

01.05 newsletter



IFP

international federation
for psychotherapy

Zurich, June 2005

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EDITORIAL

Dear colleagues,

as time goes by we show up again with a new edition of our Newsletter. As you may hopefully have experienced this journal provides a constant link between our members - a modest sign of the vitality in IFP.

As usual you find in this edition the actual information by our president as well as a short presentation of our new Council members. A new section of IFP history written by our former president Prof. Edgar Heim gives insight into the IFP life.

It was at the European Congress of Psychotherapy last November in Amsterdam where Prof. Klaus Grawe presented a paper about the latest results of neuroscience under the aspect of their practicability for psychotherapy. Grawe's intention was the foundation of a form of neuropsychotherapy. He was kind enough to allow this paper to be published in this Newsletter. We are very grateful to have this intriguing presentation.

I send you my best wishes for a pleasant summer in the northern hemisphere and an easy winter «down under»!



ALFRIED LÄNGLE, MD
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Presidential Message



The planning of the **19th World Congress of Psychotherapy** is well under way: it will be held in the Shangri-La Hotel in Kuala Lumpur, Malaysia, 22.–26. August 2006. Prof. Thambu Maniam, president of the Malaysian Psychiatric Association, and myself will collaborate as co-chairpersons of the organizing committee, while Prof. Zain Azhar will act as president of the scientific program committee. The theme for the Congress will be: „Well-being across cultures: psychotherapy in a biological era». For more information, please refer to the preliminary announcement in this Newsletter.

A number of **new Council members** have been nominated: Prof. Mechthild Neises, Germany, Prof. Maniam Tambu Malaysia, and Prof. HUH Chan Hee, South Korea. A warm welcome to these distinguished colleagues! I am looking forward to working with you! Furthermore, we have introduced a new

membership category: the IFP now officially accepts individual members of IFP. Please spread the gospel, and encourage your colleagues to apply for individual membership! All our members, meaning individual members of the IFP as well as individual members of associations who have membership status with the IFP, are offered the IFP's official journal, **«Psychotherapy and Psychosomatics»** at a reduced subscription rate. For details, please contact S Karger directly at:

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The Board and Council have approved of our new **Mission Statement**:

1. The IFP is a worldwide umbrella organisation for psychotherapy. The Federation is open to professional societies, institutions and individual members.
2. The IFP aims to promote, endorse and maintain high professional and ethical standards of psychotherapy in practice, research, and training.
3. The IFP fosters a worldwide intercultural, interdisciplinary dialogue and mutual learning among psychotherapists, psychotherapy researchers, psychotherapeutic orientations, traditions, and related sciences.
4. The IFP provides a platform for the development of theories, methods and treatment approaches, and promotes the integration of psychotherapeutic thinking in clinical and non-clinical fields.

The IFP realizes its aims by means of

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

During the inauguration ceremony of the new permanent secretariat of the World Psychiatric Association in Geneva, Switzerland, in May 2005, I had some very promising informal talks regarding a closer collaboration with WPA's psychotherapy section. During our last Board meeting in May, 2005, I was mandated by the Board to start negotiations with the WPA.

Finally, with my presidential term coming to an end in August 2006, I would like to invite everybody to come forward with nominations for the presiden-

tial term 2006–2010. Elections will be held at the General Assembly which will be scheduled during the 19th World Congress of Psychotherapy in Kuala Lumpur.

Wishing you all a wonderful summer!

PROF. ULRICH SCHNYDER, MD
President IFP
u.schnyder@ifp.name

New Council Members

PROF. DR. DR. MECHTHILD NEISES

- Biology, dietetics and medicine studied at Bonn, Berlin and Hanover
- Doctorate in biochemistry (Dr. rer. nat.) – 1977
- Doctorate in neuropsychopharmacology (Dr. med.) – 1984
- Registration as a specialist (Facharztanerkennung) for gynaecology and obstetrics – 1988
- Ten year's work as an assistant medical director (Oberärztin) and finally the managing assistant medical director (geschäftsführende Oberärztin) at the Gynaecological University Hospital of Mannheim, Clinical Faculty of the Heidelberg University, Director: Prof. Dr. F. Melchert
- Habilitation in gynaecology at the Heidelberg University with a subject from the specialist field of psycho-oncology in 1995
- Psychotherapy training in Psychosomatic and Psychotherapy Institute – 1998
- Director of the Functional Division of Psychosomatic Gynaecology and Obstetrics at the Medical College of Hanover; Director. Prof. Dr. F. Lamprecht since 1998
- Member of the scientific advisory committee of the journals *Onkologie*, *Gynäkologische Praxis*, *Zeitschrift für Geburtshilfe und Frauenheilkunde*, *Zeitschrift für Psychosomatische Medizin und Psychotherapie* since 1995
- Member of the scientific advisory committee of the Cancer Information Service (Krebsinformationsdienst – KID) of the German Cancer Research Center of Heidelberg since 1995
- Member of the scientific advisory committee of the working group *Frauengesundheit in Medizin, Psychotherapie und Gesellschaft*, AKF e.V. from 2001 to 2003
- Member of the scientific advisory committee of *Deutsche Gesellschaft für Psychosomatische Frauenheilkunde und Geburtshilfe e.V.* since 1996
- President of *Deutsche Gesellschaft für Psychosomatische Frauenheilkunde und Geburtshilfe*, DGPPF e.V. from 1999 to 2005, Past President since 2005
- First Chairwoman of *Allgemeine Ärztliche Gesellschaft für Psychotherapie*, AÄGP since 2003

Major fields of work

1. Psycho-oncology, including the aspects of quality of life, disease management and psychoimmunology
2. Implementation of an intervention programme to promote the prenatal relationship between mother and child in cooperation with the Gynaecological University Hospital of Mannheim
3. Since December 2001 DFG-promoted project to examine the influence of life events in the course of breast cancer diseases

Subjects of doctor's thesis and habilitation

Neises, M., (1977)

The incorporation of N-acetyl-D-glucosamin in cell nuclei of *Diclyostelium discoideum*. Fachbereich Biologie, Freie Universität Berlin

Neises, M. (1984)

Experimental Studies on the modulating effects of Tetra-hydronorharman (TNH) on serotonergic neurons using the Superfusion Technique. Fachbereich Medizin, Freie Universität Berlin

Neises, M. (1995)

Course of the disease of patients with breast cancer-immunologic, endocrine and psychometric parameters



PROF. DR. KLAUS GRAWÉ

Prof. Dr. Klaus Grawe, geb. 1943. 1963–1968 Studium der Psychologie in Hamburg und Freiburg i.Br. 1969–1979 Klinischer Psychologe an der Psychiatrischen Universitätsklinik Hamburg-Eppendorf, Schwerpunkt stationäre Psychotherapie. 1976 Promotion. 1979 Habilitation.

Seit 1979 Inhaber des Lehrstuhls für Klinische Psychologie und Leiter der Psychotherapeutischen Praxisstelle der Universität Bern, seitdem Schwerpunkt ambulante Psychotherapie.

Past President der Society for Psychotherapy Research und Gründungs-Herausgeber der Zeitschrift Psychotherapy Research. Autor zahlreicher Studien zu Fragen der Wirksamkeit und Wirkungsweise von Psychotherapie.

**MICHAEL ROBERTSON, M.D.**

Dr Michael Robertson is a consultant psychiatrist based at the Royal Prince Alfred hospital in Sydney. He is a conjoint lecturer with the New South Wales Institute of Psychiatry and the University of Sydney. His areas of interest include Interpersonal Psychotherapy (IPT) and the psychotherapeutic treatment of traumatic stress syndromes.

Dr Robertson is the co-author of Interpersonal Psychotherapy – A Clinician's Guide, published in 2003. He has conducted training in IPT and treatment of trauma in Australia and internationally. His research has examined areas including the nature of traumatic stress in late life and the treatment of PTSD using newer modalities of psychotherapy.

Dr Robertson has also written a number of theoretical articles on psychotherapy and post-modernist thought.



Psychotherapy in Russia: History and Current State

At the beginning of the last century psychology and psychotherapy grew intensively in Russia. Publications of Freud and other psychoanalysts were actively translated into the Russian language and rigorously debated. However, by 1936 a special government decree was passed that placed virtually all applied psychology and psychotherapy under prohibition. As a result, further development of psychology and psychotherapy in Russia fell under a long period of stagnation.

Research and treatment approaches in Russian psychiatry during the soviet era traditionally focused on biological factors. The importance of psychosocial variables was therefore underestimated. Mainstream psychiatry during this period dealt primarily with linear biological models of causality. Furthermore, political attitudes would not accept the presence and influence of unfavorable psychosocial conditions in a happy soviet society. The Center of Mental Health (Russian Academy of Medical Sciences) was one of the biggest psychiatric settings during the soviet era. We worked at the Center for more than ten years from 1983-1996 until our transition to the Institute affiliated with the Ministry of Public Health, which we represent today. Widely known Russian psychiatrist A.N. Snejnevsky guided the Center of Mental Health. The main research focus of the Center was schizophrenia. The rate of diagnosis for schizophrenia in Russia was higher than in western European countries such as Germany, France and Spain. Using current criteria, many of these cases might have been diagnosed as depressive, anxiety, somatoform or personality disorders. In many instances, however, «slowly progressive» schizophrenia was diagnosed. While therapeutic resistance to medication has been considered one of the most important criteria of this illness, psychotherapeutic interventions had minimal value since biological factors were seen as playing the main causal role in the origin and maintenance of mental disorders. Application of psychotherapeutic interventions for schizophrenic patients was seen as meaningless and virtually no one practiced them.

In the case of neurotic conditions and chemical addictions, behavioral methods based on reciprocal inhibition and the Pavlovian model of conditioned response, gained acceptance. A Russian variation of aversive techniques (known as «coding techniques») has been widely used in the treatment of alcoholism.

The fundamental idea behind these methods is the transformation of positive conditioned responses into negative ones. In contradiction to research which shows the ineffectiveness of these methods applied alone, they are still widely used as the main treatment interventions. Complex treatment programs like «12 steps» are gradually being disseminated but the number of settings where they are implemented is limited. Techniques of sameschtschenija reakzii have also been applied in the treatment of phobias. Through systematic desensitization, fear reactions have been transformed into neutral or positive ones. Seemingly, the most common treatment approaches have been hypnosis and relaxation. In 1912 the book, «Rational Psychotherapy» by French psychiatrist Dubois was translated into Russia. It has had a wide resonance within the professional community in Russia. Correction of a patient's irrational and maladaptive beliefs, namely, beliefs concerning their illnesses, was seen as an important psychotherapeutic tool. During the soviet era, theoretical concepts of psychoanalysis were considered ideologically wrong and never applied in practice. We did not have the slightest knowledge of cognitive, systemic and humanistic therapies.

Much has changed in the field during the Perestroika era. Psychoanalysis has become the only therapy to receive support at the governmental level. Boris Eltsyn passed a decree to restore and develop psychoanalysis in Russia. It is rumored that Eltsyn's wife was a close friend with one of the employees of the Center of Mental Health who had undergone a training course in psychoanalysis abroad. Likely this situation, rather than a desire to reinstate psychoanalysis, impacted the President's initiative. Since then, several Institutes for Psychoanalysis have been started. Unfortunately, the qualification level of the Institute's graduates is far from perfect. The same can be said about training in other approaches, where standards do not correspond to international norms and specialists are seen as a threat to patients rather than delivering care.

In 1990, the first «cabinet for neurotic disorders» was opened in a primary care setting. It was the first service to be separated from psychiatric hospitals. We were both offered positions as clinical psychologists in this cabinet. We were greatly surprised by the high rates of chronic forms of disorders. In some instances, patients with severe and chronic forms of

depression and panic disorders, for example, had gone undetected and untreated for more than 10 years. Some patients were afraid to see a psychiatrist in official out-patient psychoneurological clinics. Some patients initially decided to seek help, when they saw a sign «cabinet of neurosis», others were treated by doctors of internal medicine with no result. Our cardiologists, neurologists, endocrinologists and other internists were obviously lacking the skills to recognize and treat mental disorders. Their attempts to cure depression or anxiety often led to iatrogenic reactions that worsened the patient's condition. Psychiatrists at the Center of Mental Health had traditionally viewed many of the visitors to our cabinet as suffering from schizophrenia. In recent years, the importance of implementing a combination of psychological treatment with medication has had good effects with significant relief of symptoms and in many cases a full recovery.

The shortage of qualified psychotherapeutic help remains one of the most dramatic problems in the Russian Mental Health service today. The application of evidence-based psychotherapeutic methods continues to face many obstacles. The appearance of numerous western methods in Russia has been both positive and negative. Many methods accepted by Russian psychotherapists are not classified as having scientific rationale or have not proven their efficacy in controlled trials. For example, the method of NLP, which does not seem to be highly acknowledged in the western professional community, has gained wide acceptance in Russia. Further, an army of «magicians, healers and sorcerers» is rapidly growing when in fact the request for professional psychological help is only slowly developing within the Russian population. Lack of research in psychotherapy compounds this serious problem. We have to mention two possible explanations for this: first, the lack of financial resources and second, the lack of tradition in Russia for this type of scientific investigation.

Today only doctors of psychiatry have the right to receive an official license to practice psychotherapy. But legislation and everyday practice diverge significantly. Psychologists appear to be the most active in the psychotherapy-related fields and are officially recognized under the label «psychological counseling». Psychotherapy is not a free service under the Russian public health system. Therefore, it remains

inaccessible to the broad masses. Publicly funded cabinets of medical-psychological aid, however, have been established through initiatives by the Public Education Department. These are separate from the public health system. There is a network of psychotherapeutic cabinets in regional primary care settings, but these tend to provide medication only. In 2003, the Russian Ministry of Public Health passed a special decree that reinforced the further development of psychotherapeutic aid. According to this initiative, a wide network of counseling centers, inpatient psychotherapeutic wards in psychiatric and psychosomatic hospitals and psychotherapeutic cabinets in primary care settings were to be established. This network was to be financed from local budgets at discretion of local authorities. Further, multiprofessional teams made up of psychiatrists, clinical psychologists and social workers were to deliver care in these newly founded psychotherapeutic services.

Clinical psychologists are allowed to practice psychotherapy but only in cooperation with doctors who have a medical background. The right to practice psychotherapy by clinical psychologists is a matter of constant and heated debate within the Russian Association of Psychiatrists. The main obstacle to this multiprofessional approach is the shortage of well-trained specialists. Integration with social workers, for example, remains an initiative rather than being fully implemented. According to official statistics there are about 3000 psychotherapists (with a psychiatric background), about 3000 clinical psychologists and less than 1000 social workers within the mental health services in Russia today.

The most popular psychotherapeutic methods today appear to be: psychodrama, Gestalt-therapy, Peseshkian positive therapy and NLP. Wide acceptance of these methods may be due to the increased level of representatives of these theories visiting Russia from the West. With solid support from the International Association of Psychoanalysis, psychoanalysis has won a place in Russia. Interest in existential and humanistic approaches, for example, was highly stimulated by visits from Carl Rogers and Viktor Frankl. Today, the influence of existential orientations in Russia is attributed to the engaged activities of Alfred Längle. Family systemic psychotherapy is also growing in influence. Hanna Wiener, former IFTA President, trained the first groups of profes-

History of IFP: 1988–1998

sionals in family therapy. In spite of its historical link to Pavlovian theory, the cognitive behavioral approach is still one of the lesser known. The connection with Pavlov's ideas makes many specialists reluctant to adopt the ideas of CBT. In 1950 the Pavlov Session of the Academy of Sciences (a regular conference) prohibited psychological investigations. Since that time, the prohibition and its connection with Pavlovian theory has remained in the professional consciousness of many people. However, the division of clinical psychology and psychotherapy promotes the dissemination of cognitive psychotherapy. We are in ongoing communication with Aaron Beck of the Institute of Cognitive Therapy and Research. The authors of this article received a scholarship from the Beck Institute and underwent an extramural training course in cognitive therapy (we did some training work by our own and received feedback from our supervisors via e-mail and we also made visits to the Beck Institute).

Psychotherapy in Russia is currently going through a process of intensive growth and formation. Interest in its practice is strong but the qualification level of professionals and the lack of clear ethical norms and legislation are serious impediments to its successful development.

A.B. KHOLMOGOROVA

N.G. GARANIAN

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RUSSIA)

It is possible to consider an organisation like the IFP as if it were a living body - rushing through periods of unrestrained growth, marking time or growing in a more orderly fashion. The image of the tree might be an apposite one. Those in positions of responsibility have the job of tending this tree and nurturing it for an allotted span of time, which, in the case of my presidency, was ten years. I sometimes wonder how those ten years will eventually go down in history: perhaps as the «years of the new era» in the decade following the fall of the Berlin Wall?

Even before this new political era came into being, my predecessor, Finn Magnussen, had managed to create a certain opening towards the states behind the Iron Curtain. We succeeded in building further on these relationships and in developing them in a formal manner too. One clear practical outcome is probably to be seen in the fact that a specialist representative from the former German Democratic Republic, Prof. Michael Geyer of Leipzig, worked shoulder-to-shoulder with us for a number of years as General Secretary. Along with Artur Trenkel, who served as Treasurer for many years, the three of us formed the nucleus of the Board. Traditionally, the IF(M)P had stood for the interests of Western European countries, but what had to be done at that particular point in time was to attract new groups of entirely different countries. One of the prerequisites for that to become possible was to amend the Statutes or, to remain with the image of the tree, to prune away all unnecessary shoots and to encourage fresh growth. It astonished us when we realised that the old Statutes had remained virtually unamended since the IFP was re-created after the Second World War; at least they seemed to have remained intact since 1958. The first step was to ask the member societies to communicate their ideas and needs to us. This was followed by meticulous work on points of detail in the various official bodies of the IFP, in particular on the Executive Board, as it was called at the time (nowadays simply: «Board»), and on the Enlarged Board, which was later to become the «Council». At this stage, a draft was circulated to the members and a debate and preliminary vote took place during the General Assembly held in Hanover in September 1991. The extensive consultation of all the member societies culminated in a «write-in vote» in 1993, through which the revised Statutes were accepted with a broad measure of support.

Apart from the structures, the simplified proces-

sing of membership and a number of other matters, the IFP's goals were reformulated:

«The IFP is an international inter-professional cross-cultural federation. The IFP does not pursue profession-oriented politics. The goal of the IFP is to facilitate and promote international communication among the various schools, professional groups and cultures within psychotherapy. The IFP encourages and supports development within psychotherapy corresponding to the specific requirements and necessities of the various continents, regions and cultures.»

These general goals were then reformulated with greater precision in more operational language and checked as to the practical feasibility of implementing them. They, too, enjoyed broadly-based support, although individual advocates of the former structure had considerable difficulty in accepting the new emphasis on inter-professionalism. However, there was no denying the fact that particularly in the countries of Eastern Europe, but also in countries on the other continents, medical practitioners had long since ceased to be the only grouping active in psychotherapy and that various other members of the health-care professions were also actively involved and, as such, were consequently members of their national societies. In tune with this, the IFP changed and simplified its name from the old form of «International Federation for Medical Psychotherapy» to the new form of «International Federation for Psychotherapy».

The actual leadership of the reshaped federation was vested in the hands of the newly defined Board, which had two new members as of 1994: Wolfgang Senf as General Secretary and Ulrich Schnyder as Treasurer. We formed a dedicated, small team that met together several times a year. It is a good testimonial of their commitment to the IFP that both my colleagues were subsequently elected President of the organisation by the Council to which we were answerable. Apart from the rather radical pruning of the «IFP tree» through the reforms of the Statutes and structures, various other activities took place, either pre-empting this new direction or implementing it:

- The contacts with the countries of Eastern Europe were intensified. It was arranged for experienced teachers of psychotherapy from various teaching institutions to be put in touch on a voluntary basis with the regional centres and to support them in

organising key regional or national congresses;

- New attempts were launched to establish closer relations with countries outside of Europe. Repeatedly, it was confirmed that this could only be done successfully if the necessary «pacesetters» were in place;
- One example of this was when the traditionally Euro-centric federation first held out its hand to Asia, where the colleagues working in Seoul, South Korea, around Prof. Dongshick Rhee, a true doyen of the profession, organised the impressive and successful Sixteenth International IFP Congress in 1994 on the theme of «Psychotherapy: East & West (Integration of Psychotherapy)». It was a genuinely trans-cultural encounter, which had a durably enriching impact, particularly on those of us from Europe. For the region itself, it was the cradle of the regional organisation which was given due form later on and called APAP (an Asian-Pacific chapter of IFP), as if the «IFP tree» had spouted a new bough. Not long after, in 1996, APAP went on to organise its first regional conference in Bali, Indonesia;
- In the case of Africa, it was Prof. Peter Ebigbo of Enugu, Nigeria, who had trained in Europe and who was doing a really dedicated job of work in a newly-formed psychotherapy centre, who set about building up a network with colleagues in several African countries. The biggest obstacle to his endeavours to form an «African chapter of IFP» was the paucity of available financial resources. Only a few colleagues from other countries had adequate travel budgets. Despite that, his first regional conference turned out to be a success, and even the national minister of health contributed in person!
- Our long-standing Board member and Vice-President, Prof. Mauricio Knobel, set about establishing a chapter in South America and found himself confronted with similar difficulties. Nonetheless, a regional conference was staged in Belem do Para, Brazil, with the support of the IFP and organised by our Council member, Prof. Jayme Benarros;
- b Finally, the «IFP tree», cultivated by our colleagues in Europe, spouted another branch, culminating in 1998 when our Polish colleagues organised the Seventeenth World Congress in Warsaw on the subject of «Psychotherapy at the Turn of the Century – from Past to Future» with an impressive number of participants from Eastern Europe.

With their choice of title, Prof. Maria Siwiak-Kobayashi and her colleagues set a veritable challenge to all members of our guild.

Not everything that the IFP as an organisation set out to do in those ten years turned out to be a success. The resources (both in terms of finances and personnel) were too tight, and our plans were not always practicable. We are still missing a broad representation of the Mediterranean countries within the IFP. Some of Europe's national societies had already withdrawn by that time. Despite our efforts, we failed to find an adequate partnership in the USA. Today, many psychotherapists are not really bothered about joining a national or regional body and are much more committed to specialist societies following a particular school. Finally, especially within the European Union, the definition of the profession became more and more politicised, which led to new organisations, including some in competition with the IFP.

Despite all these critical reflections, the IFP has managed to become an element in a broad network. In today's parlance, presumably «globalisation» would be the apposite term for the breadth of its activities. That made it natural for us to try and establish partnerships with other umbrella organisations with a similar direction to ourselves. To list just the most important:

- SEPI, the Society for Exploration of Psychotherapy Integration, has the objective, reflected in its name, of integrating psychotherapy across various schools and methods;
- SPR, the Society for Psychotherapy Research, is the organisation which in many respects does the scientific spadework for specialist orientations to emerge later;
- WHO, the World Health Organisation, created a conference of the presidents of the astonishingly numerous umbrella organisations that are active in the field of mental health.

Today, the IFP ensures that there are regular exchanges with these organisations (and others too), and in some cases has even closer ties through individuals who serve as board members for other organisations as well. The «IFP tree» is thus not the only vegetation adorning the psycho landscape, but it is playing its part in forming a cluster whose common desire is to afford assistance to the many people whose sense of psychic wellbeing is severely buffeted in the storms – and even gales – that living

within a society causes for them.

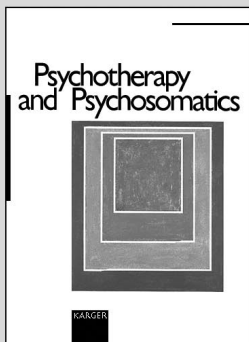
All these activities included many enriching meetings with other people. It is these that made the office-holders feel their voluntary endeavours were worthwhile, particularly when the attendant circumstances were frustrating or even hostile.

PROF. EDGAR HEIM, M.D.
President IFP 1988–1998

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As the volume of literature in the fields of psychotherapy and psychosomatics continues to grow, it becomes increasingly difficult to keep abreast of new and important developments. 'Psychotherapy and Psychosomatics' has gained a considerable reputation of independence. It has launched debates on issues such as the potential risks of antidepressant drugs, conflict of interest in medicine and national trends of research versus investments, and criteria for academic promotion. The journal features editorials and review articles on current and controversial issues; original investigations of psychotherapy research; the interface between medicine and behavioral sciences, as well as practical descriptions of psychotherapeutic models and techniques. Characterized by strong clinical orientation and rigorous methodological appraisal of contributions, 'Psychotherapy and Psychosomatics' comprises a unique and vital reference to current research.

Selected contributions

Depression and Folate Status in the US Population: **Morris, M.S.; Fava, M.; Jacques, P.F.; Selhub, J.; Rosenberg, I.H.** (Boston, Mass.)

Management of Recurrent Depression in Primary Care: **Fava, G.A.** (Bologna/Buffalo, N.Y.); **Ruini, C.** (Bologna); **Sonino, N.** (Padova)

Opportunistic 'Rediscovery' of Mental Disorders by the Pharmaceutical Industry: **Starcevic, V.** (Newcastle)
 Atypical Antipsychotic Drug Use and Diabetes: **Ananth, J.; Venkatesh, R.; Burgoyne, K.** (Torrance, Calif.); **Gunatilake, S.** (Norwalk, Calif.)

Assay Sensitivity, Failed Clinical Trials, and the Conduct of Science: **Otto, M.W.; Nierenberg, A.A.** (Boston, Mass.)

Tolerance in Antidepressant Treatment: **Baldessarini, R.J.; Ghaemi, S.N.; Viguera, A.C.** (Boston, Mass.)

Psychiatric Disorders and Coronary Heart Disease in Women – A Still Neglected Topic:

Review of the Literature from 1971 to 2000: **Bankier, B.; Littman, A.B.** (Boston, Mass.)

Therapeutic Interventions Focused on the Family of Bipolar Patients: **Reinares, M.; Colom, F.; Martínez-Arán, A.; Benabarre, A.; Vieta, E.** (Barcelona)

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Neuropsychotherapy



KLAUS GRAWE
Institute of Psychology
University of Bern

The «decade of the brain» has gone, but a century of progress in the brain sciences is on the horizon. Over the past fifteen years, groundbreaking research has begun to illuminate the neural foundations of experience and behavior. It is now clear that all we feel, act and think has very specific neural foundations. What does that mean for psychotherapy?

If all mental processes are grounded in neural processes, then changes in mental processes should also be grounded in detectable changes in neural processes. The evidence clearly indicates that mental processes can be effectively and permanently altered through psychotherapy. That means that the effectiveness of psychotherapy – in cases when therapy is effective – is mediated by its effects on the brain. When therapy doesn't alter the brain, it cannot be effective. In LeDoux's words: «Psychotherapy is fundamentally a learning process for its patients, and as such is a way to rewire the brain. In this sense, psychotherapy ultimately uses biological mechanisms to treat mental illness.» (LeDoux 2002, 299)

This is quite an unusual line of thinking for most psychotherapists, and not just for them. Let's consider the nobel prize winners Eric Kandel's position on this. Kandel -who incidentally began his scientific career as a psychiatrist – received his nobel award four years ago for his research on the neural basis of long term learning. Kandel says:

«It is a fascinating idea that psychotherapy, as far as it leads to substantial behavior change, appears to achieve its effect through changes in gene expression at the neuronal level. An analogue line of thinking suggests, then, that neurotic disorders are linked with changes in neural structure and function, just as specific forms of mental illness include structural (anatomical) brain changes. Consequently, any successful – psychotherapeutic treatment of the neuroses and personality disorders would also trigger structural changes in the involved neurons. With the improved resolution of neuroimaging methods, we are now at the brink of the fascinating possibility to use these tools not merely for the diagnosis of mental illness but also to ensure the effectiveness of psychotherapies (Kandel 1996, 711).

To be sure, we are not there yet. But the direction towards which these developments can (and will likely) move is becoming increasingly clear. Indeed, it would seem a most attractive option to replace our current merely descriptive but non-explanatory diagnostic systems (DSM and ICD) with a more func-

tional taxonomy; one that classifies phenomena based on their pathogenesis. Truly immense progress would be achieved, indeed, if we were to determine with precision which aspects of the brain would have to be altered in order to attain specific desired changes in experience and behavior. The task of neuropsychotherapy research would then be to determine which kinds of events a patient must experience in order for the desired brain changes to follow. The task of the neuropsychotherapy practitioner, ultimately, would be to ensure that such theoretically needed experiences become concrete patient reality.

At this point, all this seems rather utopian. Actually Neuroscientists and psychotherapists live in separate worlds that are quite removed from one another. It has only been a short time since they began to develop any degree of mutual interest. An area that could be a natural bridge, though, is their common interest in mental disorders. First, the interest of the neuroscientists in this area had been stimulated primarily by the discovery of specific neural correlates of mental disorders and the functional significance of neurotransmitters for them. Subsequently, however, neuroscientists discovered the enormous plasticity of the brain by environmental influences. It became increasingly clear that the genetic contribution to manifest mental disorders is far smaller than previously assumed, and that individual life experiences play a much larger role in determining gene expression. It also became clear that plasticity functions in two ways: Facilitating disorders on the one hand but on the other hand also alleviating or compensating symptoms. Since these discoveries, neuroscientific articles and books are increasingly ending with speculations on the possibilities to target neural structures and processes via psychotherapeutic means, or with speculations on how psychotherapy might be further developed from a neuroscientific perspective. Such ideas, however, tend to be found at the end of thick books that otherwise are silent on the topic; they are still unfulfilled visions of the future.

Psychotherapists, vice versa, have also become increasingly interested in the neurosciences over the past six years. There is by now a considerable number of publications that either generally review neuroscientific findings with an eye on potential therapeutic applications or that focus on specific research areas and deduce psychotherapeutic prin-

principles from them (in chronological order: Deneke, 1999; Liggan und Kay, 1999; Gabbard, 2000; Beutel, 2002; Bock & Braun, 2002; Förstl, 2002; Storch, 2002; Sulz, 2002; Westen & Gabbard, 2002 a, 2002b, Caspar, 2003; Schiepek, 2003; Grawe, 2004 – see list at the end of the paper).

This movement resembles an emerging tidal wave. At the last IFP-congress in Trondheim in 2002, Glen Gabbard gave a keynote lecture on the topic «The revolution in the neurosciences: Implications for psychotherapy research and practice» (Gabbard, 2002). The presidential address of the Annual Meeting of the Society for Psychotherapy Research by Franz Caspar was on Psychotherapy Research and Psychobiology; 2003 Schiepek edited a German book on «The Neurobiology of Psychotherapy» and recently a book by myself with the title «Neuropsychotherapy» has appeared. In short, over a short period, neuroscience has emerged as a hot topic for psychotherapists.

I am all in favor of this development. But I also believe that the implications of neuroscientific research for psychotherapy are more far-reaching than is often acknowledged in the publications and presentations on this topic. The adherers to a specific therapy approach tend to pick up those findings that fit well within the pre-existing perspectives of this approach; the rest is gladly ignored. Neuroscientific research, however, can mean much more for psychotherapy than just support of what one is already convinced of. The insights gained by neuroscience can help us to overcome the limitations of the different schools of psychotherapy. They constitute a long needed fresh input to psychotherapy. They point to a road away from the well-trodden paths of the traditional therapy schools.

Together with recent findings from empirical psychology and psychotherapy research they offer really new explanations and innovative concepts for the development and treatment of mental disorders. In the following I will try to illuminate some of these consequences of the latest research in these fields for our understanding of psychotherapy. I will take the treatment of depression as an example because the brain of depressive patients has become an especially well investigated topic of neuroscientific research during the last fifteen years.

I will embed the neuroscientific results in the thoughts that go through a therapist's mind while he is treating a depressive patient. We could call such a

therapist who systematically uses neuroscientific insights in his work with patients a neuropsychotherapist. Each statement I will make in the following case description is based on the findings of empirical studies. The specific references are of course important, but I am omitting them here in the interest of flow and understandability. A few references that summarize neuroscientific results on the brain of depressive patients are listed at the end of the paper.

Let's imagine a therapy situation in which a therapist faces a depressive female patient, Ms. B. As in every therapy session, Ms. B. sits in her chair with a sad, fatigued facial expression, as if paralyzed, making no effort whatsoever to take initiative. Instead, she waits for the therapist's action. The therapist engages with her in a friendly and caring manner, asking her how she feels and if she is able to have the therapy session today. She responds with a bitter, muted tone of voice, stating that she obviously doesn't have a choice, that nothing would change anyway, and that there is no point to begin with. Similar exchanges have occurred in previous sessions; they are typical for this patient. They are also typical in interactions occurring outside of therapy.

The therapist might relatively quickly have arrived at a conceptualization of this recurring interaction pattern. He considers whether he should try to help the patient realize how her behavior repeatedly triggers disappointing experiences by making her interaction partners feel helpless and, ultimately, angry towards her. He considers whether he should attempt to clarify the fears and wishes that give rise to this self-damaging interactional pattern, and which strategies he could use to alleviate her fears. It probably wouldn't be easy for him to control his own feelings of helplessness and anger, which naturally arise in interactions with this patient, but he knows that this is important in order to avoid a renewed confirmation and strengthening of the patient's fears.

These are typical considerations that a well-trained modern psychotherapist might come up with when faced with such a clinical situation. A neuropsychotherapist would also consider all of these possibilities. However, other considerations would be in the forefront.

Our neuropsychotherapist would think of Ms. B.'s enlarged and overactivated amygdala, which selectively and overly sensitively responds to negative situations. He would consider that the amygdala has

particularly well developed connections to the ventromedial parts of the right prefrontal cortex, whose activation is linked with negative emotional states. He knows about the wealth of firmly established projections between this area and the dorsolateral regions of the prefrontal cortex, which is critically involved in the activation of avoidance goals. In addition, he would realize how impoverished the corresponding areas in the left hemisphere are, due to their insufficient activation – areas that play an important role in positive emotions and the pursuit of approach goals. The therapist would envision a wealth of elaborately developed synapses connecting the projection areas for the activation of avoidance goals with those responsible for the production and maintenance of negative emotions. These connecting areas might be envisioned by the therapist as «brain swellings» because of their rich and elaborate development.

These projection regions which are particularly well developed in the case of Ms. B., are themselves linked with many other brain regions; for example, with areas that govern facial expression, speech modulation, motor activity, and bodily arousal. The neurons in those regions, however, could also be linked with entirely different neural activation patterns, once they are no longer chronically bombarded by the overactive brain regions. Such new activation patterns would then have the effect that entirely new possibilities would open up for Ms. B.

While he is still thinking of the «brain swellings» and their consequences, the therapist also begins to envision how a chronically elevated cortisol level has led to a noticeably damaged and shrunken hippocampus. A hippocampus in this state won't be of much use for Ms. B., even though it is critically important for the learning of new relationships, such as the relationship between her behavior and that of her interaction partners, or for the acquisition of new memory contents more generally. The therapist also considers that, for a large proportion of depressed patients, the anterior cingulate cortex (ACC) has become difficult to activate. This region plays an important role for the active engagement with difficulties and for the conscious experiencing of feelings. Both functions are therefore only partially available to the depressed patient.

The therapist realizes: It is not sensible to work with this patient directly on her problem behavior. First, he must rebuild the impoverished brain

regions because their easy activation will be necessary to enable the patient to pursue positive goals once again in a self-initiated, self-governed manner; to enable her to experience joy and contentment; and to become open and accessible for the learning of relationships that she must understand in order to consciously regulate her interpersonal encounters in new patterns. The therapist has completely internalized the neuroscientific rule of thumb, «use it or lose it». He knows that the impoverished neurons and synapses must be activated in order for them to «recover». Once this is accomplished, they will be more easily reactivated and ultimately can once again play an important role in the patient's thinking, feeling, and actions. She will then be re-enabled to pursue positive goals and experience positive emotions.

Activating impoverished neurons and synapses is not easy, though, because they tend to resist such efforts. The synapses are weak and must first be strengthened; that is, the neurons which they connect must be activated in order to ingrain the connecting pathway. This is the second rule of thumb, known as Hebb's principle, which the therapist has internalized: «Neurons that fire together wire together» (based on the Canadian psychologist Donald Hebb, who already in 1949 recognized and anticipated several principles of neuronal functioning that remain valid today). In the case of Ms. B., the neurons in the right dorsolateral and ventromedial prefrontal cortex have already fired together very frequently with those in the amygdala. This has led to a well ingrained neuronal circuit (a cell assembly, in Donald Hebb's words). This circuit can be very easily activated; for example, by even the slightest sign of impatience in the voice of the therapist. The circuit will also recurrently re-activate as if automatically, by itself, whenever Ms. B. is left on her own. Each activation is accompanied by depressive experiencing and behavior, and with each activation, the connections among the projection areas are increasingly firmly ingrained.

The therapist thus realizes: He must block the activation of these hyper-developed connections and in turn activate the impoverished synapses in the left prefrontal cortex as often as possible. If he succeeds in this quest, he can expect that Ms. B. once again becomes more active, that she experiences positive emotions more often, and that her previously dormant positive repertoire once again moves to the

forefront - the repertoire that has always been present in the form of memory traces (synaptic activation potentials), even though these traces were previously weakened. From the perspective of the therapist, Ms. B. at this point is not able to behave more positively, given the current state of her brain. It is not resistance that prevents her from engaging more constructively in therapy. In her state, she cannot simply decide to view the world more positively or to self-initiate and engage with positive activities. The knowledge about Ms. B.'s neuronally mediated inability helps the therapist to not feel angry towards her, as has been the case with many others in her environment. The therapist also does not feel helpless and incapacitated by her because he knows how he can assist her.

The therapist knows that he must take the initiative and responsibility and make himself independent of her depressive interactional patterns. He must enable Ms. B. to experience events, as frequently as possible, that trigger positive emotions in her, or that are likely to be highly relevant for her positive motivational goals (even though these goals might be hard to recognize given her current depressive state). The therapist can trust in the reactivating «power» of these motivational goals because, over the course of Ms. B.'s lifetime, they have become even more deeply ingrained than the synaptic connections corresponding to Ms. B.'s current depressive state. The therapist also knows in advance that his efforts will not be reinforced initially by changes in Ms. B.'s state. Because of this knowledge, though, he does not react with disappointment and impatience when his efforts at first appear to have no effect on her. He knows that the transcription process of gene expression, which is being stimulated by sufficiently frequent positive experiences, requires several weeks to manifest in a noticeably increased number of synapses. The key point to remember at this stage is simply that he must not be discouraged and stop with the facilitation of frequent positive experiences. The creation of new and the re-strengthening of already present synapses takes time.

For this purpose he uses the strategy of behavioral activation, originally developed by Lewinsohn, having in mind that this strategy alone, according to recent studies, has proven to be equally effective with depressives as Beck's cognitive-behavioral therapy. In addition he uses the rich repertoire of techniques of resource activation he has acquired in

special training courses after his original therapy training.

Another aspect not to be neglected are the many negative thoughts and emotions that Ms. B. experiences frequently, especially at times when she is alone. As long as these negative patterns continue to take up a large proportion of her mental activity, there is simply not enough room for the positive activation patterns that the therapist wants to facilitate. The negative patterns must be reduced or blocked. On the neural level, this means that the neural activation patterns must not be activated as frequently anymore or, should they become activated, that their activation must be disrupted or blocked as quickly as possible.

For this purpose, the therapist solicits the assistance of Ms. B.'s most important reference persons, in her case her husband and her two adolescent children. He explains to them that his wife/their mother is feeling so poorly because three brain areas that chronically produce negative emotions have developed disproportionately. He shows them a picture of the brain that illustrates this process and responds to their questions. He emphasizes that this is not her fault; that she cannot easily overcome this by herself and is not responsible for her state. Equally, he tells them there is much that can be done in order to help her, and that they can actively participate in this process. He notes that the brain cells are like muscles; if they are not used, they wither away, but if they are used continuously they become stronger. The neurons of their mother/his wife in those three areas are like highly trained muscles, with the important difference that she cannot turn them on and off by sheer willpower. This switching must come from the outside, and they can help with it, by including her in as many positive activities as possible, by not letting her just sit there by herself, left with her ruminations, but instead by engaging her in ever new activities. They should feel free to interrupt Ms. B.'s ruminating and worrying at any time. The therapist discusses this with them in great detail and supports the family in translating these principles into action, by speaking with them every couple of days on the telephone and inquiring how things are going and encouraging them to stick with the program.

A few weeks after the initiation of these resource-activating and problem-behavior-blocking interventions the first clear signs of improvement become evident in Ms. B. After three months, her depressive

symptoms have largely disappeared. If one were to use neuroimaging tools at this point, the initially clear asymmetry in the prefrontal cortex would no longer be evident. Even the size of her hippocampus would have normalized. The therapist now administers Beck's depression questionnaire and notes that Ms. B. scores within the range achieved by normal, non-depressed people.

Many therapists would find it quite obvious that therapy should be terminated at this point. After all, Ms. B. and her family regard therapy as a complete success; all are satisfied with the outcome. Our neuropsychologist however, would not go with this option because he has arrived at a conceptualization of Ms. B.'s case that prevents him from being completely content at this stage. He remembers the scientific findings that suggest that Ms. B., over the course of the next two years, has a 60–80% chance of experiencing another depressive episode (Elkin, 1994) if he terminates therapy at this point.

Up to now, Ms. B.'s therapy was purely symptom-oriented. The point was to change the neural underpinnings of her depressive symptoms and to move her once again into the range of «normal» mental functioning. The therapist's intention to continue therapy is related to his understanding of how Ms. B.'s depression originated in the first place.

It had been Ms. B.'s first depressive episode. Everyone had agreed that she had not been depressed a year earlier, even though she had for some time already been nervous, anxious, and somehow more stressed than at other times, but certainly not depressed. Slowly over time everything seemed to become overwhelming for her, she lost all energy, until eventually she did not feel up to anything at all anymore.

Let's translate what we know about Ms. B.'s depression and its history onto the neural level. How did the changes in her brain come about over the course of the last year? Synapses multiply and gain in strength when they are frequently activated, and they weaken when they are not activated for some time, which can be a consequence of an active blocking of the synapse. A year ago Ms. B. had still actively pursued goals and experienced positive emotions. Her left prefrontal cortex had not been as reduced as it was at the beginning of therapy, and her right prefrontal cortex had not been as over-developed at that time. The neurons and synapses in this area must have been recurrently activated since

then, which facilitated their strong development. Their activation was linked with negative emotions and with avoidance behavior. Thus, Ms. B. must over the course of the last year have experienced increasingly negative emotions and must have tended to avoid more and more situations. This probably led to an active blocking of left prefrontal cortex activation, such that the synaptic connections in that region began to reduce. This, in turn, was associated with Ms. B.'s tendency to pursue fewer and fewer approach goals and her reduced ability to experience joy.

Negative emotions arise primarily when events occur that have negative implications for our goals. The more important the goal, the stronger the negative emotion. There must have been events in Ms. B.'s life over the last year – or even during the longer preceding period during which she appeared anxious and stressed – that constituted a threat or an obstacle for her important goals. There is no other way to explain the over-developed state of those brain regions associated with the experience of negative emotions at the beginning of therapy. These threat- or loss-related emotions must not have been consciously experienced by Ms. B., in the same way as the threatened or lost goals must not have been consciously represented. The activation of the corresponding brain areas must not have been linked with consciously represented experience. On the contrary, the conscious awareness that important goals are not being attained, or that something of great importance has been lost, produces in itself a pronounced cognitive dissonance, which, according to Festinger's well-validated dissonance theory, is usually avoided at all costs.

Because of this, there was no conscious engagement with the events and situations that for Ms. B. constituted a threat or a loss for her implicit goal system. This process led to the emergence of strong avoidance tendencies – so strong, indeed, that the dorsolateral part of the prefrontal cortex, which is implicated in the representation of avoidance goals, was over-developed at the beginning of therapy because of its chronic activation. At the beginning of therapy, then, Ms. B. is in a state of generalized avoidance. She no longer engages with her environment and no longer responds to challenges because she expects only unpleasant, overwhelming, and negative events to follow. From this perspective, her depressive state is a generalized protective reaction

against the environment. This state is characterized by inactivity only on the level of outward appearances, only in terms of her actual exchanges with the environment. Despite this appearance of inactivity, the avoidance system is highly activated and along with it, the HPA (Hypothalamic-Pituitary Adrenal) axis, which responds to stress with increased release of cortisol. Chronic stress is not at all healthy, and certainly not for the hippocampus, which is being damaged by this high cortisol level to such a degree that its volume shrinks measurably.

Viewed from this perspective, Ms. B. has experienced over the last year a cascade of neural events, a chain reaction of positive feedback loops that

resulted in heightened synaptic action potentials, even though the neurons participating in this cascade had returned to a deactivated state by the end of therapy. As soon as Ms. B. – after relinquishing the sick role and overcoming her acute depressive state, both of which provided some protection - is exposed once again to the same influences and experiences that triggered the cascade originally, we can expect that the synapses that led to the depressive state are already primed, ready to be re-activated. These synapses are easily activated again when the same stimuli, experiences, and life events are once again encountered. And why should they not? Nothing has changed in terms of her life situation, except that

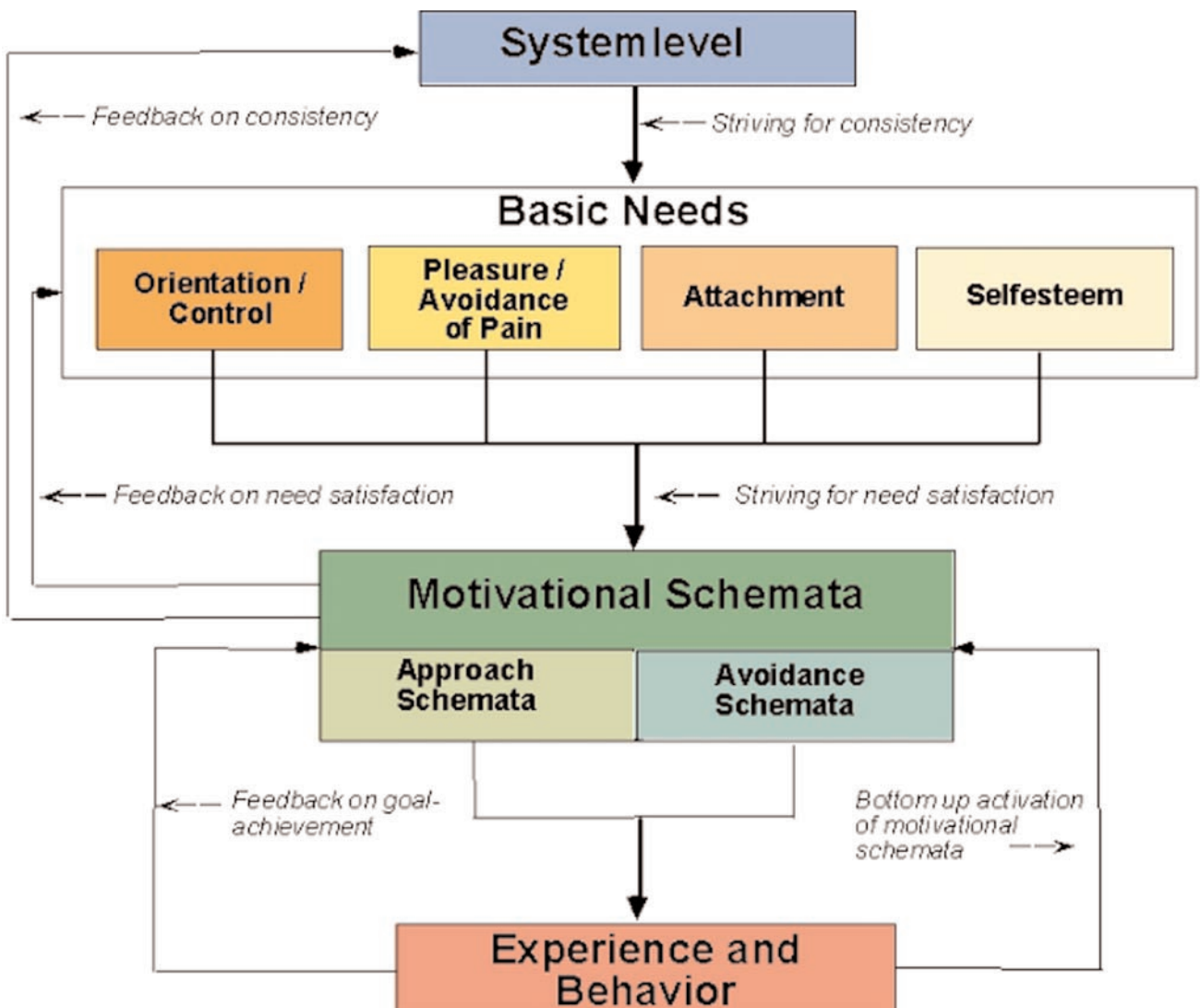


Fig. 1: The consistency theory model of mental functioning)

she is now no longer sick and will surely once again be confronted with her old set of demands and challenges. There is a high probability that the same events that led to the first depression will recur in a similar fashion. One difference is that this process should now transpire more quickly than the first time because of the neural priming. This is what happens quite regularly with depression; most depressions are indeed marked by recurring depressive episodes.

What I have tried to illuminate with this case example of a depressive patient holds true for mental disorders in general. All mental disorders have a specific foundation in very well ingrained neural activation patterns. The facilitation of these neural activation tendencies needs time, at least weeks, if not much more. During this time the patient must have been under the influence of specific life experiences which facilitated these neural activation tendencies and made him or her sick eventually. It must have been negative life experiences, experiences that had a negative meaning for important motivational goals of the patient. We also could say: There must have been permanent perceptions that were incongruent with the motivational goals of the patient. Without these negative life-experiences the genes for the development of exactly this specific disorder wouldn't have been expressed.

(see Figure 1, page 16: The consistency theory model of mental functioning)

If we regard the motivational goals an individual develops over his or her lifetime as his or her means for satisfying and protecting his or her basic needs we can regard the development of mental disorders lastly as the result of negative life-experiences that accumulate to a high degree of incongruence between motivational goals and real life experiences. A good need satisfaction is equivalent to a low level of incongruence and both go together with a good well being and mental health. They are the best protection against the development of mental disorders. A high level of motivational incongruence, vice versa, is a breeding ground for the development of mental disorders.

In a state when very important motivational goals are activated but not achieved the basic need for

control is strongly activated. Any neural activation pattern that in this situation gives some control over the aversive state of high prolonged incongruence is reinforced and will be especially effectively ingrained. Most, if not all mental disorders have such a control component as a lead symptom: The Worrying in Generalized Anxiety Disorder, the self-centered attention in Social Phobia and Panic Disorder, the avoidance in agoraphobia and so on. The simultaneous activation of the negative arousal caused by the blocking or frustration of important motivational goals and of this control component are bound together according to Hebb's law «What fires together wires together». The release of dopamin that regularly accompanies the activation of important goals has the effect that the synapses activated at that moment are especially effectively strengthened. By frequent repetition of these activation processes during a phase of high motivational incongruence the new neural activation pattern will become deeply ingrained.

After having been deeply ingrained the new neural activation pattern corresponding to experience and behavior that characterizes a specific mental disorder becomes independent from its original causes. Something new has emerged and plays now a partly independent role in mental functioning. This new pattern of experience and behavior doesn't have a need satisfying or protecting function. Rather it violates by itself the basic needs of the individual, because it means a loss of control, it is aversive, and it damages the self-esteem. Thus the existence of a mental disorder increases the level of motivational incongruence in the long run although the disorder, at the moment of its emergence, has an incongruence reducing function.

The conditions that caused the incongruence leading to the facilitation of the neural basis of the disorder are mostly not just some aversive external conditions in the environment that come and go. They are rather themselves well ingrained neural activation patterns within the same nervous system that produced the disorder. Life experiences leading to high motivational incongruence are mostly not independent from the behavior of the individual with his or her specific motivational schemata, deficits and resources. All of them have a neural basis. Thus the condition of the brain that produces a mental disorder belongs itself to the causes of the disorder. Therapy shouldn't target only the neural

activation patterns that are the product of high incongruence but also those activation patterns leading to the incongruence. They have facilitated the emergence of the disorder. They therefore should be an equally important target of therapeutic interventions like the disorder itself. Both targets can only be achieved by effectively changing the neural activation patterns underlying the problematic experience and behavior.

Incongruence can be seen as a specific and especially important form of inconsistency in mental functioning. Inconsistency means that simultaneously activated neural or mental processes are not compatible or inconsistent with each other. For example if approach and avoidance tendencies are simultaneously activated or if implicit motives and explicit goals are not in agreement with each other. Inconsistency damages the effectiveness of the goal oriented transactions with the environment and leads eventually to incongruence between motivational goals and perceptions representing reality, another form of inconsistency between simultaneously activated mental processes. Thus all forms of inconsistency in mental functioning lead in the end

to motivational incongruence and by that increase the risk for the development of mental disorders.

The empirical correlations between different forms of inconsistency and psychopathology have been the subject of intensive research during the past decade. In a metaanalysis of 58 studies investigating the correlation between some form of inconsistency in mental functioning on the one side and some aspect of well being or psychopathology on the other side we found consistent support for the assumption that inconsistency/incongruence and mental health are strongly connected (Fries & Grawe, 2004). I have not enough time to report the results of this metaanalysis in detail. But I will present some results of our own research with psychotherapy patients on the correlations between motivational incongruence and psychopathology.

Over the last few years we developed inventories for the measurement of motivational approach and avoidance goals and incongruence related to these goals. The incongruence inventory measures the general level of incongruence and where the incongruence comes from. The questions the test person has to answer look like that:

K-INK		Part 1				
Recently I've...		much too little			fully sufficiently	
1.	been productive	1	2	3	4	5
2.	been independent	1	2	3	4	5
3.	had faith in myself	1	2	3	4	5
...
13.	stuck up for the weak or needy	1	2	3	4	5
14.	lived a life full of variety	1	2	3	4	5

K-INK		Part 2				
Recently I've...		Is not true at all			Is absolutely true	
15.	been faced with accusations	1	2	3	4	5
16.	had to show my weaknesses to others	1	2	3	4	5
...
22.	felt deserted by others	1	2	3	4	5
23.	not lived up to some standard or expectation	1	2	3	4	5

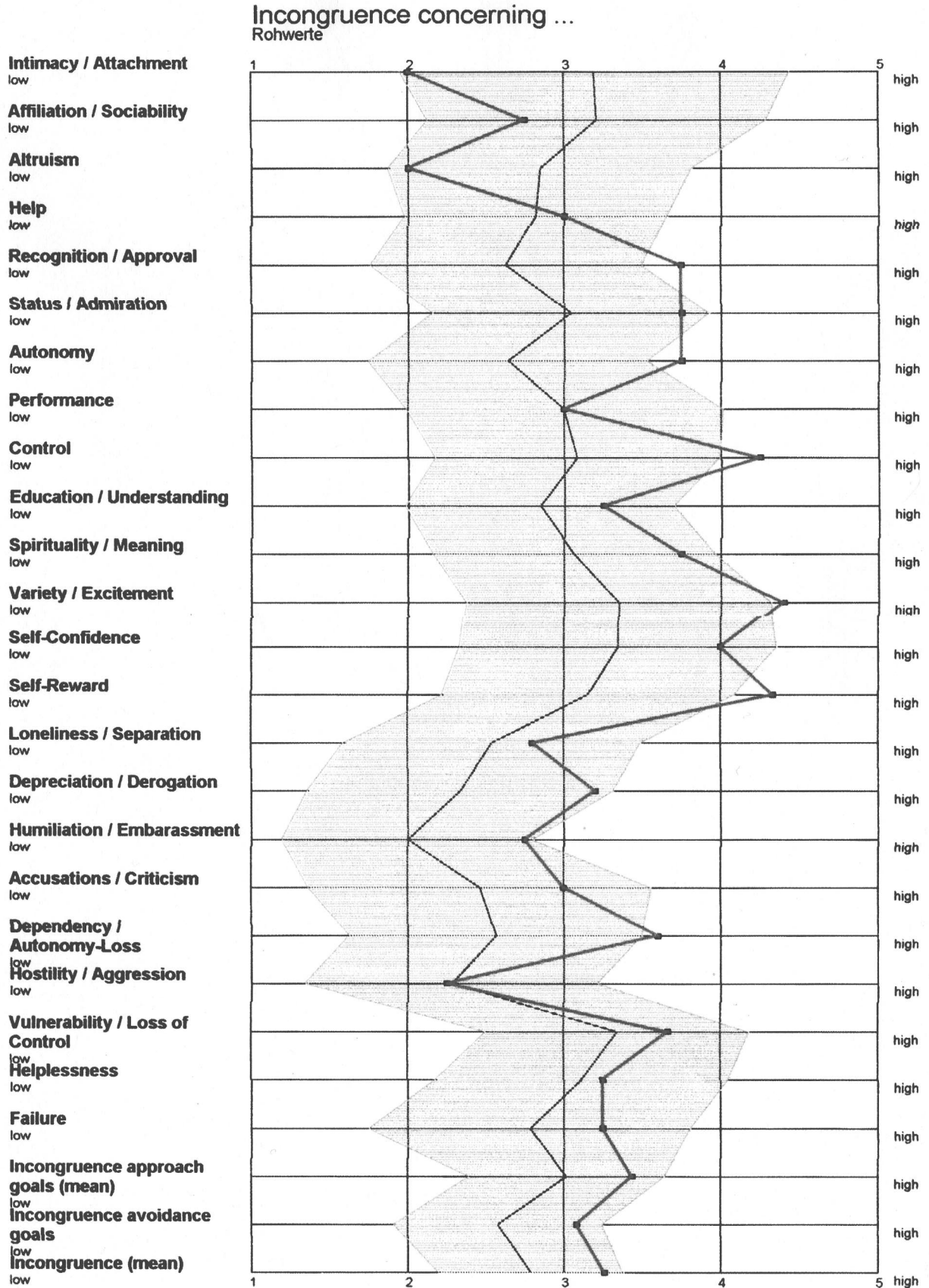


Fig. 2: Shows as an example an incongruence-profile that resulted from this inventory for a depressive patient.

Incongruence as measured with this inventory actually correlates, as assumed by consistency theory, highly significantly with low well being and a high level of psychopathology as measured with the SCL 90R.

It also correlates with other variables of clinical significance like interpersonal problems, intensity of avoidance goals, a lack of coping abilities and underdeveloped resources. All these variables can be regarded as potential sources of incongruence.

If a patient has a high level of incongruence measured with this inventory the next question is of course where the incongruence comes from. This question is of high therapeutic relevance because the incongruence-sources are all potential targets of therapeutic interventions aiming at one common goal: The reduction of the level of incongruence in mental functioning of this patient. In order to identify the most important sources of incongruence we developed an incongruence analysis according to the following scheme:

Level of incongruence

- | | |
|---|-----------------|
| ▪ wellbeing | $r = -.78$ |
| ▪ positive resources (self-report): | $r = -.40/-.68$ |
| ▪ positive resources (evaluation by significant others) | $r = -.30/-.37$ |
| ▪ conflict level | $r = .23$ |
| ▪ intensity of avoidance goal | $r = .40$ |
| ▪ interpersonal problems (IIP) | $r = .58$ |
| ▪ symptom level SCL-90 GSI | $r = .68$ |

Table 1: Incongruence analysis: correlation of incongruence with clinical variables

Therapists who have been trained according to this conception don't only target the specific disorders of the patient with disorder-specific interventions but also the different sources of incongruence that have been identified in the incongruence analysis. For this purpose they use all intervention techniques that have been elaborated in the different therapy approaches over the last hundred years. According to the view outlined so far there is no reason to restrict the therapeutic repertoire to that of a specific therapy approach. Different sources of incongruence need different approaches and techniques. Intervention techniques stemming from different therapy approaches can be combined within the same therapy case in or to achieve the best possible outcome.

Actually it is possible to reduce incongruence by a combination of techniques as effectively as mental disorders by disorder specific interventions. The effect sizes are in a similar range.

It is also consistent with the assumptions of consistency theory that the reduction of incongruence during therapy is highly correlated with improvements in those areas that can be regarded as sources of incongruence.

Lower incongruence level

- | | |
|--------------------------------------|------------|
| ▪ improved wellbeing | $r = -.76$ |
| ▪ better realization of resources | $r = -.67$ |
| ▪ more constructive thinking | $r = -.59$ |
| ▪ improved self-efficacy expectation | $r = -.48$ |
| ▪ less interpersonal problems (IIP) | $r = .47$ |
| ▪ less avoidance goals | $r = .48$ |
| ▪ lower symptoms level (GSI) | $r = .64$ |
| ▪ less depression (BDI) | $r = .64$ |

Table 2: Correlation of change in incongruence and changes in other clinical variables

If symptoms have incongruence reducing function as consistency theory assumes then there is less need for this function when the incongruence level is low. And, of course, incongruence should be low only if the important sources of incongruence have been effectively diminished.

Conclusion

I started my talk with reflections on the consequences that the insights gained in the neurosciences might have for psychotherapy. It might have been a surprise to some of you that a neuroscientific view of mental disorders leads to the conclusion that psychotherapy shouldn't only target the neural foundations of the disorders themselves but also the neural foundations of the motivational processes that laid the ground for the development of the disorders in the single case. Neuroscience has of course much more to say about the brain conditions that favor the emergence of mental disorders. I had not enough time here to show in more detail that there is convincing evidence that it is traumatic experiences related to the basic needs of an individual that make the brain ready for the development of mental disorders. You can find more evidence for that in my book with the same title as my

talk here today. The neural traces of these negative experiences are as important for therapeutic change as the neural correlates of the disorders. Both have to be changed effectively in order to achieve the best possible therapeutic outcome. Many tools for changing these neural activation tendencies are already available but until now they are distributed over the whole range of different therapeutic approaches and thus are separated from each other. They are therefore only seldom simultaneously or successively applied by the same therapist in the single case. The main reason for that is the incompatibility between the leading therapy approaches on the theoretical level. A neuroscientific view of mental disorder doesn't fit with the core assumptions of any therapy school. Behavior theory and Psychoanalysis for example, according to neuroscientific results, are both partly right, but they are at the same time in other parts of their theory definitely wrong. Integration of these theories is not a promising way for psychotherapy. We need new theoretic approaches with a far better explanatory power. Neuroscience can help us to develop a theory of psychotherapy that gives us a deeper understanding of mental disorders and of the processes leading to effective and long lasting therapeutic change. Such a theory would enable us to make use of the full repertoire of intervention techniques that already exist. If we develop a sound case conception that addresses all factors that contribute to the bad condition of the patient and if we are ready to combine all interventions, that have proven to be effective, in a tailor made treatment plan for each individual patient, then we will on the average achieve far better treatment outcomes in psychotherapy than we do now. The neuroscientific study of mental disorders is just in its beginnings. We can take it for sure that there will be a rapid progress in the neuroscientific understanding of mental disorders already within the next two decades. Time has come for psychotherapists to play an active role in this new development. We should be open to adapt our extant conceptions to these coming new neuroscientific insights instead of recruiting the neuroscientific results for the preservation of our old conceptions. A Neuropsychotherapy will be different from all existing approaches in psychotherapy. Neuropsychotherapy is just in its beginnings. We can feel privileged to be able to take part in this new endeavor that will lead psychotherapy to new horizons. If we don't do it, others will do it. The future has already begun.

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