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Vertwijfeld bang om zelf te zijn

Arabische kalligrafie ontmaskert modern Nederland toch nog

Inmiddels is het een algemeen ingevoerd begrip: angst voor het leven. In feite dus angst voor de angst. De anticipatory anxiety, Erwartungsangst, angst voor de angst is opgenomen in de DSM onder de titel Panic disorder without agoraphobic –bia (300.01). Er zijn nu zelfs RIAGG's die er cursussen voor op touw zetten, patiënten groepen draaien als lotgenoten. De herinnering aan de oorspronkelijke vorm, die verbonden is aan het voorkomen van de collectieve neurosen, is weg. Dat is althans in het geseculariseerde Westen. Dat op rationaliteit en wetenschap gebaseerde westerse model, dat zichzelf hoog boven alle andere menselijke maatstaven heeft verheven op een fundament van het recht van de sterkste, is langzamerhand de belichaming van de nachtmerrie van het fanatisme aan het worden. Kamerleden komen op televisie vertellen dat zij er als burger bezwaar tegen zouden hebben om door een mijnheer of mevrouw te worden bediend die ofwel een keppeltje draagt ofwel een hoofddoekje. Dat zou aan het loket een inbreuk zijn op hun individuele vrijheid. Een non vraagt mij de weg, en dat is een inbreuk op mijn vrijheid. Een mevrouw vraagt mij de weg, zij draagt een kruisje om haar hals… dat moet niet kunnen. Een man in een blauw streepjespak helpt mij aan een paspoort, waarvoor ik niet alleen heb betaald, maar waartoe ik de Staat ook mijn handtekening heb afgestaan (waarvan elektronische kopie en akte)…. Dat streepjespak en die overdadig drukke stropdas die mij als 'at your service' wordt aangeboden, is dan geen inbreuk op mijn vrijheid omdat het hier een neutrale overheid zou betreffen?
In een zodanig georganiseerde samenleving zou een gezond mens toch gewoon bang moeten zijn? Of in elk geval worden. Het niets dat de leegte omgeeft, is een diep en zwart maatschappelijk gat dat de eenzaamheid en de machteloosheid van een mens onderstreept zodra de solidariteit en de waardigheid er door de sterksten van dat moment uit de werkelijkheid zijn verbannen. Of je dat nu liberaal of antisociaal noemt, christen-democratisch of kapitalistisch-hypocriet noemt zal me worst zijn.
De angst voor de angst heeft geestelijk behalve een psychologisch effect van geïntimideerd worden ook nog een bijzonder gouden randje: het is onthullend voor wie maar kijken, lezen en begrijpen wil.

Aankondiging Viktor Frankl lezing 2004

26 april a.s. wordt van 19.30 – 21.30 uur in de prachtige St. Janskerk te Gouda de Viktor Frankl lezing 2004 uitgesproken over het werk van Viktor E. Frankl en zijn bijdrage aan zingeving anno 2004. Viktor Frankl (1905 – 1997) overleefde tijdens de tweede wereldoorlog vier concentratiekampen en was hoogleraar psychiatrie en neurologie en gepromoveerd in zowel de psychologie als de filosofie. Hij schreef het wereldberoemde boek “De zin van het bestaan” over zijn kampervaringen. De lezing wordt uitgesproken door Dr. Pieter Verduin. De inleiding op het werk en leven van Viktor Frankl wordt verzorgd door Prof. Dr. Willem Maas. (In bijlage treft u twee korte CV’s)

Dit jaar zal het 60 jaar geleden zijn dat de bevrijding van Europa begon. In de tweede wereld oorlog overleefde Frankl meerdere concentratiekampen, waaronder Auschwitz en Theresienstadt. Zijn vrouw Tilly stierf in Bergen-Belsen. Op zijn zus na is zijn gehele familie om het leven gekomen. Zijn belevenissen en observaties heeft Frankl beschreven in het wereldberoemde boek “Ein psycholog erlebt das Konzentrationslager.” Hiervan zijn 24 vertalingen verschenen waaronder in het Russisch, het Japans en het Chinees. Alleen al van de Engelstalige editie zijn meer dan 9 miljoen exemplaren verkocht. Het United States Library of Congress heeft het opgenomen in de lijst van 10 meest invloedrijke boeken in Amerika. De titel van de Nederlandse vertaling luidt: “De zin van het bestaan.” Beroemd is zijn psychologie van de concentratiekampbewoner. Viktor Frankl heeft wereldwijd 28 eredoctoraten ontvangen. Hij is de grondlegger van de logotherapie. Deze methode wordt al vele jaren met succes wereldwijd toegepast in de begeleiding van het menselijk lijden.
Hij heeft 32 boeken geschreven. Andere auteurs hebben over Frankl en de logotherapie zo’n 150 boeken, 154 dissertaties en ruim 1400 artikelen geschreven in wetenschappelijke tijdschriften. Hij heeft tot een jaar voor zijn dood onderwijs verzorgd op de Universiteit van Wenen. Op de site http://logotherapy.univie.ac.at/ treft u een introductie op het leven en de nog steeds zeer actuele denkbeelden van Viktor E. Frankl.

De lezing wordt georganiseerd door NILEA*. Aan de lezing zijn dankzij sponsoring geen kosten verbonden. Tijdens de avond wordt de heruitgave van het indrukwekkende boek Humaniteit van de menselijke vrijheid van Viktor E. Frankl verspreid. Inschrijven Viktor Frankl lezing: CPS-infodesk: tel. 033-3534343 of e-mail: infodesk@cps.nl

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* NILEA = Nederlands instituut voor Logotherapie en Existentiële Analyse
** CPS - Onderwijsontwikkeling en advies. (www.cps.nl)

Bijlage 1:

Kort CV Prof. dr. Willem J. Maas

Prof. dr. Willem Maas (1948) studeerde wijsbegeerte en theologie in Brussel en Amsterdam.
In 1989 kwam de Stichting Nederlands Instituut voor Logotherapie en Existentiële Analyse op zijn initiatief tot stand en begon ook de opleiding integratieve existentieel – analytische psychotherapie methoden in ons land en verscheen de eerste jaargang van het Bulletin.
Hij gaf lezingen en colleges in de VS, Canada, Duitsland, Italië en Frankrijk. Vanaf 1993 werkte hij aan universitaire en maatschappelijke inbedding van Frankl's werk in ons land en daarbuiten. Hij is medeoprichter van de nationale overkoepelende beroepsorganisatie voor Europees geregistreerde psychotherapie. In 2000 werd zijn werk in Wenen opgemerkt door een goede vriend, en ontstond in samenwerking met een enthousiast team Eureka-University. Als vice rector en EU liaison officer vertegenwoordigt hij de universiteit in tal van EU landen.

Kort CV Dr. Pieter J.M. Verduin

Dr. Pieter J.M. Verduin (1953) werkte van 1975 tot 1986 als fysiotherapeut in een psychiatrisch ziekenhuis. Daarnaast studeerde hij andragologie en filosofie aan de Universiteit van Amsterdam. Promoveerde in 1992 op *Het verdachte lichaam*, een filosofisch proefschrift over zijn ervaringen met het rationeel onderbouwen van behandelingen in de gezondheidszorg. Rondde in 2002 de opleiding Logotherapie volgens V. Frankl van het NILEA af. Sinds 1986 docent Hogeschool Leiden. Sinds 2003 wetenschappelijk onderzoek HSLeiden en Leids Universitair Medisch Centrum: 'De ervaring van een zinvol leven: een gezondheidspotentiaal bij mensen met reumatoïde artritis'. Schrijft artikelen en verzorgt lezingen op het gebied van filosofie van menselijke gezondheid. Zijn *De vraag naar het lichaam, filosofie van lichamelijkheid in de gezondheidszorg* (1998) is in 2003 in een nieuwe oplage verschenen. E-mail: p.verduin@tiscali.nl

Vitale Uitputting: rood licht voor de gezondheid

Vermoeidheid, lusteloosheid, energieverlies, prikkelbaarheid en moedeloosheid zijn kenmerken van 'vitale uitputting'. Mensen die vitaal zijn uitgeput, hebben een verhoogde kans op een hartinfarct of beroerte. Dit blijkt uit het onderzoek waarop Gert Schuitemaker recentelijk promoveerde aan de faculteit der Geneeskunde van de Universiteit Maastricht.

Tot nu toe werden leeftijd, hoge bloeddruk, verhoogd cholesterol, roken en diabetes mellitus gezien als belangrijkste risicofactoren voor hart- en vaatziekten. Vitale uitputting kwam in dit rijtje niet voor. Maar dit blijkt onterecht: vitale uitputting is een even belangrijke voorspeller als de reeds genoemde factoren.

Aan het omvangrijke onderzoek werkten ruim vijfduizend volwassen inwoners mee uit Mierlo, een dorp bij Eindhoven. Een groot deel van hen werd gescreend op diverse risicofactoren, waarvan vitale uitputting er één was, en werd jarenlang gevolgd.

De resultaten van het onderzoek betekenen voor de huisarts dat hij in zijn dagelijkse praktijk met deze nieuwe factor rekening dient te houden, naast de klassieke risicofactoren. Klachten van recente of toegenomen ongewone vermoeidheid kunnen een signaal vormen voor een dreigend hartinfarct of beroerte.

Eureka-University, where do we stand today?

The good news is that we are doing quite well. The bad news is that it takes longer than we have been hoping. This is in short how things are at the moment, in Feb.2004.
But we are doing well with the governmental organisations in Austria, as well as with the professional organisations involved. As many of you may be aware of, Eureka-University is keeping closest to the Austrian Psychotherapy Law. The importance of this issue was underlined by an interview made by the Standard, a leading Austrian newspaper. Comments from governmental and professional speakers were that Eureka is right on track and the best on spot offer in the field. We do still have to travel some more miles, though the prospect is April 2004 for finalising. With that, Eureka-University will be able to offer its Academic education and degrees to the EU public, beginning next September. We need to underline that Eureka-University is a private University, presently under Accreditation

The Eureka-University offer comprises:

- BA in Mediation (Human and Social Science)
- BA comprising the first step of the so-called Propaedeuticum, in Counselling and Psychotherapy (this is the Austrian law)
- MA in Counselling and Psychotherapy
- Dr. Phil. in counselling and Psychotherapy
- Shortcut to the MACP for those who are already state registered practising psychotherapists, or state registered (health) psychologists with a completed psychotherapy training at least meeting the levels of the European Certificate for Psychotherapy (EAP)

As a truly EU University, it goes without saying that Eureka-University is also applying the Accreditation of Previous Learning. This means that students with at least a level 4 diploma in one of the humanities will be able to enrol for one of the BA-degree Educations on offer.

Also underlining the EU University set up, Eureka-University delivers its academic educational offer throughout the EU by ways of current partner institutes, like in the Netherlands, Germany, UK, Hungary, Malta. We expect to extend this offer in the next few months in Ireland, Lithuania, Latvia, Bosnia-Herzegovina.

For further information please contact Prof. Uwe Eglau, dean of Eureka-University, in Vienna (u.eglau@epsa.at) or Prof. Willem Maas, EU program coordinator (w.maas@epsa.at)

Opleidingsmogelijkheid Integratieve existentieel-analytische psychotherapie methoden, logotherapie en existentiële analyse (Frankl) in Nederland.

De mogelijkheden voor een opleiding worden in ons land via Oostenrijk aangeboden. Voor niet-BIG geregistreerde psychotherapeuten kan dit betekenen dat een werkstage in Oostenrijk moet worden gevolgd.

Voor BIG-geregistreerde psychotherapeuten, GZ-psychologen met voltooide psychotherapie opleiding op Europees niveau en voor houders van het Europese Certificaat voor Psychotherapie (ECP) bestaat de mogelijkheid om een verkorte opleiding op MA-niveau te volgen.

Voor mensen met een hbo-diploma (of hoger) in een van de mens– of sociale wetenshappen is er een EVC traject waarin getoetst wordt in hoeverre alle basisvakken psychotherapie aanwezig zijn, waarna een 4-jarige opleiding wordt afgesloten met een MA in counseling en psychotherapie.

Voor mensen met een mbo – spw4 diploma is er een volledige, 7-jarige opleiding die voorziet in een traject met 11 basisvakken dat naar een BA in Counseling en Psychotherapie leidt. Na het volgen van een traject leertherapie, kan de kandidaat beginnen aan de 4-jarige deeltijdopleiding naar het MA-CP.

Voor allen geldt dat een deeltijdbaan in de zorg, welzijn of onderwijs noodzakelijke voorwaarde is voor het mogen volgen van een psychotherapie opleiding.
NB. Voor hen die geen BIG-registratie psychotherapie kunnen verwerven moet het gebruik van de wettelijk beschermde beroepstitel psychotherapeut worden ontraden, totdat de wetgeving op dit punt zal zijn gewijzigd.

Voor meer informatie kunt u zich wenden tot het Nederlands Instituut voor Logotherapie of tot de Stichting Integratieve Psychotherapie Opleidingen (STIPO).

Integratieve Psychotherapie, Logotherapie en existentieel–analytische psychotherapie methoden wordt in ons land aangeboden door NAP/ ECP of BIG-geregistreerde therapeuten.

Integrative Existential Analytical Psychotherapy in a Psychosomatic Perspective.

By Prof. Dr. W.J. Maas, ECP

Introduction

Integrative Existential Analytical Psychotherapy (Frankl, 1951) became an overall important and interesting integrative corrective on current psychotherapy efforts, because of the introduction of 'the complex unity' of spirit, psyche and body within a definition of human being characterised by its 'unconditional' nature (Frankl, 1949) of transsubjective being (Frankl 1946-1949). Since then, we are actually taking the various dimensions of human being into account. A second wave of development changed the practise of psychotherapy since. The profession moved from medical to paramedical and social professions, and this shift has been firmly anchored within the framework of the European Certificate of Completed Psychotherapy Training (ECP). However, with this development moving Psychotherapy somewhat away from the medical sphere with its specific ranges of various accesses to diagnostics including internal circumstances, an important aspect of dealing with clients is also neglected. This development is not new; it has been with psychotherapy since the very beginning, like between Freud and Reich, Freud and Perls, etc. Then again, a new division showed. The so-called German Psychosomatics versus the Anglo-American Psychosomatics represent the difference in emphasis between reasoning from and towards the somatic – biological one the one hand and a reasoning from and towards the supremacy of psyche – willpower - guilt on the other hand. Even here, the actual gap roots back to the days of Sigmund Freud, when he parted himself from Alfred Adler. Frankl (1974) opposed both of these developments, by offering a golden path in between. Next to the Scylla of Psychologism and Pathologism there is the Charybdis of Noologism. Here we have to consider ourselves involved, when we count our work to belong to the Integrative Existential Analytical Psychotherapy. The tendency to explain bodily phenomena from the point of 'an expression from the spiritual dimension' is the pitfall we are aware of. Psychosomatic medicine taught: 'Those who hurt themselves will fall ill', but we also know about people who enjoy themselves, and yet falling ill. We all know dedicated, warm, understanding, good people who became gruesomely ill and had to die whilst we ourselves grappled to find out what it is that takes away the good ones first. It was Frankl (1974,140 ff.) who stated that the old saying 'mens sana in corpore sano' is counterbalanced by not only healthy bodies serving utterly destructive people, but even more, by broken bodies serving the best of humankind. Thus Frankl is shifting the discussion about the somatic aspects versus the psychological and noological, towards the question of meaning. ' Certainly, every illness does carry a 'meaning', however the true actual meaning of an illness is not so much in the facticity of being ill, as it is in the *How* of suffering, and it is from here that if there is any meaning, it will have to be attached to the illness, which will only occur whenever the suffering person, the *Homo patiens*, is able to illustrate this within the limits of the unavoidable 'fatal' part of suffering in a true, and honest fashion' (ibid. p.149).
Frankl underlines that his contribution is not just in addition corrective for Psychotherapy, but it is also a completion of the Somatotherapy – or 'to be more precise, it is a somatopsychological simultaneous therapy, which actually treats both angles of neuroses at the same time, the somatic and the psychological.' (op.cit. p. 151- 152). It is therefore, that this article now focuses on a largely neglected aspect in the treatment of psycho- and somatic neuroses, on its endocrine and metabolic aspects related to human suffering in terms of both cause and result.

Back to the roots

Integrative Existential Analytical Psychotherapy is aiming to cut the bonds of what used to be called neuroses, in order to facilitate the human person to self re-establish his/her health. Health is used as the common denominator of a both existential as well as physical integrity. Using the wording 'Neuroses' offered the disadvantage of not pre-exempting the unclear in aetiology, however this also gave the use of the wording the opportunity to get through to a thoroughly planned differential diagnosis. The modern use of the word 'disorder' which was introduced in DSM-IV is not quite covering the solution we are looking for. If and insofar the human being represents a complex unity in himself, neuroses refers to both psyche and body. This is correct insofar e.g. serotonin deficiency denotes not only a psychic problem, but certainly one of intestinal origin. The other way around, psychological stress actually is a degenerating influence upon the delicate endocrine balances extending to completely derailing the reactive regulatory capacity of the body.
According to Frankl (1974)[1] the aetiology of neurotic illnesses (!) looks as follows:

1. **Individual reaction** (c.f. V. E. Frankl, 1974, 151)
    1. bad passivity: flight before anxiety/ fear: fear-neurotic reactive pattern
    2. bad activity:
        a. fight against compulsion – compulsive-neurotic reactive pattern
        b. fight against lust – sexual-neurotic reactive pattern

Neurotic reactive patterns are in fact covering both experiential and behavioural aspects of human being. They are reactive, that is: not so much attitudinal, value (of the other) oriented, unconditional.

(*As opposition or corrective to this personal reactive pattern of neuroses, there are two possible ways to approach and overcome, which are described by Frankl as follows:*

a. *Towards ad rem passivity: Ignoring the neurotic; this can only be expected and required from a patient in as far as the patient is actually acting towards or in relation with something other or someone else.*
b. *Towards ad rem activity*

2. Organismic Resonance – with this resonance we are looking *sit venia verbo* at a reaction of the bodily organ towards a reaction of the spiritual person.

As organismic resonance 'plane' we are considering:

a. congruent disposition and
b. congruent constitution.

Under **disposition** we have been acquainted with the part of both excessive *burdens* as well as *relief*. It has been shown in the field of internal medicine by Manfred Pflanz and Thure von Uexküll, that a human only falls ill when he is either too much or too little burdened, that is: when an individually fitting task is missing. As soon as the human being 'has found' such a task, this is his/her *natural antipathogen*.

Under **constitution** we are aware of the influences coming from:

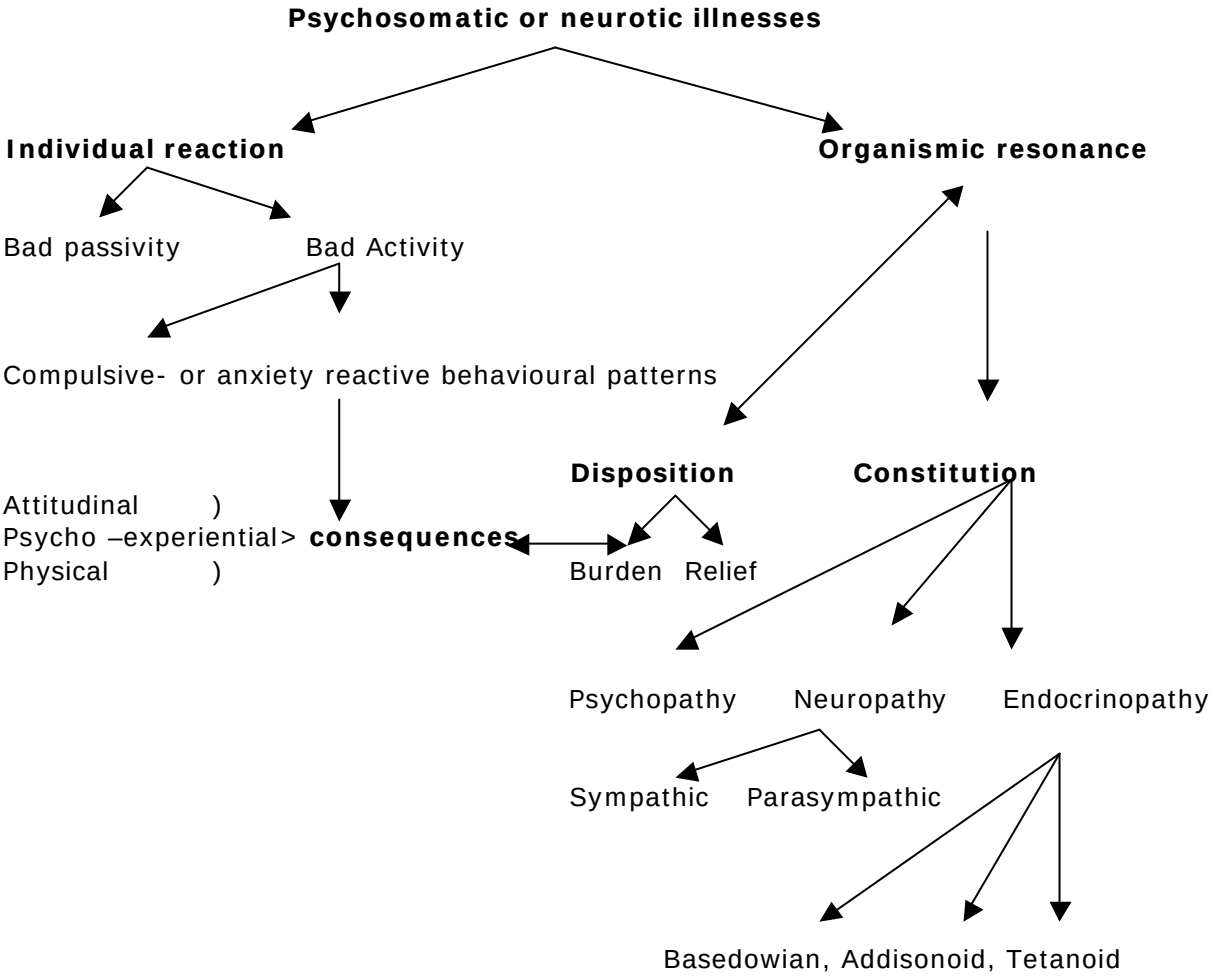
a. Psychopathology, especially the antisocial
b. Neuropathology, especially paying attention to the clinical sympathic or parasympathic

[1] **V. E. Frankl,** *Theorie und Therapie der Neurosen,* UTB Reinhardt, Muenchen –Basel 7, 1999 p. 171 ff.

c. Endocrinopathy, especially:

- the basedowian (hyperthyroid), - the addisonoid (hypocrticostic) , - the tetanoid.

We are not to overlook one of these moments leading to a neurotic illness, and we are not to overestimate one either, because if we would, we would risk stepping into the pitfalls of either Somatologism, Psychologism or even Noologism (the approach that spiritualises everything).



(Fig. 1)

In fact, the neurotic illness always shows connections with both nervous and endocrine dysfunction as well as with pathogenic reactive patterns, leading to a *circulus vitiosis* of anxiety and somatic reaction. This neurotic circle may well infest into the so-called existential vacuum – denoting a lingering life without purpose, goal or meaning and its bio-psycho-socio-spiritual consequences.

This leads us to the conclusion that we cannot begin Psychotherapy treatment without at least having both a differential as well as a *diagnosis per exclusionem* concerning the organismic resonances, or, that we should as Psychotherapists, have the ability to also address these resonances adequately. In other words, we cannot do without proper medical support. The only problem is however, that we need proper medical support. That is: if we are looking at the existential, the unconditional spiritual 'being with the other' which in fact denotes our humanness, what specified areas are we also considering in the dimensions of the somato-psycho-social resonances? It is obvious that if one leg is missing, a leap may belong to the possibilities in terms of a decision, it will however be to a larger extend be co-determined by this lack of leg. A leap down may occur, whereas a leap up is beyond reality.

Though, to get on a stool, even a one legged individual is actually taking a leap up, and even a one legged person takes leaps up into faith and hope – for without, life would be meaningless. Thus far we have been looking at illness. Frankl's explanation leads us to an understanding of neurotic illness, accompanied with the certainty that even under the most awkward circumstances, life is meaningful, the human individual resilient and the human person creatively building upon spiritual foundations.
Even as Psychotherapists we are constantly aware of the fact that we cannot solve a single problem, but that we are well equipped to support, provoke or diminish the self-healing capacities of the human being. We have seen that and how health as a individual subjective state of being, is never a permanent or static equilibrium, but a constantly fluid one. We know that illness may well arrive from nature, but health is nurtured through psyche and the spirit. Whilst Psychotherapy with psychosomatic problems is 'unspecific', but still adjuvant, it would be helpful for us psychotherapists to gain both insight in and ability to influence the organismic resonance fields, as the other way around these capacities would affect the effectiveness of Integrative Existential Analytical Psychotherapy.

Organismic Resonances

To understand organismic resonance, we need to look into the nature of biology as well as into physics. Organismic refers to organs, that is: to the conglomerate of cells and to the mesenchym which denote a separate from other complex unity, equipped with a specified biological function as well as with a limited capacity. This capacity is limited in various ways. Organs, like cells, can only react and there function is to serve the lifespan of their keeper. Our heart e.g. is an organ; its beat is the noticeable organismic resonance. We should be aware of cellular resonances as well, since we learned from biology that there is such a thing as intercellular communication. Resonance comprises energy, as we are aware of what our heart is actually helping us to: it circulates the blood, transporting oxygen and nutrients, antibodies, killer cells etc., to the separate organs it is supporting in order to let our organism be alive. Tests have shown that organs which are cut off from the complex unity of the organism, like cells that are cut off from other cells, will die rapidly. If we would not be the keeper of our organs, or, in terms of psychology, if we did not take care of or look after ourselves, our lives would end rather sooner than later. Our health would deteriorate quickly. We constantly take in energy, in order to facilitate a fluid calibrated path forward into our personal, individual and collective future. What may be new, but in fact was already known in ancient times, is that energy may come in different forms. Light, information, value, food, drinks, - even living cells are rather energy, that is: either oscillating light or frequency of vibration. Like a spiritually perceived value resonates with the existential person, formatting an organismic resonance in terms of a possible meaning, our integral being relates to both organism and resonance, down to the level of cells. Cells are the smallest recognizable human 'parts', like molecules are the smallest separately recognizable integral representatives of matter. Whereas organismic relates to biology, resonance relates to physics. Physically everything in the universe, even dark matter, resonates. The resonance determines about the nature of the matter explored. Just think of an old fashioned radio tuner, the one with the famous 'green eye'. Going along the scale, you would receive a concert of rumble and noise just until you happened to come across a specific frequency. You could determine the right frequency in three ways: 1) by number on the scale, 2.) by the sound replacing the noise and rumble, 3). by the green eye displaying its widest angle or window. The radio transmitter sends out resonance transformed into energy along a specified frequency, the receiver tunes into that specific frequency, transforming the energy back into resonance. The energy is quite weak, therefore we use so-called loudspeakers. In itself, this is a closed, a reactive system. However, through radio, at the receiving and amplifying end, we learn unconditionally.

That is: we open up to the information, and the type of information is not depending on the wavelength of the radio but on its own origin or program. We do get the news everyday differing from yesterday, however always using the same wavelength of energy. What we know now is that there is a constant wavelength able to carry different information patterns.
Back to our physicality: our internal organs function within the wavelength of our individual being, sending different signals depending on the programming available. This process also affects our mind and psyche. E.g. a shortage of serotonin, which is produced in the large intestinal mucous, affects our psychological condition. This condition will affect our physical capacity as well. Serotonin has its own frequency, like our large intestinal mucous, our brains, and even our psycho-organic condition. Neural communication is, like all organismic communication, not just through chemistry but by frequency. It is however reactive, like all organismic resonances are. Whereas our spiritual communication is pro-active, our organismic communication or resonance is reactive. That is why Frankl's dimensional ontology (Frankl, 1946, 1949, et.al.) shows the quantum leap from 'conditional field' into 'unconditional dimension'.
Consciousness and awareness may not be excluded from communication, however the cybernetics differ by one dimension. Whereas all organisms are depending on environment, the spiritual is able to leap the dimensions and actually is beyond the matter-time- space limitations. The whole point of Integrative Existential Analytical Psychotherapy is exactly this difference and its consequences, though at the same time, the integrated awareness about condition, disposition, and situation, leads our quest for a window of resonance towards also carefully looking after the issues that are co-determining our lives by reaction only. We cannot be but spirits; we need our bodies to be us. We cannot be but bodies, we need to be our spirits as well.
We would as Psychotherapists, negatively affect our clients if we ignored the organismic resonances. This however is exactly the part we are 'missing' during our training. As such psychotherapy training may mention the psychosomatic, and even get into the details of it, but it is not offering insight or possible influence here. The famous conflicts from the early days, between the German and the Anglo–American psychosomatics, have not yet been resolved. This is due to completely missing the point when it comes to investigating the nature of the organismic resonances. Psychotherapy has developed a variety of body-psychotherapies, each of them differing a little from the other, some of them even abusing the term 'somatoanalyses or somatopsychotherapy', however the organismic resonance field has not been adequately explored other than by trying to find suppressive chemicals. What we were committed to has been left behind, maybe in a widely perceived but repressed notion of powerlessness of Psychotherapy against the organismic resonance consequences. Some hope rose, when special clinics for Alcohol Addiction, Drug Addiction, Cancer and HIV, and even Hospices using e.g. Integrative Existential Analytical Psychotherapy Methods began to publish research about the positive influence of additional humane psychotherapeutic treatment. This was confirming Frankl's world famous publication from 1946, later published as 'Man's Search for Meaning'. For Psychotherapy to look into the organismic resonances remained a subject out of the scope of attention because of the basically medical set up of psychotherapy itself. In spite of resilient efforts to reconcile psychotherapy as an independent science and profession with the practical support of the medical profession, no progress whatsoever was made. As we all are aware of the competition and the often maintained monopoly policy of the clinical professionals which have come to the cost of the clients and psychotherapists.

Bioresonance Therapy, a feasible option for mutual progress.

During the 1970's ,the rapid development of electronics enabled A. Voll to successfully develop his electro-acupuncture, using the ancient Chinese Medicine breakdown of health issues in meridian systems. The organismic resonances could well be measured by impedance differences as these occurred on the skin surface, located at the finger and toe tips, as well as along the traditional Chinese meridians. The tedious work of getting to a diagnosis, had to work along about 1500 points spread over the human body. But at least, the resonating organism was appreciated within the framework of medicine. Other developments appeared, like the Electro– Encephalogram, the Electro-Cardiogram, the use of Magnetic Resonance scanners during pregnancy and to judge internal processes not using irradiation, Magnet Tomography and not to forget, spacecraft medicine. Resonance is pretty closely related to magnetism, especially to the earth–magnetic field as space travel soon taught. Alongside this, scientists like Schramm, Schumacher, Brügemann, Clarck, Choy, Monroe, Adey, Kavetzky, Koehler, Koenig, Omura, Popp, Pongraz, Plenshikov, Smith, Schulte, Van Wijk, Warnke, *et al*, developed methods and means that not just testify to the influence of resonance on the human organism. They succeeded in dividing harmonious resonance from pathologic resonance, finding out about the specific ranges (Adey) in which our organs and organism are susceptible to effective resonance. Thus a new branch in Human Medicine, called Bioresonance or Bio-Information Therapy, or Bio-physical Healthcare developed (c.f. "Wissenschaftliche Studien zur Bicom Resonanz Therapie, Naturwissenschaftliche Grundlagen, In–vitro Studien, In–vivo Studien, Klinische Humanstudien, Retrospective Praxisstudien', Institut für Regulative Medizin, 1999, Gräfeling) As a new development, Bioresonance has to face a lot of sceptics and a large amount of counter productiveness, though its results are quite encouraging. As in the development of healthcare in general, there have been and actually are, sectarian tendencies. Most of these would not have to occur as soon as proliferation would lead to funding university education and social tolerance would prevent to allow monopolised niches. There is however a large amount of scientific evidence (i.e. double blind research outcome) from which the conclusion about the truth of the Bioresonance claim cannot be denied. We are aware of ourselves; we do not like to share our secrets with everyone, because this would put us out of business. It is of no importance as soon as we acknowledge this detrimental tendency and actually do something about it. The most promising sides of Bioresonance at the moment are that it does not speak about health in terms of a goal to be reached in postponing death and defeat at all cost. The often wrongly interpreted Hippocratic oath is only feeding powerlessness with healthcare workers, whilst the integration of death (apoptosis of cells) would likely offer both freedom and opportunity to serve the ultimate goal of healthcare, which is to foster and facilitate the self-healing capacity of the human being. Another issue is the actual tailored treatment possibilities, which are quite helpful to prevent people from swallowing quite aggressive and unjustly prescribed drugs[2]. However, the most promising sides are the inclusion of the somato-psychological as well as the attitudinal change within the framework of the fluidly functioning equilibrium called 'human health'. In other words, Bioresonance as such is possibly as integrative as Integrative Existential Analytical Psychotherapy Methods can be, with the exception of its current psychotherapy development in the so-called Combined Test Technique approach. Whereas Integrative Existential Analytical Psychotherapy helps clients to find an energizing meaningful and pro-active link in the future, Bioresonance in terms of Psychotherapy tries to extinguish energetic misbalances in a framework of some sort of old fashioned homeopathy (Miasmas) sometimes linked to past psychoanalytical stations. Human *persons* do not in fact exist; they live in an individual 'meadow', called 'Psychosocial Field', or in German: 'Umfeld'.

[2] C.f., the article in November 2003, concerning the remarks of Mr. Roses of GlaxoSmithKline.

This may just be semantic; however it is expressing how Bioresonance as a stand alone runs the risk of becoming not just another form of either German or Anglo-American Psychosomatic Medicine[3], but a new stage in reductionist approaches[4]. As we know from earlier and different reductionist approaches, - even from those arranged under the heading 'holistic'-criticism is always met with exclusion, especially in reaction to the lack of acceptance from the outside establishment of the method. What actually makes Bioresonance quite attractive and a strong offer as such is the capacity to influence the organismic resonances by processing, either in terms of upgrade or debug disharmonious and even malign properties. Other than during the use of psycho drugs, clients remain open and susceptible to the therapeutic relationship, and their command of decision is unbiased. Another advantage is that the client's organism is not burdened with chemicals or scars.
Medication is at least minimized until the evidence of the illness requires differently, whilst the active contribution of the part of the client who is indeed taking responsibility for the required changes in attitude towards self and others, self care and openness to new phases and experiences, is provoked and in all dimensions also supported. Physical suffering is 'reduced' to what is unavoidable in terms of 'present fate', which in itself may have a resonating capacity.
Is it a coincidence that Bioresonance has its counter indications, like Psychotherapy does? Both Psychotherapy and Bioresonance share e.g. the counter indication 'Psychosis', be it for different reasons. Bioresonance, as the word explains, actually applies energy or frequency which *could* also affects the condition of the brain.
It would risk human and health integrity if applied in the case of a psychosis, whereas Psychotherapy knows that psychosis requires simultaneous chemical support and the courage to remain calmly present with the client, waiting for the window to finally open, while undergoing residential healthcare. This however is not how health politicians have decided the resolution. We often do meet psychotic people in ultimate desolation, due to social and healthcare 'developments'; they roam through our streets without treatment.

What is the present state of affairs?

Bioresonance and Integrative Existential Analytical Psychotherapy Methods are, when properly taught and professionally applied, compatible and mutually integrative healthcare approaches, both recognizing the integrated uniqueness of the human[5]. Bioresonance is concentrating on the human-physical resonance of weakened cells, organic and organism-systems, whereas Integrative Existential Analytical Psychotherapy Methods are involved in a similarly differentiated way by looking into the existential-attitudinal resonances (unconditional dimension), the psychological-experiential reactive or psychosomatic dimension, as well as into the behavioral dimension. Whereas Bioresonance is based upon the resonating reaction of organismic weakening or disorder as well as on the promoting stabilizing side of human biology, the Integrative Existential

[3] C.f. **M. Keymer**, *Information on 'Catayst of the central control', according to Martin Keymer,* Dermatologisches Privatinsitut, Preetz,, n.a. p. 1 – 5.
[4] C.f. **M. Keymer,** *Vernetzte Testtechnik II,* Seminar I.M.U. College, Seminar G p. 12, where it leads to the – unexpressed but implied - consequences of a psychosomatic fate or to psycho-physical automatism.
[5] **Integral Medicine: A Noetic Reader** – German Integral Medicine: A Noetic Reader, Herausgeber: Marilyn Schlitz & Tina Hyman - Beiträge von: Larry Dossey, Roger Walsh, Michael Murphy, Ivan Illich, Eugene Taylor, Lawrence LeShan, Caroline Myss, Rachel Naomi Remen, Arthur Deikman, Deepak Chopra, Stanley Krippner, Kenneth Pelletier, Bernie Siegel, Candace Pert, Joan Borysenko, Jon Kabat-Zinn, Jack Kornfield, Dean Ornish, Fred Luskin, George Leonard, Richard Tarnas, William Braud, Rupert Sheldrake, Elisabeth Targ, Dean Radin, Stanislav Grof, Kenneth Ring, Willis Harman, Charles Tart, Elizabeth Sahtouris, Thomas Berry, Christian de Quincey, David Ray Griffin, Theodore Roszak, Brian Swimme, Ralph Metzner, Duane Elgin, Erwin Laszlo, Angeles Arrien…

Analytical Psychotherapy Methods are also equipped with an explorative – debugging as well as with a humane- stabilizing and promoting side (Integrative Logotherapy).

Combined these therapeutic approaches are highly innovative and versatile. Where Integrative Existential Analytical Psychotherapy underlines the organismic resonance, Bioresonance leads to the accreditation of the individual attitude towards integrated caring. Integrative Existential Analytical Psychotherapy values, like Bioresonance, the future of human life by integrating the moment of death and the actual capacity of suffering and dying, in relation to the value of the living organism itself.
Both Bioresonance and Integrative Existential Analytical Psychotherapy are investigating individual future for an active, fluid equilibrium between the self and the other, and are actively involved of formulating their shared social responsibilities in terms of prevention, intervention and clinical humane support of those who are suffering.
Further development and scientific exploration of the possibilities of a new and integrative approach to sustainable humane healthcare, will involve and sometimes integrate both Bioresonance and Integrative Existential Analytical Psychotherapy Methods.
On a practice level it already showed a perspective, and, reporting from my own experience with the extended practices, it lead me to writing this article. My conclusion here is that the combination of both Bioresonance Therapy and Integrative Existential Analytical Psychotherapy Methods seemingly operates as the left and right hand of the therapeutic relationship. The efficiency and compatibility of these integrative forms invites for further research, whereas existing practices require revision of presently drawn financial and political as well as social borders. Special attention must be paid to the basic methodological questions of the integration, in order to stay free from reductionist or absolutes.

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Berichten uit Wenen, februari 2004

EAP meeting.

De Europese Association for Psychotherapy heeft in februari de voorjaarsvergadering gehouden. Ook wij zijn daarbij betrokken, via de EALEA. Zoals u wellicht weet is Marlot Rappard onze vertegenwoordiger bij de EAP. Zij is ook lid van het Membership Committee van de EAP en zij is een van de drie mensen die een psychotherapierichting moeten beoordelen bij een lidmaatschapsaanvraag. De vergadering was goed bezocht en vond plaats in het hotel Schönbrunn. Op de omvangrijke agenda stonden de motie in het EU-parlement en de ontwikkelingen in Frankrijk centraal. In het EU-parlement is een motie ingediend door het Oostenrijkse parlementslid mevr. Berger, die er op aandrong om het zelfstandige beroep Psychotherapeut op te nemen in een voorstel voor een directief (dat is een EU wet die boven de nationale wetten uitgaat). De motie is aangenomen en het wetsontwerp is nu doorgestuurd voor commentaar van de nationale ministers. Daarna komt het voorstel terug in het EU-parlement en wordt er gestemd. De basis voor het voorstel is de EAP – ECP tekst, en dat is een bijzonder goede reden om er blij mee te zijn. De EAP groeit uit boven het vooringenomen oordeel van het ministerie in Nederland, dat het 'slechts een particulier initiatief' is.
Inmiddels is de EAP een NGO met consultatieve status bij de Raad van Europa en is er een vertegenwoordiging van de EAP in de WHO van de UN. Dat is niet alleen maar ver van je bed; het gaat werkelijk om je concrete professionele belangen, dat blijkt maar weer eens.
Voorzichtigheid blijft geboden, en het is onverstandig om er zelfstandig iets mee te gaan ondernemen. Dat doet de politieke stabiliteit schade Dit proces gaat ongeveer twee jaar duren. In Frankrijk is een wetwijziging tot stand gekomen, waardoor psychotherapeuten zich in het Franse BIG-register kunnen laten opnemen. Daar is een relatie met het ECP. Ook hier geldt voor ons dat we er niet zelf iets mee moeten doen. Dat doen de desbetreffende nationale koepels. Vervolgens is er gesproken over de vraag naar een specifieke EU-brede regeling van de plicht tot Continuous Professional Education. Daarover komt binnenkort een besluit, maar nu al is gebleken dat de NAP-regeling (waar ook wij onder vallen) in de goede zin aansluit bij de Europese normen op dat terrein.

Waarom wij individueel lid worden van de Kamer van de NAP.

Zoals bekend betekent de NAP uiteindelijke professionalisering van zowel ons beroep als van onze bestuurlijke mogelijkheden. De mensen die een ECP hebben, weten dat van dichtbij. Telkens als er berichten zij, worden die aan alle ECP-houders als lid van de Kamer doorgestuurd.
Ook alle vergaderagenda's en ontwikkelingsschetsen gaan naar alle leden. Voor ons als relatief kleine vereniging is er een duidelijk probleem, namelijk dat we met veel te hoge lasten zitten.
Die lasten worden niet opgelegd omdat het bestuur daarvan leuke dingen kan doen, maar domweg omdat er structuur mee geschapen moet worden. Een koepel zonder kantoor en (tot nu toe nog onbetaald) personeel is ondenkbaar. Zoals bekend, heeft Willem Maas gedurende de jaren 1992 tot heden niet alleen gepleit voor een betere organisatie, hij heeft er ook al die jaren voor gewerkt. Zonder zijn inzet was er van de bovenstaande ontwikkelingen niets tot stand gekomen, en zou een project als Eureka-University met goede vooruitzichten op accreditatie door de Oostenrijkse ministeries voor Gezondheidszorg en Wetenschappen ondenkbaar zijn. Nu circuleert onder ons het voorstel om de NVLEA als vereniging op te heffen (of om te vormen voor hen die geen ECP hebben) en om als ECP-houders over te gaan tot de aanvraag van de sectie Integratieve – en Cognitieve Psychotherapie Methoden voor de Kamer van de NAP. Dat lijkt onbelangrijk, maar het is het tegengestelde. Wij kunnen dan in de sectie het initiatief nemen en zo onze invloed op het bestuurlijke vlak waarmaken.
We gaan iets van € 25,- per jaar meer betalen dan we gewend waren, maar daarbij winnen we dat afdracht en invloed effectiever geregeld zijn dan tot nu toe.

EPSA / Eureka-University en EALEA

Blijft over de jaarlijkse individuele afdracht aan de EALEA. Ook hier behoeft het geen betoog dat we met de huidige ontwikkelingen de EALEA broodnodig zullen hebben. Marlot heeft er vele jaren voor gewerkt en heel erg veel bereikt. Het moet ook hier gezegd worden, dat er nooit enige vorm van reiskostenvergoeding of urenvergoeding voor is betaald en dat Marlot dit werk sinds 1996 doet. Ook dat kan niet zo blijven. EALEA kan niet zonder EAP. Behalve lidmaatschap kost EALEA ook nog het nodige. Maar daar krijgen we dan ook echt wat voor.
De EALEA heeft een brug kunnen slaan naar de East European Association for Existential Psychotherapy (zetel in Litouwen) en naar de Oostenrijkse Gesellschaft für Logotherapie und Existenzanalyse. Dat laatste mag een groot wonder heten, en het is te danken aan de vasthoudendheid van de EALEA in samenwerking met EPSA/Eureka-University. Hoe staat het dan met de familie Frankl? Er is toch een groot verschil tussen de groepen? Ja, er zijn verschillen. Er is met Prof. Dr. Vesely en met dr. Battanye in Wenen een overleg geweest, waarin het Eureka-project kritisch is bekeken op de vraag hoe er dan met de geestelijke en culturele erfenis van Frankl wordt omgesprongen. Prof. Uwe Eglau en Prof. Willem Maas waren bij dat gesprek de betrokkenen. Duidelijk is, dat in een wetenschappelijk-professionele omgeving niets dan alleen in een vrije en kritische 'Aus-ein-ander-Setzung' kan geschieden. Daartoe hebben alle partijen zich verplicht. Eureka is de brug, want het motto van de universiteit stamt uit de metaklinische Vorlesungen en is het handelsmerk van de universiteit. Dat en hoe zaken verder ontwikkeld worden, ligt voor een deel in het verschiet, maar er is geen leven onder een glazen stolp. Zowel EALEA als ÖGLE als ook de EEAP willen aan het EPSA/ Eureka-project deelnemen. Voorwaarde daarbij is juist een committent aan de fundamentele kritisch–wetenschappelijkheid van het bovengenoemde. Het Viktor-Frankl-Institut te Wenen heeft de bereidheid om promovendi (dr. Phil.) desgevraagd te helpen bij hun onderzoek.

Tot slot

Een artikel in de Standard, een van de grootste kranten in Oostenrijk, maakte onlangs melding van de Eureka-University. Dit naar aanleiding van een dergelijk initiatief dat zich de Sigmund Freud Universität noemt, maar dat zich met veel te vroeg veel te veel zeggen de woede van de Akkreditierungsrat (min. van Onderwijs) en van de Oostenrijkse NVP en van de Psychotherapie Beirat van het ministerie van Gezondheidszorg op de hals haalde. Eureka–University heeft een diplomatieke weg gekozen en jaagt niemand in de gordijnen, maar doet in stilte wat nodig is om tot het gewenste resultaat te komen. De commentaren van de belangrijkste vertegenwoordigers op ons plan spreken ons zeer goede moed in. Heb je al een ECP en wil je nu een Masters of Arts in integrative Counselling and Psychotherapy? Doe dan de verkorte route, die via STIPO in ons land wordt aangeboden. Aan deze Eureka-University opleiding zijn drs. Pieter Hoekstra en Willem van der Mee verbonden. De ervaring die er dit jaar mee is opgedaan is echt positief, zowel van de kant van de studenten (8) als van de docenten.

25. Februar 2004
16:12 MEZ

Selbstreflexion für Fortgeschrittene

Gleich zwei Privatunis für Psychotherapie in den Startlöchern: die Sigmund-Freud-"Privatuni" und die Eureka-"University"

Wien/Maria Enzersdorf - Im April geht's los. Der Lehrbetrieb an der Sigmund-Freud-Privatuni startet. Vorerst wird es nur ein Aufbaustudium geben. Doch: Die "Privatuni" ist noch keine. "Das Risiko können wir eingehen", so Heinz Laubreuter vom Gründungskomitee. "Dieses Vorsemester richtet sich an aktive Psychotherapeuten. Bis zur Akkreditierung als Privatuni werden die Kollegen auch nichts zahlen." Später will man ein Vollstudium der "Psychotherapiewissenschaften" anbieten.

Die Psychotherapieszene ist wenig begeistert: "Mit ‚wenn' und ‚kann' die Leute zu ködern ist nicht in Ordnung", sagt Margret Aull, Präsidentin des Berufsverbandes. Die Psychotherapieausbildung ist mit eigenem Gesetz geregelt. Zwei Bausteine führen zum Beruf: Das Propädeutikum - die Grundausbildung - und das Fachspezifikum - die Vertiefung in eine spezielle Methode unter intensiver Selbstreflexion und Supervision. Nach dem Abschluss wird man in die Psychotherapeutenliste eingetragen und darf seinen Beruf ausüben.

"Chance gleich null"

Dieser Ausbildung "könnten Teile eines Studiums angerechnet werden, aber nur in geringem Maße", sagt Gerhard Stemberger vom Psychotherapiebeirat des Gesundheitsministeriums. Die Freud-Uni ist keine anerkannte Ausbildungsstätte im Sinne des Gesetzes. Die Studenten werden erst nach dem Abschluss wissen, ob der Titel reicht, um als Therapeut tätig zu sein. Und die Chance dafür geht "gegen null", so Stemberger.

Anders bei der Konkurrenz. Im nahen Maria Enzersorf wartet die Eureka-University ebenfalls auf Akkreditierung als Privatuni. Die Politik ist dort eine andere: "Ich werde doch nicht an die Öffentlichkeit gehen, wenn ich noch nicht weiß, ob ich lebe", sagt Anneliese Fuchs von Eureka. Das geplante Studium soll sich von den bisherigen Konzepten zwar unterscheiden, aber: "Dort wird die bestehende Ausbildung wenigstens nicht unterwandert", so Margret Aull. Denn Eureka bemüht sich um Anerkennung als Ausbildungsstätte für bestimmte Fachspezifika.

Das Semester wird bei Eureka 3500 Euro kosten. "Sigmund Freud" verlangt zwischen 4750 und 6250 Euro. Eine Entscheidung des Akkreditierungsrats wird in beiden Fällen nicht vor April fallen.

OPEN DAG

24 april 2004 Utrecht, gebouw
Hogeschool Inholland, Witte Vrouwenkade

Titel:
De humaniteit van de medemenselijkheid spiritualiteit en verantwoordelijkheid in Psychotherapie

Themadag in het kader van de opleiding
MA Integratieve Counselling en Psychotherapie
STIPO Eureka–University St. NILEA

programma

10.00 welkom aan de zaal, koffie
10.20 begin van de dag
10.30 Prof. Uwe Eglau, dekaan Eureka-University
11.00 koffiepauze
11.30 vragen stellen over de lezing
12.00 pauze
13.00 presentatie Eureka-University en STIPO programma's
14.00 pauze
14.30 vragen over de studiewegen die STIPO aanbiedt
14.45 uitreiking boek en certificaat van deelname
15.00 sluiting van de dag

informatie over de opleiding: www.stipo.com, download de relevante pdf's

Niet pathologie maar pathos:
Gedachten over de kern van de wetenschap en het vak dat psychotherapie is

© 2004 Prof. Dr. Willem Maas

Psychotherapie is een zelfstandige tak van wetenschap en een zelfstandig beroep. Kernvraag in die wetenschap en dat beroep is de vraag naar het mens-zijn in het lijden. Het lijden waaraan iemand lijdt en hoe iemand dat vormt, en hoe dat iemand mede bepaalt. Ik definieer voor het gemak het volgende rijtje, zodat we ons een beeld kunnen vormen van de portee van de zaak. Ik voeg er een casus aan toe.

- pathologie schrijft af op de mens: hij is minder dan bruikbaar of nuttig, want met zus of zoveel gebrek. Uitgedrukt in percentages is iemand al dan niet geheel of gedeeltelijk arbeidsgeschikt of arbeidsongeschikt.

- psychologie probeert gedrag te verklaren en dat in de zin van afwijkend van de al dan niet kunstmatige of vigerende groepsnorm.

- psychotherapie kijkt naar de vraag hoe iemand het eigen lijden levend vorm geeft.

Een door de ziekte van Lyme aangetaste en verkreupelde man die zijn hele leven met hart en ziel in zijn boerenbedrijf had gewerkt totdat zijn lichaam het domweg niet meer kon, zei mij tijdens een gesprek over zijn volharding in revalidatie:
'Weet u, een zieke heeft maar een enkele wens: gezond worden.
Een gezond mens heeft duizenden wensen'
De wijs- en middelvinger van zijn rechterhand zijn donkerbruin van de vele shagjes die hij had gerookt, en de krukken die zijn verlamde been moesten vervangen stonden in de hoek van de kamer. De weg van de parkeerplaats tot de stoel waar hij nu zat was ongeveer zoveel meter als minuten lopen geweest, 10. Maar hij kwam er en hij was er ook van overtuigd dat er een dag zou komen dat hem zijn pijn en moeite zouden worden beloond, al was het maar in het verlies van een enkele kruk

De verbluffende eenvoud en scherpte van de waarneming van mijn cliënt laat zien hoe complex de zaak ligt. Door de etikettering van ziekte (in de medische sfeer), arbeidsgeschiktheid (= in de economische/sociologische sfeer) pathologie (in de psychologisch/psychiatrische sfeer) en probleem (in de gebruikelijke psychotherapeutische sfeer) ontvalt deze man meer dan de beheersing van zijn beenspieren of zijn mogelijkheid tot maatschappelijk en financieel produceren. Pas wanneer wij gaan kijken naar de vraag hoe hij zijn lijden vorm geeft, komt naar voren wie deze mens is onder de voor hem gegeven (want onontkoombare werkelijkheid) omstandigheden.

Het kon zo zijn dat de vormgeving van zijn lijden, de wijze waarop hij in het leven staat, er op zijn manier van geniet, er mensen in ontmoet, zich geeft voor wie hij liefheeft etc. hem precies de moed en de kracht brengen die nodig zijn om zijn strijd te strijden. En hij geeft ons de ingang die nodig is om hem op een werkelijke manier te ontmoeten. Hij confronteert ons ook met vragen die wij van nature uitstellen, namelijk de vragen over wie wij zelf zijn als het precies om die moed en die kracht zou gaan.

Daar is in een notendop de hele zaak compleet op tafel.
Ons wetenschappelijk denken en ons professionele handelen willen er niet van nature, niet vanzelf, niet vanzelfsprekend aan om dit centrale punt ook werkelijk centraal op de agenda te houden.

Dat punt is het lijden als persoonlijke vormgeving van het individuele leven.

Is dat niet een willekeurige keuze? Is het niet veeleer zo in wetenschap en in de beroepspraktijk, dat alsof het een plebisciet zou zijn, 'de meerderheid beslist'?
Of is het juist andersom: dat er vanwege de gebrekkige wijze van denken en werken een wetenschapskritische en praktisch noodzakelijke correctie is die stelt dat het lijden in het middelpunt van het denken en behandelen moet staan?

Als psychotherapie een menswetenschap is, dan dienen we ons bewust en kritisch tot de vraag naar het wezenlijke van het mens-zijn te verhouden.
Het mens- en wereldbeeld is dus bepalend. Dat is wat de *prolegomena* moet beschrijven, daar liggen de klinisch-empirische fundamenten.[6]
Psychotherapie als wetenschap van de persoonlijke vormgeving van de individuele situatie is principieel noölogisch, d.w.z. houdt zich bezig met de dynamiek van de *nous*, de menselijke geest als instantie van oriëntatie en beslissing.[7] Hoe houdt een mens zich staande *als mens* is dus een zaak van diens *existentie*, het antwoord op de vraag hoe iemand de gegeven situatie in het eigen bestaan *integreert*, er zich mee verenigt en vereenzelvigt dat dit zowel de vraag als ook het eigene is.
Dit perspectief eist ook dat er onderscheid wordt gemaakt in de *dimensies* waarin het persoonlijke verschijnt. Daarmee wordt een definitief halt toegeroepen aan de pogingen om het persoonlijke te herleiden tot conflict of pathologie,[8] of vanuit het psychisme.[9] Dit laatste proces zien we tegenwoordig vooral terug bij pogingen om met behulp van psychofarmaca de hersenwerking zodanig te beïnvloeden dat de gevolgen van het lijden worden onderdrukt.
Dat daarmee de indruk wordt gevestigd als zou het lijden zelf worden opgeheven (zelfs als het alleen maar ging om de term 'last hebben van') staat hier niet ter discussie, noch de bij farmacie mogelijk optredende, dikwijls blijvende letsels.
Terug nu naar de opmerking dat menszijn een zaak is van existentie, en dat de mens een wezen is dat als persoon de gegevens van de eigen situatie in het bestaan integreert. Existentie is een zaak van de geest[10].

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[6] De klinisch empirische onderbouwing van psychotherapie is zelf natuurlijk niet psychotherapie! Onder wiskunde ligt rekenen en redeneren, zonder dat redeneren en/of rekenen per definitie ook wiskunde moeten zijn.
Binnen de traditie van het wetenschappelijke denken is het noodzakelijk om klinisch-empirische data aan te voeren die vervolgens tot de prolegomena van het betreffende vakgebied voeren.

[7] C.f. **V. E. Frankl**, *Der unbedingte Mensch, metaklinische Vorlesungen*, Wien 1949

[8] C.f. **Michael Guilfoyle**, *Power, knowledge and resistance in therapy; exploring links between discourse and materiality'* in: International Journal of Psychotherapy, Vol 7, 1, p. 83.vv, London/Vienna, 2002.
Vergelijk ook de theorie van *Alfred Adler*, die er van uitgaat date en individueel-subjectieve perceptie van een biologische incompetentie leidt tot een individuele sociale compensatie in termen van een gebrek aan zgn. Kooperationsbereitschaft – het vermogen zich aan een krachtiger leider of aan een groep te conformeren, of, tot een individuele machtsgreep.

[9] C.f. **C.G. Jung,** die de term bedacht**.** Op de site van de Association Anthropologica vinden we in Hoofdstuk 6 het begrip psychisme aldus verklaart:**Psychisme** *n.m.*, ou **Psychique** *adj.* (psychobiologie) : Qui concerne l'esprit, la pensée, la vie mentale, les états de consciences. Les phénomènes psychiques seraient produits par l'activité des régions cérébrales les plus complexes, à savoir les aires corticales associatives polymodales. Elders (www.netlexikon.de): Unter dem **Psychismus** versteht Jacques Lacan den psychischen Apparat. Anders als Sigmund Freud, der von *Ich, Überich* und *Es* spricht, spricht Lacan von folgenden Konstituenten des Psychismus: das *Subjekt* (in etwa Freuds "Ich") sieht sich zunächst in rivalistischer, aber auch libidinös besetzter Beziehung zu seinem *kleinen anderen* (sein alter ego, mit dem er im Spiegelstadium zuerst konfrontiert wurde). Eine weitere Position bilden die *Objekte*. Diese *Objekte* gehen aus der Entfremdungserfahrung im Spiegelstadium hervor, das das Subjekt die Erfahrung machen lässt, dass es nicht "komplett" ist, nicht "alles hat" - also muss es diese fehlenden Aspekte als "Objekte" geben. Außerdem gibt es eine vermittelnde Instanz, der *Große Andere*, der Regelhaftigkeit und Gesetz, aber auch Gebote und Verbote repräsentiert (in etwa Freuds Überich). In seinen Skizzen spannt sich bildlich der Psychismus zwischen diesen vier Positionen trapezartig auf.

[10] c.f. **V. E. Frankl**, *Insofern der Mensch Geist ist, existiert er als Person*

Geest echter zou geen zaak zijn van de wetenschap, maar slechts van het geloof. Geloof is als zaak van de psychologie en van de gedragsonderzoekers op dat moment ontdaan van de existentiële dimensie, want gereduceerd tot vermijdingsgedrag of min of meer pathologisch stadium van onvolwassenheid. Geloof is als zaak van de biologie niet feitelijk en niet onderzoekbaar.
Geloof als zaak van de theologie komt in het Westen uit in de kerkleer en in het Oosten in *fatum*. Ook hier is het probleem direct zichtbaar namelijk een gebrek aan onderscheidingsvermogen tussen *fides quae* en *fides qua*.
Zoals we direct zien geeft de opsomming van mogelijke standpunten ten aanzien van zoiets fundamenteel menselijks als *geest* voor wetenschap en praktijk aanleiding en reden om erbij weg te lopen. Psychotherapie blijkt dus geen *gedragswetenschap* te zijn. En ook al niet een *medische* wetenschap. Psychotherapie is geen vorm van *theologie of apostolaat*, al is er in de wereld die psychotherapie heet in een zeer breed spectrum sprake van een *dogmatisch* perspectief en van *inquisitie*.
Veel van wat zich als psychotherapie presenteert beperkt zich tot een onwerkelijke verlegenheid die nooit verder komt dan *techniek*, en *effectiviteit*, alsof het wezenlijke van de tussenmenselijke en therapeutische ontmoeting in het lijden (een andere ontmoeting heeft de therapeut immers per definitie niet) eerder een zaak van *financiële productie* is dan van beroepsmatige en wetenschappelijke integriteit.

Zoals het centrum van de psychotherapeutische praktijk gevormd wordt door het *actuele lijden waarmee de persoon die de cliënt is worstelt,* is de kern van psychotherapie als wetenschap dus *de geestelijke wereld die persoon is*.
De persoon valt als categorie buiten het zijnsveld (materie en kwantificeerbaarheid), en het lijden valt als categorie buiten het gedragsveld (er zijn teveel variabelen, of – dat wordt vaker gezegd – het is louter subjectief). Psychotherapie als wetenschap kijkt naar de vraag of en op welke wijze iemand de gegeven situatie in het eigen bestaan integreert, en psychotherapie als praktijk kijkt naar hoe iemand het eigen lijden zodanig vorm geeft dat de onvoorwaardelijkheid van de geest er niet aan te gronde gaat. Daarom is de analyse die kijkt naar de vraag of en op welke wijze iemand zich in een gegeven situatie bevindt en die vraagt naar de mogelijkheden en perspectieven die daarin nog of opnieuw zichtbaar worden, niet een zaak van willekeur of geloof, maar adequaat en ter zake. Het gaat hier immers om de existentie, of, zoals ook wel wordt gezegd: om de explicitering van het persoonlijke bestaan.

De analyse[11] van het werk van de persoon, namelijk van diens integrerende- of noödynamiek onderzoekt de in die situatie verschijnende of oprijzende persoonlijke oriëntatie van de cliënt, die zich *als deze unieke mens* expliciteert of uitdrukt *in weerwil van* of zelfs *dankzij* of zelfs beide. De kernachtige aanwezigheid van de menselijke geest als *bron* en *tertium non datur* van het mens-zijn zelf – of van het fenomeen 'mens'[12] kunnen wij omzeilen zonder zowel onszelf als ook onze geschiedenis en toekomst direct af te schaffen. De vraag van de psychotherapie als wetenschap is niet waar de mens natuurwetenschappelijk staat, is niet die naar de chemische samenstelling of cortex activiteit, maar die naar het mens-zijn van die mens in de omstandigheid of situatie of onder de conditie waarin die mens zichzelf als lijdende mens percipieert en ervaart. Het spreekt vanzelf dat psychotherapie als science oriented praktijk *niet op een eiland* leeft, maar er zich rekenschap van geeft dat pathologie medebepalend kan zijn en dat de

[11] Het gaat hier om een analyse die onderzoekt welke geestelijke coördinatiepunten en attitudinele mogelijkheden er in de gegeven combinatie van mens en situatie 'gegeven' zijn en welke handelingsperspectieven daaraan verbonden kunnen mogen worden onder het negatieve ethische voorbehoud dat degene die de handeling voltrekken moest er geen kwaad of schade mee berokkent, en onder het positieve ethische voorbehoud dat de betrokkene iets toevoegt aan het te voltooien eigen bestaan.
[12] Deze term stamt van de franse antropoloog **Pierre Teilhardt de Chardin** uit zijn beroemde hoofdwerk '*Le phenomen humain',* maar de term komt ook bij de Frankfurter Schule (**J. Habermas**) veelvuldig voor. Daarmee ligt de verbinding tussen filosofie en antropologie en psychotherapie meer voor de hand dan die tussen psychologie, farmacologie en psychiatrie.

sociale omgeving ook een eigen dynamiek heeft van waaruit in het kader van zowel vrijheid als verantwoordelijkheid eisen voortvloeien, die *ook* meebepalend kunnen zijn. Aan deze zaken kan de *cliënt* zich nu juist niet 'zonder meer' oriënteren, zolang en wanneer hem of haar het perspectief van de geest, namelijk het gerestaureerde besef van eigen waardigheid en het heropenen van een mogelijke zijnsvervulling, ontbreekt.

Terug nu naar het praktische en theoretische centrum van psychotherapie: het lijden. Het komt niet vaak voor dat mensen hun lijden als lijden definiëren. Zij zijn daar meestal te bescheiden voor. Lijden hoort bij onherstelbaar, bij doodgaan, of bij vrijwillige opoffering of bij ongelukkig verlies. Voor velen hoort lijden zelfs bij eigen schuld. In dat geval klikt de psychodynamiek niet graag over de persoon die achter de schermen van het voor de buitenwacht private iets ondernam dat slachtoffers zocht en maakte. Het kan zelfs zo zijn, dat het begrip 'lijden' vermeden wordt vanwege het collageen 'schuld', omdat er populaire gezondheidsguru's zijn die verklaren dat bijv. kanker eigen schuld is, zelfs gewenst als entree tot de vroegtijdige dood.

Een bijzonderheid van psychotherapie is dat het niet de vraag naar de intactheid van het lichaam of de flexibiliteit van de emotionaliteit is, maar het *pathos* waarmee de betrokken cliënt spreekt over de binding met het eigen bestaan. Vanuit het mensbeeld[13] dat aan verantwoorde psychotherapie ten grondslag ligt, geldt immers niet het *mens sana in corpore sane*, omdat dit principe de cliënt onherstelbare schade berokkent. De zoektocht naar een mogelijke opening naar toekomst die het heden dragen mogelijk kan maken, is de activiteit van de geest en het pathos van betrokkenheid bij de waarde en waardigheid van het eigen bestaan. Hier ligt dan ook de brug tussen psychiatrie en psychotherapie, zoals ook die naar geestelijke begeleiding. De te vinden opening is die naar de vrijheid voor het andere.

De begaanbare weg is die van het op zich nemen van de verantwoordelijkheid in het doen van die verandering. Zo kom ik terug bij de casus: de 10 minuten en de 10 meter worsteling van mijn cliënt naar de spreekkamer geven in weerwil van de verlammende gevolgen van Lyme en de snerpende pijn langs de zenuwbanen aan dat mijn cliënt niet neurotisch is, maar waardig , niet alleen nog maar een gehandicapte maar vaardig.

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[13] Hier geldt dat we vanuit het mens- en wereldbeeld dat de menselijke persoon en de geest als eigenlijk menselijk fenomeen in het centrum stelt, het dubbele credo: (**Frankl**) had al eens eerder de kans om *een psychiatrisch Credo* uit te spreken. Hij zei destijds: 'W*enn es nicht so wäre, dass die geistige Person auch noch hinter der Verbarrikadierung durch die Psychose vorhanden wäre, wenn auch noch so sehr zu expressiver und instrumentaler Ohnmacht verurteilt,* - wanneer het dus niet zò zou zijn, dat de geestelijke persoon vanuit het psychofysicum weliswaar 'gestoord' maar niet vernietigd (zerstörbar) was, *wat had het dan voor zin om psychiater te zijn?* Want als de geestelijke persoon niet gespaard zou blijven van elke vorm van psychofysiek verval, als die alleen maar zou zijn wat daar overheen geplakt werd, voor wie zouden we dan nog arts moeten zijn? Om psychiater te zijn… daar kunnen we alleen dan voor instaan zolang we het mogen zijn, niet voor een psychofysiek organisme, maar voor de geestelijke persoon, die er met smart op wacht om door ons van de psycho-fysieke handicap bevrijd te worden!

Nu moet ik echter een tweede credo uitspreken: *'Gäbe es nicht den fakultativen psychonoetischen Antagonismus, gäbe es somit nicht eine Möglichkeit, die geistige Person der Psychose als psychophysischer Krankheit gegenüberzutreten zu lassen, so wären wir niemals imstande, eine Psychotherapie bei Psychosen durchzuführen.'* ; **V. E. Frankl,** *a.a.b.* hfdst. 4.

Still Crazy after all these Years:

Why Meditation isn't Psychotherapy

by Patrick Kearney

Introduction

There is a great deal of interest in Buddhist meditation in contemporary Australia, especially among psychologists and psychotherapists who seek to integrate Buddhist meditation, and in particular the *vipassanâ* meditation of the Theravâda school of Buddhism, with various forms of psychotherapy. The popularity of this approach is shown by the success of books such as Jack Kornfield's *A path with heart: A guide through the perils and promises of spiritual life*, a runaway best-seller that has had an enormous impact on many people, including non-meditators. Indeed, Kornfield is one of the central influences behind this movement. Himself a successful meditation teacher and psychotherapist, he has inspired at least two other therapists, both of them his meditation students, to write on psychotherapy and meditation: Jeffrey Rubin, author of *Psychotherapy and Buddhism: Towards an integration*; and Mark Epstein, author of *Thoughts without a thinker: Psychotherapy from a Buddhist perspective*.

As I read these books I did not feel the excitement that comes from discovering a new and culturally relevant way of encountering the timeless essence of the Buddha-dharma. Rather, I felt somewhat disturbed by what I see as a growing confusion about the nature of Buddhist teachings and a willingness to distort and dilute these teachings, apparently in order to make Buddhist meditation more saleable in our contemporary spiritual marketplace.

In this paper I wish to discuss the issues I feel are raised by these three books in particular, seeing them as representative of a wider movement. At this point I wish to declare my own interest in this discussion. I have practised Buddhist meditation for 20 years, since 1984 in the tradition of the late Mahâsî Sayâdaw of Burma, principally under the guidance of Sayâdaw U Pandita Bhivamsa (of Mahâsî Sâsana Yeiktha and recently of Panditârâma Yeiktha) and Sayâdaw U Janaka Bhivamsa (of Chanmyay Yeiktha). I have had very little exposure to the American *vipassanâ* tradition, although I do have some experience of American Zen, gained through two years of practice with the Diamond Sangha in Hawaii. Nor have I had any exposure to Western psychotherapy. So I speak as one ignorant of psychotherapeutic practice but with a great deal of respect for the traditions of Theravâda Buddhism, and rush in to judgement in a situation where I am, at best, familiar with only half the territory.

Eastern Meditation and Western Psychotherapy

In *A path with heart*, Jack Kornfield raises the issue of the relationship between traditional Buddhist meditation and Western psychotherapy. Buddhism has always been an extremely adaptable religion, and it demonstrates a protean ability to adjust itself to new cultures. Buddhism tends to take existing elements of a new host culture and "buddhise" them, using them as vehicles for its fundamental insights. But cultural adaptation is a two-way process, and Buddhism is itself transformed as it moves from one culture to another. We are living through a period in which Asian forms of Buddhism are adapting themselves to the culture of the contemporary West, and Jack Kornfield sees Western psychology as that aspect of Western culture which is providing the most significant impact on Buddhism (244). His words are echoed by Mark Epstein in *Thoughts without a thinker*, who compares our situation to that encountered by Buddhists when

Indian Buddhism came to China. Indian Buddhism was translated into Taoist terms by the Chinese, and this process of "sinification" changed Indian Buddhism into Chinese Buddhism. Today, Epstein says, as Asian forms of Buddhism are being transformed into Western Buddhism by the same process of translation, it is the language of psychoanalysis that is providing the vehicle for the Buddha's insights to be presented to the West (7).

Suffering East and West

To what extent can psychotherapy shed light on Buddhist teachings? Let us begin by examining how the therapists understand the first of the Four Noble Truths, that of suffering. It is axiomatic to all Buddhist traditions that people begin meditation because of their discovery of the First Noble Truth: that of *dukkha*, suffering or unsatisfactoriness. The Buddha taught that all experience is fundamentally unsatisfactory, whether it be gross forms of physical pain and mental anguish, or the experiences of pleasure, success and fulfilment that we would normally regard as pleasurable or even blissful. In brief, why do we begin meditation practice? Because we are in pain, and we know we are in pain.

Kornfield approaches the question of the relationship between meditation and psychotherapy by arguing that there is a very specific kind of suffering that Westerners bring to meditation practice. He says:

[S]piritual practice attracts a great many wounded people who are drawn to such practice for their own healing. Their numbers appear to be increasing. The spiritual impoverishment of modern culture and the number of children raised without a nurturing and supportive family is growing. Divorce, alcoholism, traumatic or unfortunate circumstances, painful child-rearing practices, latchkey children, and child-rearing by day care and television all can produce people who lack an inner sense of security and well-being. These children grow up to have adult bodies but still feel like impoverished children. Many such "adult children" live in our society. Their pain is reinforced by the isolation and denial of feelings that is common in our culture. (204)

Epstein echoes this concern. He argues that Westerners commonly suffer from what has been called the *basic fault*, a chronic spiritual hunger caused by inadequate childhood attention, neglect rather than abuse (173). Epstein goes on to say:

From the Buddhist perspective, the closest parallel lies in the descriptions of the hungry ghost realm. Many Westerners require a combined approach of psychotherapy **and** meditation precisely because the hungry ghost realm is so strongly represented in their psyches. This is a phenomenon that is new to the recorded history of Buddhism: never before have there been so many Hungry Ghosts engaged in Buddhist practice. (174)

Kornfield and Epstein agree that the situation contemporary Western meditators face is unique. Kornfield calls people who suffer from this unique spiritual hunger "adult children," people who lack a healthy sense of self and who are spiritually crippled by the suffering they have undergone in childhood and their unconscious denial of this suffering (Kornfield: 217; & Epstein: 176-8).

Given that Western meditators are faced with culturally unique forms of suffering, it follows that these particular types of suffering are best dealt with by the techniques of Western psychotherapy which have been developed within this culture to deal with the problems specific to this culture. Kornfield says:

Psychotherapy addresses in directed and powerful ways the need for healing, the reclamation and creation of a healthy sense of self, the dissolution of fears and

compartments, and the search for a creative, loving, and full way to live in the world. (245)

Having established that Westerners undergo unique forms of suffering that psychotherapy has developed techniques to handle, Kornfield goes on to argue that meditation alone is not enough to heal many of the deep issues we uncover in the course of our meditation (245). Meditation alone is not enough. He makes the extraordinary claim that at least half the students at the annual three month retreat at the Insight Meditation Society cannot do traditional Insight Meditation, "because they encounter so much unresolved grief, fear, and wounding and unfinished developmental business from the past" (246). He follows up this revelation with a number of stories relating how specific students were blocked in their meditation but successfully resolved these blockages once they were able to identify traumatic events or unsatisfactory or even abusive relationships in their past. He also narrates stories of spectacular failure in spiritual practice when these issues were neglected. Indeed, much of Kornfield's argument is based on case histories of meditational success and failure that all go to support his view of the limitations of traditional meditation without psychotherapy. While these stories are interesting and sometimes even instructional, the implications behind this view need to be teased out.

I was first struck by Kornfield's claim that at least half of the students who attempt to do traditional *vipassanâ* meditation at IMS cannot do so. This is an extraordinary admission of failure for any meditation teacher or meditation centre. In my experience as a practitioner and as a teacher - and I must admit to having a very limited experience as a teacher - I have only seen evidence of such a large failure rate among the students in circumstances where it was quite clear that the teachers were doing a very bad job. Nor have I seen any evidence that such failures are confined to specific ethnic or cultural groups. It is true that *vipassanâ* meditation is very difficult, and it is true that many students engaged in this practice spend significant, even long, periods of time stuck, not moving on through the stages of *vipassanâ ñâna*, or insight knowledge, as described in the traditional meditation literature. But I have never experienced a situation where anything like half the people who begin intensive meditation practice are psychologically incapable of getting started. If Kornfield's claim is true, something very strange is going on in the world of *vipassanâ* meditation teaching.

Another aspect of this claim that struck me was the sense of specialness that underlies it; the sense that we as Westerners with a capital "W" are unique, special, not at all like those far-off foreign Easterners with a capital "E." Indeed, in my work as a student and teacher of Buddhist studies at a modern Western (with a capital "W") university, I feel an instant warning signal whenever someone starts throwing around labels like capital-W "Western" and capital-E "Eastern," and basing arguments on this level of generalisation. This is a habit much loved by first year undergraduates, but I point out to them that any argument based on this level of generalisation will almost invariably be shot down in flames once it is examined seriously.

This kind of argument requires a strong polarisation between two opposite but supporting extremes. Any attempt to exalt one group as uniquely embodying some specific trait or set of traits requires a strong sense of the "Other," some other group that embodies the opposing traits. Perhaps one of the most extreme examples of this in Western culture was seen in Nazi Germany, where Hitler's idealisation of the Aryan Germans required the invention of an opposite pole of demonised Jews. In the case of Kornfield's argument, if we are to hold up Western culture as uniquely diseased we need an opposite pole, a utopian Other culture where people are uniquely healthy. Apart from a story of how well his daughter was treated by her Balinese dance teachers, Kornfield makes only one attempt to present this elusive Other when he says:

In the best of traditional cultures, where people are embraced and nourished on both the physical and spiritual levels, they grow up with a sense of ample inner and outer resources. (217)

Unfortunately, Kornfield does not tell us which cultures these are. Are they still around? Where are they? Or is he speaking historically, of cultures which once existed but do so no longer?

Demonising one type of culture and idealising another saves us from facing the unpleasant fact that suffering is universal, that the members of every society suffer in every conceivable way. Does Kornfield expect us to believe that child abuse and neglect are unique to North America? Let's consider what we know of ancient India in the time of the Buddha. Like all highly developed traditional societies, India had a large slave population. A considerable proportion of the population were born, grew up and died knowing that they did not even own their own bodies. Practices that we would condemn as abhorrent forms of sexual abuse were so routine in such societies that they were not even worthy of comment. Can we be confident these slaves enjoyed healthy child rearing practices? Consider women in traditional India. Does Kornfield really think that women who were the chattels of their male relatives from birth to death, who had little or no control over their lives unless they escaped into the sangha, that these women were endowed with inner and outer resources uniquely missing in the contemporary West? And apart from considering slaves and women (who together made up the majority of the population), where was the quality of childhood in a society where the vast majority of people, slave or free, male or female, were set to work at the earliest possible age? Where was the sense of inner security in a society where the lives of the great majority of the population consisted of endless drudgery accompanied by endless insecurity, the insecurity which came from the certain knowledge that the question of whether they would be able to eat into the following year was entirely determined by the quality of the next harvest?

Let's forget societies in the past. Anyone who has practised meditation in Burma agrees that the Burmese give every appearance of being extremely successful at intensive meditation practice. Is Kornfield seriously suggesting that the Californian middle and upper classes suffer more than the Burmese living under the tender mercies of one of the most violently repressive regimes on the planet? Any such suggestion is obviously bizarre in the extreme - which may be why he couches the existence of the Other in such vague terms.

Meditation and the Four Noble Truths

Let's look deeper into this claim. I have already mentioned how the First Noble Truth provides the starting point for Buddhist practice. The Four Noble Truths provide the fundamental framework for all Buddhist traditions, to the extent that any spiritual teaching that fits within this framework can be legitimately regarded as Buddhist, regardless of any cultural peculiarities, and any spiritual teaching which does not fit within this framework can not be legitimately regarded as Buddhist. The Four Noble Truths are: *dukkha*; the arising of *dukkha*; the cessation of *dukkha*; and the way that leads to the cessation of *dukkha*. The Buddha made the outrageous claim that his way of practice - the Noble Eightfold Path - leads to the complete cessation of suffering. This claim is based on these four truths, and these truths are universal because they are concerned with the ***structure*** of experience, not the ***content*** of experience.

The key to understanding what the Buddha is getting at is seeing how the four truths hang together. All experience has a beginning; all experience has an end. All experience arises and ceases (the second and third truths). This arising and ceasing is structural; it is irrelevant which kind of experience we are talking about, be it pleasant or painful,

physical or mental, Eastern or Western. Further, experiences arise and cease because of causes. They do not arise and cease randomly, but because of specific causes which can be discovered in the course of *vipassanâ* meditation. The fact that all experience arises and ceases makes experience itself fundamentally unsatisfactory (the first truth). It follows from the fact that all experience ceases because of specific causes, that if we discover those causes and allow them to manifest, we can discover the way to bring painful experience to an end (the fourth truth). The Four Noble Truths hang together. Hence the Buddha said:

The one who sees dukkha sees also the arising of dukkha, sees also the cessation of dukkha, and sees also the way leading to the cessation of dukkha. (S5.437)

What Kornfield is implying is that the way that leads to the cessation of *dukkha* does not work for certain types of suffering. There are certain specific types of suffering which are immune to the path. But the path is not concerned with specific types of suffering, or specific types of experience, but simply with the fact that ***all*** suffering, of whatever type, arises and ceases. Because all suffering, of whatever type, arises and ceases, then all suffering can be brought to this point of cessation, and the bringing of suffering to this point of cessation is the practice of the path.

Because the path is concerned with the underlying, universal structures of experience, if it is true that some types of experience are immune to the treatment provided by the path, then all experience must be immune to the path. If it is true that *vipassanâ* meditation does not work for ***some*** types of suffering, then it does not work for ***any*** type of suffering. And if *vipassanâ* meditation does not work, then there is no Third Noble Truth - no path that leads to the cessation of suffering. And since the Four Noble Truths hang together, if one truth is denied, all are denied, and Buddhism has just disappeared out the window.

However, it may be objected at this point that my analysis is going too far. Is Kornfield really denying the Four Noble Truths? Or is he simply saying that some people need extra help to enable them to seriously engage *vipassanâ* meditation? In other words, is he simply suggesting that psychotherapy can play an effective supporting role in traditional meditation practice? To examine this question, we must examine how Kornfield treats Buddhism in his book, *A path with heart*.

The Great Way

Throughout the course of his book, Kornfield presents a view of the Buddha and his teachings which is based on a particular concept of the role of spiritual traditions, a concept which we might loosely describe as universalist liberal. He introduces this view early in the book, for example when he compares spiritual practice to a journey up a mountain, and warns us that "it is crucial to understand that there are many ways up the mountain - that there is never just one true way" (32). He sees the various traditions as providing maps which guide the seeker up the mountain. Different traditions map different paths, and all paths are equally valid, all may be useful to the earnest seeker.

Kornfield was trained primarily in the *vipassanâ* meditation of Theravâda Buddhism, and we can see how he applies his universalist liberal attitude to this tradition. In Theravâda we find a literary genre of path manuals, teachings which describe the path of *vipassanâ* meditation from the beginning to the end. Probably the best known and elaborate of these is contained in the *Visuddhimagga*, a medieval text written in the 5th century by Âcariya Buddhaghosa. Here we find an elaborate scheme of the path analysed in terms of 16 *ñânas*, or knowledges, and Kornfield devotes part of Chapter 10 to presenting it to his readers. However, he introduces his account with a warning:

The map of the Elders is used in Insight Meditation. As you read about it in detail, keep in mind that such maps are both helpful and limiting. Depending on the form of practice used and the individual, meditation can progress in quite different ways. Mystical texts outside of Buddhism also describe the process of awakening, in hundreds of other languages and landscapes, although they all share common elements. So I offer this map with some caution, as an example of promises and perils we may encounter on our spiritual journey. (137)

Note the warning to the unwary reader. Maps are helpful, but they are apparently dangerous (otherwise why the need for caution?) because they are limiting. But what is being limited? Earlier in his book, Kornfield introduces the notion of the "Great Way," of which any given teaching or practice is simply one part (for example, 121). Buddhism in general, and Theravâda Buddhism in particular, is merely one aspect of this Great Way. While the Great Way does seem very attractive in the hands of a skilful writer like Jack Kornfield, it has one fundamental problem: it doesn't actually exist; or rather, it exists only in Kornfield's imagination. When I say that it doesn't actually exist, I mean that there is no living Buddhist tradition found on the planet which manifests as the Great Way described by Kornfield.

This raises the issue of what exactly do we mean when we use the word "Buddhism." You may remember the scandal which broke out after Pope John Paul II published a book called *Crossing the threshold of hope*, in which he explained his world view, including his view of other religions. He devoted a chapter to Buddhism in which he described it as an atheistic system which aims to make its devotees perfectly indifferent to the world around them (86). This description of Buddhism caused a great deal of offence to Buddhists around the world, because they saw it as blatant propaganda designed to discredit their religion. The problem with John Paul's description of Buddhism, the factor that made it propaganda rather than genuine analysis, was that no Buddhist could recognise his or her Buddhist tradition in John Paul's words. This was a Buddhism which existed only in John Paul's imagination, and therefore this was a Buddhism which simply did not exist at all.

The same is true of Jack Kornfield's Great Way. This Great Way can not be found in any specific Buddhist or Hindu or Sufi or Christian or other school or tradition, but is an abstract entity which somehow floats above and encompasses every tradition. In the name of this non-existent Great Way, Kornfield takes bits and pieces from every tradition and mixes them up into a kind of Great Way Soup. For example, he occasionally quotes the Buddha, using him as an authority to justify one or another teaching. However, if one is actually acquainted with the Buddhist scriptures he is drawing upon, it soon becomes evident that when Kornfield says, "The Buddha once said ... ," what he really means is, "This is what the Buddha would have said, had he been a psychotherapist living in late 20th century California."

Throughout his book, Kornfield cheerfully changes Buddhist teachings in order to make them fit into his scheme. We can find a number of cases when he supposedly quotes the Buddha or explains some traditional teaching where he makes some slight change, some subtle adaptation, which in isolation may seem trivial to the casual reader, but in total create a cumulative effect in which Buddhist teachings are distorted to give a false impression of traditional support for the position Kornfield is taking. To give just one example, he quotes the Buddha as saying:

Just as the great oceans have but one taste, the taste of salt, so too there is but one taste fundamental to all true teachings of the Way, and this is the taste of freedom. (76)

This sounds very nice and very liberal. However, the passage should read something like: "Just as the great ocean has but one taste, the taste of salt, so this *dhamma* has but one

taste, the taste of freedom." What's the difference? Kornfield skilfully changes the passage to insert his key concept of the Tao, the Great Way, and present the Buddha as liberally accepting the validity of all ways of practice which correspond to the Great Way. The strong probability that the Buddha never heard of this Great Way, and the fact that it is nowhere mentioned in the scriptures Kornfield is purporting to expound, is not allowed to get in the way of a good story.

Linked with this notion of the Great Way is Kornfield's extensive use of the map metaphor. Spiritual traditions provide maps for practice, as outlined above. These traditions and their maps often contradict each other, and this creates a problem for the spiritual seeker. Kornfield tells a story about a married couple who practiced with Sufis, Christians and Tibetan Buddhists. At some point, the husband fell into a depression and committed suicide. Some weeks later his widow was comforted by a friend from her Buddhist community who assured her that her husband had been safely reborn in a pure land. This had been seen in meditation. Later, friends from her Sufi and Christian communities on different occasions also assured her that they too had seen her husband safely reborn in one or another circumstance - and all of these circumstances were different! She went to Kornfield for guidance, and he advised her "to put away all her philosophies and beliefs, the maps of past and future lives and more," and asked her: What is she convinced is true, regardless of what anyone else says? She replied: "I know that everything changes and not much more than that. Everything that is born dies, everything in life is in the process of change." Kornfield asked: Could that be enough?

Kornfield turns to his readers and argues on the basis of this case that we must maintain a sense of inquiry rather than seek to imitate the spiritual ideals provided by each tradition. We must not look beyond ourselves and our own experience (158-63).

I feel that the advice Kornfield gave to the widow was very good: As practitioners of meditation, we must learn to rely fundamentally on our own experience. However, what I find most interesting is not what he did tell her, but what he did not. What he did not say was: You are practicing in three different spiritual traditions, and have ended up being very confused. Are you surprised by this? If we set out on a journey into the unknown using three contradictory maps to show us the way, surely we are guaranteed confusion. If we want to develop clarity rather than confusion, at some time we have to decide: What am I? Am I a Buddhist? A Sufi? A Christian? And having decided, then go for it, and follow the map provided as far as it goes.

But instead of advising the practitioner to settle on ***one*** tradition, Kornfield advises her to settle for the lowest common denominator of all of them. At this point he brings in a distorted version of the *Kalama-sutta* to bolster his position, to give the entirely false impression that this advice is somehow in accordance with the Buddha's teachings. The Buddha's teachings are misused to support a position no Buddhist tradition would endorse - that we should use the practice as a means of avoiding commitment to the tradition, even if this means reducing our spiritual aspiration so we can remain comfortably within our limitations. The one thing that seems to be entirely off the agenda is to place one's faith on one tradition and to surrender totally to it.

What am I getting at here? The point I am trying to make is that Kornfield is not merely suggesting that psychotherapeutic techniques be added to our practice of Buddhist meditation; he is inventing a whole new tradition, a new religion, the "Great Way" which embraces all that is good in all of the ancient wisdom traditions, and transcends all that is limited in each of them. As each tradition provides a specific map which guides the practice, it follows that Kornfield is teaching from the "Map of Maps," and so he becomes the ultimate spiritual authority. For if all traditions are relative except for the "Great Way" that embraces them all, and if Kornfield is our authority for this Great Way, then it

follows that Kornfield is the master of every tradition. Even the Pope doesn't make this claim.

None of this, of course, is openly stated. It is simply hidden in the rhetoric, wrapped up in layers of inspirational writing which is designed to make its readers feel that they have somehow penetrated into the mysteries of all the mystic paths of the planet and that, by avoiding commitment to any specific tradition, they have demonstrated their superiority to all specific traditions, and to those deluded and bigoted people who stick to a single path.

Does Enlightenment Exist?

Let us return to the Four Noble Truths. Jack Kornfield's approach to the teaching has found supporters in other meditating psychotherapists. One of these is Jeffrey Rubin, author of *Psychotherapy and Buddhism*. Claiming Kornfield as an authority (89), Rubin moves the agenda forward by examining the claims made about Enlightenment by Theravâda Buddhism. In a chapter titled "The emperor of enlightenment may have no clothes," Rubin says: "In this chapter, I shall challenge certain foundational assumptions of the Theravadin Buddhist conception of Enlightenment" (83).

Rubin explains that enlightenment in Theravâda Buddhism is described as completely purifying the mind of the defilements of greed, hatred and delusion. This ideal assumes that the mind can be permanently and completely purified and therefore transformed (83-4 & 87). However, Rubin points out that in 1983 "five of the six most esteemed Zen Buddhist masters in the United States" were involved in grossly unenlightened behaviour such as sexual exploitation and stealing money (88). The question arises: How can these scandals occur if these people are supposed to be enlightened? How can this have happened? Rubin concludes that these scandals suggest that:

... psychological conditioning from the past that inevitably warps personality cannot be completely eradicated and that there is no conflict-free stage of human life in which the mind is permanently purified of conflict. This is consistent with psychoanalytic insights about the essential non-transparency of the human mind; that is, the inevitability of unconsciousness and self-deception.

For an individual to be enlightened, they would have to be certain that they were completely awake without any trace of unconsciousness or delusion. Even if that existed in the present, it is not clear to me how one could know for certain that would never change in the future. From the psychoanalytic perspective, a static, conflict-free sphere - a psychological "safehouse" - beyond the vicissitudes of conflict and conditioning where mind is immune to various aspects of affective life such as self-interest, egocentricity, fear, lust, greed, and suffering is quixotic. Since conflict and suffering seem to be inevitable aspects of human life, the ideal of Enlightenment may be asymptotic, that is, an unreachable ideal (90).

From the context of the Four Noble Truths, Rubin has just torpedoed the third truth. He does this in an attempt to integrate Buddhism and psychotherapy, to create a new Buddhism more suited to Western culture. Unfortunately, Rubin is so confused about Buddhist teaching that he seems oblivious to the fact that he is not adapting or integrating Buddhism, he is simply destroying it. We referred earlier to the Buddha's teaching that to see one of the Noble Truths is to see all of them. These truths form a pattern which is so closely interwoven that to deny one of them is to deny all of them. If there is no cessation of *dukkha*, there is no path leading to the cessation of *dukkha*. And if there is no cessation of *dukkha* and no path leading to the cessation of *dukkha*, then the Buddha

New Training Organisation on Malta

In 2003, our Maltese colleagues David Attard and Charles Cassar in close cooperation with Willem Maas and Uwe Eglau have founded the training organization called Osiris. This institute will offer the Integrative Existential-analytical Psychotherapy Methods training program linked to Eureka-University. The emphasis on integrative existential-analytical methods, consciously including the contribution of V. E. Frankl, will offer a fine opportunity for Southern European students. Charles Cassar is presently chairing the National Umbrella Organizations Committee of EAP in Vienna. His commitment to the development of Psychotherapy and tot he standardization of training on an internationally recognized level is a great contribution. David Attard is a well known colleague, who trained with the Italian Logotherapy institute of Mrs. Barbona. We most warmly welcome both David and Charles as Members of EALEA. We are looking forward to visit future post-academic master classes during the winter!

DAVID ATTARD'S PSYCHOTHERAPEUTIC PHILOSOPHY, APPROACH & METHODOLOGY

PHILOSOPHICAL FOUNDATIONS OF MY PSYCHOTHERAPEUTIC APPROACH

I consider myself as an existentialist psychotherapist and counselor. The life, work and teachings of Prof. Viktor E. Frankl has been the strongest influence in my life and therapeutic approach. To me his works are a constant inspiration and seem always fresh and act as my foundation. There are other philosophers, writers and therapists on which I draw upon for my constant learning and development, but I remain a logotherapist at heart, who uses a lot of hypnotic techniques together with paradoxical intention and de-reflection and an existentialist in worldview. Existentialism is a natural outgrowth of phenomenology. Existentialists are concerned with concrete human existence. They are deeply interested in the existence of the individual in the concrete situation in which he lives. They ask these questions: what is the meaning of existence for man; what is the aim of life; is a person free to shape his own existence; has man responsibilities? Existentialism is not a school, nor even a group of thinkers. Existentialism is a collective name for widely divergent existential currents of thought which have only a few characteristics in common. The first philosopher who may be called an existentialist is the Dane, Sören Kierkegaard (Sonnemann, 1954). A French religious author, Francis Libermann, developed at the same time his own existential view. This current of thought developed further in Germany, under Jaspers (Caruso, 1948) and Heidegger (Boss, 1957) and especially in France where we find Sartre (Van Eeden, 1946) and his school, Gabriel Marcel (Binswanger, 1953) and Merleau-Ponty (van den Berg, 1953).

What existentialism studies is the real concrete man, human life not as an abstract quantity but here and at the moment in its lively quality. The existentialist likes to define this human being as "existence." In this term he tries to stress that the human being is not only a conscious being but a conscious being that is in the world, a being that is a conscious presence. This is implied in the term existence, which is composed from the prefix "ex" which means out, outside, beyond and "sistere," meaning to cause to stand. Existence, therefore, infers a standing outside of oneself, a going beyond oneself, a being present outside in the world. The human being is a conscious being that is essentially in the world, that is essentially a presence. It is a conscious being that is embodied and that by its body is present in the world. The German existentialists use mostly the term "da-sein" — being there. Indeed the human being is a "being there." It is essentially present there in the world. This conception of man is fundamental in existentialism. Rationalism considered man as being "pure consciousness" and even a consciousness that developed itself from inside, independent of the world. Against this view of man, existentialism con-

firms that man is a consciousness that is world-bound, a consciousness that goes beyond itself, that always is found in an environmental world, made meaningful by this consciousness. But, by the same fundamental concept, existentialism determines its position against empirism and positivism. These philosophies, from which positivistic psychology borrowed its basic postulates made man totally a part of the world. Man would be subjected to the laws of a postulated material universe. Against this view of man existentialism confirms the basic intuitive conviction of mankind that man has his own characteristic place in the universe, for he is essentially a conscious being, a presence. In shaping his world by making it meaningful in relative freedom he is not completely subjected to physiological or physical laws. Human existence is not static but in continual development. Also in its development human existence is world-bound. We develop our understanding by a continual intercommunication with the things surrounding us in the world. Our aesthetic feeling develops in a meeting with the world. All that is in man, his knowledge, his emotions, his intuition and volition all develop in contact with the world, in world-boundness. Existence is thus essentially becoming, development. And in this becoming, human existence is not perfectly determined by compelling laws as other things in nature. The human existence is at least partly a conscious and free becoming. We “become” consciously and we “become” in freedom. Numerous possibilities are included in the human existence. Man is continually trying to realize certain possibilities. And it is in this sense that the existentialist contends that the existence precedes the essence: because man just by existing, by relating himself meaningfully to the world shapes himself, shapes character in freedom. The basis of this philosophy lies in the conscious experience in the conscious being with oneself, in the existential experience. But his knowledge has to be based totally on the fertile soil of the true and authentic experience. Conceptual knowledge does not have an independent value. It is valuable in so far as it is nourished by pre-reflexive experience, by life, because being and knowing are one in the depth of our existence. All concepts have to be existentially loaded to ascribe a meaning to life (Frankl, 1956). The beloved themata of study for the existentialist are the various aspects of human existence as, for instance, historicity, economy, freedom, consciousness, love, loneliness, anxiety, personality and so on. Existentialists have written about these subjects, often in a brilliant way. Do they also study the world? Of course. Our existence is world-bound and our conscious acts are intentional. Therefore, the existentialist cannot speak about the human existence without mentioning the world. But he will deal with the world not as it is in itself but as milieu of existence for man, as his home. And so this philosophy develops in the light of human existence. We are here confronted with a new way of thinking. Many an existentialist accepts only this way of thinking and will dissent from all other approaches to the truth. Existentialism embodies great values. Existentialism means the rediscovery of man, man who was mummified and nailed in his deterministic coffin by such undertakers as empiricism, rationalism and positivism. Very deep truths about man have been formulated in a totally new and often surprising way. And this continual concentration of the great contemporary thinkers on man could not remain without influence on the science of man: psychology. On the other hand, it is not difficult to discover some exaggerations in the existentialistic formulations. A reaction goes easily too far. In the light of common sense and the residues of human thinking during its long history, it is certainly not true that existential thinking is the “only” valuable way of thinking. It is also bold to contend as certain existentialists do that there are no universal truths or laws. Science would be impossible if this were true. One of the causes of the impact of existentialism on psychology is undoubtedly that existentialists such as Sören Kierkegaard (Strasser, 1957), Martin Heidegger (Binswanger, 1955), Karl Jaspers (Caruso, 1948), Jean Paul Sartre (Van Eeden, 1946), Gabriel Marcel (Binswanger, 1953) and Maurice MerleauPonty (Van den Berg, 1953) devoted their brilliant minds exclusively to the study of characteristically human phenomena and approached them in a surprisingly new fashion. Take for instance, the psychological phenomenon of anxiety as studied so profoundly by Martin Heidegger. Heidegger is a disciple of Husserl, but he is very independent of his master and he may be called one of the most brilliant existentialists. The existentialist does not attack anxiety, this human mode of being, in

an empirical inductive way nor does he try to state statistically where and when the anxiety phenomenon manifests itself in man. Neither does he indicate the physiological conditions accompanying anxiety. He does not measure the amount of this emotion by measuring certain behavioral characteristics that are its results or indicators. All these devices are justified and fruitful. But the existentialist engages himself in a more profound approach to this human phenomenon. He does not consider anxiety as a condition just overcoming man as a common cold or a feeling of dizziness. For him anxiety lies deeper and is so interwoven, so identified with the human existence that he has no hope that he will ever understand it by enumerating the times and the conditions of its manifestation. For him anxiety mirrors something of the essence of man. It characterizes man just as much as thought, laughter, weeping, language and art. For him fear, anxiety, hope, love are not purely fortuitous and accidental but they are authentic human modes of existence, they are a specifically human mode of being in the world (Strasser, 1957). It was inevitable that the new insights gained by the keenest European thinkers who concentrated, as perhaps never before, year after year exclusively and persistently on the understanding of man, wakened the interest of "the science of man": psychology. The fascinating voice about human existence meant a real revolution in the universities and the departments of psychology. The stunning rediscovery that there were other fruitful ways of understanding man besides the positivistic one was a tremendous shock for the European mind which was so deeply committed to positivism. Not only that, but already two totally different trends of psychiatry found their origin in the new approach: "Daseins analyse" represented by its leaders Ludwig Binswanger (1953, 1955) and Medard Boss (1954, 1957) in Switzerland and "Existensanalyse" the school started by Viktor Frankl (1955, 1956) in Austria. Also Sartre (Van Eeden, 1946) wanted to replace psychoanalysis by what he called "une psychoanalyse existentielle." Another existential psychotherapy called "Vital Anxiety' has been developed by the Spanish psychiatrist Juan J. Lopez Ibor (1955). Further, we have the existential psychotherapeutic doctrine of the psychoanalyst E. V. von Gebsattel (1940, 1944) and the so-called "Integral Psychotherapy" of the Austrian psychologist Igor Caruso (1948, 1952). These classical existentialist thinkers, particularly Frankl and Caruso, have influenced my thinking and psychotherapeutic practice strongly.

My personal worldview of psychotherapy

I will try now to elaborate on my view and philosophy of psychotherapy which takes strongly into account the tenets of phenomenological and existential psychology in which I was trained and certified by Associazione Logotherapeutica Italiana (ALI). This does not mean that I disregard or underestimate the tremendous contributions made by the psychoanalytic and behavioristic systems, in fact, I strongly believe that techniques from behavior modification and cognitive approaches are highly effective modalities. Phenomenological psychology is by no means a bold denial of all psychological tradition; it pretends only to be a reforming of the past. "Normal", mature, self-actualizing human existence is basically a free existence. As I have said, man lives in a human world. His phenomenal world is the totality of "evaluated" people and things which play potential or actual roles in his existence. Their significances are continually determining his ways of behaving. His behavior therefore may be called free, firstly, so far as he himself is free in his evaluation of people and things and secondly, so far as his patterns of behavior smoothly respond to these free evaluations. By changing the meaning of his world, normal self-actualizing man changes himself and by changing himself he changes his behavior. There is thus a dependent relationship between behavior and the meaningful world of man when everything is functioning normally in him. The normal self-actualizing man, for instance, may attribute to the phenomenon "father" the meaning of "a man who in spite of many shortcomings and defects gave him life, a home and many other worthwhile things and who is a limited imperfect representative of God's love and authority." He may also freely concentrate on the imperfections of this representation of

authority and so attribute freely to him the meaning of “a bad autocratic figure, whose only purpose is to inhibit his development and to destroy him if possible” (Van den Berg, 1953). The mature self-actualizing person is psychologically free in shaping his world in this or another way. In this sense Professor Buytendijk could say to the assembled students of the different departments of the State University of Amsterdam in a now famous guest lecture concerning coeducation: “It is not necessary to fall in love with a person. You are responsible even for your love,” indicating that there is a moment of decision in the life of the free, mature, self-actualizing person in which he freely attributes this meaning of “the special and only one” to a woman he meets on his way through his world. Human existence is “basically” free.

Existentialism and more explicitly, logotherapy, defines human existence as a “basically” free existence; “basically” because by a free choice man exposes himself freely to the meanings he attributes to people and things, he exposes his behavior to become conditioned by these freely chosen cues and signs. The later everyday responses of man are for a remarkable part automatic, conditioned by the signs he erected himself. But the mature, self-actualizing person remains basically free because he himself was originally erecting these signs along his life path, and because he remains potentially free to change these signs, so that in normal cases a new evaluation of people and things will be followed by a change in his conditioned responses — at least after a sufficient lapse of time. (Note: We speak about “evaluation,” a change in the depth of existence, not a change in conceptual knowledge alone — which evidently may remain without influence on behavior.) Human existence is “basically” free also in another sense. Namely that the actual freedom is not his part from the first moment of conception or birth. The human being has to win his own freedom, has to overcome courageously his original bindings to not-freely-chosen conditioned responses that were predominant in the life of the neonate and the child. To formulate it in a different way: Humanization is freedom, dehumanization is regression to or fixation on the pre-human state of not-freely-chosen conditioned responses. The common influence of parents, schools, churches, society, literature, science give the mature self-actualizing man the disposal of a sufficient range of worthwhile insights to enable him to choose freely his evaluation of people and things. “Abnormal” human existence is a dehumanized unfree existence. We have seen that human existence is basically free. The really mature self-actualizing person can actually dispose of his freedom in a normal way;

1 — if there is sufficient insight possible for him by consulting the common cultural and social sources of information,

2 — if the conditioned behavior responses are originally freely chosen or freely accepted and if these responses remain in such a relation to the freely chosen meanings or people and things that a change in evaluation will result in a gradual change of conditioned behavior, that in turn will become conditioned to the new signs,

3 — if the person has overcome by humanization, by shaping his own existence, the original pre-human non-free chosen responses to freely-chosen conditioned responses which were predominant in early childhood. (Humanization does not necessarily mean that man does away with all the initially not-freely-chosen conditioned responses, but that he at least accepts them freely, or attributes new meanings to them.)

Consequently we will speak of abnormality when the existential freedom of man is handicapped to a serious degree by:

1 — lack of possibility to gain the necessary insights by the common ways of education, information and general public counseling.

2 — lack of possibility of gradual change of conditioned behavioral responses in spite of a new insight and new evaluations gained by the individual.

3 — lack of possibility to overcome the not-freely-chosen conditioned responses of childhood by the common way of maturation and education.

It is possible for phenomenological-existential psychology in attacking this problem of the not-free human existence to integrate many useful thoughts of the traditional schools of psychology. The great pre-phenomenological traditional currents in thinking about man are rational-, positivistic-, and psychoanalytic psychology. Therapy may be more effective if we clearly know what we want to reach, if we know what is essentially normal for man in his totality. Psychoanalytic schools on the other hand provide us with a great deal of information concerning the factors that make it extremely difficult for certain people to gain the necessary insight in their own behavior and personality. The learning theories of positive psychology gave us a wealth of scientific data concerning the process of conditioning of behavioral responses .

Psychotherapy – my methodology and specific approach.

Psychotherapy is, to me, essentially a free-making, a humanizing of the person who lost his freedom in some sectors of his existence. This loss of freedom means that the person is no longer free to transcend some of his life situations by freely giving meaning to it. He behaves in these situations more or less as a lower form of existence, as a dehumanized, determined existence. Psychotherapy has to assist the person in regaining his freedom in these areas — by creating insight into the meanings he attributes to these situations, by starting the extinction of the responses which the patient (after gaining insight) no longer likes to retain, and by the conditioning of other responses corresponding to the new free evaluation of the situation by the patient. What are the psychotherapeutic conditions to obtain these results?

1. In order to make the patient free we have to place him in real life situations where he reacts with his whole human existence spontaneously and pre-reflexively. The conceptualization of his behavior or his introspection is of no great value. Conceptualization is the explication of the pre-reflexive reality (Frankl, 1955). In this process a patient or therapist can easily go beyond that which is contained in his intuitive, pre-reflexive experience and so, contaminated by theories and preconceptions, he can give easily a false account of what is really going on. Also introspection does not yield great results because if patient or therapist try to look into themselves as did the Wundtian psychologists, then in the last analysis they will discover nothing. The person is only knowable in his world, in the situation, in his concrete relation to people and things. The “things” inside are never introspectable as such, they are only known by their intentionality, their being oriented to the world. Introspection is a very odd means of gaining any knowledge that is worthwhile for the understanding of man (van den Berg, 1955).

2. This real life situation has to be induced during the therapeutic sessions. It is impossible for the psychotherapist to follow the patient during the course of his daily life in the hope of observing him in just these kinds of existential situations that reveal his limited un-free understanding of people and things or that show the abnormal lack of correspondence between his behavior and his free evaluation. The psychotherapist therefore has to create a substitute for the concrete life situation.

3. These induced life situations, during the therapeutic sessions, have to be of such a kind that they are revealing the basic responses of the patient to the crucial

aspects of everyday life. They have, for instance, to show how and when and to what degree anxiety is aroused in the patient.

4. This therapy has to be organized in such a way that it is possible for patient and therapist to gain insight out of these artificially induced concrete situations and the use of therapeutic techniques like paradoxical intention is one way to generate insight indirectly. This insight is necessary in order that the patient may come to a free choice, to another way of evaluating people and things. It is not always necessary for everyone and in every case that this insight is a conceptual one. In many cases it may remain pre-reflexive and existential. On the other hand an insight that remains purely conceptual is never sufficient for a radical change of behavior.

5. At the same time the psychotherapeutic method has to enable the therapist to start the reconditioning of the behavior of the patient to his new freely chosen evaluation of people and things. Here the use of hypnotic modalities and NLP are very helpful to my practice.

The integral psychotherapeutic techniques I have developed over the past twelve years as an illustration of the fulfillment of these therapeutic conditions

Let me now illustrate this theory by one of the many possible techniques in psychotherapy, namely, what is called the integral hypnotherapeutic technique. This technique has been developed by the Frenchman, Desoille (1945). It was integrated in an existential frame of reference by the Dutchman Van den Berg (1953) on whose description I draw heavily. I chose this technique not because it is the best possible one — I personally, as a therapist, prefer less directive techniques — but this kind of technique offers an excellent opportunity to show how the therapeutic process can be viewed from an existential and logotherapeutic frame of reference. A person who is in trance is more or less inhibiting his higher cortical centers which results in a release of lower subcortical ones. The classical experimental research of Russian physiologists such as Pavlov, Koltouchi, Ivan Smolenski, A. N. Leontiev and others have demonstrated this very clearly (Nesmeianov, 1949; Sokolev, 1951). Because of this inhibition of the higher centers a person in trance is not living on the conceptualized level of explication and theorizing, with all the dangers of distorting the reports about his life, but he exists on the pre-reflexive level of every day reactions in concrete situations. To induce this state of trance the psychotherapist asks the patient to lie down on a couch or sit in comfort in a noiseless, semi-dark corner, to relax completely, to abstain from conceptualized thinking, to forget about the place where he is, to be as at the moment between being awake and asleep, and then to day-dream aloud.

Most important is to maintain a concrete existential situation. Therefore the patient is not asked to tell what comes into his mind. We know the person from his phenomenal universe, not from “free associations” in his isolated and interior world. Therefore from the very beginning the attention of the person is not directed on himself but on a vivid world of concrete events and meetings. The patient is asked to see, to hear, eventually to smell. A resulting difference from the traditional analysis will necessarily be that the guided day-dream never moves into the past but always in the present, in the “here and now” of the actual world of the patient. In this situation the patient lives and reacts as a human existence: as “conscious engagée”, “a consciousness that is involved” (Merleau-Ponty, cited by Van den Berg, 1953), as an “être en situation”, “a being in a situation” (Gabriel Marcel, cited by Binswanger, 1953, 1955). The patient is never allowed to escape his world by a flight into the past, into his life history where there are no decisions to make and where there is not the necessity to shape freely a world of “here and now” — where the existence is totally determined and explained by needs. Instead of allowing the patient the revision of a fixed history of the past and the enjoyment of all

the excuses of inescapable traumas or bad environments, the therapist invites his patient to face his world here and now, not to excuse himself but to return to his world in a new mode of being and to accept in a new way the tasks with which he is confronted in this world. This is the central fulcrum of logotherapy as an integral and fully fledged existential therapy. The patient is thus asked to meaningfully day-dream in a special way. But this by itself would not be very efficient. I am not interested in all kinds of day-dreamed situations, but only in that kind of situation that will show me the responses of the patient to crucial situations — in order to help him to reshape those situations by another free choice of their significance, and to start the extinction of unwarranted conditioned responses, replacing them by others. In order to create these crucial situations I have to exercise some guidance of his "hypnostory". But how can we influence the trance state in a constructive manner? Here we find an answer in psychology itself, in the scientific study of the world of human phenomena and of the laws governing this phenomenal world. When we introduce a certain image in the phenomenal world of the hypnotic subject, what will be its phenomenological impact on the psyche of the average man in our culture? If we could know by scientific research these laws of phenomenological influence we would be able to direct the psychological process of hypnotic day-dreaming, if the patient is willing to follow our guidance. Here I find the modalities of NLP as most helpful, particularly the use of metaphor (Rubin Battino, 2001). Firstly, we like to evoke that kind of situation in which the person shows us the quality and quantity of his activity in life situations. To obtain this we suggest to him that he travel. Traveling, as we know by phenomenological research, does not only mean "moving through a certain space." The phenomenon space is not a purely mathematical notion in the "lived world" but is a distance to conquer, an invitation to expose oneself to new situations, to take initiative, to respond courageously to an ever widening horizon. Therefore by asking him to travel we may observe what is the courage, the freedom of inhibitions, the fear, the activity, the boldness or shyness of the patient when approaching new situations in life. I like also to know how he is reacting when confronted with the difficult, with the dangerous and unpleasant aspects of life.

How do I guide the hypnotic process in such a way that the person creates spontaneously unpleasant situations?

Here is where the beauty of integrating psycho-synthesis techniques (Assagioli, De Coppens) and more modern modalities from NLP (Bandler, Grinder, Dilts) come in handy and prove very effective. By phenomenological research we know that "going down," "descending" does not purely mean "a measurable movement in a certain vertical direction" as in the world of mathematics and physics but that it phenomenologically is associated with going backwards, with negative experiences, with darkness and threat. By telling the person to go down, to daydream about a travel in the depths he will usually meet unpleasant and threatening persons, animals and things. Many a patient, for instance, makes a depth travel into the sea. At the bottom he meets an octopus. Another explores deep caves and he finds himself confronted with an old sea serpent in a dark grotto. The day-dreaming patient will often develop an overwhelming anxiety during these meetings because he is not only sharing our common cultural phenomenological world in which octopus and serpent are experienced as symbols of the unpleasant and the threatening, but he lives his individual phenomenological world too, and in this personal phenomenological world this concrete appearance may have the same cue value as other concrete threatening appearances in every day life; for instance, the appearance of his overprotecting mother. We do not know for sure that it is a symbol of his mother, wife, father or girlfriend. Therefore, in my belief, the therapist is not allowed to produce that kind of information. The therapist asks only what kind of anxiety the patient is feeling. Maybe he answers that he is afraid that the octopus will suck out his blood. If in many session this image and this kind of anxiety come back again and again then it is quite possible that he feels threatened in every day life situations by a certain person — for instance, his mother, who is so overprotecting that he is afraid that she in her continual exaggerated care will suck out all his independent personal living, thinking,

feeling and acting. But the therapist never communicates this hypothesis. He waits until the person himself finds out, because this explication by the therapist would imply the possible involvement of theories and prejudices, distorting the true pre-reflexive knowledge. The integral hypnotherapist easily goes further than pre-reflexive knowledge and allows the patient to go; therefore it is better to wait patiently until the patient himself finds out. The only thing he might insinuate is: do you think of one or another person in your environment that arouses the same kinds of feeling as the octopus or the serpent? This therapeutic modality was learned during my supervised training in curative hypnotherapy with my teacher David Lesser. In most cases, David tries to induce the person to overcome his anxiety and uses metaphoric and symbolic language (which I have now developed fully into a technique I call the hypnostory), for example, by telling him that perhaps the octopus is not so dangerous as it seems to be. He asks him for instance to grasp the octopus and to ascend with it. This part of the guidance is essential. The frequent use of ideomotor response is essential to maintain trance logic fluency in the patient. We can only extinguish the conditioned anxiety-response by giving the patient the repeated experience in concrete situations that the threatening being is not so dangerous as it seems to be. And here a thorough understanding of the laws of conditioning and extinction as developed by the school of Pavlov in Russia and by the different learning theorists in the United States appears helpful. The patient is not only invited to descend but also to ascend, to go as high as possible. This kind of travel too is subjected to phenomenological laws. The images show a characteristic style corresponding to the phenomenon “high” or “low” that is suggested by the therapist. From low to high the images produced by the patient become brighter, more transparent, more euphoric, more benevolent and more comprehensive. In accordance with this the mood of the riser becomes better, more sublime. When the patient imagines that he is rising to the highest level the brightness becomes of an inexpressible white, colorless; all images lose their contours. They are dissolved in a victorious light of glory (van den Berg, 1953). In this way phenomenological research gives a very interesting insight into the pre-reflexive structure of the “inhabited” human universe. It goes without saying that we can present here only some short superficial notes concerning the guided trance state in order to show the relation between phenomenological psychology and psychotherapy. There are classical studies (Desoille, 1945; Van den Berg, 1953) concerning the more detailed significances of the images, when the person goes ahead or down, to the right or to the left, concerning also the interventions of the therapist in order to assist the patient in descending deeper or ascending higher or in overcoming his various anxieties and so on. There are further a great number of case studies from therapists using the integral hypnotherapeutic approach. Usually after a session the therapist asks the patient to return at a certain time or at a date when the patient himself thinks it is useful to visit again his therapist. He is asked to bring then with him his elaborated day-dream. Preferable is a description of the hypno-story that is illustrated with notes borrowed from his every day life experience. Writing down this elaboration of his last “hypno-story” he has to ask himself whether it is not possible to improve the hypnological process of his last session. At the next session the therapist and the patient talk over these notes, during which discussion not the therapist but the patient has to tell the most. By means of this kind of elaboration the patient gains gradually the necessary insight into his behavior, enabling him to find another way of behaving by giving other meanings to his world. The aim of the integral hypnotherapeutic approach is the cure of the patient: to make him feel at home in his real world by reshaping his phenomenal world. The therapy consists of the imaginative regaining of the lost territories and insight education with the creation of personal concrete meaning (logosynthesis). We make his real world habitable again by firstly making habitable the phenomenal world of his hypno-story and imagination. We recondition his behavior in his real world by reconditioning his behavior in his phenomenal world and making meaningful contexts and bridges to the here and now. This is, I believe, a truly strong and effective education-based psychotherapy. The neurotic patient who is in his hypnostory overcomes his barriers and who learns to travel and to conquer the regions at the other side of these obstacles — so that for him all the regions phenomenologically are again attainable. He will know how to move himself with

a new freedom in his world of every day reality. In other words he will be cured of his neurotic disturbances. For our world is the daily illustration of our subjectivity, showing itself most purely in the images of the dream. Only he is happy who calls the real world his dwelling places the whole world from high to low and from right to left; not only the bright side of the world but its shady side as well: the happy person says yes to the whole world. Nowhere is this so fruitful as in the hypnostory. The happy man can re-enact in a liberating way and he can allow himself to lose himself in the miraculous world of his creative imagination. Of course, there is also an imagination that seeks to escape the reality, but it is not just to call this form of imagination the only one.

I would like to finish this cv and representation of my approach of psychotherapy with the remark: phenomenological-existential psychology does not consider this successful therapy as the only one or as the best one for all cases. It is evidently also true that this technique, which only served as an illustration of my theory of therapy, can also be used to illustrate other frames of reference. I believe that modalities like Logotherapy, Gestalt, Hypnotherapy, Psychosynthesis, NLP and even other approaches can be blended by a well trained therapist to created an effective approach but what will actually create a truly effective and integral psychotherapist will be a well-founded philosophical formation coupled with human warmth and empathy.

David Attard

The Efficacy of Psychotherapy

Re-examined the data of M. L. Smith et al (1980) on the benefits of psychotherapy in 475 controlled studies, using only studies of patients seeking treatment for neuroses, true phobias, and emotional-somatic complaints. The results of 81 controlled trials were integrated statistically using the meta-analytic technique. The condition of the typical patient after treatment was better than that of 77% of untreated controls measured at the same time, and the rate of relapse in the 1st 2 yrs was small. Behaviour and psychodynamic verbal therapies appeared to be superior to other therapies. The relationship between severity of illness and choice of therapy is unknown, and could account for some of the differential effects, but does not vitiate this further evidence of the efficacy of psychotherapy. (94 ref)
--Does psychotherapy benefit neurotic patients? A reanalysis of the Smith, Glass, and Miller data. Andrews, Gavin; Harvey, Robin. Archives of General Psychiatry; 1981 Nov Vol 38(11) 1203-1208

Results of 375 controlled evaluations of psychotherapy and counseling were coded and integrated statistically. The findings provide convincing evidence of the efficacy of psychotherapy. On the average, the typical therapy client is better off than 75% of untreated individuals. Few important differences in effectiveness could be established among many quite different types of psychotherapy. More generally, virtually no difference in effectiveness was observed between the class of all behavioural therapies (e.g., systematic desensitisation and behaviour modification) and the nonbehavioral therapies (e.g., Rogerian, psychodynamic, rational-emotive, and transactional analysis).
--Meta-analysis of psychotherapy outcome studies. Smith,-Mary-L.; Glass, Gene V. American Psychologist; 1977 Sep Vol 32(9) 752-760

Discusses the Office of Technology Assessment (OTA), an agency of the US Congress, which was established in 1972 to aid legislators in understanding the impacts of technology and to provide science-based information on legislative problems. The process used by OTA in conducting assessments of psychotherapy is described. OTA's report on psychotherapy, entitled 'The Efficacy and Cost-Effectiveness of Psychotherapy,' concluded that psychotherapy is effective. However, the report also indicated that the field of psychotherapy is relatively new and that only in recent years has substantial data been accumulated. (20 ref)
--Reimbursement for psychotherapy: Linking efficacy research and public policymaking. Banta, H. David; Saxe, Leonard. US Congress, Office of Technology Assessment, Washington, DC, American Psychologist; 1983 Aug Vol 38(8) 918-923

Applied meta-analysis to 475 studies of the effectiveness of psychotherapy and 112 studies of the comparative effects of psychotherapy and psychoactive drugs. The studies' effect sizes were examined--the standard mean difference on the outcome variable between the treated group. Since many studies had more than 1 outcome variable, the 475 studies actually produced 1,766 effect sizes. Meta-analysis showed that psychotherapy is effective in enhancing psychological well-being, regardless of the way it is measured by researchers. The patient's age and diagnosis, the therapist's training and experience, and the duration and mode of therapy bear little relation to the psychotherapy's outcome. Behavioural therapies are somewhat more effective than verbal ones, and drug therapy, while combining well with psychotherapy, is not more effective than psychotherapy alone. (23 ref)
--What research says about the effectiveness of psychotherapy. Smith, Mary L. Hospital and Community Psychiatry; 1982 Jun Vol 33(6) 457-461

While modern psychotherapies have often demonstrated a significant degree of effectiveness, in that they help clients overcome their presenting symptoms, their degree of 'efficiency' may not measure up to their 'effectiveness.' Efficiency in psychotherapy includes several issues that are often neglected in research on 'effectiveness.' These criteria include such ingredients as depth-centeredness, pervasiveness, extensiveness, thoroughgoingness, maintenance of therapeutic progress, preventive psychotherapy, minimization of therapeutic harm, and encouragement of scientific flexibility. It is contended that these aspects of psychotherapy are of profound importance to therapists and clients and that such aspects should be consciously included as values in psychotherapy. (31 ref)
--The value of efficiency in psychotherapy. Ellis, Albert. Psychotherapy Theory, Research and Practice; 1980 Win Vol 17(4) 414-419

Examined 75 studies, published between 1952 and 1983, in which children who received psychotherapy were compared with controls or children receiving another form of treatment. Only those studies using Ss younger than a mean age of 13 yrs at the time of treatment were included. Exceptions to the age limitation were made only if separate analyses for younger children were reported or if individual data from older Ss could be eliminated. Results show that therapy with children was similar in effectiveness to therapy with adults; treated children achieved outcomes about two-thirds of a standard deviation better than untreated children. Although behavioural treatments appeared to be more effective than non-behavioural treatments, this apparent superiority was due largely to the types of outcome and target problems included in behavioural studies. No differences in outcome were found to result from other treatment characteristics such as the use of play in therapy or the administration of treatment individually or in groups. The evidence suggests that previous doubts about the overall efficacy of psychotherapy with children can be laid to rest. A bibliography of the studies examined is appended. (17 ref)
--The outcome of psychotherapy with children. Casey, Rita J.; Berman, Jeffrey S. Psychological Bulletin; 1985 Sep Vol 98(2) 388-400

Examined the outcome of psychoanalytically oriented psychotherapy administered to 50 15-54 yr olds who presented with a variety of syndromes, including personality disorders, anxiety/somatoform disorders, psychotic disorders, psychosexual disorders, and bulimia. Ss and 16 non-treatment controls (aged 16-38 yrs) were evaluated 4 mo postintake. MMPI scores, target symptoms, global evaluation, and other clinical evaluations were used as outcome measures. Findings show that Ss who underwent therapy improved significantly more than controls on subjective and objective parameters. The efficacy of psychotherapy and the relative spontaneous improvement of untreated Ss are discussed. (20 ref)
--Evaluation of psychoanalytic psychotherapy outcome. Manos, Nikolas; Vasilopoulou, E. Acta Psychiatrica Scandinavica; 1984 Jul Vol 70(1) 28-35

Discusses efforts made by the US Congress in the late 1970's and early 1980's to explore the extent to which those seeking psychotherapeutic services could be assured that the care they would receive would be beneficial. It is contended that psychology, psychiatry, and the mental health field have presented few summary statements to guide the educated consumer or enlightened 3rd-party payers in decision making about mental health care. The mental health field is still young, and there has been insufficient time to evaluate the efficacy of all forms of therapy for all the problems for which patients/clients seek help. But the knowledge gained from clinical experience can be used in a tentative fashion to direct more rigorous empirical investigation. (12 ref)
--Psychotherapy--is it safe, effective, and appropriate? The beginning of an evolutionary dialogue. DeLeon, Patrick H.; VandenBos, Gary R.; Cummings, Nicholas A. American Psychologist; 1983 Aug Vol 38(8) 907-911

Hypothesized that outpatient psychotherapy in a mental health centre would result in an improvement rate of 65% or more, a spontaneous remission rate of 36% or less, and a difference of at least 29% from gain in improvement due to therapy. An analysis of 201 follow-up questionnaires completed by adult outpatients during 1967 and 1970 supported all 3 hypotheses. A 5-yr follow-up questionnaire provided evidence for external validity in the form of a correlation between original improvement rate and subsequent need for outpatient treatment and inpatient treatment. Results are interpreted as significant evidence for the efficacy of psychotherapy and for the validity of the self-report method of measuring improvement and spontaneous remission. (9 ref)
--Research note: A self-report measure of spontaneous remission and psychotherapy outcome. Chadwell, Buddy H.; Howell, Robert J. Journal of Community Psychology; 1979 Jan Vol 7(1) 69-71

Discusses research published between 1980 and 1984 regarding the treatment of adults by a range of individual psychosocial therapies. The contradiction between increased conceptual and methodological sophistication and increased scepticism regarding the scientific merit of positive research findings in the field of psychotherapy is examined. Efficacy research findings are discussed through a critique of global outcome surveys via meta-analysis and studies of particular therapies for specific problems/disorders according to Diagnostic and Statistical Manual of Mental Disorders (DSM-III) and behavioural medicine categories (e.g., depression, schizophrenia, anxiety, alcoholism). Issues and trends with regard to therapy manuals, brief therapies, clinical trials, placebos and specificity of effects, theory development and integration, and koans are also discussed. (6 p ref)
--Individual psychotherapy and behaviour change. Parloff, Morris B.; London, Perry; Wolfe, Barry. Annual Review of Psychology; 1986 Vol 37 321-349

Considers design issues and strategies by comparative outcome studies, including the conceptualisation, implementation, and evaluation of alternative treatments; assessment of treatment-specific processes and outcomes; and evaluation of the results. It is argued that addressing these and other issues may increase the yield from comparative outcome studies and may attenuate controversies regarding the adequacy of the demonstrations. (64 ref)
--Comparative outcome studies of psychotherapy: Methodological issues and strategies. Special Issue: Psychotherapy research. Kazdin, Alan E. Journal of Consulting and Clinical Psychology; 1986 Feb Vol 54(1) 95-105

Applied probit analysis to 15 sets of data to specify the relationship between length of treatment and patient benefit. Data were based on more than 2,400 patients, covering a period of over 30 yrs of research. The probit model resulted in a good fit to these data, and the results were consistent across the studies, allowing for a meta-analytic pooling that provided estimates of the expected benefits of specific 'doses' of psychotherapy. Analysis indicated that by 8 sessions approximately 50% of patients were measurably improved, and approximately 75% were improved by 26 sessions. Further analyses showed differential responsiveness for different diagnostic groups and for different outcome criteria. Findings hold promise for establishing empirical guidelines for peer review and 3rd-party financial support of psychotherapy. (30 ref)
--The dose-effect relationship in psychotherapy. Special Issue: Psychotherapy research. Howard,-Kenneth-I.; Kopta,-S.-Mark; Krause,-Merton-S.; Orlinsky,-David-E. American-Psychologist; 1986 Feb Vol 41(2) 159-164

Argues that the American Psychological Association's (APA; 1979) review of several studies on the cost-effectiveness of psychotherapy does not consider viable alternative interpretations or qualify findings in line with the studies' substantial limitations (e.g., their lack of controls for regression or selection biases). It is suggested that in light of the financial contingencies surrounding conclusions about the effectiveness of psychotherapy, special care must be taken to ensure that psychology's public stance on the value of

psychotherapy contains the qualifications suggested by the scientific evidence. Public statements by the APA on the effectiveness of psychotherapy might be based on a review of the scientific merits of pertinent studies by an independent body of research methodologists. (17 ref)
--'Psychology as a health care profession': How healthy was APA's case for the cost-effectiveness of psychological health care? Belden,-Brian-D.; Braukmann,-Curtis-J.; Wolf,-Montrose-M. Psychological-Reports; 1985 Apr Vol 56(2) 391-401

Conducted a randomised, controlled trial in which 92 neurotic patients (mainly phobics and obsessive-compulsives) in primary care were assigned to behavioural psychotherapy from a nurse therapist (NT) or to routine care from their general practitioner (GP). 29 Ss remained in the NT group and 37 in the GP group after 1 yr. An economic questionnaire was returned by 22 NT Ss and 28 GP Ss. At the end of 1 yr, clinical outcome was significantly better in Ss cared for by the NT. Economic outcome to 1 yr, compared with the year before entering the trial, showed a slight decrease in the use of resources by the NT group and an increase in resource usage in the GP-treated group that were mainly due to the latter's increased absence from work and more hospital treatment and drugs. On the reasonable assumptions that NTs treat 46 patients a year and that such patients treated behaviourally maintain their gains for 2 yrs, the economic benefits to society from NTs treating such patients may outweigh the costs. This excludes any monetary value on the substantial clinical gains such as reduction in fear and anxiety. However, the numbers were small, few economic differences were significant, and many Ss either did not complete the trial or waiting-list periods or they failed to return economic data. It is suggested that conclusions must be tempered with caution, even though pre-treatment demographic and clinical data of non-returnees were comparable with those of returnees and the few dropouts who could be rated at 1 yr had not improved. (38 ref)
--Cost-benefit analysis of a controlled trial of nurse therapy for neuroses in primary care. Ginsberg,-Gary; Marks,-Isaac; Waters,-Helena. Psychological-Medicine; 1984

Meta-analysis has been widely adopted as a quantitative approach to reviewing and evaluating a body of literature. The present article discusses the utility of meta-analysis in the context of the evaluation of psychotherapy. Benefits and limitations of meta-analysis are highlighted to identify essential characteristics of the approach as a methodological tool. The major focus is an exploration of meta-analysis in relation to alternative design and data evaluation strategies within clinical psychology. The unique contributions of meta-analysis are discussed. Fundamental issues and assumptions about psychotherapy research are identified to point to the need for critical (and qualitative) evaluation of existing meta-analyses. (48 ref)
--The role of meta-analysis in the evaluation of psychotherapy. Special Issue: Meta-analysis and clinical psychology. Kazdin,-Alan-E. Clinical-Psychology-Review; 1985 Vol 5(1) 49-61

Describes and critically evaluates studies on individual, group, and family therapy that were published largely from 1967 through 1977. Of 33 independent investigations, 5 are judged as exemplary in methodological scope and rigor. Although methodological deficiencies abound, the greater weight of available evidence on adolescents does point toward the superiority of psychotherapy over no-therapy conditions, with the median rate of positive outcome with psychotherapy being approximately 75%, compared with a rate of 39% without psychotherapy. Little is presently known, however, regarding the effects of specific patient, therapist, and process variables on adolescent therapy outcome. (56 ref)
--Critical review of research on psychotherapy outcome with adolescents: 1967-1977. Tramontana,-Michael-G. Annual-Progress-in-Child-Psychiatry-and-Child-Development; 1981 521-550

176 psychiatric inpatients were randomly assigned either to 1 of 3 group therapy programs or to a no-treatment control group. Patient diagnoses and initial level of

psychological disturbance were included as potential predictor variables. Outcome was assessed by the SCL-90 (Revised) administered at the time of Ss' admission, at discharge, and again 10-18 mo later and by ward ratings of patient behaviour and by discharge ratings. The 3 group therapy programs were based on (1) an interactive, process-oriented group format; (2) an expressive-experiential-oriented group format; and (3) a behaviourally oriented group format. Both group process and therapist compliance were closely monitored. Results suggest that after artifactual and milieu effects were accounted for, a systematic deterioration effect occurred among patients exposed to the expressive-experiential group. The process-oriented program tended to produce the best results, which were maintained at follow-up 13 mo later. Results are discussed in terms of the short-term, crisis-oriented nature of the inpatient program, the experience levels of the participating group therapists, and the nature of the group therapies. (16 ref)
--Comparative effects of group psychotherapies in a short-term inpatient setting: An experience with deterioration effects. Beutler,-Larry-E.; et-al Psychiatry; 1984 Feb Vol 47(1) 66-76

Discusses the importance of empirical evaluations of health and mental health procedures to providing the highest quality of care and to reimbursing the most appropriate and efficient techniques. The National Centre for Health Care Technology, during its brief existence, provided the federal government with a mechanism for making such assessments. The now-abandoned plans for the assessment of psychotherapy are described. (8 ref)
--The National Centre for Health Care Technology: Assessment of psychotherapy for policymaking. Perry,-Seymour. American-Psychologist; 1983 Aug Vol 38(8) 924-928

Surveys recent issues and findings about clinical interventions, focusing on those aimed at the individual client. Developments in individual psychotherapy practice (including psychoanalysis, behaviour therapies, European imagery methods, and assertiveness and vicarious rehearsal procedures), health psychology and behavioural medicine, and evaluations of psychotherapy effectiveness are reviewed. It is concluded that psychotherapy as a form of clinical intervention is thriving, and its practice is becoming more problem-focused and amenable to evaluation. The move toward cognitive behaviour therapies has integrated psychodynamic components with techniques of behaviour therapies. The most important development is seen as being the increasing overlap between therapy practice and the basic research areas of psychology; clinical practice may represent the best empirical knowledge in the study of cognition, emotion, personality, and social psychology. (55 ref)
--Clinical intervention: New developments in methods and evaluation. Singer,-Jerome-L. Stanley-Hall-Lecture-Series; 1981 Vol 1 101-128

Randomly assigned 44 outpatient enrolees of a Health Maintenance Organization (HMO) to 1 of 3 treatment modalities: (1) a cognitive behaviour therapy group, (2) a traditional process-oriented interpersonal group, and (3) cognitive behaviour therapy in an individual format. All Ss were referred by their physicians for treatment for anxiety and/or depression.
The Beck Depression Inventory, the State-Trait Anxiety Inventory, and the Adult Self-Expression Scale (an assertion measure) were administered pre- and post- treatment on the Hamilton Rating Scale for Depression. All 3 experimental groups significantly improved on all dependent measures from pre- to post-treatment, and no differential treatment effects were found. (12 ref)
--Cost effectiveness of individual vs. group cognitive behaviour therapy for problems of depression and anxiety in an HMO population. Shapiro,-Joan; Sank,-Lawrence-I.; Shaffer,-Carolyn-S.; Donovan,-Donna-C. Journal-of-Clinical-Psychology; 1982 Jul Vol 38(3) 674-677

In Ontario, there have been threats to restrict psychotherapy benefits. The Ontario Medical Association has rejected such restrictions and prepared an internal brief that was largely devoid of cost-benefit studies. The present article reviews traditional psychotherapy outcome studies, which show that psychotherapy is more effective than placebo, long-term psychotherapy is as effective as brief, and limited hard data are available as to the effectiveness of the psychotherapies. Cost-benefit studies show that brief psychotherapy is cost effective, while long-term psychotherapy clearly reduces hospitalisation costs. Psychotherapy costs in Ontario pertaining to psychiatrists do not support any evidence of abuse by either consumer or provider. It is suggested that cost-benefit studies be instituted in Ontario and that peer review be considered. (25 ref)
--Psychotherapy, benefits and costs. Lesser,-A.-L. Psychiatric-Journal-of-the-University-of-Ottawa; 1979 Jun Vol 4(2) 191-196

Reports on the work of a 5-member clinic team who studied the effect of several forms of treatment of various psychiatric disorders of children. The sample of 151 Ss (101 males and 50 females) did not include psychotics or those of subnormal intelligence. The 40 most severely disordered as well as the neurotics usually received individual therapy. Ss with immature personalities often received group therapy. All patients also participated in 'ward therapy.' Medication was used only for half of the most disturbed Ss. Follow-up 1.5-2 yrs after termination of hospital treatment showed that 85% had clearly improved. The author's 1973 report (see PA, Vol 52:6149), which details methods used and factors affecting results, had found that the post-treatment environment had played the most significant role in maintaining improvement. The current study shows about equal improvement with individual and group treatment, while medication did not seem significant in terms of overall results. (11 ref)
--The psychiatric treatment of pre-puberty aged children--forms and results: A study of children aged 11 to 15 treated in the Child Psychiatric Ward of the Helsinki Children's Castle Hospital during 1966-1969. Arajarvi,-Terttu. Psychiatria-Fennica; 1975 201-207

The results of psychotherapy outcome research to date are briefly reviewed, and the reasons this research has not had greater impact on the practice of psychotherapy in mental health service agencies are presented. Sources of pressure to conduct evaluation research are enumerated. Involving mental health practitioners in field research is proposed as a means of increasing the relevance of psychotherapy outcome research to service personnel. Difficulties frequently encountered in the planning, data gathering, and implementation of results phases of evaluation projects are discussed, and recommendations are made for ameliorating these problems. An improvement-oriented feedback model of program evaluation is presented, and the value of individualized measurement, repeated-measures designs, and experimental case studies in maximizing the utilization of research results are discussed. (86 ref)
--Researching psychotherapy effectiveness in mental health service agencies. Thomander,-Darryl. Journal-of-Community-Psychology; 1976 Jul Vol 4(3) 215-238

A pilot study is reported of costs and benefits of behavioural psychotherapy by nurse-therapists for selected neurotic problems. Figures are based on the treatment of 42 neurotics (mainly phobics and obsessive-compulsives) who completed treatment with nurse-therapists in a mean of 9 sessions (16 hrs). The year before and after treatment was studied. Apart from significant and lasting reduction in patients' distress, economic benefits to them, their families, and the community yielded a worthwhile internal rate of return when benefits from the cohort continued for 3 yrs, a reasonable assumption based on available evidence. (16 ref)
--Costs and benefits of behavioural psychotherapy: A pilot study of neurotics treated by nurse-therapists. Ginsberg,-Gary; Marks,-Isaac. Psychological-Medicine; 1977 Nov Vol 7(4) 685-700

Reviews the research literature concerning the effectiveness of group psychotherapy and the characteristics of client and therapist which promote or hinder a successful outcome.

Issues considered include therapy casualties, evaluation of outcome, similarity of cognitive style between patient and therapist, positive confrontation, pre-group preparation of patients, duration and frequency of treatment, group cohesiveness and composition, therapist's behavioural characteristics, and patient's sociological characteristics. A therapist's behaviour is considered more important than his belief system. (2 p ref)
--A soft-hearted review of hard-nosed research on groups. Grunebaum,-Henry. International-Journal-of-Group-Psychotherapy; 1975 Apr Vol 25(2) 185-197

Evaluated progress of 62 phobic children 1 and 2 yrs after termination of treatment or waiting period. 80% were either symptom free or significantly improved; only 7% still had a severe phobia. Successfully treated Ss tended to remain symptom free and to be free from other deviant behaviours as well. 60% of the failures at termination continued to receive treatment and most were symptom free 2 yrs later. After 2 yrs, the effects of the original psychotherapy and reciprocal inhibition therapy no longer were related to outcome. However, age, status at the end of treatment, and time were related to outcome. Results are discussed in terms of the nature of child phobia and implications for research.
--Phobic children one and two years post-treatment. Hampe,-Edward; Noble,-Helen; Miller,-Lovick-C.; Barrett,-Curtis-L. Journal-of-Abnormal-Psychology; 1973 Dec Vol. 82(3) 446-453

Reviews 6 meta-analyses (e.g., M. L. Smith et al (1980); L. Prioleau et al (1983)) on the efficacy, or lack thereof, of psychotherapy and the differential effectiveness of some schools of therapy as compared to other schools. General criticisms of the meta-analytic technique are offered, with references made to those studies that best exemplify these faults. Conclusions are drawn about both the meta-analytic strategy itself and the lessons that have been learned about the practice of psychotherapy from these quantitative reviews. Suggestions for resolving persistent meta-analytic problems and for future research directions in psychotherapy are offered.
--A review of meta-analyses conducted on psychotherapy outcome research. Brown,-Joseph. Clinical-Psychology-Review; 1987 Vol 7(1) 1-23

Discusses the tremendous growth that has occurred in the number of mental health providers, the rate of use of mental health services, and public and private reimbursement for mental health care. Governmental policymakers and leading insurance officials continue to seek information regarding the appropriateness and efficacy of specific psychotherapeutic techniques with various types of presenting problems. The efforts during the Carter administration to stimulate additional efficacy research and knowledge synthesis regarding the efficacy of psychotherapy are described. A public policy proposal is forwarded that no form of health intervention--physical or mental--should be supported through 3rd-party reimbursement and publicly supported training programs unless it has been demonstrated to be safe and effective. It is argued that randomised controlled clinical trials should be viewed as the most valid, though not exclusive, source of evidence. (10 ref)
--The efficacy of psychotherapy as the basis for public policy. Klerman,-Gerald-L. American-Psychologist; 1983 Aug Vol 38(8) 929-934

Examined the effects of maintenance treatment on social adjustment in 150 25-60 yr old female depressed outpatients randomly assigned to 8 mo of amitriptyline hydrochloride, a placebo, or no pill, with or without psychotherapy, using a 2 * 3 factorial design. The Social Adjustment Scale by E. S. Paykel et al (1971) was used as a change measure. Results for the 106 patients who completed the trial show a significant main effect for Psychotherapy apparent only after 6-8 wks of treatment. Psychotherapy improved overall adjustment, work performance, and communication, and reduced friction and anxious rumination. There was no effect on the patients' social adjustment for amitriptyline, and there were no drug-psychotherapy interactions. Results support the value of weekly

maintenance psychotherapy in recovering depressives. Since amitriptyline reduced relapse and prevented symptom return, and psychotherapy enhanced adjustment, there is evidence for combined treatments.
--Treatment effects on the social adjustment of depressed patients. Weissman,-Myrna-M.,; et-al. Archives-of-General-Psychiatry; 1974 Jun Vol. 30(6) 771-778

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Patti Havenga-Coetzer

Viktor Frankl's Avenues to Meaning –
a Compendium of Concepts, Phrases and Terms in Logotherapy

Onlangs verscheen er van de hand van Dr Patti Havenga-Coetzer een handzaam woordenboekje voor Frankl's Logotherapie.
Het is een kleine uitgave waarvan de student wellicht heel veel plezier kan hebben. Het is de verdienste van onze Zuid-Afrikaanse collega Havenga, dat zij vanuit haar overzicht over het basiswerk van Frankl allerlei begrippen scherp definieert en zo het taalveld van de Logotherapie toegankelijker maakt. Een dergelijk project is dus zeer welkom, al zijn er de nodige risico's. Een van de grote risico's in het maken van een dergelijk overzicht is dat de grens tussen Frankl's werk en de christelijke interpretatie - met name een theologiserende - te vaag wordt. Frankl heeft zijn psychotherapie niet bedoeld om kerkelijke dogma's als antwoord op een persoonlijk situationele zinvraag te vervatten. Een grondige kennis van Hebreeuwse, Rabbijnse achtergronden moet daar feitelijk een tegenwicht tegen bieden. Helaas is ook daaraan het nodige riskant. Psychotherapie als Logotherapie is een waardenvrije benadering, waarin het *'unconditional yes'* nu van de kant van de therapeut moet komen. Met name waar het gaat over euthanasie, abortus en andere ethische problemen was het dus wenselijk geweest om juist daaraan de nodige extra aandacht te besteden. Een volgende uitgave kan wellicht deze noodzakelijke herbronning grondiger doorvoeren dan thans het geval is. Toch is het boekje een aanrader omdat het overzicht dat er in naar buiten komt compleet genoeg is.

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On the future of psychotherapy- Thomas Szasz

Today, the term "psychotherapy" is used to refer to all manner of interventions, ranging from a voluntary dialogue to electrical, pharmacological, and surgical procedures imposed on persons against their will. This usage reflects the fashionable failure to distinguish between bodily disease and "mental disease"; between treating diseases with chemical and physical methods and influencing persons with "religion, rhetoric, and repression"; and between help that people seek for themselves and harm that people seek to impose on others (and call "treatment").

I use the term "psychotherapy" as the name of a freely contracted relationship between two competent and responsible adults, one paying the other for assisting him, by means of a dialogue, to live his life better. The wellspring of voluntary medical-therapeutic relationships is the patient's need for helping the Self, whereas the wellspring of involuntary psychiatric interventions is the family's (or the court's) need for controlling the Other. The former rests on consent, the latter on coercion. It is as absurd to conflate voluntary and involuntary "therapeutic" relations as it is to conflate sexual relations between consenting adults and rape.

The contractual conception of psychotherapy requires that the client / patient pay the therapist. Accordingly, most contemporary psychotherapeutic practices, based on the therapist's being paid by an insurance company or other "third party," preclude the practice of such "autonomous psychotherapy." If the client/patient does not obtain psychotherapeutic help by paying for it with money, then he will find himself in a situation of having to pay for it by producing symptoms.

Correlatively, if the therapist does not get paid for service by the client/patient, then he will find himself in a situation of having to receive reimbursement for it by producing diagnoses. The result is a deceptive, intrinsically anti-therapeutic collusion between patient and therapist.

When a person suffers - from disease, oppression, or want - he naturally seeks the assistance of persons who have the knowledge, skill, or power to help him or on whom he projects such attributes. In ancient times, priests - believed to possess the ability to intercede with gods - were the premier wielders of power. For a long time, curing souls, healing bodies, and relieving social-economic difficulties were all regarded as priestly activities. Only in the last few centuries have these roles become differentiated, as Religion, Medicine, and Politics, each institution carving out its "proper" sphere of influence, each still overlapping with and struggling to enlarge its scope and power over the others. One of the results of this process of role-differentiation is the dual function of the modern healing professional, sometimes acting as the individual's ally, sometimes acting as his adversary (albeit officially he is always defined as his ally).

The therapist's integrity depends largely on his representing his role to the patient truthfully and on keeping the promises he makes to the patient. Because an element of dependency is intrinsic to the "patient role", the only way to compensate for the asymmetry of power between therapist and patient is by limiting the therapist's behavioural repertoire vis-à-vis the patient.

Psychotherapy aimed at enlarging the patient's liberty and responsibility requires that the therapist and the patient view themselves as existentially equal moral agents, each responsible for his own conduct and self-control.

The major obstacle preventing psychotherapy from reaching its promise in the past - and boding ill for its future - is the spirit of paternalism and the passion for coercion that animates many of its practitioners. The following statement by two prominent therapists is illustrative: "Once the patient's suicidal thoughts are shared, the therapist must take pains to make clear to the patient that he, the therapist, considers suicide to be a maladaptive action, irreversibly counter to the patient's sane interests and goals ... Suicidal intent must not be part of therapeutic confidentiality. ... The therapist must be prepared to step in with hospitalisation, with security measures, and with medication."

"The plumber does not install wiring and the ophthalmologist does not remove appendices. The psychotherapist who professes to heal with words ought not to prescribe drugs, prevent suicide, or otherwise interfere with the patient's life."

Most contemporary psychotherapists cling to the concept of mental illness and reject limiting their discretionary powers to interfere in the life of the patient. This vitiates what I regard as a requirement for "autonomous psychotherapy" and for the maintenance of the therapist's role integrity. The plumber does not install wiring and the ophthalmologist does not remove appendices. The psychotherapist who professes to heal with words ought not to prescribe drugs, prevent suicide, or otherwise interfere with the patient's life. Today, this kind of therapeutic self-restraint is professionally censured as "withholding essential treatment" from the patient and is rendered de facto illegal by tort law.

Our attitude toward the relationship between the individual's need for mental health services and the state is the very opposite of our attitude toward the relationship between the individual's need for religious services and the state. The American government provides no religious services for its citizens. Clergymen provide no involuntary religious services for atheists or others who do not voluntarily seek it. Were an educated American to interpret this as "withholding" religious services from people who need and would benefit from them, he would be dismissed as a person ignorant not only of the relationship between Church and State but also of the constitutionally imposed prohibitions against coercion in the name of God. Coercion in the name of mental health is permitted, indeed mandated.

"The major obstacle preventing psychotherapy from reaching its promise in the past - and boding ill for its future - is the spirit of paternalism and the passion for coercion that animates many of its practitioners."

In our present collectivised medical-economic climate, mental health professionals have grown estranged from, and hostile to, reciprocity and responsibility in human relations. As a result, ostensibly in the patient's best interests, they not only coerce patients, they also defraud employers and insurance companies. A prominent American psychotherapist declares that "the mentally ill deserve job protection" and describes "Jill", one of his patients, as deserving such protection despite being "dour, deeply and chronically depressed, consider[ing] suicide every day of her adult life, gruff, and lack[ing] drive."

Were Jill's employer - let us call him James - to display the same set of behaviours towards her, psychiatrists would rush to help Jill and her lawyers extort compensation from James on the ground that he is the cause of Jill's "mental illness." Yet when Jill displays such behaviour, psychiatrists rush to enlist the formidable powers of the government's criminal law enforcement apparatus to prevent James from firing her as an unsatisfactory employee.

Burke warned that "it requires a deep courage to be temperate when the voice of multitudes (the specious mimic of fame and reputation) passes judgement against you. The impetuous desire of an unthinking public will endure no course, but what conducts to splendid and perilous extremes. Then, dare to be fearful, when all about you are full of confidence..."

I am fearful for the future of psychotherapy, not only because the unthinking revolutionaries of mental health and the public they have successfully gulled are full of confidence, but also because I share Burke's concept of liberty which, as he put it, is that state of things in which liberty is secured by the equality of restraint. Mutatis mutandis, the therapy I value is that sort of human relationship in which personal assistance is secured by an equality of self-restraint.

Thomas Szasz is Professor of Psychiatry Emeritus at the State University of New York Health Science Center in Syracuse, New York. He is the author of 25 books, among them the classic The Myth of Mental Illness (1961) and most recently, Fatal Freedom: The Ethics and Politics of Suicide (Westport, CT: Praeger, 1999).

Szasz is recognized as a foremost critic of psychiatric coercions and excuses. A frequent and popular lecturer, he has addressed professional and lay groups, and has appeared on radio and television, in North, Central, and South America as well as in Australia, Europe, Japan, and South Africa. His books have been translated into every major language.

Allergie en Voedselovergevoeligheid

Nu al is 1 op de 3 kinderen in Nederland allergisch voor iets. Het lijkt er op of dat in de toekomst alleen maar erger zal worden. Op donderdag 12 februari 2004 werd een Europees plan gelanceerd om allergieontwikkeling in Europa in kaart te brengen en strategieën te ontwikkelen om met de groeiende epidemie om te gaan. Het gaat om het Global Allergy and Asthma European Network, gecoördineerd door de Universiteit van Gent.. De vrees bestaat dat in de mate waarin allergie toeneemt in 2015 de helft van de Europese bevolking allergisch zou kunnen zijn.

Allergie is een ruim begrip. Er zijn verschillende allergische reacties van het lichaam bekend. Onmiddellijke allergische reacties en ook vertraagde reacties. Het uit zich ook in verschillende orgaansystemen als astma, eczeem, hooikoorts, voedselintolerantie. Voor ouders met kinderen met een allergie is het leven soms erg moeilijk en voor de kinderen trouwens ook. Het hele leven komt te staan in het vermijden van stoffen die allergieaanvallen kunnen veroorzaken en in het verzorgen van eczeem of astma. De astma kan variëren van een licht piepende ademhaling waar kinderen weer overheen groeien en waar verder geen behandeling voor noodzakelijk is tot een ziekte die een enorme invloed heeft op de ontwikkeling van het kind.

Hoewel er ook een zekere erfelijke aanleg voor allergie blijkt te zijn wordt e oorzaak van de snelle toename van het aantal allergieën gezocht in het steeds sterielere leven dat we leiden. Het afweersysteem wordt op jonge leeftijd niet meer voldoende uitgedaagd. Maar juist kinderen die als ze jong zijn veel infecties hebben blijken minder kans op allergie te hebben. Kinderen die met katten en honden opgroeien hebben minder kans een allergie te ontwikkelen. Kinderen die borstvoeding hebben gekregen (en niet een steriel poeder opgelost in gekookt water) hebben grotere kans vrij te blijven van die hinderlijke aandoening.

Als de trend die de wetenschappers verwachten zich inderdaad voorzet, dan zal binnenkort een op de drie mensen niet meer zomaar naar een restaurant kunnen gaan omdat ze niet weten wat er precies in de maaltijden verwerkt wordt. Nu al is astma de belangrijkste reden voor schoolverzuim. In 2015 zal dat dramatisch omvangrijker zijn. Er moet iets gebeuren, vandaar dit Europese netwerk.

Samenhang Allergie en Antibiotica

Als kinderen gedurende de eerste zes maanden van hun leven antibiotica gebruiken hebben ze een grotere kans om astma te ontwikkelen. Ook andere soorten allergie voor onder andere huisdieren, graspollen en huismijt bleken meer voor te komen bij gebruik van antibiotica in de eerste zes maanden. Een en ander bleek uit onderzoek dat gepresenteerd werd gedurende de conferentie van de Europese Vereniging voor Luchtwegaandoeningen in Wenen (Lancet 2003;361:1131).

Uit het onderzoek onder 448 kinderen die gevolg werden van hun geboorte tot hun zevende jaar, bleek dat als ze in hun eerste half jaar ten minste één keer antibiotica kregen, de kans op allergie 1 tot 5 keer zo groot was als bij kinderen die ze niet kregen. Het interessante is dat de kans weer wat minder was als die kinderen tenminste twee honden of katten in huis hadden. Als de moeder aanleg voor allergie had, bleken de kinderen ook meer risico op allergie ontwikkeling te hebben bij gebruik van antibiotica.

De combinatie van ouders die aandringen op een antibioticakuurtje vanwege de snotneus van de baby en een arts die graag van die druk af wil terwijl hij ook wel weet dat het kind een virusontsteking heeft waar antibiotica niet helpen, leiden nog wel eens tot het voorschrijven van antibiotica. Als ouders zou je al die dingen beter tegen elkaar af kunnen wegen. Zit er allergie in de familie? Heeft mijn kind wel een bacterie-infectie zodat een antibioticum echt noodzakelijk is? Wil ik die verhoogde kans op astma of een andere allergie? Denk altijd mee voor je geneesmiddelen aan je kind geeft.