatly dressed in a short-sleeve blouse and a maxi long skirt. She brought a big hand-bag which color was fit to her skirt. She talked not spontaneously, cried sometimes, using Indonesian language with Tapanuli's or Batak's characteristic intonation.

PRESENTED SYMPTOMS

At the first meeting, Ms R visibly looked sad but also anxious and restless. When I asked her whether I can help her and to tell me about her problems, she began to speak in a rather quiet voice, slowly and gesticulating vigorously. She began by stating that she did not know how and where to start because she had a very long story. She was complaining

about how much pain she experienced in the left chest which appeared often when she woke up in the morning. This symptom had been examined by several internist and they all found that there were not any organic explanation for it. She mentioned that because of this symptom, she went to Singapore to have a second opinion there, but the result was similar with the previous one from Indonesia

She stated that she felt tired of her condition. She had been suffering from depression since two years receiving several medications. During these two years the symptoms gradually disappeared and she decided not to see her psychiatrist because she thought that she felt so much better and was able to do her previous activities although she was not as active as before. Because her symptoms appeared again two months ago, her cousin, a physician, referred her to me for psychotherapy.

The two months before she came to therapy she felt that her previous symptoms appeared in the similar way as before and gradually became more severe, especially the pain in the left chest, beside other physical symptoms such as gastric pain and weakness all over the body. Other symptoms of her were very low energy and motivation, impaired concentration, increased appetite with weight gain. The most disturbing symptom for her was the chest pain, which she experienced as very severe in the morning with a lowering in the afternoon. She remembered that before she experienced the exacerbation of her illness, her second older sister moved to Malang – a city in East Java – which made her pondering that it would be difficult to be together any more. According to her, this sister was a very kind person; she always listened and accompanied her whenever she needed her. Her two servants, a lady and a man – who worked for her since ten years – quitted their job; the man became a driver and the lady got married. She felt happy for them – because they left for the sake of their happiness. She treated them as part of the family. She liked them because of their work and loyalty. The lady servant often accompanied her to the traditional market every week and sometimes was with her when she was watching television. She was very sad after they left.

The last few weeks she also felt that her children, especially her only son, had not understood her condition and had not given her attention. They left home early in the morning for working and studying and came home late. They seldom talked to her although she asked for it. She felt disappointed but she had not expected much from them. She felt guilty and thought that they became that way because of her.

HISTORY OF PREVIOUS ILLNESS

Twenty five years ago she woke up in the morning with a sudden gastric cramp. Her husband brought her to a hospital and she was hospitalized for five days. After having consulted several clinicians, they finally found out that she was not suffering from any organic illnesses; therefore they referred her to a psychiatrist.

At that time, she had been married for five years. Her brothers in law stayed with her and she felt disturbed by their different views and daily habit. They left house early in the morning and came home late at night almost everyday; in holidays they slept all days and never involved themselves in housework. They often quarreled with each other in loud voices what made her feel disappointed and sad. She sometimes liked to tell her husband about this but she was not able to do it: first, because she never expressed her anger and disappointment, and the second reason was she did not want to make other person - especially her husband - feel unhappy because of her complaint. Her psychiatrist finally suggested her husband to help his brothers to look for other places to stay. Her symptoms subsided then and she felt happy living with her husband. At that time she got her second child.

Personal history

Ms R was born in Medan, North Sumatra. She comes from Tapanuli or Batak ethnic. She is the fifth among nine siblings. The first and the second siblings of her are women; the third, fourth, sixth, seventh and eighth are men, and the youngest is a woman again. In Tapanuli or Batak's culture, a family has to have one son - at least - in order to continue the Marga (Marga is a name of a family which represent the family's self-esteem or pride); that is why a boy takes a more important role than a girl. This condition made a situation that a boy has a higher self-esteem than a girl. A boy has a central role also in the big family.

On the other hand a girl becoming a woman has a less important role in the family. She even has not existed before she gets married to somebody. She would automatically have to change her family name

from her father's towards her husband's family name. After that she would be appreciated by people and her big family. Furthermore, a woman has a value of herself – and in the big family – when she succeeded to give birth to a baby boy. She then would be given a new name as a "mother of her son's name". Therefore, a son is very important to her, because a son also has a narcissistic value. If she fails to give birth to a son this would be considered as she had committed a sin.

Because of this dictate in the culture, many Batak woman have accepted the tradition and very aware of their role and their right in the family. Related to this narcissistic value of a son, a woman who fails to give birth to a son would experience low self-esteem. For a Batak man who has only a boy this means to have more importance than having many daughters. In Batak community, if a man is asked about the number of children he has, he would only indicate the number of sons (he would not mention the number of his daughters).

Since her childhood, Ms R noticed and felt that her father treated his sons differently compared to his daughters. Boys are allowed to go out of the house whenever they want. They also can get almost anything they want. They are also allowed to continue their study as high as they want. On the other hand, girls were forbidden to go out except for going to school or other important places; they had to do the household, cooking, etc. Since her latency period, she remembered that she never expressed her real feelings to anybody although it was not forbidden by her parents.

According to the patient, her father was an easily furious and authoritarian man, did not allow other persons - especially his children - to have any different opinion or ideas with him. She and her siblings were very afraid of him.

On the other hand, her mother was a very patient and warm person. She often did not tell her husband what faults her children did. She protected her children a lot, but the children sometimes did not appreciate her and did not obey her. The children – included the patient – loved their mother a lot compared to their father.

After finishing Junior High school, Ms R wanted to continue her study to Senior High School, because she wanted to be a pharmacist. Her father did not allow her to choose her preference; therefore she continued her study in a Specific Senior High School to be an assistant of a pharmacist. At first she felt disappointed but later she mentioned that she had to obey her father.

After graduation from Senior High School, she worked at a drug store as a pharmacist's assistant for a few years. Her father then asked her to get married. After knowing her future husband for about six months, she finally agreed to get married to obey her father although she was not emotionally prepared for that step. She mentioned that at that moment she had not loved her husband yet but she tried hard to do so. Nevertheless according to her, she started to love her husband gradually after a few years. She mentioned that her husband is a kind man, but he is too silent and rather serious. He concentrated a lot on his work and let her decide everything related to their children. He is a hard worker and she is happy with it because of the good revenue which made them quite wealthy.

As a wife of a Tapanuli's man, she had to accept all the norms and values this people lived since decades, especially to deliver at least one son for the continuation of her husband's family name. Shortly after her marriage Ms R became anxious and worried about whether she could give her husband a son or not. After waiting for a year of her marriage, she finally delivered a boy. Her husband was very proud of their son and the big family also felt very happy for her. She was very happy herself because she now could feel as a real person who was appreciated by the people around her. Since that time, in every family meeting she was allowed to sit at the front part of the table beside her husband and was no longer allowed to help in the kitchen. She finally was "somebody".

After the birth of the baby, as suggested by her husband, she stopped working in order to take personally care of her child. She enjoyed her obligation to take care of her baby. But during those years, her brothers in law came to Jakarta to look for a job. They lived and stayed at their house. She did not mind about that fact, but she did not like their manner and behavior which were very different from her. Although she was very upset she was afraid to tell her husband about her bad feelings because she did not want to hurt him. It was only after her hospitalization that her psychiatrist disclosed it to him. This was a great relieve and so she improved and was able to do her daily activity as before.

Two years later she delivered another baby and

she was very happy too. The husband also felt happy although it was a girl. Six years later she delivered one more girl. She and her husband were very pleased and tried to accept that they got a baby girl again despite their hope for a boy.

She loved her children very much. She prepared everything for them – from early in the morning until late at night – and did not allow them to do other things besides studying. She accompanied her children in making their homework. She fetched them from school and other activities, like sports, arts, etc. She was very proud of her children because they got excellent performances at school, especially her boy. He was very bright. The patient was very proud of him and put great hope in him. Besides that, she keeps deeply in her mind that he made her very happy, because through this boy, she was appreciated as a real Batak's woman who gave a son to her husband and to her big family.

As the children grew up and became gradually independent, she felt disappointed because of their less need of her. They did not ask her for things they wanted to do as before. In contrast to other Tapanuli people, she was not able to express her feelings. She also withheld this from her husband. She frequently felt hopeless about changing the situation and being exhausted of these conditions. She viewed herself as a worthless lady who does not deserve attention and appreciation from people around her and from her children, especially from her only son. She felt very disappointed by him of whom she was at the same time very proud. The beloved son was no longer kind to her and did not give enough attention. Furthermore, she felt that this son who – in her culture is also her source of identity (as mentioned before, a narcissistic value for her) – rejected her. She was very sad, felt disappointed, and suffered from a loss of self-esteem.

The course of the therapy

From the beginning of the therapy, she mostly talked slowly. The spontaneity of her speech was improving from time to time. She never missed a session and was almost never late. At the beginning of the treatment, most of her comments reflected dependency although her behavior towards me was criticizing and aggressive. Her symptoms were possibly expression of her anger, disappointment and injured feelings. She mentioned about her symptoms in a long and detailed story. The dialogue was often like this:

P (patient): «I am tired of this condition. How long do I have to experience these symptoms?»

D (doctor): «Let's see what we can work together to overcome it …Would you..?»

P: «I wonder about whether I will improve or not. I don't know why .. because my previous psychiatrist gave me these medication..(*she showed me several pills and capsules*). Can you imagine, doc, after these two months, I still feel this pain» (*she puts her hand on her left chest ..*).

D: «Yes, I'll try to imagine how you feel …here?» (*I followed her touching my left chest*)

P: «That's good, because nobody understands me…, I feel this directly after I wake up every morning ..»

If we try an interpretation of the mentioned pain in her left chest it could be a representation of the self-alienation or self-estrangement due to the rejection of her son who made her feel as if she lost him and not having him anymore.

She mentioned that "nobody understands me". This could be understood as: "I am not somebody, I do not exist", and subsequently she would felt as if she disappeared. The pain in this context plays a role as a substitute or replacement of being. The pain linked her to her existence (as mentioned before that in Batak ethnic, there is a cultural dictum that a woman has to deliver a son if she wants to exist in the culture community); Ms R placed her son as a saver of her existence; in her mind, she exists in the family because of him. If he now rejects her, she feels her existence is in danger.

At the second meeting the week after, she described herself as a housewife who likes to work and does a hard job in the household from early in the morning until late in the evening. She went out to the traditional market once a week, and frequently attended a gathering with her friends and then went shopping together with them, or sometimes gave prayer services to sick people at hospitals and children's prison with a group of people from her church. She liked also to read pocket books and biographies of famous persons.

From the third until the ninth session she enthusiastically expressed her feelings about her eldest son of whom she was very proud. Since he entered the university, the son started to disobey her, answering her questions with high tone and loud voice. She

was very sad of this impoliteness and verbal aggression. She frequently cried after having tried to talk to him. When she talked to me she experienced such strong feelings that she had even images before her mind. This son is in her culture her source of identity (is the ground she stands on). Therefore his rejection was perceived by her as a deep insult.

P: «When telling you this story about him, I usually imagine how and what he'd been done to me.. I visualize his face when he talked to me with his high tone voice ..»

D: «Oh …You did not expect this …?» (*confrontation*)

P: «Yes, I was shocked, because he's been changed, he behaved to me as if..» (*she cried ..*)

D: «You are …»

P: «Not his mother …!, yes, I feel that way …, but now I've forgiven him already … I also pray to God, asked for His forgiveness to me; I have to love my son …He became like that is possibly because of me ..» (*self-directed rage, guilt feelings*).

In this interview we can see that her narcissistic vulnerability results in sensitivity to disappointment and rejection and thus easily triggered rage, which leads to feelings of guilt and worthlessness.

In the tenth session, she mentioned about her trip to Medan a few days before. She went there to look for an alternative medicine to be cured. She went with her sisters. She enjoyed the trip. Since that time she began to be active in cultural parties and activities. In these ten sessions, we can see that the transference has been built, the therapeutic alliance has grown up.

In the fifteenth session, she seemed more freely to express her feelings, talked about her progress in her daily activities: she went together to give prayer in some hospitals, went also to reunions gathering with her Junior and Senior High School friends, went to the traditional market; she mentioned also that she got the eagerness to read pocket books and biographies and watched enthusiastically television programs. She told me that she finally found her self back. The transference has formed well.

The twentieth session was filled again with her pain in her left chest that she experienced as severe since three days. Four days before early in the morning her son – before leaving for his office – shouted at her after quarreling with his sisters and also finally with his mother. She touched her left chest and mentioned that it was very painful. Fortunately in the afternoon her son was apologizing when he came back home, what surprised her very much. Finally she found out that her son's girl friend asked him to be kind to his mother. Her son had a girl friend since two months and since that time he seemed to behave a little bit better.

The next session, she looked at me calmer and spoke more spontaneously. She mentioned that she liked to attend cultural parties and activities more frequently. At this period her symptoms disappeared possibly because of transference.

The patient's progress in therapy paralleled the evolution of the transference. She kept appointments faithfully, was compliant with medication, and expressed appreciation for the therapeutic alliance which was built. She gradually became aware of herself, her situation, and her relationship with her son. Fortunately, the son – after engaging with his girl friend - also grew up and became more mature afterwards. He sometimes asked his mother to advice him which meant a lot for her. She was surprised of this situation; she felt she became somebody who was able to help others, and she was happy that she became somebody who was needed by other people.

Discussion

From her personal history and her current condition, Ms R seemed to have a narcissistic vulnerability, possibly related to the role of women in her culture (being less important compared to men from child on continuing after marriage until having born a son). This vulnerability could have been triggering the susceptibility to her depression. The basis of this vulnerability possibly came from her disappointments in early relationships, leading to a fragile self-esteem. This vulnerability results in sensitivity to disappointments and rejections and to easily triggered rage (although she was not able to express it). This condition leads subsequently to feelings of guilt and worthlessness. The self-directed rage compounds the injury to her self-esteem, which then escalates the narcissistic vulnerability, and so on in a vicious circle. Her defenses, including denial, projection, passive-aggression, and reaction formation, are triggered in an attempt to diminish her painful feelings but resulted in an intensification of the depression.

The treatment strategy of Ms R consisted of an ini-

tial evaluation of the depression and her capacities to engage in dynamic psychotherapy, then forming the therapeutic alliance and frame of treatment. Furthermore therapy comes to the vulnerability to depression, i.e. understanding the core dynamics for depression in the present and during the patient's development (narcissistic vulnerability based on experiences and perception of loss, rejection; her conflicted anger that often directed toward the self, guilt resulting from anger, compensatory idealization of self or others, and defenses employed in coping with painful affects).

The patient was cooperative in the therapeutic alliance, and the depressive symptoms were decreasing gradually. The transference also played a role. She increasingly became aware of herself, her situation, and her relationship with her son afterwards. Fortunately, the son also grew up and became more mature. His changing behavior toward the mother meant a lot to her. This and the experience of being needed by other people, made her feel as if she was born again. This became a foundation of her self-esteem.

Conclusion

In the case of Ms R, the narcissistic vulnerability was possibly related to the cultural dictum. The basis of this vulnerability might have come from her disappointments in early relationships leading into a fragile self-esteem. This vulnerability resulted in a sensitivity for disappointments and rejections and thus to easily triggered rage (although she was not able to express it), which lead to feelings of guilt and worthlessness. The narcissistic vulnerability could have played as trigger of the susceptibility to her depression. The self-directed rage compounded the injury to her self-esteem, which then escalated the narcissistic vulnerability.

The treatment strategy of Ms R consisted of an initial evaluation of the depression and her capacities to engage in dynamic psychotherapy, forming the therapeutic alliance and frame of treatment. Furthermore therapy turned towards the vulnerability for depression, i.e. understanding the core dynamics for depression in the present and during the patient's development. In the middle phase were used several techniques such as interpretation, confrontation, clarification also dealing with transference and counter transference problem.

In doing psychotherapy in our area, cultural standards of moral and ethics are necessarily to be considered as well as the social role of the patient.

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Psychosomatic in Orient and Occident: The «Healing» of the Caliph

Nossrat Peseschkian

If you give someone a fish, you feed him only once.
If you teach him how to fish, he ran feed himself forever.
Oriental wisdom

Introduction

When a European or American comes home in the evening, he wants his peace and quiet. That, at least, is the general rule. He sits down in front of the television, drinks his hard-earned beer and reads his newspaper, as if to say, "Leave me in peace. After working so hard, I have a right to it." For him, this is relaxation.

In the East, a man relaxes in a different way. By the time he comes home, his wife has already invited a few guests, relatives, or family and Business friends. By chatting with his guests, he feels relaxed, as though freely translating the motto "Guests are a gift from God." Relaxation can thus mean many things. There is no set definition for everything that relaxation comprises. People relax in the way they have learned how, and the way they have learned is what is customary in their family or group, or in the social circle to which they belong.

Just like leisure and relaxation, so customs, habits, and values have many faces. This does not mean that one model is better than the other; rather it means that various value systems have a lot to say to one another. A set of attitudes developed in one culture can be helpful to persons in another culture. The sustaining motivation for my work is the transcultural view. Over the last fourty years I have developed a new concept of psychotherapy and self-education, which has been worked out from a transcultural point of view. I am interested in this transcultural aspect as a result of my own transcultural situation (Germany and Iran). Equally important is my interest in Mideastern stories as resources and communication aids, as instruments in my field of specialization, psychotherapy. An additional factor has been the connection between the wisdom and intuitive thoughts of the Mideast and the new psychotherapeutic methods of the West.

Stories and examples from different cultures

- With their playful character and their closeness to fantasy, intuition, and irrationality, stories stand in obvious contrast to the rational and technological models of modern industrial society. The latter's achievement orientation contradicts the essence of stories. Achievement is given priority; the quality of human relationships is relegated to the background; reason and intellect are more highly valued than fantasy and intuition. But we can confront this historically and culturally determined imbalance by supplementing out habitual way of life with different roles and modes of thought, even some that have arisen in a different historical-cultural framework (transcultural starting point).
- In my work I have tried to explain the universal significance of the transcultural aspect, to systematize the contents of the transcultural problems, and to show its significance for the development of conflicts. With this aspect in mind, I also had another aim, namely to develop a concept for conflict-centered therapy. Different psychotherapeutic methods can be integrated into this short-term therapy according to the indications.

The "Healing" of the Caliph

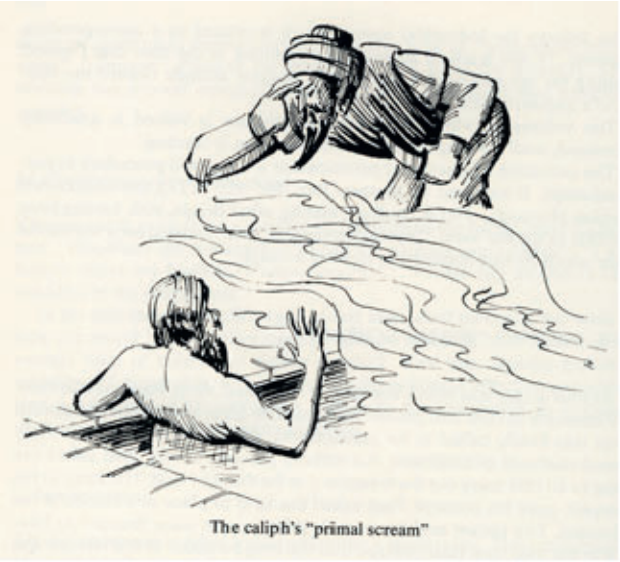
A serious illness had struck the king. All attempts to cure him proved fruitless. The great and famous persian physician Rasi was finally called in for consultation. At firm, he tried all the traditional methods of treatment, but without success. Finally Rasi asked the king to let him carry out the treatment as he thought best. The king, in his despair, gave his consent. Rasi asked the king to place two horses at his disposal. The fastest and the best Arabian horses were brought to him. Early the next day, Rasi ordered that the king be brought to the famous spa "Jouze Mullan" in Buchara. Since the king could not move, he was carried on a stretcher. At the spa, Rasi told the king to get undressed and ordered all the king's servants to get as far away from the spa as possible. The servant hesitated, but then drew back when the king let them know they should do as the hakim ordered.

Rasi had the horses tied at the entrance to the spa. Working with one of his pupils, he placed the king in a tub and quickly poured hot water over him. At the same time he fed him a hot syrup, which raised the sick man's temperature. After all this had happened, Rasi and his pupil got dressed. Rasi stood in front of the king and suddenly began to curse and insult him in the most horrible way. The king was shocked and became terribly upset over this rudeness and unjustified insult, especially because he was so helpless. In this state of upset, the king moved. When Rasi saw

this, he drew out his knife, stepped close to the king, and threatened to kill him. Frightened, the king tried to save himself, until finally his fear suddenly gave him the strength to stand up and run away. At this moment, Rasi quickly left the room and, with his pupil, fled from the town on the horses.
The king collapsed in exhaustion. When he regained consciousness, he felt more free and was able to move. Still very angry, he called for his servant, got dressed, and rode back to his palace. The people gathered there rejoiced when they saw their king free of his ailment.
A week later, a letter from the physician reached the king. The letter contained these words of explanation: "I did everything I had learned as a doctor. When it produced no results, I artificially raised your temperature and by kindling your anger I gave you the strength to move your limbs. When I saw that your cure had begun, I left the city in order to escape your punishment. I ask you not to have me brought in, for I am aware of the unjust and vulgar insults I hurled at you in your helplessness and I am deeply ashamed of them." When the king heard this, deep gratitude filled his heart and he asked the doctor to come to him so that he could show his thanks.

Conclusion

Activating emotional participation is a very old procedure in medicine. So it was with Rhases (Rasi A.D. 850-923), the famous Persian physician, of whom it is said, among other things, that he was the first to use the word "psychotherapy."
His treatment was not "cathartic" in the actual sense of the word. The treatment did not take place by releasing an existent blockage of feeling. The congestion of feeling was first awakened by the insults and threats from Rasi, and introduced as the driving force in his cure. Rasi had taken care of the necessary prerequisites: The caliph had to be handed over to the hakim naked and helpless. Without these measures, the treatment would have surely become a double failure. The ruler would not have gotten himself into the excited condition that brought about his cure, for his servants would have prematurely and forcefully interrupted the therapeutic developments upon hearing his cries for help; Rasi would have had to fear for his own life.
As old as the story might be, it describes a problem of contemporary psychotherapy: Just like the caliph, out patients are surrounded by a crowd of allies, family members, friends, and their doctors who, in their mistrust, do not shy away from attempting to interrupt the treatment if the course of the treatment leads to crises or does not go according to their own views.



The caliph's "primal scream"

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International memberships

- World council of Psychotherapy (WCP)
- European Association for Psychotherapy (EAP)
- European Wide Accrediting Organization (EWAO)
- American Psychiatric Association
- International Federation for Psychotherapy (IFP).

Prof. Peseschkian is the founder of Positive Psychotherapy (1968), which is based on a transcultural approach. As an international lecturer, he has traveled to 67 countries worldwide. A global network of about 100 local, regional and national centres of Positive Psychotherapy has been established in 23 countries to date.

Positive Psychotherapy is an accredited modality for the European and the World Certificate of Psychotherapy (EAP and WCP).

"Positive Psychotherapy is a notable synthesis of psychodynamic and behaviourtherapeutic elements, making an essential contribution to unified relationships within psychotherapy" (Prof. G. Benedetti, Basel).

Prof. Dr. med. Peseschkian is the author of 26 books, which are partly translated into 23 different languages. He was awarded the Richard-Merten-Prize in 1997 for Quality Assurance and Effectiveness Study of Positive Psychotherapy. In 2006, he was distinguished with the Order of Merit – Distinguished Service Cross of the Federal Republic of Germany.