***YES WE DO:***
***Now for those of the English or***
***American-English mothertongue***

Language is the essential instrument in any psychotherapist's workshop. This is true for verbally oriented methods as well as others that may predominantly use nonverbal means of expression or influence. No fixed set of methods can be applied successfully to every patient. Although today's therapeutic methods have outgrown the boundaries of the original „talking cure„ dating back to Sigmund Freud's time, all therapies depend on verbal communication that works well and can distinguish every nuance of expression.

In central Switzerland, patients from English speaking countries sometimes have difficulties finding a psychiatrist or psychotherapist who is fluent enough in their language to be helpful. Having had a long lasting affection for the cultural backgrounds of the English language and the countries where that language is spoken, I have read and traveled widely in the world of books and the physical world. If you are looking for a doctor specializing in psychiatry or psychotherapy please feel free to give me a call, so that we could take a closer look at your needs and interests. To familiarize you with my personal and professional background, I am giving a brief review of my work and history below.

My private practice here at Lucern has been in continuous operation since 1996. I was born in 1955 in the city of Basel, where I grew up, studied medicine and got my degree as an M.D. in 1981. During the course of my postgraduate work over the following 15 years I concentrated my professional career on achieving my qualification as „*Spezialarzt FMH für Psychiatrie und Psychotherapie*„, which I completed in 1998. This qualification and my fellowship with the Federation of Swiss Physicians (FMH) allows me to treat patients with psychiatric problems, with the treatments normally covered by medical insurance. The only requirement for insurance coverage is that the patient's condition is of a serious medical-psychological nature (and does not, for example, merely come out of a personal interest in self experience).

Ask ten therapists about the solution of a well defined psychological problem and you will get at

least twenty different suggestions. Indeed, it is not too rare to find that several answers from one particular therapist contradict themselves. Conclusion: methods are one matter, human beings are another. Applied to a psychotherapeutic setting, this means that a patient with some problem cannot work with every psychotherapist. In terms of the best possible outcome of a psychotherapeutic procedure, the nature of the interpersonal relationship counts almost as much as the theoretical background on which the therapist relies. Needless to say that the therapeutic relationship between patient and therapist, which is supposed to be both truly and authentically human *and* professional at the same time, strongly depends on the therapist's methodological orientation and experience. A crucial task of their initial meetings is to find out whether a patient and his or her therapist could form a winning team for a promising collaboration. This collaboration depends to a great extent on the „chemistry„ (consisting mainly of trust, sympathy and understanding) between patient and therapist. Also, the specific needs defined by the patients particular problem need to be considered. These needs may call for a particular psychotherapeutic technique or approach.

Therefore, I should give you some insight into my own orientation within the vast framework and intricately intertwined branches of psychotherapeutic schools and methods. During the first five years of my postgraduate work as a psychiatrist and psychotherapist, I underwent a classical psychoanalysis with four sessions a week, for a total of about 700 sessions. My interests, reading, and taking part in courses and seminars during those years naturally focused on developmental analytic psychology and psycho-dynamics. Conflict, subconscious motivation and it's opposing forces; self concept and it's validation on the basis of unconscious ideas, patterns or loyalties; attitudes towards feeling guilty and unworthy, tendencies towards suffering, self degradation and re-victimization, to name just a few, are still among the conceptual cornerstones of my theoretical orientation. Remembering and rearranging traumatic experiences after a secure basis for the confrontation of such experiences has been established; recognising and working through conflicting tendencies within the model relationship between patient and therapist are powerful and highly effective means belonging to the psychoanalytic repertoire which I wouldn't want to

miss. Nevertheless, I do not work with a couch. Based on many years of experience with psychodynamic psychotherapy, I do not see this as a disadvantage for the fruitful application of the psychoanalytic concepts and instruments mentioned above, at least not if they are supported and completed by other means, tools and techniques.

After moving from Basel to Lucern in 1985, I began to work in the outpatient department of the then newly opened cantonal Social Psychiatric Services of Lucern. There, I acquired much theoretical knowledge and gained practical experience about the concepts of and the philosophy behind social psychiatry. By then these concepts had already been integrated elsewhere (and sometimes even started their decline) in several areas in the daily routine of major treatment centers, but they were still in their „revolutionary„ infancy in the heart of our country. Social psychiatric thinking is more a holistic view, an attitude or an orientation, than a technique or theoretical concept. It may be one of the nobler essential structures that differentiates psychiatry from normal medical thinking.

From 1989 to 1990 I studied couple and family therapy with Prof. Jürg Willi and his fellow researchers in Zurich. Back then, they drew their integrated concepts from a systemic and psychodynamic perspective, as well as from a point of view that focused on developmentally critical turning points in the history of a couple. The latter approach was later termed „psycho-ecology„ by Jürg Willi. I have done a lot of therapeutic work with couples since then and, based on that work, learned to judge more decisively to differentiate possibilities from limits of this very helpful domain of psychotherapy.

Simultaneously with the beginning of the „biological rollback„, which set in around the early nineteen-nineties, cognitive and behavioral intervention techniques gained a wider respect for their efficacy in the treatment of compulsive and anxiety disorders and depressions. I followed these lines with close interest and proceeded to use in an even more considerate way some of the essential ingredients of cognitive-behavioral therapy in my work with patients for the treatment of these disorders. By the way, I extended their use into other areas of psychiatric nosology.

To conclude this brief review, I emphasize that

methods -- the benefits or „superiority„ of which had initially been defined and qualified by opposing them to others, more traditional ones -- do much better if they are brought together to form an eclectic repertory that can be applied suitably to the profile of a patients' needs, and that may be blended and modified according to the requirements of each particular phase in the course of an individual psychotherapeutic process.

Since 2002 I have focused much of my professional work on attention deficit and hyperactivity disorders and other cognitive impairments in adults. For more than a decade, extensive research had been done on ADHD in adults in the United States and Britain, while here in Switzerland well into the first years of the new millennium the mere existence of this syndrome in adulthood was barely recognized, even among medical professionals. Well defined diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association call for an exploration in detail, including a set of questionnaires and neuropsychological tests in order to assess the history, symptoms, level of impaired functioning and differential diagnosis of patients referred for the treatment of problems associated with focusing attention, maintaining attention span, concentration, working memory and other elementary mental functions. Before specific interventions* can be applied, a comprehensive assessment by an experienced physician is paramount.



* *Such as, the prescription of stimulants and other psychoactive drugs; psychotherapy in order to cope with the depressing or even devastating effects of a lifelong experience of being different, vulnerable or less effective in particular situations; counseling or coaching in order to develop alternative strategies and skills in areas where the disorder is most disturbing.