INTERNATIONAL FEDERATION FOR PSYCHOTHERAPY IFP

01·03

newsletter

Content

Editorial

DR. ALFRIED LÄNGLE, M.D.,
SECRETARY GENERAL, IFP

To ensure a good flow of information between the members of IFP, the Council, and the Board, Professor Schnyder suggested to (re-)establish an IFP Newsletter. We plan to publish two issues per year. I feel honoured to be appointed as Newsletter Editor of the IFP.

The main aim of the Newsletter will be to provide the members with regular and relevant information about things going on in the IFP, and about psychotherapy in general as far as we get such information which we think to be of interest for you. We would also like to publish from time to time – or even regularly – short scientific papers. We hold the Newsletter to become a platform for exchange betweeen the members thus contributing to a better and closer relationship amongst them. So any contribution is welcome, and I would like to invite you to send me information as well as other material you would wish to be published in the Newsletter. In addition, if you have any questions or comments, please feel free to contact me at: alfried.laengle@existenzanalyse.org.

For the coming issues we plan to publish some of the papers of the last World Congress in Trondheim. We are very grateful to Professor Peter Fonagy for the chance to get his intriguing and basic presentation of Trondheim already in this issue. We also thank the oranizer of the Trondheim Congress, Professor Gunnar Götestam, for his review of this great event which will bring back vivid images and good memories to all those who had a chance to attend this remarkable World Congress. Also in this issue, please find Dr. Douglas Kong's report on the 3rd Asia Pacific Conference on Psychotherapy that was recently held in Singapore.

I am closing with my best greetings and wishes for a good collaboration!

Presidential Message

PROF. ULRICH SCHNYDER, MD
PRESIDENT, IFP

In August 2002, at the General Assembly held during the 18th World Congress of Psychotherapy in Trondheim, Norway, I was elected President of the IFP for a four years term. I feel honoured to serve as President of one of the oldest professional organizations in the field of psychotherapy, founded as early as 1935 by one of the pioneers of modern psychotherapy, Carl Gustav Jung.

At the beginning of my term, I would like to thank Prof. Wolfgang Senf, MD, our outgoing President: he has guided the Federation through the last four years. Under his wise leadership, the IFP managed to survive «in troubled waters», in times characterized by increasing tensions among professional societies of psychotherapists, and by ever growing economic difficulties our field was confronted with. Please find more details about Prof. Senf's presidency in his report in this Newsletter.

According to my nominations, the IFP Council has appointed Dr. Alfried Längle, MD (Vienna, Austria) as Secretary General, Dr. Ria Reul-Verlaan, MD (The Hague, The Netherlands) as Treasurer, and Prof. Tsutomu Sakuta, MD (Tokyo, Japan) as chairman for the 19th World Congress on Psychotherapy, for the 2002-2006 term. Welcome to our new Board members!

As President, I will try to lead the Federation in a way that ensures, on the one hand, that we can build on our great tradition and provide a sufficient degree of continuity. On the other hand, change and adaptation to new challenges are necessary as well. The Board and myself will work towards an increase of our membership, particularly in those regions where IFP is not yet very well represented, for instance in the Spanish speaking countries. Apart from this, we will have to improve and bring more reliability into the Federation's offers to its membership. We are well aware that membership satisfaction depends to a great degree on swift and problem-free communication. Please let me know if communication between you and our new secretariat at the Psychiatric Department, University Hospital Zurich, Switzerland (Ms. Cornelia Erpenbeck; c.erpenbeck@ifp.cc) does not work according to your expectations! We will also aim at strengthening the IFP profile through fostering the Federation's publication activities. We have decided to resume the publication of a Newsletter on a regular basis, at least twice a year. In a few weeks time, you will find our new, completely revised website at http://www.ifp.cc/ in the internet. We hope the website will provide you with easily accessible and up to date information about the Federation, future congresses, and other issues on psychotherapy.

We will continue our conference policy, namely to have World Conferences every four years. In addition to this, we will organize or co-sponsor various smaller meetings, seminars, and workshops on a regional level. Just recently, the 3rd Asia Pacific Conference on Psychotherapy was held in Singapore (March 12–15, 2003). Please find Dr. Douglas Kong's report on this most successful conference in this Newsletter. Furthermore, regional congresses are planned to be held in Amsterdam in 2004, Taiwan in 2005 (organizer: Prof. Jung-Kwang Wen, president, Taiwan Association of Psychotherapy), and Hongkong in 2008 (organizer: Prof. Char-Nie Chen). Last but not least, it was decided in Trondheim that the 19th World Conference on Psychotherapy will take place in Japan (probably in Tokyo or Kobe) in 2006 (organizer: Prof. Tsutomu Sakuta).

As you can see from this Newsletter, we are in the process of giving the IFP a new external appearence. From now on, our headed paper and envelopes will come in a new, fresh outlook. Over the last months, we have been working hard on the development of a new logo, too. However, we have not come to a final decision yet. On the following pages, you will find a selection of draft logos. May I invite you send me your comments on these drafts? We would be happy to incorporate your ideas into the reconstruction of IFP's corporate identity!

Last but not least, I should like to ask you for your support: the IFP can only florish if there is lively interaction and communication amongst us. So please let me or any member of the Board know about your ideas and visions, about your activities, about your experiences. There is a rapidly growing body of knowledge and professional competence in the field of psychotherapy: please help us in seeking to ensure that clinical applications in the field of psychotherapy are informed by scientific evidence! ■

IFP Corporate Design

May we ask you for your opinion with regard to the future corporate identity of IFP? In the following, you will find three draft logos. In the future, the logo will appear on IFP headed paper and envelopes, as well as on our newsletter and website. Your feedback and comments will be greatly appreciated. Also we would be happy to incorporate your additional ideas!

International Federation for Psychotherapy

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Sample

01·03

newsletter

International Federation
for Psychotherapy

May 2003
sunt Belgae, propterea quod
a Cultu atque Humanitate
tres Provinciae longissime

Horum omnium fortissimi

Gallia est omnis divisa in partes tres, quarum unam incolunt Belgae, aliam Aquitani, tertiam qui ipsorum lingua Celtae, nostra Galli appellantur. Hi omnes lingua, institutis, legibus inter se differunt. Gallos ab Aquitanis Garunna flumen, a Belgis Matrona et Sequana dividit.

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Past President's Message

PROF. WOLFGANG SENF, MD
PAST PRESIDENT IFP

Since the congress in Hanover in 1991, I have been involved with the Board of the IFP, at first as General Secretary and since the congress in Warsaw in 1998 as President. I decided to hand over this office at the 18th World Congress of Psychotherapy in Trondheim in August 2002. I ask for your understanding, but I am no longer in the position to reconcile the active demands involved with presidency of the IFP and my position as Head of the Department of Psychosomatics and Psychotherapy at the University of Essen with the many and increasingly extended tasks involved in this position.

Please allow me to recapitulate the past 10 years of the IFP. As positive, I would like to emphasize

- the congresses since Hanover 1991; these were supported financially by the IFP (Table 1)
- the promotion of the development of psychotherapy in different countries involving concrete projects and financial support as was the case especially for Nigeria, Russia, and China
- the development of the Asia-Pacific Chapter with the APAP
- the Web Site of the IFP (www.psychotherapy.de)
- the cooperation and the contacts with other umbrella organizations

Psychotherapy is one of the oldest cross-sectional disciplines of medicine besides pharmacology and surgery. It is with great satisfaction that I see psychotherapy gaining ever more importance as a recognized scientific discipline and as an extremely effective treatment method worldwide in medicine and psychology. This is also reflected in the growing number of IFP congresses that will or have taken place on the various continents (Table 1). The topics of the congresses reflect the development of psychotherapy.

In addition, there are the great number of international and national congresses that are organized by the different psychotherapy schools, so that we can now say: Today, psychotherapy is accepted world-wide as a field of health care and specifically as a method for the treatment of psychiatric, neurotic, and psychosomatic disorders as well as a method to enhance well-being in somatic diseases. Many scientific studies have demonstrated the efficacy of psychotherapy. The results of psychotherapy, when compared to other medical disciplines, are excellent.

Despite this, however, many questions remain unanswered concerning the present state and the future development of psychotherapy. And here very important questions must be asked, e.g.: Is psychotherapy not to a great extent dependent on the individual context of culture, society, and public health care?

I am sure that more than in any other field of medicine, psychotherapy is oriented towards the respective norms

Table 1

YEAR	LOCATION	THEME
1948	London (U.K.)	The problem of guilt in psychotherapy
1951	Leyden (Netherlands)	The affect contact
1954	Zürich (Switzerland)	Transference in psychotherapy
1958	Barcelona (Spain)	Daseinsanalysis and psychotherapy
1961	Vienna (Austria)	Psychotherapy and clinical medicine
1964	London (U.K.)	New development in psychotherapy
1967	Wiesbaden (Germany)	Psychotherapy, prevention and rehabilitation
1970	Milan (Italy)	Psychotherapy and human sciences
1973	Oslo (Norway)	What is psychotherapy?
1976	Paris (France)	Psychotherapeutic process
1979	Amsterdam (The Netherlands)	Research and training
1982	Rio de Janeiro (Brazil)	Psychotherapy and culture
1985	Opatija (Croatia)	Health for all by the year 2000
1988	Lausanne (Switzerland)	Culture and theory
1991	Hannover (Germany)	Psychotherapeutic health care
1994	Seoul (Korea)	Psychotherapy: East and West
1996	Bali (Indonesia)	Psychotherapy Asia Pacific
1998	Warsaw (Poland)	Psychotherapy at the turn of the century from past to future
1999	Sokoto (Nigeria)	First regional conference
2000	Kuala Lumpur (Malaysia)	Partnership in growth and development in the new Millenium
2000	Barcelona (Spain)	Psychotherapy in a unified Europe
2001	China (Kunming)	Psychotherapy: Dialogues between East and West
2002	Trondheim (Norway)	The crossroads between clinical practice and research
2003	Singapore	Breaking barriers – building bonds

and human images. The socio-cultural context is of great importance; differences therefore exist for the different cultures, societies and countries with regard to the development, the organization, the psychotherapeutic treatment structures, and in the application of psychotherapy. It will therefore be quite difficult to determine a global definition of what psychotherapy is and in which manner psychotherapy may be practiced and by whom.

Nevertheless: If psychotherapy is a scientific method for the treatment of psychiatric, neurotic, and psychosomatic disorders using psychological methods then it must in future be possible to come to joint agreement – at least to a large degree – on psychotherapy in general, general criteria, as well as guidelines. It is my opinion that the Future of Psychotherapy lies in the development of general definitions and guidelines that we have all come to an agreement on – and it is this that has to be discussed in the future. The discussion concerns the following topics and questions: definition of psychotherapy; professions allowed to practice psychotherapy; psychotherapy versus counseling; reimbursement; training regulation; ethical aspects.

At this point allow me to take the opportunity to thank Ulrich Schnyder, Ria Reul-Verlaan, our loyal Treasurer, and Lucia Alvarez-Buylla for their excellent and kind cooperation during the last years.

The future of the IFP lies in the advancement of the dialogue on psychotherapy on a high scientific level between different cultues, societies and psychotherapy schools, as well as between the fields of medicine and psychology. In this respect, the future of Psychotherapy must be of the utmost concern to the IFP. To achieve this, I wish the new Board of IFP, Prof. Ulrich Schnyder, Dr. Ria Reul-Verlaan, Dr. Alfried Längle, and Prof. Tsutomu Sakuta success in the future. ■

How can psychotherapy practice be informed by research findings: The pros and cons of evidence-based psychotherapy or «Nobody has won and all their prizes are going to be taken away».

The Roads to Evidence Based Practice

Evidence based medicine and its inseparable companions (systematic reviews, technology appraisals and clinical or practice guidelines) are today as ubiquitous as Pizza Hut and Starbucks, pervading all regions of the world from Santiago to Washington, from London to Sydney. All over the world there is an initiative to alter the culture within which health care is offered from one based on expert knowledge and authority to one founded on the principle of evidence based practice.

The Committee on Science and Practice of the American Psychological Association has published a statement of objectives for this new culture in a policy paper entitled: «Stressing the (Other) Three Rs in the Search for Empirically Supported Treatments: Review Procedures, Research Quality, Relevance to Practice and the Public Interest» (Weisz, Hawley, Pilkonis, Woody, & Follette, 2000). John Weisz and colleagues identify four principles: (1) public accountability, a continued effort to keep training and practice aligned with the current state of the scientific evidence; (2) systematic, reflexive, unbiased and rational review of the best available evidence; (3) the identification of what treatment works for whom under what conditions and why – this last question implying the importance of identifying the causal mechanisms of change; and (4) the wish to close the gap between research and practice by moving clinical trials into the clinical training and practice contexts. These are uncontroversial principles to which all psychotherapy practitioners and researchers must subscribe if psychosocial interventions are to retain a place in the science driven health care of the twenty-first century. Precisely because of the profundity of the enterprise of evaluation, the details of how the integration of research findings with psychotherapy practice might productively be achieved are crucial.

I am a firm believer in evidence-based practice, notwithstanding my strong allegiance to psychodynamic approaches, which have, by and large, fared badly in EBP initiatives. But in my view, considerable intellectual work remains to be done before treatment choice in psychological therapies can be genuinely made on the basis of empirical data alone. All practitioners therefore ought to be aware of the limitations of the empirical foundations of current assessments and guidelines and some, as yet unsolved, problems with drawing conclusions from the research literature.

I will divide my comments on the unresolved problems of «evidence based practice» in relation to psychotherapy under three headings. These are: (1) What counts as evidence in evidence based practice? (2) What are the limitations of the current research base? (3) What might help translate findings into practice?

What is sufficient «Evidence» for Evidence Based Practice?

The rules for integrating evidence in reviews raise important and controversial issues. Reviews of the evidence base are usually carried out by panels of professionals (researchers and practitioners) who have to decide when evidence reaches a critical mass to enable the designation of a treatment

approach as empirically supported or evidence based. Since the rules created (appropriately in the interest of transparency) to support this kind of decision-making are untested and necessarily somewhat arbitrary, they may well have serious unintended consequences. The issue of «grandparenting» is one example. Some well-accepted treatments are based on studies performed years ago, which by current standards are flawed. They are «grandparented» into evidence based schemes as the inclusion of evidence from early studies was consistent with the standards of outcome studies available at the time. This happened in the APA Science & Practice Committee in the case of many early behavioral studies of the effects of exposure treatments for anxiety related disorders. No one proposes to redo these studies. Yet strict application of the «grandparenting rule» would make it possible to consider Freud's case studies as empirical support for psychoanalysis, since Freud's methodology was consistent with the case study approach standard in turn of the century medicine.

Most evidence based systems need to produce treatment guidelines and thus group psychotherapy treatments by diagnosis. Yet the reliability of diagnostic systems is in some critical instances quite limited, and the heterogeneity of the clinical groups they cover is well recognized (Cantwell, 1996; Westen, 1998). Treatments may only be effective with a limited range of individuals. For example, dialectical behaviour therapy was established as effective in reducing self-harming behaviour in a women-only sample (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). The production of treatment guidelines by diagnosis also makes it more difficult to address issues of comorbidity, which is highly prevalent in clinical populations for most disorders studied. Decisions concerning effectiveness are often based on effect size, but this depends as much on the comparison group as the treatment under scrutiny. If effect sizes are going to be used to compare treatment modalities then the control group must be a standard intervention. Reviews of drug trials clearly demonstrate that active placebos – placebos that mimic the side-effect of the drug (Fisher, 1997) – cut effect sizes by half. Therefore a mere waiting-list control for any psychosocial treatment is quite unacceptable. In studies claiming to have a «minimal treatment arm» clients randomized to these groups often use their own initiative to obtain alternative treatment (e.g. Smyrnios & Kirkby, 1993) which may be highly effective, reducing the effect size of the observed treatment effects.

The oft-cited solution that the control group should always be the «best available alternative treatment with established efficacy» is similarly problematic. What counts as an «established treatment» must be specified in order to avoid leaving the door open to a circular definition of effectiveness. As the variable nature of the comparison conditions are likely to generate quite different effect sizes for the same treatment, a different approach than a «league table» of effect sizes may be required to guide the selection of «evidence based treatments». This might be to predefine a minimum level of change that an evidence based treatment is expected to achieve in a given period of time or for a given quantity of financial or other resources. This approach has arguably been implicitly already adopted in those countries where reimbursement is offered for a limited number of psychotherapy sessions often linked to the patient's diagnostic condition.

Such a protocol raises the even more complex issue of what a minimal degree of effectiveness should be for a treatment. How many patients need to show a significant change for us to consider a treatment to be effective? The effectiveness of the treatment critically depends on the baseline we take. [In a study of cognitive therapy for depression, Thase and colleagues (Thase et al., 1992) screened 130 depressed patients. Of these 76 (58%) were deemed suitable for the treatment protocol. Of the 76, 64 (81%) completed treatment. Of these 64, 23 (40%) were described as fully recovered and 27 (42%) as partially recovered giving an impressive improvement rate of 78%. But as Westen and Morrison (Westen & Morrison, 2001) point out, clinicians in practice cannot select out patients for example because of complicating co-morbidities or personality disorder. Calculating the improvement rates on the basis of patients referred for the trial, the figures are both more realistic and more sobering. 18% of those who completed therapy fully recovered with an additional 21% showing partial improvement (i.e. 39%). By one year a third of those who had recovered to any extent had relapsed. If those who developed a mood disorder other than major depression in the intervening year are also included in the relapse group, then only 38% of those who entered treatment can be said to be still benefiting at one year and only 22% of those originally referred. Can a treatment that leaves 80 per cent of those who received the intervention remitting within a year and a half reasonably be considered effective? Yet CBT for depression is the best validated treatment and is recommended as the treatment of choice by most guidelines (including the DoH)(Shea et al., 1992). Westen and Morrison (2001b) suggest that we should adjust the observed success rate of a treatment for the number of individuals who have not been offered the treatment because they were excluded. The likelihood of successful outcome with that treatment in an actual clinical encounter is likely to be less than that observed in the study.

How many measures need to show significant effects for a treatment trial to be considered successful? Should effects be judged in terms of the number or percentage of measures on which improvement was observed? Do we know that all the measures that were applied were included in the report? Effect size is usually used to compare one study with another, but some effects are easier to achieve than others. For example, the Child Behavior Checklist (Achenbach, 1991) is notoriously difficult to shift, whereas laboratory-based behavioural measures of anxiety are, by contrast, relatively easy to affect through treatment. In a review of 2000 studies of schizophrenia (Thornley & Adams, 1999), 649 different scales for measuring outcome were used. Comparing these studies in a single matrix would only make sense if each of these measures were accompanied by a weighting for sensitivity to change. Is there general agreement that the standard deviation of the control group is equivalent to such a sensitivity index?

Treating states of distress and offering treatment for specific disorders should be distinguished. Whilst more than half of

patients with major depression will recover naturally within 6 months, the risk of a repeat episode exceeds 80% (Judd, 1997). The state is resolved but the disorder does not disappear. What are measures of distress and what are measures of the resolution of a disorder? Ken Howard and colleagues (Howard et al., 1996; Howard, Lueger, Maling, & Martinovich, 1993) suggested that a few sessions of treatment achieved remoralisation where distress is reduced and the patient's hope is restored. Remediation resolves chronic distress and brings symptom relief in four or five months of treatment. Rehabilitation addressing characterological problems takes substantially longer. Only this last category is unequivocally indicative of the treatment of a disorder. I suggest that it may be operationalised as the replacement of pathological or dysfunctional mental processes with healthy capacities leading to continued improvement after treatment termination. As healthy processes replace toxic ones, the client is able to generate an increasingly favourable social context creating a virtuous cycle. To take two examples from the psychoanalytic literature: the Karolinska Institute Study (Sandell et al., 2000) showed that while intensive and non-intensive therapy did not differ in terms of their effectiveness at the end of treatment, only intensive therapy was associated with continued improvement after termination. The St Anne's Partial Hospital Study (Bateman & Fonagy, 1999, 2001) was a randomized controlled trial of borderline patients in treatment as usual or treated with psychoanalytic psychotherapy in a day hospital. The control group showed the expected fluctuating course but the treatment group showed improvements after the 18-month treatment period was over and they were discharged from the program.

Does the notion of clinically significant change provide a solution (Jacobson & Truax, 1991)? The ideal of reducing client scores to a point that is more likely to belong to a community sample is rarely achieved. In its absence, a reliable change score is identified as clinically significant – for example, a 20% reduction in the Brief Psychiatric Rating Scale (Kennedy et al., 1998). But for most scales in current use, it is a risky assumption that a 20 per cent decline relative to base line has the same clinical meaning if the person started at a score of 100, rather than a score of 40. In any case, high symptom scores do not invariably imply high levels of disability. And what if measures disagree? Which of these is more important in determining whether a treatment is empirically supported?

Current categorization in evidence-based psychotherapies conflates two radically different groups of treatments: those that have been found ineffective, and those that have not been tested at all. It is crucial to make this distinction, since the reason that a treatment has not been subjected to empirical scrutiny may have little to do with its likely effectiveness. It may have far more to do with the intellectual culture within which researchers operate, the availability of treatment manuals, and peer perceptions of the value of the treatment (which can be critical for both funding and publication).

The absence of psychoanalytic research raises a related problem that particularly concerns me. A recent study from Lester Luborsky's research team (Luborsky et al., 1999) demonstrates that researcher allegiance predicts almost 70% of the variance in outcome across studies with a remarkable multiple r of .85 if three different ways of measuring allegiance are simultaneously introduced. 92% of the time we can predict which of two treatments compared will be most successful based on investigator allegiance alone. This becomes a pernicious self fulfilling prophecy as investigators who favour less focused more long term treatment approaches are gradually excluded from the possibility of receiving funding and if their treatments are subjected to systematic inquiry at all, these studies are performed by those with least interest in such treatments.

Finally, there is the problem of when two versions of a treatment should be considered as equivalent, in which case the second study is a replication (by some criteria of EBT an independent replication is essential for a treatment to be well established), or, in contrast, when key changes are introduced, in which case, considering the treatments as in the same category may be unwise. This is particularly relevant to more complex multi-component treatments, such as multi-systemic therapy for delinquents (Borduin, 1999) or home visitation, as part of primary prevention of conduct problems (Olds et al., 1998). How do we stop our natural inclination to assume that if the results are what we expected then the researchers must have replicated the original study, and conversely, if they are worse than expected, that they did not follow the protocol closely enough? In meta-analyses, effect sizes are often used to define homogenous clusters of treatments (i.e. all those studies that have similar effect sizes are considered to have manipulated the same independent variable). This is a fine research procedure but as a guide to practice … well, it stinks.

The implication of all these points is that the criteria used to determine what counts as evidence based practice must themselves be empirically tested. Their specificity (the likelihood of falsely identifying a treatment as effective) and sensitivity (the chance of misclassifying an effective treatment as ineffective) should be established against a variety of other public health criteria. The same empirical standards should be applied to these criteria as would be expected in association with other clinical decision making tasks. Face validity, which is what we have, is clearly insufficient. Treatments designated as evidence based by some criteria must be distinguishable from treatments that do not meet these criteria on several concurrent independent but relevant indicators ranging from theoretical coherence to user/consumer acceptability.

The Research Base

Most UK evidence-based treatment reviews have been uniquely based on RCTs. RCTs in psychosocial treatments are often regarded as inadequate because of their low external validity or generalizability (Anon, 1992). In brief, they are not relevant to clinical practice—a hotly debated issue in the field of psychotherapy (Hoagwood, Hibbs, Brent, & Jensen, 1995) and psychiatric research (Olfson, 1999). There are a number of well publicized reasons why randomized

trials in many areas of health care may have low external validity: (1) the unrepresentativeness of health care professionals participating, (2) the unrepresentativeness of participants screened for inclusion to maximize homogeneity, (3) the possible use of atypical treatments designed for a single disorder and (4) limiting the measurement of outcome to the symptom that is the focus of the study and is easily measurable but practically irrelevant dimensions (Fonagy, 1999).

RCTs cover only a limited number of treatments, and there are so many disorders and therapies that it is inconceivable that a matrix of types of therapy by types of disorder could ever be populated by appropriate studies (Goldfried & Wolfe, 1996). Studies that attempt to identify which component of a treatment program is essential to its success frequently find that apparently most of the layers of the onion can be removed and the effect is still there. Many traditional influential supporters of outcome investigations are therefore calling for fewer rather than more outcome studies.
Beyond these fairly well publicized issues, the question arises whether manualized treatments or treatment packages are the appropriate level of analysis in our search for effective interventions. For example, a study by Olfson and colleagues (Olfson, Mechanic, Boyer, & Hansell, 1998) followed up schizophrenic patients discharged from hospital, and found that patients who had contact with the outpatient clinician prior to discharge were better off in terms of symptom reduction than those who had no communication with outpatient staff. Such apparently minor, process parameters of care may be far more important in determining outcome than entire treatment packages. It is hard to imagine that a sufficient number of RCTs could ever be performed to assess all such, potentially key, parameters.

At the root of the problem might be that the model of the mind implicit in current designs of outcome studies of psychological therapies fits poorly with what we know about people as psychologists. Westen and Morrison (Westen & Morrison, 2001) list some of these, I have added others:
(1) The bulk of outcome research assumes that psychological processes are malleable. Yet research, for example on cognitive biases in depression, shows that even remitted depressives tend to have attentional biases favouring depressive content (Williams, Mathews, & MacLeod, 1996).
(2) EBP assumes that the disorder for which patients are referred is their central problem, yet it is most unlikely that psychiatric symptoms alone constitute the reason for referral, since study after study has demonstrated that only one fifth to one half of people who meet criteria for a mental disorder actually seek help for it (e.g. Andrews & Henderson, 2000). Thus it makes little sense to assess the outcome of the treatment merely in terms of the fate of the disorder as this was only one component of their reason for «needing» the intervention.
(3) EBP assumes that it is the specified treatment that accounts for observed improvements. Yet, empirical studies have made it clear that there is at best a loose connection between improvement and the treatment administered. Indeed, some recent research on cognitive therapy for depression suggests that therapist adherence to a manual may actually be negatively correlated with outcome (Ablon & Jones, 1998; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).
(4) EBP assumes that factors extraneous to treatment are not relevant to change. Yet we know that treatment assignment accounts for a relatively small portion of variance in outcome. Naturalistic follow-along studies of even quite severe disorders show that the correlates of improvement or remission are frequently not associated with mental health care systems. They are more likely to be socially supportive experiences, spiritual encounters, improvements in financial circumstances – in general, systems beyond the control of health care. Little is known about the way these might interact with treatment delivery.

Alan Kazdin has proposed a solution to these problems (Kazdin, 2003), but as it would require us to rethink our entire approach to outcome studies and EBP it is unlikely ever to be implemented. Kazdin suggests that treatment research should begin with the identification of key dysfunctions associated with a disorder and the empirical demonstration of these dysfunctions in a sizeable proportion of the clinical group. Further, a conceptual link must be established between a proposed treatment method and the dysfunctional mechanism hypothesized to underpin the disorder. Only when this has been done can manualization commence, followed by the collection of the hierarchy of evidence that forms the body of systematic reviews. Process-outcome studies can then be implemented to establish key treatment components and necessary treatment length. Experimental studies of hypothesized processes and mechanisms need to confirm the correlational findings from process-outcome investigations. Finally, the boundary conditions for the treatment need establishing, in terms of patient and environmental characteristics that promote or undermine the effectiveness of the therapy. This is a radically different approach to the one normally undertaken where the starting point is the evaluation of a designated treatment. Currently the identification of key psychological processes follow post hoc at best. No wonder there are too many different treatment modalities. No wonder that we know so little about why any of them work.

Relevance to Practice

Tremendous informational resources have been made available to support EBP initiatives, whether initiated by professional bodies, governments or purchasers of health care. There are excellent collections of reviews, guidelines and critical appraisals of research evidence, although there is as yet no single comprehensive index that covers all the relevant information, such as the UK Turning Research into Practice (TRIP) database (www.tripdatabase.com) and the databases of the NHS Centre for Reviews and Dissemination (CRD) at the University of York. Such documents are immensely valuable compilations of evidence drawn up to explicitly specified criteria (both search and evaluation). Their advantage, which is at the same time their limitation (beyond the inevitable limitation of the evidence), is that they are often carried out by review experts rat-

her than by practising clinicians. There is no genuine shortcut for the clinician reading the original report rather than taking a trained reviewer's opinion for the significance of findings. The criteria used by the latter principally concern the methodological details of a study, often evaluated relatively superficially.

Clinicians join at the stage of turning systematic reviews into practice guidelines. Clinical practice guidelines are the received method of dissemination. If they are well put together, they combine good research with sensible evaluation of current practice.

Clinical guidelines are summarized on another database at the Centre for Evidence Based Mental Health (www.cebmh.com) or at the National Guideline Clearinghouse™ (NGC) (www.guideline.gov)[1]. The very richness of these sources might discourage some from extended searches. In reality most clinicians have a surfeit of guidelines and it is doubtful whether busy practitioners have the opportunity to thoroughly absorb any extra output. Authors undertake to do regular updating but in practice this is rarely performed.

In addressing the failure of translation of guidelines into clinician behaviour (Chilvers, Harrison, Sipos, & Barley, 2002; Higgitt & Fonagy, 2002), it is useful to differentiate between «diffusion», «dissemination» and «implementation» (Palmer & Fenner, 1999). These are inter-related and increasingly active phases of a process. Publication in a journal article (diffusion) is a passive form of communication, haphazard, untargeted and uncontrolled. The development of practice guidelines, overviews etc. are more active and targeted to an intended audience (dissemination). Implementation is yet more active, with sanctions and incentives, monitoring and adjustment to local needs. The methods for translating guidelines to practice include written materials, educational efforts, product champions, financial incentives, patient mediated interventions and reminder systems. Notwithstanding problems of the currency of guidance, there is a very real question about the extent to which guidance is utilized. At a recent Australian meeting to review the fate of 14 guidelines, none were found to have fared well. The shorter they were, the more likely they were to have had a noticeable impact. Successful implementation was most likely if it was initiated at a local level.

So what is the evidence base for dissemination strategies? The NHS Centre for Reviews and Dissemination published an Effective Health Care Bulletin devoted to reviewing the research evidence on dissemination and implementation of interventions (NHS Centre for Reviews and Dissemination, 1999). The review boasts 44 systematic reviews, altogether covering over 1,000 investigations. The conclusions that emerge are perhaps unsurprisingly far from profound. Thus a «diagnostic analysis» is recommended that identifies all groups involved, assesses the characteristics of the proposed change and the preparedness of the professions involved to change, identifying both barriers and enabling factors. The evidence indicates that dissemination alone is unlikely to lead to changes in behaviour. Multi-faceted strategies that are broad-based are more likely to be effective, but will cost more. Educational outreach, sending of reminders, patient mediated interventions are all effective under certain circumstances, but none is effective under all circumstances.

Part of the problem seems to be that clinicians do not perceive treatment guidelines based on large-scale RCTs as relevant to practice. Addressing this problem will require a paradigm shift in evaluation research along the lines suggested by Alan Kazdin and perhaps, more immediately, 2 other suggestions. The statistical modeling paradigm recommended by Howard and colleagues (Howard et al., 1996) should be given serious consideration as a method for the ongoing evaluation of outcomes in conjunction with «quality control» of treatments. Here treaters monitor treatment effects during the course of therapy constantly estimating likely eventual outcome using, among other techniques, growth curve analysis. This will clearly focus the treater's mind on techniques associated with improvements in particular groups of patients. This method is more relevant to brief treatments of simple disorders.

The essence of this system is its close integration of a standardized assessment protocol, a treatment plan constructed in light of this assessment, and a definition of the outcome goals within a standardized system that permits monitoring of change in relation to service elements provided to patients. The system permits comparisons between individual patients and relevant group norms, between patient groups, between clinicians, and between treatment settings. The computer-assisted reporting of individual records is a further strength of the system. To ensure reliability, there is some need for staff training. The minimization of reporting biases (perverse incentives) is ensured by quality assurance spot-checks in independent assessments. The multi-perspective orientation of the approach is ensured by using additional measures for recording patient ratings on a quality-of-life measure and on a measure of patient satisfaction.

Observational designs may indeed be helpful. But as the British epidemiologist, Archie Cochrane (Cochrane, 1979), whose legacy includes the Cochrane Collaboration, pointed out: «Observational evidence is clearly better than opinion, but is thoroughly unsatisfactory.» (p.3). The answer to the controversy between efficacy and effectiveness studies of psychotherapy may lie in so called pragmatic or «real-world» trials. These minimal effort trials require experimentation in addition to ongoing outcomes measurement.

The experimental component of pragmatic trials includes randomization to alternative methods of care. Importantly, non-specific aspects of care are controlled under these circumstances yet questions of direct relevance to the clinicians may be asked and answered. Patients who participate naturally reflect the clinical population and exclusion crite-

1 The latter is a comprehensive database of evidence-based clinical practice guidelines and related documents produced by the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research [AHCPR]), in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP).

ria are kept to a minimum. Comparison treatments are with routine practice which usually involves combination treatments and treatments titrated according to the client's response. The pragmatic trial imposes minimal constraints on management. The only major sacrifice to internal validity is the loss of blindness in assessment. Blindness, which is likely to be imperfect in psychosocial treatments in any case, may offer little advantage as regards objectivity of outcome assessment. Double blindness imposes unrealistic restrictions even upon routine pharmacological care and deviations from normal practice threaten the validity and generalizability of any cost data used in the estimation of cost effectiveness. Concealment of allocation (the prevention of foreknowledge about the group to which the patient will be allocated if recruited) that is an important source of selection bias, is readily achievable in this context. The unique feature of such trials lies in the relevance of the questions that clinicians may ask of their routine practice. Ideally, clinical equipoise (genuine uncertainty concerning outcome) should drive the search for evidence. In EBP, clinical curiosity is sadly rarely the motivator.

Pragmatic trials could be a key additional line of information for evidence based practice. In combination with more rigorous RCTs (particularly relevant to new treatments) and the judicious use of observational data, they will provide evidence of sufficient richness to significantly advance standards of mental health care. The establishment and support of a profession-wide methodology for pragmatic trials should be considered an important additional task of evidence based practice initiatives.

The Lack of Evidence for the Evidence-Base Approach

While the quasi-positivist epistemology of an evidence-based approach is both logically and ethically hard to dispute, there is surprisingly little evidence on the benefits of an evidence-based perspective to clinical work. Are clinicians who have more up-to-date knowledge more effective than their less well-read colleagues? And if so, what is the effect size of this intellectual effort? How much of the variability in outcomes can it account for relative to harder to regulate variables such as clinician warmth and empathy, or simply the amount of time a clinician spends with a patient? Roth (1999) cautions us that clinicians may be alienated from the evidence based practice endeavour if they see it as a justification for favouring cheap, short-term interventions (where the research is easier to conduct) over longer-term therapies.

Research, with its focus on selected patient populations, cannot tell clinicians what to do with specific individuals. Clinicians have to ask the research database specific questions with an individual client in mind. Posing such questions of this massive accumulation of data and, even more challengingly, obtaining meaningful answers are far more complex skills than that of generating a systematic review. Many hope that clinical guidelines can and will perform the role of translation of research into practice increasingly well. Yet I cannot see guidelines, however sophisticated, ever substituting for clinical skill and experience any more than the Highway Code can substitute for skilled driving. Future research should perhaps look also at the skill with which clinicians implement guidelines and the relationship of that to patient outcome.

It is rarely better not to know. The EBP movement is a method for the integration of the clinical knowledge base which, if pursued with thoughtfulness and rigor, can enhance our understanding of clinical work and yield improved services for a disadvantaged and underserved group. Though sometimes perceived as imposing alien «objective» norms on a practice which prides itself on its intuition and subjectivity, the movement has the potential to liberate the scientist in the practitioner and to empower clinicians to offer improved services by focusing on what they do best: offering informed individualized care to their clients in distress. There is no viable alternative to evidence based practice. Yet the pendulum between research and practice has swung too far and the balance will have to be redressed by moving towards practice as a source of evidence.

We all have a need for certainty and our discomfort with not knowing can put us at risk of anxious retreat from ignorance into pseudo-knowledge (so characteristic of the early years of medicine). A scientific approach has obviously been incredibly helpful and has saved many millions of lives. To argue against it is unethical and destructive. But to argue for a mechanical reading of evidence is equally risky. Evidence has to be evaluated, placed into the context of what is possible, desirable and fits with existing opportunities. In mental health at least but also probably in most areas of clinical treatment, method accounts for a relatively small proportion of the variance in outcome relative to the nature of the patient's problem which may well interact with the skills of the attending clinician. This latter form of variance is to be cherished, not only because that is where the art of psychotherapy lies, but also because it is in the study of that variability that future major advances in health care may be made, as long as we can submit these to empirical scrutiny. ■

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The 18th World Congress of Psychotherapy in Trondheim 2002

The World Congress of Psychotherapy was held in Trondheim, Norway in August 2002. There were gathered 604 participants from 26 countries and all continents. This was the 18th World Congress in a series that started in London 1948.

The main theme of the Congress was «Crossroads of Clinical Practice and Research». Meeting places were created for many clinicians participating, both in the 15 Clinical Workshops, and the more theoretically angled plenary Keynote Lectures, which were followed by 24 Group Discussions.

In the Keynote Lectures there were presentations about evidence-based psychotherapy, research on short term psychotherapies, importance of therapist factors for outcome, assessments to increase effect of interventions, change factors in the psychotherapy process, the neuroscience revolution and its implications for psychotherapy research and practice, the two worlds of therapist and scientist, do they ever meet?

The Workshops covered a broad spectrum of themes, like short term anxiety-regulating therapy, cognitive therapy in anxiety, statistical methods in clinical practice, psychotherapy in children, psychoanalytical child psychotherapy, cognitive therapy with personality disorders, treatment of obsessions and compulsions, interpersonal psychotherapy (IPT) for depression, integrated treatment of serious psychiatric disorder and alcohol and drug abuse, to give silent voices sound in relation to sexual abuse, and conceptual tools for psychotherapy supervision.

The Congress had 32 Symposia, both over themes related to the main theme, and on other themes. In addition there were 47 posters. All in all, there were 194 presentations during the congress.

The Congress opened in the Olav Hall, Trondheims big concert hall, with a solemn opening ceremony, where the University president (NTNU – Norwegian University of Science and Technology), Eivind Hiis Hauge, declared the Congress for opened. Health Minister Dagfinn Høybråten gave an opening speech, and the congress president, K Gunnar Götestam gave an opening address. In addition there were several greetings to the congress, and there were also additional honorary guests present on the podium. The ceremony was surrounded by music, among other things to connect the former congress in Warsaw (represented by music written by Frédérik Chopin), and this one in Trondheim (represented by music written by Chopins favorite pupil Thomas D A Tellefsen, born in Trondheim). A group of small children played a potpourri, giving the audience good music, and a moving moment, towards a good mood for the forthcoming events. This ceremony was followed by a cocktail party, given by the Mayor of Trondheim city. After this intermission, we listened to an exciting opening concert, with many top musicians.

Among the 18 Congresses held so far, 16 have been held in the «Old World», none in the «New World», and two in the «Third World» (Rio, Seoul). In spite of that, the participants to this Congress were coming from all corners of the globe. Many people were busy during the congress, and a core group had been preparing for the congress during the last four years. It was the University departments of Psychology, Psychiatry, and Child and Adolescent Psychiatry, who arranged the Congress, in collaboration with IFP (International Federation for Psychotherapy).

The Congress has attracted a great interest, with many newspaper articles, and programs in radio and television

Next World Congress is planned for the Fall 2006 in Tokyo, with professor Tsutomu Sakuta as president.

Some more information about this, former, and forthcoming congresses can be found on the internet (www.evp2002.no, www.psychotherapy.de). ■

GUNNAR GÖTESTAM, TRONDHEIM
CHAIRMAN, 18. WORLD CONGRESS OF PSYCHOTHERAPY

Singapore, March 12-15, 2003

3rd Asia Pacific Conference on Psychotherapy

The 3rd Asia Pacific Conference on Psychotherapy was held in Suntec City Convention Centre, Singapore from the 12 to 15 March 2003. The theme of the conference was «Breaking Barriers, Building Bonds», a most appropriate theme given the insecure and troubled times that we now live in. It was also appropriate for Singapore where there is a multi-ethnic and multi-religious society.

The conference's plenary speakers included Assoc Prof Stella Quah, a sociologist who expounded on the sociological factors of mental illness and in the psychotherapeutic relationships. She drew attention to the fact that cultural expectations may hinder therapeutic communication as when a culturally inappropriate piece of clothing may distract and distort verbal communication. Prof. Sidney Bloch, the second plenary lecturer, spoke on the social factors involved in disease and how intervention can make a difference. On the last day, Prof Bachtiar Lubis, discussed the cultural barriers that limit the development of psychotherapy in the region and his thoughts as to how they may be eventually be overcome.

The scientific program throughout the 3 days of scientific program consisted of at least 4 concurrent sessions with a wide spectrum of presentations. Practical presentations range from workshops that impart a variety of skills such as music therapy, family therapy, or working with specific groups such as gays and lesbians; to whole day symposium and workshop on Tao Psychotherapy presented by the Korean Academy of Psychotherapy. There were also many academic presentations among the offerings available to participants. Reports of various treatment trials especially those in cognitive behavioural therapy, case studies with Morita therapy, reflective presentations such as the relationship between psychotherapy and psychiatry as well as presentations on theoretical formulations of psychopathology made for an interesting array of discussion, debate and dialogue.

In all, the conference provided for a rich experience of academic exchange and dialogue, skill transfer and sharing as well as for renewing old ties and new friendships. This is apart from sampling a culturally eastern society in an outwardly western city, with its exotic foods and fanciful sightseeing. ■

DR. DOUGLAS KONG
CHAIRMAN, 3RD ASIA PACIFIC CONFERENCE ON PSYCHOTHERAPY

IFP European Congress in Amsterdam Holland, October 2004.
In collaboration with the Dutch Society of Psychotherapy

Mind, Brain and Psychotherapy

The Nobel prize winner Kandel pointed out that psychotherapy has a great and vital future if it wants to listen to biology and especially to neurosciences. On the other hand there is a great future for biology if biologists want to listen to psychology and psychotherapy. Psychotherapy has a lot to offer to biology. Modern research shows us a circular interdependency between psychotherapy and biology. Psychotherapy is on the interface of both: that is the theme of the next European Congress of NVP (Netherlands Federation for Psychotherapy) and the IFP in Amsterdam in October 2004. ■

DR. M.H.M. DE WOLF, M.D.
PRESIDENT NVP