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IFP
international federation
for psychotherapy

newsletter

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Zurich, June 2004

EDITORIAL

According to the specific task of the IFP Newsletter – establishing a continuous communication and forwarding information of ongoing activities in the IFP and in the world of psychotherapy – we come again and bring some more themes concerning IFP.

We do hope you feel quite acquainted with the IFP logo and the new outfit of the Newsletter. Did you also have a look on our website **www.ifp.cc**? It has been installed in January this year by a professional graphic designer. The website is managed by our secretary, Cornelia Erpenbeck. Let me take this occasion to thank her again for her commitment in preparing Newsletter and homepage.

In the **president's message** you will learn about the central task we have to deal with: the changes in the preparation of the 19th IFP World Congress. Prof. Schnyder has also established a well functioning cooperation with our journal «Psychotherapy and Psychosomatics», our official scientific journal. You will find a reminder again in this Newsletter.

We also want to introduce our new **Council Members** by means of short portraits.

Please also read **Prof. Shapiro's paper on brief psychotherapy**. Because of its length the paper will be divided into two parts. The second part will be printed in our next Newsletter.

The Board – apart from the daily business, the budget and the Congress preparations – has been working on the mission statement and on the definition of criteria for acceptance of new members. This way, the status of membership in IFP will be raised and transformed into a quality criterion for their members.

This may remind you that there are **three groups of membership** in the IFP: psychotherapy associations, university institutes and individual members. The Board decided to promote individual membership (which is still very cheap: 20.– Euro per year). If you know persons interested in that please inform them about this possibility.

Another important contribution for our society stems from **Dr. Magnussen**, our former president. He is writing a contribution to the **history of IFP**. We are glad we can announce that Prof. Heim is compiling material of the IFP history. Whoever has historical documents or information on IFP is kindly requested to send it to Prof. Heim directly (email: edgar.heim@bluewin.ch) or to the IFP secretariat.

Dr. Trenkel wrote an **obituary** for Erna Hoch, a long-standing member of IFP who passed away last year.

The **congress calendar** could contain much more announcements. We encourage all member societies to provide information about their congresses to be listed in this calendar. We are also interested in publishing International Congresses where our members collaborate. Please drop us a line to: a.laengle@ifp.cc

Dr. Grosbois reports on the situation of psychothery in France. The full text of his paper in French will also be available on our website.

I hope you enjoy reading this Newsletter and join the spirit of collaboration.

I am sending my best regards again!

ALFRIED LÄNGLE, MD
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Presidential Message

First and foremost, I have to inform you that on the occasion of its meeting on May 23, the Board of IFP has decided not to hold the **19th World Congress of Psychotherapy** in Japan.

A few months ago, we learned that a World Council of Psychotherapy WCP plans to hold regional conference in Tokyo in August 2006. I contacted Prof. Pritz, president of WCP, and Prof. Sasaki, the convenor of the WCP conference in Japan, asking them to either defer their conference, or to do a joint conference. Unfortunately, Prof. Sasaki did not respond to my letter. Furthermore, I consulted with the IFP Council. Clearly, the great majority of Council members advised against a joint conference with the WCP, while a minority suggested joining forces. Given the available information, the Board unanimously decided to follow Prof. Sakuta's suggestion to not hold the 19th World Congress of Psychotherapy in Japan. The decision was taken with great regret as we would have been extremely satisfied to see this important congress taking place in Japan.

On behalf of the Board, I would like to thank Prof. Sakuta for the great effort he and the Japanese Federation for Psychotherapy JFP had put so far into this project which regrettably, and due to circumstances outside of our control, did not come to fruition. Prof. Sakuta will of course continue to be an active member of the IFP Council. Also, we send our best wishes to the JFP: may the JFP continue to flourish so that the IFP will be able to refer to a strong and active partner in Japan!

We are now under great time pressure to find another suitable venue for the 19th World Congress of Psychotherapy. In cooperation with Dr. Douglas Kong, president of the Asia Pacific Association of Psychotherapists APAP which is a chapter of IFP, we are currently ventilating different options in Asia. Only if we do not find a viable alternative to Japan, we will try to find a conference location elsewhere. Any ideas and advice from your side would be greatly appreciated!

The following distinguished colleague has been appointed as new member of the Council of IFP:

- Dr. Michael Robertson, M.B.B.S. (Hons) FRANZCP, Consultant Psychiatrist, Mayo Private Hospital, Lot 1 Potoroo Drive, P.O. Box 480, Taree 2430, Australia

The IFP Board has been keeping a lookout for an affiliation with a first-rate psychotherapeutic journal for some time. Today, I can inform you with great satisfaction that with the beginning of 2004, **«Psychotherapy and Psychosomatics»** will become the **IFP's official journal**. «Psychotherapy and Psychosomatics» does not only comply to refined scientific standards, it is a journal which has kept a vital drive in many fields of current research on psychotherapeutic models and medication. I therefore consider «Psychotherapy and Psychosomatics» and its Editor-in-Chief, Prof. Giovanni A. Fava, as well suited partners in our further endeavours to advance and implant the IFP in the scientific community of psychotherapists and we are very pleased, in deed, with this cooperation.

Beginning January 2004, we have started to publish our own news section in «Psychotherapy and Psychosomatics». These pages contain announcements, our newsletters and other communications concerning our society's public appearance. Our logo and the statement «Official Journal of the International Federation for Psychotherapy (IFP)» appear as inset on the editorial board page. All our members, meaning individual members of the IFP as well as individual members of associations who have membership status with the IFP, are offered a reduced subscription rate by the publisher S. Karger AG. For details, see S. Karger's ad in this Newsletter.

As you may already know, the Board has decided to have the **history of IFP** been written up. We asked its former president, Prof. Edgar Heim, to take on this task, and we were delighted to learn that he was happy to act as «IFP historian». Edgar Heim is now looking for feasible and important historical documents existing within the different member societies. I would like to encourage you to support Edgar Heim in his difficult, but most interesting task. Please find additional information on his request for information in the Newsletter.

I hope you enjoy reading this Newsletter. If you do so, please let me know! If you don't, please give me a note, too!

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Times is of the essence: brief psychotherapy

Time is of the essence: A selective review of the fall and rise of brief therapy research

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For compelling reasons of equity and the advance of public health, brief psychotherapy has become the dominant format in both practice and research. One consequence of this is the apparent decline of a distinct stream of brief therapy research. However, much of the agenda formerly identified with that research stream is of increasing importance to the field. Time is indeed of the essence in current psychotherapy research. For example, factors conducive to the time efficiency of brief psychodynamic therapy have been described recently. The important question 'How much therapy is enough?' has been addressed by studies inspired by the dose–response analysis of Howard and colleagues. The value of ultra-brief interventions has been examined. These issues are considered in a selective review, drawing in particular on the work of the Sheffield/Leeds psychotherapy of depression research group. This research treats the number of treatment sessions as an independent variable, thereby providing a causal analysis of the dose–response relationship over a range from two to 16 sessions, illuminated by a comparative analysis of change processes in treatments of different durations. Its results enable some specification of the extent and nature of incremental benefit derived from additional sessions in the psychotherapy of depression.

Earlier versions of this paper were presented at the International Meeting of the Society for Psychotherapy Research, Santa Barbara, California, June 2002, and at the World Congress of Psychotherapy, Trondheim, Norway, August 2002. ** Requests for reprints should be addressed to David A. Shapiro, Clinical Psychology Unit, Department of Psychology, University of Sheffield, Western Bank, Sheffield S10 2TP (e-mail: david@shapiro.co.uk).*

The concept of *brief* therapy poses the question, 'How much therapy is enough?' Answers have depended on economic and political factors, as well as clinical and scientific factors, and the evidence is best understood in a broader, historical research context. Traditionally, psychotherapy research has sought to improve psychological treatment services through outcome research demonstrating the efficacy of treatments based on established psychological principles, together with process research seeking to specify the mechanisms underpinning the effects of treatment on mental health outcomes. The good news is that meta-analytic reviews of outcome studies have established the general efficacy of psychotherapy for a wide range of mental health problems (Lambert & Ogles, in press). However, such reviews also generally support 'outcome equivalence' (Stiles, Shapiro, & Elliott, 1986) among contrasting forms of psychotherapy (Lambert & Ogles, in press; Wampold *et al*., 1997), although some authors maintain that specific efficacy has been shown for particular treatments of certain disorders (Chambless & Ollendick, 2001). In addition, evidence continues to accumulate, implicating investigator or therapist allegiance in those treatment differences that have been observed in the comparative outcome literature (Luborsky *et al*., 1999). Wampold (2001) suggests that therapist allegiance is the largest single determinant of outcome in psychotherapy research.

The extent to which the findings of efficacy research (demonstrating the most powerful effects attainable under idealized conditions) can be convincingly translated into evidence of effectiveness (extent of health gain obtained in routine service settings) remains debatable. On the one hand, Shadish, Navarro, Matt, and Phillips (2000) returned a reassuring verdict, supporting the effectiveness of psychological therapies that are conducted under clinically representative conditions. On the other hand, Westen and Morrison (2001) found that the more patients were excluded from a trial of psychological treatment, the more favourable were the findings of that trial. This suggests that efficacy trials with rigorous exclusion criteria tend to overestimate the benefits of therapy.

In sum, the traditional approach to developing and testing specific treatment methods has not yielded a robust evidence base for the improvement of psychological treatment services.

Meanwhile, healthcare systems worldwide are under increasing pressure to optimise their cost-effectiveness. Accordingly, since the 1980s, some research focus has been diverted away from traditional concerns with the content and rationale of specific treatments toward temporal or quantitative aspects of treatment delivery that apply to all types of treatment. In particular, the question 'How much is enough?' has been addressed with increasing clarity and with increasingly powerful implications for treatment design since the landmark dose–response analysis of Howard, Kopta, Krause, and Orlinsky (1986).

In this paper, we offer a selective review of the context, origins, and key themes of brief therapy research, before presenting a synthesis of relevant findings from our own programme of comparative psychotherapy process-outcome research.

The growth of brief psychotherapy

Over the first half of the 20th century, traditional psychoanalytic and psychodynamic psychotherapies developed theory, custom, and practice favouring frequent treatment sessions continued for many months or indeed years. In contrast, from the 1940s onwards, there emerged alternative approaches such as behavioural, client-centred, and systemic methods, which were designedly short term. In addition, from the 1960s onwards, the priorities of community mental health services exerted pressures toward brief interventions, including crisis intervention, that could reach more clients. Indeed, 850-session psychoanalysis (Voth & Orth, 1973) was never within reach of many individuals or care-delivery systems in any country. From the 1970s onwards, healthcare systems across the world developed rationing systems such as managed care or an internal market. In response, psychodynamic therapists such as Alexander and French (1946), Malan (1976), and Sifneos (1972), developed brief therapy methods seeking to mobilize the change processes invoked by psychodynamic theory over briefer timescales (typically 25 or fewer sessions).

A significant and long-standing discrepancy between idealized theory and real-world practice concerns the number of treatment sessions undertaken by most clients. Empirical studies have found that psychotherapy clients typically attend surprisingly few treatment sessions (Hansen, Lambert, & Forman, 2002). Even before the impact of the current policy and economic constraints discussed below, the median number of sessions of time-unlimited therapy attended was only five or six sessions (Garfield, 1986; Phillips, 1985).

Research suggests that time-limited and time-unlimited therapies are comparably effective (Orlinsky, Rønnestad, & Willutzki, in press). In addition, costs and the limited availability of trained therapists argue in favour of planning for briefer treatments rather than seeking to extend treatment duration.

Although the majority of clients receive a number of sessions falling within most definitions of brief therapy, a relatively small proportion of patients often take up a high proportion of the treatment sessions. From a public-health perspective, this *utilization paradox*, in the context of efficacy data supporting brief therapy, points to a remediable inefficiency of psychotherapy services. From a utilitarian perspective of seeking the greatest good for the greatest number, placing limits on the number of sessions taken up by individual patients would appear to promise greater aggregate health gain within the population served. However, delivery and reimbursement systems, such as Health Maintenance Organizations (HMOs) and the commissioning arrangements of the UK's National Health Service (NHS), are commonly criticized for the imposition of arbitrary limits of this kind, which appear driven by economic rather than clinical considerations.

In practice, how much therapy is thought to be enough?

In practice, treatment length depends on both therapist and client factors, in addition to features of the service setting. Therapist and client factors may each be formulated in terms of reasons to extend therapy, and reasons to end it.

The therapist will wish to be professional and thorough, and offer sufficient sessions to address the client's needs. In addition, however, this desirable concern for professional standards and quality of care may be self-servingly reinforced (consciously or otherwise) by psychological factors such as the need for validation of one's core beliefs and self-image as a concerned and generous helper. Economic factors may also play a part, whether the therapist is reimbursed on a session-by-session basis or employed in a job whose security depends on demand for services.

Considerations that may incline therapists toward ending therapy include the principles of cost-efficient care, the wish to help the largest possible number of clients to the best possible extent within the limited professional time available. In addition, however, psychological factors such as the relief of discrading the challenging, unrewarding or frustrating client, should not be underestimated. From an economic perspective, some healthcare systems may reward therapists for the number of cases seen, at the possible expense of quality and effectiveness of care.

In considering the client's perspective, it may be difficult to distinguish 'needs' from 'wants'. For example, clients may hope for succour from their relationship with the therapist and want to extend this for as long as possible, or they may feel unable to meet the challenge of the termination of the therapeutic relationship.

Thus, in addition to realistic assessment of the amount of work required to overcome their presenting problems, clients' reasons to extend therapy could include psychological factors such as dependency. They might also include economic factors, as, for example, where continuance in therapy constitutes evidence in relation to claims for compensation or for social security benefits.

Clients may also have reasons to end therapy, ranging from psychological reactions (e.g. resistance to, or outright rejection of, the challenges presented by the therapist) to economic factors such as the time required to attend therapy, often including time away from employment, as well as any fees paid by the client.

In most countries where psychotherapy is established, most clients receive brief therapy, in the sense of treatment lasting no more than about 25 sessions, as a result of policy or economic considerations or the choice exercised by the client. Britain and America, at least, have seen the widespread adoption of treatment models that are prototypically brief, such as cognitive-behavioural (CB), experiential, systemic, and family/couple therapies. Also noteworthy is the considerable influence on practice exercised by published brief therapy models, including those by Davanloo (1980), Malan (1976), Ryle and Kerr (2002), and Sifneos (1972). Nevertheless, the utilization paradox has not been abolished, and a small number of clients typically consume a disproportionate number of most therapists' clinical time. In addition, repeat and extended treatment episodes figure in the work of most therapists, and

these likely reflect the incomplete gains achieved through initial, brief courses of therapy.

The fall of brief therapy research?

Since 1971, successive editions of Bergin and Garfield's *Handbook of Psychotherapy and Behaviour Change* have defined the current status of psychotherapy research and its subfields. Its fourth edition included a review of brief therapy research (Koss & Shiang, 1994). This identified the core principles of brief therapy as including a focus on changes over the client's life span, a limited time being available for therapy, and an emphasis on the working alliance between client and therapist. Technical aspects reviewed include client recruitment criteria, early assessment of the client, and specific therapist behaviours characteristic of brief therapy, including timeliness of interventions, their highly focused nature, the relatively high activity level of the therapist, flexibility of technique, and focus on termination issues.

Koss and Shiang (1994) highlighted brief therapy as a 'proving ground' for psychotherapy research. For the researcher, there are pragmatic advantages to brief therapy, including the readier control of extraneous variables, the relative ease of operationalizing more focused and goal-oriented treatment, and the more manageable logistics of completing studies, including the shorter total time required to complete treatment and secure follow-up data.

Substantive topics reviewed by Koss and Shiang included dose–response analysis, and an overall conclusion, less equivocal than that of Orlinsky *et al*. (in press) cited above, that time-limited therapy is generally more effective, and specifically more cost-effective, than time-unlimited therapy. They also presented mixed results of meta-analytic comparisons between different treatment durations, and the interaction observed by Piper, Debbane, Bienvenu, and Garant (1984) between length and format (individual vs. group), favouring short-term individual or long-term group therapy over long-term individual or short-term group therapy.

Significantly, the fifth edition of the *Handbook* (Lambert, in press) contains no chapter on brief therapy. This reflects the fact that most contemporary psychotherapy research concerns treatments planned to be no longer than 25 sessions, a manifestation of the pervasive influence on practice of brief therapy models. Brief therapy is no longer a distinct subfield of therapy research because brief therapy practice has become mainstream, and the associated research issues have gained pervasive importance. We identify the key issues as: How much therapy is enough, and does this vary with the type of client or problem or therapy?

Ultra-brief therapy: The new brief therapy

Ultra-brief therapies (say, therapies designedly including six or fewer sessions) are emerging in response to the resource constraints of treatment services. These now bear

a similar relation to the dominant 12- to 25-session therapies to that previously obtaining between this latter class of therapies and longer-term therapies of more than 25 sessions, and they give rise to parallel research questions concerning their value and modes of action.

Several studies of ultra-brief therapies exist. For example, Copeland, Swift, Roffman, and Stephens (2001) compared one- and six-session CB programmes imparting skills to promote cannabis cessation and abstinence maintenance. They found benefits of both programmes relative to controls. However, only the six-session group reported significantly reduced levels of cannabis consumption relative to controls. Kunik *et al.* (2001) compared a 2-h group CB session with a group health education session in elderly patients with chronic obstructive pulmonary disease. The CB session secured greater reductions in depression and anxiety, although there was no change in patients' physical functioning. Newman, Kenardy, Herman, and Taylor (1997) found just four sessions of cognitive-behavioural therapy (CBT), supplemented by the use of palmtop computers for practising therapy techniques or for self-assessment, to be a close match for 12-session therapy in the treatment of panic disorder.

Psychodynamic treatment: A special case?

What counts as 'brief' therapy varies with treatment orientation. Currently, only psychodynamic therapists would describe a 25-session treatment as 'brief'. Other approaches, at least as written up in research studies and treatment manuals, are expectedly no longer than this, even when not specifically described as 'brief'. However, it would be worth auditing the number of sessions received by patients in routine practice of CB or experiential therapies. For example, CB treatment of depression could be extended beyond 25 or 30 sessions, if client and therapist both considered it beneficial to extend the work beyond the prototypical number of sessions.

This difference between psychodynamic and other therapies raises interesting and important research questions. For example, does psychodynamic therapy require more treatment sessions to achieve a given therapeutic response than do other modalities that are typically offered in briefer formats? Or does psychodynamic therapy achieve different goals (e.g. something beyond symptom reduction) not achieved by other therapies? Or again, does psychodynamic therapy, when offered in a brief format, require more careful client selection than do other therapies offered in a similarly brief format? Such questions were addressed in the Sheffield Psychotherapy Projects (described below) via comparisons between Psychodynamic-Interpersonal (PI) and CB therapies.

Messer (2001) characterized brief dynamic therapy as applying psychoanalytic principles to selected disorders within a 10- to 25-session format. Treatment uses reflection, clarification, interpretation, and confrontation of interpersonal patterns, wishes, conflicts, and defences, and may be understood using Malan's (1976) concepts

of the triangle of person (current figures, transference, and childhood relationships) and the triangle of conflict (impulses/feelings, defences, and anxiety).

Messer (2001) noted that brief dynamic therapy is characterized by a relatively active therapist, the early formulation of a focus, the setting of achievable goals, and attention to termination issues, and he highlighted studies of adherence to the dynamic focus. For example, a transference focus is associated with poor outcomes where the client is rated low on Quality of Object Relations (QOR) but with good outcomes where the client is rated high on QOR (Piper, Joyce, McCallum, & Azim, 1993). Adherence to the plan, as defined by Weiss, Sampson, and the Mount Zion Psychotherapy Research Group (1986), predict progress in the early- and mid-phases of brief dynamic therapy (Messer, Tishby, & Spillman, 1992). Messer (2001) described brief dynamic therapists as appropriately avoiding clients whose severity of disturbance precludes insight-oriented therapy or who need more time to work through their problems. This approach suggests the value of a trial intervention period to test the client's suitability to the methods of brief dynamic therapy.

Several studies have converged on a likely conclusion that personality disorders or interpersonal problems can weaken therapeutic response to brief dynamic therapy. Hardy, Barkham, Shapiro, Stiles *et al.* (1995) found that depressed clients with comorbid Cluster C personality disorders responded less well to PI (but not to CB) treatment of their depression. Barber, Morse, Krakauer, Chittams, and Crits-Christoph (1997) found that clients with avoidant personalities were slower to improve in brief dynamic therapy than were those with obsessive–compulsive personalities. Messer (2001) summarized the work Høglend and colleagues as suggesting the following patient factors as predicting good outcome of brief dynamic therapy: high motivation for therapy; realistic expectations; a circumscribed problem; good interpersonal relations (QOR); and the absence of a personality disorder. Similarly, Piper, Joyce, McCallum, and Azim (1998) found that good interpersonal relations (QOR) predicted the outcome of interpretive therapy, although not of supportive therapy. This suggests some treatment specificity of this predictor.

Hardy, Barkham, Shapiro, Reynolds, and Rees (1995) uncovered another client variable predicting outcome of PI but not CB therapy of depression. The client's endorsement of the credibility of theoretical principles underlying both treatments, measured before assignment to one or other of these treatments, helped clients benefit from PI but not CB therapy.

The scientific basis for brief dynamic therapy has been strengthened and clarified by studies identifying contributions of both common and specific factors to its outcome. For example, the common factor of therapeutic alliance predicted outcome even when early symptomatic improvement was controlled for statistically (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000). Meanwhile, the specific factor of competent delivery of expressive techniques predicted a change in depression in a study by Barber, Crits-Christoph, and Luborsky (1996). In addition, the further specific factor of accuracy of interpretations predicted outcome in the study of Crits-Christoph, Cooper, and Luborsky (1988).

How much therapy is enough? Dose–response analysis

A seminal paper by Howard *et al.* (1986) presented a dose–response analysis of clinical improvement in psychotherapy. Data from almost 2500 patients were combined from research published over some 30 years. The percentage of patients attaining clinical improvement was plotted against the number of treatment sessions completed. A negatively accelerating curve was obtained, indicative of (1) a minimum number of sessions required to deliver clinical improvement to worthwhile proportions of patient samples and (2) diminishing returns as the duration of therapy substantially exceeded that minimum. For example, by the eighth session, some 50% of patients were measurably improved; this figure had reached 75% after around 25 sessions. This was an important finding.

However, such response rates are only a general guide. As explored by Howard *et al.* (1986) themselves, response rates varied with client characteristics such as diagnosis. In addition, by aggregating different samples receiving different amounts of treatment, and through the likely impact of client choice upon the uncontrolled number of sessions received by each individual, their analysis did not permit causal inference concerning the effects of treatment duration on outcome.

The dose–response analysis was subsequently refined by Howard, Lueger, Maling, and Martinovich (1993) in a 'phase model' defining differential improvement rates for different aspects of the client's functioning. The phase model proposes that client change can be described as passing through three sequential phases: *remoralization*, the enhancement of well-being; *remediation*, the attainment of symptomatic relief; and *rehabilitation*, the reduction of difficulties in life functioning. The phase model attributes the decelerating curve of improvement to the increasing difficulty of treatment goals across these phases.

Howard *et al.* (1993) presented their supporting data in two ways. The first took the form of three curves representing normalized scores for each of the three aspects of functioning distinguished by the model. This presentation failed to distinguish the rate from the amount of change; the improvement curves were essentially parallel. More convincing was Howard *et al.*'s (1993) presentation of 2 × 2 contingency tables classifying patients as improved or unimproved with respect to well-being and symptoms. The relatively small number of patients, at each of three points in time, who were unimproved with respect to well-being but not with respect to symptoms, supported the proposition that a change in the former is a precondition for change in the latter. Similarly, there were substantially more patients at each time point whose well-being was improved but their symptoms unimproved. These results, supporting the causal model postulating that passage through earlier phases is a necessary condition of completion of later phases, are depicted in Fig. 1.

In a related study, Kopta, Howard, Lowry, and Beutler (1994) analysed data arising from multiple administrations of one of four versions of the Symptom Checklist 90 (SCL-90-R; Derogatis, 1983). They made an empirical grouping of symptoms, based on treatment response rates, into three categories (not precisely those of the phase model);

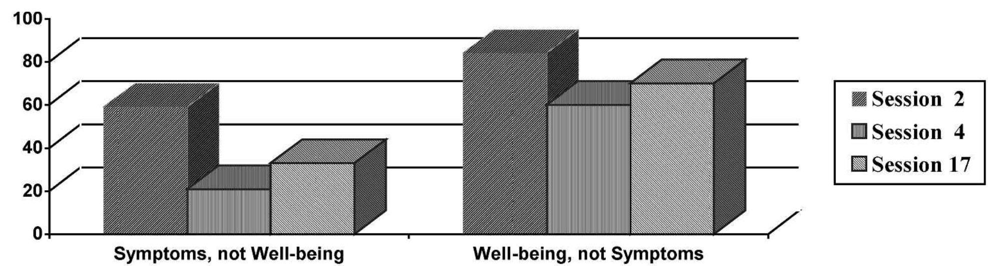


Figure 1. Improvement in well-being and symptoms at three sessions, observed as a percentage of expected numbers of patients differing in improvement status on the two dimensions. Data are from Howard *et al.* (1993). Reprinted with permission.

these were acute distress, chronic distress, and characterological. Recovery rates for the three symptom classes over the course of 52 sessions of treatment differed substantially, although the curves presented do not distinguish rate from amount of change. Thus, the answer to the question 'How much therapy is enough?' was seen to vary with the type of symptom: for example, over 65% of patients had recovered with respect to acute symptoms after some 14 sessions, whereas fewer than 40% had recovered with respect to characterological symptoms at this time.

Hansen *et al.* (2002) analysed a representative sample of randomized clinical trials with a wide range of treatment durations ranging from three (Barkham, Shapiro, Hardy, & Rees, 1999) to around 26. Hansen *et al.* concluded that in carefully controlled and implemented treatments, between 58% and 67% of patients improved, within an average of 12.7 treatment sessions. In contrast, they reported that naturalistic data revealed that the average number of sessions received in a US national database of over 6000 patients was less than five, with an improvement rate of only around 20%. This suggests that it is typical for clients to receive insufficient therapy to secure the improvement rates seen in clinical trials. In addition, the randomized trials are most commonly of CB interventions, whilst naturalistic data, including the original Howard *et al.* (1986) analysis, are predominantly of psychodynamic and cognate therapies. This indicates the need for a systematic evaluation of dose–effect relations in contrasting treatment modalities.

The dose–response and phase models propose that treatment response is negatively accelerated. In terms of cost-efficient service design, this suggestion of diminishing returns with longer treatment has the important implication that relatively strict time limits would be desirable. However, that implication is open to challenge by an alternative explanation. Both models are based on group average curves based on diminishing numbers of clients. If clients improve at different rates and end treatment when they reach their personal goals, the group curve could appear negatively accelerated, even though individual curves were linear (Stiles, Honos-Webb, & Surko, 1998). Should the client's primary goals not extend beyond access to limited information or coping tools and increased hopefulness, maybe two or three sessions

will be enough, and the client will 'drop out' (Given, 2002). A less ambiguous test of negatively accelerated change would be achieved by experimental comparison between treatments of different durations, provided that dropout rates were acceptably low.

Causal analysis of the effects of treatment duration in the Sheffield/Leeds psychotherapy programme

The Sheffield/Leeds psychotherapy of depression programme[1] has pursued a comparative, content-impact-outcome research strategy (Shapiro, 1995) over some 20 years from 1982.

Our research strategy has included the following elements:

- randomizing clients to treatments of different durations, as well as different treatment methods, in a factorial design;
- stratifying clients for severity of depression at intake;
- comparison of within-session content, immediate impacts of sessions upon participants, clinical outcomes, and the relationships among these, as between different durations and methods of treatment;
- a multi-level measurement strategy to enable these comparisons, including observations of within-session content, immediate post-session impact ratings, 'mini-outcomes' or client self-ratings of symptoms and problems at each session, and clinical outcomes assessed at intervals of time that are matched for groups of clients receiving different durations of treatment.

The PI treatment method included in these studies is based on Hobson's (1985) Conversational Model. Using psychodynamic, interpersonal, and experiential concepts, it focuses on the therapist–client relationship as a vehicle for revealing and resolving interpersonal difficulties that are viewed as primary in the origins of depression. The method emphasizes negotiation, a language of mutuality, the use of statements rather than questions, and the offering of hypotheses about the client's experiences and their interconnections. This was compared with a CB method which is multimodal and somewhat more behavioural than Beck's cognitive therapy (Beck, 1995; Beck, Rush, Shaw, & Emery, 1979). It emphasizes the provision by the therapist of cognitive and behavioural strategies for application by the client.

In what follows, this work is selectively reviewed with a focus on studies of the duration of treatment. These have been based on the Second Sheffield Psychotherapy Project (SPP2; Shapiro *et al.*, 1994) and the MRC–NHS Collaborative Psychotherapy Project (CPP; Barkham, Rees, Shapiro *et al.*, 1996). In both of these studies, depressed clients were randomized to either eight or 16 weekly sessions of either PI or CB therapy.

[1] This work was undertaken at the former Medical Research Council/Social and Economic Research Council Social and Applied Psychology Unit under the direction of Peter Warr.

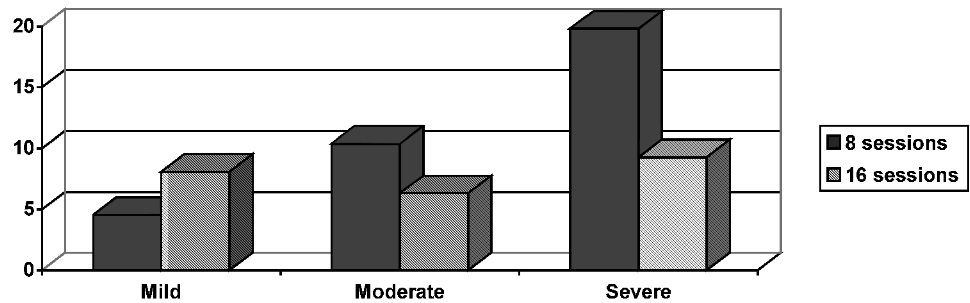


Figure 2. Second Sheffield Psychotherapy Project: adjusted post-treatment mean Beck Depression Inventory for clients with mild, moderate, and severe depression at intake.

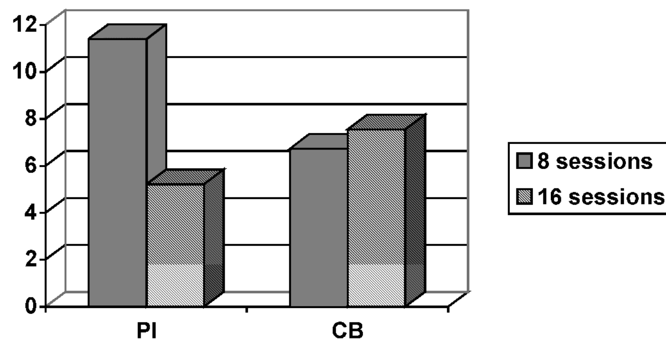


Figure 3. Second Sheffield Psychotherapy Project: adjusted 12-month follow-up mean Beck Depression Inventory following eight or 16 sessions of psychodynamic-interpersonal or cognitive-behavioural therapy.

In addition, Barkham *et al.* (1999) investigated the benefits of ultra-brief treatments using PI and CB methods. These treatments consisted of two sessions a week apart, followed by a review session 3 months later. Data from the above studies were combined by Barkham, Rees, Stiles, Hardy, and Shapiro (2002), to analyse a quasi-experimental comparison between mildly depressed clients receiving eight- and 16-session therapies and clients receiving three sessions of PI or CB therapy in the '2 + 1' format. These studies thus provided randomized or quasi-experimental comparisons between treatments of different duration, enabling a stronger causal analysis of the dose–effect relationship described by Howard *et al.* (1986). Data analyses included analyses of covariance of continuous variables such as Beck Depression Inventory (BDI) scores, alongside response rates defined in terms of reliable and clinically significant change (Jacobson & Truax, 1991) or social comparison (Neitzel, Russell, Hemmings, & Gretter, 1987).

An early product of the group was the first Sheffield Psychotherapy Project (Shapiro & Firth 1987). This compared PI (then called 'exploratory') and CB (then called 'prescriptive') therapies in a cross-over design in which each client received eight sessions of one treatment followed by a further eight sessions of the other. Improvement

on the BDI was greater during the first eight sessions than during the second eight sessions, suggesting negatively accelerated change, but this was not found for the SCL-90.

The second Sheffield Psychotherapy Project (SPP2)

As described by Shapiro *et al.* (1994), in SPP2 we analysed data from 117 depressed clients who had been randomized to, and completed, either eight or 16 sessions of either PI or CB therapy. Prior to randomization, clients were stratified on intake BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) severity as mild (16–20), moderate (21–26) or severe (27 and above). As shown in Fig. 2, a significant interaction between severity and duration resulted in poorer results for severely depressed clients randomized to receive only eight sessions of treatment. This finding did not vary according to whether the treatment was CB or PI in orientation. There was thus no evidence that PI required a greater number of sessions than did CB to achieve a given level of short-term efficacy.

In contrast, data collected 12 months following the end of treatment (Shapiro *et al.*, 1995) revealed substantially less maintenance of therapeutic gains following eight-session PI treatment than following 16-session PI treatment or CB treatment lasting eight or 16 sessions (Fig. 3). This suggests that more PI sessions than CB sessions are required to secure lasting therapeutic gains.

Within SPP2, Hardy, Barkham, Shapiro, Stiles *et al.* (1995) considered whether clients with a comorbid personality Cluster C personality disorder derived any greater incremental benefit of 16 over eight treatment sessions than did clients with no such personality disorder. No significant interactions were found between personality-disorders status and duration of treatment. However, a significant three-way interaction with assessment occasion led to the observation that, at the end of treatment, eight-session clients with a personality disorder did significantly worse on the BDI than those without a personality disorder; in addition, personality-disordered clients receiving eight sessions did significantly worse on the BDI than did personality-disordered clients receiving 16 sessions. These effects were no longer apparent at 3-month and 1-year follow-ups.

Also within SPP2, Hardy, Barkham, Shapiro, Reynolds *et al.* (1995) assessed the credibility accorded by clients to their assigned treatment both prior to their first session (initial credibility) and following that session (emergent credibility). Across both treatment methods, both initial and emergent credibility predicted outcomes of eight-session treatments, and this association remained significant at the 3-month follow-up. However, for clients receiving 16 sessions, neither initial nor emergent credibility significantly predicted outcome after the first eight sessions, at the end of therapy, or at the 3-month follow-up.

History of IFP

As you may already know, the Board has decided to have the history of IFP been written up. IFP past president Edgar Heim was commissioned to do this work for us. In our last Newsletter, we started to publish short summaries of some of our past presidents. Pierre-Bernard Schneider (IFMP president 1969–1979) was the first to share his subjective thoughts and appraisals of the time of his presidency with the current IFP membership. Now it is Finn Magnussen's term: he was IFMP president until 1988. At this point in time, I am not quite sure whether Finn Magnussen took over presidency in 1973 or in 1979. Edgar Heim will clarify the historical details in due time. Anyway, I am delighted to present Dr. Magnussen's summary!

PROF. ULRICH SCHNYDER, MD
President, IFP

The IFP 1958–1988

Annotations on the activities of the IFMP – in the years 1973–1988, during my tenure as general secretary and president.

My earliest memories of the IFMP goes back to the 4th international congress of psychotherapy in Barcelona 1958; I recall the almost prophetic figure of Professor Frankl, with his raised hand and call for the existential core of psychotherapy.

From the following congresses those of us from Scandinavia brought home important impulses and useful contacts with key people in the world of psychoanalytically oriented therapy.

Some time after the Wiesbaden congress in 1967 «The Norwegian Psychiatric Association» was approached on the possibility of having a congress in Norway. It seems that they had offered our Swedish colleagues the arrangement at first but turned to us when the Swedes could not agree among themselves.

At that time I chaired the Norwegian Psychiatric Association, with a board of young and enthusiastic colleagues. The then general secretary, Dr. Fierz, and president, Professor Schneider, visited us in Oslo, to check out our professional and practical credibility, and we needed to get their experiences and ideas of the implications of such an arrangement.

At this 9th international congress of psychotherapy in Oslo 1973 I was elected general secretary at a Board meeting at the end of the congress.

I shall dwell on the organization of this congress because the concept and structuring of it became essential to my work on the board.

We realized early that the point of having such an arrangement was not only to serve the cause of the IFMP and psychotherapy in general, but the leverage it might have on a national level.

Thus, we mobilized as broadly as possible the whole psychiatric community, involving senior colleagues in psychiatry and psychology in an advisory council and many others in various sub-committees. The task might be to show films relevant to therapy, chair discussion groups, organize private parties, cultural events etc.

Our chosen theme, «What is Psychotherapy?» permeated our professional life for some years and we also hosted a two-day pre-congress seminar for all major speakers and section- and group chairmen in order to imbue them with the theme and thus facilitate the expected discussions. And to make it a real congress, that is, a meeting of minds, we aggressively invited participants to enroll in daily discussion groups, according to language preference, after the main mornings lectures. We even managed to have the some 30 discussion group leaders lunch together, to exchange ideas and experiences.

The congress explored its issue from rather extreme positions; dr. Seidel from the DDR saw psychotherapy from his Marxist platform as an adjustment to society, Dr. Szaz from USA saw it as just another way of influencing people. But the main emphasis was on the various clinical and prophylactic implications of psychotherapy, as an attitude or as one of many methods applied on an individual, family, group or community level.

And the strategy of involving as much as possible of the psychiatric community paid off in an increased interest in psychotherapy and a major push to implement an extensive training in psychotherapy in the psychiatric specialty training in Norway.

During my time as president (1979–88) I used this experience when encouraging other societies to plan the next congresses, which appeared to me the main concrete responsibility of the federation, although we also discussed other aims.

It seems that annual European congresses of psychotherapy was initiated as early as 1926, with professor Kretschmer as one of the key persons, and held annually, in Baden-Baden. Carl Gustav Jung was the president from 1934–40. He allegedly made

it into an international federation in order to provide membership for the Jewish colleagues who were ousted from the German societies in the 1930-ies. After the WW-2 the English Dr. Crichton. Miller reorganized the federation and a congress was held in Zurich 1946. This congress discussed «14 gemeinsame Punkte der Psychotherapie aller Richtungen» – an approach which since has prevailed as an ecumenical orientation of the IFMP.

For reasons unknown to me the present numbering of congresses, however, started only with the London congress in 1948.

The IFMP has subsisted on a minimal economy, based on small per capita fees from the various member societies, barely covering expenses for stamps and stationary and the very occasional travel for board members to secure congress venues.

During the Oslo congress we became aware of the psychotherapy societies in Eastern Europe and their great difficulties, economically as well as politically, in participating in a normal professional exchange. We had the opportunity to invite some of them to the Oslo congress, and from this grew an awareness of the use of the IFMP to support these societies by visiting them and thus represent a window to the West, which seemed welcome.

Over the following years some of the board, not least myself, attended and spoke at national psychotherapy meetings in Erfurt, Dresden, Warsaw and Krakow, one of the meetings even specifically intended as an East-West-German get-together. Our past gen. secretary Michael Geyer will be able to comment on this aspect of the IFMP as he was a key person in DDR. We even discussed the possibility of having the 1991 international congress as a joint German arrangement, long before the Berlin wall fell. It went to Hannover, as a West-German affair,. but to my regret it did not use this excellent opportunity to focus on the mental hygiene and therapeutic implications of such a dramatic and possibly traumatic event as the unification must have been.

On the wider international level we never managed to interest the large and self-sufficient Anglo-American psychotherapy societies, in spite of serious attempts. It seemed that we served our purpose by being an umbrella organization for smaller societies worldwide, who felt the need for a common ground.

We did, however, try to broaden our scope by seeking congress venues internationally, with a first ever congress outside Europe, in Rio de Janeiro, in 1982.

The board also managed to keep representatives from all over the world, from Chorea and USA, Australia, India in addition to the core European societies, representing at times some 40 different member societies.

Suggestions were forwarded during the 1980-ies for regional chapters, e.g. in Latin-America. The German. speaking world, The Far East. The idea was that such organizational structures would be of use in between the triennial congresses. At the time the larger board voted down the suggestions with the argument that time was not yet ripe, whereas the executive board had felt the need for such expansions.

Essentially – as the IFMP is an umbrella organization for national and regional societies but also more narrowly defined psychotherapy groups, and not a service union for individual members, there were obvious limits to its activities. That left us with the task of providing a tradition of international congresses, and in particular to find the professional groups and milieus which not only was capable of managing such an event but which also could make good use of it in their own development at that time, in addition to give a world-wide audience a chance to meet the key people in psychotherapy research and practice.

FINN MAGNUSSEN, MD
Bjernveien 127 0773 Oslo, Phone 22 14 05 70

Erna Hoch (1919–2003)

It was on a hot day last summer that we learned that Erna Hoch had «passed away peacefully and painlessly in her sleep» – as her sister broke the sad news to us. Our late colleague had spent her last fifteen years living in Carnago in the Swiss canton of Ticino, after having lived much of her professional life in India from 1956 to 1988. Between 1969 and 1980, she was Professor of Psychiatry at the Government Medical College in Srinagar and, at the same time, she was the director in charge of the only psychiatric hospital unit in the whole of Kashmir.

Throughout all those years abroad, Erna Hoch stayed in professional and cultural contact with her homeland in the West, including regular attendance and lecture presentations at the «Zürcher Gespräche» («Zurich colloquia»), where representatives of different fields came together for an interdisciplinary, transcultural exchange of views on the vital intellectual and psychogenic issues of the day. Erna Hoch was an occasional participant at specialist national and international conferences too, for instance the 1976 IFMP congress in Paris, where she presented a paper on the significance of instant events in the psycho-therapeutic process.

The author of these reminiscences first made Erna Hoch's acquaintance at the time he was the IFMP treasurer – to begin with only by name. Her membership records showed that she was one of very few loyal individual members of the international federation, who did not belong to any national grouping (in her case, neither a Swiss nor an Indian one), and who, incidentally, could always be relied on to pay her modest membership contribution.

Her formal status within the federation was a perfect parallel with the life she led for many decades as a «bridge between the worlds» and she was extremely skilful at carving it out in such a way that it bore much fruit for the two banks it joined and for herself too. This is witnessed in the compelling account contained in her last book, **«Das Irrenhaus am Lotos-See»**. In it she describes what she experienced at first-hand as she journeyed between continents and mentalities. Anyone reading this extraordinary narration can follow step by step how this native of Basel, in her job as a medical practitioner, faces up to the complex task confronting her with expertise and deeply-rooted knowledge. At the same time, she allows herself to take in the enchantment of foreign climes, for which she opens up the deepest interest, but never ceases to be herself. The reader can readily appreciate what the course of the writer's own life must have been like, as she advances from the committed helper, which is how it all began for her, to an erudite, sympathising «dual citizen», who has grown intimately familiar with the world of her chosen home.

It was in this role of «dual citizen» and with her commensurate skills in «trans-lating» that she generously made herself available to serve both sides, and the IFMP was always grateful to be able to call on that generosity whenever it needed to weave a mesh of contacts between the West and the East.

Given her western perception of psychotherapy, Erna Hoch felt particularly close ties with the existential analysis of Medard Boss and those around him and she remained in continuous dialogue with him even when she was in India. Medard Boss was also renowned for his interest in building intercultural bridges, and it was something he put into practice within the IFMP too during his time as the federation's president. Over a period of many years, Erna Hoch was something like a landmark for him in India, whilst it was through him that she, in turn, had several opportunities of voicing her views in the West and of relating her experiences there. Their dependable mutual relationship also brought lasting benefits for the IFMP. When the undersigned contacted Medard Boss in the run-up to the 1988 Congress in Lausanne to ask his assistance in finding suitable speakers from Asia, he received a one-sentence reply: «our colleague, Erna Hoch, knows all there is to know in India». After that, «our colleague» gave us the benefit of her sound advice, and that was by no means limited to India. She turned out to be an equally essential go-between for Japan and Korea too and, finally, she also helped us translate a number of documents. Erna Hoch gave us moral and practical support on later occasions too, especially, of course, in preparing the 1994 Congress in Seoul.

In latter years, the «dialogue between the worlds», although gradually beginning to wane, was prolonged on many a Ticino stroll.

ARTHUR TRENKEL
Massagno, Switzerland

Congresses

Vancouver, Canada, July 22–25, 2004

3rd Biannual International Conference on Personal Meaning

The conference theme focuses on the positive existential psychology of transforming loss, trauma, illness, suffering, grief and death.
www.meaning.ca/conference04

Seoul, Korea August 21–22, 2004
International forum on Tao psychotherapy and western psychotherapy

Lotte Hotel

Program 1 (August 21, 13.30–16.20)
«What is Tao Psychotherapy?» Co-Chairs: Peter Kutter, KANG Suk-Hun, Presenter: HUH Chan Hee
«Introduction to Tao Psychotherapy» Presenter: RHEE Dongshick
«The essence of Tao Psychotherapy in comparison with Western psychotherapy/psychoanalysis»; Discussants: Allan Tasman, Erik Craig
Program 2 (August 21, 16.30–18.40)
«Tao Psychotherapy Case» (1); Case introduction: KIM Jong-Ha, CHOI Tae-Jin; Chair: Erik Craig; Presenters: Peter Kutter, Allan Tasman, LEE Dongsoo
Program 3 (August 22, 9.00–12.00)
Panel: The Meeting of the Ways: Psychotherapy East and West; Chair: Erik Craig; Presenter: Peter Kutter
«Contemporary schools of psychoanalysis (classical Freud, independent group, Klein-Bion, Self Psychology), compared with Tao»; Presenter: KANG Suk-Hun
«Ways to be a bodhisattva and to be a psychotherapist»; Presenter: Erik Craig
«How is it Tao, Dasein, and Psyche? An Inquiry into Theoretical and Therapeutic Implications»; Discussants: Allan Tasman, LEE Zuk-Nae
Program 4 (August 22, 13.30–15.40)
«Tao Psychotherapy Case» (2); Chair: Allan Tasman; Case introduction: OH Dong-Won, RIM Hyo-Deog; Presenters: Erik Craig, Peter Kutter, RIM Hyo-Deog
Program 5 (August 22, 16.00–18.00)
Meet Prof. Rhee, the Founder of Taopsychotherapy (East and West Dialogue in Psychotherapy); Peter Kutter, Allan Tasman, Erik Craig, Sharon Summers, Julian Boulnois, Vijoy Varma, Norbert Vogt

Amsterdam, The Netherlands, Nov. 26–27, 2004

European Congress for Psychotherapy

RAI Congress Center

Both in science and in clinical practice is great evidence that co-operation between disciplines is very important. The fields of psychology and psychotherapy are no exception to this. There is a great future for the development of psychotherapy if it takes advantage of the results which are found in neuroscience and biology. On the other hand biology and especially neuroscience can take advantage of results of research in psychology and psychotherapy. The dialogue between both branches is the main theme of this conference.
Organising Committee: Dr. Thijs de Wolf, president; Drs. Gerrit Paarlberg, secretary; Drs Peter Dekker, treasurer; Drs Ria Reul-Verlaan, IFP
www.psychotherapie.nl; www.psychotherapy.de

Vienna, Austria, April 29 – May 1, 2005

Die verletzte Person Trauma und Persönlichkeit – Kinder und Jugenliche

Kongresszentrum Messegelände

In Referaten, Symposia und Workshops wird dem Einfluss der Traumagenese in der Entstehung von Persönlichkeitsstörungen nachgegangen sowie protektive Faktoren diskutiert.
Organisation: Internationale Gesellschaft für Logotherapie und Existenzanalyse. Referenten: A. Längle, U. Reddemann, U. Schnyder, L. Tutsch u.a.
www.existenzanalyse.org
a.laengle@existenzanalyse.org

Taipei, Taiwan, September 24–28, 2005

- **7th Pacific Rim Regional Congress of Group Psychotherapy**
- **4th Asia Pacific Conference on Psychotherapy**

Howard International House

Theme: Containment with courage in a century of challenges
Information: WEN Jung-Kwang, MD, President
Taiwan Association of Psychotherapy
tap79637@ms.71.hinet.net; www.tap.org.tw

Regulation plan about psychotherapy in France: inventory of fixtures

Some news from France where there is a plan to regulate psychotherapy in the frame of the reform of public health politics. In France, a law project has to be examined first by the National Assembly (deputies), then by the Senate (senators), a second time by the National Assembly and finally by the Senate or a mixed Committee with parity of representation of the two chambers. Then will be settled the application decrees by the Health Minister.

The National Assembly adopted the following amendment the 8th of October 2003:

«Psychotherapies constitute therapeutic tools used in the treatment of mental disorders. The different categories of psychotherapy are settled by decree of the health minister. Their implementation are only on the responsibility of physicians or psychologists professionally qualified by this decree. The National Agency for Accreditation and Evaluation in Health brings its participation to draw up these conditions.

The professional now in activity and not qualified who practice psychotherapies since more five years at the publication of this law, will be authorized to pursue this therapeutic activity on condition to satisfy in the three years after the present law to an evaluation of their knowledge and practice by a jury. The composition, the attributions and the working modalities of this jury are settled by a joint order of the health minister and the education minister».

All the professional organizations (psychologists, psychiatrists, psychoanalysts and «psychotherapists» who defend in France the regulation of a new profession independent of medicine and psychology on the model of Austria and the European Association of Psychotherapy) contested the reduction of psychotherapy to «tools» (technical and instrumental point of view) and to the treatment of mental disorders. The second unanimous objection was about the role of the National Agency for Accreditation and Evaluation in Health which is a department of the Health Minister which has only a technocratic and economic point of view about psychotherapy like in USA.

The Senate adopted a new version of this amendment the 19th of January 2004 axed not yet on the protection of the practice but on the title of psychotherapist (Mattei amendment, Health minister)

«To use the title of psychotherapist is reserved to the professionals recorded in the national register of psychotherapists. The registration is recorded on a list settled by the State representative in the department of their professional residence. Are exempted from the registration the holders of a doctorate of medicine, the psychologists holding a State Diploma and the psychoanalysts regularly registered in the annuals of their associations. The modalities of application of the present article are settled by a decree».

The objection of the professional organizations was on the fact that every physician (not only psychiatrists) would be authorized to practice psychotherapy by this law. The psychologists contested that the law plan notifies a State Diploma which doesn't exist for psychologists! (it exists in the health field for paramedics, but psychologists are not a paramedical profession; the threat was to put psychologists under the supervision of the physicians). Some psychoanalytical associations contested to present their annuals to the Health Minister under the reason their activity has to be totally independent from the Government and psychoanalysis is not concerned by this plan.

This text was examined by the National Assembly the 7th of April 2004 and it added the first section on the necessity of a training in psychopathology (Dubernard amendment, deputy of the majority and President of the Social Matters Committee of the National Assembly)

«To practice psychotherapy requires either a theoretical and practical training in clinical psychopathology or a training recognized by the psychoanalytical associations. To use the title of psychotherapists is reserved to the professionals recorded in the national register of psychotherapists.

The registration is recorded on a list settled by the State representative in the department of their professional residence of people wishing to use the title of psychotherapist. This list notably mentions the trainings followed by the professional. It is actualised, put at the general public disposal and regularly published. In the case of a transfer of the professional residence in another department, a new registration is compulsory. Tha sa me obligation stands out for the people who, after two years of interruption, wish to use again the title of psychotherapist.

Are exempted from the registration on the list mentioned at the previous alinea the holders of a doctorate of medicine, the people authorized to use the title of psychologist in the conditions defined by the article 44 of the law settled different provisions of social matter n° 85–772 of the 25 of July 1985 and the psychoanalysts regularly registered in the annuals of their associations.

The modalities of application of the present article are settled by a decree in State Council». The first section on psychopathology training was asked by psychiatrists and psychologists organizations but it is strongly contested by the psychotherapists associations who represent in France the humanistic trend in psychotherapy (historically Californian body therapies: bio energy, primal therapy, rebirth and so on) which are in the confusion between personal development and psychotherapy and refuse the difference between normality and mental pathology.

Now, before the examination of the law plan again by the Senate (in June 2004), we struggle both psychiatrists and psychologists for a psychopathology training at university as a pre-requisite training and against the regulation of a title of psychotherapist which would open to the recognition of a new profession. We consider that psychotherapy is essentially a further training of psychiatrists and clinical psychologists. We are not against the fact that other people than psychiatrists and psychologists practice psychotherapy but under the conditions they have a previous in psychopathology to secure a minimum the patients. So we agree for a regulation of the practice of psychotherapy but not for a regulation of a title of psychotherapist.

The fight goes on!

PHILIPPE GROSBOIS
IFP Council Member
Manager of the National Specialized Committee on Psychotherapy of the French Union of Psychologists

Call for historical documents

IFP is probably one of the oldest, if not the oldest, international umbrella organization in the area of psychotherapy. Its roots go back to the early Thirties of the last century. Over the years there have been considerable changes in its goals and structure.

The present board decided therefore to have the history of this organisation been written up. It therefore asked its former president, Prof. Edgar Heim, to take upon himself this task which he gladly accepted. To be able to do so he is looking for feasible and important documents existing within the different member societies, such as:

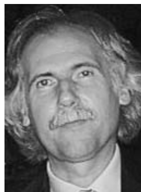
- Programs and Proceedings of earlier congresses or symposia, either organized by the IFP or by member societies.
- Documents and correspondence concerning major changes or debates within the member societies, especially when dealing with school orientation or membership definition.
- Listing of outstanding events or members acting for or within the member societies.
- Reports or publications on the history of psychotherapy at large.
- Any suggestions how the truth-finding of the past of this umbrella organization or the development of the field of psychotherapy as such can be documented.

To allow for prompt processing of the available documents the board would appreciate to be hearing from you in the near future.

Once all material is available a report will be written up which, of course, then would be distributed to all member societies. The report will also be published on the IFP website.

PROF. ULRICH SCHNYDER, MD
President, IFP

New Council Members



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